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It is hard to overstate the importance of insurance in personal and commercial life. It is the key means by which individuals and businesses are able to reduce the financial impact of a risk occurring. Reinsurance is equally significant; it protects insurers against very large claims and helps to obtain an international spread of risk. Insurance and reinsurance play an important role in the world economy. It is an increasingly global industry, with emerging markets in Asia and Latin America developing apace.

Given the expanding reach of the industry, there is a need for a source of reference that analyses recent developments in the key jurisdictions on a comparative basis. This volume, to which leading insurance and reinsurance practitioners around the world have made valuable contributions, seeks to fulfil that need. I would like to thank all of the contributors for their work in compiling this volume.

Insured losses in 2018 have been estimated at between US$79 billion and US$90 billion, a 40 per cent reduction from the disastrous 2017, but still above the 10-year average. While no single event stands out, the aggregation of losses from hurricanes Michael and Florence in the United States, and typhoons Jebi, Trami and Mangkhut in the Asia-Pacific region, along with earthquake losses and the California fires has been significant. Also noteworthy in 2018 were the number and scale of cyber events, including the huge data breaches of Facebook and Marriott International, which may be a portent of things to come. Events such as these test not only insurers and reinsurers but also the rigour of the law. Insurance and reinsurance disputes provide a never-ending array of complex legal issues, and new points for the courts and arbitral tribunals to consider.

Looking ahead, 2019 is likely to see new developments and new legal issues. In particular, the impact of insurtech on the way in which insurance is underwritten, serviced and distributed will present challenges around the world. To reflect this, we have added a new chapter on artificial intelligence.

I hope that you find this seventh edition of The Insurance and Reinsurance Law Review of use in seeking to understand today’s legal challenges, and I would like once again to thank all the contributors.

Peter Rogan
Ince Gordon Dadds LLP
London
April 2019
Chapter 1

ARTIFICIAL INTELLIGENCE

Simon Cooper

I INTRODUCTION

The rapid development of artificial intelligence (AI) is bringing about fundamental changes to the insurance industry. In the long term, organisations that are slow to embrace this new technology will struggle to compete and to retain their place in the market.

In the insurance sector, the use of AI is known as ‘insurtech’. This is an elastic term that includes the use of complex algorithms to analyse data and associated technologies such as chatbots, robotics, telematics and gamification. Blockchain may also be included in this definition.

These innovations are impacting the consumer market and the markets servicing small and medium-sized enterprises, and it seems inevitable that as the technology beds down, it will expand into more complex risks.

The discussion that follows provides an overview of the current and future use of insurtech and also seeks to highlight some of the commercial, legal and even philosophical issues that its use will raise.

II INSURANCE UNDERWRITING

Insurtech is deployed in two principal areas of the underwriting process: the gathering and analysis of data to create personalised policies, and the elimination of repetitive tasks and unnecessary delays. Essentially, this involves the combination of highly specific source data from the potential insured and broader big data, with the application of algorithms to the material to provide a fast but targeted risk analysis.

III USAGE-BASED INSURANCE

One of the major innovations that insurtech has introduced is usage-based insurance (UBI), which is used to develop more personalised insurance products. Personalisation is achieved by the use of algorithms to analyse the insured’s own data together with external information from a broad range of sources to generate a bespoke risk score. This process is intended to significantly improve the relevance of the insurance to the buyer, as well as the underwriter’s ability to assess risk.

Pay-as-you-drive insurance is at the forefront of this process and there are a number of examples in the market. This insurance is priced on the basis of a fixed cost for the car's
stationary risk, such as fire and theft, and a flexible element that is based on the number of miles driven each month. Mileage information is collected through the use of telematics, which involves a ‘black box’ in the car to relay information to the insurer in real time. Drivers can also see the cost of their insurance as it is incurred.

More particularly, however, insurance can be tailored not only by reference to how far an insured drives but also by reference to how the insured drives. This will involve the use of telematics to monitor variables such as the speed at which a vehicle is driven on different kinds of road, whether the driver brakes or accelerates sharply, whether the driver takes rests on long drives, and where and when the car is driven. This information is transmitted from the black box in the car to the insurer. It is then compared with data from others to set a premium. Clearly this involves the collection and analysis of personal data from a large group of individuals to see, for example, where the accident hotspots may be and what times of day and days of the year are the most dangerous. There are obvious data protection issues that arise from this but also, perhaps, wider issues relating to privacy and consumer caution, and concern about the amount of their data held by distant corporations.

UBI is clearly also applicable to the commercial environment; for example, it may be used to achieve a more accurate picture of where particular ships navigate and how much time is spent at sea. It will also enable insurers to keep track of particular cargos with black boxes attached to shipping containers to measure location, distance travelled, method of storage and speed.

The application of UBI to life and health insurance is also being actively explored. For example, the insured’s success in achieving quotas on Fitbits and other similar devices can be monitored. The use of AI technology can also improve the accuracy of data used to underwrite insurance by providing information about how much we actually drink, smoke and exercise as opposed to what we say we do.

In a similar vein, insurers are using gamification to enhance these processes. Gamification, as the name suggests, involves the inclusion of some gaming experiences into the insurer–client relationship, for example by encouraging the insured to achieve health targets in relation to exercise (among other things) in order to strengthen the relationship between insurer and insured, and introduce risk management elements. These techniques also increase the insurer’s ability to give insureds the kinds of insurance products that they want.

While initiatives of this nature will benefit the healthy insured, there is a danger that the use of this personal source data may result in less affordable insurance for less healthy insureds. This in turn may lead to regulatory challenges in relation to potential discrimination. Particular regulatory issues may also arise in connection with the use of sensitive personal information (called ‘special data’ in the General Data Protection Regulation (GDPR), which has been supplement and tailored for the United Kingdom by the Data Protection Act 2018).

IV ROBOTIC PROCESS AUTOMATION

The introduction of robotic process automation (RPO) means that underwriting decisions can be made and policy documentation issued much more quickly than in the past. This is achieved by using the RPO and chatbots to interrogate the insured in respect of key variables, to process that information and take the necessary underwriting decisions. There is a similar process in connection with the purchase of motor or home insurance; the difference here
is that the process can be entirely automated by using RPO, and the analysis of big data provides a far more accurate and sensitive basis for setting premium for particular risks on the basis of the information provided by the insured.

Initiatives of this nature will become increasingly common as the full impact of the internet of things is realised. We can expect to see increasing use of location-based sensors, such as smart thermostats and geographical information systems relaying information to insurers in real time to facilitate more accurate underwriting.

V BLOCKCHAIN AND THE VERIFICATION OF DATA

Many commercial transactions require the existence of relevant insurance contracts to be verified. For example, the sale of goods and their transhipment overseas involves a significant amount of paperwork, including commercial invoices and bills of lading, which provide the basis upon which the insurer will issue a policy of insurance to the shipper and its banker. Blockchain will allow all of the parties to the transaction to view and verify the paperwork in real time, thus significantly speeding up the shipping process by removing the requirement for the physical transfer of documents between banks.

Similarly, worldwide insurance for a multinational corporation will involve locations and assets around the world. The underwriting process for this insurance involves collecting and verifying a range of data, such as asset values and loss histories, and the making of that data available to different interests. This can be a lengthy process but the use of blockchain technology can significantly simplify and speed up the process, while at the same time providing the necessary degree of transparency and reliability.

This use of blockchain to verify the existence of insurance can have other applications too, for example by providing a platform to streamline the process by which a company can verify that a contractor has the insurance it claims to possess.

VI CLAIMS HANDLING

As well as introducing fundamental changes to the underwriting process, insurtech is having a significant impact on the speed and manner in which insurers can process claims. Indeed, one new tech-driven company promises to process home insurance claims in seconds and pay them in minutes. While these speeds are clearly not appropriate to many classes of claim, insurers that do not take steps to incorporate insurtech into their claims-handling process, for example in the management of administrative tasks, will become increasingly unattractive to buyers.

Detecting fraudulent claims is a major issue for insurers. Recent figures from the Association of British Insurers show that approximately 113,000 fraudulent claims with a value of approximately £1.3 billion were detected in the United Kingdom alone in 2017. It is no surprise, therefore, that insurers are developing algorithms that use big data and machine learning to identify the markers of a fraudulent claim. Claims are then tested against these markers by the AI so that suspicious activity can be subjected to closer examination.

At present, these tools are being developed principally with the resolution of high-volume low-value insurance claims in mind, as it is easier to develop statistical models and predictive AI for this type of business. Nonetheless, predictive modelling is also expected to have an application for high-value complex claims.
VII POTENTIAL PROBLEMS

The growing use of AI is not without its pitfalls for buyers and sellers of cover as well as for brokers and other intermediaries.

i The insurer

For the insurer, the huge volume of often sensitive personal data required to maximise the benefits of AI requires very careful handling. Failure to safeguard this material, or to obtain the necessary consent for its use, can expose the insurer to severe financial penalties (up to 4 per cent of its annual turnover under the GDPR). Perhaps more importantly, however, the loss or abuse of this data is likely to have a devastating impact on the insurer’s reputation and commercial position. In addition, information of this kind is particularly attractive to cyber criminals and, at a time when even sophisticated operators are vulnerable to attack, managing this risk will require constant vigilance from the insurer and its service providers.

Just as significantly, it will be important to manage the machine learning aspect of both underwriting and claims handling to avoid discrimination on the grounds of race, gender or location. For example, AI deployed in the underwriting process may note that males are more likely to have a motor accident than females. If the AI starts to adjust premiums taking this information into account, there is a clear risk that it will place the insurer in danger of breaching anti-discrimination laws, such as the EU Gender Directive. This is a complex issue and discrimination is not always obvious – for example, discriminating on the basis of an insured’s address can be a proxy for discrimination on the grounds of ethnicity and it has even been suggested that discrimination on the basis of the insured’s email address has taken place.

A recent focus paper by the EU’s Fundamental Rights Agency (FRA) draws attention to the fact that when algorithms are used in decision-making there is a potential for breach of the principle of non-discrimination contrary to Article 21 of the EU’s Charter of Fundamental Rights. The FRA recommends, among other things, that potential biases and abuses created by the algorithm should be recognised, that the quality of data should be checked and that the way in which the algorithm was built should be capable of explanation.

ii The insured

While AI should provide the insured with quicker and more focused insurance cover, it does not come without its pitfalls. In particular, the use of AI will make it much easier for insurers to identify sub-prime risks and there is clearly a danger of anti-selection or ‘writing down’, which will make it much harder for insureds with particular or unusual characteristics to obtain cover. Ultimately, this may require regulatory change to address.

iii The intermediaries

One of the perceived advantages of AI is that it will create more direct contact between the insured and the insurer, enabling the insurer to broaden its offering to the insured, and to respond more precisely to the insured’s needs. Similarly, existing distribution networks will be bypassed to remove unnecessary friction and cost from the insurance-buying process. This will mean that, like insurers, brokers and other intermediaries will find their business model under attack. While in the short term this may be an issue principally in the mass market, it is inevitable that it will also find a role in commercial placements. This development, along with greater scrutiny of the role of intermediaries from regulators, threatens to create a perfect storm, which will require intermediaries, like insurers, to adapt to survive.
Legal challenges

The use of AI raises a number of legal issues, but perhaps the most difficult in the context of insurance is the question of liability. In order properly to underwrite the policies that they issue, as well as to enable them to resolve claims and analyse their own exposure, insurers will need to understand not only where the liability rests for damage caused by malfunctioning AI, but also who is liable for damage caused by the decisions taken by AI. In cases in which errors by the developer or manufacturer of the AI results in the AI malfunctioning, issues of liability would appear at first sight to be relatively straightforward. As the decisions taken by AI systems become further removed from direct programming and increasingly based on machine learning principles, however, it may be difficult to identify the precise cause of a particular AI decision or the source of any damage. A system that learns from information it receives from the world can operate independently from its operator and in a way that its designers did not or could not have anticipated. Who will be liable if the actions of AI are inexplicable or cannot be traced back to human error?

The European Union has begun to address this issue through the European Parliament’s resolution and recommendations to the Commission contained in the Civil Law Rules of Robotics passed in February 2017. This document invites the Commission to consider two approaches to liability: strict or risk-based. The latter would focus on ‘the person who is able . . . to minimise risks and deal with negative impacts’. It also considers the possibility of a compulsory insurance scheme that would take into account ‘all potential responsibilities in the chain [of causation]’. These recommendations are now under consideration by the European Commission.

Similarly, the upper house of the UK Parliament issued a paper in April 2018 entitled ‘AI in the UK – Ready Willing and Able’. In the paper, the authors consider the question of liability in the context of AI and recommended that the issue be reviewed by the Law Commission of England and Wales to decide whether legislation is required to allocate liability with the consequences for insurers that will surely follow.

VIII SUMMARY

Insurtech is set to revolutionise all aspects of insurance from underwriting to claims handling to dispute resolution and distribution. This process is already underway, but its full extent is difficult to predict. Traditional insurance models face fundamental challenges, but at least the early indications are that they are beginning to recognise and respond to those challenges. Insurers that do not engage with this new technology will, however, face the risk of being left behind in a rapidly changing market.

One remaining obstacle to the exploitation of insurtech is uncertainty over the legal and regulatory framework in which it operates. While governments have taken some initial steps to address these issues, it is far from clear where that particular journey will end.
Chapter 2

CYBER INSURANCE

Simon Cooper

I  INTRODUCTION

As the use of cloud-based computing, electronic platforms and smart devices continues to increase, it goes without saying that businesses have had to adapt quickly to technological advances and the corollary demands of their customers.

With widespread cyberattacks becoming more common, cyber risk has become a subject of much greater concern for businesses of all sizes.\(^2\) Over the past year, we have seen attacks on a number of leading companies such as Facebook, Uber, British Airways and Marriott International, which followed the widespread WannaCry and NotPetya viruses of 2017.

The cybersecurity insurance market is expected to grow from US$4.52 billion in 2017 to US$17.55 billion in 2023.\(^3\) Given that the average cost of a cybersecurity breach is in the region of £0.6 million to £1.15 million (£65,000 to £115,000 for SMEs),\(^4\) it is of little surprise that businesses are increasingly looking to cyber insurance to provide additional levels of protection.

II  WHAT IS CYBER RISK?

In order for insureds to be adequately protected against cyber risks, they must fully understand the potential exposures they face. Typically, cyberthreats come from:

a  malicious external attacks (such as cyber extortion, whereby external third parties illegally restrict access to their victim’s computer systems unless and until a ransom is paid);

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1 Simon Cooper is a partner at Ince Gordon Dadds LLP.
malicious insiders (this could include deliberate acts by disgruntled employees who compromise their employer’s systems or intentionally leak confidential or sensitive information); and

accidental losses (such as human error and lost or stolen devices).

The above is by no means an exhaustive list.

In addition to understanding the potential risks a business could face, the impact of such risks must also be fully evaluated. Losses are typically categorised as ‘third party’ (where loss is suffered by third parties (such as customers)) and ‘first party’ (risk to the insured’s own assets). Incidents involving the leak of client data can be particularly damaging to a company, as can attacks that prevent an insured from trading.

III CYBER COVERAGE

A raft of cyber products are available to insureds, which can be tailored to their particular circumstances, and there is generally no uniformity of terms across the market. Cyber coverage can typically be obtained for:

a Business interruption (e.g., in respect of losses resulting from a business being unable to trade owing to its website being compromised, thus preventing it from accepting orders). The indemnity will be subject to a time deductible or ‘waiting period’ as well as a financial deductible. The precise scope of cover, however, varies so that some policies will only respond where the insured alone was the target of the cyberattack that gave rise to the loss. Other policies will respond where the insured is the victim of an untargeted attack or incident.

b Loss of data. Cyber insurance typically provides third-party cover in respect of data breach. This will include cover for any liability payments that have to be made to individuals or corporations whose data has been lost or damaged by the insured as a result of a data breach. Usually, however, these costs are only payable where the quantum of the payment has been the subject of judicial ruling or is the result of a settlement that the insurer has endorsed. Typically, this cover also includes defence costs.

c Recovering and repairing data.

d Payment of compensation to customers for their loss of data.

5 The Court of Appeal’s decision in *Morrisons Supermarkets Plc v. Various Claimants* [2018] EWCA Civ 2239 is significant in this regard because it confirmed that an employer can be liable for a data breach by an employee even where the breach is a criminal act that is intended to damage the employer. It also confirms that an employer can be vicariously liable for an employee’s breach of the Data Protection Act 1998.

6 See *Vidal-Hall v. Google Inc* [2015] EWCA Civ 311 where the Court of Appeal held that victims of a data breach could recover compensation for distress associated with a contravention of the Data Protection Act 1998, even in circumstances where no direct financial loss had been suffered by the claimant. This principle was subsequently applied in a case against the Home Office (*TLT and others v. The Secretary of State for the Home Department and the Home Office* [2016] EWHC 2217 (QB)), where a number of asylum seekers’ personal data was wrongfully published on the Home Office website. The claimants in this instance were each awarded between £2,500 and £12,500. While the amount of damages a court may award will be determined on a case-by-case basis, these cases demonstrate that a cyberattack resulting in a large volume of data being compromised could result in significant third-party liability.
Ransom demands. Extortion is one of the most common forms of cyberattack. It occurs when an attacker disables the insured’s computer systems by contaminating it with ‘ransomware’. The system can only be unlocked by payment of a ransom, which is often relatively low and to be paid in bitcoin. The relatively modest level of the ransom payment is intended to encourage early payment and to prevent the response to the attack being ‘escalated’ outside the insured’s own organisation. First-party cyber insurance will usually provide cover for such payments. Many, but not all, policies will also indemnify the insured when a ransom is paid in response to a threat to disable its computer system but before any attack has actually been carried out.

Expenses associated with an attack. Some, but not all, policies will provide insurance for associated costs such as call centre costs to deal with enquires from individuals whose data has been lost or destroyed, credit monitoring and Payment Card Industry Data Security Standard expenses.

To the extent insurable at law, losses associated with complying with regulatory investigations and the related defence and enforcement costs.

Incident response. More complex policies provide an incident response package that will include public relations and legal advice as well as technical assistance to address the IT vulnerability that gave rise to the breach.

IV POLICY TERMS AND FEATURES

There is no standard form or template for a cyber insurance policy, and the clauses included in the policy may vary significantly. There are, however, some policy requirements that are almost universal, including the following.

i Claims made cover

Cover under cyber policies is invariably provided on a claims made basis, that is to say that the policy will respond to claims that are made within the policy period or within an agreed extended notification period after the policy has expired. In the latter circumstance, however, the claim will normally have to arise during the policy period to be accepted. Usually, policies will also respond to claims arising from circumstances that are notified within the policy period. A circumstance in this context is an incident or event that the insured believes may give rise to a claim against it at a later date. If the circumstance is notified during the policy period, any subsequent claim arising from that circumstance will be covered under the policy, regardless of when the claim itself occurs.

ii Notification

It is a requirement of all cyber policies that any claims against the insured that are covered under the policy are notified to the insurer within a specified period of time. The precise time will vary depending on the policy and may be anything from ‘immediately’ to ‘as soon as possible’, ‘promptly’ or ‘as soon as practical’, or within a fixed number of days of the insured becoming aware of the claim. These requirements are conditions precedent to the insurer’s liability; cover can be refused if the claim is not notified as required. Many policies also require the insured to notify circumstances that may give rise to a claim.
iii  Claims control
Under cyber policies, the insurer usually has the right (but not the obligation) to take over
the management of the insured’s response to any third-party claim. Where this right is not
exercised directly, it is likely to be a condition precedent to coverage under the policy that
the insured does not admit liability or enter into negotiation or settlement with a third-party
claimant without the insurer’s written consent.

iv  Claims cooperation
Cyber policies also require that the insured provides the insurer with all information and
data about the claim that is reasonably requested and cooperate fully with the insurer in the
management of the claim and in the defence of any third-party claim. These provisions are
often conditions precedent to the insurer’s liability, with the result that the insured’s failure to
comply with them will discharge the insurer from liability for the claim.

v  Other common terms
Other terms commonly found in cyber policies include obligations on the insured to:

- notify the authorities of any extortion attempt;
- take reasonable steps to mitigate loss and to preserve the insurer’s rights of subrogation;
- preserve evidence;
- take reasonable steps to avoid loss, for example, by ensuring software is patched
  regularly and firewalls are in place; and
- not to disclose the existence of the policy to any third party.

vi  Important policy exclusions
As noted, there is considerable inconsistency in the scope of coverage offered under a cyber
insurance policy and, therefore, in the policy exclusions. Some important exclusions that are
commonly included, however, cover the following areas of loss:

- physical damage and personal injury, whether directly or indirectly caused by a cyber
  event;
- contractual liability – this provision excludes cover for losses incurred by the insured
  following a cyber event as a result of its contractual liabilities, except to the extent that
  such liability would have attached in any event;
- losses occurring prior to the retroactive date – all cyber policies include a retroactive
  date. Cover is excluded for losses occurring prior to that date even if the loss is only
  detected and notified during the policy period;
- losses resulting from the fraud, dishonesty or reckless conduct of a director or senior
  officer of the insured;
- claims resulting from the insured’s use of unproven or illegal software;
- claims resulting from the failure of the cloud or other utilities or external services;
- betterment;
- employer’s liability claims; and
- losses recoverable under another insurance policy.
INTERACTION WITH OTHER INSURANCES AND ‘SILENT CYBER’

Cyber insurance policies will generally purport to exclude physical losses and, increasingly, property policies will also seek to exclude cyber-related incidents. However, there are instances where policies will not explicitly include or exclude cyber-related losses (known as ‘silent’ or ‘non-affirmative’ cyber cover). The question of whether a non-cyber policy would respond to cyber losses is untested and will turn on the construction of the specific policy wording.

Silent cyber is best illustrated with examples:

\( a \)
A computer is hacked and compromised in such a way that leads to it overheating, causing fire damage to the insured’s and a third party’s property. In this situation, which of the insured’s policies should respond (property, liability or cyber)?

\( b \)
A law firm’s computer systems are hacked resulting in client data (or money) to be lost. This may give rise to a claim under the firm’s professional indemnity policy as well as its cyber policy.

The UK regulators are aware of issues relating to silent cyber and the Prudential Regulatory Authority has issued regulatory guidance,\(^7\) which sets out how it expects insurers to ‘introduce measures that reduce the unintended exposure’ to cyber risk from physical and non-physical damage.

VI CYBER REGULATION

As well as being a pressing issue for businesses, UK and EU legislators have introduced new regulatory regimes that go some way to ameliorate cybersecurity standards. One of the key pieces of legislation is the General Data Protection Regulation EU2016/679 (GDPR), which overhauled previous data protection rules, and which requires data controllers and processors to ensure that appropriate measures are in place to protect against unlawful processing of personal data. The GDPR is reflected in the United Kingdom in the Data Protection Act 2018.

The Security of Network and Information Systems Directive EU 2016/1148 (the NIS Directive) was also implemented by EU Member States in 2018.\(^8\) Broadly speaking, the NIS Directive purports to ensure the reliability and security of network and information systems across the European Union by requiring certain ‘operators of essential services’ (such as energy, transportation and banking sectors (as well as others)) and ‘digital service providers’ (online marketplaces, search engines and cloud computing services) to adopt appropriate measures to manage cybersecurity risks. Non-compliance with the GDPR and the NIS Directive will expose firms to significant fines.

It is anticipated that both of these regimes will remain in force in the United Kingdom after Brexit.

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\(^7\) See PRA Supervisory Statement SS4/17.

\(^8\) In the United Kingdom, the NIS Directive has been introduced by the Networks and Information Security Systems Regulations (2018 No. 506).
I INTRODUCTION

Dishonesty in general, and fraudulent claims in particular, cost the insurance market considerable amounts each year. The legal consequences of dishonesty are not always the same, however, and will depend on a number of factors, including how it manifests itself and the point in the process at which it occurs.

Since 2016, the definitions of dishonesty, a fraudulent claim and the remedies available to insurers battling against such claims have been radically reformed through a combination of legislation and guidance from the highest court in the United Kingdom.

II DISHONESTY DURING THE CLAIMS PROCESS

Historically, the courts have recognised three types of fraudulent insurance claim:

a wholly invented claims;
b fraudulently exaggerated claims; and
c genuine claims advanced by ‘fraudulent devices’.

Until 2016, the insurer’s remedy in respect of each of the above-mentioned categories was forfeiture of the entire claim – the fraudulent claims rule. The essence of the rule is that, if an insured presents a claim that is in whole, or in part, fraudulent, the insured will forfeit the entirety of the claim. Since the Supreme Court’s decision in Versloot Dredging v. HDI-Gerling (The DC Merwestone), however, genuine claims that are advanced by fraudulent devices or collateral lies are no longer classified as fraudulent claims and so do not attract this remedy.

Under the Insurance Act 2015 (which came into effect on 12 August 2016), in the event of a fraudulent claim, the insurer is also entitled to cancel the insurance from the date of the fraud and to retain the premium in its entirety.

If a claim has come before the courts, acts of fraud or dishonesty by the insured during the litigation will give rise to a different set of remedies that are governed by the rules of the court. Similarly, the fraudulent claims rule and the Insurance Act 2015 remedies do not apply to a fraudulent claim by a dishonest third party against an innocent insured who is entitled to an indemnity from insurers, but the sanctions available under the court rules may be applied against the third party in those circumstances.

The different types of fraud and the remedies available are discussed further below.

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1 Simon Cooper is a partner at Ince Gordon Dadds LLP.
2 Versloot Dredging v. HDI-Gerling (The DC Merwestone) [2016] Lloyd’s Rep IR 468.
i  **Wholly invented claims**

These are claims in respect of which the loss has either been deliberately brought about by the insured's own actions (e.g., scuttling a ship) or where the loss has been completely fabricated (e.g., arising from a staged motor accident). The forfeiture rule applies to wholly invented claims.

ii  **Exaggerated claims**

Claims may arise where the loss itself is genuine but the value of the claim has been deliberately exaggerated. The fact that a claim has been exaggerated does not of itself mean that it is fraudulent. Judges are prepared to accept that a certain amount of ‘horse trading’ goes on between an insured and its insurer. The difficulty is in deciding where the line is to be drawn between ‘acceptable’ exaggeration and fraud. Generally, the courts look at the degree to which the claim has been inflated; the greater the exaggeration the easier it is to impute a fraudulent intent.

In *Orakpo v. Barclays Insurance Services*[^3], Lord Justice Hoffman stated that: ‘...one should naturally not readily infer fraud from the fact that the Assured has made a doubtful or even exaggerated claim.’

If, however, there is fraudulent exaggeration, Sir Roger Parker said: ‘If he is fraudulent, at least to a substantial extent, he will recover nothing, even if his claim is in part good.’

In *Danepoint Ltd v. Underwriting Insurance Ltd*[^4], an insured claimed for loss of rent in relation to a property divided up into 13 flats, each of which had been sublet. The insured claimed that all flats had been vacated following a fire at the property and his loss of rent claim was based on all of the flats being unoccupied. This was untrue; a lot of the flats remained occupied. In deciding whether the claim should be forfeit for fraud, the court found that an exaggerated claim would be categorised as fraudulent where:

- **a** the exaggeration was more than trivial;
- **b** the insured was dishonest – exaggeration of itself did not establish dishonesty; there had to be an intention to deceive the insurer, or recklessness; and
- **c** the fraud must have been material, in that it would have had a decisive effect on the readiness of the insurers to make payment.

On the facts of this case, it was not difficult for the court to conclude that all of these criteria had been satisfied and that the evidence in favour of a finding of fraud was overwhelming.

If a claim for, say, loss of items by theft is partly genuine and partly fraudulent, the law says the claim is not severable. Thus, if the degree of fraud in relation to one part of the claim is material, the entire claim will be forfeited. For example, in *Galloway v. Guardian Royal Exchange (UK) Ltd*[^5], Mr Galloway suffered a burglary and submitted a claim not just for the probable true value of the loss (£16,133) but an additional £2,000 claim being the supposed value of a computer. In fact there had been no theft of a computer as there had been no computer at all. The Court of Appeal held that the degree of fraud was sufficient to render the entire claim fraudulent.

The position in relation to personal injury claims is governed by Section 57 of the Criminal Justice and Courts Act 2015. This provides that if a claimant is fundamentally dishonest in relation to a claim, the claim must be dismissed in its entirety (including any valid element), unless doing so would cause the claimant to suffer a substantial injustice. The definitions of fundamental dishonesty and substantial injustice have been examined recently in *London Organising Committee of the Olympic and Paralympic Games v. Sinfield* and *Razumas v. Ministry of Justice.* In judging dishonesty in this context, the courts applied the test set out by the Supreme Court in *Ivey v. Genting Casinos (UK) Ltd.* This requires the Court to ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts and then determine whether his or her conduct was honest or dishonest by the (objective) standards of ordinary decent people. There is no requirement that the individual concerned must appreciate that what he or she has done is, by those standards, dishonest. Fundamental dishonesty is dishonesty of the type described above, which goes to the 'root' of the claim. That means that the dishonesty substantially affects the presentation of the claimant's case in respect of either liability or quantum in a way that potentially adversely affected the defendant in a significant way.

The legislation is intended to have a punitive or deterrent element and so the mere fact that the claimant will lose the valid element of his or her claim is not enough to establish that he or she will suffer substantial injustice – something more is required.

iii  **Fraudulent devices**

In *Agapitos v. Agnew (The Aegeon),* the Court of Appeal held that if an insured used a fraudulent device to support his or her claim or to better his or her chances of a favourable settlement before litigation, then the insurer could rely on the common law defence of forfeiture. A fraudulent device in this context meant a lie or other false evidence that was deployed in support of a genuine claim.

This principle was approved and applied in subsequent cases by courts up to and including the Privy Council.

As previously mentioned, in its landmark 2016 decision in *The DC Merwestone,* however, the Supreme Court (by a majority of 4–1, Lords Sumption, Toulson, Clarke and Hughes, with Lord Mance dissenting) abolished the insurer's remedy of forfeiture for the insured's use of a fraudulent device.

In doing so, it overturned the Court of Appeal's judgment in the same case and decided that the Court of Appeal had been wrong in *The Aegeon* in expressing the opinion that the public policy objective of deterring fraud in the insurance claims context warranted the forfeiture of a claim that had been promoted by fraudulent means, even though the claim was in all other respects valid.

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10  Equivalent to the Supreme Court, the Judicial Committee of the Privy Council is the court of final appeal for the UK overseas territories and Crown dependencies, and for those Commonwealth countries that have retained the appeal to Her Majesty in Council or, in the case of Republics, to the Judicial Council.
While upholding the fraudulent claim rule in respect of fraudulently exaggerated claims, the majority considered it to be ‘a step too far’ and ‘disproportionately harsh’ to deprive a claimant of his or her claim by reason of his or her fraudulent conduct if it turns out that the fraud had been unnecessary because the claim was in fact always recoverable.

In reaching that decision, the majority considered there to be an important difference between a fraudulently exaggerated claim and a legitimate claim supported by a fraudulent statement or evidence. It was held that forfeiture is appropriate in the former case because the insured will have been seeking to obtain something to which it was not entitled, but not in the latter case because the fraud deployed would not have involved an attempt to obtain anything more than the insured’s actual legal entitlement.

In a strong dissenting judgment, Lord Mance expressed the opinion that there was no distinction to be drawn between the deployment of a fraudulent device and the pursuit of a fraudulently exaggerated claim. In his view, forfeiture was proportionate in both cases, and justified by the public policy objective of deterring fraud in the insurance claims context. Lord Mance stated that the proposition that a lie told to promote a claim ‘is immaterial to the parties’ rights and obligations’ [per Lord Toulson] simply because, perhaps years later, it can be seen that the lie was unnecessary and the claim good without it, appears to be a ‘charter for untruth’. He stated that this proposition overlooked both the ‘obvious imperative of integrity on both sides in the claims process’ and ‘the obvious reality that lies are told for a purpose, almost invariably as here to obtain an uncovenanted advantage of having the claim considered and hopefully met on a false premise’.

The implications of this judgment are significant for insurers. Lord Mance put it thus: ‘Abolishing the fraudulent devices rule means that claimants pursuing a bad, exaggerated or questionable claim can tell lies with virtual impunity.’

III DISHONESTY DURING THE LITIGATION PROCESS

Different rules governing the consequences of fraudulent claims come into effect once legal proceedings are commenced in respect of that claim. That does not mean that the insured will receive no sanction for dishonesty during the legal process; simply that the court rules of procedure apply instead.

There is a very old rule that witnesses, even if malicious or dishonest, have absolute immunity from civil suit for what they say in proceedings. However, immunity from civil suit is not a complete answer to dishonesty in civil litigation. There has been a lot of attention in recent years on the ways in which dishonesty in proceedings can be controlled.

i Contempt of court

Since the introduction of the Civil Procedure Rules (CPR) in 1999, statements of case, witness statements and disclosure lists must be verified by a statement of truth, putting them almost on a par with sworn evidence. CPR 32.14 provides that ‘[P]roceedings for contempt of court may be brought against a person if he makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.’

11 Manifest Shipping Co Ltd v. Uni-Polaris Shipping Co Ltd (The Star Sea) [2001] 2 WLR 170.
In the 2004 case of *Sony Computer Entertainment v. Ball*,[12] the judge suggested that the court’s discretion to permit such proceedings should be exercised with caution: ‘the claimant must satisfy the court that there is a strong case – and preferably an admitted case – that a particular misrepresentation is untrue.’

Since then, however, the courts have become increasingly willing to penalise parties who knowingly give false evidence. In the 2016 case of *Aviva Insurance Ltd v. Randive*,[13] for example, following the trial of a road traffic accident claim that was held to be fundamentally dishonest, the court granted the defendant insurer permission to bring contempt proceedings against the claimant for making false statements verified by a statement of truth. The court noted that bringing a false claim in the courts was extremely serious, leading to a waste of court time and resources. Although the claim in this case was small in financial terms and contempt proceedings would be costly, in the interests of justice and the overriding objective of the CPR (namely, to deal with cases justly and at proportionate cost), the court found that it was appropriate to pursue them. Similarly, in the 2017 case of *Liverpool Victoria Insurance Company v. Yavuz*,[14] nine individuals were given prison sentences after being found guilty of contempt of court for making false and dishonest statements in support of their motor insurance claims.

**ii Striking out**

The question for the Supreme Court in *Fairclough Homes Ltd v. Summers*[15] was whether the defendants were entitled to have an entire claim struck out in circumstances where the claimant had put forward a grossly exaggerated and fraudulently maintained claim for personal injuries. It held that while the court had jurisdiction to strike out such a claim, it should only do so in very exceptional circumstances. The test in each case, it held, must be what was ‘just and proportionate’.

**iii Adverse costs consequences**

The default position under English law is that a losing party pays the winning party’s legal costs – the ‘costs follow the event’ rule. However, in deciding whether to make a different order the court is entitled to take into account the conduct of the parties. The courts have shown that they will express their disapproval of dishonest claims in adverse costs orders. For example, in *Sulaman v. Axa Insurance Plc*,[16] insurers sought to recover sums paid before discovery of a fraud. After a three-month trial they succeeded against most of the defendants but failed against Sulaman. Following her ‘victory’, Sulaman applied for her costs but was awarded only one-third of them because the trial judge was satisfied she had lied in two respects in her evidence. This decision was upheld on appeal.

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Reopening a fraudulent settlement

In 2016, the Supreme Court gave a landmark judgment in *Hayward v. Zurich Insurance Company plc*, holding that where an insurer suspected fraud but nonetheless chose to settle a claim, it was entitled to set aside the settlement when new evidence of the fraud came to light.

Mr Hayward injured his back in an accident at work and sued his employer, which was insured by Zurich. In the litigation, Zurich contended that Mr Hayward had exaggerated the consequences of his injury, relying on video surveillance evidence. Shortly before trial the parties settled, Zurich agreeing to pay approximately £135,000. Two years later, Mr Hayward’s neighbours gave evidence to Zurich that Mr Hayward had entirely recovered from his injuries at least a year before the settlement and that his claim to have suffered a severe back injury was dishonest. Zurich commenced proceedings asking for the settlement agreement to be set aside. The judge at first instance found in favour of Zurich, set aside the settlement agreement and awarded Mr Hayward the much reduced sum of £14,720. Mr Hayward appealed and the Court of Appeal unanimously allowed the appeal. The Supreme Court, however, unanimously allowed Zurich’s appeal. It found that Zurich did as much as it reasonably could do to investigate the position before entering into the settlement but it did not know the extent of Mr Hayward’s misrepresentations until the neighbours came forward. Qualified belief in a misrepresentation did not rule out the conclusion that the insurer was induced by it.

In *UK Insurance v. Gentry*, an insurer who had paid out sums in relation to a road traffic accident successfully claimed repayment after suing the claimant for fraudulent misrepresentation after evidence subsequently came to light that the accident giving rise to the claim had been staged.

III CONCLUSION

The common law remedy of forfeiture is available to insurers where the insured has: deliberately or recklessly caused a loss; fabricated a loss; or suffered a genuine loss but fraudulently exaggerated the value of the claim.

Following the decision in *The DC Merwestone*, however, forfeiture no longer applies to cases where the insured has presented a genuine claim but used a fraudulent device – what was described in the judgment as a collateral lie – in support of it; such claims are no longer considered fraudulent claims. This represents a seismic shift, upsetting settled expectations and assumptions as to the state of the law.

In a move that may provide some comfort to insurers, however, Section 12 of the Insurance Act 2015 gives them the right to cancel an insurance from the date of a fraudulent claim on the policy and to retain the entire premium.

Once legal proceedings are brought in respect of a claim, the sanctions for fraud are governed by the courts’ procedural rules. These rules apply not only to fraudulent insureds but also to dishonest third parties bringing claims against innocent insureds. A range of penalties is available and the courts are increasingly willing to use them. Finally, the Supreme Court’s decision in *Hayward v. Zurich* provides authority at the highest level that it is now open to an insurer who suspects fraud, but has insufficient evidence to prove it, to reopen the settlement should further evidence subsequently come to light.

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18 *UK Insurance Ltd v. Gentry* [2018] EWHC 37 (QB).
I  INTRODUCTION

Latin America is entering a new period of political and economic transition. Targeted focus on reducing corruption and driving growth with increased transparency for a frustrated and determined population, is set to influence the region’s course over the next few years. As is often the case, this new phase is led by a political shift in Brazil, but populist leaders across the region – and from both sides of the political spectrum – have seized on the cry for corruption to be wiped out.

There is also growing potential for further insurance and reinsurance penetration in response to increased demand. This will be especially pronounced if newly elected political parties can effectively implement economic and judicial reforms, and increase certainty in the region.

Each country has its own, distinct commercial and legal requirements, and it remains crucial for insurers and reinsurers to understand these factors when carrying out all functions of business, from underwriting to claims handling. This chapter considers some of the reasons behind the growth of the insurance and reinsurance markets across the region, and the international expansion of insurance and reinsurance companies. It assesses the status of regulatory developments in each of the main jurisdictions, as well as providing a snapshot of how experience of applying these regulations in practice is leading to increasingly sophisticated insurance markets.

II  OVERVIEW OF THE REGION

The demand for insurance and reinsurance continues to increase across the region as the population’s average per capita income rises. In particular, 2018 has shown that directors’ and officers’ (D&O) risks, class actions and cyber insurance cover is more important than ever, alongside the usual infrastructure and natural hazard damage provisions.

Operation Car Wash, which first hit Brazil in 2014 before expanding across the region, has led to interesting political and judicial changes for 2019, as expanding middle classes become frustrated with what they see as corrupt regimes disguised as, for the most part, leftist governments.

In particular, in March 2018, calls for impeachment for moral incapacity resulted in the resignation of Peruvian President, Pedro Pablo Kuczynski. The opposition leader, Keiko Fujimori, was placed under pretrial detention and Supreme Justice Cesar Hinostroza was the...
object of an arrest warrant, as the release of audio recordings highlighted corrupt practices within the Peruvian judiciary. The subsequent reform resulted in the appointment of a new attorney general, Pedro Chávarry (who himself is now the subject of a President-induced state of emergency for dismissing two lawyers accusing him of obstructing justice in the Odebrecht investigations). A preliminary investigation was also opened against the former President, Alan García, for alleged corruption crimes.

In Brazil, Sérgio Moro, who led the inquiry into Operation Car Wash, has become the new Brazilian justice minister amidst claims that he targeted left-wing politicians in his operations, resulting in the imprisonment of former president, Luiz Inácio Lula da Silva.

Petrobras settled the bribery and corruption-related securities class action lawsuit in New York in January 2018 for US$2.95 billion. Its auditors, PwC, also settled with pension fund company USS for US$50 million in February 2018, bringing the total value of the class action to approximately US$3 billion. Both Petrobras and USS deny any wrongdoing or misconduct.

Following his successful election in October 2018, with 55 per cent of the votes, Jair Bolsonaro assumed the Brazilian presidency in January 2019, marking a significant shift in the country’s political and economic landscape. The far-right president has already been dubbed by the media as ‘Trump of the Tropics’ owing to his stance on women, homosexuality, race, gun laws, control of the media and foreign relations. However, it is hoped Bolsonaro will provide much-needed support for businesses, focusing on pensions, employment, income and fiscal balance, liberalising interstate commerce and privatising state enterprises to restore government finances and produce a united market. In principle, the new government has the majority support of Congress, but none of its leaders have yet had to test its support on hard topics. Concerns have also been expressed as to how the proposed expansion of production and reduction of protected lands will threaten the environment. Such challenges will need to be overcome to maintain the support of the Brazilian people, while providing the required economic and institutional reforms.

In July, Andrés Manuel López Obrador was triumphant in his presidential campaign in Mexico, although political violence targeted many of his supporting politicians in the process (a total of 175 politicians were assassinated between 1 September 2017 and 31 August 2018, according to consulting firm Etellekt Consultores). López Obrador is not a fan of the North American Free Trade Agreement and there is concern that both he and President Trump could reject engaging with it. López Obrador’s party (the Morena party) is also small and any implementation of policy will require compromising with opposition parties. In contrast with other Latin American nations, López Obrador is the first left-wing president to have been elected in Mexico since the 1920s. His campaign promised to ‘purify public life’, mandating relief for the poor, eradicating corruption and continuing to strengthen currency.²

López Obrador has highlighted the increasing importance of Mexico’s oil and gas industry by unveiling his National Hydrocarbons Production Plan at the end of 2018. The plan seeks to boost production to 2,624,000 barrels a day by 2024, by repairing and modernising Mexico’s current refineries, expanding targeted exploitation of new reserves and reducing theft from pipelines. Parties bidding for Mexican gas resources recognise the potential for Mexico to soon generate the most demand in the world’s energy landscape. At the same time, the new government has cancelled many existing infrastructure projects,

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² Associated Press in Mexico City, as reported by The Guardian on 2 December 2018.
including public tenders for investment in the energy sector and the half-built new airport for Mexico City. The question is whether economic growth can be sustained in the midst of sweeping changes in public policy.

Elections were also held in Colombia, with conservative Iván Duque becoming the country’s youngest president. The result may lead to challenges in policymaking, owing to Duque lacking a congressional majority, and put at risk peace deals reached with the Revolutionary Armed Forces of Colombia and the National Liberation Army in 2016 and 2017. Nonetheless, economic growth and investment are anticipated to continue during 2019. Chile is also stable under Sebastián Piñera, who was elected for a second term at the end of December 2017. Economic recovery continues to be dictated by copper prices, investment from China and rising protectionism in the region. However, growth is anticipated to remain at over 4 per cent for 2019 through focus on structural reforms, including standardisation of regulation, pension system reform and increased diversification.

Mauricio Macri will be running for re-election in Argentina in October 2019. President Macri has necessarily focused on reducing public spending in 2018 with some success. Inflation is a continuous problem for the government, with tax pressure and public spending at a record high in proportion to gross domestic product when compared to other countries in the region. For Argentina to foster sustained growth, a decrease in both of these variables is crucial. Progress now appears to be being made with public spending dropping to 39 per cent in 2018 from a high of 42.2 per cent in 2015 to 2016. However, inflation remains in double digits and is expected to be 31.7 per cent in 2019 (recorded at 24.8 per cent in December 2017) with real growth at minus 1.6 per cent. Accordingly, the economic recession continues with a currency freeze in place until June 2019. Macri has also sought to renegotiate a deal with the International Monetary Fund (IMF), sparking protests and directly impacting his own popularity with the Argentine population, which recalls previous IMF policies leading to the economic crisis of 2001.

The economic crisis in Venezuela continues with a reduction in oil exportations, failing state-owned PdVSA and ineffective currency controls, with the suggested introduction of the Petro token for the sale of oil expected in 2019. The IMF predicts that growth will fall to minus 5 per cent with inflation reaching 10,000,000 per cent in 2019. EU sanctions against Venezuela have been extended for another year, owing to the deteriorating human rights situation. Amidst this background, Nicolás Maduro was re-elected in May 2018 against a limited opposition, removing optimism of imminent change. Other Latin American nations are now directly impacted by the Venezuelan crisis with 600,000 people officially recorded as having migrated from Venezuela to Colombia, sparking concerns that instability could spread across the border. The migration issue has also reached the Supreme Court of Brazil, which has refused to close Brazilian borders to Venezuelan nationals. Such incidents may provide the opportunity for increased collaboration and dialogue between neighbouring countries.

Challenges regarding migration between Mexico and the United States also intensified during 2018, leading to the deaths of two Guatemalan minors under US detention and allegations of US security forces using tear gas against local children across the border in Mexico.

In addition to political and economic challenges, Latin America also faced multiple natural disasters during 2018, including widespread flooding and droughts.

Colombia saw multiple flooding incidents throughout the year. This included flooding on 12 May 2018 upstream and downstream of Hidroituango, Colombia’s largest hydroelectric dam, which left 600 homeless and damaged local infrastructure. In February 2018, torrential
rain caused flooding and landslides across Bolivia. At least six people died and approximately 10,000 families were impacted. Venezuela also saw record levels of rain in July 2018, resulting in the declaration of a state of emergency as major rivers overflowed displacing thousands. Paraguay also suffered from flooding that, by November 2018, had affected over 30,000 people evacuated to emergency facilities.

By contrast, between November 2017 and April 2018, Argentina and Uruguay suffered from the worst droughts since those of 2008 and 2009, which prompted economic recession. Some regions experienced rainfall of only 50 per cent of the usual level hindering President Macri’s attempts to reduce Argentina’s inflation and fiscal deficit. The droughts caused billions of dollars’ worth of damage to exportable cash crops, such as soy beans and maize, and indirectly impacted associated livestock sectors increasing global food prices by 1 per cent on the Food and Agricultural Organisation’s Food Price Index. In northern Argentina alone, 20,000 people were displaced.

These disparities in weather are likely caused by El Niño, which is increasing in frequency as a result of climatic change. According to the World Meteorological Organisation, 2018 saw the worst El Niño in over 15 years. Heavy rains are predicted to continue until March 2019, although the effects of El Niño have been known to last for up to 24 months.

In June 2018, Volcán de Fuego erupted in Guatemala causing the deaths of 200 people. Debris from the explosions travelled up to 40km and ash reached a height of 10,000 metres above sea level, forcing thousands to evacuate their homes and the closure of the international airport.

In September 2018, a fire destroyed the National Museum of Rio de Janeiro, Brazil and its irreplaceable archives of artefacts. Although the cause of the fire is yet to be determined, there has been widespread criticism of the government withdrawal of funding for restoration work. The museum was knowingly lacking in maintenance, unprotected from fire damage and without insurance provisions, although it is understood that funds from the national development bank had just been secured to improve conditions.

III INTERNATIONAL EXPANSION AND CONSOLIDATION

Expansion of the Latin American insurance market continued throughout 2018, owing to existing low insurance penetration rates, recovering economic growth promoting demand for insurance to an expanding middle class and a diversifying trade platform. However, insurance companies must rise to the challenge of complying with stricter regulations, increased local and foreign competition and heightened expectations from insureds to be successful in the region. Diversifying the means of promotion and access to insurance products, including through the embracement of fintech developments, will be important in increasing penetration rates in 2019 and beyond.

The Chilean market is arguably still the most sophisticated Latin American insurance market, boasting a competitive environment and innovative drive for offering tailored customer solutions. One example (now utilised in at least Chile and Mexico) is auto insurance that is based on the distance travelled by the insured. This method provides lower premiums for months of reduced car use, while simultaneously protecting the environment.

At the other end of the spectrum, Venezuela poses difficulties for the international market, owing to uncertainty surrounding the political and economic landscape. In April 2017, President Trump imposed new sanctions against Venezuela and, in December 2017, the
European Union imposed the Venezuela (European Financial Sanctions) Regulations against specific Venezuelan individuals and entities. The lists of individuals continue to be extended. Insurers and reinsurers must now be even more careful during the process of scrutinising the ultimate beneficiaries of any reimbursements made to Venezuelan bodies, under their policies.

Like most of Latin America, Peru is underinsured owing to a traditional lack of insurance culture with respect to both business and property. Last year, for example, El Niño losses reached US$3.1 billion but only US$600 million (or 19 per cent) was insured. As a result, the Peruvian market has begun to purchase insurance for catastrophic risk. For the first time in history, the government has obtained cover for up to US$200 million of catastrophe risks for 2019.

There also remains a serious lack of awareness on the part of Peruvian insureds of the value of cyber risk insurance, despite this having been identified as a significant risk since 2012. Local populations must be made aware of the benefits available (i.e., restoring, repairing and replacing damage and loss caused by breach, as well as any operating cost overruns) if the delivery of this product, and other new products, are to be successful.

Legislative developments in Colombia are providing new opportunities for the expansion of insurance products on offer to customers. A new D&O bill is being drafted to amend the responsibilities of company executives that, among other factors, will oblige companies to reimburse any costs incurred in defending the actions of directors and officers when exercising their duties. This is expected to consequently promote the underwriting of Side B policies in the country.

Premium collections on surety bonds in Brazil increased by 8.9 per cent during 2018 (amounting to 2.44 billion reais) and are expected to continue growing, as economic growth fosters public works focused on the infrastructure and energy markets. Judicial bonds have also contributed to boosting the market since the labour reform in 2017 authorised their use as an alternative to appeal deposits. Discussions over a new Bidding Law and an amendment that provides for mandatory surety bond insurance of at least 30 per cent over the project’s amount for large construction works over 100 million reais, are also expected to develop during 2019.

The Peruvian market is also expected to increase its penetration of D&O insurance as more regulation increases certainty for insurers. Currently, it appears that approximately 2 per cent of Peruvian companies take out a policy to cover their directors and officers, so there remains much opportunity for expansion.

It remains common practice across the Latin American region, for many local insurers to act as fronting operations for risks placed in international reinsurance markets, particularly in London. However, some significant international market moves into the region took place during 2018. In particular, in February, Zurich entered into an agreement to acquire the operations of QBE in Latin America, immediately becoming the leading insurer in Argentina.

Mexico’s large population and low insurance penetration rates make it a popular choice for the market. While Lloyd’s has been a licensed foreign reinsurer in Mexico since 1985, it was not until 2015 that Patria Re (and Pembroke) obtained Lloyd’s approval to establish a special purpose syndicate, becoming the first Mexican reinsurer to write Latin American

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3 These sanctions can be viewed in Council Regulation (EU) 2017/2063.
5 Bill No. 6,814/2017.
specialty risks through the Lloyd’s platform. In 2018, Swiss Re began operations from Mexico City after receiving formal authorisation from local regulators, and Pioneer Underwriting launched a new regional hub with a focus on property and casualty business.

Brazil’s reinsurance market continues to increase in competitiveness with multiple admitted and eventual foreign reinsurers (including Amlin Insurance Societas Europaea, MS Amlin AG, Aviva Insurance Limited and Atradius Reinsurance Designated Activity Company) accessing the market during 2018. At the same time, authorisation was withdrawn from Amlin Corporate Insurance NV and Atradius Reinsurance Limited and suspended from Hyundai Marine & Fire Insurance Company Limited, Seguros Inbursa, SA and WR Berkley Insurance (Europe) Limited.

In most Latin American countries, there are strict requirements applicable to insurance and reinsurance companies. For example, in Peru, solvency restrictions are dependent on whether a company operates in life or general risks, or insurance or reinsurance. Minimum capital limits reach almost £2.5 million for reinsurance companies, roughly £1.6 million for insurance companies and approximately £4.1 million for those operating in both markets. In all cases, it is vital that an insurer or reinsurer seeking to make an international move considers the requirements of the specific market. This is not an environment where one size fits all.

IV REGULATION

Regulation in insurance and reinsurance continues to develop in many of the main jurisdictions. A diverse group of markets, each with a distinct identity, exists after the advances of the past decade. Each regulatory regime should be considered in its own right, prior to underwriting risk in the country.

Progress has continued with targeting corruption and money laundering with the Lima Commitment for Democratic Governance Against Corruption agreed at the Eighth Summit of the Americas in April 2018 reaffirming intentions for prevention and tackling of corruption through strengthened institutions and judicial autonomy. The government of Nicaragua expressly denied its approval of the Lima Commitment owing to its non-participation in negotiations. Nicaragua appears to have the third-lowest Corruption Index rating in South America (ranked 151st out of 180 global nations), after Venezuela (169th out of 180) and ahead of Haiti (157th out of 180), despite comprehensive legislation. Enforcement of the region’s developing regulations is therefore key in combating such issues – and to understanding the commercial environment.

Over the past two years, Peru has sought to establish provisions on the personal liabilities of specific officers in public and private entities. For example, a 2018 tax ruling provides for the personal liability of private sector officials designing, approving or executing tax planning intended for avoidance. This new liability scenario is considered an attractive opportunity for the placing of D&O policies, given the risk to which officials are exposed and the demand for cover of administrative fines and defence costs.

Also, in March 2018, Peru approved Law No. 2408, ensuring that civil damages to the state are immediately payable in corruption circumstances and preventing paralysis of public and public–private partnership works. The new law obliges offenders to establish a compliance programme and to meet international standards. The passing of this law provided

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that bond letters and surety bonds guaranteeing the obligations of those associated with the Odebrecht scandal to the Peruvian state would be honoured. It remains unclear whether insurers will be able to safeguard themselves from associated claims.

A new Anti-Money Laundering Regulation has also been proposed by the Brazilian Superintendency of Private Insurance (SUSEP) and is currently under public consultation. The new regulation will include increased regulation regarding the control and monitoring of operations, and establish obligations for companies and some brokers to issue annual internal assessment reports and annual audits of all clients in relation to money-laundering and terrorism-financing risks. There are also rumours about a potential merger between SUSEP, the National Superintendence for Pension Funds and the National Agency of Supplementary Health, creating a single regulator on insurance and social security matters. The idea is to reduce government size and prevent unnecessary costs. However, it seems that the new government has abandoned this project, at least for now. Expert opinions on this subject are divided, with some suggesting a merger would put the decision-making independency of each agency at risk.

Brazil approved a data protection bill in July 2018, which is strongly inspired by the General Data Protection Regulation formulated by the European Union. The new law is set to become effective in August 2020 but compliance procedures are anticipated during 2019. The new regulation is expected to have a double impact on the Brazilian insurance and reinsurance market, not only creating the need for data processing companies to adjust their internal controls, but also increasing demand in the cyber insurance market. In 2017, Brazil was the country with the second-highest number of cyber attacks, with more than 62 million people being victims of attacks and approximately US$22 billion of losses. According to studies by Willis Towers Watson, Jardine Lloyd Thompson and Aon, the interest in cyber insurance has more than doubled since the new law was published. This is not surprising when data breach claims concerning redress to data subjects involve defence costs and administrative fines that can reach up to 2 per cent of the company’s net annual turnover, limited to 50 million reais.

The introduction of the new Financial Market Commission (CMF) in Chile has created a specific, prosecutor-led investigation unit for financial markets resulting in the devolution of the Superintendency of Securities and Insurance on 15 January 2018. The revamped regulator is intended to enforce compliance with legislation, facilitating the operation of market agents in a manner that protects public confidence. In September 2018, the CMF proposed a draft bill for Risk-Based Supervision of Insurance Companies to the Senate to adequately manage risks and strengthen the insurance market. In November 2018, the CMF also agreed to a multilateral memorandum of understanding with the International Organisation of Securities Commissions. It is hoped that this increased regulation will serve to strengthen the credibility of the Chilean market and prompt a rise in the number of foreign market players in the years to come.

V POLICY INTERPRETATION AND DISPUTE RESOLUTION

In Latin America, laws affecting policy interpretation may be found in a variety of types of legislation, from civil codes and codes of commerce, to financial regulation and regulatory

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8 As at January 2019.
guidance. In many jurisdictions, laws on consumer protection will also be relevant. In Brazil, for example, all individuals, as well as corporate entities in some circumstances, will benefit from consumer protection, which imposes strict rules (in favour of the insured) when it comes to interpreting insurance contracts.

The interpretation of reinsurance policies is more complicated as there is often not an established body of law. Peru and Chile are two of the few jurisdictions where insurance law includes a definition of reinsurance, including recognition that reinsurance is independent of the underlying policy.

Meanwhile, whether the insurance cession provisions of the Brazilian Civil Code apply equally to reinsurance contracts as to insurance contracts remains an area of continued debate. Many Brazilian lawyers consider that the provisions in the Civil Code are limited to insurance contracts. Others consider that the Code applies to reinsurance by analogy. The latter view reflects the approach in Colombia and Argentina, and now appears to be supported by the Brazilian draft Insurance Law Bill, placed before the Federal Senate for voting. This remains an area where clarification of the law or comment by SUSEP would be welcome.

There is similar discussion in Mexico over the law applicable to reinsurance contracts. Although it is largely accepted that reinsurance contracts are subject to the general rules applicable to commercial contracts in the Civil Code, some argue that the Insurance Contract Law also applies to fill in any gaps left by the terms of the reinsurance contract. This view runs counter to allowing parties autonomy to agree to the terms and conditions of the reinsurance.

It seems that the modernisation of the insurance regime and increased sophistication of the market (particularly in Chile) have entrenched the view that reinsurance is expected to respond as an indemnity policy for the reinsured. This is in contrast to the traditional position in the law of England and Wales, which recognises reinsurance as a separate insurance of the underlying insured risk.

By way of example, Peruvian contract law defines reinsurance as obliging the reinsurer ‘within the agreed limits’ to meet ‘the debt that arises in the patrimony of the reinsured as a consequence of the obligation assumed by it as the insurer under the contract of insurance’. It is difficult to reconcile this statement with the separate recognition of autonomy between insurance and reinsurance, such that the payment of an indemnity under the original policy must not be conditional on the relationship between the insurer and reinsurer. The simple explanation is that the aim of this provision is to prevent insurers from deferring to reinsurers as an excuse for late payment.

Consequently, it is possible that reinsurers may find themselves unable to rely on the terms of the reinsurance contract, unless they reflect the original policy. Reinsurers are also at risk of being bound to make payments, because of unauthorised actions of the reinsured (even where that reinsured retains little or none of the risk). For example, reinsurers must pay close attention to the reports issued by the independent loss adjuster appointed to manage claims in Chile and Peru.

Meanwhile, Chilean law provides for the need to determine the reinsurer’s obligation to indemnify the reinsured in the context of the terms and limits established in the reinsurance contract. It also recognises the benefit of looking to ‘international custom’ when interpreting reinsurance contracts.

9 Article 138 of the Insurance Contract Law No. 29946.
10 Article 139.
11 Article 584.
It is therefore helpful for all parties, whether a local insurer or an international reinsurer, to accept that there is significant uncertainty when it comes to the interpretation of wording drafted in line with common law principles, such as those emanating from the London market. The use of terms such as ‘condition precedent’ will usually mean nothing to a local court.

The overarching objective of Chilean insurance contract law is to protect the insured, regardless of its status or size. There is a general prohibition on insurers altering the wording of registered policies in any way that does not favour the insured. Although the 2013 law is not mandatory for policies with a premium above 200 unidades de fomento (UF), it is influential on the way risks (irrespective of their size) are written. There may also be times where a fronting operation for the facultative reinsurance of a large risk does not meet this requirement.

The Brazilian market has also traditionally been consumer-focused. The current text of the draft Insurance Law Bill (first drafted in 2004 but undergoing many changes) continues this trend, being considered highly protectionist to insureds and making no distinction between sophisticated commercial and retail consumers.

The most effective way for insurers and reinsurers to protect their position is to take active involvement in managing claims from an early stage and, where possible, to include a clause to resolve any dispute by arbitration.

At the beginning of 2017, legislation was issued in Peru that stated that institutional arbitration must be used to resolve all disputes that arise from state contracts for the purchase of services and goods. Chile went one step further by providing for the automatic arbitration of large disputes (above UF 10,000), as well as for arbitral awards to be filed with the regulator.

Substantial progress has been made in Brazil in recent years, with arbitration agreements now permitted in adhesion contracts (such as insurance policies) providing that the specific clause is expressly executed by the insured to demonstrate agreement. This has resulted in a rise in the number of both domestic and international arbitration cases. However, the draft Insurance Law Bill threatens to impede foreign arbitrations by establishing that all forms of conflict resolution involving contracts entered into in Brazil, Brazilian domiciled insureds, assets located in Brazil or interests over assets relevant to Brazilian infrastructure, must be performed in Brazil with the exclusive application of Brazilian law. If the law is passed, this would represent a step backward in the reduction of protectionism demonstrated by the Brazilian state in recent years as it has sought to establish the country as a reputable and competitive arbitration centre for external, and higher-value, disputes.

Subject to new laws being issued in Venezuela, it is likely that a reinsurance contract would be considered an ‘international contract’, allowing for the inclusion of an arbitration clause subject to a foreign seat and law.

Meanwhile, in Colombia, arbitral awards already form part of a significant body of case law relating to the interpretation of insurance contracts. However, there is no clear rule establishing the confidentiality of arbitration awards.

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12 Insurance Law No. 20,667 came into force on 1 December 2013.
13 Unidades de fomento is an alternative currency that varies daily based on the previous month’s inflation rate.
14 Legislative Decree 1341.
15 Article 543 of the Code of Commerce.
The main disadvantage of the increasing popularity of arbitration in Latin America (as with other regions) is the reduction of binding judicial precedent available for consideration in court deliberations. Considering the longevity of litigation in Latin America, case law is likely to take an even longer time to develop in the future.

Another common theme to the handling of claims in Latin America is that there are strict periods for insurers to comply with their obligations.

In Peru and Chile, the loss adjuster is usually at the centre of the process. The rules in Peru\(^\text{16}\) provide for 30 days, from the delivery of complete documentation, for insurers to respond to a claim. Any request for additional information must be made within the first 20 days, even where a loss adjuster has been appointed. In Chile, insurers must make any challenge to a loss adjuster’s final report within 10 days. In both countries, failure to comply with these periods will be taken as an acceptance of cover.

A similar 30-day rule in Mexico puts an insurer at risk of paying interest, or being subject to fines or sanctions. In Colombia, insurers that fail to respond to claims (in which the insured has duly accredited the occurrence and amount of the claim) within one month may face expedited judicial proceedings and interests on arrears (of approximately 30 per cent). Brazilian legislation also allows 30 days for the conclusion of a loss adjustment, counted from the date in which all of the relevant documents have been provided by the insured to the insurer. There is no specific law applying this deadline to reinsurance, which must self-determine an applicable time frame. Failure to comply with the period will result in the tacit acceptance of cover. If passed by the legislature, the draft Insurance Law Bill would interfere with the claims adjustment procedures currently regulated by SUSEP. For example, a claim would be considered covered if partial or total consideration passes between insurer and insured, or if a denial of cover fails to contain reasoning. Additionally, the deadline for a reinsurers’ response to a request for cover would be stipulated as 10 days. The Brazilian Superior Court of Justice has also consolidated rules that an insurer may only deny insurance indemnity based on premium default if the insured has been previously notified of its default.\(^\text{17}\)

In Argentina, it is now possible to use electronic means to comply with deadlines to deliver the policy documentation to the policyholder within 15 working days of the signing of the contract. The issue of Resolution No. 219/2018 in March 2018 provides a more reliable and cost-effective method of delivery. It also reinforces the importance of policy delivery to the policyholder.

Peru has confirmed the importance of an insurer knowing the extent of the risk it is writing at time of placement by codifying the duty to enquire into circumstances that may influence the terms of it entering into the policy.\(^\text{18}\) A policy will only be found null when there is fraud or inexcusable fault on the part of the insured. The insurer will also only have 30 days from obtaining knowledge of the inaccurate statement to dispute cover, otherwise the right to such a defence will be lost. Insurers and reinsurers must, therefore, make sure that they know the true state of the risk at the time of contracting; if necessary, tailor their questionnaires appropriately to the potential insured, and act quickly if fraud or fault is confirmed.

Colombian law recognises the right of a third-party victim to commence a direct action against the insurer in cases of third-party liability insurance. It is usual for insurers of

\(^{16}\) Article 74 of the Insurance Contract Law.

\(^{17}\) Precedent No. 616 of the Superior Court of Justice.

\(^{18}\) Insurance Contract Law No. 29,946
third-party liability policies in Colombia to be the subject of a ‘call into guarantee’, by which they become a defendant to the proceedings brought against an insured. In a 2015 case, the Colombian Supreme Court confirmed that the limitation period against the third-party claimant starts to run from the date of the loss, while the limitation period for the insured to issue proceedings against the liability insurer runs from the date of the ‘judicial or extrajudicial claim’ made by the third-party victim.

A similar right is available in Brazil, following a 2012 court decision. However, a statement issued by the Superior Court of Justice on 13 March 2015, clarified that a direct action cannot be filed exclusively against an insurer by a third-party claimant; all claims against an insurer must also include the insured as a defendant.

This is a further example of how, even though case law is non-binding across Latin America, the courts are becoming increasingly important to the development of insurance and reinsurance law.

To further illustrate this point, a 2014 decision of the Mexican Supreme Court opened the door for the incorporation of punitive damages into future judgments where it is necessary to provide a deterrent for others from engaging in harmful conduct or to the detriment of a third party.

Meanwhile, the Mexican Federal Civil Code was amended in January 2018 to alter the measure and restatement units applicable for calculating compensation to victims of personal injury, with the effect of reducing the basis for such calculation to 25 per cent of that previously anticipated. These changes may mark the end of a trend in the increasing moral damages awarded by the Mexican courts, shifting from an award to punishment method of controlling undesirable actions. From an insurer perspective, this is a welcome change. Punitive damages are often excluded under an insurer’s general terms and conditions, while moral damages are more likely to be governed by the expressed general liability policy provisions.

In a decision of particular relevance to the D&O and casualty markets, the Colombian Supreme Court of Justice held that an insurer cannot deny cover for defence costs on the basis that those defence costs were incurred without the prior authorisation of the insurer. The Court has also reaffirmed that the deadline for insurers to dispute a claim for defence costs remains 15 days. However, contrary to other areas of law, an insurer’s silence will be interpreted as tacit acceptance of cover, provoking an interruption to the running of the limitation period from the 15th day.

The Appellate Court of São Paulo has developed its interpretation of defence costs for D&O claims where there is concrete evidence of misconduct by the insured. According to the judge, a case was dismissible, regardless of whether an arbitration clause was effective, if the cause of action was illicit. In the matter in question, one of the involved directors had confessed to acts of fraud and corruption. This decision may provide support for claims for defence costs to be denied in similar conditions.

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19 Judgment on 14 December 2015.
20 Superior Court of Justice, Special Appeal 962230/RS, Judge Luis Felipe Salomão, 8 February 2012.
21 Súmula 529, which is a non-binding but persuasive statement to clarify the law.
22 Admivac case.
23 Unidad de Medida y Actualización.
VI DEVELOPMENT OF REINSURANCE LAW

The continued liberation of local reinsurance markets in Latin America during 2018 is a welcome development in a region that has traditionally been underserved. Asian and eastern European reinsurers are now also seeking the potential growth that the region has to offer and are increasing their exposure to Latin American risks.

It is expected that the demand for reinsurance cover for infrastructure and energy projects; life and health products; cyber and insurtech; as well as D&O, and property and casualty, will continue to grow during 2019 as per capita income of local populations increases in the medium term. Although the immediate impact of annual hurricane season is likely to spark an upturn in premium rates in South American markets, the development of new products to combat the risks posed by natural hazards is encouraging. Last year saw a record-breaking catastrophe bond of US$1.36 billion, being issued by the World Bank and structured by Aon, to provide earthquake reinsurance protection to multiple Latin American countries including Mexico, Chile, Colombia and Peru. This diversification of risks and international support for local economic development is likely to boost the confidence of foreign investors to take on more business in the involved nations.

Meanwhile, the development of Latin American regulatory systems continues. It will, however, take time before there is a clear, established body of law on the interpretation of reinsurance contracts.

Brazil terminated its requirement for a mandatory retainment of local reinsurance at the end of 2017 and established minimum preferable risk offerings to local reinsurers at 40 per cent of each contract, with the same conditions applicable to local and foreign reinsurers.24 This move demonstrates the continued relaxation of protectionist regulations and barriers to international investors going into 2018.

The year was also marked by the liberalisation of the placement of reinsurance and retrocession policies in the Brazilian market by foreign cedants, regardless of these entities’ registration with SUSEP, so long as the Brazilian reinsurer only cedes business in lines for which they have SUSEP’s approval to offer locally. Parties may now negotiate directly, or through local or foreign brokers, without any restrictions regarding wordings, subject to compliance with Brazilian anti-money laundering and anti-terrorism legislation, and express mention of the covered and excluded risks.25

Local Brazilian reinsurers are now also permitted to cede nuclear risks to foreign entities, when there is a lack of registered reinsurers that are specialised in nuclear risks in Brazil. For all other risks, authorisation will now depend solely on the lack of local market capacity (i.e., when the risk had been offered to all local, admitted and eventual reinsurers, and totally or partly rejected).

Argentina also relaxed its regulatory framework in 2017 regarding the local placement of reinsurance, increasing the maximum placement that local cedants can place directly with authorised ‘admitted reinsurers’ to 50 per cent, rising to 75 per cent by 2019.26 The overall objective of the resolution is to open up the reinsurance market in Argentina to international markets, but also to increase the minimum capital that is required in order to strengthen the solvency of local reinsurers.

26 SSN Resolution No. 40.422.
These changes will cause a reduced need for local reinsurers to operate as fronting companies between the original cedants and foreign reinsurers, simplifying placements in the international market.

That said, in Peru, new rules for taking out reinsurance and coinsurance via fronting arrangements entered into force during 2018. These rules allow insurance companies to incorporate a clause into insurance and reinsurance contracts that allows the insurer to pay a loss when the reinsurer pays (i.e., ‘pay when paid’ provisions). This clause may only be agreed in fronting operations when the insurer transfers 100 per cent of the risk and highlights the importance of ensuring that the underlying policy is aligned with the reinsurance in back-to-back reinsurance. It is also understood that the Superintendency of Banking, Insurance and Pension Fund Administrators is preparing new reinsurance regulations regarding the accountability of insurance companies, and disability and survival insurance premiums so further changes are anticipated for 2019.

In practice, it is rare to see reinsurance contracts that are not subject to an express choice of local law and jurisdiction. The absence of any clear principles applicable to the determination of reinsurance contracts creates difficulties for reinsurers, particularly where fronting arrangements are in place. The default position under local law seems to be that reinsurers will be bound to ‘follow the fortunes’ of their reinsured, but this is a complex area of law at an early stage of development in Latin America.

A new wording with respect to the Control Clause in Reinsurance Contracts was agreed between the Chilean Insurance Association and Lloyd’s in 2017, acknowledging the strength and credibility of the country’s insurance market. Upon agreement of the clause by parties, reinsurers are now permitted to manage the adjusting process and the aftermath of the claims. This clause also provides assurance on the jurisdiction and governing law that should apply when resolving disputes arising from insurance contracts.

In Chile, there is a requirement for all insurance and reinsurance matters to be determined within Chile. Naturally, this has led to reinsurance policies being issued subject to Chilean law and jurisdiction, although it is not known how Chilean courts would react to an express preference for a different law, such as that of England and Wales.

The position is similar in Brazil, which demands the use of Brazilian law and jurisdiction with the exception of arbitrations, which may be governed by any express law.

The governing principle under Colombian law is related to the place of performance of the contract. There is little doubt that this means any contract with a Colombian insured or insurer must be subject to Colombian law. The position in Mexico is less clear, despite the regulator’s insistence that local law and jurisdiction must be used.

It is necessary that reinsurers carefully and explicitly express any deviations from the original policy or the claims control options required, in the reinsurance policy, and in accordance with rules specific to the jurisdiction.

**VII OUTLOOK AND CONCLUSIONS**

This chapter has highlighted the renewed focus in Latin America on improving risk management and challenging corruption. This is necessary to support renewed economic growth and to protect against a repeat of widespread scandals, such as those uncovered by Operation Car Wash. In the previous edition of this chapter, we commented that protectionist
regulation was continuing to wane in favour of growth and transparency, but that political and economic volatility could undermine the progress being made. This remains the case at the beginning of 2019, with many Latin American countries having recently elected presidents promising change.

When it comes to interpreting insurance contracts, the approach of the courts tends towards favouring the insured. There is a continuing debate over whether contracts negotiated between sophisticated commercial entities (including reinsurance contracts) merit separate treatment from consumer contracts, and the approach to be taken where there is business discrepancy between insured and insurer. There is a sense that renewed growth in the region will be accompanied by the need for risk transfer, and an opportunity for insurers and reinsurers to offer new products.

Arbitration continues to gain momentum as the new preferred dispute resolution option. At the same time, Latin American regulation is modernising, allowing insurers to include express arbitration provisions, even though protectionism still exists with regards to the associated governing law and jurisdiction clauses that may be applied.

The comments in this chapter provide an overview of the current position in the main jurisdictions. The most important message is that each market is at a different stage of development and each requires close, individual analysis. In addition to consideration of the legislative regime, it is becoming more important to review court decisions and arbitration awards (where available) in determining the response of insurance and reinsurance contracts.

The Latin American market has entered a new phase of potential growth in 2019, as political and economic changes spark optimism among populations. While emphasis will be placed on the growth of cyber insurance products, the development of traditional products for D&O and property and casualty, to keep pace with commercial demands and changing legal environments, will be crucial to enabling the success of insurers and reinsurers in the region.
Chapter 5

AUSTRALIA

David Gerber and Craig Hine

I INTRODUCTION

Australia has a developed insurance market that is effectively divided between registered life insurance and reinsurance companies, authorised general insurance and reinsurance companies (including Lloyd’s underwriters), registered health insurers and insurance intermediaries.

At the end of September 2018, there were 29 registered life companies (including both direct insurers and reinsurers) in Australia with combined assets of A$232.7 billion, and 95 authorised general insurers (including both direct insurers and reinsurers, but not including Lloyd’s Australian operations) with combined assets of A$121.2 billion. There are currently 38 registered health insurers in Australia.

The Australian insurance market is highly regulated by statutes, delegated legislation, guidelines and codes.

II REGULATION

i The insurance regulator

The Australian Prudential Regulation Authority (APRA) is the prudential regulator of the financial services industry. It is also responsible for administering the Financial Claims Scheme in the Insurance Act 1973 (the Insurance Act).

The Australian Securities and Investments Commission (ASIC) is the corporate regulator. It monitors and promotes market integrity in the financial system. The ASIC also has functions and powers related to consumer protection that are conferred on it by or under the Corporations Act 2001 (the Corporations Act), the Australian Securities and Investments Commission Act 2001, the Insurance Contracts Act 1984 (the Insurance Contracts Act) and the Life Insurance Act 1995 (the Life Insurance Act).

1 David Gerber is a partner and Craig Hine is a senior associate at Clayton Utz.
5 Australian Prudential Regulation Authority Act 1998 (Cth), Section 8.
6 Australian Securities and Investments Commission Act 2001 (Cth), Section 12A.
ii Regulation and authorisation of general insurers and life insurers

The Insurance Act regulates general insurance business through a system of authorisation. Subject to a few exceptions, it is an offence for a person or body corporate (other than a Lloyd’s underwriter) to carry on ‘insurance business’ if the person or body corporate is not an authorised general insurer.\(^7\)

A body corporate may apply in writing to the APRA for authorisation to carry on insurance business. Lloyd’s is specifically authorised to carry on insurance business under, and to the extent specified in, Section 93 of the Insurance Act. General insurers authorised to conduct insurance business must comply with the Insurance Act.

The Life Insurance Act regulates life insurance business through a system of registration. A person other than a registered life company must not issue a life policy (which is a specified type of contract of insurance relating to life insurance)\(^8\) or undertake liability under such a policy.\(^9\)

A body corporate may apply in writing to the APRA for registration to carry on life insurance business. Companies registered under the Life Insurance Act must comply with that Act.

Both general insurers and life insurers are subject to prudential supervision by the APRA and must comply with applicable prudential standards. The APRA sets prudential standards that deal with matters such as minimum capital requirements, reinsurance management, risk management, outsourcing and governance.\(^10\)

The Insurance Contracts Act regulates some, but not all, contracts of insurance and proposed contracts of insurance in respect of both general and life insurance.\(^11\)

The Corporations Act regulates the sale of certain general and life insurance products by imposing uniform licensing, disclosure and conduct requirements. Those requirements are found in Chapter 7 of the Corporations Act and associated regulations. Every person who carries on a financial services business, which includes the business of insurance, must hold an Australian financial services licence, be an authorised representative of an Australian financial services licensee or fall within an exemption from the requirement to be licensed.

There is other legislation that applies more specifically to certain types of insurance, such as the Marine Insurance Act 1909, which regulates marine insurance.

iii Regulation and authorisation of health insurers

There is a substantial regulatory distinction between health insurance on the one hand, and life and general insurance on the other. However, health insurers are also subject to prudential supervision by the APRA.

The Private Health Insurance Act 2007 and Private Health Insurance (Prudential Supervision) Act 2015 regulate private health insurance business. A body corporate may apply to the APRA for registration as a private health insurer.\(^12\) The private health insurance regime

\(^7\) Insurance Act, Sections 9 and 10.
\(^8\) See Section 9 of the Life Insurance Act for what constitutes a ‘life policy’.
\(^9\) Life Insurance Act, Section 17.
\(^11\) See Section 9 of the Insurance Contracts Act, which excludes several types of contracts of insurance, including contracts of reinsurance.
\(^12\) Private Health Insurance (Prudential Supervision) Act 2015 (Cth), Section 12.
sits alongside and is closely linked to the government-funded Medicare scheme. Medicare is a Commonwealth scheme administered by the Department of Health in accordance with the National Health Act 1953.

iv Position of non-admitted insurers

General insurance

Foreign general insurers and reinsurers are subject to Australian licensing and regulatory requirements by virtue of Section 10(1) of the Insurance Act. However, there are some exemptions to the obligation to be authorised.

Generally speaking, an entity is prohibited from conducting insurance business in Australia unless it is authorised. Under the Insurance Act, ‘carrying on insurance business in Australia’ includes the insurance business of an insurer carrying on business outside Australia through an agent or broker in Australia, except where the insurance business of the insurer is solely a business of reinsurance.13

There are exemptions from the need to be authorised for certain types of insurance business. Part 2 of the Insurance Regulations 2002 specifies a number of types of insurance contracts that do not constitute ‘insurance business’ where the insurer is a non-admitted insurer. Those types of insurance contracts include:

\begin{itemize}
  \item[a] contracts for which the policyholder is a ‘high-value insured’ (as defined by the regulations);
  \item[b] contracts for specified atypical risks;
  \item[c] contracts for other risks that cannot reasonably be placed in Australia; and
  \item[d] contracts required to be issued by an insurer, or a kind of insurer, under a law of a foreign country where they are authorised or permitted to do so.
\end{itemize}

Life insurance

Foreign life insurers and reinsurers may operate in Australia by establishing a locally incorporated subsidiary to carry on life insurance business in Australia. Alternatively, they may, if they are from a jurisdiction specified in the Life Insurance Regulations 1995, seek to operate in Australia through a branch as an ‘eligible foreign life insurance company’. In either case, there are a number of different prudential and other requirements that the foreign life insurer will need to satisfy.

v Position of brokers

Brokers are regulated under Chapter 7 of the Corporations Act to the extent that they provide a financial service. Brokers usually provide the financial services of dealing in a financial product (which includes a contract of insurance) and providing financial product advice. However, a broker may also provide other types of financial services. Brokers that carry on a financial services business must hold an Australian financial services licence, unless they fall within a relevant exemption.

Reinsurance brokers usually do not need to hold an Australian financial services licence because reinsurance does not constitute a financial product under the Corporations Act.

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13 Insurance Act, Sections 3(6) and 3(6A).
vi Regulation of individuals employed by insurers

Individuals employed by an insurer that holds an Australian financial services licence are exempt from the requirement to be licensed pursuant to Section 911A(2) of the Corporations Act.

vii Compulsory insurance

There is some insurance that is compulsory for persons or entities based on their circumstances. For example, employers who meet the relevant threshold in a state or territory are required by the legislation in that jurisdiction to hold workers’ compensation insurance that meets certain minimum requirements. Motorists are required to purchase compulsory third-party personal injury insurance in order to be able to register a motor vehicle.

viii Compensation and dispute resolution regimes

The APRA administers the Financial Claims Scheme, the purpose of which is to protect policyholders of general insurance companies from potential loss owing to failure of the insurer. The scheme is structured so that an insurance claimant becomes entitled to be paid by the APRA in place of the insurer if the insurer is insolvent. This entitlement is subject to the rules in the Insurance Act and the regulations as to eligibility. The scheme also provides for a month of continued policy coverage to give policyholders time to find alternative insurance cover.

The Australian Financial Complaints Authority (AFCA) is a dispute resolution body established by legislation, overseen by the ASIC, and formed on 1 November 2018 by the amalgamation of the Financial Ombudsman Service, the Superannuation Complaints Tribunal, and the Credit and Investment Ombudsman. The AFCA resolves disputes between its members, which are financial services providers across the spectrum of the financial services industry, and consumers. Policyholders and other insurance consumers can refer disputes related to certain life or general insurance contracts, including complaints related to life insurance acquired through superannuation, to the AFCA. The AFCA has jurisdiction to resolve insurance disputes involving prescribed maximum amounts, agreed by the insurance industry with the approval of the ASIC. For the general insurance industry, the AFCA administers and monitors compliance with the General Insurance Code of Practice 2014 (the General Insurance Code), which is applicable to general insurers writing certain domestic and personal classes of insurance who are signatories to the General Insurance Code.

ix Other notable regulated aspects of the industry

The general and life insurance legislation deals with portfolio transfers between Australian insurers. Under the Insurance Act, a general insurer may not transfer its rights and liabilities under policies to another Australian regulated insurer, except under a scheme confirmed by the Federal Court of Australia.14 Similarly, under the Life Insurance Act, a life company may not transfer to, or amalgamate with, another life company its life insurance business, except under a scheme confirmed by the Federal Court of Australia.15

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14 Insurance Act, Division 3A.
15 Life Insurance Act, Section 190.
For both general insurers and life insurers, portfolio transfers comprising 15 per cent or more of an insurer’s book of unearned premiums are regulated by the Insurance Acquisitions and Takeovers Act 1991 and require approval by the APRA.

There are also regulations that affect the acquisition of an Australian insurance company more generally. Such acquisitions must be in accordance with provisions of various pieces of legislation, including the Financial Sector (Shareholdings) Act 1998, the Foreign Acquisition and Takeovers Act 1975 and, if applicable, the Insurance Acquisitions and Takeovers Act 1991.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Insurance and reinsurance law in Australia derives from the general law of contract and common law insurance principles, many of which originated in jurisprudence from the United Kingdom. These principles are modified to some extent by the Insurance Contracts Act and other legislation, but only in respect of insurance contracts to which the legislation applies.

ii Making the contract

Essential ingredients of an insurance contract

The characteristics of a contract of insurance are not defined in statute. There are a number of judicial pronouncements that have identified several characteristics that ought to be present for an agreement to be considered one of ‘insurance’. The essential ingredients of an insurance contract are as follows:

a the insured must have a contractual right to be indemnified; \(^{16}\)
b the insurer must be legally obliged to pay money (or its equivalent) to the insured in the event of a specified event occurring; \(^{17}\)
c it must be uncertain whether the specified event will occur, or the time at which it will occur; \(^{18}\) and
d the contract must be for some consideration: usually, but not necessarily, periodical payments called premiums. \(^{19}\)

Traditionally, it was a requirement of insurance that the insured have a legal or equitable interest in the subject of the insurance. However, this requirement has essentially been removed in relation to most contracts of general and life insurance by the Insurance Contracts Act. \(^{20}\)

The principles governing the formation of an insurance contract are essentially the same as the principles that govern the formation of ordinary contracts. However, the principles

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\(^{16}\) See, for example, Department of Trade and Industry v. St Christopher Motorists Association Ltd [1974] 1 WLR 99, 102 and 103; Medical Defence Union v. Department of Trade [1979] 2 All ER 421; Bank of Nova Scotia v. Hellenic Mutual War Risks Association (Bermuda) (the ‘Good Luck’) [1988] 1 Lloyd’s Rep 514, 545. As to the extension to a statutory right to be indemnified, see R v. Cohen: Ex parte Motor Accidents Insurance Board (1979) 27 ALR 263.

\(^{17}\) Medical Defence Union Ltd v. Department of Trade [1979] 2 All ER 421, 429.

\(^{18}\) Prudential Insurance Co v. Inland Revenue Commissioners (1904) 2 KB 658, 663.

\(^{19}\) ibid.

\(^{20}\) Insurance Contracts Act, Sections 16 to 18.
are modified by statute in some cases. For example, for contracts to which the Insurance Contracts Act applies, the insurer must supply a variety of statutory notices to the insured pursuant to Sections 22 and 37 of the Insurance Contracts Act.

The Insurance Contracts Act prescribes terms and conditions that certain consumer contracts must provide, unless the insurer modifies the statutory standard cover in accordance with the legislation.

**Utmost good faith, disclosure and representations**

There is a duty of utmost good faith in respect of both contracts of insurance and contracts of reinsurance. For contracts of insurance that are subject to the Insurance Contracts Act, there is also a duty implied by statute into those contracts of insurance under Section 13(1) of the Insurance Contracts Act. The duty under the Insurance Contracts Act is described as a duty requiring each party to act towards the other party, in respect of any matter arising under or in relation to the contract of insurance, with the utmost good faith.

There is also a duty of disclosure. At common law, this duty requires the insured to reveal all material facts of which it is aware in the negotiations leading up to the formation or renewal of the contract.21 The duty of disclosure ends once the contract is concluded, unless the parties specifically agree otherwise. Under the Insurance Contracts Act, the insured must disclose matters it knows to be relevant to the decision of the insurer (or which a reasonable person in the circumstances could be expected to know to be relevant) whether to accept the risk and, if so, on what terms.22

The common law regarding misrepresentations is impacted by the Insurance Contracts Act. Misrepresentations are treated differently depending on whether they are fraudulent or innocent. A fraudulent misrepresentation is a false representation, made knowingly or recklessly, without regard for its truth or falsity. The legislation restricts a general insurer’s right to avoid a contract in the circumstances of an innocent misrepresentation by an insured.23 The Insurance Contracts Act also modifies the common law rights of life insurers in relation to misrepresentations, non-disclosures24 and misstatements of age.25 A court may disregard avoidance in certain circumstances.26

**Recording the contract**

Contracts of insurance and reinsurance are usually evidenced by a written policy. For contracts of insurance to which the Insurance Contracts Act applies, an insurer is required to give to the insured a statement in writing that sets out all the provisions of the contract upon written request by the insured.27 Prudential standards issued by the APRA regulate the documenting of contracts of reinsurance.

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21 *Carter v. Boehm* (1766) 97 ER 1162.
22 Insurance Contracts Act, Section 21.
23 Insurance Contracts Act, Section 28(3).
24 Insurance Contracts Act, Section 29.
25 Insurance Contracts Act, Section 30.
26 Insurance Contracts Act, Section 31.
27 Insurance Contracts Act, Section 74.

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Interpreting the contract

General rules of interpretation

The ordinary rules applying to the interpretation of commercial contracts in general apply equally to insurance contracts. The ordinary rules include that:

a. as a commercial contract, an insurance policy will be given a ‘business-like’ interpretation unless they have a technical meaning or the sense in which they are used suggests that such a meaning is inappropriate;

b. the contract is read as a whole, taking into account the text, context in which words appear and the purpose of the policy’s provisions, which, if appropriate to consider, may include relevant surrounding circumstances;

c. the main object or commercial purpose of the contract is to be taken into account; and

d. any ambiguity is to be resolved against the party who drafted the contract (the contra proferentem rule).

Another rule relevant to the interpretation of insurance contracts is the parol evidence rule. This dictates that evidence of a party’s intention extrinsic to the written document should not be considered to explain or vary the written terms within it. The rule is subject to a number of exceptions. For example, extrinsic evidence may be considered to resolve inherent ambiguity. Extrinsic evidence may also be adduced to prove that a policy does not express what was clearly agreed by the parties to it or that there is a collateral contract that contains a separate undertaking.

Types of terms in insurance contracts

The terms ‘condition’ and ‘warranty’ can have different meanings in insurance law than in general contract law. They can both refer to clauses for which the insurer may repudiate the contract for breach. Whether a term is in fact a condition or warranty is a question of construction. The use of the word ‘condition’ or ‘warranty’ will not be conclusive. In construing the contract, the courts will seek to ascertain the intention of the parties.

References:

35 L & M Electrics Pty Ltd v. SGIC (Qld) (1985) 3 ANZ Ins Cas 60-641, 78, 946.
The effect of breaching a condition or warranty may be impacted by Section 54 of the Insurance Contracts Act. In summary, Section 54 restricts an insurer’s ability to refuse to pay a claim, in whole or in part, by reason of a post-contractual act of the insured or some other person. Section 54 provides that the act must reasonably be regarded as capable of causing or contributing to a loss covered by the contract of insurance before the insurer may refuse to pay the claim.\(^{39}\) If this is not the case, the insurer’s liability will be reduced by the amount that fairly represents the extent to which the insurer was prejudiced as a result of the act.\(^{40}\)

iv Intermediaries and the role of the broker

Conduct rules

Brokers and other intermediaries regulated under the Corporations Act are subject to the various conduct requirements in Chapter 7 of the Corporations Act.

Insurance brokers who are members of the National Insurance Brokers Association (NIBA) are also bound to comply with the Insurance Brokers Code of Practice (the NIBA Code). This is an agreement between the NIBA and its members. Other brokers who are not members of the NIBA may also subscribe to the NIBA Code. The Code sets minimum service standards that clients can expect from brokers, and outlines how complaints and disputes regarding potential breaches of the Code can be resolved.

Agency and contracting

Brokers usually represent insureds. However, insurance intermediaries may act for either the insurer or insured. In some cases, they operate under a binder that gives them the authority to bind insurers by entering insurance contracts on their behalf.

Where intermediaries act on behalf of insurers, they typically do so as an authorised representative or distributor of the insurer, and enter into formal written agreements that record that arrangement.

v Claims

Notification

The requirement to notify insurers of a loss or claim is generally dictated by what is required under the insurance or reinsurance contract. However, there is a statutory extension to the notification rights of an insured.

Section 40(3) of the Insurance Contracts Act, which applies in respect of certain contracts of liability insurance (essentially, claims made and notified insurance policies),\(^{41}\) has the effect of attaching coverage where an insured notifies circumstances within the policy period.

If an insured fails to notify facts or circumstances to an insurer in accordance with a contractual requirement (e.g., a circumstance notification or ‘deeming’ provision), the failure may be remedied by Section 54 of the Insurance Contracts Act.

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\(^{39}\) Insurance Contracts Act, Section 54(2).

\(^{40}\) Insurance Contracts Act, Section 54(1).

\(^{41}\) Insurance Contracts Act, Section 40(1).
Good faith and claims
The statutory duty of utmost good faith applies in connection with claims. If an insurer has failed to comply with the duty of utmost good faith implied under Section 13(1) of the Insurance Contracts Act in the handling or settlement of a claim under a contract of insurance, the ASIC is effectively empowered to treat the insurer as being in breach of the conditions of its Australian financial services licence. In those circumstances, the ASIC may exercise its powers of enforcement against the insurer. In sufficiently serious cases, the ASIC has the power to vary, suspend or cancel an Australian financial services licence, and to ban persons from providing financial services.

Dispute resolution clauses
Australian financial services licensees must have a dispute resolution system in place as a condition of their licence. That system must meet the standards prescribed by the ASIC. Accordingly, the dispute resolution clauses in many contracts of insurance are governed by these standards.

Some insurance policies, particularly professional indemnity and directors’ and officers’ liability policies, commonly have clauses that provide for expert determination by a senior counsel or senior lawyer with relevant experience. These clauses typically apply to disputes, such as whether a third-party claim should be contested or settled, or the allocation of defence costs between insured and uninsured parties.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses
It is common for parties to a contract of insurance or reinsurance to submit to the courts of a selected jurisdiction and agree to be governed by its laws.

Jurisdiction clauses typically identify whether the nominated jurisdiction is an exclusive or non-exclusive jurisdiction. If a jurisdiction clause identifies courts that are the natural forum for a dispute, this is a factor that would support the clause being read as an exclusive jurisdiction clause. In a contract of insurance, ambiguity as to the jurisdiction tends to be interpreted in favour of the insured.42 Where a contract is subject to the Insurance Contracts Act, any provision purporting to specify an alternative jurisdiction may be void under Section 52 of the Insurance Contracts Act, which prohibits contracting out of the Act.43

Parties may also agree that disputes are to be determined by arbitration. Under Section 43(1) of the Insurance Contracts Act, arbitration clauses in insurance contracts governed by that legislation are void. This does not prevent parties from agreeing to arbitrate after a dispute has arisen. Arbitration clauses in reinsurance contracts are generally enforceable.

Jurisdiction, choice of law and arbitration clauses, where they may be used, need to be drafted clearly to ensure that they are not unenforceable because of uncertainty.

42 See, for example, ACE Insurance Ltd v. Moose Enterprise Pty Ltd [2009] NSWSC 724 (Justice Brereton, 31 July 2009).
43 See, for example, Akai Pty Ltd v. The People’s Insurance Co Ltd (1996) 188 CLR 418.
ii Litigation

Litigation stages

Litigation stages, including appeals, differ depending on the particular court in which the litigation is taking place.

Typically, proceedings are conducted by an exchange of pleadings. Court rules may allow, or one or more parties may seek orders for, discovery of documents. Discovery requires the party that is subject to the order to undertake a search for particular documents that are relevant to the issues in dispute, including those that may be adverse to their case. Following discovery, parties will usually be required to exchange evidence in preparation for trial. The final stage is a trial that usually involves evidence (including cross-examination) and legal argument.

Depending on the relevant jurisdiction, the parties may agree to attend, or be ordered by the court to attend, mediation at any stage of the proceedings.

An unsuccessful party at the trial may, subject to the rules applicable to the court, appeal a judgment or order to a higher court. In some cases, this may require the leave of the court.

Evidence

Witness evidence usually takes the form of a signed statement recording the oral evidence to be given at trial. For a party to rely on witness evidence, the witness must be called to give oral evidence in court and may be cross-examined by the other parties. Witness evidence may also include the evidence of an expert who has been asked to provide an opinion on one or more particular issues relevant to the proceedings. Parties may also seek to rely on documentary evidence, which in many cases is simply the business records of a party to the proceeding.

The rules of evidence differ depending on the court in which evidence is being adduced.

Costs

An order to pay costs usually follows an award, so that the unsuccessful party is required to pay the reasonable costs incurred by its opponent. If the amount is not agreed, the costs are assessed by the court. An award of costs may not cover the full amount actually incurred by the successful party.

iii Arbitration

Format of insurance arbitrations

In Australia, the format of insurance arbitrations depends on whether the arbitration is an international or domestic arbitration. There is a separate statutory regime for each. Domestic arbitrations are regulated by mostly uniform state-based legislation. International arbitrations are regulated by the International Arbitration Act 1974, which ensures that arbitration practice in Australia complies with internationally accepted norms. The format of insurance arbitrations generally does not differ from the format of other commercial arbitrations.

The Australian Centre for International Commercial Arbitration (ACICA) is a leading international arbitration institution. It is common for parties to adopt, and conduct arbitrations in accordance with, the ACICA Arbitration Rules or ACICA Expedited Arbitration Rules.
Procedure and evidence

An arbitral tribunal is permitted under the ACICA Arbitration Rules to conduct an arbitration in the manner it considers appropriate. The procedure and evidence may be tailored to meet the requirements of the parties. The procedure is bound only by the requirement to give effect to the principles of procedural fairness and natural justice.

The role of witnesses may be limited by agreement of the parties. The process may be similar to a court procedure, and allow for oral testimony of witnesses with the ability of the other party to cross-examine each witness. Conversely, the parties may agree that only written evidence is allowed. Similarly, sometimes oral submissions may be made or, as is the case under the ACICA Expedited Rules, oral submissions may be prohibited.

Costs

In respect of both domestic and international arbitrations, the tribunal is empowered to determine and award costs at its discretion, unless otherwise agreed by the parties. The relevant legislation does not offer any guidance as to how a tribunal should exercise that discretion. As a general rule, and consistent with the ACICA Arbitration Rules, in most cases costs will generally follow the event.

iv Mediation

Mediation is commonly used as a way for the parties to attempt to resolve disputes without being bound by the decision of a third party, such as a judge or arbitrator. In some circumstances, mediation may be ordered by a court before court proceedings can continue to trial. It is more common for parties to agree voluntarily to attend mediation.

For claims that meet the relevant criteria, insureds may have the option of pursuing the claim through the AFCA.

V YEAR IN REVIEW

i Regulatory changes

There have been a number of recent regulatory developments affecting the insurance industry, some of which are likely to lead to further changes. In particular, the industry has seen the conclusion of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, which was established on 14 December 2017, and which culminated in the issuing of a final report on 1 February 2019. The Royal Commission’s broad terms of reference included an inquiry into, among other things, whether conduct of any financial services entities (including insurers and reinsurers) amounted to misconduct and, if so, whether the question of criminal or other legal proceedings should be referred to the relevant government agency, and whether such conduct fell below community standards and expectations. The terms of reference also included an inquiry into the adequacy of existing laws and policies of the Commonwealth, the internal systems of financial services entities and forms of industry self-regulation. In that context, and in respect of the insurance industry, the final report of the Royal Commission made a number of recommendations. Some of the key recommendations include:

a the prohibition of the hawking of insurance products, including by way of unsolicited offers and sales;
the implementation of a deferred sales model for the sale of any ‘add-on’ insurance and a cap on commissions paid to vehicle dealers;

c the replacement of the existing statutory duty of disclosure (under the Insurance Contracts Act) with a duty to take reasonable care not to make a misrepresentation to the insurer (essentially, adopting the duty enacted under the UK Consumer Insurance (Disclosure and Representations) Act 2012, which introduced a duty in the terms recommended by the UK Law Commission and the Scottish Law Commission in their 2009 report entitled ‘Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation’);

d a change to the circumstances in which a life insurer may avoid a contract on the basis of non-disclosure or misrepresentation;

e the application of ‘unfair contract terms’ legislation to certain insurance contracts; and

f legislative changes to make insurance claims handling subject to the Corporations Act licensing regime and regulation by the ASIC under the Corporations Act.

As mentioned in Section II.viii, the industry also saw the formation of the AFCA on 1 November 2018. The AFCA is an external dispute resolution body, which was established under statute as a ‘one-stop shop’ for complaints (disputes) by consumers against financial firms, including insurers, banks and superannuation fund trustees. The AFCA has jurisdiction to hear a wide range of disputes, including insurance disputes. It is empowered to resolve a dispute by mediating a settlement between the disputing parties, and, ultimately, by issuing a binding decision.

ii Key case

In Onley & Anor v. Catlin Syndicate Ltd (as the underwriting member of Lloyd’s Syndicate 2003), the Full Court of the Federal Court considered the circumstances in which an insurer may deny cover, including the advancement of defence costs, on the grounds of non-disclosure by the insured parties.

The case concerned the insured parties, Onley and Cranston, who were alleged to have orchestrated a scheme to avoid liabilities owed to the Australian Tax Office (ATO). Onley and Cranston allegedly established companies that would provide each other with payroll services, which allowed pay-as-you-go withholding amounts to be transferred to the service providers, only for those funds to be transferred, indirectly, to Onley and Cranston. It was alleged that the intended consequence was for the ATO to only be able to enforce the taxation obligations against straw companies. Two sets of criminal proceedings were brought against Onley and Cranston under the Criminal Code Act 1995 (Cth) and the Proceeds of Crimes Act 2003 (Cth).

Onley and Cranston sought indemnity, as well as the advancement of defence costs, from the insurer under the policy. The policy excluded losses ‘resulting from Claims against any Insured arising directly or indirectly from . . . any Wrongful Act committed by that Insured with . . . fraudulent . . . or criminal intent’. Regarding the insurer’s advancement of defence costs, the policy provided that:

a the insurer would cease to advance the defence costs if Onley and Cranston were not entitled to cover; and
If a claim alleged a ‘wrongful act’, the defence costs would be advanced until a judgment or adjudication determined that Onley and Cranston had in fact committed the wrongful act.

Onley and Cranston asserted before the Court that they were entitled to defence costs because their alleged conduct had not been determined by judgment or adjudication. The Court disagreed, finding that this provision did not restrict Catlin Syndicate’s ability to rely on its rights under the Insurance Contracts Act 1984 (Cth) to avoid the contract because of Onley and Cranston’s non-disclosure. The Court accordingly found that Catlin Syndicate was not required to advance the defence costs.

The judgment highlights the importance of an insured’s duty of disclosure in respect of pre-contractual matters. The Court found that the courts ‘will not allow a party to contract out of the consequences of their own fraudulent conduct’.

VI OUTLOOK AND CONCLUSIONS

The insurance industry in Australia is constantly adapting to regulatory and other changes. Consumer protection through the regulation of both sales and claims conduct has been a focus of insurance regulators in recent times and the Royal Commission, which issued its final report on 1 February 2019. The government has promised substantial regulatory change following, and in accordance with, the conclusion and findings of the Royal Commission. To that end, the Royal Commission’s specific recommendations in respect of insurance will significantly impact the insurance industry in the years ahead.

Certain types of insurance products, and conduct by insurers, have also been targeted for regulatory enforcement action. In light of the Royal Commission’s final report, the general and life insurance industries will clearly remain a focus of regulators in the near future.
AUSTRIA

Ralph Hofmann-Credner

I INTRODUCTION

Austria accommodates large dominant local insurers with strong ties to the retail business, as well as international specialist insurers who benefit from the geographical advantages of Austria as a hub for the central-eastern Europe and south-eastern Europe markets.

The Austrian insurance industry employs approximately 29,000 people, whereby the Austrian Insurance Association (VVO)\(^2\) represents the interests of all private insurance companies active in Austria. The VVO is also registered in the Austrian lobbying register.\(^3\) Membership in the VVO is voluntary and, according to the homepage of the VVO, there are 126 members.\(^4\)

In October 2002, insurers that are members of the VVO established a market terrorism pool (Terrorpool) as a private scheme that covers risks with effect from 1 January 2003. Terrorpool is a mixed coinsurance and reinsurance pool, with no government participation. It acts as reinsurance, with the direct writing insurer issuing a separate terrorism policy and then ceding the business to it, and is open to insurers and reinsurers writing business in Austria. Participation in the pool is not compulsory, and insurance of the terrorism risks covered by the scheme is voluntary.

On 9 May 2018, the VVO published its annual report for 2017, which reflects a premium volume of €17.1 billion generated by Austrian licensed insurers of local direct contractual insurance businesses, whereas insurance payments for the same period amounted to €14.56 billion.\(^5\)

II REGULATION

Conducting insurance and reinsurance business requires the holding of the respective licence. Depending on whether it is a domestic company or a third-country insurer, the Austrian Financial Market Authority (FMA)\(^6\) grants a licence upon application and fulfilment of

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\(^1\) Ralph Hofmann-Credner is a counsel at Wolf Theiss Rechtsanwälte GmbH & Co KG.

\(^2\) www.vvo.at.


\(^4\) As at February 2019.

\(^5\) https://www.vvo.at/vvo/vvo.nsf/033bc38c04cb4a8bc12574dc005de1e4/cadacf33211c6b0cc1258288002a6df7?OpenDocument.

\(^6\) The homepage of the FMA is available in English. For a general overview on supervision of insurance undertakings, licensing and notification and other special topics, see www.fma.gv.at/en/insurance.
preconditions. A European Economic Area (EEA) insurance company holding a licence and situated outside Austria does not require a further or domestic insurance licence. The EEA insurer may, upon notification of the competent supervisory body, conduct insurance business in Austria on a freedom-of-services basis or on an establishment basis by opening a local branch. The ongoing supervision of the insurance and reinsurance market is also carried out by the FMA.

Since implementing the Solvency II Directive,\(^7\) the Insurance Supervision Act has been revised and came into force on 1 January 2016 (VAG 2016).\(^8\) The Insurance Distribution Directive (IDD)\(^9\) is implemented in Austria predominantly by two legislative acts: the Insurance Sales Law Amendment Act 2018, which came into force on 1 October 2018; and the Insurance Sales Act, which was approved by Parliament on 12 December 2018. It is an overriding objective of the Austrian legislature to avoid ‘gold-plating’ when transposing supranational law.

### III  INSURANCE AND REINSURANCE LAW

#### i  Sources of law

The substantive insurance law is primarily governed by the Insurance Contract Act (VersVG). In addition, certain advice and information obligations of insurers towards insureds are stipulated in the VAG 2016. For certain insurance types (e.g., motor liability insurance), special statutes exist. Where the insurance statutes do not provide for any special rules, general civil law provisions of the Civil Code apply: for example, general rules regarding the conclusion, interpretation and rescission of a contract.

The VersVG is, in general, applicable both in consumer and non-consumer contracts without distinction. It aims to protect the insured as the weaker party, mainly by means of various coercive provisions that cannot be deviated from to the detriment of the insured. However, reinsurance does not fall within the scope of the VersVG; therefore, reinsurance contracts are not subject to those restrictions, and may be concluded according to general principles of contract law (the Civil Code and the Business Enterprise Code).

In addition, general insurance terms and conditions play a key role in insurance law. Model insurance terms are published by the VVO,\(^10\) and although these are not binding, they are usually adopted by insurers and incorporated into insurance contracts with only minor changes. In 2018, the VVO published its model terms for cyber risk insurance.

Although court judgments are, in general, only binding on the parties involved in a dispute, case law plays an important role. Furthermore, the courts of lower instance have to

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8 An English translation of the VAG 2016 is available online: www.fma.gv.at/download.php?id=825.


10 Model insurance terms and conditions in German can be found on the homepage of the VVO: https://www.vvo.at/vvo/vvo.nsf/sysPages/musterbedingungen.html.
observe and apply the judicature of courts of higher instance, such as the courts of appeal and of the Supreme Court of Justice of the Republic of Austria (the Supreme Court), which is the highest instance in civil and criminal matters.\footnote{www.ogh.gv.at/en.}

\section*{Making the contract}

According to the general rules on the conclusion of contracts, the making of an insurance contract requires an offer and an acceptance. If the insured places his or her offer via a standard application form of an insurer, then the offer of the insured shall be binding for a maximum of six weeks unless a longer period has been individually negotiated between the insurer and the insured.

An insurer is obliged to furnish an insured with a copy of the relevant terms and conditions before application; provide the information required by the VAG 2016 (see below); and hand out to the insured a copy of his or her application, and instruct him or her that the failure of the insurer to provide these documents and information entitles him or her to rescind the contract (within two weeks or one month of receipt of the documents and information respectively).

The insurer may accept the offer of the insured simply by producing a policy that will be handed over to the insured. If the policy differs from the offer (application) of the insured, the insured is entitled to object to the deviations in writing within one month of the receipt of the policy. The insurer is obliged to point out any deviations in the policy, and inform the insured about his or her right to object. Provided that the insurer has informed the insured properly, the law assumes that the insured accepts any deviation if he or she does not object.

Section 16 et seq. of the VersVG stipulate pre-contractual notification obligations for the insured.

Thereby, before the conclusion of the contract (i.e., acceptance of the offer by the insurer), the prospective insured is obliged to provide the insurer with full and complete information on circumstances relevant for the assessment of the risk. The prospective insured has to disclose all facts that are relevant for the risk assessment even if the insurer did not ask for a specific piece of information. However, an insured is only obliged to reveal facts that he or she has actual knowledge of and that are substantial regarding the terms of the contract (e.g., facts relevant for the calculation of the premium or the exclusion of certain risks). Information that the insurer explicitly asked for in writing is presumed to be relevant by law.

If the insured fails to comply with the information obligations, then the insurer is entitled to rescind the contract within one month of gaining knowledge of the violation of the information obligation. However, the right of recession depends on various factors, such as:

\begin{itemize}
\item[a] the degree of fault of the insured;
\item[b] the relevance of the information;
\item[c] to what extent the information has been specifically asked for by the insurer; and
\item[d] whether the insurer was already familiar with or has waived his or her right to be informed about the relevant circumstances.
\end{itemize}

However, the insurer is obliged to grant coverage to the insured in spite of recession of the contract if and insofar as the information withheld by the insured did not have any influence on the occurrence of the damage event or the amount of indemnification.
Information obligations of the insurer prior to the conclusion of the contract

According to the provisions of the VAG 2016, the insurer must provide the insured with specific information in writing prior to the conclusion of the insurance contract, such as:

- the name, head office address and legal form of the insurance undertaking and, where appropriate, the branch by which the contract will be concluded;
- the name and address of the authority supervising the insurer; and
- the complaints procedures.

As of 1 January 2019, the VersVG contains further information requirements and a modified rescission right for an insured (Section 5c).

Interpreting the contract

Austrian law contains specific rules on the interpretation of a contract or a declaration of intention of a party to an agreement. As regards the interpretation of general insurance conditions, the Supreme Court constantly rules that such an interpretation has to be aligned to the understanding of an average prudent insured. Any clause limiting the covered risk shall be ineffective to the extent that an insured would not be able to understand the scope without any legal qualification. Finally, the burden of proof for the existence of an exclusion lies with the insurer.

An incorporation of terms of insurance follows the general rule of concluding an agreement. Except where the law stipulates a written form or a higher degree of legal certainty (e.g., a notary public confirming the identity of a party to an agreement), parties may freely agree orally on certain provisions to a contract. Likewise, not all provisions that are contained in a document, even if this is attached to an agreement, are deemed to be agreed upon by the parties and be effective. It is the understanding of the Supreme Court that general terms and conditions shall be applicable if they have been sufficiently clearly agreed upon. It is insufficient to simply refer to general terms and conditions in the offer signed by the customer and in the policy. On the other hand, it is not necessary for a copy of the general terms and conditions to be physically handed over to the customer or insured for the agreement to be effective. There is no differentiation between consumer and business contracts in this regard.

Intermediaries and the role of the broker

Brokers and agents play a key role in generating business for insurers. The activity of an independent insurance intermediary (both as direct and reinsurance broker) is regulated under the Trade Regulation Act 1994 (GewO). An insurance intermediary must hold a trade licence granted by the local trade regulation authority, and must be registered in the register of intermediaries (i.e., the Austrian Business Licence Information System (GISA)). A national list of registered intermediaries is available on the GISA website.

To be registered as an insurance intermediary, the applicant must provide proof of his or her professional competence (e.g., a proper educational background). In addition,
the insurance intermediary has to obtain compulsory professional indemnity for insurance intermediaries (see Section 137c of the GewO) or an equivalent guarantee of coverage. Intermediaries from EU or EEA Member States may do business in Austria on a freedom-of-services basis upon notification of the Austrian trade authority. Intermediaries from EU or EEA Member States that want to establish a branch in Austria on a freedom-of-establishment basis must provide the Austrian authority with their registration documents from the state of origin, and evidence of compulsory professional indemnity insurance.

Sections 137f to 137h of the GewO, which, inter alia, reflect the requirements set out in the EU Insurance Mediation Directive, provide for specific conduct rules for the insurance intermediary and specific obligations regarding pre-contractual disclosure. The information must be provided to the customer on paper or in some other durable medium, in a clear and accurate manner comprehensible to the customer, and in German or in another language agreed by the parties.

Co-insurance (disclosed or hidden) is a common instrument as capacity or risk appetite may be limited. Hidden co-insurance is also commonly used by the larger Austrian insurance companies. In order to keep only a share of the risk in their books, they commonly consult other insurers with respect to a certain risk (in general, if capacity for a certain risk is limited) but issue the policy on their own letterhead.

v Claims

In cases where an insured event occurs, the insured is, in general, obliged to notify the insurer with undue delay (see Section 33 of the VersVG). The burden of proof that a notification was not timely lies on the insurer. A late notification may release the insurer from the obligation to indemnify the insured, unless the insured proves that he or she is not at fault for breaching his or her obligations, or that the late notification did not have any influence on the assessment of the insured event or the amount of indemnification to be paid by the insurer.

The insured is obliged to provide the insurer with full, complete and correct information. Providing false information intentionally could result in criminal liability of the insured for insurance fraud.

The insurer is due to pay a claim on completion of the necessary investigations (see Section 11 of the VersVG). If investigations of the insured event are not completed within two months of submission of the claim, the insured is entitled to request from the insurer a statement outlining the reasons why the investigations had not been completed to date. If the insurer fails to comply with such a request within one month, the payment of the claim becomes due.

If coverage on the merits is undisputed, then the insured may claim instalment payments from the insurer if the investigations are not completed within one month of submission of the claim (see Section 11(3) of the VersVG). The provisions of Section 11 are coercive and cannot be deviated from by agreement.

Insurance claims in general become time-barred in three years. However, if the insurer denies coverage, he or she may impose on the insured the obligation to file a lawsuit within one year by declaring a ‘qualified denial of coverage’, otherwise the claim of the insured expires (see Section 12(3) of the VersVG). A qualified denial requires a reasoned denial of coverage by the insurer in writing, along with an express statement of the legal consequences if no lawsuit is filed within one year.
iv DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Since Austria is a member of the EU, jurisdiction in international insurance disputes is determined by the rules of Brussels I Regulation (recast). As a general rule (see Articles 11 to 14), the Regulation stipulates that an insurer may bring proceedings only in the courts of the Member State in which the defendant (the policyholder, the insured or a beneficiary) is domiciled. However, the insurer may be sued in the courts of the Member State in which he or she is domiciled (including where he or she has a branch, agency or establishment); or in the Member State where the claimant (the policyholder, the insured or a beneficiary) is domiciled; or, if he or she is a co-insurer, in the courts of a Member State in which proceedings are brought against the leading insurer. For liability insurance, the insurer may in addition be sued in the courts of the place where the harmful event occurred and may in general be joined in proceedings that the injured party has brought against the insured.

The Regulation sets extensive limits on the inclusion of choice of forum clauses in insurance disputes (however, these clauses do not apply in insurance cases of large risks and some other risks connected with shipping and aircraft). In principle, the parties to an insurance agreement may only depart from the provisions of the Regulation if the choice of forum agreement:

a is entered into after the dispute has arisen;
b allows the policyholder, the insured or a beneficiary to sue in other courts than those set out by the Regulation;
c is concluded between a policyholder and an insurer domiciled in the same Member State with the aim to conferring jurisdiction on the courts of that Member State for damage events that occur abroad; or
d is concluded with a policyholder not domiciled in a Member State.

Regarding international insurance disputes falling within the scope of the Rome I Regulation, the choice of law is limited especially by the restrictions as listed in Article 7, Paragraph 3. For contracts covering risks (other than large risks) that are situated in a Member State, the choice of law is limited to the law of:

a the Member State where the risk is situated;
b the country where the policyholder has his or her habitual residence;
c in the case of life insurance, the Member State of which the policyholder is a national;
d for insurance contracts covering risks limited to events occurring in one Member State, the law of that Member State; or

e where the policyholder pursues a commercial or industrial activity or a liberal profession, and the insurance contract covers two or more risks that relate to those activities and are situated in different Member States, the law of any of the Member States concerned or the law of the country of habitual residence of the policyholder.

For compulsory insurance, special provisions apply.

In addition, Article 7 of the Rome I Regulation provides that if the parties are entitled to choose Austrian law, and Austrian law allows greater freedom on choice of law in insurance contracts, then the parties are allowed to make use of this freedom. In Austria, according to the Statute on Private International Law (see Section 35a(1) of the Private International Law Act), the parties may choose any law as the law applicable to the insurance contract. However, if the insurer carries out his or her business or otherwise directs his or her activities to the state of residence of the insured, then by choice of law he or she may not be deprived of the rights granted under mandatory provisions of the law that would be applicable in the absence of choice. In consumer contracts, further limitations exist.

For arbitration clauses, the general norms of the Civil Procedure Code stipulate that an arbitration agreement may be concluded between parties for both existing and future civil claims that may arise out of or in connection with a defined legal relationship (certain matters are excluded, e.g., family law and tenancy matters). The arbitration agreement must be in writing and indicate the parties' will to submit to arbitration. In consumer contracts, stricter requirements exist.

ii Litigation

The state court system in civil proceedings consists of a maximum of three domestic stages (i.e., without preliminary ruling procedures at the Court of Justice of the European Union (ECJ)). A lawsuit is filed with the court of first instance in which a case is generally heard by a single sitting judge. With the exception of minor cases, an appeal may be raised to the court of higher instance sitting as a court of appeals with a bench of three professional judges. A further appeal may be filed with the Supreme Court in the event that the legal requirements are fulfilled. The interpretation of a contract (including the interpretation of the scope of a clause in an insurance contract) in general does not allow for filing an appeal to the Supreme Court, because the interpretation of a specific contract has no influence beyond the specific case. The alternative is a clause in general terms and conditions that needs to be interpreted and that is commonly used in a similar way.

Evidence is taken by the court of first instance and encompasses the examination of the parties or parties’ representatives in the event of a legal entity being the party, witness examinations, obtaining the expertise of a court appointed expert and analysing any documents filed (in German, or filed in a language other than German together with a certified translation into German) as evidence in a proceeding. The judge is free to take into consideration as evidence everything that is appropriate to prove a certain fact. There is no need for a person to prove his or her legal position in court.

Austrian law recognises the (partial) reimbursement of legal fees by the (partial) losing party towards the (partial) winning party. However, reimbursement of legal representation fees and court fees is capped by, *inter alia*, the Attorneys Tariff Act irrespective of the fee agreement between a party and its attorney. Certain types of litigation funding by third parties exist, and taking out legal expenses insurance is quite common for Austrian consumers. However, profit sharing in the event of winning a case is not permissible for attorneys under Austrian law.

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19 RIS – Justiz RS0044358 (T45).
20 RIS – Justiz RS0044358 (T3).
iii Arbitration

Arbitration proceedings do not play a key role in Austrian insurance practice. A distinction can be made between arbitration and an expert procedure – the latter can be viewed as a form of arbitration, which is quite popular (see subsection iv).

If the parties do not stipulate a specific procedure (be it individually negotiated or by reference to the rules of an arbitral institution), the law contains a number of default provisions regulating the most important procedural aspects. For example, the law foresees that where there is no agreement between the parties, the number of arbitrators shall be three. Each party shall appoint one arbitrator, and the two party-appointed arbitrators shall nominate the third arbitrator, who shall serve as the chair of the arbitral tribunal. Should one of the parties fail to appoint an arbitrator, or the two party-appointed arbitrators fail to appoint a chair, either party may file a request to the Supreme Court to make the necessary appointment. Austrian law mandates that arbitrators be impartial and independent. The only other restriction that parties must observe is that Austrian judges may not accept appointments as arbitrators. Otherwise, the arbitrators may be freely chosen by the parties to the dispute.

The taking of evidence in arbitral proceedings is generally comparable to the taking of evidence in court proceedings. However, in practice, there are certain differences. Witness evidence is usually provided in the form of written witness statements. An increasingly common practice is that the written witnesses’ statements are often tested by party-appointed experts. The possibility to request documents from the opposing party is usually broader than in state court proceedings.

Although there is no strict rule regarding the awarding of costs in arbitral proceedings, arbitral tribunals usually follow the principle ‘costs follow the event’. The recovery of costs for legal representation is not limited to a tariff, but is usually awarded based on reasonable hourly fees. The costs of arbitral institutions are, as a general rule, determined based on a fee schedule.

iv Alternative dispute resolution

The extent to which agreeing on an expert procedure in an insurance contract may be admissible is stipulated in Section 64 of the VersVG. In practice, such a proceeding is concluded by the parties within the framework of the general terms and conditions, which is somehow harmonised within the several types of insurance because of the VVO model conditions. Inter alia, the following general insurance terms and conditions contain provisions for an expert procedure: non-life insurance, legal expenses insurance and accident insurance.

The general terms and conditions regarding contractual accident insurance contain a clause that either the insured or the insurer, or both, may apply for a medical arbitrator panel, which shall determine the indemnity in the event of disagreement on the type or the scope of the consequences of an accident. According to a ruling by the Supreme Court, in which a clause was deemed illegal because it was disadvantageous to the specifications for the reimbursement of legal fees according to the Civil Procedure Code, an insured shall bear the costs or parts of the costs of a medical arbitration that are unforeseeable for the insured. In consequence, certain insurers have adapted this clause of the General Conditions for Accident Insurance by including a maximum amount that the insured

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21 Article 8 of the General Conditions for Property Insurance (ABS 2012).
22 Article 9 of the General Conditions for Legal Expenses Insurance (ARB 2015).
24 Supreme Court, 10 September 2014, 7 Ob 113/14i.
shall be obliged to pay in the event of losing the case, and the insurer is obliged to notify the insured of the maximum expense loading prior to the commencement of an expert procedure; the respective VVO model conditions for accident insurance have also been adopted accordingly. The decision of an expert procedure is binding on the parties to that procedure, except in accident insurance cases if the decision apparently deviates from actual facts (see Section 184 of the VersVG).²⁵

Another form of alternative dispute resolution was established by the trade association of insurance intermediaries within the Austrian Economic Chambers, which stipulates that an intermediary can call a mediation body on behalf of one of its insureds who disagrees with a decision of an insurer, most commonly if coverage has been partly denied.²⁶ Whereas a conciliation committee of five experts chaired by a former judge of a higher regional court releases a legal recommendation on the facts that are undisputed between insurer and insured, such recommendation is not legally binding and is unenforceable.²⁷

Complaints from consumers (not commercial entities) may be referred to the Complaint Management Department of the FMA unless they are complaints with respect to insurance contracts written by an EEA insurer. The FMA could also handle such a complaint on a voluntary basis. An online complaint form is available on the FMA website.²⁸

The VVO has established its own permanent point of contact for complaints or legal questions and concerns in relation to insurance contracts.²⁹ If an email is sent describing the facts at hand, the VVO will contact the insurer to enquire about the status of a claim.

**Mediation**
Austrian courts recognise mediation proceedings. However, in practice, mediation does not play a key role, and especially not in insurance cases. Austrian law does not stipulate that a party must go through mediation before filing a lawsuit in a contested insurance matter.

**YEAR IN REVIEW**
The Austrian legislature was quite active with regard to the insurance industry in 2018. The IDD was implemented by two distinct bills and the right of an insured to withdraw from an insurance agreement was simplified on 1 January 2019, and a respective information template was released.

**OUTLOOK AND CONCLUSIONS**
In 2019, it is anticipated that the ECJ will hand down a further ruling related to the withdrawal right of an insured from a life insurance contract. It is also expected that the number of cyber risk insurance policies sold by Austrian insurers will increase following the new VVO model terms that were presented in 2018.

²⁵ Supreme Court, 5 November 2014, 7 Ob 148/14m.
²⁷ Anonymised recommendations of the mediation body can be found online: https://www.wko.at/branchen/information-consulting/versicherungsmakler-berater-versicherungsangelegenheiten/empfehlungen-schlichtungskommission-nach-versicherungsart.html.
²⁸ https://webhost.fma.gv.at/RequestsAndComplaints/Complaint.
²⁹ www.vvo.at/vvo/vvo.nsf/sysPages/infostelle.html.
I INTRODUCTION

The Brazilian insurance market is the largest insurance market in Latin America, and one of the largest insurance markets in the world. It has 118 general insurance companies (life and non-life), 137 reinsurance companies, 1,053 healthcare operators, 18 entities operating open-ended private pension funds, and 90,000 insurance and reinsurance brokers. These companies include globally operating all-liners to locally based providers of tailor-made solutions.

In 2018, Brazilian insurers had a turnover of approximately 75 billion reais in non-life insurance, 150 billion reais in life insurance, 200 billion reais in healthcare and 21 billion reais in capitalisation bonds, totalling 446 billion reais, corresponding to approximately 6.5 per cent of the total Brazilian gross domestic product. Although insurance penetration is still very low, it is expected to increase as the economy improves.

II REGULATION

i Financial regulation

In Brazil, there is no unified financial regulator with authority over insurance, banking, securities and pension funds. Financial regulation has long been organised at the federal level along functional lines with different regulators for each sector.

The national financial system regulation is commonly divided into three components: policy boards, supervisory entities and operators.

Policy boards set general guidelines to the financial system, but do not have executive functions. When deciding on an issue, they generally use the technical structures provided by supervisors. After a policy board sets guidelines, the relevant supervisory entities issue their own regulations thereof and become responsible for enforcing them. There are currently three policy boards (the National Monetary Council; the National Private Insurance Council (CNSP) and the National Complementary Pension Council (CNPC)) and four supervisory
entities (the Central Bank of Brazil, the Securities and Exchange Commission, the Private Insurance Authority (SUSEP) and the National Complementary Pension Authority (PREVIC).

Finally, operators include other public or private institutions directly or indirectly involved in obtaining, intermediating between or investing resources within the national financial system. It is quite common to subdivide them into monetary institutions, official entities, other financial institutions, other financial intermediaries, supplementary institutions, and insurance or pension institutions.

ii Insurance regulators
Authority for the oversight and regulation of the Brazilian insurance market is even more fragmented. The CNSP and SUSEP regulate the National Private Insurance System (SNSP), which comprises insurance and reinsurance companies, entities operating open-ended private pension funds, capitalisation companies, and insurance and reinsurance brokers;

The CNPC, together with PREVIC, regulates and oversees entities operating private closed pension funds.

The National Regulatory Agency for Private Health Insurance and Plans (ANS) regulates the health insurance and healthcare industries.

CNSP and SUSEP
The CNSP and SUSEP are governmental entities under the Ministry of Finance, responsible for regulating the insurance sector (life and non-life, excluding health).

The CNSP is the policy board for the insurance market. It was designed to set general governmental policies regarding private insurance and capitalisation. Later, open-ended private pension funds also fell into its purview. CNSP responsibilities include:

a setting general policies and guidelines for private insurance and reinsurance;
b regulating the constitution, organisation, functioning, enforcement and sanctioning of those who operate under the SNSP;
c setting the basic features of insurance and reinsurance, private pension and capitalisation contracts;
d setting criteria for the incorporation of insurance and reinsurance companies and for open-end pension and capitalisation firms, determining technical and legal limits of their operations; and
e regulating insurance intermediaries.

SUSEP further details the rules enacted by the CNSP, and supervises the entities of the SNSP through routine inspections and disciplinary proceedings in the administrative sphere. SUSEP’s main responsibilities are:

a executing CNSP policies by inspecting the incorporation, organisation, functioning and operation of insurance and reinsurance companies, capitalisation companies and entities operating open-end private pension funds;
b ensure that the entities within those markets are liquid and solvent; and
c protect the rights of the insured persons.
Although this chapter focuses on insurance companies regulated by CNSP and SUSEP, which carry out life and non-life insurance businesses, below is a summary of the roles of the other governmental authorities that regulate other products of the Brazilian insurance industry (e.g., closed-end pension funds and health insurance).

**CNPC and PREVIC**

The CNPC regulates complementary pension funds operated by entities operating closed-end pension funds. It is composed of the Social Security Minister (who acts as CNPC chair) and representatives of PREVIC, the Special Secretariat for Pension Policies under the Chief of Staff at Ministerial Level, the Ministry of Finance, the Ministry of Planning, as well as delegates from pension funds, pension fund sponsors and pension fund beneficiaries. PREVIC is a governmental agency under the Ministry of Social Security, responsible for supervising and inspecting closed-end complementary pension entities (pension funds) and for executing the policies set for complementary pensions. The government has made public its intent to merge PREVIC and SUSEP, which would create a single supervisory entity for insurance and pension funds.

**ANS**

The ANS is an agency established by the government under the Ministry of Health that operates nationwide to regulate, standardise, control and inspect the private health insurance and plans sector in Brazil, including private health insurance, health management organisation, self-insured plans, medical cooperatives, non-profit health organisations and dental assistance.

### iii Offer of insurance by foreign entities

Brazilian laws and regulations provide that the following insurance should be exclusively contracted in Brazil: mandatory insurance; and non-mandatory insurance related to risks in Brazil taken out by individuals resident in Brazil or by legal entities (of any kind) domiciled in the Brazilian territory. In other words, as a rule, only local accredited insurance companies can underwrite risks onshore in Brazil. This does not mean that foreign insurers cannot underwrite local risks for Brazilian residents and legal entities headquartered in Brazil through policies issued abroad, but this practice is restricted to a narrow list of circumstances (e.g., whenever there is no local insurer interested in underwriting the local risks, or whenever foreign corporations may take out worldwide coverage abroad, including Brazil, but this coverage is not provoked, requested, funded or caused by the Brazilian insured).

Companies underwriting insurance in Brazil without authorisation or in cases that do not fall under the exception above are subject to fines of up to 3 million reais, and their shareholders, directors and officers could be held jointly liable for the fine and may be criminally indicted in some cases.

### iv Authorisation to operate as an insurance company

Authorisation to operate as a Brazilian insurance company is granted according to the business segment and the regions of the country where the entity seeking to do business will distribute its products. The authorisation procedure is divided into three major steps: prior approval, ratification and product approval.
A prior approval request must first be submitted to SUSEP by the entities that intend to control the insurance company. This request must be made prior to any organisational corporate act. The prior approval phase focuses on the financial and operational capacity of the shareholders in relation to the types of insurance segments that they intend to operate (life, non-life, private pension funds etc.). Together with the prior approval request, an applicant also needs to submit a business plan to SUSEP detailing the estimated projections of the insurance company’s business for a time span of at least three years.

Once the prior approval of the project is granted by SUSEP, applicants must undertake to hold the relevant corporate acts for organising the insurance company, which are subsequently submitted to SUSEP for ratification purposes. The ratification phase seeks to confirm, through the documents submitted to SUSEP at this stage, whether the organisational structure described in the prior approval phase was duly implemented by the insurer’s controlling shareholders; and to check whether the minimum capital requirements (which vary according to the types and number of products the insurance company intends to offer to the public at large, and the regions of the country in which it wishes to operate) were duly met.

Even though the authorisation to operate is granted by SUSEP in the same document in which it ratifies the resolutions taken in the insurer’s organisational corporate acts, the insurer still needs to file before SUSEP a product approval request enabling it to sell its insurance products within Brazil.

Mergers and acquisitions involving local entities that comprise the SNSP are also subject to the prior approval and ratification proceedings described above.

v Product regulation

Prior to offering any type of insurance product to the public at large, regardless of the nature of the embedded coverage, the general and special terms and conditions of said product, as well as the related technical actuarial note (which sets forth the conditions for provisioning related to the insurance product), needs to be approved by SUSEP. At this stage, SUSEP will review and check whether the wording of such product meets the requirements established by the applicable regulation, and is drafted in a clear and objective manner so as to comply with the principles set forth by the Civil Code and Consumer Protection Code.

vi Other regulatory requirements of insurance companies

There are other restrictions inherent in insurance and reinsurance activities, most of which seek to protect insured parties by preventing insurers from engaging in several types of transactions, especially with assets and funds of the technical provisions of each product. A good example of this is the rule that forbids entities regulated by SUSEP from granting any type of guarantee or security to any third party; and from granting, receiving, or both, any loan to or from any related parties (shareholders, managers, subsidiaries or any affiliates).

Brazilian insurance companies are not subject to the insolvency and bankruptcy laws applicable to non-regulated entities. If an insurance company is in a dire financial situation, it will be subject to the following specific procedures originally created to target financial institutions: intervention, extrajudicial liquidation and the temporary special management regime. SUSEP is entitled to check the solvency situation of all entities accredited to do business within the SNSP and, if necessary, implement the above proceedings. This authority
may also place insurance companies under a fiscal management regime, which is essentially a measure under which SUSEP allocates one of its agents to supervise all activities of the regulated entity that are not meeting the applicable solvency requirements. The supervisor agent has broad powers to conduct – jointly with the entity’s management – the latter’s business, and must keep SUSEP informed about all activities of said company.

As a rule, insurance companies are not subject to bankruptcy. They can, however, be adjudicated bankrupt under two specific circumstances: if a filing for extrajudicial liquidation is issued, but the assets are not enough to settle its liabilities with at least half of its unsecured creditors; or if there is sufficient evidence of bankruptcy crime.

vii Reinsurance and retrocession
Reinsurance and retrocession activities can be carried out in Brazil by the following types of reinsurers, all of which need to be accredited as such by SUSEP prior to engaging in any related activities:

a Local reinsurers must be organised as joint-stock companies headquartered in Brazil. These entities must engage exclusively in reinsurance and retrocession activities (with exclusive corporate purpose). The proceedings to obtain a prior authorisation to operate, transfer control, and elect officers and directors, as well as the minimum capital rules, are the same as those applicable to local insurers. Since these rules are more stringent, there are fewer local reinsurers than admitted or occasional reinsurers doing business in Brazil. Brazilian insurance companies must give preference (right of first refusal) to local reinsurers to underwrite at least 40 per cent of the reinsured risks in each treaty or facultative agreement.

b Admitted reinsurers may be headquartered abroad, but need to have a representative office in Brazil. The representative office must be organised either as a joint-stock or limited liability company, but must have as its exclusive corporate purpose the representation of the offshore admitted reinsurer in reinsurance and retrocession transactions. There are some eligibility requirements that must be met by this type of reinsurer for purposes of accreditation, in particular the requirements to opening a local bank account and to keep, at all times, a balance of US$5 million in such account. The representative office’s management must follow the same ratification rules applicable to local insurers upon the election, appointment or replacement of its officer or director, or both.

c Occasional reinsurers are in many ways very similar to admitted reinsurers, the only difference being that they do not need to have a representative office in Brazil. For this reason, eligibility requirements for purposes of accreditation by SUSEP are more stringent than those applicable to admitted reinsurers.

viii Intermediaries and the role of the broker
The distribution of insurance contracts may be carried out directly by the insurance company, insurance agents, policyholders or insurance brokers and their agents.

Insurance agents represent insurance companies in the distribution of certain types of insurance to the public. As a result of certain regulatory restrictions, this model is generally used by retailers to distribute extended warranty insurance. Policyholders represent insured groups – the policyholder model is generally used in bancassurance to distribute group insurance.

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4 As provided in Decree-Law No. 73/1966 and in Decree No. 60,459/1967.
Insurance brokers are the legally authorised intermediaries for the distribution and promotion of insurance contracts, policies and plans. Insurance brokers may be individuals or companies. To conduct insurance brokerage activities, insurance brokers must be previously accredited for this by SUSEP. The accreditation entails undergoing a procedure before the authority, in which the individual or firm will have to provide evidence that all the eligibility requirements for accreditation purposes have been duly met. For example, among other requirements, they must:

a. be organised in accordance with Brazilian law;

b. be headquartered in Brazil;

c. include the expression ‘insurance brokerage’ as part of their own corporate name;

d. include insurance brokerage services as part of the activities that comprise their corporate purpose; and

e. have an officer responsible for insurance brokerage who is duly registered before SUSEP as an insurance broker.

Once an applicant firm is accredited as a brokerage company, it must keep SUSEP updated about any changes relating to its corporate documents and governance or its organisational structure. Insurance brokers may also intermediate the distribution of insurance contracts through their own agents.

**ix Mandatory insurance**

The contracting of certain insurance coverage is mandatory according to the applicable Brazilian law and regulations, such as property insurance with respect to damages to assets and facilities of legal entities headquartered in Brazil arising from fire, lightning and explosion; and civil liability insurance for damages caused to third parties by land-based vehicles. The need to contract mandatory coverage prescribed by law varies according to the activities conducted by the Brazilian entities or individuals (except for the above-mentioned property insurance, which must be contracted by all legal entities headquartered in Brazil).

**III INSURANCE AND REINSURANCE LAW**

**i Sources of law**

Brazil’s legal system is based on civil law; therefore, its framework is composed of numerous laws and legal codes. For this reason, the insurance market is not regulated by a single law or code, but is governed by several different types of legal documents, including the following:

a. the Civil Code (enacted by Law No. 10,406/2001), which dedicates an entire chapter to insurance contracts and the main principles that must govern the relationship between insured and insurer;

b. Decree-Law No. 73/1966, which is still in full force and effect, and which allows the regulation of this specific activity and market through regulations enacted by the CNSP and SUSEP; and

c. Supplementary Law No. 126/2007, which sets forth the main rules for reinsurance and retrocession transactions in Brazil after dismantling IRB Brasil’s monopoly in this area.

Notwithstanding the above, given the adhesive nature of most insurance policies (there is no arm’s-length negotiation of their terms and conditions), the interpretation of insurance
agreements by the courts tend to protect insureds. Protection tends to be more intense in cases where the insured is a consumer (especially under the Consumer Protection Code enacted by Law No. 8,078/1990).

ii Making the contract
The formation of an insurance agreement is preceded by a written proposal sent by an insured person or an insurance broker. Local regulation, however, allows the contracting of policies through digital channels, provided that certain conditions are met.

Insurance contracts must contain the identification of the parties (insurance company, policyholder, insured parties, beneficiaries), term of effectiveness, limit of liability, covered risks, applicable premium, details of the obligation to indemnify (claim notification and regulation rules), among other information. The insurance company has to provide very clear and objective information to the insured parties regarding the specific terms of the coverage being taken out, especially the events that are excluded from coverage, limits to the right to indemnification (maximum indemnification limits, deductibles, etc.) and the claim regulation procedures to be carried out in the event that a covered claim takes place.

At the time of placement, the applicable law and regulations demand the exchange of certain information between the insured parties and the insurance company. The insured parties must comply with the duty of utmost good faith, disclosing all material facts and acting honestly towards the insurance companies, in such a way that the insurance company has sufficient information about the circumstances involving the risk and coverage. If the insured party fails to provide the requested information (or omits relevant data), the insurance company may increase the premium, if the omission was not in bad faith; or refuse to cover any claims that would otherwise be covered under the terms and conditions of the policy issued to the insured party, if the omission was in bad faith. The courts require more than a showing of mere negligence to support a bad faith claim – as a general rule, the insured party must have engaged in intentional wrongdoing.

iii Interpreting the contract
The interpreting of insurance contracts must abide by the general rules for interpretation of private contracts under Brazilian law.

The Civil Code establishes the general rules for interpretation of private transactions. In this sense, the interpretation of any contract between private parties should seek and comply with the genuine intention of the parties when entering into the transaction; the uses and customs or traditions of the place where it occurred; and the principle of good faith of the contracting parties (which is more strict in insurance contracts).

In addition to this general rule, the interpretation of insurance contracts may also be subject to the rules of interpretation of the adhesive nature of contracts (set forth by the Civil Code and Consumer Protection Code, as the case may be), which determines that in the event that any provisions are ambiguous or contradictory, the contract must be interpreted in favour of the party that adhered to the contract.

iv Claims
Claim regulation procedures for payment of indemnification by the insurer are generally triggered by the remittance of a claim notice by the insured or beneficiary to the insurer as soon as the insured or beneficiary becomes aware of a potentially covered event (claim).
Upon receipt of the claim notice, the insurance company will start procedures to verify the information provided by the insured party, whether the claim is covered by the policy and the amount of the sum to be paid as indemnification. This procedure is known as claim adjustment or regulation. SUSEP establishes a maximum term for claim adjustment proceedings, which varies according to the type of insurance product. In general, the term is 30 days, counted from the date on which all documents requested from the insured or beneficiary for claim regulation purposes are forwarded by the latter to the insurer (SUSEP allows an insurance company to make one request for additional documents and information during the above-mentioned term, the counting of which is suspended until such additional request is met by the insured or beneficiary). Some complex claims adjustments tend to last longer – reaching six to 12 months.

IV DISPUTE RESOLUTION

i General remarks

Although the Brazilian insurance market has recently grown considerably, there are no relevant court precedents or specialised courts for insurance and reinsurance matters. The lack of familiarity of judges (especially those of lower instances) with the laws and regulations applicable to insurance and the time-consuming nature of judicial proceedings (i.e., some proceedings may last more than 10 years) have caused complex insurance-related disputes to end up being decided in arbitration courts with experience in this field of law.

ii Governing law

The basic principles of private international law were incorporated into Brazilian law by Decree-law No. 4,657 of 4 September 1942 (usually known as the Law of Introduction to the Rules of Brazilian Law). This Decree provides guidance on the effectiveness, applicability and interpretation of Brazilian law and sets forth conflict of law rules. It also provides that agreements should be governed by the law of the country they were entered, but this legal provision does not exclude the contractual freedom of the parties to elect the law that will govern the rights and obligations under international agreements. This contractual freedom is more limited if the dispute is subject to Brazilian courts, and the right of the parties to choose the governing law of agreements would depend on the existence of a link between the chosen governing law and the underlying transaction. It is more broad if the dispute is subject to arbitration, because arbitration law expressly allows parties to freely choose the governing law and rules.

iii Litigation

The Brazilian litigation system has three instances:

- first instance composed of state and federal lower court;
- second instance composed of regional federal court or state high courts; and
- third instance composed of the Superior Court of Justice and by the Supreme Federal Court.

Insurance disputes may be time-consuming if the parties refuse to accept the first instance judgment.

The New Civil Procedure Code, which became effective in March 2016, attempts to make litigation less time-consuming by developing and enhancing the rules concerning
alternative dispute resolution mechanisms (especially arbitration and mediation); rendering certain decisions by the superior courts binding, and making a decision in a single case the model for court decisions in cases that are similar (similar to precedents in the United States). The New Civil Procedure Code’s incentive for conciliation and mediation is clear, since judges, upon receiving any petition, shall establish a conciliation or mediation hearing to be carried out by experts in the matter who will try to resolve the situation by consensus.

iv Arbitration
The parties may agree to submit insurance disputes to arbitration. Court decisions have recognised the validity of clauses providing for mandatory arbitration for civil and commercial matters; however, courts have decided that these clauses will only bind consumers if they expressly agree to it.

Arbitration is becoming an increasingly popular alternative dispute resolution mechanism in Brazil for the following reasons:

a it is a faster than procedures in the courts;
b arbitrators are chosen by the parties and may be more experienced on specific technical questions (as is the case regarding insurance and reinsurance matters);
c parties may choose the applicable law;
d the procedure is more flexible; and
e arbitration decisions may be enforced by courts.

These characteristics make arbitration procedures more attractive than regular court procedures, especially considering that insurance matters are highly specific and complex. In fact, SUSEP encourages those entities that belong to the SNSP and operate big risk portfolios to include specific arbitration clauses in the general terms and conditions of this type of product.

v Mediation
The use of mediation procedures has also grown recently because of the mandatory conciliation and mediation hearing required by the New Civil Procedure Code. An agreement executed among the parties may determine that they will be subject to extrajudicial mediation, regardless of any arbitration or court procedure. If any of these procedures have already begun, they will be suspended until the end of the negotiations. In the event that there is no ongoing procedure, the limitation period shall be suspended until the end of the negotiations. The parties may also determine the form of the mediation, including its date, the place of any meetings and the mediator. The main characteristics of mediation are informality, good faith and confidentiality. The mediation seeks to resolve conflicts in a consensual manner, without resorting to any court or arbitration proceedings (but not prejudicing the right to resort to said dispute resolution mechanisms).

V YEAR IN REVIEW
In 2018, there were few changes to Brazil’s insurance and reinsurance regulation. The most relevant changes involved capitalisation bonds.

Capitalisation bonds should not be held as proper insurance or investment instruments, but rather as instruments of financial discipline, which allow unbanked low-income populations to save money. Part of the funds used in the acquisition of capitalisation bonds
is used to build capital, which is paid back after a certain period; the other part is used to pay for the drawings, which distribute prizes to the bondholders. In 2018, SUSEP improved the regulation of the traditional modes of capitalisation (traditional, programmed, popular and incentive purchase), created two new capitalisation modalities (instrument of guarantee and philanthropy) and also allowed instant prize draws, such as scratch-off games. The guarantee and philanthropic modalities of capitalisation bonds were already offered by the market for years, but were not regulated by SUSEP. The new regulation creates an environment of greater legal certainty and allows the sustainable growth of these modalities. The guarantee modality is an alternative to insurance bonds and the philanthropy modality is an instrument for social welfare charities to raise funds.

Although 2018 was not a very active year in relation to changes to insurance regulation, SUSEP published its regulation plan for 2019, which indicates it plans to change the rules regarding, among other things, the organisation and authorisation of insurance companies and insurance brokers; to create an electronic system to monitor the activities under its purview; to change rules related to the investment of insurance companies, especially to allow insurance companies to invest abroad; to enhance microinsurance regulation; and to allow the structuring of insurance products with short-term coverage.5

In addition, in past years the CNSP and SUSEP have improved the insurance regulation, which is becoming more market-oriented and more open to foreign competition. They are also addressing key issues to drive innovation through regulation, such as the regulation of insurtech companies, which have made several partnerships with insurance companies in 2018 (with many more are expected in 2019), and distribution of insurance through digital means. Going digital will be crucial in order to improve efficiency, reach underserved demographics and raise insurance awareness.

VI OUTLOOK AND CONCLUSIONS

In past years, Brazil has struggled with economic mismanagement and corruption, experiencing its deepest recession in decades coupled with a political crisis that resulted in the impeachment of President Dilma Rousseff in 2016. After the impeachment, there was a decoupling between the political and economic scenarios, and in 2017 and 2018, Brazil emerged from the recession; it reduced inflation and interest rates to a record low, passed a labour overhaul to add certain flexibility to rígido law and strengthened anti-corruption measures.

The current government expects to pass ambitious reforms through congress, including pension reform, privatisations, streamlining the tax regime and reducing economic barriers. The performance of the government and the passing of the above-mentioned reforms through Congress will likely drive not only insurance, but all economic activity in the country. Following the elections in October 2018, business confidence has substantially increased,6 companies have begun recruiting higher numbers of employees after a long period,7 and players in the market are expecting strong mergers and acquisitions and initial public offering activity in 2019.

5 SUSEP’s Deliberation No. 217, dated 19 December 2018.
6 Industrial Entrepreneur Confidence Index (Icei), calculated by the National Confederation of Industry.
7 ‘Bolsonomics: the reform plans of Brazil’s new president’, Financial Times. Available at: https://www.ft.com/content/ab6d338a-09f8-11e9-9f68-acdb36967cfc; access on 22 January 2019.
Chapter 8

CAMBODIA

Antoine Fontaine

I  INTRODUCTION

Although the insurance market in Cambodia is in its sixth stage of development, it can still be considered relatively new.

The first stage began in 1992 with the introduction of the Law on Insurance, which can be viewed as the rebirth of the insurance industry after many years of war. Three companies obtained licences within the subsequent three years. However, most of the business consisted of acting as insurance brokers and no risks were retained in the country. The Law on Insurance was abrogated in 2000 and again in 2014. The new Law was promulgated on 4 August 2014. Any references to the Law on Insurance in this chapter refer to the 2014 version.

The second stage required the government to strengthen the industry by the design of two main tools: a new law in 2000 to increase the solvency and capital requirements, and the establishment of a state-owned reinsurance company. The latter also had the purpose of retaining part of the reinsurance premium in Cambodia and to offer a local reinsurance option to the Cambodian insurers. Following this new law, two general insurance companies obtained their licences in 2007 and in 2015.

In the third stage, banks’ affiliated insurance companies entered the market from 2007 to 2009, as the fast-growing banking industry required insurance to cover the assets provided as collateral. This stage has been reinvigorated as a result of three financial groups proposing bank, general insurance and life insurance services.

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1 Antoine Fontaine is a founding partner at Bun & Associates.
5 Cambodian Reinsurance Company Plc (Cambodia Re) (2002).
6 The law provided a pre-emption right on 20 per cent of the reinsurance premium for the benefit of the Cambodia Re. This privilege was aborted through the accession of Cambodia to the WTO with effect from 1 January 2009. WTO WT/ACC/KHM/21, 19 August 2003 (03-4316) especially its Addendum Part II-Schedule of Specific Commitments in Services List of Article II MFN Exemptions.
7 Infinity General Insurance.
8 People & Partners Insurance Plc.
10 PhillipCapital Group, which operates PhillipBank and Kredit MFI, Phillip General Insurance (Cambodia) Plc (2017) and the recently established Phillip Life Insurance Plc (2018); Canadia Investment Holding Plc.
Until 2010, the market was limited to non-life insurance businesses (i.e., general insurance and reinsurance), but continued to maintain low retention rates.

The fourth stage occurred in 2011. General insurance companies could have satisfied themselves in playing a limited role, providing standardised and limited insurance policies to the urban middle class while still getting a profit at the level of their investments. However, the government considered it a priority to offer access to insurance to the rest of the population. Without waiting for a new law, and based on non-governmental organisations’ experiences and comparative studies, it passed one temporary ministerial order to start micro-insurance in Cambodia. After the Ministry of Economy and Finance (MEF) granted the first micro-insurance licence, seven others followed in quick succession from 2014 to 2017, which were mainly in health and life, often in partnership with microfinance institutions. The first micro-life insurers played a very strong role in promoting insurance. A micro-insurance business is sustainable only by selling products to the mass market; micro-insurers have opted to use the three best methods available to promote their insurance policies to those in Cambodia who can afford to pay a small amount of premium: by using networks of micro-finance institutions (MFIs), selling to companies and factories, and retailing through mobile technology.

The first method consists of using the very wide MFI networks to propose credit-life insurance by paving the way to the bancassurance activity. This approach was fruitful, but was jeopardised by a series of new regulations that mainly originated from the National Bank of Cambodia (see Section II.iii).

This strategy also generated a new business opportunity for the non-bank affiliated general insurance companies, which found risks that they were financially able to underwrite by themselves. This unexpected competition in their own market (the indigent population) led micro-insurers to the second method, which was to start competing with general insurers in the general insurers’ own market by selling group personal accident and group health insurance policies to companies and factories to cover their employees. The viability of this last segment was threatened by the National Social Security Fund (NSSF). Until the end of 2015, the NSSF only covered work-related accidents, but in January 2016, the government adopted a sub-decree to establish a healthcare scheme to cover those persons defined by the provisions of the Labour Law, and to be executed and managed by the NSSF. As of the end of 2017, it is compulsory for every employer to contribute to the NSSF for both accident and health schemes.

The third method used by micro-insurers to target the poor is to work with telecommunication operators to sell insurance products using mobile technology. Even with one of the worldwide leaders in micro-insurance products operating in Cambodia (Milvik

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12 Mainly the GRET, through its SKY project (Sokophap Krousar Yeung).
(Cambodia) Micro Insurance Plc (BIMA), which uses mobile technology for insurance distribution, micro-insurers are facing competition from other general and life insurance companies in this area.

The fifth stage began in 2012 and led to the introduction of the life insurance industry, which was a significant move in the market and recognised by the government as necessary. In order to introduce life insurance, the government relied on two main pillars: the new regulation (passed in 2014), and the establishment of a state-owned life insurance company.15

While non-life insurance companies, like other industries in Cambodia, remain mainly regional in their shareholding (including companies from Singapore, Indonesia, Thailand, Malaysia, Hong Kong and Vietnam), leading worldwide life insurance companies entered into the Cambodian market soon after life insurance was introduced in 2012 and the flow of companies has been steady since then. The MEF granted licences to Manulife,16 Prudential,17 AIA,18 and Dai-Ichi Life,19 and four life insurers from the Association of Southeast Asian Nations (ASEAN) obtained their own licences.20

Life insurers have undoubtedly become the main players in the insurance industry; by investing a lot, through the mounting of large advertising campaigns, they have generated new interest for insurance in the general population. Since 2013, life insurers have experienced exponential growth,21 with endowment accounting for 93 per cent of the market share. 22

The sixth stage of development started in 2017 and is concomitant with the massive Chinese investments in Cambodia and the will of several local tycoons involved in the finance industry to diversify their investments in insurance concerning both general23 and life activities.24

Insurance intermediation has grown very slowly. Until 2007,25 only one insurance agent and one insurance broker were duly registered. In recent years, however, there has been an unstoppable flow of new brokers.26 Although bancassurance suffers from an inconsistency

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15 Cambodian Life Insurance Company Plc (2012), which were eventually privatised and purchased by the Royal Group of companies.
16 Manulife (Cambodia) Plc (2012).
17 Prudential (Cambodia) Life Assurance Plc (2013).
22 However, term life has increased by 266.4 per cent since 2016.
23 EverCare Insurance Plc (2017), a member of Chinese AIBO group; East Insurance Plc (2017), a member of Guangzhou Yuetai Group; and Ly Hour Insurance Plc (2017).
26 MGA Insurance Brokers Co Ltd (2014); Gras Savoye (Cambodia) Insurance Brokers Plc (Willis) (2015); Bassac Insurance Broker Co Ltd (2015); Hong Kong TeamYou (Cambodia) Insurance Brokers Co Ltd; Branch of Toyota Tsucho Insurance Management Corporation; Insurance Broker Solutions (Cambodia), Ltd (2016); Icon Insurance Brokers Co Ltd (2016); Provita Insurance Broker Co Ltd (2017);
between banking and insurance regulations and practices; many banks, MFIs, financial leasing companies and telecommunication operators have been granted insurance agent licences. However, the number of insurance agents operating as a main activity remains very low, and has even decreased owing to aversive legal requirements.

With the exception of the General Insurance Association of Cambodia, which was established in 2005 and became the Insurance Association of Cambodia in 2013 (to include life insurers), brokers have also established an association to protect the interests of their profession.

Despite the fact that the insurance market is still nascent, Cambodia has many assets, even if pitfalls exist. The key assets are as follows:

- **a** an insurance penetration rate of only 5 per cent of the population, with a middle class that is the fastest growing among the ASEAN Member States;
- **b** a very fast premium growth rate of 20 per cent per year during the past 15 years, which nevertheless should be minimised because of the very low amount of premium (US$143 million in 2017 compared to US$113.6 million in 2016) largely boosted by the life insurance segment;
- **c** very few businesses purchase insurance policies to cover their risks, and when it happens, it is generally through a fire insurance policy that the banks require for granting loans;
- **d** while some foreign businesses are covered in Cambodia through their worldwide policies, any risk in Cambodia must be underwritten by a duly authorised insurance company (sanctions drastically increased with the Law on Insurance); and
- **e** more generally, the existing legal framework offers notable incentives that foreign investors might not be entitled to in neighbouring countries, including no restriction on foreign ownership, no local joint-venture requirement, free repatriation of benefits, no exchange control and minimum currency risk owing to a highly dollarised economy.

II Regulation

**i Insurance regulator**

The MEF is competent to issue regulations, and to manage and control the conduct of insurance businesses. An insurance business is not clearly defined by the law, but the term is widely interpreted. Insurance supervision is delegated to the Insurance and Pension Division of the Ministry of Economy and Finance (MEF).

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27 Banks: Cambodian Public Bank Plc (Lonpac-2006 and AIA’s agents-2017); ACLEDA Bank Plc (Prudential’s-2013 and Forte’s-2016 agent); Maybank (Cambodia) Plc (Manulife’s agent-2016); ANZ Royal Bank (Cambodia) Ltd (Manulife’s agent-2016), CIMB Bank Plc (Manulife’s agent-2016), Foreign Trade Bank of Cambodia Plc (Manulife’s agent-2016); and Advanced Bank of Asia Limited (Manulife’s agent-2016). MFIs: Angkor Mikroheranhvatho (Kampuchea) Co Ltd (Forte’s agent-2014). Telecoms: SMART Axiata Co Ltd (Forte’s and BIMA’s agents-2014); and Amret (2018). Other: Infinity Financial Solutions (Cambodia) Ltd; Samic Plc; Asiaone Insurance Agency (Cambodia) Co Ltd; Cover Link Insurance Agent Co Ltd (Forte Agent 2018); and Safetynet Insurance Services (Cambodia) Co Ltd (Forte Agent 2018).

28 0.5 per cent for life insurance as at the beginning of 2016.

29 Overall insurance coverage only amounted to 0.35 per cent of gross domestic product in 2016.
of the General Department of Financial Industry. It also manages an Insurance Industry Development Fund for promoting, supporting and encouraging the dissemination of interests in insurance to the public.

The Insurance Strategic Plan 2011–2020 foresees the establishment of an independent insurance commission by 2020. However, there is no plan to merge the regulatory bodies of the insurance business (i.e., the MEF), the securities market (i.e., the Securities and Exchange Commission of Cambodia) and the banking sector (i.e., the National Bank of Cambodia) under only one supervising authority.

ii Non-admitted insurers

Any entity that carries out an insurance activity, except a reinsurance activity, is required to operate through a licence granted by the MEF. This rule applies to insurance companies, micro-insurance companies, insurance agents and brokers, and loss adjusters. The Law on Insurance created two important rules. First, to combat illegal insurance activities the Law drastically increased its related sanctions; underwriting insurance businesses without a licence will result in a fine of between 50 million and 100 million riels. Recidivism by an entity is sanctioned at four times this rate. Recidivism by a natural person is sanctioned at two times this rate, one to five years’ imprisonment, or both. Second, the Law allows for further sub-decrees to provide exceptions for licensing, although none currently exist.

The MEF requires a reinsurance company to have an equivalent Standard & Poor’s rating of at least AA+. Since this requirement is no longer practical, the MEF accepts a rating of BBB-.

iii Distribution of products

According to the law, there are only two ways to distribute insurance products: through a duly licensed insurance agent or through a broker. The law does not mention the possibility of an insurance company’s staff distributing products, but the MEF has permitted it, and a ministerial order even provides a specific authorisation for life insurance companies’ staff to be sellers. Even if the regulation does not mention group insurance policies, the MEF considers that a compulsory group insurance policy is an insurance policy in itself; therefore, the policyholder, acting for a group of insureds, is not considered to be an insurance intermediary. The MEF also understands that a pure referrer does not require a licence as it does not act on behalf of the insurance contract parties.

However, distribution of insurance through a third party is particularly difficult owing to the requested minimum capital deposit of US$10,000 for an agent and US$50,000 for a broker, which will double with the long-expected draft sub-decree on insurance to be adopted soon. Therefore, life insurers that used to distribute through a wide network of individual agents have no choice but to recruit employees as consultants. The employment relationship must be genuine, otherwise the insurer may be heavily sanctioned under the insurance, tax and the labour regulations.

Furthermore, bancassurance, which is essential for micro-insurers, life insurers and, to some extent, general insurers, is generally not permitted, owing to the National Bank of Cambodia’s position stating that financial institutions can only refer insurers and cannot act on their behalf. While it may seem that these establishments (acting as referrers only) should not be required to obtain a licence from the MEF, surprisingly, they are obliged to obtain an agent licence. Therefore, insurance companies must have their own staff (not agents) in the banks and MFIs’ premises, which drastically increases the acquisition cost.

There are no restrictions on outsourcing activities that are not subject to licensing.
iv Authorisations

According to the Law on Insurance, there are four kinds of insurance companies: life insurance, general insurance, micro-insurance and reinsurance. Both general and life insurance companies may conduct health and micro-insurance business. However, this provision requires urgent clarification, as it appears to exclude micro-insurers from offering micro-health insurance, and further appears to indicate that a life insurance company can provide any micro-general insurance business, and vice versa. According to a temporary ministerial order that will be amended by a future sub-decree, a micro-insurance company is not permitted to cover risks exceeding US$5,000 and exceeding a period of 12 months.30

The Law on Insurance provides limited information on obtaining an insurance licence. It states that insurance companies are required to obtain a licence from the MEF, and imposes a three-month time limit on the MEF to decide on an application following the deposit of the required application form and supporting documents. In practice, it generally takes longer than three months. In addition, it is likely that the MEF will not grant many other life insurance licences in order to maintain a sustainable market. A sub-decree will provide further details for obtaining a licence. The former sub-decree and related ministerial order remain valid in the meantime.31 Currently, the MEF exercises a two-step approach where, after obtaining an approval in principle from the MEF, an applicant must complete its set-up within six months, including by incorporating the company at the Ministry of Commerce. Otherwise, the licence granted will automatically become null and void. Brokers, agents and loss adjusters are required to have a licence to operate.

The MEF is drafting a new ministerial order on the licensing of insurance agents and insurance brokers, which is expected to be adopted in 2019, including through the bancassurance channel.

Licences issued are not alienable under any circumstances. However, a change of control (greater than 10 per cent) is still possible, although the regulator must be properly notified. Furthermore, the portfolio may be partially or totally transferred, subject to prior approval by the regulator.

A licence is valid for the following periods:

a. insurance company: five years for both the initial licence and renewed licences;
b. micro-insurance company: one year;
c. insurance agent: one year for both the initial licence and renewed licences;
d. insurance broker: one year for both the initial licence and renewed licences; and
e. loss adjuster: one year for both the initial licence and renewed licences.32

v Compulsory insurance

The former regulation mentioned three types of compulsory insurance (construction insurance, motor vehicle third-party liability insurance for vehicles used for commercial purposes and

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31 Article 113, Law on Insurance.
32 A ministerial order dated 15 September 2015 provides a duration of five years for general and life insurance licences, while a former ministerial order dated 17 January 2007 provided a duration of three years. However, for agent and loss adjuster licences the same 2015 ministerial order provides a duration of one year while, in practice, these licences are granted for three years, in compliance with a former ministerial order dated 23 November 2001, which should be abrogated.
passenger transportation liability insurance whatever the means of transportation). However, as these requirements were not systematically implemented, the Law on Insurance increased fines for non-compliance to an amount of up to 150 million riels. However, the MEF has not put in place any system in the event of refusal by an insurance company to provide coverage.

In addition to the above-mentioned compulsory insurance, the Law on Insurance requires owners of motor vehicles (on roads or waterways) to purchase motor vehicle liability insurance. A sub-decree will determine the conditions. This compulsory insurance is not likely to be implemented soon for many reasons, including challenges in determining an affordable premium for the poorest owners of vehicles (which will sociologically appear as a tax) and collecting premiums throughout Cambodia. This may also leave the illusion of sufficient insurance while the maximum coverage will in fact be very limited. There will also be challenges in organising the insurance industry to ensure proper claim adjustments and payment in a timely and reasonable manner.

With the exception of the Law on Insurance, the Sub-Decree on Insurance dated 22 October 2001 adds one more type of compulsory insurance: insurance brokers are required to purchase professional liability insurance of US$500,000.33

vi Taxation

Tax on insurance companies and their intermediaries

Like many other countries, because of the economic specificity of insurance in Cambodia, tax on income (TOI) (corporate income tax in other countries) is imposed at a flat rate of 5 per cent on gross premiums. The fact that the scope of this tax also covers the savings part of the premiums clearly jeopardises the development of life insurance companies’ activities and bancassurance activities. The Law on Financial Management 2017 (LFM17) substantially changed the tax regime of the insurance industry by imposing tax depending on type of insurance. As opposed to life insurance, general insurance on risk and property is still subject to the tax of 5 per cent on gross premiums, while life insurance, which has a savings part and other activities (that are not property or risk insurance, or reinsurance), shall be subject to the TOI at a rate of 20 per cent.

Essentially, this change is far from an adequate solution. Life insurers do not necessarily offer endowment policies only; they can also offer term life, bodily injury and healthcare policies that are not substantially saving products. Under the LFM17, it was unclear whether the latest insurance policies would be deemed as risk and property insurance, which would then be subject to TOI at the flat rate of 5 per cent on gross premiums. However, the MEF released Ministerial Order No. 490 on 30 April 2018 to remove this ambiguity by concluding that premiums of life insurance policies regardless of either endowment, term life, bodily injury or healthcare policies will be subject to TOI at a rate of 20 per cent, and general insurance will be subject to the flat rate of 5 per cent on gross premiums.

Under the LFM17, insurance intermediaries (insurance agents or insurance brokers), important actors in the insurance industry, do not seem to have been treated as part of the insurance industry although the nature of their business activities is important for industry development and promotion. For example, for insurance companies, income from the sale of products and policies is not subject to value added tax (VAT) owing to the fact that it is not treated as taxable supplies for VAT purposes (for a short notice, under Cambodian tax

33 Article 86.
laws, insurance activity is not subject to VAT). However, under current practice, Cambodian tax officials tend to interpret that an insurance intermediary’s income from its activities (i.e., commission) does not count as insurance activity and thus is subject to 10 per cent VAT.

Moreover, the tax administration has not put in place any set-off system when the payment to an insurance intermediary originates from a prepayment subject to other tax (1 per cent minimum tax on income, VAT or specific tax applicable on certain merchandise and service), and in addition to the 5 per cent tax on gross premiums, insurance companies must pay the 0.5 per cent contribution to the MEF Insurance Industry Development Fund. These kinds of issues have resulted in the cost of doing business with insurance industries to become unnecessarily high for the policyholder, and also discourages intermediaries and insurance companies from investing in the Cambodian market.

**Tax on reinsurance companies**

Formerly, reinsurance premiums paid abroad were generally not subject to the 14 per cent withholding tax. This rule was welcomed and was justified because of the fact that the reinsurance premium (as a part of the insurance premium) was subject to 5 per cent taxation. However, Ministerial Order No. 490 has brought in new requirements. The payment of life reinsurance abroad will be subject to withholding tax of 14 per cent on the net reinsurance premium, although the payment of general reinsurance abroad remains not subject to the withholding tax.

**vii Ownership**

There is no restriction on foreigners investing in insurance businesses; there is only one form of entity available. An insurance company must be registered in the form of a public limited liability company. However, while an insurance company must have at least three shareholders, this minimum is not required for banks or MFIs, and is not generally required for a public limited company. The Law on Commercial Enterprise only requires a minimum of three directors.³⁴

For other insurance businesses (i.e., insurance intermediaries and loss adjusters), the form can be a branch of a foreign company, a private limited company or a public limited company.

**viii Transfer of portfolio**

A Cambodian insurance company may apply to the insurance regulator for approval to transfer all or part of its insurance business to another Cambodian insurance company. The transfer will come into effect following an agreement between the transferor and the transferee once the MEF’s approval is given.

As far as we are aware, no portfolio transfer has ever been carried out. The draft sub-decree on insurance will develop details of the process that are in the best interests of policyholders.

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ix Capital
The law on insurance provides a minimum capital of 5 million special drawing rights (SDRs)\(^{35}\) for general and life insurance companies, and reinsurance companies. The draft sub-decree on insurance will provide rules to determine the amount of capital to be maintained to ensure an insurance company’s solvency. According to the current rules, the minimum capital requirements are as follows:

\(a\) micro-insurance company (life or non-life): one-quarter of the amount of the underwritten premium with a minimum of 600 million riels;

\(b\) insurance brokers: 200 million riels; and

\(c\) insurance agent and loss adjusters: 20 million riels.

The draft sub-decree on insurance intends to double the capital of insurance intermediaries and loss adjusters.

x Solvency requirements
There are two kinds of solvency requirement.\(^{36}\) First, insurance companies and intermediaries must maintain a deposit with the National Treasury (i.e., the MEF’s account at the National Bank of Cambodia (this account does not generate interest)) as follows:

\(a\) insurance company: 10 per cent of the registered capital;

\(b\) insurance broker: US$50,000 (equivalent to the minimum capital); and

\(c\) insurance agent and loss adjustor: US$10,000.

Second, insurance companies must maintain a solvency margin. For the first year of operation, the solvency margin is 50 per cent of the registered capital. Thereafter, each case is assessed on the previous year’s premiums:

\(a\) 13.3 billion riels where net premiums are less than or equal to 66.5 billion riels;

\(b\) 20 per cent of the total premium where net premiums are between 66.5 billion riels and 332.5 billion riels; and

\(c\) 66.5 billion riels plus 10 per cent of the insurance surplus from the previous year where the net premium is greater than 332.5 billion riels.

In addition to the 50 per cent solvency margin, the MEF requires micro-insurance and life insurance companies to maintain their assets (cash or property) equal to their minimum capital in order to guarantee that they have sufficient capital in accordance with the law. This requirement means that life insurance companies must have an initial minimum capital of US$7 million invested in assets, which cannot be used to pay expenses.

The new sub-decree on insurance and additional ministerial orders should be passed in 2019 that could change both capital and solvency requirements. The MEF has been implementing part of the drafted regulation since the second half of 2017.

\(^{35}\) International Monetary Fund SDRs. As of 1 January 2019, 1 SDR = US$1.39. The MEF practically considers the minimum capital required for life and general insurance companies to be equivalent to US$7 million.

\(^{36}\) These requirements could be modified under the Law on Insurance as they originate from a previous regulation.
Control

The MEF maintains three kinds of control: financial, legal and economic. Financial control is exerted over, *inter alia*, licence applications and yearly financial statement requirements (e.g., financial audits, business plan approvals and approvals for distributions of dividends).

Legal control generally consists of obtaining MEF approval for almost all activities, including changes in memoranda and articles of association (e.g., change of address, change of representative shareholders, change of directors, increase of capital), products approval (understanding that each rider is considered as one product), advertisement campaigns, and organisation of the distribution network. This approach was generally successful, but the huge increase of insurer players (with over 31 new licences in less than 18 months) has made it very difficult for the Insurance and Pension Division of the MEF to cope with the amount of requests. It is not rare to wait six months for a simple approval of a change of directors. The MEF has also limited the number of polices insurance companies can submit to two at a time. In addition, some of the above actions require authorisation from other ministries, particularly the Ministry of Commerce, which further lengthens the process.

Economic control over the industry involves, *inter alia*, gathering data, issuing and renewing licences, maintaining fair competition and approving any transfer of shares exceeding 10 per cent of the capital. The MEF may organise inspections, and has wide powers to do so. Measures undertaken during an insurance inspection may be challenged by bringing a complaint within 45 days to the MEF. The MEF then has two months to make a decision. However, this delay may vary depending on the MEF’s internal rules. This results in insurance institutions being delayed in requiring prior approval, which is sometimes not practicable when unexpected – for example, the resignation of a director or the transfer of a portfolio, which requires the parties to act fast to maintain the economic interests of the transactions. The fine imposed for not obtaining prior approval, and the frequency with which it was imposed, increased drastically in the past year.

The Law on Insurance considerably reinforced both the MEF’s control and procedures in cases where an insurance company is facing a serious financial crisis. In such a case, the MEF may appoint a provisional director to recover the insurance company for a period of no longer than three months. This mandate may be extended for another three months if necessary. After this period, if the evaluation of the company has shown that it may be sufficiently solvent and can comply with the law and all cautious measures, the provisional director will send a report to the MEF to cancel any cautious measure taken against the company and the provisional governance will be terminated. However, if the evaluation has shown that the company is sufficiently solvent but cannot comply with the law and cautious measures within three months, the company’s licence will be temporarily revoked by the MEF and the provisional governance will be changed to a voluntary dissolution of the company. Moreover, if it is shown that the company is insolvent, the company’s licence will be revoked by the MEF and the provisional governance will be changed to liquidation through a court proceeding.

Unless the insurance company is in a solvent condition, the company may initiate voluntary liquidation and dissolution processes. An insolvent company may submit to the MEF a request to liquidate voluntarily in cases where the company reaches its due duration period, or by a resolution of a general or extraordinary assembly of the shareholders in accordance with the memorandum and articles of association. Upon receiving a statement of intent from the company to voluntarily liquidate, the MEF will issue a certificate of authorisation provided that the company has appropriate grounds. After receiving the
If a company becomes insolvent, the MEF must submit a complaint to a court to initiate the liquidation through court proceedings. A liquidator is selected by the court from the MEF’s permitted list of liquidators. A court order may also select a provisional director as a liquidator.

The liquidator has the obligation to liquidate all assets and repay all the liabilities of the insurance company under the supervision of the court.

III INSURANCE AND REINSURANCE LAW

i Sources of law
The MEF launched an important reform in 2000 and 2001, which consisted of an increase in the minimum capital held by insurance companies to 5 million SDRs, as well as a classification of insurance companies into three categories. These categories were general insurance companies, life insurance companies and reinsurance companies. This was followed in 2011 by the introduction of a fourth category: micro-insurance companies.

As mentioned in Section I, the National Assembly of Cambodia adopted the new Law on Insurance, which was promulgated on 4 August 2014 and entered into force on 4 February 2015. The Law maintains all former regulations. Three sub-decrees are expected to be adopted in the near future, which will be followed by many ministerial orders. The most important and notable changes will cover the following areas:

- a. general and life insurance contracts;
- b. insurance companies’ liquidation and dissolution processes;
- c. the micro-insurance legal framework;
- d. insurance control; and
- e. dispute resolution and disciplinary measures.

ii Making the contract
Generally, Cambodian regulations do not differ from other countries’ regulations in terms of contract formation. The policy must be written and must indicate:

- a. both parties’ names and addresses;
- b. the subject matter to be insured;
- c. the type of covered risks;
- d. the commencement date and location of risks;
- e. the insured value;
- f. the insurance premium and method of payment;
- g. the method and conditions for declaration of risks;
- h. the term of contract and period of coverage;
- i. the terms and conditions of nullification and forfeiture of rights; and
- j. the conditions for early termination.

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For life insurance, it must also indicate the name of the beneficiary, and the event and conditions for refund of the insured amount.

The above-mentioned standard requirements are not always economically or practically adapted to some forms of insurance distribution networks. This is especially true for micro-insurance products, which should be easily executed. The draft sub-decree on insurance maintains that a written agreement with signatures is required; however, after discussions with the private sector, the MEF now accepts paperless insurance policies.

In addition, the Law on Insurance provides specificities that are sometimes difficult to understand. At first, it may appear normal that insurance policies are required to be written in the Khmer language with clear terms and conditions, but the Law does not provide for any exception, especially for major risks and for international risks.

Further, the Law on Insurance seems to indicate that no insurance policy can enter into force prior to the payment of the premium. Put another way, the payment is a condition for the enforceability of the insurance policy. This rule seems to be mandatory.

The Law on Insurance foresees only three parties to an insurance contract: the insurer (or its representative), the insured and the beneficiary (the latter in the case of life insurance contracts). There is also a definition of a policyholder; however, it is not the usual definition of a policyholder as it is commonly understood. In addition, the Law does not mention the possibility of underwriting a group insurance policy even if, in practice, group insurance policies are widely spread out and accepted by the MEF, which even distinguishes between compulsory and facultative group insurance policies.

The Law on Insurance states that an insurance contract is a commercial contract, to which it can be objected that, while the insurer may always be a merchant, the policyholder may not be one.

Finally, the insurance regulation may contradict other regulations, which can be problematic. For instance, a regulation applicable to general insurance companies (but interpreted as applicable to any institution) prohibits the chairman of the board from holding an executive role. However, the Ministry of Labour and Vocational Training and the Ministry of Interior require them to hold a working permit in order to get a business visa allowing them to lawfully remain in Cambodia. The working permit requires an employment contract, which must not include a fake salary as the General Department of Taxation could reassess it.

### iii Interpreting the contract

#### General rules of interpretation

There is no rule of interpretation clearly stated in the Law on Insurance and no law on consumer protection. Furthermore, there are very few rules of interpretation in the Civil Code.

However, because every insurance product must be approved by the MEF, this means that the MEF has its own interpretation that may be used as a benchmark for policyholders and insureds that are under the same insurance policy.

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38 In accordance with the Law on Insurance, a policyholder refers to a natural person or legal entity that has a legal right over the insurance policy.
Type of terms in insurance contracts

The MEF is also very cautious regarding the Khmer language terminology that is used. A sub-decree on insurance contracts should be adopted detailing, inter alia, rules regarding conditions and interpretation.

The Law on Insurance adds two important details regarding the interpretation of a contract. First, and naturally, it provides for nullification in cases where the insured (policyholder) has concealed the truth or wilfully misrepresented material facts leading to any change of the insured subject of risk. However, negligence does not necessarily lead to nullification. Second, it provides that for property insurance, the indemnity made by the insurance company must be the same amount as the declared property, unless agreed otherwise. This rule seems contradictory to the indemnification principle, although the reasons behind it are understandable. The Cambodian population is not familiar with insurance policies, and may not understand that insurers provide an amount lower than the declared or insured value of the property. This rule obliges insurers to either assess the real value before covering the property, or to clearly state that it will not pay the declared value if it exceeds the actual one.

iv Intermediaries and the role of the broker

In addition to the descriptions in Sections I, II.iii and III.ii regarding the distribution of products, there remain very few active insurance brokers and most of them received their licence relatively recently, with an uptick in July 2018 of four new licensed brokers. However, with an insurance penetration rate of 5 per cent among the population, the lack of knowledge of many businesspeople (especially local tycoons), the growing interest in insurance and stronger protections for duly licensed insurance companies are all factors that will contribute to an increase in the number of brokers.

Brokerage is typically defined as acting on behalf of the policyholder. Although the brokers are organising themselves (a draft ethical code is circulating and an association is being developed), the legal relationship between insurance companies and brokers falls broadly under the Civil Code and more specifically under the regulation applicable to agency agreement.39

Brokers are not specifically protected when bringing business to insurance companies, even if insurance companies generally comply with general standards in these situations.

v Claims

The Law on Insurance provides only a few rules regarding claims, and the former regulation, which is still applicable, is useless in this regard. Therefore, claims must follow the common rules as provided for in the Civil Procedure Code.

The Law only states that the insurer may complain before the court in order to void its responsibility if a risk occurred because of a fraudulent act of the insured.

The Law also provides a subrogation mechanism to claim reimbursement of a duly paid insurance indemnity from the third party that caused the damage. However, subrogation is not possible against relatives, managers, etc., except in the case of malicious acts caused by any one of them. In addition, the Law on Insurance provides the victim with a direct payment mechanism against the insurance company for liability insurance.

39 Article 637 et seq. Civil Code.
The law provides no payment of life insurance if the insured committed suicide. All the procedures for dispute resolution will be determined by sub-decree. In 2017, the net rate ratio of claims was 30.7 per cent for non-life activity.  

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Arbitration clauses are commonly provided in insurance policies in cases of a dispute between the policyholder or insured and the insurer, except notably for micro-insurance policies. However, there is generally no reference to any arbitration forum and no indication of the arbitration procedure to be followed (e.g., designation of arbitrators).

As compulsory liability insurance does not really exist, there is no set-off of mutual debts between insurance companies. 41

There is no compensation fund or warranty fund in place, except the NSSF.

ii Litigation

If a dispute is brought before a court, parties will follow the rules as provided in the Civil Procedure Code. However, when an arbitration clause exists, there is generally no description of the claim procedure and the use of loss adjusters, nor any explanation on how to challenge an insurer’s decisions. Until recently, there was no commercial arbitration centre in Cambodia.

iii Arbitration

Even though a commercial arbitration centre has been established, it is unlikely that it will be used for small claims, and large insurance claims are quite rare. However, the Law on Insurance suggests that the MEF will establish an insurance arbitration centre.

iv Alternative dispute resolution

With regard to the Law on Insurance and sub-decree regarding mediation, the first mediation case was brought before the MEF at the very beginning of 2019 involving a micro-insurer.

V YEAR IN REVIEW

Several large life insurers entered the Cambodian insurance market, while some other insurance institutions left the country.

During 2017, the total gross premium of general insurance rose to US$75.3 million, representing a 7.1 per cent year-on-year increase. This is clearly a slowdown as the average yearly growth was 16 per cent for the past five years. This 7.1 per cent growth follows that of gross domestic product, while the life insurance sector continues to grow significantly with 56.5 per cent year-on-year growth in premiums, according to the Insurance Association of Cambodia.

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41 However, set-off is legally possible by application of Article 464 et seq. Civil Code.
VI OUTLOOK AND CONCLUSIONS

Although there are still a lot of opportunities in the general insurance market, the life insurance market is becoming overloaded and highly competitive. The micro-insurance industry has stalled in anticipation of a sub-decree on micro-insurance.

With regard to human resources and the MEF’s availability, dealing with the increase in players is the main challenge, which has already resulted in the MEF being very delayed in granting authorisations. Since the decision to increase the average salary in the public sector, the administration is very restricted when recruiting civil servants. In addition, owing to a lack of skilled human resources, entities in the public and private sectors tend to poach staff from each other, causing salaries to rise to an unaffordable level for the ministries.

With regard to claims, fraud has become a major issue, especially with a small number of loss adjusters.\(^{42}\) In addition, the tax regime applicable to life insurance activities and the double taxation of brokers and agents may cause frustration.

In terms of investing capital and premium, the options are incredibly limited. An insurance company must use at least 75 per cent of its reserve funds created from insurance premiums for reinvestment in Cambodia. The new draft regulation pertaining to the use of the minimum capital and solvency margin drastically limits the number of possibilities. It is even worse in practice, despite the new tax incentives, as the stock exchange is still in its infancy (although the first private bonds have recently been issued); investment in real estate is generally forbidden to foreign entities; investment in government bonds is not currently available; and investment in the private sector is not sufficiently reliable. Therefore, insurance companies try to repatriate their premiums through a reinsurance scheme or make a deposit in a bank that provides a relatively good interest rate.

Finally, regarding distribution, we do not envisage any improvement in the conditions to become an independent insurance agent and insurers are still waiting for a more clement bancassurance framework.

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\(^{42}\) There are only three insurance loss adjusters: Mclarens Cambodia Ltd, MSM International Adjuster (Cambodia) Limited (2011) and Branch of AJAX Adjusters & Surveyors Pte (2017).
I  INTRODUCTION

The insurance market in the Cayman Islands is divided into domestic business, captive insurance, special purpose vehicle (SPV) insurance and commercial reinsurance.

Domestic business is conducted primarily by companies incorporated in the Cayman Islands, although a number of approved external insurers are also permitted to write insurance (e.g., Lloyd’s of London). Some external insurers have manned offices in the Cayman Islands while others operate through local agents.

Captive insurance business may be taken to be all insurance (and reinsurance) business where the premiums originate from the insurer’s related business. The captive market began to develop in the late 1970s and there has been a steady natural growth since then. As at 30 September 2018, the Cayman Islands international insurance market reported total premiums of US$16.1 billion, with US$68.95 billion in total assets. The Cayman Islands is the leading jurisdiction for healthcare captives, representing almost one-third of all captives. Medical malpractice liability continues to be the largest primary line of business in the Cayman Islands with approximately 32 per cent of companies insuring and reinsuring medical malpractice liability. The other significant class for captives is workers’ compensation coverage, which is the second-largest primary line of business in the Cayman Islands with 22 per cent of companies assuming this risk.

SPV insurance is driven principally by the insurance-linked securities market, in particular, the catastrophe bond market. Cayman is a leading market for the formation and licensing of SPV insurers.

The commercial reinsurance market is an area seeing interest and growth with a number of reinsurers setting up physical presence in the Cayman Islands.

II  REGULATION

The body responsible for regulating the insurance and reinsurance business in the Cayman Islands is the Cayman Islands Monetary Authority (the Authority). The Insurance Division

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1 John Dykstra and Abraham Thoppil are partners with the Maples Group. The authors would like to thank Kaneesa Ebanks-Wilson for her assistance with the preparation of this chapter and Mac Imrie for his assistance with the section on dispute resolution.

2 Insurance statistics and regulated entities as maintained by the Cayman Islands Monetary Authority.

3 ibid.

4 ibid.
of the Authority discharges those responsibilities. The Authority operates independently of the government and meets international standards of supervision, accountability and transparency.

The Insurance Law was first enacted in the Cayman Islands in 1979. Since that time it has been updated periodically to ensure that the jurisdiction maintains a strong regulatory framework. At the end of 2012, the Insurance Law 2010 (as amended) (the Law) came into force, bringing a new insurance regulatory regime into effect. The new regime provides for greater regulatory transparency for existing and prospective licensees, and streamlines the regulation of licensed entities.

There are currently no proposals to achieve Solvency II equivalence for the Cayman Islands regulatory regime.

i  Insurance licensing

All persons carrying on or wishing to carry on insurance business, reinsurance business, or business as an insurance agent, insurance broker, or insurance manager in or from within the Cayman Islands need to be licensed by the Authority. Insurers are licensed under one or more of the following categories:

a  Class A – for the carrying on of domestic business or limited reinsurance business as approved by the Authority;
b  Class B – for the carrying on of insurance business other than domestic business (however, a Class B insurer may carry on domestic business where such business forms less than 5 per cent of net premiums written or where the Authority has otherwise granted approval). Class B insurers are further categorised based on net premiums written, where:
   •  Class B(i) – at least 95 per cent of the net premiums written will originate from the insurer’s related business;\(^5\)
   •  Class B(ii) – over 50 per cent of the net premiums written will originate from the insurer’s related business; or
   •  Class B(iii) – 50 per cent or less of the net premiums written will originate from the insurer’s related business;
c  Class C – for the carrying on of insurance business involving the provision of reinsurance arrangements in respect of which the insurance obligations of the Class C insurer are limited in recourse to and collateralised by the Class C insurer’s funding sources or the proceeds of these funding sources that include the issuance of bonds or other instruments, contracts for differences and such other funding mechanisms approved by the Authority. Typically such licensees would be ‘cat-bond insurers’ or ‘special purpose insurers’; and

d  Class D – for the carrying on of reinsurance business and such other business as may be approved in respect of any individual licence by the Authority.

Agents, brokers and managers are required to be licensed as follows:

a  ‘insurance agent’ licence, for the soliciting of domestic business on behalf of not more than one general insurer and one long-term insurer;

\(^5\) ‘Related business’ is defined under the Law as business that originates from the insurer’s members or the members of any group with which it is related through common ownership or a common risk management plan, or as determined by the Authority.
b ‘insurance broker’ licence, for arranging or procuring, directly or through representatives, insurance or reinsurance contacts or the continuance of such contracts on behalf of existing or prospective policyholders; and

c ‘insurance manager’ licence, for providing insurance expertise to or for Class B or Class C insurers.

ii Organisation of licensees

Except for domestic business, where external insurers are permitted, only an entity incorporated under the Companies Law (2018 Revision) of the Cayman Islands (the Companies Law) or registered by way of continuation and that has a minimum of two directors (who have been approved by the Authority to be fit and proper persons) may be granted a licence by the Authority.

An insurance broker, an insurance manager, a Class A insurer or a Class D insurer is required to have a place of business in the Cayman Islands while a Class B insurer or a Class C insurer (unless it maintains permanently a place of business approved by the Authority) is required to appoint an insurance manager in the Cayman Islands that has been licensed by the Authority and maintain, at the insurance manager’s place of business (or at another location approved by the Authority), full and proper records of the business activities of the Class B insurer or Class C insurer.

iii Licensing requirements

Every licensee is required to carry on insurance business in accordance with its approved licence application and business plan submitted to the Authority (as modified by any subsequent changes as approved in writing by the Authority). To satisfy the Authority’s licensing requirements, an applicant is required to ensure that:

a the persons carrying on the business to which the application relates are fit and proper to be directors, managers or officers in their respective positions;

b it is able to comply with the Law and the Anti-Money Laundering Regulations 2018 of the Cayman Islands;

c the grant of a licence will not be against the public interest of the Cayman Islands;

d it has personnel with the necessary skills, knowledge and experience, and such facilities and such books and records as the Authority considers appropriate, having regard to the nature and scale of the business;

e the structure of its insurance group, if any, will not hinder effective supervision; and

f its capital complies with the prescribed level.

iv Capital and solvency requirements

Every applicant for an insurer’s licence needs to comply with the prescribed capital and solvency requirements. The prescribed capital and solvency requirements for each category of licence are set out in the relevant insurance regulations.

v Segregated portfolio companies

Since 1998, the Companies Law has provided for the formation of segregated portfolio companies (SPCs). An SPC is a single legal entity divided into an unlimited number of portfolios, the assets and liabilities of which are legally segregated from each other. The
potential uses are varied and include rent-a-captives, life insurance, reinsurance and composite insurers. An insurer that is not a Class D insurer and not a Class B insurer incorporated as an SPC must be separately licensed for long-term and for general business.

In this context, general business is all insurance business other than ‘long-term business’, which means insurance business involving the making of contracts of insurance:

a on human life or contracts to pay annuities on human life, including linked policies, but excluding contracts for credit life insurance and term life insurance other than convertible and renewable term life contracts;

b against risks of the persons insured:

• sustaining injury as the result of an accident or of an accident of a specified class;
• dying as the result of an accident or of an accident of a specified class;
• becoming incapacitated in consequence of disease or diseases of a specified class; or
• being contracts that are expressed to be in effect for not less than five years or without limit of time and either are not expressed to be terminable by the insurer before the expiry of five years from the taking effect thereof or are expressed to be so terminable before the expiry of that period only in special circumstances therein mentioned; and

c whether by bonds, endowment certificates or otherwise whereby in return for one or more premiums paid to the insurer a sum or series of sums is to become payable to the person insured in the future, not being contracts falling within points (a) or (b).

vi Portfolio insurance companies

The relevant provisions of the Law allowing SPCs to register subsidiary companies as portfolio insurance companies (PICs) with the Authority came into force on 16 January 2015. A PIC may be able to write insurance business without the need for a separate insurance licence, provided its SPC parent is licensed. The principal aim of PICs is to provide SPCs with a mechanism that facilitates risk-sharing arrangements between portfolios. The introduction of PICs therefore provides a means by which SPCs can transact insurance business between segregated portfolios. PICs also facilitate the incubation of smaller captives, which might wish, at a later stage, to spin-off as stand-alone captives.

PICs have the express power to contract with the parent SPC, any segregated portfolio of the parent SPC and any other PIC related to the parent SPC. This is of particular importance as it now allows for segregated portfolios within the SPC structure to participate in different portfolio insurance strategies. Each PIC is a separate legal entity from the SPC and any other PIC. This facilitates the drafting of legal documentation as each entity is a distinct legal person, which in turn streamlines compliance with the requirements of the Companies Law.

The Law also provides an option for the automatic novation and vesting with the PIC of all assets and liabilities of a segregated portfolio either at the time of registration of the PIC with the Authority or within 30 days of registration – all of which makes it easy for existing SPC insurers to incorporate a PIC and to move the insurance business from a segregated portfolio to a PIC.

A captive can be established on an SPC platform using a PIC and, as and when the programme grows to the point of justifying its existence on a stand-alone basis, the PIC can simply be spun-off from the SPC and apply for its own insurance licence.
Share issuances and transfers

A licensee cannot issue shares totalling more than 10 per cent of its authorised share capital without the prior approval of the Authority. In addition, a licensee cannot transfer shares totalling more than 10 per cent of the issued share capital, or total voting rights, without the prior approval of the Authority.

Annual requirements

Every insurer is required to pay the prescribed annual fee on or before 15 January every year after the first grant of its insurance licence. A licensee who fails to pay the prescribed annual fee on time may be subject to penalty fees.

Every licensee is required to comply with continuing requirements under the Law. As such, all licensees are required to appoint auditors approved by the Authority. In addition, and subject to certain exceptions, all insurers are required to submit by way of annual return to the Authority: audited financial statements; an actuarial valuation of their assets and liabilities; a certification of solvency; written confirmation that the information set out in the application for the licence (including the business plan), as modified by any subsequent changes approved by the Authority, remains correct; and such other information as may be prescribed by the Authority.

The position of unlicensed insurers

An unlicensed insurer carrying on insurance business in the Cayman Islands would be guilty of an offence and liable on summary conviction to a fine of CI$100,000 or to imprisonment for five years, or to both. In the case of domestic business, insurance brokers can be permitted by the Authority to place limited amounts of this business with unlicensed foreign insurers. Accordingly, an unlicensed insurer with whom a broker can place insurance business pursuant to any such dispensation would not be considered as carrying on insurance business.

For the purposes of the Law, a person would not be considered as carrying on insurance business solely by reason of the fact that the person effects or carries out a contract of reinsurance with an insurer in the Cayman Islands, unless that person's principal place of business is in the Cayman Islands.

Intermediaries and the role of the broker

As noted above, the Authority may grant a special dispensation to an insurance broker to place a contract of domestic business with one or more insurers that are not licensed under the Law. These dispensations are granted on a case-by-case basis only, and are subject to review at such intervals as the Authority may specify. An insurance broker who has not been granted a special dispensation shall be personally liable to the insured on all contracts of insurance placed with insurers not licensed under the Law in the same manner as if the insurance broker were the insurer.

In addition, an insurance broker is prohibited from entering into a binding authority with an insurer other than a Class D insurer. However, the Authority may grant a dispensation to an insurance broker for a fixed period (despite the duty of the insurance

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6 Insurance Law 2010, Section 3(2).
7 Insurance Law 2010, Section 19(5).
8 Insurance Law 2010, Section 19(1).
broker to act for the prospective insured) to enter into a binding authority with an insurer if it is satisfied that the insurance broker needs (in terms of additional capacity, policy coverage, cost savings or otherwise) the binding authority to be permitted. Such a dispensation granted by the Authority would be subject to any conditions that the Authority prescribes, including restrictions to lines of business, specific contracts, types of client and requirements for disclosure, and review at such intervals as the Authority may specify.

Under the Law, an insurance broker shall maintain in force, and comply with the conditions of cover of, professional indemnity insurance placed with an insurer licensed to carry on domestic business (or an insurer accorded special dispensation by the Authority) and provide for an indemnity of not less than US$1 million for any one loss, or another figure prescribed by the Authority. The professional indemnity insurance shall extend to include the activities conducted on behalf of the insurance broker and be subject to review by the Authority. In the event that the professional indemnity insurance is invalidated, becomes voidable or is withdrawn, cancelled or not renewed, the broker shall immediately notify the Authority and shall forthwith cease to solicit further insurance business until the professional indemnity insurance has been reinstated or replaced.9

III  INSURANCE AND REINSURANCE LAW

i  Sources of law

As noted in Section II, the Law came into force at the end of 2012 and governs insurance regulation in the Cayman Islands, including the authorisation and regulation of insurers, reinsurers, insurance managers, insurance brokers and insurance agents. While the Cayman Islands has its own body of case law, English case law is also of persuasive authority and may often be cited in court.

ii  Making the contract

Parties

The insurance contract will normally be made between two parties: the insurer and the insured. Both parties may be carrying on insurance (or reinsurance) business as in the case of reinsurance or retrocession.

Insurable interest

There is no statutory requirement for insurable interest in Cayman Islands law, although English common law may be taken to imply a requirement for insurance interest in all types of indemnity insurance. In Rowe v. Proprietors, Strata No. 8310 the court ruled that a party has an insurable interest if it had a legal relationship with property that renders it liable to pay money in the event of it being damaged. In this case, the strata by-laws included a contractual obligation to keep the property insured and this was held to give the strata corporation an insurable interest.

9  Insurance Law 2010, Section 13(1)–(3).
10  (Grand Court), 2009 CILR N [31].
Formation

Consistent with English common law, contracts under Cayman Islands law do not need to be in writing. In practice, policies are issued in writing and, for the purposes of regulatory policy, documentation must be available for inspection by the Authority and meet certain requirements.

Disclosure and misrepresentation

The general principles of English insurance common law regarding non-disclosure and misrepresentation have been followed in the Cayman Islands as demonstrated by the decisions of Zeller v. British Caymanian Insurance Company Ltd11 and McLaughlin v. American Home Assurance Company.12

In Zeller, the Court of Appeal upheld the judgment, applying the English authority Economides v. Commercial Union Assurance Co Plc13 and ruled by a majority that the insurance policy was voidable for non-disclosure, confirming that as a contract in utmost good faith the appellant was under a duty to disclose all that a reasonable person would have considered material, being disclosure of all that he ought to have realised was material.

The decisions in Zeller were, however, overruled on appeal by the Judicial Committee of the Privy Council, thereby declaring that the respondent insurer’s notice of cancellation of the appellant’s health insurance cover was invalid and of no legal effect. The Privy Council concluded in the case that the basis of the contract was that the statements made by the appellant in the application form were true to the best of his knowledge and belief, which it considered to be consistent with the approach of the Court of Appeal of England and Wales in Economides.

The essence of the judgment was that, on the facts of the case, given the construction of the health questionnaire, the appellant was expected to exercise his judgement on what appeared to him to be worth disclosing. As a result, he did not lose cover after failing to disclose a complaint that he thought to be trivial but that later turned out to be a symptom of a much more serious underlying condition.

In McLaughlin, a case primarily concerning proof of arson and a fraudulent insurance claim, it was confirmed obiter dicta, pursuant to the English authority Pan Atlantic Insurance Co Ltd v. Pine Top Insurance Co Ltd,14 that for an insurer to be entitled to void a policy for misrepresentation or non-disclosure, not only does it have to be material, but in addition it has to have induced the making of the policy on the relevant terms. On the facts, it was ruled that a previous fire at the premises that had caused damage, but for which an insurance claim had not been made, was not material as it would not have induced the making of the contract on the relevant terms.

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11 [2004–2005] CILR 464 (CA) and 283 (Grand Court), and [2008] CILR 11 (Privy Council).
iii Interpreting the contract

English general principles of interpretation of contracts apply to insurance contracts in the Cayman Islands. In *Jackson v. Cayman Insurance Company Ltd.*,\(^\text{15}\) the court followed the view of Lord Goddard CJ in the English case of *Edwards v. Griffiths*,\(^\text{16}\) where he ruled that a contract should be construed against the insurer where there is an ambiguity or a doubt as to its extent; if a question should arise as to liability of the insurer, the court should apply a construction most favourable to the insured.

There is no case law that has confirmed the distinction between types of conditions and warranties in insurance contracts and thus the English common law remains of persuasive authority. *Jackson* considered the interpretation of a condition in a motor policy, whereby the insurer sought to rely on a breach of a term of the policy to deny liability. It was ruled that the breach could only obviate liability of loss to third parties caused by negligence and not loss caused by breach of a statutory provision. There was, however, no discussion of the classification of the term that had been breached.\(^\text{17}\)

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

As a British overseas territory, the Cayman Islands has a democratic system of government based upon the British Westminster model. Judicial independence in the Cayman Islands is protected by the Constitution, which is a cornerstone of the system of government.

Litigation is conducted on the adversarial system, based generally on English principles of civil procedure. Because of its status as a leading offshore financial centre, the Cayman Islands courts are accustomed to dealing with complex insurance disputes, often with significant cross-border aspects.

The most common alternative to litigation is arbitration. Large commercial contracts involving Cayman Islands entities tend to have arbitration clauses. The Cayman Islands courts play a supportive role to facilitate arbitration procedures and will generally recognise and enforce foreign arbitral awards made in any of the contracting states to the New York Convention under the terms of the Convention.

ii Litigation

*Litigation stages*

The Grand Court of the Cayman Islands (the Grand Court) is the superior court of record of first instance for the Cayman Islands. The caseload of the Grand Court is divided between five divisions: civil, family, admiralty, financial services and criminal.

Insurance actions, where the amount claimed exceeds CI$1 million, are tried in the Financial Services Division. Every proceeding in the Financial Services Division is assigned to a commercial judge, that is, one of a number of commercially experienced judges including the Chief Justice. Commercial judges sit alone, without a jury. Where the assigned judge

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\(^{16}\) [1953] 2 All ER 874.

\(^{17}\) The decision actually focused on whether the policyholder was in compliance with the statutory provision as this was the requirement of the term. On the facts, the policyholder was found to be in breach of the law and therefore the term.
Evidence
The issues in the litigation are defined by pleadings exchanged by the parties, including a statement of claim, a defence and (if necessary) a reply. The pleadings set out the parties’ various factual allegations, and in the case of the plaintiff, the relief sought. All such allegations must be pleaded with a reasonable degree of particularity, to a level that is generally higher than what would be typical in the United States. At trial, the parties’ arguments are limited to those matters set out in their pleadings.

Parties’ discovery obligations are broad, and extend to all documents that are relevant to matters in issue on the pleadings or that may reasonably lead to a train of enquiry. Certain classes of privilege apply, including, most significantly, legal professional privilege.

Depositions do not form part of the usual civil procedure. There is a mechanism known as ‘discovery by oral examination’, which is in some ways similar to a deposition. However, only parties may be examined in this way, not witnesses. Discovery by oral examination will only be ordered in exceptional or unusual circumstances.

Evidence at trial is usually given by way of oral testimony and cross-examination. Interlocutory matters are usually decided on affidavit evidence. The Court has wide-ranging interim powers, including the power to trace and preserve assets, order discovery or preservation of documents and appoint interim receivers.

Costs
The court will normally order that the unsuccessful party pay the successful party’s costs of the litigation. The costs, which are recoverable on a typical costs order, are assessed on a ‘standard’ basis by reference to a set of prescribed rates. The prescribed rates are invariably lower than the actual cost of litigation, and indicatively a party could expect to recover between around 50 per cent and 70 per cent of their actual costs. However, if the court takes the view that the losing party’s conduct of the litigation has been particularly unreasonable, it may order that party to pay costs on an ‘indemnity’ basis; in that case, recovery is not limited to the prescribed rates.

iii Arbitration
The Arbitration Law 2012 of the Cayman Islands (the Arbitration Law) modernises the arbitration law of the Cayman Islands and brings it into line with the standards applicable in most of the world’s leading arbitration centres. The Arbitration Law is based on the UNCITRAL Model Law, which has been adopted in a large number of countries, and on the Arbitration Act 1996, which applies in England, Wales and Northern Ireland and is similar to the UNCITRAL Model Law in many respects. In interpreting the Arbitration Law, the Cayman Islands courts have regard to the decisions of the courts of these countries where the provisions of the Arbitration Law are the same or substantially the same as those of the 1996 Act, which they are in many cases.
The Arbitration Law is founded on the following principles:

- The object of arbitration is to obtain the fair resolution of disputes by an impartial arbitral tribunal without undue delay or undue expense;
- The parties should be free to agree how their disputes will be resolved, subject only to such safeguards as are necessary in the public interest; and
- In matters governed by the Arbitration Law the court should not intervene except as provided in the Arbitration Law.

**Arbitration agreement**

An arbitration agreement may be in the form of an arbitration clause in a contract or a separate agreement. An arbitration agreement that forms, or was intended to form, part of another agreement is to be treated as distinct from that agreement. Thus, an arbitration clause may be valid and enforceable even though the insurance contract of which it forms part is found to be void.

**Procedure and evidence**

The parties of the insurance contract are free to tailor the procedures that are to be followed in the arbitration to meet their needs, subject to the mandatory provisions of the Arbitration Law.

In the absence of agreement by the parties as to the powers that may be exercised by the tribunal, the tribunal may make orders in relation to a variety of matters including: security for costs; disclosure of documents and interrogatories; the giving of evidence by affidavit; examination on oath or affirmation of a party or witness; and the preservation and interim custody of evidence for the purposes of the proceedings and property that forms part of the subject matter of the dispute.

All directions given by the arbitral tribunal may, with the permission of the court, be enforceable in the same manner as if they were orders made by the court and, where such permission is given, judgment may be entered in the terms of the directions given by the tribunal.

**Costs**

Costs of the arbitration are generally at the discretion of the tribunal. If the tribunal does not make provision for costs in its award, any party may apply for a direction from the tribunal within 14 days of the delivery of the award, or such further time as the tribunal allows. Costs will generally follow the event, such that the unsuccessful party will be ordered to pay the successful party’s costs. Only the costs of attorneys admitted to practise in the Cayman Islands are recoverable and this includes the costs of foreign attorneys who have been granted limited admission to the Cayman Islands for the purpose of appearing or advising in proceedings.

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18 Subject to the proviso in Section 38(4) that security is not to be required solely on the grounds that the claimant is an individual ordinarily resident outside the Cayman Islands, or a company formed or with its central management outside the Cayman Islands.
19 Arbitration Law 2012, Section 38.
20 Arbitration Law 2012, Section 38(5).
iv Alternative dispute resolution
There is no formal requirement in the Cayman Islands to pursue alternative dispute resolution (ADR). The Grand Court Rules require parties to deal with each case in a just, expeditious and economical manner, and judges encourage the parties to pursue ADR where appropriate. Although the court cannot compel the parties to use ADR, there will usually be costs consequences where the parties do not follow such a suggestion. ADR methods such as mediation, early neutral evaluation and expert determination are still relatively uncommon in the Cayman Islands.

V YEAR IN REVIEW
In 2018, the Cayman Islands licensed 33 new captive insurers, which included a PIC and Class B insurers, and at year end had a total of 699 licensed captives. Medical malpractice liability continues to remain the primary line, followed by workers’ compensation. SPV insurers are increasingly used by commercial reinsurers to access the capital markets to distribute reinsurance risk.

The Cayman Islands is also continuing to develop as an insurance and reinsurance domicile, as evidenced by the number of licences being pursued by fund-sponsored reinsurance vehicles, as well as other direct write vehicles. As the leading domicile for private equity and hedge funds, the Cayman Islands is ideally placed to be the domicile for insurers and reinsurers affiliated with investment funds.

VI OUTLOOK AND CONCLUSIONS
An overhaul of the insurance regulatory regime has had a positive impact on the insurance and reinsurance industry. The government, working together with local service providers, is committed to facilitating industry growth. The efforts to date have yielded very positive results. In 2018, the Cayman Islands licensed 33 new captive insurers and at year end had a total of 703 Class B, C and D licensees. Medical malpractice liability continues to remain the primary line, followed by workers’ compensation. The two main types of captives were pure captives and group captives. North America continues to be the main geographical source of business.

With a momentum driven by the new insurance regime and a renewed effort of the jurisdiction to market its position as a leading reinsurance domicile, it can be expected that other insurance products will also make increasing use of the Cayman Islands.
I  INTRODUCTION

Chilean insurance and reinsurance companies can be stock corporations as long as they provide these services only and comply with the special regulations established in the Chilean Corporations Act (companies subject to special regulations).2

The sale of insurance in Chile can be made by a general insurance company (first group) or a life insurance company (second group). The former covers the risk of loss or damage of goods or patrimony, while the latter covers the risks of persons or guarantee, within or upon termination of a certain term, capital, a paid-off policy or income of the insured party or its beneficiaries. Exceptionally, personal risk and health can be covered by both types of companies. Risks related to credit can only be insured by general insurance companies having the sole purpose of covering this type of risk, which could also cover surety and fidelity.

Anyone is free to take out insurance in Chile. Taking out insurance abroad is not forbidden, but insured parties are subject to the legislation governing international charges and taxation.3 Insurance and reinsurance companies are allowed to underwrite risks arising abroad. Contracting insurance policies with foreign companies not established in Chile are subject to the same taxes that apply to the insurance policies signed locally, notwithstanding other applicable taxes.

As regards reinsurance, this can be contracted with the following entities:

a  national corporations whose exclusive scope of business is reinsurance;
b  national insurance companies, which can only reinsure risks from the group they are authorised to operate; and
c  foreign reinsurance entities, which are classified by risk-classification agencies approved by the regulator, the Commission for the Financial Market (CMF), and ranked at least within the BBB risk category or its equivalent.4

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1  Ricardo Rozas is a partner at Jorquiera & Rozas Abogados.
2  Title XIII.
3  According to Article 58 bis of the Insurance Companies Act (DFL 251), dated 22 May 1931, foreign insurers or brokers may sell direct insurance cover in Chile in connection with international marine carriage, international commercial aviation and goods under international transit provided that they are based in a country with which Chile keeps in force an international treaty that allows taking out such insurance from that country.
4  According to Article 16 of the Insurance Companies Act (DFL 251), dated 22 May 1931, the London Lloyd’s insurance market is expressly recognised as a reinsurance entity.
Reinsurance can be provided to the above-mentioned entities either directly or through reinsurance brokers registered in the Registry of Reinsurance Foreign Brokers Registry, which is managed by the CMF.

The foreign entities listed in point (c), above, must designate an attorney with broad powers to act on their behalf in Chile, including the power to serve court proceedings. However, it is not necessary to designate an attorney if the reinsurance is made through a reinsurance broker registered with the CMF that is deemed to represent the foreign reinsurance underwriters of the reinsurance contract for all legal purposes.

II REGULATION

i The insurance regulator

The CMF supervises the solvency and operations of insurance and reinsurance companies, brokers and loss adjusters, and has the power to request balance sheets, financial statements and portfolio information. In addition, the CMF issues general rules relating to intermediation, underwriting, adjustment and policy contracts, which are compulsory for all the companies under its supervision.

ii Position of non-admitted insurers

Foreign insurers that are incorporated in a country that is a party to a free trade agreement (FTA) with Chile may offer and sell direct insurance cover in Chile relating to international marine transportation, international commercial aviation and cargo in international transit as far as is allowed by the FTA, and provided that they comply with all the requirements set forth under the FTA and domestic law.

In addition, in June 2007, Decree No. 251 (DFL 251) was amended to allow companies incorporated abroad to establish branch offices in Chile. These branch offices are subject to the general procedure provided by the Corporations Act for the incorporation of agencies of foreign companies, and must obtain authorisation from the CMF. In addition, the branch offices must prove to the CMF that they comply with all requirements established for the authorisation of insurance companies, and need to follow further publication and registration formalities.

iii Requirements for authorisation

There are no requirements or restrictions regarding the financing of the acquisition of an insurance or reinsurance company. In addition, there are no specific requirements or restrictions concerning investment in an insurance or reinsurance company by foreign citizens or companies or foreign governments, except for general provisions relating to foreign investment.

The minimum capital required to be held by a Chilean insurance company is 90,000 Chilean indexation units (UF). In the case of Chilean reinsurance companies, this is 120,000 UF.

To meet the obligations of underwriting insurance and reinsurance business, Chilean-regulated insurers and reinsurers must establish technical reserves in accordance

5 Matter regulated under Title XIII of the Chilean Corporations Act.
with the current principles, procedures, mortality charts, interest rates and other technical parameters within the time limit and in the format established by the CMF through general rules.

iv Position of brokers

Brokers are regulated under the Regulations Applicable to Insurance Industry Officers (Supreme Decree 1055-2013), which regulate the activities of both insurance brokers and adjusters.

v Regulation of individuals employed by insurers

In general, directors of insurance and reinsurance companies must be at least 18 years old and comply with the general requirements that operate in Chile for stock corporations, namely:

a not being a member of a board of directors that was revoked owing to rejection of the company’s balance sheet by shareholders;

b not being accused of or charged with the criminal offences indicated in the Corporations Act;

c not being a governmental officer or executive of a state-owned company that exercises supervision or control functions; and

d not holding a public position, which applies to members of Congress, government ministers or undersecretaries, chiefs of public services, CMF employees and stock brokers.

There are further requirements for directors and officers of companies in the life insurance sector.

vi The distribution of products

Insurance products must be sold mainly in accordance with the CMF regulations and the Consumer Protection Act.

vii Compulsory insurance

Some areas of compulsory insurance cover in Chile are motor liability, employers’ liability for occupational accidents and diseases, and brokers’ errors and omissions. In addition, Decree-Law 3500 of 1980, which regulates the Chilean pension system, also establishes compulsory insurance in connection, inter alia, with disability and social security life annuity to be contracted jointly by all the companies authorised to manage the pension funds covering.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The legislative framework applicable to insurance and reinsurance is constructed from various regulations and laws:

a Title VIII of Book II of the Code of Commerce, called ‘About Insurance in General and in Particular about Non-marine Insurance’ (Article 512 et seq.);

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6 DS 1055-2013 came into force on 1 June 2013.
Title VII of Book III of the Code of Commerce, called ‘About Marine Insurance’ (Article 1158 et seq.);

DFL 251, which regulates insurance companies;

Supreme Decree 1055-2013;

resolutions issued by the CMF (and previous resolutions issued by the Securities and Insurance Superintendency (SVS)); and

the general provisions relating to the interpretation of contracts that are found in the Civil Code (Article 1560 et seq.).

The provisions on general and non-marine insurance contained in the Code of Commerce were enacted almost 140 years ago and for a long time were not revised, despite numerous industry developments. However, on 9 May 2013, a new law was enacted (Law 20,667 (the New Insurance Law)), which replaced all the former non-marine provisions (contained in Title VIII of Book II of the Code of Commerce) and finally updated Chilean insurance law to be in line with current trends and market practice. The New Insurance Law also changed certain provisions on marine insurance (contained in Title VII of Book III of the Code of Commerce) and introduced a couple of amendments to DFL 251. The New Insurance Law entered into force in December 2013.

Making the contract

Essential ingredients of an insurance contract

Under the New Insurance Law, an insurance contract is an agreement whereby one or more risks are transferred to an insurer, in exchange for a premium, who becomes obliged to indemnify the damage suffered by the insured or to satisfy capital, income or other agreed provisions.

The essential ingredients of an insurance contract are the insured risk, the insurance premium and the insurer’s conditional obligation to indemnify. The absence of any of these ingredients renders the contract void.

In addition, the New Insurance Law defines reinsurance as an agreement whereby the reinsurer undertakes to indemnify the reinsured within the limits and modalities set forth in the agreement, for liability affecting its patrimony as a consequence of the obligations it has undertaken in one or more insurance or reinsurance contracts. For construing the will of the parties, the New Insurance Law takes into account international reinsurance practice.

Utmost good faith, disclosure and representations

Chilean law recognises the concept of utmost good faith, and the insured must honestly disclose the information requested by the insurer to allow the latter to identify the object of the insurance and assess the nature of the risk. For these purposes, it suffices that the insured reports exclusively in accordance with the insurer’s request.

If the insured provides information that is false, the insurer can avoid the policy and return the premium. The insured must also disclose circumstances that increase the risk during the policy period. However, if the insurer fails to request information at the placement stage, the insurer may not then allege any errors, reticence or inaccuracies by the insured, as well as those facts or circumstances that are not included in the request for information.
**Recording the contract**

Pursuant to the New Insurance Law, the execution of an insurance contract is consensual, and its terms and existence can be proved by all legal means of proof, including but not limited to electronic documents, provided that there is *prima facie* written evidence arising from a document. In this respect, the insurance policy is defined as the document that justifies the insurance, and once issued, the insurer cannot challenge its terms.

**iii Interpreting the contract**

**General rules of interpretation**

As stated in subsection i, insurance and reinsurance contracts are subject not only to the Code of Commerce, but also to the general provisions relating to the interpretation of contracts in the Civil Code (Article 1560 et seq.) plus certain provisions contained in DFL 251.

The Chilean position can be broadly summarised as follows.

*a* The provisions of the New Insurance Law are in general mandatory, unless stated to the contrary. However, if a clause is deemed to provide an insured with a greater benefit than is provided under the law generally, the specific terms of a policy will prevail over the Code of Commerce.

*b* Chilean law considers it of paramount importance to determine the intentions of the parties at the time of contracting and to give effect to those intentions even if they are not reflected in the literal words of the contract.

*c* A Chilean tribunal will strive to facilitate clauses in contracts with the goal of ensuring that the parties’ intentions are fulfilled. Actions can include amending the contract if no provision is made for a given state of affairs.

*d* Under Chilean law, it is permissible for a tribunal to ascertain the parties’ intention by looking outside the contract at, for example, the negotiations between the parties and market practice at the date of contracting.

*e* In the event of ambiguity in a policy, the interpretation that is more favourable to the insured prevails. Given that DFL 251 Article 3(E), Paragraph 3 specifically imposes a duty on the insurer to make sure that the wording is clear and understandable, this remains the position even if the insured or the broker has drafted the wording, or if the wording is the result of negotiation between the insurer and insured.

**Incorporation of terms**

Insurance and reinsurance companies must word their contracts using the models of policies and clauses in the Register of Policies of the CMF. Exceptionally, they are able to use non-registered models when this relates to general insurance, where the insured or the beneficiary are legal entities, and when the annual premium is higher than 200 UF. In addition, non-registered models can also be used for cargo, transport, marine or aircraft hulls, or related insurances.

As regards reinsurers, they are subject to the principle of freedom of contract with a few mandatory restrictions, such as the fact that the reinsurer cannot alter the terms of the insurance contract and that fund provision clauses are not enforceable. Direct actions of the insured against the reinsurer are not valid unless otherwise agreed in the reinsurance contract or as per an assignment of rights after the loss from the reinsured to the insured.
Types of terms in insurance contracts

Under Chilean regulations, insurance policies must contain the following basic provisions and information:

1. identity of the insurer, insured and beneficiary (if applicable);
2. insured matter;
3. insurable interests;
4. risks taken by the insurer;
5. policy period;
6. insured amount;
7. value of the insured matter;
8. premium;
9. policy date and the insurer’s signature; and
10. the insured’s signature when mandatory by law.

Warranties

An insurance warranty is defined as ‘the requirements aiming to confine or decrease the risk, which are stipulated in the insurance contract as conditions that must be met to allow payment of an indemnity after a loss’.7

Conditions precedent

Conditions precedent are not regulated. However, the insurer or reinsurer can achieve similar effects if they are treated as essential conditions of the contract, which are defined by the Civil Code as those without which the contract does not produce effects at all or degenerates into a different contract.

Intermediaries and the role of the broker

The law regulates the activities of insurance and reinsurance brokers, sales agents of insurers and loss adjusters. Their main licensing requirements can be summarised as follows.

Sales agents

To act as a sales agent, the person or entity in question must first be registered in the special sales agent registry that will be kept by each insurer, which will contain certain minimum information required by Chilean regulations.

Insurance brokers

Insurance brokers are defined as natural persons or legal entities who have been registered as such with the CMF and who act as independent intermediaries in the contracting of insurance policies with any insurer.

According to Chilean regulations, insurance brokers must provide information to all their clients on the diversification of their businesses and on the companies with which they work, in the manner determined by the CMF. In addition, insurance brokers are subject to a duty of providing information, and must notify the CMF of any change of their address registered with the CMF, any amendment to the partnership agreement, and any changes in

managers, general representatives, directors or other administrators. They must also provide a summary of their operations in the manner and on the dates determined in a general rule issued by the CMF. Insurance brokers who become disqualified or have incompatibilities with their position, or who do not provide proof that they have contracted an insurance policy in the time and form required for their job, will be eliminated from the registry and may not work again as brokers. This notwithstanding, they will continue to be obligated and liable to the insured for the brokerage they have already made. Insurance brokers must be registered in the Insurance Trade Auxiliaries Registry kept by the CMF and comply with different requirements to conduct their activity, including establishing a guarantee, either through a bank bond or insurance policy, as determined by the CMF, which cannot be less than 500 UF or 30 per cent of the net premium of the insurance contracts brokered in the immediately preceding year (whichever is the higher), limited to 60,000 UF to cover liability for correct and complete compliance with all obligations arising from their activity, and particularly for damages that they might cause to the insureds who contract through them.\(^8\) In addition, legal entities must be legally incorporated in Chile. Managers, legal representatives or employees of the legal entity may not engage independently in insurance brokering, or work for an insurance company or for another person engaged in insurance brokering.

**Reinsurance brokers**

Reinsurance brokers are subject to specific rules contained in SVS General Rule No. 139/2002. In general, they have to be registered in the special Registry of Reinsurance Brokers kept by the SVS (currently, by the CMF) and comply with the following requirements:

- They cannot be registered as insurance brokers;
- They must establish a liability insurance policy for no less than 20,000 UF or one-third of the premium intermediated in the immediately preceding year, whichever is higher (the policy must not be subject to any deductible); and
- Foreign reinsurance brokers must be legal entities, and must certify that they have been legally incorporated abroad and are entitled to intermediate risks ceded from abroad. In addition, foreign reinsurance brokers must designate an attorney with a broad range of faculties to act on their behalf in Chile, including the power to serve and be served with court proceedings.

**Loss adjusters**

Unlike in many jurisdictions, the loss adjuster is appointed to act as an impartial claims specialist who must be licensed and supervised by the CMF. The loss adjuster’s role is to investigate and review the circumstances of the loss or damage, and to report on the validity of the policy coverage in respect of the claim. The adjuster’s report is released to both the insured and the insurer.

**Agencies and contracting**

As regards agency issues, intermediaries are subject to the general agency provisions of both the Civil and Commercial Codes.

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\(^8\) However, 30 per cent on the first 15,000 UF premiums for annuity insurance will be the percentage that will be used to determine such a sum in the case of the said insurance and only 10 per cent on any excess above that amount.
v Claims

Notification

When any event that may constitute a loss occurs, the insured must notify the loss to the insurer as soon as possible upon becoming aware of the event. The insured must also take all necessary measures for saving or recovering the subject insured or for keeping its remains.

Good faith and claims

Criminal law forbids the fraudulent collection of insurance.

Set-off and funding

Under the New Insurance Law, there are specific provisions for bankruptcy. If the insurer goes bankrupt, the insured has the right to terminate the contract and request a proportional return of the premium. The insurer has the same option if the insured bankrupts before payment of the entire premium.

Dispute resolution clauses

Under the New Insurance Law, there is no need for dispute resolution clauses as insurance disputes are now subject to arbitration. Nevertheless, an insured has the right to make a claim in the local courts where the sum in dispute is less than 10,000 UF. In this respect, the arbitrator has to be appointed when the dispute arises.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

According to Article 29 of DFL 251, any dispute arising from insurance and reinsurance contracts governed by the law shall come under the jurisdiction of the Chilean courts. This rule is mandatory and cannot be repealed by agreement of the parties. Therefore, although there is contractual freedom to agree on the applicable law, in principle any dispute must be settled in the Chilean courts. Nevertheless, once a reinsurance dispute effectively arises, the parties to the reinsurance policy are entitled to resolve disputes under Chile’s international arbitration rules.

ii Litigation

Stages of litigation

Generally, in Chile, civil and commercial disputes at first instance comprise three main phases, namely discussion (exchange of pleadings), evidence and issuance of the judgment.

Unless remedies are waived, the right of appeal arises when the decision of the inferior tribunal causes grievance to one or more parties (there are no specific causes). The appeal remedy is available for most first instance court rulings and is usually heard by a court of appeal. The appeal remedy must comply with basic form requirements. The regular term for appealing is five days, but, in the case of final decisions, the period is 10 days counted from the service of the decision. Depending on the subject of the trial and the type of decision appealed, the processing of an appeal can take up to two years.
Regarding appeal stages, in Chile there is only one appeal stage, and the second instance tribunal is allowed to review both factual and legal issues. However, it is possible to challenge the decision of a second instance tribunal through exceptional remedies such as cassation (these remedies are heard by the Supreme Court).

**Evidence**

There are no discovery obligations in Chile, but the parties are free to submit evidence based on documents, witnesses, parties’ confessions, inspections ordered by the court, expert reports and presumptions.

In respect of insurance and reinsurance disputes, under the New Insurance Law, ordinary and arbitration courts are entitled to the following specific faculties relating to evidence issues:

- at the request of a party, to accept additional means of proof to those pointed out above;
- to decree evidentiary measures *ex officio* at any stage of the trial;
- to request recognition of documents and deal with objections; and
- to assess evidence under the ‘sane critic’ doctrine.

**Costs**

Except for minor expenses associated with service, paperwork and auxiliary officers, there are no court fees payable in Chile. As to lawyers’ fees, they can be recoverable, but only if the judge rules that there was no reasonable basis to litigate.

### Arbitration

**Format of insurance arbitrations**

The Tribunal Code establishes the general rules for arbitration. These rules are complemented by the procedural rules contained in the Civil Procedure Code. Furthermore, Article 222 of the Tribunal Code establishes that ‘arbitrators are the judges appointed by the parties or by a judicial authority for the resolution of a litigious matter.’ Article 223 of the Tribunal Code provides that there are three types of arbitrator, as follows: arbitrators at law; arbitrators *ex aequo et bono* (friendly mediators); and mixed arbitrators.

Arbitrators at law are arbitrators who must render a judgment, in accordance with the positive law. The judgment must fulfil all the formal requirements established for judgments rendered by the ordinary courts. In addition, the procedure through which the matter is resolved must be in accordance with the law that would be applicable to the claim had it been brought before the courts (Article 223(1) of the Tribunal Code). Arbitrators *ex aequo et bono* are arbitrators who are authorised to resolve a conflict in accordance with what they deem to be prudent and equitable. With respect to the formalities of the judgment and the formalities relative to the procedure, these arbitrators must submit themselves to the procedures agreed by the parties that appointed them (Article 223(2) of the Tribunal Code). Finally, mixed arbitrators must render a judgment according to the positive law, but they may abide by the rules agreed upon by the parties.

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9 Title IX, Articles 222 to 243.
10 Title VIII of Book III.
It is not necessary to fulfil any special requirements to act as an arbitrator, and only arbitrators at law and mixed arbitrators need be lawyers (Article 225 of the Tribunal Code).

In the context of insurance disputes, if the parties reach an agreement as to who the arbitrator should be, he or she shall be appointed as an arbitrator *ex aequo et bono*. If there is no agreement, the appointment must be performed by an ordinary civil court. If so, the formalities commence with a petition to appoint an arbitrator and end with a resolution issued by the aforementioned court appointing the arbitrator as a mixed arbitrator. The procedural rules to be applied during the arbitration are settled in a subsequent hearing before the appointed arbitrator.

**Procedure and evidence**

Unless the parties agree something different or use institutionalised arbitration, the arbitration procedure is usually based on the Chilean general procedural rules.

**Costs**

Local arbitration centres work based on a public fees scale subject to quantum. *Ad hoc* arbitrators also negotiate their fees based on quantum, but do not necessarily follow the guidelines of the arbitration centres.

**iv Alternative dispute resolution**

Apart from arbitration, there are no other industry-specific settlement mechanisms. In addition, alternative dispute resolution is not often used in the context of insurance disputes.

**v Mediation**

Mediation is not compulsory. However, prior to entering the evidence stage, the courts are obliged to call for a conciliation hearing that has the main aim of helping the parties to achieve settlement.

**V YEAR IN REVIEW**

The CMF was created in March 2017 to replace the former Securities and Insurance Superintendency (SVS). Generally speaking, the CMF is vested with broader faculties to supervise the financial market and enforce its regulations. The CMF works through a Council comprised of five members known as ‘commissioners’. The Council has one president vested with several faculties, including executing and enforcing the regulations and agreements of the Council. In addition, the President represents the CMF. The law that creates the CMF also separates the functions of investigating potential breaches to the law and regulations and imposing sanctions. In this sense, all investigations are now led by a ‘prosecutor’, while the potential sanctions are determined and decided by the Council.

While the law that creates the CMF implied certain organic changes, there are no substantive changes with regard to the regulation that deals with insurance and reinsurance

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11 Law 21,000 published in the Chilean Official Gazette on 23 February 2017. Law Decree No. 3,538 of 1980 that regulated the SVS was also modified to allow the replacement of the latter by the CMF.

12 Transitory Article 4 of Law 21,000 established that the CMF would commence to function on 14 December 2017 and that the SVS would cease to exist effectively by 15 January 2018.
(including regulations for brokers and loss adjusters). However, the CMF has more faculties than the former SVS in connection with different operational aspects of the companies under its supervision, including requesting financial information in connection to process of mergers, acquisitions, divisions, transformation, liquidation of companies; coordinating and cooperating with other government entities such as the Chilean Internal Revenue Service and the Public Prosecutor’s Office; examining specific operations of companies and requesting the corresponding information.

VI OUTLOOK AND CONCLUSIONS

The CMF’s main objectives are to continue contributing, among other things, adequate control measures, maintaining and increasing markets’ confidence and providing more efficient tools for their development.
I INTRODUCTION

In 2018, the Chinese insurance industry embraced several changes. First, the central government established the China Banking and Insurance Regulatory Commission (CBIRC) by combining the functions of the former China Banking Regulatory Commission and the former China Insurance Regulatory Commission (CIRC), in an effort to strengthen financial supervision. Secondly, internet insurance has undergone significant developments; internet giants, such as Alibaba, Tencent and JD, have made deployments in the insurance industry by combining user data traffic with distinct sales scenarios. Thirdly, artificial intelligence is powering the further development of the insurance industry, providing solutions for the problems that arise in customer service, underwriting, insurance product sales and claim settlement. Fourthly, the CBIRC is intensifying its regulation of the insurance industry by issuing anti-fraud guidelines and regulatory letters to certain insurance companies, and publishing typical infringement cases. Lastly, insurance funds are encouraged to contribute to the revitalisation of the real economy by participating in the disposal of non-performing assets and bailout funds.

Based on data released by the CBIRC on its official website on 29 December 2018, overall original insurance premium income reached 3.541 trillion yuan, rising by 2.97 per cent year on year; insurance indemnities and other expenditures reached 1.109 trillion yuan, rising by 9.93 per cent; the total assets of the insurance industry reached 18,006.802 billion 18 trillion yuan, rising by 7.51 per cent; the net assets of the insurance industry reached 1.99 trillion yuan, rising by 5.63 per cent; and the overall amount of insurance funds reached 16.03 trillion yuan, rising by 7.44 per cent.

II REGULATION

In 2018, several new regulations were issued by the CBIRC to press ahead with the reform and development of the insurance industry.

i CBIRC Notice on Expanding the Business Scope of Foreign-Invested Insurance Brokerage Companies

On 27 April 2018, the CBIRC released the Notice on Expanding the Business Scope of Foreign-Invested Insurance Brokerage Companies. As prescribed in the Notice, a
foreign-invested insurance brokerage company that obtains a permit for insurance brokerage business upon approval of the insurance regulatory authority of the State Council may engage in the following types of insurance brokerage business within the territory of China:

a. developing insurance application plans, selecting insurers and handling insurance application procedures for insurance applicants;
b. assisting the insured or beneficiaries to make claims;
c. carrying on reinsurance brokerage business;
d. providing clients with disaster prevention, loss prevention or risk assessment, and risk management consulting services; and
e. conducting other business approved by the CBIRC.

Before the issuance of the Notice, the business scope of foreign-invested insurance brokerage companies was limited to undertaking cross-border brokerage for insurance of large-scale commercial risks, brokerage for insurance, and international marine, aviation and transport insurance and reinsurance, and to providing master policy brokerage services in accordance with the national treatment. The Notice expands the business scope of foreign-invested insurance brokerage companies.

ii Guidelines on Developing Individual Tax-Deferred Commercial Pension Insurance Products

On 7 May 2018, the CBIRC released the Guidelines on developing individual tax-deferred commercial pension insurance products (the Guidelines). The Guidelines are basic requirements and uniform rules for insurance companies to develop and design tax-deferred pension insurance products during the trial period of such insurance. When developing and designing these products, insurance companies must follow the principles of 'steady proceeds, long lock-up period, lifetime benefits, and actuarial balance', and meet the requirements of the insured on safety, proceeds and long-term management of pension funds. The Guidelines set certain requirements pertaining to basic product elements, such as the qualified insured, insurance period, payment of premium, accumulation period and benefit period, types of insurance proceeds, insurance liabilities and pension receipt choices. The Guidelines also provide certain requirements for the insurance companies with respect to the management of the products in different phases.

iii Interpretation of the Supreme People’s Court on Several Issues concerning the Application of the Insurance Law (IV)

On 1 September 2018, the Interpretation of the Supreme People’s Court on Several Issues concerning the Application of the Insurance Law (IV) (the Interpretation) came into effect. The Interpretation, consisting of 21 articles, was announced on 1 August 2018 and covers a number of important issues related to property insurance contracts. It mainly refers to the assignment of the insured subject matter (Articles 1 to 3 and 5), significant increase of risk (Article 4), insurance subrogation right (Articles 6 to 13) and liability insurance (Articles 14 to 20). The Interpretation has also clarified certain controversial issues, providing the following conclusions, among others:

a. whether the property assignee is entitled to the insurance interest depends on whether the insured subject matter and the risk of loss and damage have been delivered to the assignee or not;
b. the insurance applicant can be subrogated by the insurer;
when the insured waives the right to claim indemnity against a third party, the insurer may claim a refund of the premium; and

the conditions for a third party to sue the liability insurer.

With the Interpretation, insurance companies will be more prudent when designing the insurance plan and drafting the policy terms. They may also be motivated, in light of the Interpretation, to pursue subrogation rights more proactively.

iv  CBIRC Notice on Issues concerning the Establishment of Special Products by Insurance Asset Management Companies

On 25 October 2018, the CBIRC released the Notice on Issues concerning the Establishment of Special Products by Insurance Asset Management Companies. The main purpose of this Notice is to establish the advantages of using insurance funds for long-term and stable investment, allow the utilisation of insurance funds to mitigate the liquidity risks of public companies’ equity pledges and support insurance funds’ investment into profitable listed companies. This Notice prescribes certain requirements for insurance asset management companies, and imposes restrictions on the qualified investment targets, investors of special products, the closed period and duration of special products. In sum, insurance asset management companies are encouraged to take active roles as institutional investors, and support listed companies to improve corporate governance, enhance corporate value, and maintain long-term and stable operations. Special products must exit the market in a stable manner mainly by way of transfer by shareholder, repurchase by listed companies, bulk trading and transfer by agreement.

III  INSURANCE AND REINSURANCE LAW

i  Sources of law

As China is a civil law country, the sources of law are statutory codes. The sources of insurance law mainly consist of:

c  the Insurance Law;

d  judicial explanations issued by the Supreme People’s Court;

c  other relevant laws promulgated by the National People’s Congress; and

d  regulations and guidelines issued by the CBIRC and other relevant government institutions.

ii  Making the contract

The Insurance Law does not define a reinsurance contract. In practice, a reinsurance contract is deemed to be a special type of insurance contract concluded between the ceding insurer and the reinsurer.

Pursuant to the Law, an insurance contract is defined as an agreement in which an applicant and an insurer set out their respective rights and obligations under the insurance policy. The term ‘applicant’ refers to the party that concludes the insurance contract with the insurer, and who must pay the premium in accordance with the contract. The term ‘insurer’ refers to the insurance company that concludes the insurance contract with the applicant, and that is liable for paying insurance indemnities in accordance with the contract.
The Law classifies insurance contracts into personal insurance contracts and property insurance contracts classes. A personal insurance applicant shall have an insurable interest in the insured at the time when the insurance contract is formed, while an insured in property insurance shall have an insurable interest in the subject insured at the time when an incident covered by the insurance occurs.

An insurance contract is formed when an insurance applicant applies for insurance and the insurer accepts the application. The insurer shall issue to the insurance applicant an insurance policy or any other insurance certificate in a timely manner.

Pursuant to Article 18 of the Law, an insurance contract shall contain the following:

a. the name and address of the insurer;
b. the names and addresses of the insurance applicant and the insured, and the name and address of the beneficiary in the case of insurance of a person;
c. the subject insured;
d. insurance liability and liability exemption;
e. the period of insurance and commencement date of insurance liability;
f. the amount insured;
g. the premium and payment method;
h. the method for paying indemnity or insurance benefits;
i. liabilities for breaches of contract and resolution of disputes; and
j. the day, month and year of the conclusion of the contract.

The insurance applicant and the insurer may agree upon other particulars related to insurance in the insurance contract.

In concluding an insurance contract, the applicant shall make an honest disclosure when the insurer enquires about the subject insured or relevant circumstances concerning the insured. The insurer shall have the right to rescind the insurance contract if the applicant intentionally or with gross negligence fails to perform his or her obligation of making an honest disclosure, thereby materially affecting the decision of the insurer about whether to provide the insurance or whether to increase the premium rate. If an applicant intentionally fails to perform his or her obligation of making an honest disclosure, the insurer shall bear no insurance liability as regards the insured incident occurring prior to the rescission of the contract, or for returning the paid premiums. If an applicant fails to perform his or her obligation of making an honest disclosure out of gross negligence, and this has a material effect on the occurrence of an incident covered by the insurance, the insurer shall, with respect to the incidents occurring prior to the rescission of the contract, bear no insurance liability, but shall return the paid premiums. If an insurer enters into an insurance contract with an applicant knowing that the applicant has failed to disclose a material fact, the insurer shall not rescind the contract, and if an insured incident occurs, the insurer shall bear the insurance liability.

For those clauses in the insurance contract that exempt the insurer from liability, the insurer shall give sufficient warning to the applicant of those clauses in the insurance application form, the insurance policy or any other insurance certificate, and expressly explain the contents of those clauses to the applicant in writing or orally; if the insurer fails to give a warning or explicit explanation thereof, those exemption clauses shall not be effective.
iii  Interpreting the contract
The provisions of the insurance contract become ambiguous when the insurer and the
insurance applicant, the insured or the beneficiary, have different interpretations of the
policy. If a provision is found to be ambiguous, it should be interpreted in accordance with
the following interpretation methods.

Semantic interpretation
Semantic interpretation means interpreting the policy with common knowledge in
accordance with the common sense of ordinary people. The interpretation cannot deviate
from the wording of the policies, and other methods of interpretation can be applied only
when the outcome of a semantic interpretation is still unclear. The semantic interpretation
method is also the fundamental method.

Systemic interpretation
Systemic interpretation refers to interpreting the provisions based on the entire contents of
the contract, and taking into consideration the connection of each provision with the other
provisions in the contract.

Contract aim-based interpretation
Contract aim-based interpretation means interpreting the policy in accordance with the real
intention of the parties to the insurance contract.

Good faith interpretation
Good faith interpretation is based on the utmost good faith principle, and will interpret the
insurance contract by applying the waiver and estoppel rules. The good faith principle is an
essential principle in the civil law system, and is similar to the utmost good faith doctrine in
the common law system.

Special interpretation
Under a special interpretation, the contents of the schedule outweigh the policy clauses; the
handwritten clauses outweigh the printed clauses; and a special exception is that the contents
of the application form outweigh the insurance policy and schedule even if the application
form is formed earlier than the latter two parts of the insurance contract.

Unfavourable interpretation
Where the insurer and applicant, insured or beneficiary have a dispute over a clause in an
insurance contract concluded by using the standard clauses provided by the insurer, the
clause shall be interpreted as commonly understood. If there are two or more possible
interpretations of the clause, a court or arbitration institution shall interpret the clause in
favour of the insured and beneficiary.

iv  Insurance intermediaries
Insurance intermediaries include insurance brokerage companies, insurance agencies and
insurance assessment institutions. China has adopted the Regulatory Provisions on Insurance
Brokerages, the Regulatory Provisions on Professional Insurance Agencies and the Regulatory Provisions on Insurance Adjusters to regulate insurance brokerage companies, insurance agencies and insurance adjusters.

Insurance brokerage companies and insurance agencies have to be in the form of either a limited liability company or a joint-stock limited company. Brokers provide intermediary services to insurance applicants and insurance companies to execute insurance contracts based on the interests of insurance applicants, while insurance agencies are, based on authorisations by insurance companies, authorised to handle insurance business on their behalf. The two regulations on insurance brokerage companies and insurance agencies respectively provide the requirements on market access, operation rules, market exit, supervision and inspection, and legal liabilities. Further details are also provided regarding the business establishment, qualifications of personnel, scope of business and prohibited acts.

For instance, an insurance brokerage company must meet the following conditions to be established:

- a Shareholders, promoters and sponsors must have a good reputation, and must have no record of major irregularities in the immediately preceding five years.
- b The registered capital must reach a minimum requirement. The minimum registered capital of an insurance brokerage company must be 50 million yuan if it operates beyond a province, autonomous region, centrally administered municipality or the municipality with unilateral planning at the place of its industry and commerce registration. The minimum registered capital of an insurance brokerage company must be 10 million yuan if it operates within a province, autonomous region, centrally administered municipality or the municipality with unilateral planning at the place of its industry and commerce registration. The registered capital of an insurance brokerage company must be paid in cash.
- c The articles of association must comply with the relevant provisions.
- d The chair of the board of directors, the executive director and senior management must comply with the qualifications specified in the Regulatory Provisions mentioned above.
- e It must have a sound organisational structure and management system.
- f It must have a fixed domicile commensurate with the scale of its business.
- g It must have business, financial and other computer hardware and software facilities commensurate with its business.
- h It must meet other conditions specified in laws, administrative regulations and provisions of the CBIRC.

The same conditions apply for a professional insurance agency.

An insurance brokerage company may engage in the following business:

- a drafting insurance application proposals, selecting insurance companies and handling the insurance application formalities for insurance applicants;
- b assisting the insured or beneficiaries in claiming compensation;
- c reinsurance brokerage business;
- d providing clients with disaster, loss prevention, risk assessment or management consulting services; and
- e other business approved by the CBIRC.
To engage in insurance brokerage business, an insurance brokerage must enter into a written brokerage contract with a client agreeing to the rights and obligations of both parties and other relevant matters. A brokerage contract may not violate any laws or administrative regulations, or the provisions issued by the CBIRC.

In conducting business, an insurance brokerage company must prepare a standard client notification letter. This letter must, at minimum, include basic information about the company, such as its name, business premises, scope of business and any contact methods. If there is any affiliation between the company or its director or senior executive and an insurance company or insurance intermediary institution related to its brokerage business, this must be explained in the client notification letter.

An insurance brokerage practitioner must present the client notification letter to each client and, at the request of the client, explain the manner of collection and the rate of commissions. The practitioner must also inform the clients of the insurer of an insurance product, make a full and fair analysis of any similar products recommended, and clearly alert an insurance applicant to the clauses in the insurance contract regarding, *inter alia*, liability exemptions or exceptions, surrender, deduction of other expenses, cash value and the cooling-off period.

A professional insurance agency may engage in the following insurance agency business:

- selling insurance products as an agent;
- collecting insurance premiums as an agent;
- conducting damage surveys and claim settlements for the relevant insurance business as an agent; and
- other business approved by the CBIRC.

To engage in insurance agency business, a professional insurance agency must enter into a written agency contract with an insurance company, agreeing on the rights and obligations of both parties and other relevant matters. An agency contract may not violate any laws or administrative regulations, or the provisions issued by the CBIRC.

A professional insurance agency must prepare a standard client notification letter and present it to the client while conducting business. The client notification letter must, at a minimum, include basic information about the full-time insurance agency and the represented insurance company, such as their names, business premises, scope of business and contact methods. If there is any affiliation between the professional insurance agency or its director or senior executive and the represented insurance company or the relevant insurance intermediary company, this must be explained in the client notification letter. A professional insurance agency must also clearly alert an insurance applicant of the clauses in the insurance contract regarding, *inter alia*, liability exemptions or exceptions, surrender, deduction of other expenses, cash value and the cooling-off period.

v Claims

Under the Insurance Law, the applicant, insured or beneficiary shall, in a timely manner, notify the insurer after becoming aware of the occurrence of an incident covered by the insurance. Where an applicant, insured or beneficiary fails to notify the insurer in a timely manner either intentionally or out of gross negligence, making it difficult to ascertain the nature, cause and extent of the loss of the incident covered by the insurance, the insurer will not be liable for indemnification or payment of the insurance benefits for the indeterminable part, unless the insurer has known or should have known about the incident in a timely
manner through other channels. An applicant also has a duty to cooperate with the insurer that is defending a claim on its behalf. The applicant must keep the insurer informed of all major case developments, respond to the insurer’s reasonable enquiries and notify the insurer.

After receiving an insured’s or beneficiary’s claim for indemnity payment, the insurer must assess the claim in a timely manner. If the circumstances are complex, the insurer must complete the assessment within 30 days, unless otherwise agreed upon in the insurance contract. The insurer must notify the insured or beneficiary of the assessment result. For a claim that falls within the insurance coverage, the insurer must perform the obligation of paying the indemnity within 10 days of after reaching an agreement on the payment of indemnity with the insured or beneficiary. If the insurance contract provides otherwise for the time limit for indemnity payment, the insurer must perform the obligation of paying the indemnity as agreed upon therein. If the insurer fails to perform the obligation as prescribed, it shall, in addition to paying the insurance indemnity, pay compensation for the insured’s or beneficiary’s loss suffered.

In cases where an insurer cannot determine the amount of indemnity to be paid within 60 days of receiving a claim for indemnity and the relevant certificates and materials, it must first pay the amount that can be determined according to the current certificates or materials, and after it finally determines the amount of indemnity to be paid, it shall pay the difference.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Jurisdiction

China’s court hierarchy consists of four levels. The primary courts, intermediate courts, high courts and Supreme Court all have jurisdiction as courts of first instance over civil cases, including insurance litigation, in accordance with the amount of a dispute and the influence of the case.

Generally speaking, the primary courts act as the first instance courts in most insurance cases. On 30 April 2015, the Supreme People’s Court issued the Notice of the Supreme People’s Court on Adjusting the Standards for the Jurisdiction of the Higher People’s Courts and Intermediate People’s Courts over Civil and Commercial Cases of the First Instance, and this can be referred to for the hierarchical jurisdiction of insurance disputes.

In terms of territorial jurisdiction, a lawsuit brought on an insurance contract dispute will usually be under the jurisdiction of the court where the domicile of the defendant or the insured object is located. Further, pursuant to Article 21 of the Interpretation of the Supreme People’s Court on the Application of the Civil Procedure Law, which was issued on 30 January 2015, for an action instituted for a dispute arising from a property insurance contract, if the subject matter insured is a transport vehicle or goods that were in transit, the case may be under the jurisdiction of the people’s court at the place where the transport vehicle is registered, the place of destination or the place where the insurance accident occurs. A case of dispute over a personal insurance contract may be under the jurisdiction of the people’s court of the place of the domicile of the insured.

For litigation involving marine insurance, the court of first instance is the professional marine court, and the Marine Special Procedure Law is applied in such procedure.
Choice of law
As a common rule, the parties to a contract can choose the governing law in a contract. However, pursuant to Article 8 of General Principles of the Civil Law, Chinese law shall apply to civil activities within China, except as otherwise stipulated by law. According to Article 3 of the Insurance Law, this Law shall also govern insurance activities conducted within the territory of China.

For an insurance contract concluded within the territory of mainland China, and where both the insurance applicant and insurer are Chinese entities or Chinese citizens, Chinese laws will usually be applied compulsorily.

Arbitration clauses
More and more insurance companies are choosing arbitration as their dispute resolution method, and the most popular arbitration institution in China is the China International Economic and Trade Arbitration Commission.

However, in the insurance contracts of some foreign-invested insurance companies, a dispute resolution clause gives the parties the right to select the method of dispute resolution, either by arbitration or litigation.

Article 7 of the Interpretation of the Supreme People's Court on Certain Issues Concerning the Application of the Arbitration Law states that an arbitration agreement will be invalid if the parties thereto agree that disputes may be resolved either through submission to an arbitration institution for arbitration or by filing an action with a people's court, unless one of the parties applies to an arbitration institution for arbitration and the other party fails to raise an objection within the time limit specified in Article 20, Paragraph 2 of the Arbitration Law.

Consequently, a dispute resolution clause will usually be deemed invalid. If either the insured or the insurer submits a dispute in connection with an insurance policy for arbitration, the other party may argue for the invalidity of the clause and refuse arbitration, which means that the dispute will ultimately be resolved by litigation.

ii Litigation
Pursuant to Article 26 of the Insurance Law, the statute of limitation for an insured or beneficiary to claim the insurance indemnity against the insurer in any insurance other than life insurance shall be two years, which shall be counted from the day when the insured or beneficiary knew or should have known of the occurrence of the insured accident.

The statute of limitation for an insured or beneficiary in life insurance to claim indemnity against the insurer shall be five years, which shall be counted from the day when the insured or beneficiary knew or should have known of the occurrence of the insured accident.

The litigation procedure for insurance disputes is no different from that of other kinds of civil disputes, and the Civil Procedure Law and Interpretation of the Supreme People's Court on the Application of the Civil Procedure Law will be applied. The court must complete trials of first instance cases within six months. It must complete trials of appeal cases against a judgment within three months of the appeal being docketed, but for an appeal case against a ruling, the court shall issue a final ruling within 30 days of the appeal being docketed.

If any party is unsatisfied with the judgment or verdict of the first instance court, the party can appeal to the appellate court at the higher level. The judgment or verdict of the appellate court is binding. The remedy for a binding judgment and verdict is legal review, but this procedure is rarely initiated.
The judge plays an active role in court hearings. He or she will direct the trial process and is responsible for finding the facts. It is very much an inquisitorial approach. During the civil procedure, the party shall submit evidence to prove the facts upon which its own litigation requests are based or upon which its refutation of the counterparty's litigation requests is based. However, in insurance disputes, the insurer shall bear the burden of proof under several conditions based on the Interpretations of the Supreme People’s Court on Several Issues Concerning the Application of the Insurance Law (II). For instance, if the parties concerned have any dispute over the scope and content of the inquiry at the time of concluding the insurance contracts, the insurer will bear the burden of proof.

iii Arbitration

There is no difference between the arbitration procedure of an insurance dispute and that of other kinds of commercial disputes. The parties shall refer to the arbitration institution's arbitration rules and evidence guidelines in an arbitration procedure. The costs for an arbitration procedure are decided by the arbitration rules of each arbitration institution.

iv Mediation

On 18 December 2012, the former CIRC and the Supreme People's Court jointly issued the Notice of the Supreme People's Court and the China Insurance Regulatory Commission on Carrying out Pilot Work of Establishing the Mechanism for Linking Insurance Dispute Litigation with Mediation in Some Regions of China to establish a mediation system for insurance litigation in some cities. The local courts and insurance associations oversee this system.

Pursuant to the Notice, the courts in the pilot regions can, in accordance with the spirit of the Overall Plan of the Supreme People's Court on Expanding the Pilot Reform of the Mechanism for Settling Disputes by the Linkup of Litigation and Non-Litigation, establish registers of mediation organisations and mediators that are specially invited. Where conditions permit, the courts can also provide mediation organisations and invited mediators with mediation rooms that are specifically provided to carry out the work required for settling insurance disputes.

The courts in pilot regions must, under the precondition of respecting the parties’ will and in accordance with the relevant provisions of the Several Opinions of the Supreme People’s Court on Establishing a Sound Mechanism for Settling Disputes by the Linkup of Litigation and Non-Litigation, guide parties in effectively settling disputes with low costs through the mechanism for linking insurance dispute litigation with mediation by means of appointed mediation before a case is docketed, and by means of authorised mediation after a case is docketed.

In 2016, the Supreme People's Court and the former China Insurance Regulatory Commission jointly issued the Opinions on Comprehensively Advancing the Building of the Mechanism Linking Litigation with Mediation for Insurance Disputes. With the exception of regions carrying out the pilot programme at the earlier stage, the Opinions will actively expand the scope of the regions carrying out the pilot programme to include all municipalities directly under controlled by the central government and all provincial capitals (capitals of autonomous regions).

3 No. 116 [2012] of the Supreme People's Court.
4 No. 45 [2009] of the Supreme People's Court.
After receiving the bill of complaint and before registering a case, a people’s court shall guide the parties to resolve insurance disputes via mediation. If the parties agree to this, they must complete relevant mediation forms or sign a letter of consent; if the parties do not agree, the people’s court will register the case. After the case is registered, the people’s court can still appoint mediation organisations to mediate the dispute with the consent of the parties based on the development of the case. The mediation organisations must finish mediating the dispute within 20 working days of being assigned the case. The mediation period can be extended by seven working days in special circumstances, with the consent of the parties. The mediation organisations can consult with the people’s court when dealing with complicated cases.

If a contract is civil in nature, the mediation agreement concluded by the parties to insurance disputes will take place under the mediation of a mediation organisation or mediators. With the signatures and seals of the organisation or mediators, the parties may apply to the court with jurisdiction to confirm the validity of the mediation agreement. A mediation agreement that is confirmed to be valid by the court will have enforceability.

V YEAR IN REVIEW

In 2018, the reform of commercial vehicle insurance clauses and rates has continued. The Insurance Association of China is charged with developing and continuously improving the model commercial vehicle insurance clause system. Property insurance companies are encouraged to vigorously develop innovative commercial vehicle insurance clauses. The pricing model for automobile damage insurance has transformed from one based on traditional insurance amounts, to the now-prevalent vehicle-type-based pricing model, where the premium for automobile damage insurance is determined with comprehensive consideration of various elements, such as vehicle value, safety factor and maintenance expenditure, rather than considering the insurance amount or the purchase price of a new vehicle alone. Moreover, property insurance companies are granted a certain degree of autonomy in the pricing of commercial vehicle insurance. Property insurance companies, which are under the jurisdiction of the Sichuan, Shan Xi, Fu Jian, Shan Dong, He Nan and Xia Men Bureaus of the CBIRC, can develop a plan for adjustments to the independent underwriting coefficient and independent channel coefficient for commercial vehicle insurance within a specific range, and report it to the CBIRC for approval before putting it into practice.

In 2018, insurance funds were encouraged to invest in the housing rental market. An insurance company can make a direct investment into the long-term housing rental market, and an insurance asset management company can participate in the long-term housing rental market by establishing debt investment schemes, equity investment schemes, asset-backed schemes or insurance private equity funds. In any of these scenarios, the target long-term rental housing project must satisfy the following conditions: maintain stable current or expected cash flows; and be located in Beijing, Shanghai, Xiong’an New Area, or a large or medium-sized pilot city with net population inflow. In the event that the target project is situated on collectively owned construction land, the following applies:

a the relevant piece of land shall be located in pilot city where rental housing can be built on collectively owned construction land;

b the property rights of the target project shall be clear and be free from any ownership dispute and encumbrance;
the land allocation contract or the certificate of land-use right shall specify that the land and the ground structures of the target project shall only be used for rental housing and may not be transferred; and

the target project has undergone necessary examination and approval procedures during each phase of the project – including planning, construction, completion and final acceptance, and operations and management – or has undergone the necessary examination and approval procedures in the project construction phase.

In 2018, insurance companies were required to further strengthen and improve insurance services. Insurance sales activities were strictly regulated. Insurance companies and insurance intermediaries reinforced control of sales promotions to prevent them being one-sided and false, and strictly managed and controlled insurance marketing and promotion activities on self-media, and the activities of insurance practitioners, to eliminate illegalities, irregularities and improper promotions.

Insurance companies were also advised to increase investment in claims settlement service facilities, and strengthen the functions of claims settlement services in their business outlets to provide consumers with convenient claims settlement services. An insurance company or insurance intermediary should do the following:

- strengthen the management of internet insurance business, standardise service behaviour and raise service quality;
- use plain and accurate language on promotion and sales pages to describe the main functions and features of insurance products, highlight content that is ambiguous or could be easily overlooked by consumers, and refrain from using misleading words;
- fully consider its after-sales service supporting capabilities for internet insurance sales to ensure that internet insurance consumers enjoy insurance services that are not inferior to those provided by other business channels; and
- refrain from practising tie-in sales in violation of relevant provisions, and resorting to means such as forced box-ticking, default checking, etc., to sell insurance.

Although 2018 saw stricter regulation of the insurance industry by the regulators, a review of the major events in 2018 demonstrates that the year was also one of reform, innovation and development for the sector. The industry has already become a significant part of the national economy, and its influence looks set to grow further.

VI OUTLOOK AND CONCLUSIONS

The year 2019 will play an important role in achieving the goals of the people-centred development philosophy and serving the real economy. Based on the idea proposed by the former CIRC that ‘the main function of the insurance industry is to insure, the main function of CIRC is to regulate’, 2019 will see the intensifying of insurance regulations, the active and prudent disposal of potential risks, and the promotion of supply-side structural reform, which will in turn give full play to the safeguarding function of insurance, and further ensure that the insurance industry contributes to the development of the economy and society. Meanwhile, further reforms and innovations concerning the insurance market system, auto-insurance premiums and insurance asset utilisation will take place.

Thus, by 2020, a modern and mature insurance industry will be established, and China will have a stronger insurance industry overall.
Chapter 12

COLOMBIA

Neil Beresford, Raquel Rubio and Andrés García

I  INTRODUCTION

Colombia is among the world’s most dynamic and competitive insurance markets. During the past few years, the industry has grown at a strong pace supported by the country’s general economic expansion, a growing middle class, product development and the entry of new participants. Despite the economic downturn faced by other economies in the region, Colombia continues to enjoy growth at an annual rate of 2.7 per cent and it is estimated to grow in 2019 at a rate of between 3.5 per cent and 4 per cent.2 The insurance sector is growing at a rate above the national average; it increased by 4.9 per cent during 2018.

The Colombian legal system remains challenging but it is constantly improving. A gradual review of financial regulation has been advanced, including measures to lower the barriers for foreign insurers and brokers entering the market; strong consumer protection laws; a regulatory sandbox to test new financial products; and easier complaints procedures. All of these reforms will lift the industry’s domestic reputation and stimulate local demand.3 The market also continues to attract new entrants – in 2018, Zurich acquired QBE’s operation in Colombia; Youse, a Brazilian-based online insurer, was authorised by the Colombian insurance regulator; and HDI took over Generali’s operations.

II  REGULATION

i  The insurance regulator

Insurers, reinsurers and brokers operating in Colombia are supervised by the Financial Superintendency (FS), an independent body attached to the Colombian Ministry of Finance and Public Credit.4

The main regulatory framework is contained in the Organic Statute of the Financial System (EOSF),5 and other regulations including:

a  Decree 2555/2010, which sets reserve and minimum asset requirements and contains the regime applicable to insurance intermediaries;

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1 Neil Beresford is a partner, Raquel Rubio is a senior associate and Andrés García is an associate at Clyde & Co LLP.
3 For example, the adoption of International Financial Reporting Standards and Law 1870 of 21 September 2017, which regulates the regulation and supervision of financial conglomerates.
4 Article 325, Decree 663/93 EOSF.
5 Decree 663/1993, EOSF.
a Law 1328/2009, which regulates access to the Colombian market by foreign non-domiciled insurers and contains consumer protection rules specific to financial products;
b Law 1480/2011 on general consumer protection;
c Law 1870/2017 on the regulation of financial conglomerates;
d Part I of External Circular 029/2014 of the FS, which establishes the regime applicable to general insurance operations, some special lines of insurance, solvency requirements, risk management procedures and the registration rules for foreign non-domiciled insurers and reinsurers. Part 2 regulates brokers and agents; and
e the Commercial Code.

### ii Position of non-admitted insurers

Unregulated insurance and reinsurance activity is prohibited. Contracts made with unauthorised entities are void and the unauthorised insurer may be required to return all premiums received. It may also be subject to further sanctions in the form of fines, compulsory dissolution and disqualification.

 Colombian residents are generally free to purchase insurance outside Colombia, in which case the contract will fall outside the scope of Colombian regulation. Colombian insurers may cede 100 per cent of their written risks abroad by way of reinsurance. However, the following policies must be purchased from a regulated entity within Colombia:

a insurance that is compulsory under Colombian law or is contingent upon compulsory coverage;
b insurance in the nature of social security such as life insurance, annuities and employers’ liability insurance; and
c insurance issued to state entities.

### iii Requirements for authorisation of insurers

Colombian law provides four options for insurance entities wishing to do business in Colombia: incorporated insurance or reinsurance companies; branch offices of foreign insurers; registered foreign insurers or reinsurers; and representative offices of foreign reinsurers.

**Incorporated insurance and reinsurance companies**

Insurers or reinsurers wishing to incorporate in Colombia require prior authorisation from the FS. The principal requirements for authorisation are as follows:

a the proposed entity must be structured as a limited company or a cooperative association;
b the proposed entity must satisfy a minimum capital requirement, of which 50 per cent is paid at the point of incorporation and the remainder within 12 months; and

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6 Articles 39 and 108, EOSF.
7 Article 108, EOSF.
8 Article 39, EOSF.
9 Article 53, EOSF.
10 Articles 80 and 81, EOSF.
c in addition to its minimum capital, the proposed entity must maintain assets,\textsuperscript{11} a solvency margin\textsuperscript{12} and minimum reserves\textsuperscript{13} according to law.

Upon receipt of an application, the FS institutes a short period of public consultation. If no objections are received, and the FS is satisfied with the proposed entity, authorisation will be granted and incorporation may proceed.

\textbf{Branch offices of foreign insurers}

Foreign insurers (not including reinsurers) are able to access the Colombian market by establishing branch offices. These are treated as an extension of the parent company and are free from the strict requirements of incorporation. However, branches are treated as regulated entities within the jurisdiction of the FS and they must comply with the same regulations that apply to incorporated entities.

Branch offices are subject to the following additional requirements:\textsuperscript{14}

\begin{itemize}
\item[a] minimum capital, which must be paid immediately upon the establishment of the branch office;
\item[b] minimum assets located in Colombia; and
\item[c] the presence of a permanent local representative with professional credentials and moral standing.
\end{itemize}

\textbf{Registered foreign insurers and reinsurers}

Limited classes of insurance and reinsurance may be marketed in Colombia by foreign entities that are not regulated by the FS, on condition that they obtain local registration.

\textbf{Marine and aviation transport insurance}

Foreign insurers may issue transportation policies (marine and aviation transport (MAT) insurance), in respect of goods, vessels and associated liabilities arising in the course of international transportation by air and sea, including space launch.\textsuperscript{15} A foreign insurer wishing to issue MAT policies must apply to the FS for a place on the Register of Foreign Insurers offering Marine and Aviation Transport. The principal requirements are a minimum rating of BBB- by Standard & Poor’s or equivalent and minimum capital, solvency levels and asset levels equal to those that are required of incorporated Colombian insurers.\textsuperscript{16}

\textbf{Agricultural insurance}

Foreign insurers may also issue agricultural insurance policies\textsuperscript{17} by applying to the FS for a place on the Register of Foreign Insurers and Brokers of Agricultural Insurance. The

\begin{footnotes}
\item[13] Article 186, EOSF and Title 1, Chapter 2, Book 31 of Decree 2555/2010 (as modified by Decree 2954 of 2010).
\item[16] Chapter V, Title II of Part I of External Circular 029/2014.
\item[17] Article 74, Law 1450/2011.
\end{footnotes}
principal requirements are similar to those that apply to MAT insurers, as set out above. The government subsidises between 60 per cent and 80 per cent of individual agricultural insurance premiums and up to a certain limit per hectare through Finagro, Colombia’s rural development bank. The government is currently exploring the reforms that would be required to promote the use of parametric insurance.

**Foreign reinsurers**

Foreign entities may transact reinsurance business in Colombia. Foreign reinsurers should apply to the FS for a place on the Register of Foreign Reinsurers and Reinsurance Brokers (REACOEX) and demonstrate compliance with requirements that are very similar to those that apply to MAT insurers.

**Representative offices and subscription agencies of foreign reinsurers**

A reinsurer that is included on the REACOEX register may also open a representative office in Colombia. Applications are made to the FS and require extensive documentation to be served in support. Representative offices are subject to the control and supervision of the FS. Since November 2018, foreign reinsurers may also carry out business through subscription agencies that are in charge of placing reinsurance on behalf of foreign reinsurers. Subscription agencies must be registered in REACOEX and set out the business lines available through the agent.

**Position of brokers**

To operate in Colombia, insurance and reinsurance brokers must be authorised and regulated by the FS.

**Incorporated entities**

If a broker wishes to incorporate in Colombia, it must satisfy the following principal requirements:

- If the proposed entity is an insurance broker, it must be incorporated as a limited company or general partnership. If a reinsurance broker, the proposed entity may be structured differently.

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18 Chapter IV, Title II of Part I of External Circular 029/2014.
20 Article 94, EOSF.
21 Chapter III, Title II of Part I of External Circular 029/2014.
22 The list is specified in Article 4.1.1.1.4, Decree 2555/2010.
23 External Circular No. 20 of 3 October 2018, which creates Articles 2.2.1.8, 3.1.2.1.9 and modified Article 3.1 of the Basic Legal Circular.
24 Article 1351, Commercial Code.
25 Article 1347, Commercial Code.
26 Article 44.1, EOSF.
The managing directors and administrators of the proposed entity must be approved by the FS and possess a minimum level of qualifications and personal standing. A candidate is presumed to be suitable if he or she can show they have sufficient experience in the brokerage industry and good business management records.27

The proposed entity must satisfy a minimum capital requirement.28

**Registered foreign brokers**

Foreign brokers wishing to market agricultural insurance or reinsurance products in Colombia without establishing a local office may apply to the FS for inclusion on the relevant register. Registration for MAT brokers is effected through the relevant MAT insurer.

**v Regulation of individuals employed by insurers**

The names of the directors and senior management of an insurance entity must be disclosed to the FS as part of the authorisation process.29 Those individuals must demonstrate that they are fit and proper persons, and authorisation may be denied if they have criminal convictions or sanctions for breach of duty.

The directors and senior management of regulated entities are also subject to a code of conduct requiring that they act within the law, in good faith and in the advancement of the public interest.30

**vi The distribution of products**

Regulated entities must submit their policy wording, including any schedules, amendments and premium models to the FS whenever they begin writing a new line of business.31

The FS may disallow the use of wording that does not comply with Colombian insurance law and regulation or is insufficiently clear.32 The FS may also prohibit the sale of a product if it determines that the proposed premium is unfair or unjustified by statistical evidence.

**vii Compulsory insurance**

There are more than 50 types of compulsory insurance, including various forms of motor liability, employers’ liability, transportation liability, environmental liability and credit insurance in transactions involving international trade and state entities. Unfortunately, there is no single point of reference and it is beyond the scope of this chapter to list them all. However, reinsurance brokers are among a very small number of professions that are required to carry professional indemnity and fidelity insurance.33 The legislature frequently adds new mandatory insurance requirements affecting different sectors. Developments in recent years include a bill requiring compulsory building guarantee insurance and liability policies for certain types of dangerous dogs.34

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28 Chapter III, Title IV of Part II of External Circular 029/2014.
29 Article 53, EOSF.
30 Article 72, EOSF.
31 Article 184.1, EOSF.
32 Article 184.4, EOSF.
33 Article 2.30.1.4.4, Decree 2555/2010.
Compensation and dispute resolution regimes within the financial services context

Law 1328/2009 requires regulated entities to set up (at their own expense) a customer complaints procedure known as a Consumer Attention System (SAC) and to offer the services of an independent adjudicator. In theory, the procedure applies to all disputes involving any type of customer, line of business and magnitude of the claim. However, the adjudicator’s decision will be binding only if the statutes of the regulated entity make provision for binding determination and prior agreement has been reached with the customer.

If the SAC fails to resolve the dispute, the customer can either refer it to the FS or pursue a claim in court. The FS has jurisdiction over all contractual claims brought against regulated entities.

The law does not provide for a statutory fund of last resort for customers of insurance or reinsurance firms. The solvency and reserving practices of these institutions are kept under continuous review by the FS.

Other notable regulated aspects of the industry

The FS must be notified of any proposed merger or acquisition involving a regulated entity; or transaction by which an investor will acquire 10 per cent or more of a regulated entity. The FS may object to such transactions for technical reasons or for the protection of the public interest. A transaction made without the approval of the FS is void.

III INSURANCE AND REINSURANCE LAW

Sources of law

Colombian law is a civilian system with codified laws and a written political constitution.

The courts are subject to codified law but are allowed to use, at their discretion, ancillary tools such as jurisprudence, custom, doctrine, general principles of law and equity. Although the lower courts are expected to follow the decisions of higher courts, there is no absolute doctrine of precedent and judges frequently depart from previous rulings on questions of law.

The basic rules of Colombian contract law are set out in the Civil Code and those that are specific to insurance law are contained in the Commercial Code. The law has been supplemented by consumer protection legislation, some of which is specific to insurance contracts and some of which is of a more general nature.

35 Articles 8 and 13, Law 1328/2009.
37 Article 56, EOSF and Article 2.36.12.2.4, Decree 2555/2010, Ministry of Finance and Public Credit.
38 Article 88, EOSF.
39 See Articles 58 and 88.1, EOSF.
40 Article 230, Colombian Constitution.
41 Article 10/36 et seq. for non-marine, Article 1703 et seq. for marine and Article 1900 et seq. for aviation insurance.
Making the contract

Essential ingredients of an insurance contract

The essential elements of a valid insurance contract are as follows:

a an insurable interest, namely any lawful interest that can be subject to pecuniary valuation. The courts have approached the question of insurable interest by asking whether the insured risk event would directly or indirectly affect the wealth of the policyholder;

b an insurable risk – non-fortuitous or impossible events do not constitute risks and are therefore uninsurable. Wilful misconduct, gross negligence and deliberate acts of the beneficiary are also uninsurable;

c the agreement on the part of the insured to pay a premium in exchange for the transfer of risk to the insurer; and

d the agreement on the part of the insurer to pay an indemnity upon the occurrence of an insured event.

Utmost good faith

Insurance contracts are subject to the duty of utmost good faith at inception. The insured is obliged to declare sincerely all facts and circumstances that are material to the risk. Material facts are those that, if known to the insurer, would have prevented it from entering the contract or caused it to apply more onerous terms.

The duty of disclosure applies in all cases. However, the insurer’s remedy depends upon whether a proposal form is used – if it is, any incomplete or inaccurate answers result in the policy becoming voidable. If no proposal form is used, the policy is voidable if the insured gives incomplete or inaccurate information by reason of negligence or fraud. If the insured acts innocently, the policy is not voidable but a proportional remedy applies. In other words, if the misrepresentation or non-disclosure leads to the insured paying only 50 per cent of the correct premium, the insurer is required to pay only 50 per cent of the claim.

The law is silent on the question of severability. Directors’ and officers’ (D&O) insurers are therefore free to include severability provisions to address non-disclosure or misrepresentation on the part of individual directors. Provided the declarations are made on their own behalf and not on behalf of the company, there is no reason to prevent insurers from pursuing the partial avoidance of the policy.

No remedy will be granted if the undisclosed or misrepresented facts were known to the insurer, or ought to have been known to the insurer, at the date of inception.

The duty of good faith continues throughout the duration of the contract. The insured must notify the insurer in writing of any material increase in risk, whereupon the insurer may

43 Article 1083, Commercial Code (CCo). With the exception of one’s own life in cases of life insurance (Article 1137).
44 Supreme Court, decision of 21 March 2003, exp. 6642, magistrate César Julio Valencia Copete.
45 Article 1054, CCo.
46 With the exception of liability insurance (Article 1127, CCo).
47 Article 1055, CCo.
48 Article 1058, CCo.
cancel the policy or vary its terms.\textsuperscript{49} If the risk has decreased, the insurer is legally obliged to reduce the premium.\textsuperscript{50} If no notification is made, the contract is terminated automatically upon the increase in risk.

**Recording of the contract**

Insurers must issue written policy documentation within 15 days of concluding the agreement.\textsuperscript{51} In the absence of any express terms and conditions, the standard wording that the insurer has deposited with the FS will be deemed to apply.\textsuperscript{52}

The proposal form and any attachments to it are considered part of the policy.\textsuperscript{53}

Consumer insurance policies are subject to a series of formal requirements. The policy document must be written using plain language and a clear typeface. In addition to the policy documents, the consumer must also be given a clear explanation of the cover. Failure to comply with these requirements is considered an abusive practice and may result in sanctions and penalties being imposed by the FS.\textsuperscript{54}

**iii Interpreting the contract**

**General rules of interpretation**

Insurance contracts are subject to the rules of interpretation set out in Articles 1618 to 1624 of the Civil Code, which apply to contracts generally.\textsuperscript{55} The law operates even-handedly between the insurer and the insured: if the parties are of equal commercial strength they are treated as equal before the law.

The overriding principle is that the intention of the parties, when clearly known, will prevail over the literal meaning of the words in the contract.\textsuperscript{56} Therefore, a high degree of emphasis is placed upon the evidence of those involved in the contracting process and the correspondence exchanged at the time of contracting. The parties’ prior conduct may also be taken into account if they have entered into similar contracts or acted in a manner that is relevant to the contract under review.

The contract is interpreted in its entirety, such that each clause will be given the meaning that is most appropriate for the functioning of the contract as a whole. There is a presumption against any part of the contract being redundant, so preference is given to interpretations that produce effect.

Ambiguous clauses are interpreted contra proferentem,\textsuperscript{57} a principle that is applied rigorously in the context of consumer insurance.\textsuperscript{58}

\textsuperscript{49} Article 1060, CCo.

\textsuperscript{50} Article 1065, CCo.

\textsuperscript{51} Article 1046, CCo as amended by Article 3, Law 389/1997.

\textsuperscript{52} Article 1047, CCo as amended by Article 2, Law 389/1997.

\textsuperscript{53} Article 1048, CCo.

\textsuperscript{54} Articles 7 and 9 to 12, Law 1328/2009 and Articles 9 and 10, Chapter 6, Title 1 of External Circular 007/1996.

\textsuperscript{55} Article 822, CCo.

\textsuperscript{56} Article 1618, Civil Code.

\textsuperscript{57} Article 1624, Civil Code.

\textsuperscript{58} Supreme Court, decision of 27 August 2008, exp. 1997-14171. Magistrate William Namén Vargas. See also Article 34, Law 1480/2011.
The interpretation of the above principles might differ depending on the forum in which the claim is being heard. For instance, an insurance dispute might be heard before the administrative courts where principles of public law will be read into the contract. Equally, regulators such as the Office of the Controller General (the Controller’s Office),59 a public body with discretion to commence quasi-judicial proceedings against private and public officials or entities involved in the management of public funds, might join their liability and bond insurers on the basis of inapplicable wording or multiple policy periods.

**Mandatory rules**
The parties to an insurance contract enjoy relatively wide freedom to set the terms of the agreement, subject to the limits of public policy and the mandatory rules of Colombian law.60 Colombian law recognises two types of mandatory rule: those from which no departure is allowed and those that can be modified only in the insured’s favour. A contract term that violates a mandatory rule will be declared void.61

The list of mandatory rules is not closed. A rule may be declared mandatory either because it is expressed to be mandatory or a mandatory nature may be inferred from the general character of the rule.

The most important mandatory rules at the pre-contractual stage are as follows:

\[ a \] the insured is under a general duty of good faith in the manner set out above;62
\[ b \] if a policy is issued for the benefit of multiple insured parties with different interests (e.g., a D&O policy), non-disclosure by one insured party will not affect the validity of the coverage issued to others;63 and
\[ c \] if the insured purchases a limit of indemnity in excess of its real interest, with a view to defrauding insurers, the policy is void.64

The most important mandatory rules affecting the operation of a policy are as follows:

\[ a \] a policy (other than a life policy) may provide for automatic termination in the event that premium is paid late. In such cases, the insurer is entitled to claim from the insured the amount of premium for the risk incurred, together with its expenses and interest at a punitive ‘moratorium’ rate;65
\[ b \] the insured is under a continuing duty to inform the insurer of any material increases in risk, and the insurer is obliged to reduce the premium if the insured gives notice of a reduction in the risk;66
\[ c \] the insured is under a duty to inform the insurer of any double insurance within 10 days of the duplicate cover being taken out. If the insured fails to give notice, the policy will be terminated automatically;67 and

60 The rules made mandatory by the Commercial Code are listed in Article 1162.
61 Article 899, CCo.
62 Article 1058, CCo.
63 Article 1064, CCo.
64 Article 1091, CCo.
65 Article 1068, CCo. Note that different rules are applicable to life insurance policies, pursuant to Article 1151, CCo.
66 Article 1065, CCo.
67 Article 1093, CCo.
121

either party may effect cancellation by giving notice in writing, although, in the case of cancellation by the insurer, 10 days’ notice is required. Following cancellation by either party, the insurer must return the unused part of the premium.

The most important mandatory rules affecting the claims process are as follows:

- The insurer may not characterise any claims condition as a condition precedent to its liability under the policy. The insurer’s only remedy for breach of a claims condition is a claim in damages to the extent that prejudice has been caused;
- The insurer may not impose a notification requirement that is less than three days from the date on which the insured discovered, or ought reasonably to have discovered, the loss;
- In the case of double insurance, each insurer is required to pay a rateable proportion if the insured has acted in good faith; and
- The insured will forfeit its right to indemnity if it acts in bad faith during the claims process.

The most important mandatory rules affecting the settlement of claims are as follows:

- The insurer must pay the indemnity within a month of the insured having proved its loss, failing which interest applies at the punitive moratorium rate;
- If the insured incurs genuine mitigation costs, the insurer is required to pay the costs even if they exceed the sum insured; and
- In the case of liability policies, the two-year limitation period that applies to the insured’s claim against the insurer does not begin to run until the third party makes a claim against the insured.

**Conditions precedent**

Colombian law does not use the language of conditions precedent. It neither prohibits nor endorses them. The effect of clauses that are expressed as conditions precedent must therefore be approached on an individual basis, in the context of the mandatory rules explained above.

The law may be summarised as follows:

- Some conditions precedent are prohibited by mandatory rules. For example, there is a general prohibition on expressing claims conditions as conditions precedent to an insurer’s liability. Except in the case of fraud, the only remedy for breach of a claims condition is a claim in damages to the extent that the insurer has suffered prejudice.

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68 Article 1071.
69 ibid.
70 Article 1078, CCo.
71 Article 1075, CCo.
72 Article 1092, CCo.
73 Article 1078, CCo.
74 Article 1080, CCo, although Article 185.1, EOSF provides that the period can be extended by agreement up to 60 working days provided that the insured is a company and the sum insured exceeds approximately US$4.5 million.
75 Articles 1074, 1079 and 1089, CCo.
76 Article 1131, CCo.
77 Article 1078, CCo.
Some conditions precedent are positively reinforced by mandatory rules. For example, Article 1068 of the CCo contemplates that an insurer may make the payment of premium a condition precedent to its liability.

Other conditions precedent are not touched upon by the law. If an insurer wishes to impose a condition precedent that does not contravene one of the mandatory rules, Colombian law will not prevent it. An example of a clause falling into this category would be a reasonable precautions clause or an unoccupancy condition.

**Warranties**

The law defines a warranty as:

\[
\text{[A] promise by virtue of which the insured is obliged to do or not to do a certain thing, or to comply with a certain requirement, or by which [the insured] confirms or denies the existence of a factual situation.} \text{[78]}
\]

To be valid, a warranty must be clearly expressed and indicate an unequivocal intention to impose a strict duty of compliance.

The insurer may rely upon a breach of warranty to terminate the policy from the date of breach, irrespective of its materiality to the risk or the eventual loss.

**The integrity of the policy limit**

It is important to be aware that claims under insurance policies will often be put at a level that exceeds the limit of indemnity. Two particular arguments are made.

The first is that insureds occasionally seek indexation of the policy limit. For example, if the rate of national inflation is 5 per cent, a policy limit of 500 million pesos issued in 2014 would be worth less than 400 million pesos in ‘real’ terms by 2020. Since litigation can take several years to resolve, the insured will sometimes ask a judge to make an award that reflects the real value of the original policy limit. This is generally regarded as heresy, and, in 2009, the Supreme Court held that indexation of a premium would involve an illegitimate re-authoring of the policy. However, insurers and reinsurers should be aware of a small number of cases where Colombian courts have allowed the indexation of limits.

A second argument is that the defence costs of an insured under a liability policy are payable in addition to the limit, regardless of the wording of the policy. As mentioned above, the law requires that insurers pay reasonable mitigation costs in excess of the limit,\textsuperscript{79} and it is said that the costs of defending a third-party claim may be brought within this rule. The courts have yet to make any authoritative pronouncement on this important question.

**Intermediaries and the role of the broker**

**Intermediaries**

There are four types of insurance intermediary: agents, brokers, Bancassurance and correspondents. Agents are contractors or employees of the insurer and act on the insurer’s behalf. Unless they are especially large, agents are regulated by the FS as part of the insurer for whom they act. Their precise rights and obligations depend upon the extent of their delegated

\textsuperscript{78} Article 1061, CCo.
\textsuperscript{79} Articles 1074, 1079 and 1089, CCo.
authority, although all agents have power to collect money, inspect the physical risk and assist in arranging the policy. Some agents have delegated underwriting and claims authority. Increased scrutiny has led the regulator to tighten regulation for agents. As of July 2017, all agents are required to register with the Insurance Intermediaries Registry\textsuperscript{80} and undertake a training course before they are allowed to offer their services to the public.\textsuperscript{81}

A broker, on the other hand, is formally independent of either party to the transaction. Their role is defined in the following terms:

\begin{quote}
A broker is a person who, by reason of his special knowledge of the markets, operates as an independent intermediary for the purpose of bringing together two or more persons to enter a commercial contract, without being linked to the parties by way of collaboration, dependency, mandate or representation.\textsuperscript{82}
\end{quote}

As a result of this privileged legal status, claims against brokers are rare. Only reinsurance brokers are required to carry professional indemnity insurance.\textsuperscript{83}

Most recently, the FS promoted alternative intermediation methods, including bancassurance, to increase the availability of insurance in the mass market. It also extends to other retailers acting as correspondents with allowances to offer consumer products, such as mandatory vehicle insurance or basic life insurance.\textsuperscript{84}

\textbf{Code of conduct}

All brokers and agents are subject to the same code of conduct that applies to regulated entities in general.\textsuperscript{85} The specific duties of intermediaries include prohibitions on:

\begin{enumerate}
\item misrepresenting the scope of cover or the terms of the contract;
\item paying commission to the insured;
\item interfering with the business of other brokers;
\item competing unfairly; and
\item acting without instructions.\textsuperscript{86}
\end{enumerate}

A sufficiently serious breach of the code of conduct may result in the intermediary’s authorisation being withdrawn.

In exchange for the services rendered, the broker is entitled to a commission, which will be freely determined between the parties and paid by the insurer.\textsuperscript{87} The commission falls due as soon as the insurance contract is signed.\textsuperscript{88}

\textsuperscript{80} Circular No. 50 of 28 December 2015.
\textsuperscript{81} Section 7, Chapter II, Title IV, Part II of Circular 029 of 2014. As modified by Circular No. 50 of 2015.
\textsuperscript{82} Article 1340 CCo.
\textsuperscript{83} Article 2.30.1.4.4 of Decree 2555/2010.
\textsuperscript{84} Articles 2.36.9.1.17 and 2.36.9.1.78 of Decree 2555 of 2010 as modified by Decree 2123 of 2018.
\textsuperscript{85} Article 72, EOSF.
\textsuperscript{86} Article 207.3, EOSF.
\textsuperscript{87} Article 2.30.1.1.4, Decree 2555/2010.
\textsuperscript{88} Article 1341, CCo.
Claims

Notification

The parties to an insurance contract may agree upon whichever rules of notification they choose, subject to two mandatory rules as set out above. First, an insured must be given at least three days from the date of discovery to notify a loss.89 Second, duties of notification cannot be made conditions precedent to an insurer’s liability.90

The general limitation period for a claim by an insured against an insurer is two years from the date on which the insured knew or ought to have discovered the facts giving rise to the claim, up to a maximum of five years from the date when the cause of action arose.91 The Controller’s Office applies a five-year limitation period based on its own procedural rules.

Good faith and the claims process

The duty of good faith subsists throughout the contract. In the claims context, the duty of good faith is reflected in Articles 1074 and 1079 of the CCo, which oblige the insured to mitigate loss92 and oblige the insurer to meet the reasonable costs of mitigation, even if they exceed the eventual limit of indemnity.93 Save in the case of subrogation,94 the law does not impose on the insured any specific duties to cooperate with their insurers in the defence or adjustment of claims.

In practice, these rules can leave insurers with only limited control of claims. However, if an insured commits bad faith in the claims process, it will forfeit the right to indemnity.95

Claims by parties other than the insured

A liability insurer may be drawn into underlying proceedings in one of two ways. Either a third party with a claim against the insured may bring direct proceedings against the insurer,96 or the insured or a regulator may bring the insurer into litigation by issuing a form of third-party notice known as a ‘call-in-warranty’. The Controller’s Office has the discretion to draw liability and bond insurers into a form of recovery proceedings as guarantors of their insured’s potential liabilities.

In contrast, a reinsurer can be sued only by the reinsured: it is not legitimate for a third party or an original insured or a regulator to bring proceedings directly against a reinsurer.97

Payment of indemnity

After receiving proof of loss, the insurer is legally required to pay the indemnity within a month, failing which interest applies at the punitive moratorium rate.98

89 Article 1075, CCo.
90 Article 1078, CCo.
91 Article 1081, CCo.
92 Article 1074, CCo.
93 Article 1079, CCo.
94 Article 1098, CCo.
95 Article 1078, CCo.
96 Article 1133, CCo.
97 Article 1135, CCo.
98 Article 1080, CCo.
However, for policies with a sum insured in excess of a determined threshold (currently US$3.9 million) the payment period can be extended by agreement up to 60 working days.\(^9\) If the insurer fails to make payment within the appropriate time, liability for interest is extremely onerous. The moratorium rate is 150 per cent of the commercial lending rate and is sometimes assessed on a compound basis.

**Subrogation**

Insurers and reinsurers benefit from a general right of subrogation, supported by a positive duty that is imposed on the insured to assist the insurer in pursuing its rights of recovery.\(^{10}\) However, the law imposes certain limitations upon the scope of subrogation rights arising from personal lines insurance. For example, an insurer is not entitled to subrogate against relatives of the insured.\(^{11}\)

### IV DISPUTE RESOLUTION

**i Jurisdiction, choice of law and arbitration clauses**

Policies issued in Colombia are subject to the mandatory application of Colombian law and jurisdiction.\(^{12}\) Policies issued outside Colombia may be subject to foreign law and jurisdiction.

**ii Litigation**

The judicial system is divided into four jurisdictions: ordinary, administrative, constitutional and special.\(^{13}\) The roles of the courts follow this division according to subject matter:

- **a** The courts of the ordinary jurisdiction hear commercial, civil, labour, family and criminal cases. This jurisdiction is headed by the Supreme Court. The conduct of proceedings is regulated by the General Procedure Code enacted in 2012 and fully in force since January 2016.\(^{14}\)

- **b** The courts of the administrative jurisdiction attend to cases related to the responsibilities of the state or involving state entities or agents, and they exercise judicial supervision over administrative acts and delegated legislation. The highest administrative court is the Council of State and the conduct of proceedings is regulated by the Administrative Procedure Code.\(^{15}\)

- **c** The constitutional jurisdiction is overseen by the Constitutional Court, which decides upon the constitutionality of laws and decisions taken by other tribunals.

- **d** Special jurisdictions include tribunals set up for the determination of indigenous rights, the supervision of the judiciary, military functions, and for the enforcement of the peace agreement with the Revolutionary Armed Forces of Colombia.

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99 Article 185.1, EOSF.
100 Article 1096, CCo.
101 Article 1099, CCo.
102 Article 869, CCo.
103 Article 11, Law 270/1996.
104 Law 1564/2012. Implemented through agreement PSAA1510442 of the Judicial Branch Administrative Council.
105 Law 1437/2011.
Insurance disputes may be heard in either the ordinary or administrative jurisdiction, according to the identity of the insured. Cases are heard by professional judges appointed by an independent government agency. Juries are not used in Colombia.

Traditionally, the court system has suffered badly from delays; the World Bank ranks the speed of Colombian justice at 177th in a survey of 190 countries. In practice, a commercial case proceeding in the ordinary jurisdiction takes an average of three-and-a-half years to reach a first instance decision. Appeals can add a further three years. Administrative proceedings last substantially longer: it is not uncommon for a case before the courts of the administrative jurisdiction to run for more than a decade. Strikes are common every couple of years; for example, during 2014 and the beginning of 2015, the judiciary went on strike for over 90 days. In 2018, the lower court judges suspended activities on demand for higher salaries and reduced workload.

**Litigation stages**

Commercial cases follow a particular sequence. The typical components of an action before the courts of the ordinary jurisdiction are explained below. This is a detailed explanation because in many respects it is also representative of the procedure followed in domestic arbitration and in the administrative jurisdiction:

a. Before a claim is submitted, Colombian law requires the parties to participate in a mediation hearing, which suspends the statute of limitations.

b. If mediation is unsuccessful, the claimant must file a formal complaint within the limitation period. If the claim is formally valid, it is admitted by the judge and personal service is made on the defendant. The defendant has 20 days to answer the claim and detail any ‘previous exceptions’, such as lack of jurisdiction or breach of an arbitration clause.

c. Once the claim has been answered, the judge decides the ‘previous exceptions’, if any. If the exceptions are successful, the claim is returned to the claimant, otherwise a date is set for the initial hearing.

d. Once pleadings have closed, the claimant may amend the pleadings on one occasion only. The defendant has no right to amend other than in response to a complaint by the claimant.

e. The pleadings must include reference to any evidence that the party wishes to volunteer as part of its case. By virtue of a legislative reform in 2012, parties can adduce their own expert evidence.

f. During the initial hearing, the judge makes concrete proposals that are intended to encourage a settlement between the parties. If no agreement is possible, the judge will seek to establish the disputed facts and order the evidence in the case. The types of admissible evidence include statements of the parties, confessions, oaths, witnesses,

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108 Articles 82 to 84, Law 1564/2012.
109 The content of the answer is determined by Article 96, Law 1564/2012.
110 Article 227, Law 1564/2012.
experts’ opinions, judicial inspections, documents, circumstantial evidence and reports. The evidence is not limited to material that the parties have requested: judges often order additional factual or expert evidence of their own accord.

g. At the initial hearing, the parties may request the other side to disclose documents that are described by category. Disclosure takes place by the order of the judge. There are no developed rules governing legal professional privilege but parties commonly withhold documents containing legal advice on the basis of their constitutional right to a fair trial.

h. Witness evidence is usually heard in person, without the use of witness statements. Courts may summon reluctant witnesses with the assistance of the Colombian police. Witnesses based abroad who are unwilling to travel to Colombia can be examined by video conference in their local Colombian consulate by a procedure involving letters rogatory. However, this is an intricate process, which can take several months to negotiate.

i. If expert evidence is required, the judge will normally appoint a single expert from an official court list. The expert’s evidence is received in writing and the cost is met either by the party that requested the evidence or by the parties jointly, as appropriate. Since the General Procedure Code became fully enforceable in 2016, expert evidence may also be received verbally.

j. Once the evidence is complete, the case moves to the conclusion hearing, at which the attorneys for each party have 20 minutes to make oral closing statements. The judge will take a decision in the case either immediately or at a separate judgment hearing.

**Funding and costs**

The costs of proceedings consist of an official tariff, lawyers’ fees, and miscellaneous costs such as expert evidence, administrative expenses and witnesses’ expenses.

Contingency fees, conditional fees and third-party funding are all permitted by law. The law makes no obvious provision for security for costs.

The judge may order the losing party to pay the winner’s fees and legal costs, although the amount is subject to a cap. In the case of commercial disputes, the losing party should not be required to pay more than 20 per cent of the judgment sum in costs.

**Rights of appeal**

The law guarantees that judicial decisions have two instances: a first instance decision and a right of appeal.

An appeal must be notified either orally at the judgment hearing or in writing within three days after service of the first instance decision. In exceptional circumstances, a direct right of appeal to the Supreme Court or the Council of State may exist.

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111 Article 165, Law 1564/2012.
112 Articles 171 and 182, Law 1564/2012.
114 Article 9, Law 1564/2012.
115 Article 322, Law 1564/2012.
116 For the ordinary jurisdiction, see Article 333–351, Law 1564/2012. For the administrative jurisdiction, see Law 1437/2011.
Duration of proceedings

As mentioned above, delays in the court system are a significant and continuing problem. The General Procedure Code states that cases before the courts of the ordinary jurisdiction should take no more than a year to be resolved at first instance and no more than a further six months on appeal.\footnote{Law 1395/2010 and Article 121, Law 1564/2012.} It remains to be seen whether this objective will be achieved.

iii Arbitration

Arbitration is a well-established and relatively sophisticated mechanism of dispute resolution in Colombia. Arbitration clauses can be agreed in consumer contracts if the consumer expressly agrees to submit a dispute to arbitration, although arbitration clauses in standard consumer contracts are likely to be struck down as abusive.

Separate rules apply to domestic and international arbitrations. Both sets of rules are found in Law 1563/2012, which came into force in October 2012. The domestic rules are closely modelled on the procedural rules that apply in the Colombian courts, while the international rules derive from the UNCITRAL Model Law.

Format of insurance arbitrations

The arbitration agreement

The arbitration agreement must be in writing and may be incorporated in the policy as a clause or in a separate document that identifies the parties and the policy to which it applies.\footnote{Article 4, Law 1563/2012.} The parties may also submit an active dispute to arbitration by way of a submission agreement.\footnote{Article 6, Law 1563/2012.}

The relevant elements to take into account when drafting an arbitration clause or a submission agreement are as follows:

\begin{itemize}
  \item[a] whether the arbitration is a domestic or international arbitration and, if the latter, the applicable law and jurisdiction;
  \item[b] whether the arbitration will be \textit{ad hoc} or institutional and, if the latter, which arbitration centre should be used;
  \item[c] the number of arbitrators and the method of appointment; and
  \item[d] whether the tribunal should decide according to law or equity.
\end{itemize}

Jurisdiction and choice of law

As indicated, Colombian insurance policies are subject to the mandatory application of Colombian law\footnote{Article 869, CCo.} and an arbitration involving a Colombian policy will always be of a domestic nature. For this reason, international arbitrations will mainly be relevant to reinsurers, whose policies may be subject to different jurisdiction and law.\footnote{Articles 92 and 101, Law 1563/2012.}
An arbitration will be international if any of the following conditions are met:122

a at the time of entering the arbitration agreement, the parties had their places of business in different states;

b the matters in dispute relate to international trade;

c a substantial part of the contract is performed outside the state in which the parties have their places of business; or

d the subject matter of the dispute is most closely connected with a place that is outside the state in which the parties have their places of business.

Ad hoc and institutional arbitration

Unless the arbitration agreement provides expressly to the contrary, domestic arbitrations are deemed to be institutional,123 that is to say that they are administered by one of the many arbitration centres that exist across the country. Colombia has more than 100 arbitral institutions, although the majority of domestic arbitrations are heard in the Chambers of Commerce of Bogotá, Medellín, Barranquilla and Cali.

The arbitration centres have convenient locations and a generally high standard of facilities. The costs are generally set by reference to the sum in dispute.

The parties may agree to an ad hoc arbitration, which operates on a different costs scale and can be more cost-effective. However, ad hoc arbitration is not available in disputes involving state entities.124 Moreover, the procedural rules of ad hoc arbitration are the same as those that apply to institutional arbitration.125

For those reasons, the vast majority of arbitrations are carried out on an institutional basis.

Appointment of arbitrators

Unless provided for in the arbitration agreement, the law presumes that three arbitrators will hear a dispute. If the value of the claim is less than US$100,000, it will be heard by one arbitrator.126

In domestic arbitration, each of the arbitrators must be a Colombian-qualified lawyer with a valid practising certificate.127 Party-appointed arbitrators are not permitted, and the parties must agree upon the choice of arbitrators. If no agreement is reached, the parties may delegate the selection to a third party or the arbitration centre, in which case the selection will be made by reference to the centre’s list of registered arbitrators.128 Ultimately, the decision may be referred to the civil circuit judge.

International arbitration allows greater flexibility in the selection of arbitrators. Party arbitrators are permitted and the arbitrators may be of any nationality and background.129

122 Article 62, Law 1563/2012.
123 Article 2, Law 1563/2012.
124 Article 2, Law 1563/2012.
125 Article 57, Law 1563/2012.
126 Articles 2 and 7, Law 1563/2012.
127 ibid.
128 Article 8, Law 1563/2012.
129 Article 73, Law 1563/2012.
**Procedural steps of a domestic arbitration**

As stated, the format of a domestic arbitration is closely modelled on the general civil procedure explained above. The principal differences are as follows:

*a* Mediation is not compulsory before the commencement of a claim.

*b* The process of commencing an arbitration involves some additional steps beyond those that are necessary to commence court proceedings. The arbitration procedure begins with the claimant filing the claim at the chosen arbitration centre or at the defendant’s place of business. The claim must be accompanied by proof of the arbitration clause.\(^{130}\)

Once the claim is filed and notified to the defendant, the arbitration centre calls the parties for a meeting to appoint the arbitrators. This can be a drawn-out process as both parties look for tactical advantage in the negotiations. After the parties reach an agreement, the arbitrators meet for an installation hearing to nominate the president and appoint a secretary. At the first formal hearing, the arbitrators formally confirm their jurisdiction over the dispute.\(^{131}\)

\[*c* If the defendant to the arbitration is a state entity, the arbitration centre must notify the Agency for the Defence of the State\(^{132}\) of the existence of the claim.\(^{133}\) The Agency is entitled to intervene in the process as an interested party.

\[*d* The arbitrators’ fees are fixed during the early hearing when the parties are encouraged to reach a resolution.\(^{134}\)

**Rights of appeal**

The factual determinations of arbitration tribunals cannot be challenged on appeal. However, appeals on points of law can be made in the ordinary or administrative jurisdictions on any of the following grounds:\(^{135}\)

*a* the invalidity or unenforceability of the arbitration award;

*b* lapse of limitation prior to issuing the claim;

*c* lack of jurisdiction on the part of the arbitration tribunal;

*d* the unlawful constitution of the arbitration tribunal;

*e* the failure of the tribunal to order or collect evidence requested by the parties;

*f* the failure of the tribunal to clarify the award in response to a question from the parties within the relevant time limits;

*g* an award that is wrongly based on equity and not rules of law;

*h* arithmetical errors in the decision;

*i* the failure of the tribunal to adjudicate solely on the points of dispute; or

*j* a technical defect in the service of the claim or the appointment of representation.

Some of these grounds are valid only if the appellant raised an objection in good time during the arbitration proceedings.

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\(^{130}\) Article 12, Law 1563/2012.

\(^{131}\) Article 30, Law 1563/2012.


\(^{133}\) Article 12, Law 1563/2012.

\(^{134}\) Article 25, Law 1563/2012.

\(^{135}\) Article 41, Law 1563/2012.
The procedure to be followed for making an appeal is to ask the tribunal to clarify the perceived errors\textsuperscript{136} and then to ask the tribunal itself to annul the award\textsuperscript{137} before approaching the relevant court.\textsuperscript{138}

A party may also petition the Constitutional Court for an order quashing an arbitration award if it feels that the tribunal infringed its rights to a fair hearing.

Costs

The arbitrators will determine the fees and expenses of the tribunal in accordance with the amount claimed. The maximum amount allowed by law to be charged by an arbitrator is currently US$260,000 and up to half of this for the secretary’s fees.\textsuperscript{139} In theory, the parties can agree the fees between themselves and inform the arbitrators of what has been decided when they are designated. However, that option is not always open if the list of available candidates is short.

There are additional costs relating to the functioning of the tribunal in an arbitration centre. These are usually a fixed percentage of the sum in dispute. The arbitrators’ fees and the sum paid to the centre are subject to a new 2 per cent arbitral tax for the financing of the ordinary courts.\textsuperscript{140}

iv Alternative dispute resolution

Mediation and third-party adjudication are both recognised by law.\textsuperscript{141} As mentioned in subsection ii, ‘Litigation stages’, mediation is a mandatory step before accessing the courts. Agreements obtained through alternative dispute resolution (ADR) are binding on the parties and enforceable before a judge.

v Other forums

Insurance disputes may also be heard before the Controller’s Office, which has discretion to adjudicate on matters involving negligent or fraudulent misconduct on the part of public and private entities or individuals trusted with the management of public funds.

If it has grounds to suspect that public funds have been misused, the Controller’s Office may pursue a recovery action, known as a fiscal liability proceeding (FLP), against any relevant entity or individual. It does not impose fines or penalties but seeks restitution, hence its relevance to insurers: not only does an investigation trigger defence costs but awards against individual or corporate entities may attract indemnity under D&O insurance, professional indemnity insurance, crime or bond policies. Insurers are frequently called to FLP proceedings to guarantee the obligations of their insureds.\textsuperscript{142} The Controller’s Office has no jurisdiction over insurers based abroad or reinsurers.\textsuperscript{143} Insurers have the same rights of defence as their principals. The Controller’s Office has its own procedural rules, set out in Law 610/2000. They involve a two-stage process whereby the Controller’s Office first carries

\textsuperscript{136} Article 39, Law 1563/2012.
\textsuperscript{137} Articles 40 to 43, Law 1563/2012.
\textsuperscript{138} Article 45, Law 1563/2012.
\textsuperscript{139} Article 26, Law 1563/2012.
\textsuperscript{140} Articles 16 to 22, Law 1743/2014.
\textsuperscript{141} Decree 1818/1998.
\textsuperscript{142} Article 44, Law 610 of 2000.
\textsuperscript{143} Article 1135, CCo.
out an audit and later presents charges via FLP proceedings. A final decision must be reached within five years of commencement of the FLP\(^\text{144}\) (overriding the usual Colombian rules of limitation) and payment becomes enforceable within five days of a final decision. Liability is commonly imposed on a joint and several basis among the principals, and severally across their insurers. Policy limits tend to be observed but little regard is given to the policy wording or the nature of the cover. For example, it is not uncommon to see various claims-made policy periods involved on the basis that the irregularities occurred for a prolonged period of time.

The decisions of the Controller’s Office may be challenged through judicial review before the administrative jurisdiction. In the event of a successful judicial review, any amounts paid to the Controller’s Office will be returned.

V YEAR IN REVIEW

The most significant feature of 2018 was the accession of Colombia to the Organisation for Economic Co-operation and Development in May, making the country more attractive for foreign investment.\(^\text{145}\) One of the conditions to enter the organisation was to demonstrate the necessary conditions to increase insurance penetration. Also in May, the FS established a regulatory sandbox to test new financial and insurance products and services that can be accessed by incumbent and new market entrants.\(^\text{146}\) In June 2018, the FS issued the Cybersecurity Circular, which imposes strict cybersecurity requirements to financial institutions and companies with online businesses.\(^\text{147}\) The Ministry of Agriculture issued Decree No. 2458 of 28 December 2018, which sets out the basic rules for parametric insurance for crops.

The insurance market has continued to grow despite deceleration of the economy owing to the uncertainty created by the general elections. The internal regulatory regime continues gearing up to face international shocks through strict capital and reserving rules, and the gradual implementation of risk-based regulation as set out by international organisations.\(^\text{148}\) The regulator has also simplified the procedures for consumers to file complaints online.

The local insurance market has benefited from increased competition from local and foreign companies, and abundant reinsurance options. However, industry profitability has been under constant pressure because of competition and local currency devaluation. Market consolidation continued to take place during 2018. Zurich, which entered the market in 2016 from a standing start, acquired QBE’s operations in Latin America; in March 2018 US insurer BMI was authorised to offer life and health insurance; Bupa signed an agreement

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\(^{144}\) Article 9, Law 610 of 2000.


\(^{146}\) ‘Superfinanciera lanza un espacio para el desarrollo de Fintech’, [Portafolio](https://www.portafolio.co/negocios/superfinanciera-lanza-un-espacio-para-el-desarrollo-de-fintech-516613), 25 April 2018.

\(^{147}\) Circulars 29, 42 and 25 and Cybersecurity Circular SFC 007 of 5 June 2018.

with Seguros Bolívar to offer international health insurance plans;\textsuperscript{149} Seguros Santalucía from Spain entered into an alliance with a local player to offer funerary and health insurance; China Minsheng Group international purchased the operations of Old Mutual in Colombia; the FS authorised Youse, a joint venture by French insurer CNP Assurances and Caixa Seguridade from Brazil, as the first online insurer in Colombia offering mandatory insurance and other consumer products;\textsuperscript{150} and HDI started operating after acquiring Generali’s business in 2017.

The stability of compulsory vehicle liability insurance is seriously compromised as a result of chronic evasion, fraud and high accident rates on Colombian roads. This line of business represents approximately 13 per cent of total premiums in the market; however, it could be almost US$900 million higher because of the current evasion rate of 42 per cent and an exponential increase in losses in certain regions. Insurers are seeking a change in the regulation to allow for more flexibility in the pricing of this type of insurance.

The rate of growth of 4.9 per cent in premium sales was led by commercial and regulated lines (6.6 per cent), and life and health insurance (3.3 per cent).\textsuperscript{151}

VI OUTLOOK AND CONCLUSIONS

On a technical level, the main areas of focus in 2019 and beyond are likely to be:\textsuperscript{152}

\textit{a} the continued efforts of the FS to meet international standards and consolidate risk-based supervision methodologies through the gradual implementation of EU Solvency II regulations and International Financial Reporting Standards;\textsuperscript{153}

\textit{b} pension and social security reform will be high on the agenda of the new government to reduce the impact of social spending on the public budget and increase individual savings;

\textit{c} cost standardisation of payments under the mandatory vehicle insurance (SOAT) to reduce fraud and a mandatory third-party liability insurance in addition to SOAT;

\textit{d} delegated legislation for the implementation of the mandatory building insurance;

\textit{e} widening of the consumer base and financial inclusion of the lower-income population and remote areas of the country previously inaccessible owing to the internal conflict;

\textit{f} the 2019 government budget for agriculture insurance has increased by 128 per cent from US$15.2 million to US$27 million;\textsuperscript{154}

\textit{g} implementation by financial institutions and online businesses of the new cybersecurity requirements (see Section V) will prompt businesses to request cyber insurance; and


\textsuperscript{150} ‘Superintendencia Financiera dio autorización a nueva firma de seguros100% digital’, \textit{La República}, 2 October 2018, https://www.larepublica.co/finanzas/superfinanciera-financiera-dio-autorizacion-a-nueva-firma-de-seguros-de-100-digital-2777311.


Professional indemnity and product liability will be highly important for Colombian small and medium-sized enterprises as they continue to grow in line with the general economy and start competing in global markets.

Commercially, the challenge remains to persuade Colombian consumers that insurance is more than a luxury. Insurers, intermediaries and the government are working hard to raise the profile of consumer rights, highlight the advantages of insurance cover, and implement technological solutions to facilitate claims and the purchase of insurance. It is estimated that, currently, only 30 per cent of Colombian households have non-mandatory products.

In the meantime, the market continues on its upward curve, fuelled by a combination of growth in areas such as personal lines, professional indemnity and the insurance of major one-off infrastructure projects already underway.

The Colombian market is still dominated by compulsory insurance, workers’ compensation and life insurance, which will continue to grow with the increase of formal employment. Although commercial lines are relatively undeveloped, liability and construction are significantly outperforming other sectors of the market. The constant expansion of compulsory insurance requirements is a major source of business for the sector, including commercial lines such as building guarantees and other sorts of construction insurance. New trends include lines such as fintech and the digital economy. Cyber coverage will likely be an important source of business in the next few years; according to reports, Colombia is the country with the most ransomware attacks in Latin America with reported losses in 2017 of US$65 million (non-reported losses are estimated to be higher).

The insurance sector will continue to benefit from stable economic growth, and it is expected to outpace the general economy.

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Chapter 13

DENMARK

Henrik Nedergaard Thomsen and Sigrid Majlund Kjærulff

I INTRODUCTION

The majority of Danish insurance companies are members of Insurance and Pension Denmark (IPD), an association that promotes the interests of the entire insurance (and pensions) industry. Foreign insurance companies engaged in the provision of services in Denmark may become ‘info’ members.

The Danish insurance market is characterised by strong competition for customers. According to the statistics published by the association, the number of Danish insurance companies has more than halved over the past 20 years, from 138 companies subject to Danish supervision in 1999 to 65 in 2017. In the same period, the number of employees fluctuated, from 13,751 in 1999 to 10,305 in 2005 to 13,533 in 2014 to 10,343 in 2017. Customers are also switching between companies more frequently to get better cover and prices. In 2013, the number of new customers (less than four years as a customer) increased by 22 per cent, which grew to 35 per cent in 2017. Customer satisfaction is also very high, with a score of 77 (out of 100) in 2017 and 75 in 2018. Denmark also has the highest industry score in Scandinavia.

The annual profit of the insurance industry increased by 1.5 per cent from 2016 to 2017, to 13 billion kroner before tax. Underwriting profits increased by 5 per cent in the same period to almost 8 billion kroner. This was primarily a result of increasing premiums and lowering operating expenses. However, despite this, two big companies, Alpha Insurance and Qudos Insurance, went bankrupt in 2018.

In terms of the balance sheet total in 2017, Tryg Forsikring was the biggest insurance company in Denmark, followed by Codan and Topdanmark. This includes foreign assets, which, according to the IPD’s estimate, account for 12 per cent of the Danish market.
II REGULATION

i The insurance regulator

The insurance market is regulated, and the requirements for establishing and carrying on insurance business are laid out in the Danish Financial Business Act.\(^{12}\) However, a large number of other statutory provisions also apply, including those contained in:

\(a\) the rules on money laundering;
\(b\) the Danish Companies Act;
\(c\) the Danish Capital Markets Act; and
\(d\) the Danish Act on Processing of Personal Data.

The Financial Business Act also applies to reinsurers. However, special rules for these companies may also apply.

The Danish Financial Services Authority (FSA)\(^{13}\) monitors and regulates the financial sector in Denmark, including insurance and reinsurance companies. The purpose of the FSA is to supervise, legislate and provide information. In 2018, the FSA was authorised to obtain information from enterprises subject to the new Danish Insurance Mediation Act\(^{14}\) (see subsection ii, ‘Insurance distribution’). The FSA is also authorised to obtain information from persons and enterprises not subject to the Act in order to assess whether they should be subject to the rules.

The FSA may prosecute, issue orders and report issues to the police if insurers or reinsurers fail to comply with the rules applying to financial services firms, and, as another consequence of the new Act, violation of the rules of the Act could be punishable by a fine or imprisonment for up to four months.

ii Registration with the FSA

Insurance and reinsurance companies

Insurance and reinsurance business in Denmark requires a licence from the FSA.\(^{15}\) The licence is issued based on a plan of operations prepared by the insurer or reinsurer. The FSA establishes the rules for the information that must be included in the plan of operations.

Foreign insurance and reinsurance companies in the European Economic Area and European Union

Insurance and reinsurance companies from other Member States of the European Economic Area (EEA) or the European Union (EU) may carry on insurance business in Denmark on either an establishment or a freedom-of-services basis (without the need for a licence from the FSA) if they have already been licensed in another EEA or EU Member State.

\(^{12}\) Consolidated Act No. 793 of 20 August 2009.
\(^{13}\) www.dfsa.dk.
\(^{14}\) Act No. 41 on Insurance Distribution of 22 January 2018.
\(^{15}\) Section 11(1) of the Financial Business Act (Consolidating Act No. 1140 of September 2017).
These companies may operate in Denmark on a cross-border basis immediately after the FSA has received notification from the supervisory authorities of the company’s home country, or the home country can notify the FSA and the company may operate through a branch in Denmark two months after the notification has been given.\textsuperscript{16}

The company must observe Danish good business practice rules, consumer protection regulation and certain insurance contract requirements that are contained in, for example, the Insurance Contracts Act (ICA).\textsuperscript{17}

**Foreign insurance and reinsurance companies from outside the EEA or the EU**

Insurance and reinsurance companies from outside the EEA or the EU may not carry on insurance business in Denmark using a licence from their home country.

If the company wants to carry on business in Denmark, it is required to set up an insurance company or a branch in Denmark and apply for a licence from the FSA.

**Other requirements**

As a result of the implementation of the EU Solvency II Directive into Danish law (with effect from 1 January 2016), the law distinguishes between Group 1 and Group 2 insurers. Group 1 insurers are big companies calculated (among other factors) according to their gross annual premium. Group 2 companies include all other companies.

Depending on which group the insurer belongs to, there will be different additional capital and solvency requirements, as well as organisational requirements.

**Insurance distribution**

On 1 October 2018, the new Insurance Mediation Act came into force, implementing the EU Insurance Distribution Directive into Danish law. The Act increases the protection of consumers by, among other things, introducing stricter licence and registration requirements. It is no longer enough for agents and subagents to be registered; they must also have a licence from the FSA (provided that they fall under the definition of insurance intermediaries).

Enterprises selling goods or services and selling insurance in connection with the sale of these other goods or services are not required to have a licence, but must be registered. This applies to travel agents and car dealers, for example.

One requirement for receiving a licence from the FSA to distribute insurance is that the registered office of the enterprise is in Denmark. It is also a requirement that the enterprise has liability insurance or another corresponding guarantee against claims for damages and has measures in place ensuring that customers are protected against the distributor’s inability to pay. The enterprise must also have a management fulfilling the suitability and integrity requirements of the Act, ensuring a responsible and efficient operation of the insurance intermediaries.

It follows from the transitional provisions of the Act that enterprises already licensed as insurance brokers before the Act entered into force have to submit a new application, but that the enterprise may continue its activities until the FSA has made a decision on the matter.

\textsuperscript{16} Sections 30 and 31 of the Financial Business Act (consolidating Act No. 1140 of September 2017).
\textsuperscript{17} Consolidating Act No. 1237 of 9 November 2015.
The same applies to enterprises registered as insurance agents or as subagents and to enterprises selling insurance that did not require a licence under the preceding Act (Consolidating Act No. 174 of 31 January 2017). These enterprises must submit an application for a licence but may continue their activities until the FSA has made a decision.

**Non-compliance**

If insurance is effected before a licence to carry on insurance business has been issued and registration has been made, the individuals who have effected the insurance or who are responsible are jointly and severally liable for the performance of the contract. However, if the insurer accepts the liability no later than four weeks after registration, the liability is repealed (provided that the policyholder’s security is not significantly weakened as a result).18

If the rules for are not complied with, the FSA can exercise certain powers. For instance, an order may be issued stipulating that the insurer or reinsurer will be subject to strict supervision. Ultimately, the company could risk losing its licence to carry on business in Denmark.

The members of the executive board and the board of directors of an insurance or reinsurance company may incur liability if the management does not fulfil the necessary requirements.

### iii Compulsory insurance

A number of specific laws, contracts and other regulations stipulate that compulsory insurance cover must be taken out in certain areas, including the following: motor vehicle; professional liability (for some advisers, such as lawyers and accountants); industrial injury; dog and horse liability; railway liability; aviation liability; occupational disease; oil pollution; maritime claims (for all Danish ships with a gross tonnage of 300 or more); drones (that are not micro-drones); and, as of 15 May 2018, injuries caused by jet skis, etc., in connection with maritime accidents.

Insurance brokers must also take out liability insurance and provide security for the claims that may be raised against them as a result of their business.

### III INSURANCE AND REINSURANCE LAW

#### i Sources of law

The ICA regulates insurance contracts and provisions, which are mandatory to a certain extent, governing the relationship between an insurer and a policyholder.

Different rules on consumer protection and good practice also apply (e.g., the insurer must give correct advice on insurance products). These rules must be complied with or the advisers may incur professional liability. The rules on good practice are laid down in Part 6 of the Financial Business Act, and they apply to insurers in contractual relationships.

The ICA does not apply directly to reinsurance, but it is applied by analogy together with the general law of contract, including the freedom of contract.

Insurance brokers and others selling insurance commercially are subject to the Danish Insurance Mediation Act (see subsection iv).

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18 Sections 22 of the Financial Business Act.
Denmark

ii Making the contract

Any issues relating to the rights and obligations between an insurer and a policyholder are regulated by the ICA. However, the characteristics of an insurance contract are not defined in the ICA, but are governed by the Contract Act19 and the general principles of Danish contract law, including freedom of contract (for some areas insurance is compulsory, see Section II.iv.)

An insurance contract is generally defined as ‘an agreement to take over a financial risk for the occurrence of an unexpected event, against a consideration calculated statistically based on the distribution of that risk on a plurality of policyholders’ 20

When entering into an insurance contract, an insurance seeker will usually apply for cover from the insurance company, after which it will fill out a form with a number of questions provided by the insurance company. The underwriters will draft the policy terms based on the information provided and enter into an insurance contract with the insurance seeker on behalf of the insurer.

A general duty of good faith and fair dealing in respect of other contracting parties applies to all contractual relationships. Furthermore, when it comes to insurance and reinsurance contracts, the ICA stipulates that the insurance seeker has a duty of disclosure and to provide answers. If it fails to answer the questions in the application form truthfully or fails to disclose an important fact, the rules of the ICA will determine whether an insured event is to be compensated and whether the company is bound by the contract at all.21

The insurance premium must be paid 21 days after a claim for payment has been made. Only then may the insurer terminate the insurance contract.

iii Interpreting the contract

Denmark has a civil law system that is based on general rules and principles to some extent, and the interpretation of insurance and reinsurance contracts is, in line with the interpretation of other contracts, subject to these rules and principles.

The interpretation of an insurance contract involves both the disputed provision and the agreement as a whole, including the other provisions of the contract, and the background and purpose of the contract.

As a general rule, the provisions of an insurance policy should be interpreted strictly, and in relation to the other provisions of the policy (both general and specific).

If the policy wording generates doubt as to the contents, the circumstances of the conclusion of the contract and the purpose of the insurance may be included in the interpretation. Occasionally, ambiguities regarding the contents of the specific policy provision will be detrimental to the insurers that wrote the policy (the ambiguity rule).

When interpreting the contract, the ICA and the general rules of contract law must always be read with a consideration of trade usage, case law and other legal standards and rules of interpretation that apply (which can vary depending on the contract type).

19 Consolidated Act No. 193 of 2 March 2016.

20 Ivan Sorensen, Forsikringsret, sixth edition, p. 57, with additional references.

21 Sections 4 to 10 of the ICA (Consolidating Act No. 1237 of 9 November 2015).
iv  Intermediaries and the role of the broker

Insurance mediation is regulated by the Insurance Mediation Act. The Act does not apply to insurers, but rather to brokers and other parties that have a licence to sell insurance commercially. This licence is issued by the FSA. According to the Act, insurance agents will also require a licence from the FSA to carry out activities (see Section II.ii, ‘Insurance distribution’).

The parties responsible for insurance mediation must have general knowledge of insurance mediation. The responsible persons must have theoretical training in, and practical knowledge of, insurance mediation activities. Insurance brokers must comply with the duty of disclosure and other obligations about regular reporting.

The FSA monitors insurance brokers. If the insurance broker does not comply with the guidelines laid down in the Insurance Mediation Act, the FSA may cancel the insurance broker’s licence to sell insurance commercially.

v  Claims

The party with an insurance claim must file the claim with the insurer before the statute of limitations expires. There are no formal requirements on how an insurance claim must be filed, and thus it can be made both orally and in writing. In recent years it has become commonplace to file the claim through a form on the insurer’s website.

It is sufficient in respect of certain types of business insurance that a party entitled to damages has filed its claim for damages with the policyholder in time (the business covered by insurance).

A policyholder must provide the insurer with all available information on matters of significance to the assessment of the claim. If the holder fails to do so, the insurer may refuse to take a position on the insurance claim.22

An insurer may also refuse to provide cover to a policyholder or a third party entitled to damages if the claim for damages or the insurance event has not been proved, or if it is clear that the claim is not covered by or is exempt from the insurance cover.

An insurer may also refuse cover if the insurance contract was based on incorrect information given by the policyholder. The insurance contract is either void (based on fraudulent misrepresentation or non-disclosure) or the insurer is exempt from liability or entitled to reduce compensation (based on a negligently false statement).

vi  Third-party action

An injured third party is free to file a claim directly with the insurer if the claim is filed under liability insurance. The insurer is directly liable to an injured third party in certain situations (e.g., bodily injury caused by a motor vehicle).

When the insured’s liability for damages to the injured party has been established and the amount of damages assessed, the injured party must be subrogated to the insured’s rights against the insurer, but only to the extent that the party entitled to damages has not already received the amount claimed in whole or in part.23

A policyholder cannot be a party to a reinsurance contract and cannot file a claim directly with the reinsurer. As a contractual party, the insurer may file a claim with the reinsurer.

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22 Sections 21 and 22 of the ICA.
23 Section 95 of the ICA.
vii Subrogation

As a general rule, if an insurer has paid damages to an injured party, it is subrogated to the injured party’s claim. However, the Danish Consolidation Act on the Liability to Pay Compensation contains important exemptions in this regard, as it limits an insurer’s right to recourse in many situations where insurance cover has been taken out.24

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Insurance litigation and arbitration are governed by the Danish Administration of Justice Act25 and the Danish Arbitration Act.26 Regarding the issue of jurisdiction and the choice of law, Denmark has ratified the relevant parts of the Brussels I Regulation27 and the Rome Convention.

As a general rule, parties may agree both before and after a dispute has occurred that proceedings are to be heard in Denmark by a specific court. However, in certain instances the courts in a specific country have exclusive jurisdiction and the consequence is that the agreement cannot be relied upon. The parties are not allowed to agree that a case is to be heard by a court that has no jurisdiction in respect of the substance of the matter. For example, the parties are not allowed to agree that the case is to be brought before the Danish Supreme Court as the court of first instance.

In addition, the parties may agree to resolve disputes by arbitration. They may also enter into an arbitration agreement either before or after a dispute has arisen, which Danish courts, if the arbitration clause has the necessary clarity, will recognise and enforce. Both written and oral arbitration agreements are valid under Danish law. However, to enforce the agreement, the Danish Institute of Arbitration recommends the following standard clause to be included in the contract:28

Any dispute arising out of or in connection with this contract, including any disputes regarding the existence, validity or termination thereof, shall be settled by arbitration administrated by The Danish Institute of Arbitration in accordance with the rules of arbitration procedure adopted by The Danish Institute of Arbitration and in force at the time when such proceedings are commenced.

With regard to a consumer contract, the costumer is not bound by an arbitration agreement concluded before the conflict arose.

ii Litigation

Any disagreement between the insurer and a consumer regarding an insurance policy may be brought before the Insurance Complaints Board, directly before the courts or settled by arbitration (see subsection iii).

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24 Part 2 of the Act. Corresponding limitations can be found in other acts.
26 Consolidating Act No. 553 of 24 June 2005.
The Insurance Complaints Board

In case of any disagreement between the insurer and a consumer regarding an insurance policy, the matter may be brought before the Insurance Complaints Board, which is a private complaints board authorised by the Minister for Business and Growth.

The advantage of bringing the matter before the board is that it is possible to get a decision in a few months if the policyholder pays a nominal amount. Any decision by the board may be brought before the relevant district court. As a main rule, the board only hears complaints concerning insurance taken out by private individuals.

The judicial system

In broad terms, the judicial system is composed of the Supreme Court, the High Courts of Western and Eastern Denmark, the Maritime and Commercial Court, the Land Registration Court and 24 district courts. No courts in Denmark are specialised in insurance disputes, so as a general rule insurance cases (like all other court cases) commence in the district courts.

The legal system is based on a two-tier principle, according to which it is usually possible to appeal against a decision made by a court once. However, there are many exceptions to this rule. If a case is of general public importance (implications for rulings in other cases), the Danish Appeals Permission Board may grant leave to appeal to a court of third instance (the Supreme Court).

In addition, if the case involves a matter of general public importance, the district court may commit the case to one of the High Courts upon request. In this case, the first instance High Court judgment may be appealed directly to the Supreme Court.

Judgments delivered by a district court concerning an amount of less that 20,000 kroner cannot be appealed without leave from the Appeals Permission Board. The High Court may also dismiss an appeal if there are no prospects of a different result than that of the district court.

The Maritime and Commercial High Court is a specialised first instance court. The Court hears cases concerning the Danish Trademarks Act, the Danish Designs Act, the Danish Marketing Practices Act and the Danish Competition Act, and cases concerning international trade conditions as well as other commercial matters. The Court is not specialised in insurance law. Decisions passed by the Maritime and Commercial High Court may be appealed to the Supreme Court if the case is of general public importance; otherwise, they will be appealed to one of the High Courts.
The main stages in civil proceedings

A court case is initiated by the plaintiff filing a writ with the court. The defendant will then file a statement of defence if the defendant disputes the plaintiff’s claim. The exchange of pleadings may take several months.

Further pleadings will often be exchanged and a pretrial hearing (by telephone) will be held during which the court discusses the matter with the parties. An expert opinion may also be requested at that stage. The duration of the procedure depends on the nature of the case and can vary from a few months to more than a year.

When the case has been set down for the final hearing, the court will inform the parties of when the pretrial stage ends. After this date, new claims, allegations or evidence will not, as a general rule, be permitted. After the final hearing, the court will make its decision on the claims submitted. Normally, one to two months will pass from the time of the conclusion of the pretrial stage until a final appealable judgment is delivered.

Sometimes the court will decide on procedural issues during the case, including on whether to admit certain evidence, whether to commit the matter to another court, etc. These procedural issues may, as a general rule, be appealed during the case; however, this is often subject to prior leave by the Appeals Permission Board.

For cases involving claims of up to 50,000 kroner, the case may be brought before the courts according to the cheapest and fastest small-claims procedure.

Time frame for insurance litigation

Insurance litigation includes everything from small cases to large and complicated claims for damages covered by business insurance. A hearing by a court of first instance could take anything from a few months to several years. According to the most recent statistics published by the courts in 2018, the average case processing time in civil cases decided by settlement or judgment before the district courts was 10 months.

Evidence

As a general rule, the parties are free to determine which evidence and legal issues should be considered in cases and all types of evidence, in board terms, are admissible.

The most important types of evidence are documents, witness statements and expert surveys by specialists who may be examined in court. Expert opinions or expert witnesses are not widely used because expert surveys (reports based on an appraisal by experts appointed by the court) are preferred; however, new rules encourage their use to a wider extent. Courts may bar unnecessary evidence, but they are generally reluctant to do so. Evidence produced by an illegal or criminal act is also admissible in most cases, but the court will decide the level of importance to attach to the evidence.

The court may also, either at the request of one of the parties or on its motion, request the opponent to produce relevant evidence and may also bar unnecessary evidence. The evidence is for the court to assess and is not subject to particular rules. Even in the absence of a pending case, evidence may be taken before a court without a trial, including for use

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35 Part 33 of the Administration of Justice Act.
37 Sections 298 and 299 of the Administration of Justice Act.
in a later case. In personal injury matters, special bodies have been established by law that provide medical assessments of the nature of the personal injury or assessments of the extent and impact of the personal injury.

Persons called as witnesses of fact are not allowed to make observations as experts when giving evidence. They are therefore only allowed to give evidence of their knowledge of the incident in the specific case. Written statements on factual information may be used as documentary evidence and are sometimes used as an alternative to witness statements, provided that the court has no objections.

Witness statements are generally presented during the final hearing. However, in special cases, the court may decide that the statement is to be given before the final hearing. The witness statement may be given by using telecommunication (with or without an image) if found appropriate and if special considerations for the witness favour the procedure (e.g., if a witness resides abroad).38

The disclosure of documents and witness statements is subject to some limitations (see Sections 169 to 172 the Administration of Justice Act). As a result, persons bound by professional secrecy cannot give evidence about matters that have come to their knowledge in the course of their function.

**Costs**

The institution of proceedings is subject to a court fee of 500 kroner.39 If the value of the case exceeds 50,000 kroner, another 250 kroner is added, plus 1.2 per cent of the part of the value of the case exceeding 50,000 kroner. However, the court fee cannot exceed 75,000 kroner. If the matter concerns a review of a decision by an authority, the maximum fee is 2,000 kroner. The same applies to certain other types of cases. If appealing to the Supreme Court, the court fee is increased by 50 per cent.

In addition to the fee payable if the value of the matter exceeds 50,000 kroner, a fee is to be paid for the final hearing (the trial hearing) or the written proceedings that may replace the trial hearing. The fee will generally be the same as the fee for instituting proceedings.

As a general rule, it is the party making or requesting a procedural step that, provisionally, has to pay the costs in this respect. The unsuccessful party to a case will usually have to compensate the costs of the successful party. Legal fees, however, are not covered according to realised costs, but will be fixed according to certain rates as a rule, depending on the financial value of the claim and whether an expert opinion has been obtained.

**iii Arbitration**

The parties are entitled to agree that an insurance dispute is to be settled by arbitration, and both ad hoc and institutional arbitration are widely used. The framework applying to arbitration follows from the parties’ contract and the Arbitration Act, which follows the UNCITRAL Model Law of 1985 to a wide extent.

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38 Section 174(2) of the Administration of Justice Act.
Denmark does not have a specific board of arbitration that deals with insurance disputes, but several institutes handle arbitration cases. The Danish Institute of Arbitration\footnote{40} processes all types of cases, and the rules governing the arbitration procedures of the institute entered into force on 1 May 2013. The Arbitration Board\footnote{41} is reserved for construction matters.

In the Danish Institute of Arbitration, the judges are usually appointed by the parties, whereas the chairman is appointed by the Institute. Expert judges usually participate in Arbitration Board cases. Both institutions offer mediation, conciliation and expert opinions. These methods are used to a minor extent, but in particular there is a trend towards mediation being an attractive alternative to the parties. Mediation is also offered by the special institution, the Mediation Institute, and by individual mediators.

\textbf{iv Mediation}

At the request of the parties, the court may appoint a mediator to assist the parties in reaching a settlement during the proceedings,\footnote{42} but it has no powers to force the parties to participate in mediation.

Mediation is also offered by the Danish Mediation Institute\footnote{43} and other private, independent institutions.

\textbf{V YEAR IN REVIEW}

The FSA has been focusing on business models primarily based on cross-border activities and the sale of products involving bigger risks compared to standard products.

In addition, there was a particular focus on Solvency II in 2018 because the European Commission carried out a review (evaluation) of the framework and published a draft delegated regulation with a feedback period that ended on 7 December 2018.\footnote{44} It is also due to carry out another review before the end of 2020.\footnote{45}

As of 1 January 2019, it is compulsory for foreign insurance companies from the EU and EEA that carry on insurance business in Denmark on either an establishment or freedom-of-services basis (see Section II.ii) to join the Danish Guarantee Fund for Non-life Insurance Companies to continue carrying out this business.

The cover by the Guarantee Fund was also changed in 2018: as of 1 January 2019, the Fund only covers insurance companies’ direct activities in Denmark for risks in Denmark (it previously also covered insurance companies’ direct activities in EU and EEA Member States).

\textbf{VI OUTLOOK AND CONCLUSIONS}

\textbf{i Climate change risk}

In recent years, as a result of climate change, Denmark has increasingly been affected by bad weather, such as torrential rain and storms, that has resulted in insurers having to
pay substantial compensation. By way of example, in January 2019, Storm Alfrida caused significant damage in southern Denmark. This has also led insurers to focus more on limiting their risks by reinsurance and this focus is likely to continue in 2019.

Another aspect to consider is that some companies, such as those in the oil and gas industry, could be more vulnerable to climate change risks. It could become more important in 2019 for directors and officers (D&O) to demonstrate that they have considered climate change risks, and that they have taken actions to mitigate them where necessary. This means that D&O insurers may be affected by climate change disclosure claims in the year ahead.

ii Increased interest in technology

Artificial intelligence, insurtech, smart contracts, machine learning and other technology-based products are becoming increasingly popular, and are likely to result in new insurance products, more cost-effective claims handling and new types of claims in 2019.

As a consequence of the growth of and interest in technology, digital contracts will become more common. This could result in a new generation of insurance companies in Denmark as well as new digital strategies from established companies. For example, the biggest insurance company in Denmark, Tryg, has announced that by the end of 2020 it will be using innovative products and solutions to streamline business processes, which will contribute to the achievement of its overall financial target of 3.3 billion kroner.46

iii Insurance Mediation Act

With regard to regulatory developments, it will be particularly interesting in 2019 to see how the rules of the Insurance Mediation Act are administered and sanctioned. This includes to what extent the FSA makes use of the fact that it now has access to obtain information from businesses that are subject to the Act, and also from persons and businesses not subject to the Act, to assess whether they should be subject to the rules.

There are also likely to be examples of the penalties for breach of the Act (which were adjusted in line with other financial legislation (see Section II.i)) being determined and administered in 2019.

I INTRODUCTION

The nature of the UK insurance and reinsurance market

The UK insurance and reinsurance industry is the largest in Europe and the fourth-largest in the world.\(^2\)

Commercial insurance business in the UK is dominated by the ‘London Market’, which today is the world’s leading market for internationally traded insurance and reinsurance.

The London Market has two strands: the company market and the Lloyd’s market. It is primarily a ‘subscription market’ in which the broker plays a crucial role in producing business and placing risks with a variety of insurers willing to accept a share.

As its name suggests, the company market is composed of corporate insurers and reinsurers. It is organised through a market body, the International Underwriting Association, and operates principally out of the London Underwriting Centre building and its environs.

From its beginnings in a coffee house in 1688, Lloyd’s has grown to be the world’s leading market for specialist insurance. It is not itself an insurance company but rather a society of members, largely corporate but still involving some individuals, that accept insurance business through their participation in competing ‘syndicates’. Each syndicate is administered by a ‘managing agent’ and makes its own business decisions, but Lloyd’s provides both a physical location in which to carry out this business and a regulatory framework of rules with which the syndicates must comply. Lloyd’s also manages the unique regime that protects the security underlying the Lloyd’s market. Lloyd’s accepts business from over 200 countries and territories worldwide.\(^3\)

An important strength of the London Market lies in the number, diversity and expertise of the insurers and reinsurers writing business. Brokers can find the capacity and expertise required for the underwriting of virtually any type of risk. A key feature is the presence of highly skilled ‘lead underwriters’ whose judgements on the terms to be offered for different risks are followed by other insurers in London and overseas. Another important attribute is geographical concentration, with many insurers and intermediaries located in close proximity to the EC3 district, an insurance hub in the City of London. Thus, brokers have a personal relationship with the underwriters with whom they deal. Similarly, buyers of insurance can meet providers and market information is easily shared among participants.\(^4\)
ii The legal landscape for insurance and reinsurance disputes

It is common for insurance and reinsurance contracts placed in the London Market to be governed by English law and subject to the jurisdiction of the English courts, or heard in London arbitration, even where, as is often the case, not all the parties to those contracts are UK companies. There are a number of reasons why London is a premier venue for insurance and reinsurance dispute resolution.

Perhaps the most important factor is the specialist judiciary who are familiar with the practices of the London Market. Disputing parties may expect that the judges of the Commercial Court (a specialist court, part of the Business and Property Court of the High Court of Justice, handling complex national and international business disputes), and indeed the appellate courts, understand, for example, what a ‘slip’ is and what roles are played by all involved in the placement of business in the London Market.

Secondly, England has a highly developed body of insurance and reinsurance case law. Court judgments create binding precedent, such that they can be relied on to determine future disputes. This means that parties can expect a fair and rigorous judicial system and a reasonable degree of predictability.

Arbitration continues to be a popular alternative to court proceedings (particularly for reinsurance disputes), in part at least because of its confidential nature. The pool of arbitrators available to deal with insurance and reinsurance disputes benefits from many of the same attributes as the court system, and parties can be confident of a fair resolution of the issues by arbitrators who understand them.

The English courts encourage the use of alternative dispute resolution, and in particular mediation, to settle insurance and reinsurance disputes.

II REGULATION

i The insurance regulator

Since 1 April 2013, the regulation of insurers and brokers (as well as other financial services providers) has been divided between two regulators: the Prudential Regulation Authority (PRA) and the Financial Conduct Authority (FCA). The PRA is responsible for prudential matters (e.g., regulatory capital) while the FCA is responsible for conduct of business issues (e.g., the distribution of products). Insurers are regulated by both the PRA and the FCA, whereas insurance intermediaries such as brokers are regulated only by the FCA.

The regulation of the Lloyd’s market is more complex. Lloyd’s managing agents are regulated by the PRA, FCA and Lloyd’s itself. Lloyd’s brokers and members’ agents are regulated by the FCA and Lloyd’s. However, Lloyd’s members (who provide capital and participate in Lloyd’s syndicates) are only subject to Lloyd’s regulation. The Society of Lloyd’s is regulated by the PRA and the FCA.

When the PRA and the FCA took over as the prudential and conduct regulators of the UK financial services industry, they each adopted distinct supervisory approaches. For dual-regulated firms such as insurers, the practicalities of working with two regulators have become clearer, although concerns continue to exist about the possible duplication of regulatory efforts.

On 1 April 2015, the FCA also became a ‘concurrent regulator’ alongside the Competition and Markets Authority (CMA) with ‘concurrent powers’. These powers are in addition to its regulatory powers under Financial Services and Markets Act 2000 (FSMA) as amended by the Financial Services Act 2012. The FCA now has the ability to enforce the
prohibitions in the Competition Act 1998 on anticompetitive behaviour in relation to the provision of financial services, together with investigatory powers under the Enterprise Act 2002, to carry out market studies and to make market investigation references to the CMA relating to financial services.

ii Principle of ‘regulated activities’

There is no express prohibition on insurers or reinsurers. Rather, the UK regulatory regime prohibits the performance of regulated activities within the UK by unauthorised firms. These include insurer activities such as effecting and carrying out contracts of insurance, and distribution activities such as arranging, advising upon, selling and administering contracts of insurance.

It is a criminal offence to perform a regulated activity without being an authorised (or exempt) firm.\(^5\) Additionally, an authorised firm commits a regulatory breach if it does not have specific permission (or exemption) for a particular regulated activity that it performs.

Provisions in the legislation can deem regulated activities to be taking place in the UK (e.g., where there is a binding authority granted by an offshore insurer to a UK broker), and so care needs to be exercised by offshore insurers seeking to underwrite risks in the UK.

At the time of writing, the UK is part of the European Economic Area (EEA), and so EEA insurers and brokers authorised under one of the EU single market directives\(^6\) are able to ‘passport’ into the UK, on a freedom of establishment (branch) or freedom of services (no branch) basis, on the basis of their home state authorisation. The notification procedure that firms should follow when exercising their ‘passporting’ rights is set out in each single market directive. Subject to notification, such passports are, in effect, automatic, with the FCA having only a subsidiary regulatory role (conduct of business and marketing) with limited powers to block, or impose conditions on, an incoming EEA firm. Similarly, UK-authorised insurers and brokers are able to passport into other EEA Member States. One of the key advantages of passporting is that a regulated firm will have only one principal (home state) regulator, and for insurers this means only one regulatory capital regime. The role of the host state generally relates to the conduct of a regulated firm’s business in the host territory. For pure reinsurers (whose insurance business is restricted to reinsurance) there is no requirement for notification, as the Solvency II Directive (2009/138/EC) grants automatic passporting rights.

The UK’s EU referendum in June 2016 saw the UK electorate vote to exit the EU (Brexit), and the triggering of Article 50 of the Treaty on European Union by the UK government on 29 March 2017, an action that may have significant impact on passporting rights. At the time of writing, the full outcome of the exit negotiations remains uncertain. However, it is clear that unless the passporting regime is retained in an agreement between the UK and the EU, UK insurers will lose their passporting rights either if the UK exits the EU with no deal or at the end of any transition period if a deal is agreed. The passporting

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5 Section 19 FSMA.

rights of EU insurers into the UK will be similarly impacted. Even if certain passporting rights are retained, it seems inevitable that a major shift away from EU to UK regulation is likely (see Section VI).

iii  **Position of brokers**

Insurance intermediaries such as brokers are also required to be authorised when they perform regulated activities and their rights to passport into the EEA will also change following Brexit.

iv  **Requirements for authorisation**

A firm intending to carry on insurance or reinsurance business must obtain Part IVA FSMA permission from the PRA unless it is exempt or able to rely on the EU’s passporting regime\(^7\). Such firms are required to meet a number of threshold criteria, primarily relating to geographic location, regulatory capital, and systems and controls. A condition of obtaining permission is that the threshold criteria must be satisfied on authorisation and must continue to be maintained. Most of these requirements are a function of EU law and may change following Brexit.

Brokers are required to meet very limited regulatory capital requirements, but are required to have professional indemnity insurance in place.

For both insurers and brokers, certain senior individuals will need to be assessed as fit and proper persons and able to perform senior management functions, and must be ‘approved persons’ (see subsection v).

Application for authorisation is made to the PRA for insurers, and the FCA for intermediaries (such as brokers).

v  **Regulation of individuals employed by insurers**

Certain activities, such as being a director (including a non-executive director), or a chief executive (or a manager who can exert significant influence over the business) of an insurer or insurance intermediary such as a broker, are controlled functions, meaning that the appropriate regulator must approve an individual in that role. That ‘approved person’ is then subject to regulatory sanctions in the event of non-compliance. These sanctions can include financial penalties or restrictions on working in part or all of the financial services sector.

Additionally, the financial services legislation also extends to criminal offences committed by a regulated firm against its directors and officers, where the offence has been committed with the consent or connivance, or because of the wilful neglect of, such individual.

vi  **The distribution of products**

The Insurance Distribution Directive (IDD)\(^8\) came into effect on 22 February 2016. EU Member States adopted and began to apply the measures contained in the IDD by 1 October 2018, and the Insurance Mediation Directive (IMD) was repealed.\(^9\)\(^10\) While the

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7  Section 19 FSMA.
8  Directive on insurance distribution ((EU) 2016/97).
10  The IDD has been transposed into UK law by the Insurance Distribution (Regulated Activities and Miscellaneous Amendments) Order 2018 (SI 2018/546) and the Insurance Distribution Directive
changes imposed by the IDD are less fundamental than those presented by Solvency II, the effects are more far-reaching as they capture both insurers and intermediaries distributing insurance products. Like Solvency II, there will be a raft of rules and guidance under the new regime.

The IDD was implemented with a view to harmonising insurance sales practices across Europe and ensuring consumer protection across all distribution channels from brokers to direct sales by insurers. The IDD imposes a range of obligations, for example product oversight, remuneration and information disclosure. The Brexit vote has led many to question whether the IDD will continue to be implemented in the UK. Currently, the position is that all directive requirements will be implemented or met until Britain’s exit from the EU is effected. The FCA has further indicated that until any changes are made by Parliament, firms must continue to abide by their obligations under UK law, including those derived from EU law.

vii Compulsory insurance
Within the UK, the principal compulsory covers are motor liability and employers’ liability. There are also requirements specific to certain industries such as nuclear power, merchant shipping (pollution cover) and riding establishments. Aviation is subject to EEA rules on mandatory liability cover. The FCA requires insurance intermediaries such as brokers to have professional indemnity cover, and indeed many professions (such as the legal profession) require such cover as a condition of membership.

viii Compensation and dispute resolution regimes
If a regulated firm cannot resolve a customer complaint, then certain complainants – generally consumers, small businesses and some other small organisations – have the right to use the services of the Financial Ombudsman Service.

If a regulated firm is unable to meet its financial obligations, for example because of insolvency, then the Financial Services Compensation Scheme is available to compensate policyholders. However, the regime is generally restricted to consumers and small organisations – although there are important exceptions for compulsory insurance (notably employers’ liability) where large organisations are also able to bring a claim. Compensation available under the scheme will also depend on the type of claim.
Taxation of premiums

Insurance premiums, for general insurance, are subject to insurance premium tax (IPT) where the risk is located in the UK. This also applies to overseas insurers covering a risk located in the UK.

The standard rate of IPT increased on 1 October 2016 from 9.5 per cent to 10 per cent and rose again to 12 per cent on 1 June 2017. Premiums that relate to risks for which the period of cover began before 1 June 2017 will be subject to IPT at the old rate of 10 per cent, provided that they were received before 1 June 2018. The higher rate of 20 per cent (applied to travel insurance, and some vehicle and domestic or electrical appliance covers) remains the same.

Reinsurance is exempt from IPT, as is insurance for commercial ships and aircraft, and insurance for commercial goods in international transit. Premiums for risks located outside the UK are not subject to IPT, but may be liable to similar taxes imposed by other countries.

Insurance premiums are exempt from UK value added tax (VAT), as are commission payments to brokers and insurance agents. However, the analysis is more difficult in relation to payments between entities in the insurance ‘supply chain’, such as introducers, and case law is still developing as to which of those payments are VAT-exempt and which are not. Her Majesty’s Revenue and Customs has updated its internal guidance on tax, confirming that an introducer-appointed representative selling leads is not perceived to act as an intermediary and therefore is unlikely to be exempt from VAT.

Other notable regulated aspects of the industry

A purchaser of a regulated firm such as an insurer or intermediary requires prior consent from the appropriate regulator. It is a criminal offence to acquire or increase control in an insurer, reinsurer or intermediary without notifying and obtaining prior approval from the relevant regulator, which can lead to a fine and the transaction being held void. A purchase of a book of business from an insurer will require both regulatory and court consent under the UK’s Part VII FSMA process. This is designed to work cross-border within the EEA to meet European requirements. In terms of the regulators, the PRA will be principally responsible for the process. However, the FCA also has an interest and will need to satisfy itself that, as a minimum, the transfer will not adversely impact the customers of the firms involved in the transfer.

Both regulators are able to make representations to the court during the transfer process. The PRA is also required to consult the FCA at the start of and during the transfer process. However, the transferring parties may find that the contribution of the two regulatory bodies to the transfer process could lead to more convoluted negotiations given the different objectives of the PRA and FCA. Therefore, early engagement with both regulators to agree a timeline remains key.

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13 Westinsure Group Ltd v. HMRC [2014] UKUT 00452 (TCC); Riskstop Consulting Ltd v. Revenue and Customs Commissioners [2015] UKFTT 469 (TC).
14 VATINS5205 September 2014.
15 Section 191F FSMA.
III INSURANCE AND REINSURANCE LAW

i Sources of law

The basis of insurance law lies in the general law of contract. Until August 2016, the most significant legislative provision in relation to commercial insurance was the Marine Insurance Act 1906 (MIA), which codified the case law as it existed at the time. In August 2016, however, the Insurance Act 2015 (IA15) came into force. This introduced the most significant changes to English commercial insurance law in over 100 years and swept away central provisions of the MIA (though parts of the MIA remain in force). IA15 applies to contracts and variations of contracts entered into on or after 12 August 2016. Most provisions of the MIA and IA15 apply equally to marine and non-marine insurance, and to reinsurance. Other relevant legislation includes the FSMA, which regulates financial services (including insurance), the Life Assurance Act 1774 (LAA) and, in relation to consumer insurance, the Consumer Insurance (Disclosure and Representations) Act 2012.

ii Making the contract

Essential ingredients of an insurance contract

Under English law, an insurance contract is an agreement by the insurer to provide, in exchange for a premium, agreed-upon benefits to a beneficiary of the contract upon the occurrence of a specified uncertain or contingent future event, affecting the life or property of the insured.

The distinguishing features of a contract of insurance are the transfer of risk and the requirement for an insurable interest. These are considered in more detail below.

The transfer of risk when the uncertain event occurs

The contract must be such that, when the insured-against event occurs, the insurer responds by bearing all or part of the risk. Often, this response will mean that the insurer pays money to the insured. However, the contract may set out that the insurer is to provide benefits in kind, rather than a monetary payment, such as the reinstatement of property damage,16 the cost of a hire car while the insured vehicle is repaired17 or the restoration of a computer network. A Supreme Court decision in 2013 established that the insurer may offer services of one kind or another, such as the repair or replacement of satellite television equipment.18

The insured-against event must be uncertain in its occurrence.19 This uncertainty is tested at the time that the contract is concluded.20 The element of uncertainty may relate to whether the event will occur at all (e.g., a house fire), how often or to what extent the event will occur (e.g., damage to taxis) or when a certain event might occur (e.g., death).

The requirement of insurable interest

There is no all-embracing definition of insurable interest. In practice, the requirement has generally been taken to mean that the insured must have a legal or equitable relationship to

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16 Prudential v. Commissioners of Inland Revenue [1904] 2 KB 658.
the adventure or property at risk, and would benefit from its safety or may be prejudiced by its loss. This can be an issue in particular in relation to complex forms of insurance-backed financial instruments.

Historically, indemnity policies have required the insured to have an insurable interest in the subject matter and policies without such an interest were seen as unenforceable (and deemed to be gambling contracts). The LAA and the Gaming Act 1845 created the obligation for insurable interest in non-marine indemnity insurance, and the MIA made insurable interest a necessity in marine insurance.

Uncertainty regarding the requirement for insurable interest was, however, introduced by the Gambling Act 2005. Under the terms of this Act, gaming or wagering contracts are now enforceable. This arguably removes the requirement for an insurable interest in non-marine indemnity insurance in English law. There is some debate, however, over whether the Gambling Act 2005 has abolished the need for insurable interest in marine insurance. Modern case law suggests that the courts will lean in favour of finding insurable interest where possible. It is obviously unattractive for insurers to take the premium and then deny the existence of an insurable interest. As noted by the Law Commission of England and Wales, ‘the courts would make every effort to find an insurable interest where both parties have willingly entered into the contract’.21

The Law Commissions of England and Wales and of Scotland (the Commissions) have been undertaking a review of the law of insurance contracts. In June 2018, the Commissions published an updated version of the April 2016 draft Insurable Interest Bill. The Bill is designed to address concerns that the current law, described by the Commissions as unclear in some respects and antiquated in others, has had the effect of inhibiting the market’s ability to write particular types of product for which there is a demand. The intention of the Bill is to ensure that such products can be made available without technical concerns about insurable interest. The Commissions are currently considering responses to the draft Bill and are expected to make their final recommendations in 2019.22

Utmost good faith

Unlike other commercial contracts, insurance contracts are contracts of utmost good faith, which imposes an obligation of ‘the most perfect frankness’ on the parties. For contracts entered into before 12 August 2016, the statutory basis for this is found in Section 17 MIA, which provides that ‘[A] contract of marine insurance is a contract based on the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.’ This imposes an onerous duty on the party seeking insurance cover to disclose, before the contract is entered into, all material facts pertaining to the risk of which it is, or ought to be, aware, and to avoid misrepresenting any of the material facts.

Under the MIA a similar duty is imposed on the insured’s placing broker.

Material facts are judged objectively, and are defined as those that would be likely to influence the judgement of a hypothetical prudent insurer in determining whether and on what terms to accept the risk, and in fixing the level of premium. In this regard, it is not necessary that a prudent insurer would have refused the risk, or even charged a higher premium, but enough to show that it would have liked the opportunity to consider

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22 https://www.lawcom.gov.uk/project/insurance-contract-law-insurable-interest/.
the position. In the event of a material misrepresentation or non-disclosure, the insurer is entitled to avoid the contract from inception if it can demonstrate that the individual underwriter to whom the misrepresentation or non-disclosure was made was induced by that misrepresentation or non-disclosure to write the contract on the terms that he or she did.

Following a lengthy review of British commercial insurance law by the Commissions, IA15 was passed in 2015 and came into effect on 12 August 2016. IA15 retains the name and concept of the duty of utmost good faith and amends Section 17 MIA to provide that ‘a contract of marine insurance is a contract based upon the utmost good faith.’ It introduces, however, a number of changes to the insured’s pre-contractual duty. IA15:

a) replaces the pre-contractual duty of disclosure and non-misrepresentation with a ‘duty of fair presentation’, whereby the insured is required to disclose all material circumstances about the risk or give the insurer sufficient information to put it on notice that it needs to make further enquiries for the purpose of revealing all the material circumstances about the risk. This puts a greater emphasis on the insurer to ask questions about the risk and to make clear what information it requires;

b) replaces the single remedy of avoidance for breach of the duty with a system of graduated remedies based on what the insurer would have done had it received a fair presentation; and

c) requires the insured to carry out a ‘reasonable search’ prior to the placement for material information available to it within its own organisation and ‘held by any other person’.

Consumer insurance has already been the subject of similar reforms, as enacted by the Consumer Insurance (Disclosure and Representations) Act 2012.

Recording the contract

Insurance contracts are usually evidenced by a written policy, and Section 22 MIA and Section 2 LAA require a written policy. The London Market has also introduced the Market Reform Contract, a standard form that aims to increase contractual certainty and that is widely used in practice.

Interpreting the contract

General rules of interpretation

Insurance and reinsurance contracts are subject to the same general principles of construction that apply to other commercial contracts. The guiding principles are as follows.

Interpretation is the ascertainment of the meaning that a document will convey to a reasonable person having all the background knowledge that would reasonably have been available to the parties in the situation in which they were at the time of the contract.

The background knowledge has been referred to as the ‘matrix of fact’. It includes anything that would have affected the way in which the language of the document would have been understood by a reasonable person. This is subject to two points: first, that the

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background knowledge should have been reasonably available to all the parties; and second, that the law excludes from the admissible background the previous negotiations of the parties and their declarations of subjective intent.

The meaning that a document would convey to a reasonable person is not the same thing as the meaning of its words. The meaning of words is a matter of dictionaries and grammar; the meaning of the document is what the parties using those words against the relevant background would reasonably have been understood to mean.

The rule that words should be given their natural and ordinary meaning reflects the common-sense proposition that it is not easy to accept that people have made linguistic mistakes, particularly in formal documents. However, if it could nevertheless be concluded from the background that something must have gone wrong with the language, the law does not require judges to attribute to the parties an intention that they plainly could not have had.

**Incorporation of terms**

Reinsurance contracts often contain general words such as ‘all terms, clauses and conditions as original’ or ‘as underlying’. Such general words are not necessarily sufficient to incorporate a term from the insurance contract into the reinsurance contract. In *HIH Casualty & General Insurance Ltd v. New Hampshire Insurance Co*, the court held that a term will be incorporated only if it:

- is germane to the reinsurance, rather than being merely collateral to it;
- makes sense, subject to permissible manipulation, in the context of the reinsurance;
- is consistent with the express terms of the reinsurance; and
- is apposite for inclusion in the reinsurance.

By way of example, arbitration clauses, jurisdiction clauses and choice of law clauses are unlikely to be incorporated from an insurance contract into a reinsurance contract because they are not considered germane to the reinsurance. These provisions should, therefore, be dealt with specifically in the reinsurance contract. Similar principles apply to attempts to incorporate wording into excess layer contracts from the primary layer insurance.

**Types of term in insurance and reinsurance contracts**

Terms in insurance and reinsurance contracts may be divided into three broad categories: conditions, conditions precedent and warranties. Of these, the latter two require some comment.

**Conditions precedent**

There is more than one possible type of condition precedent in an insurance or reinsurance contract. A term can be a condition precedent to the existence of a binding contract, the inception of the risk, or the insurer’s or reinsurer’s liability. This is a matter of the wording of the particular clause. Whatever the type of condition precedent, there is no need for an insurer or reinsurer to prove it has suffered any prejudice before it can rely on a breach of the term.

A condition precedent to the contract must be satisfied, otherwise the contract will not come into being. A condition precedent to the inception of the risk presupposes a valid contract but one where the risk does not attach until the condition precedent has been met.

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A condition precedent to the contract or to the risk may, for example, relate to the provision of further information by the insured or reinsured or payment of the premium. Both types (in the absence of any specific wording) mean that the insurer or reinsurer cannot be liable for any loss that predates the fulfilment of the condition precedent.

A condition precedent to the insurer’s or reinsurer’s liability usually means that the insurer or reinsurer will not be liable for a claim unless the condition precedent is satisfied but the contract will generally continue in force. These conditions precedent are often concerned with the claims process. For example, the time period within which notification of a claim must be given is often expressed as a condition precedent to the insurer’s or reinsurer’s liability (as to which, see below).

The effect of a condition precedent to liability has been altered by Section 11 IA15. Under Section 11, if the condition precedent is, on its proper construction, one that would tend to reduce the risk of loss of a particular kind, at a particular location or at a particular time, insurers cannot rely on the insured’s breach of the condition precedent to deny a claim if the insured can show that its breach could not have increased the risk of the loss that actually happened in the circumstances in which it occurred. The only exception to this is in relation to terms that ‘define the risk as a whole’ (e.g., a term that defines the age, identity and qualifications of the owner or operator of a vehicle, aircraft, vessel or item of personal property).

**Warranties**

An insurance warranty is not the same as a warranty in an ordinary commercial contract. For contracts entered into before 12 August 2016, the former is defined by Section 33(1) MIA as ‘a promissory warranty, that is to say, a warranty by which the assured undertakes that some particular thing shall or shall not be done, or that some condition shall be fulfilled, or whereby he affirms or negatives the existence of a particular state of facts’. A warranty is a way in which the insurer or reinsurer can procure from the insured or reinsured a guarantee of the accuracy or continued accuracy of a given fact or a promise that certain obligations will be fulfilled.

Under the MIA, the effect of a breach of warranty is to discharge the insurer or reinsurer automatically from liability as from the date of breach. The insurer or reinsurer is not required to show that the warranty was in any way material to the risk or that the breach has contributed to the loss. The severity of this remedy attracted considerable criticism from insureds and their brokers, and IA15 radically amended the law relating to warranties when it came into force in August 2016. Under IA15:

a A breach of an insurance warranty no longer automatically discharges insurers from further liability under the contract.

b Instead, the contract is suspended until the breach of warranty is remedied. Insurers remain liable for losses occurring or attributable to something happening prior to the breach but are not liable in respect of losses occurring or attributable to something happening during the period of breach. Once the breach is remedied, insurers are again liable for losses attributable to something happening after the breach (subject to the remaining terms of the contract).

c As noted above, under Section 11 IA15, where a loss occurs when an insured is not in compliance with a term that tends to ‘reduce the risk’ of loss of a particular kind, at a particular location or at a particular time, and that is not a term that defines the risk as a whole, the insurer cannot rely on that non-compliance to exclude, limit or
discharge its liability if the insured can show, on the balance of probabilities, that its non-compliance could not have increased the risk of the loss that in fact occurred in the circumstances in which it did occur. The example given by the Commissions is that of a lock warranty in an insurance policy, requiring the hatch on a private yacht to be secured by a special type of padlock. Compliance with the lock warranty would tend to reduce the risk of a specific type of loss: loss caused by intruders. Under Section 11, breach of such a warranty would not suspend the insurer’s liability for other types of loss, such as loss in a storm. However, if there was a break-in, liability would be suspended even if the special padlock would not have prevented it.

‘Basis of the contract’ clauses, whereby the insured’s answers in a proposal form are converted into warranties in the policy, have been abolished. In the context of consumer insurance, basis of the contract clauses were abolished as a result of the implementation of the Consumer Insurance (Disclosure and Representations) Act 2012.

iv Intermediaries and the role of the broker

English law usually views an insurance broker as the agent of the insured for the purposes of placing an insurance contract. The essence of the relationship between the broker and the insured is one that gives rise to a number of fiduciary duties, including an expectation that the broker will put the insured’s interests before its own.

Commission

Notwithstanding that the broker is the agent of the insured at placement, the commission or brokerage that it earns when an insurance contract is placed is usually agreed and paid by the insurer – often as a percentage of the premium.

Consistent with ensuring that brokers act in the best interests of their clients, English regulation places a strict prohibition upon additional payments that are contingent upon the amount of business or the profitability of the business being entered into.

The agent’s duty of disclosure

For contracts entered into before 12 August 2016, the law on the duty of disclosure affecting brokers is contained within Section 19 MIA. This provides that a placing broker is required to disclose to the insurer every material circumstance about the risk to be placed that is known to it or that in the ordinary course of business ought to be known by, or to have been communicated to, it. When IA15 came into force in August 2016, this provision was repealed; now, the broker’s knowledge is attributable to the proposer, insofar as it is reasonably available to it. The broker owes a professional duty of care to the proposer to ensure that it does not cause the proposer to be in breach of its duty to make a fair presentation. The only exception to this is that a broker will not be required to disclose material information that it acquired while acting as agent for a third party if that information is confidential to the third party.

26 In their July 2014 report entitled ‘Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies for Fraudulent Claims; And Late Payment’.
Claims

Issues frequently discussed in the London Market include claims notification and the role of the doctrine of utmost good faith in claims, the latter being the subject of a landmark Supreme Court decision in 2016. 27

Notification

An insurance contract, particularly in liability classes, often requires the insured to notify a claim to its insurer in a particular way and within a particular time frame for the claim to be valid. Prompt notification is often stated to be a condition precedent to coverage under a policy, and failure to comply with the notification requirements can give an insurer or reinsurer a complete defence to the claim.

The specific terms of a notification clause are, of course, crucial. Liability policies will, however, usually require notification of a ‘circumstance’ that ‘may’ or ‘is likely to’ give rise to a claim. ‘Circumstance’ has not been judicially defined. ‘Likely to’ has been held to mean a 51 per cent chance of a claim. 28 ‘May’ means a circumstance that ‘objectively evaluated, creates a reasonable and appreciable possibility that it will give rise to a loss or claim against the assured’. 29 The Court of Appeal has also made clear that, unless the language of the clause particularly requires it, an insured is not expected to carry out a continuous ‘rolling assessment’ of a circumstance to monitor whether, what was initially something that was unlikely to give rise to a claim, mutates into a circumstance that is likely to give rise to a claim. 30 Finally, the term ‘give rise to a claim’ requires a causal as opposed to a mere coincidental link between the circumstances notified and the ultimate claim. 31

Other policies will require the notification of a loss. In this context, loss has been interpreted differently in two cases on very similar facts (RSA v. Dornoch 32 and AIG Europe (Ireland) Ltd v. Faraday Capital Ltd 33). Considerations of space preclude a detailed analysis of the difference between these two cases, but they demonstrate that the question of whether notification under any particular policy ought to be given is very fact-specific and where in doubt, legal advice ought to be sought at an early stage.

Good faith in claims

As noted above, insurance contracts are contracts of the utmost good faith. The duty of good faith is mutual and is not limited to the pre-contract negotiations. Nonetheless, the courts have preferred to use an independent common law remedy of forfeiture to regulate fraudulent claims. Until recently, forfeiture was the remedy in respect of any claim that was materially tainted by fraud, whether entirely false, exaggerated or involving a fraudulent device to ‘gild the lily’ of an otherwise genuine claim. In 2016, however, in Versloot Dredging BV v. HDI Gerling & Ors (The DC Merwestone) 34 the Supreme Court (by a majority of 4–1) abolished

27 Versloot Dredging BV & Anor v. HDI Gerling Industrie Versicherung AG & Ors Lloyd’s Rep IR 468.
28 Layher Ltd v. Lowe.
29 HLB Kidsons v. Lloyd’s Underwriters and others [2008] EWCA Civ 1206.
33 [2008] Lloyd’s Rep IR 454.
34 ibid., footnote 27.
the insurer’s remedy of forfeiture for the assured’s use of a fraudulent device to further an otherwise valid claim. In doing so, it overturned the Court of Appeal’s judgment in the same case and decided that Lord Justice Mance (as he then was) had been wrong in The Aegeon in expressing the opinion that the public policy objective of deterring fraud in the insurance claims context warranted the forfeiture of a claim that had been promoted by fraudulent means, even though the claim was in all other respects valid.

While upholding the fraudulent claim rule in respect of fraudulently exaggerated claims, the majority considered it to be ‘a step too far’ and ‘disproportionately harsh’ to deprive a claimant of his or her claim by reason of his or her fraudulent conduct if the fraud had been unnecessary because the claim was in fact always recoverable. In a strong dissenting judgment, Lord Mance expressed the opinion that there was no distinction to be drawn between the deployment of a fraudulent device and the pursuit of a fraudulently exaggerated claim. In his view, forfeiture was proportionate in both cases, and justified by the public policy objective of deterring fraud in the insurance claims context.

IA15 seeks to clarify insurers’ remedies for fraudulent claims. The statutory regime, which came into effect in August 2016, stipulates that, in the event of a fraudulent claim, the insurer will have no liability to pay the claim, and have the option, by notice to the insured, to treat the contract as having been terminated from the time of the fraudulent act (and to retain all of the premium); however, the insurer will remain liable for legitimate losses before the fraud.

Owing to the mutual nature of the duty of good faith, an issue also arises (at least in theory) as to whether poor claims handling practices can place an insurer in breach of duty. Prior to the coming into force of the Enterprise Act 2016 (EA16) on 4 May 2017 under English law punitive damages against an insurer or reinsurer were not available for breaches of this duty; nor could an insurer or reinsurer be made to pay compensatory damages for any losses caused by an unreasonable declinature of a claim or delay in processing it. From 4 May 2017, however, EA16 introduced a new Section 13A into IA15. This Section introduces an implied term into every insurance contract subject to English law entered into on or after that date to the effect that insurers and reinsurers must pay claims within a reasonable time. A breach of that term gives rise to a right to claim damages. However, there is a special one-year limitation period for such a claim; and damages will be subject to the usual criteria for assessing contractual damages, which are that the loss must have been (1) foreseeable when the contract was entered into; (2) caused by the breach of contract; and (3) not too remote; and also that (4) the insured must have taken all reasonable steps to mitigate its loss.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

It is usual for the parties in their contract to submit to the courts in a selected jurisdiction to hear disputes arising between them. The parties may also agree that any dispute is to be determined by arbitration rather than in the courts by insertion of an arbitration clause. Arbitration may be favoured for a variety of reasons, but in particular, for confidentiality. English courts generally will uphold and enforce these choices.

ii Litigation

Litigation stages

Civil proceedings in the High Court are governed by the Civil Procedure Rules (CPR). Once proceedings have been commenced and written statements of a case filed and served, the litigation stages are as follows:

a case management conference: the judge will set down the pretrial timetable;
b disclosure: each party is under a duty to undertake a reasonable search for, and disclose to the other parties, documents on which they rely, those that adversely affect their own case and those that support the other party’s case. This includes electronic documents. The duty is limited to those documents within the party’s control. Those documents attracting privilege (legal advice, litigation) are not obliged to be disclosed. The duty of disclosure continues until proceedings have been concluded;
c witness statements (see below);
d expert reports (see below);
e trial; and
f appeal – an unsuccessful party may, with the permission of the court, appeal an order or judgment to a higher court.

Evidence

Witness evidence is provided by signed statements setting out the evidence a witness would be allowed to give orally at trial. If a party has served a witness statement and wishes to rely on the evidence of the witness at trial, the witness must be called to confirm their written evidence in court, and may be cross-examined by the other party or parties.

The court’s permission is required if the parties wish to adduce expert evidence at trial. The expert’s duty is to set out an independent, objective, unbiased opinion on matters within his or her expertise, arrived at without regard to the exigencies of the dispute or of either party’s position in it, based on and taking account of all the factual evidence provided for their review. The expert’s overriding duty is to assist the court (not the party who has undertaken to pay their fees). If a party puts an expert’s report in evidence at trial, that expert may be cross-examined by the other party or parties to the case.

Costs

The default position in English proceedings is that the losing party pays the reasonably incurred, reasonable costs of the successful party. These costs are ‘assessed’ by the court and, in practice, only 60 per cent to 70 per cent of the costs actually incurred by the successful party is usually recoverable from the unsuccessful party.

The parties have the ability to alter a costs outcome early in the proceedings by utilising the mechanism afforded by Part 36 CPR. If a party makes an offer to settle (in the prescribed form) that is rejected by the other party but the other party fails to ‘beat’ the offer at trial then the declining party, even though ultimately successful at trial, will be liable for the offering side’s costs (including interest) from the date of expiry of the offer.

36 In the Admiralty and Commercial Courts, where many commercial insurance disputes are brought, there is an additional Guide that supplements the CPR.
The ‘Jackson reforms’, implemented on 1 April 2013, affect the conduct of litigation in general but focus mainly on costs management (and disclosure that drastically affects costs). In particular, the reforms introduced a further 10 per cent sanction payable by defendants who decline a reasonable offer.

Under the CPR, each party is required to submit a budget for the case to the judge at the case management conference for approval by the court, and the court may order the budget to be reduced or disallowed in certain respects. The parties are entitled to apply to the court for variations in the budget during the case if new developments justify additional expenditure.

In recent years there has been an increase in the provision of third-party funding, also known as litigation funding. This is where a third party, with no previous connection to the litigation, agrees to finance all or part of a party’s legal costs of the litigation in return for a fee payable from the proceeds recovered by the funded litigant.

iii Arbitration

Format of insurance arbitrations

The Arbitration Act 1996 codified English arbitration law and will govern the terms of an arbitration unless the parties have determined different rules (by reference to the rules of a particular institution) are to apply. The International Chamber of Commerce and the London Court of Arbitration are examples of commonly used international arbitral institutions with their own independent rules to govern the proceedings. However, most insurance and reinsurance arbitrations are *ad hoc*.

Procedure and evidence

Many London arbitrators will follow Commercial Court procedure, particularly in relation to evidence. It is open to the tribunal, however, to adopt different rules, for example, the International Bar Association Rules on the Taking of Evidence in International Arbitration, which allow for each party to request specific documents or a category of specific documents that are reasonably believed to exist, and to be in the possession of another party with reference to how the particular documents are relevant and material to the outcome of the case.

Costs

In the absence of a particular provision or agreement between the parties, costs in a London insurance arbitration will usually be payable by the unsuccessful party on the same basis as in the courts. While arbitration can be quicker than litigation, there are also added costs to consider. A panel of three arbitrators (the tribunal) each charging hourly rates, compared with a judge who is effectively free (save for the initial court fee), will quickly add up. Further, on top of, *inter alia*, legal fees, experts’ fees, administrative fees and arbitrators’ expenses, the parties must supply and fund the venue.

iv Alternative dispute resolution

While the courts actively encourage mediation and routinely ask the parties whether they have considered it, they cannot ‘order’ mediation. Rather, they have the power to penalise the parties from a costs perspective if they believe settlement options have not been adequately investigated. Given the soaring cost of litigation, an adverse costs order can be grave, so a threat of this kind is substantial. Our experience is that parties to insurance and reinsurance
disputes will usually attempt to mediate prior to trial. In addition, now that the amendment to IA15 has come into force introducing Section 13A (see Section III.v, above) so that insurers can be liable for damages for the late payment of claims, an insurer’s failure to consider alternative dispute resolution is likely to be one of the factors taken into account in deciding whether a claim has been settled within reasonable time.

Various alternatives to litigation, arbitration and mediation have been devised over the years to fast-track a resolution and keep costs down. These include expert appraisal (early neutral evaluation), expert determination, final offer arbitration, mediation-arbitration and the structured settlement procedure.

V YEAR IN REVIEW

The past 12 months have seen some interesting developments in the regulatory and legislative landscape, as well as a number of significant judgments.

i Regulation

Solvency II

While Solvency II has been integrated well since being implemented in the UK on 1 January 2016, it continues to be the subject of adjustment at EU and domestic level. The European Insurance and Occupational Pensions Authority conducted a planned review of the regime and consulted on advice to the European Commission about changes to the Solvency II standard formula. On 9 November 2018, the Commission published for consultation a draft version of a Commission Delegated Regulation intended to amend the Solvency II Directive. There are several proposed amendments, including the simplification of burdensome elements of the capital requirement standard formula, and the alignment of the Solvency II standard formula with those rules that are applicable in the banking sector. The review is expected to be completed in the first half of 2019.

On 11 January 2018, the PRA also published a consultation paper (CP2/18) in which it laid out proposals to reduce the reporting obligations of firms falling within the ambit of the Solvency II regime (particularly in relation to smaller firms). A policy statement was published on 6 July 2018, containing the PRA’s final policy following completion of consultation.37

GDPR

The EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR), adopted in May 2016, became directly applicable in all EU Member States without the need for local implementing legislation on 25 May 2018. The GDPR is supplemented and tailored within the UK in the Data Protection Act 2018 (DPA18). The GDPR strengthens and unifies data protection for all individuals within the EU. It also addresses the export of personal data outside the EU. The changes create a number of issues for insurers. For example, customers are now entitled to ask their insurers to delete their personal data where it is no longer

37 Policy statement 16/18.
required for its original purpose or where they have withdrawn their consent. Following industry concerns, DPA18 was amended to allow for personal data to be processed where this is necessary ‘for an insurance purpose’. 38

The Senior Insurance Managers Regime
On 10 December 2018, the Senior Managers and Certification Regime (SM&CR) was extended to insurers through the Bank of England and Financial Services Act 2016. The SM&CR replaced the PRA’s Senior Insurance Managers Regime, and the FCA’s revised approved persons regime, extending to employees who are not necessarily senior managers but whose roles could potentially cause significant harm to the firm. 39

ii Dispute resolution
The year 2018 did not provide any guidance from the courts on the construction and operation of the Insurance Act 2015. There were, however, a number of significant court decisions across all sectors of insurance. Some examples are outlined below.

In the liability sector, the always complex issue of notification was before the Commercial Court again in The Cultural Foundation and Abu Dhabi National Exhibition Company v. Beazley Furlong Limited and Others. 40 The case involved a dispute between insureds, primary and excess insurers concerning which insurance policy and which policy year had been activated by a notification of circumstances likely to give rise to a claim. The case turned on its particular facts but the Court set out some general principles of interest. In particular, it confirmed that the question of whether there is a likelihood of a claim is an objective test from which it follows that a notification is only valid to the extent that the circumstances identified are such that a reasonable person would think they are likely to give rise to the subsequent claim. Further, the term ‘give rise to a claim’ requires a causal as opposed to a mere coincidental link between the circumstances and ultimate claim.

Interestingly, in his obiter (i.e., non-binding) comments, the judge also expressed the view that an insured may choose which insurance to claim under if it has made a valid notification to more than one policy (subject always to the specific wordings of the policies).

Liability insurers will also take note of the Court of Appeal’s decision in Morrisons Supermarkets Plc v. Various Claimants, 41 which appears to extend the scope of an insured’s vicarious liability for the act of its employees. In this case, the Court held that an employer could be vicariously liable for an employee’s actions, even though in this case the employee was guilty of a criminal act (for which he was sentenced to eight years in prison) and even though Morrisons itself was the target of the employee’s action. Morrison’s submission that an employer could not be vicariously liable for an employee’s breach of the Data Protection Act 1998 was also rejected. Significantly, the Court found that the fact that insurance cover is available for losses of this nature meant that extending vicarious liability in this way would not impose an unjustified liability burden on businesses.

40 [2018] EWHC 1083 (Comm).
41 [2018] EWCA Civ 2339.

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The Marine Market saw a number of important judgments addressing the interpretation of standard London market clauses. Perhaps the most well known of these was the Supreme Court’s decision in *Navigators Insurance Company Limited and others v. Atlasnavios – Navegação, LDA (B Atlantic)*.\(^{42}\) This case concerned coverage under a marine war risk policy in respect of a vessel that had been detained in Venezuela after drugs were found strapped to its hull. The ship was declared a constructive total loss and was abandoned to the Court. The owners made a claim in respect of the loss under Clause 4.1.5 of the Institute War and Strike clauses 1/10/83. Clause 4.1.5 provides cover in respect of loss caused by persons ‘acting maliciously’. In finding that insurers were not liable for the loss, the Supreme Court concluded that malice in this context must be directed against the property insured, the owner or other personal property that could cause harm to the owner by damage to the insured vessel. In this case, however, the smugglers’ decision to attach cocaine to the ship’s hull was not done with any intention to cause damage to the insured and, consequently, did not constitute a malicious act and so cover was not available under the policy.

The Commercial Court also had cause to consider a standard marine policy wording in the case of *Mamandochet Mining Limited v. Aegis Manging Agency Limited and Others*\(^{43}\) in which underwriters sought to deny liability for a cargo loss in reliance on a standard form ‘sanctions limitation and exclusion’ clause. This provided that insurers would not be liable to pay any claim that ‘would expose that insurer to any sanction’. The Court held that this exclusion would be effective only if the insurer could show that payment would more likely than not be prohibited by an applicable law; it was not enough to show that there was merely a risk that sanctions may be applied.

The proper construction of an all-risk cargo and storage policy was at issue in *Engelhart CTP (US) LLC v. Lloyd’s Syndicate 1221 and Ors.*\(^{44}\) The insured in this case was the victim of a fraudulent transaction in which it agreed to buy copper ingots that did not in fact exist. It made a claim under its cargo policy and, in particular, under the container and fraudulent documents clauses of that policy. The container clause provided cover for ‘shortages’ (i.e. the difference between what was actually in a container and what should have been in it). In this case, however, the Court agreed with insurers that shortage should be given its normal meaning and that there could be no shortage of a cargo when there was no cargo in the first place.

*RSA Insurance PLC v. Assicurazioni Generali*\(^{45}\) addressed the issue of contribution between insurers and is an important decision for insurers with exposure to long-tail liability risk. RSA had paid an employer’s liability claim in respect of an employee who had been exposed to asbestos while working for the insured. RSA then sought a contribution from another insurer, Generali, that had also provided cover to the insured during the period of the employee’s exposure. Generali argued that the claim against it was time barred because it was a claim for damages for which the Civil Liability and Contribution Act 1978 stipulates a limitation period of only two years in contrast to the period of six years that applies to a claim in debt. The court agreed with Generali’s defence and the case is an important reminder to insurers of the short time limit in which a contribution claim must be brought in these circumstances.

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\(^{43}\) [2018] EWHC 2643 (Comm).

\(^{44}\) [2018] EWHC 900 (Comm).

VI OUTLOOK AND CONCLUSIONS

i Insurance contract law reform
The first substantive court decisions on the interpretation of IA15 have yet to be published and it is to be hoped that in 2019 the courts will give guidance on, for example, the application of the new proportionate remedies for breach of the duty of fair presentation and the operation of Sections 10 and 11 IA15, which deal with the operation of warranties.

ii Impact of Brexit on insurance regulation
As at the time of writing, no agreement has been reached on the process of the UK leaving the EU and there is a possibility that this will happen with no formal withdrawal agreement in place.

Until the formal withdrawal of the UK from the EU, the legal and regulatory framework will continue as normal. As such, the UK will remain subject to existing EU legislation and any new EU laws coming into force prior to the effective date of Brexit. In addition, the UK government passed the European Union (Notification of Withdrawal) Act 2018, which, among other measures, transposes directly applicable EU legislation into UK domestic law in preparation for Brexit. Following Brexit, these laws may be repealed or amended as the UK Parliament sees fit.

The two principal areas of regulation likely to be affected by Brexit are passporting rights and Solvency II. It seems likely that UK-based insurers will lose their passporting rights when Brexit comes into effect and, in anticipation of that development, many insurers have established authorised branches or subsidiaries in another EEA country so that risks can be written on a passporting basis in that country. In addition, Lloyd's has established Lloyd's Brussels, which will be able to write business in the EEA that will then be fully reinsured back to Lloyd's syndicates in London. Insurers are also introducing ‘contract continuity clauses’ into their policy wording, which allow risks currently underwritten by a UK entity to be transferred to an EEA licensed insurer in the event of Brexit.

If Brexit pushes the UK to amend the Solvency II regime, it could have significant consequences for insurers; for example, a UK solvency regulatory regime may not be recognised as ‘equivalent’ by the European Commission under Solvency II.

On 20 December 2017, the PRA published a consultation paper (CP30/17) on the proposed regulatory framework for international financial services firms (insurers and intermediaries) wishing to carry on regulated activities in the UK post-Brexit. The consultation envisaged that, subject to the outcome of Brexit negotiations, EEA insurers and intermediaries would be required to apply for authorisation to undertake regulated activities in the UK. When considering applications from such firms, the PRA notes that its assessment is ‘likely to be linked to, but not necessarily the same as, formal determinations of equivalence in respect of Solvency II’. The consultation closed in February 2018, following which a new supervisory statement was published,46 introducing new factors to be considered alongside the PRAs current requirements for third-country branch authorisation. Importantly, the consultation made clear that the existing passporting regime would remain unchanged until

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46 International insurers: the Prudential Regulation Authority’s approach to branch authorisation and supervision (SS2/18).
the UK withdraws from the EU. The UK government has also announced that, if necessary, there will be a prospect of legislating a ‘temporary permission’ regime, allowing relevant firms to continue operating for a limited period after Brexit.

It is evident that a number of challenges remain, including adapting to the post-Brexit environment while continuing to manage market conditions and ongoing pressure from the regulators. Inevitably, consolidation looks set to continue with insurers focusing on their core activities and disposing of their non-profitable books. It seems that Part VII transfer activity is set to continue.

### iii Insurtech

Insurtech refers to the use of technology innovations designed to increase efficiency in the insurance market. Over the past couple of years, innovations such as automation have brought improvements around risk and quality. There is likely to be real momentum in 2019 in terms of the development and implementation of blockchain technology, virtual reality, robotics, artificial intelligence and the internet of things.

### iv Summary

The insurance industry in England has undergone some of the most significant regulatory and legal reforms to affect it for many years. These changes have provided both challenges and opportunities for the London Market, whose strength historically has been built, inter alia, on its ability to adapt to change. The London Market appears to have embraced the rapidly changing landscape and many within it have begun setting their sights on growth.

The most interesting development will of course be the changes affecting insurance and reinsurance regulation following Brexit. At the time of writing, the future regulatory regime remains uncertain; although no laws or regulations have changed, the London Market is having to activate its contingency arrangements for a no-deal Brexit.
I INTRODUCTION

The French insurance and reinsurance market is doing well. The latest available numbers, which are for 2017, show increased year-end results compared to 2016 (€10.6 billion in 2017 compared to €9.7 billion in 2016), and a high and stable level of investment by the insurance industry in the real economy (€2.4 billion in 2017 compared to €2.35 billion in 2016).²

II REGULATION

i The insurance regulator

An independent administrative authority, the French Prudential Supervision and Resolution Authority (ACPR), was created by Ordinance No. 2010-76 of 21 January 2010 and modified by Law No. 2013-672 of 26 July 2013. It licenses and supervises banking, insurance and reinsurance activities, with the aim of providing more effective regulation of these sectors. The ACPR combines two roles, namely:

a overseeing insurance policies written by insurers; and
b issuing general rules and guidelines (by way of circulars, decrees, etc.) regarding banking, insurance and reinsurance activities.

ii Position of non-admitted insurers

According to Articles L310-2 and L310-10 of the Insurance Code (IC), non-admitted insurers cannot do business in France. Any breach results in sanctions set out in Article L310-6 et seq. of the IC, which include fines (from €4,500 to €375,000) and may go as far as having the offending company wound up. Exceptions exist for maritime and aviation risk coverage.³

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1 Alexis Valençon and Nicolas Bouckaert are partners at Kennedys. The authors are grateful to Thomas Garandeau and Sébastien Tadiello for their invaluable assistance in the preparation of this chapter.
2 According to the Tableau de bord de l’assurance (year in review) produced by the French Federation of Insurance for the 2017 calendar year.
3 Article L310-10, IC.
iii Requirements for authorisation

In order for a new insurance or reinsurance company to be authorised to write insurance or reinsurance, it must comply with the licensing procedure prescribed in Articles L321-1 to L321-3 and R321-1 to R321-5 of the IC. A licence may be granted conditionally or unconditionally, or be refused, by the ACPR, which bases its decision on the following criteria:

- the extent and suitability of the technical and financial means that the applicant plans to implement;
- the integrity, expertise and experience of the applicant’s managers; and
- the applicant’s shareholding structure and shareholder status. 4

In addition, the vast majority of insurance companies operating in France are subject to the EU Solvency II Directive (Solvency II) 5 and must therefore comply with minimum capital requirements, 6 have a governance system that ensures sound and prudent management, organise regular internal reviews and have an adequate risk management system. 7

In the event that the ACPR refuses to grant the licence sought by an applicant, the latter can challenge the decision before the highest administrative court, the Conseil d’État. Licences are granted to insurance companies for specific categories of business. Applicants must choose among the 26 categories listed in Article R321-1 of the IC. Insurance companies, unlike reinsurance companies, may not be licensed for both life and non-life insurance business. 8

iv Regulation of individuals employed by insurers, position of brokers and the distribution of products

Articles A512-6 and A512-7 of the IC lay down the requirement that insurance company employees and general agents and brokers must hold a master’s or bachelor’s degree or professional certificate in finance, banking or insurance.

The European Union’s legal framework for insurance distribution was thoroughly reformulated by Directive (EU) No. 2016/97 of 20 January 2016 on insurance distribution (the Insurance Distribution Directive). Article L511-1 et seq. and Article R511-1 et seq. of the IC, which regulate the activity of distributing insurance products, were amended accordingly. In this context, the definition of the distribution of insurance products was broadened to include distribution over the internet and over the telephone. Also, whereas formerly only intermediaries who undertook distribution as a principal activity fell under the scope of former Article L511-1 of the IC, its recast version now also applies to insurance companies and includes the majority of distributors who undertake the activity on a secondary basis. 9

v Compulsory insurance

There are more than 200 instances of compulsory insurance (e.g., employers’ liability), which concern a vast array of sectors and activities: automobile; transport; health; housing; real

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4 Article L321-10-1, IC.
5 Article L310-3-1, IC.
6 Article L352-5 et seq., IC.
7 Article L354-1 et seq., IC.
8 Article L321-1 Section 3, IC.
9 Article R511-1, IC.
Compensation and dispute resolution systems

In principle, any natural or legal person may bring a claim before the ordinary courts or, in certain cases, an arbitral tribunal.

By way of exception, since 2014, some authorised consumer associations are allowed to file specific group or class actions against insurers. These types of group or class actions were initially limited to non-bodily injuries; however, since 2016, they include claims for bodily injuries and their scope has been extended to other fields, such as health products, personal data and discrimination.

The ACPR regulates banks and insurers and, more generally, the distribution of financial products. Although it does not have jurisdiction to hear individual claims, it does have the power to impose fines on insurers that breach statutory provisions or engage in conduct likely to jeopardise the interests of policyholders or the market.

In addition, the Financial Markets Authority (AMF) was established by the Financial Security Act of 1 August 2003 to prevent any malfunction in the financial markets. For this purpose, it is empowered to conduct investigations into professionals operating in these markets and may impose fines or sanctions for breaches of the AMF General Regulations or professional obligations. It may also organise mediations between individuals and entities through its ombudsman, whose role is to facilitate compensation for losses but does not include the power to impose penalties or award damages.

On 16 December 2005, the French Federation of Insurance Companies (FFSA), a professional insurance federation of which the majority of French insurers are members, adopted an arbitration convention that is binding on all its members and provides that any disputes between insurers (that are members of the FFSA) regarding the indemnification of a given loss must be brought before an FFSA arbitral tribunal, rather than state courts. The FFSA became the FFA by merging with another professional body, the Group of Mutual Insurance Companies (see Section IV.iv).

Taxation of premiums

French insurance premium tax (IPT) is regulated under Article 991 et seq. of the General Tax Code and applies to all insurance policies covering risks situated in France.

Insurance companies that are not established in France must be registered with the French tax authorities and appoint a representative responsible for paying IPT.

The rate of IPT varies from 7 per cent to 33 per cent, depending on the insured risk.

Proposed changes to the regulatory system and other notable regulated aspects of the industry

On 1 January 2019, a recast version of Solvency II was meant to enter into force, however the European Parliament and Council have yet to adopt the text and no provisional calendar has been made public.

In addition, on 24 May 2018, the European Commission proposed to amend Directive 2009/103/EC relating to insurance against civil liability in respect of the use of motor vehicles. Prior to the proposal, the industry had participated in the Commission’s consultation phase and favourably received the proposal, which has yet to be adopted.
III INSURANCE AND REINSURANCE LAW

i Sources of law

The statutory framework for insurance mainly consists of the IC, the Mutual Code, the Social Security Code, and the Financial and Monetary Code. Provisions of other codes, such as the Civil Code (CC), may also apply. French insurance regulation is widely influenced by EU legislation. In addition, French case law clarifying insurers’ and policyholders’ duties can also be considered a source of law.

ii Making the contract

The IC lays down specific obligations for insurers to provide information and documents both during the pre-contractual phase and during the life of the insurance contract itself. Pursuant to Article L112-2 of the IC, prior to the conclusion of the contract, the insurer must provide the policyholder with an information sheet that sets out the particulars regarding the premiums owed and the policy limits, the functioning over time of occurrence-based or claims-based coverage and the consequences of a succession of contracts with different bases for triggering coverage.

The insurer must also provide the insured with a copy of the draft contract and the attachments thereto, or a brochure on the contract precisely describing the coverage and exclusions and the insured's obligations. The draft will not be binding on the insured or the insurer, as only the policy or the cover note will prove their agreement.

The Insurance Distribution Directive modified Article L112-2 of the IC imposing a new obligation on insurance distributors to provide their clients with a standardised document detailing essential information regarding the contract (e.g., coverage type and summary, main exclusions, duration). The requirements of this document are provided by Article A112 of the IC.

These obligations do not apply to insurance contracts covering large risks as defined by Articles L111-6 and R112-2 of the IC. As regards the information to be supplied by the policyholder to the insurer, Law No. 89-1014 introduced a system based on the completion of a questionnaire drawn up by the insurer. The duty to disclose is not, however, confined to the questionnaire and can include any question submitted by the insurer by fax, letter, etc., provided that the insurer can prove that it clearly phrased the question. As a consequence, the policyholder only has a duty to answer the insurer's questions and is under no obligation to spontaneously disclose information that might be relevant to the insured risk. The policyholder can, however, make spontaneous statements upon taking out the policy, regardless of the absence of any legal duty forcing him or her to do so. In such a case, the policyholder's spontaneous statements must be truthful and accurate, as otherwise the contract could be avoided for fraudulent misrepresentation. The information given in relation to a risk at the time of the insurance contract's inception will also determine the scope of the policyholder's continuous duty to disclose all new relevant information to the insurer, pursuant to Article L113-2 Section 3 of the IC.

10 Article L113-8 of the IC.
Regarding the truthfulness of the information provided by the policyholder (whether upon inception of the insurance contract or during its lifespan), the law makes a distinction between erroneous answers (or absence of disclosure) that are made in good faith or bad faith (i.e., deliberately).11

If the misleading information was provided in good faith, the possible indemnity owed will be reduced according to a pro rata calculation based on the premium the insurer would have requested, had it been informed of the true nature of the risk. If, on the other hand, the misleading information was provided deliberately and had an impact on the insurer’s choice to cover the risk or the price of the premium requested for said cover, then the insurance contract can be deemed to be null and void.

None of these provisions apply to reinsurance contracts.12

iii Interpreting the contract

General rules of interpretation

The CC provides general rules of interpretation in Article 1188 et seq., but these are only guidelines and the courts may interpret contracts as they deem fit.

However, judges should only interpret contracts when their terms are unclear or ambiguous,13 otherwise they risk being overturned upon appeal;14 this principle also applies to the pre-contractual questionnaire submitted by the insurer to the policyholder (and the policyholder’s answers thereto).15

When interpreting contractual provisions, the overarching principle is that it should be interpreted according to the parties’ common intention.16 In case of doubt, a private agreement shall be interpreted against the creditor and in favour of the debtor, and standardised pre-drafted contracts (such as those habitually offered to consumers) shall be interpreted against the party who offered the agreement.17

In the event of a contradiction between a clause contained in the general terms and conditions of a contract and a clause contained in the special terms and conditions of the contract, the latter will prevail.18

Furthermore, contracts are to be interpreted in their entirety, and clauses are not to be read independently from one another; similarly, contracts that concern the same operation should not be interpreted independently from one another, but together.19

Regarding the case of exclusion clauses, Article L113-1 of the IC provides that these must be ‘express and limited’, failing which the insurer would be unable to enforce the clause and

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11 Articles L113-8 and L113-9, IC.
12 Article L111-1, IC.
13 Article 1192, CC.
15 Cour de cassation, 2nd civil division, 3 March 2016, appeal No. 15-12464.
16 Article 1188, CC.
17 Article 1190, CC.
18 Cour de cassation, 1st civil division, 9 February 1999, appeal No 96-19538; 4 October 2018, appeal No. 17-20624.
19 Article 1189, CC.
would have to cover the loss.\textsuperscript{20} They must also appear very clearly in the policy, as per Article L112-4 of the IC.\textsuperscript{21} Any exclusion clause that requires interpretation is necessarily found not to comply with Article L113-1 of the IC\textsuperscript{22} and will, therefore, be deemed unenforceable.

Finally, with respect to the specific case of insurance offered to consumers or non-professionals, Article L211-1 of the Consumer Code provides that the terms of the contract ‘must be set out and written in a clear and comprehensible manner’. Moreover, ‘in case of doubt, they are to be interpreted in the sense which is most favourable to the consumer or non-professional’.\textsuperscript{23}

**Incorporation of terms and types of terms in insurance contracts**

Insurance contracts must be written in French and in clear print. They must also comply with the requirements of Articles L112-4, L113-15 et seq. and R112-1 of the IC, which respectively provide that the policy must indicate:

\begin{itemize}
  \item[a] the nature of the insured risks, the starting point and period of coverage and the policy limit;
  \item[b] the duration of the contract and the terms applicable to termination; and
  \item[c] the duration of the mutual undertakings made by the parties, the terms of tacit renewal of the policy, the policyholder’s duty to disclose, and the two-year limitation period for insurance claims and the causes of interruption of that period.\textsuperscript{24}
\end{itemize}

**Warranties, conditions precedent and conditions**

The policy may stipulate that the contract will only enter into force once certain conditions precedent are satisfied by the insured, such as, for instance, the payment of the first premium.\textsuperscript{25} The policy may also contain coverage conditions, which should be distinguished from conditions precedent. If these conditions are not satisfied during a certain period of the insurance contract’s life, coverage will not be owed for that particular period. Conversely, as soon as the condition in question is satisfied again, coverage would be available from that date onwards. These types of conditions are common, for instance, in relation to coverage for breaking and entering or theft,\textsuperscript{26} where policies will often provide that coverage may only be owed under the contract if certain security measures are maintained at all times (such as the presence of a working alarm system). Though they may sometimes lead to the same results, coverage conditions are distinct from exclusion clauses and are not, therefore, subject to the obligations of being written in bold characters or drafted in an ‘express and limited fashion’.\textsuperscript{27}

\textsuperscript{20} Cour de cassation, 2nd civil division, 26 October 2017, appeal No. 16-23696.
\textsuperscript{21} Cour de cassation, 2nd civil division, 24 May 2018, appeal No. 17-16431.
\textsuperscript{22} Cour de cassation, 2nd civil division, 12 April 2012, appeal No. 10-20831.
\textsuperscript{23} Cour de cassation, 2nd civil division, 20 December 2012, appeal No. 11-27225; 26 October 2017, appeal No 16-22.564.
\textsuperscript{24} Cour de cassation, 3rd civil division, 16 November 2011, appeal No. 10-25246.
\textsuperscript{25} Cour de cassation, criminal division, 17 January 1996, appeal No. 95-80847.
\textsuperscript{26} Cour de cassation, 2nd civil division, 30 June 2011, appeal No. 10-23309.
\textsuperscript{27} Cour de cassation,1st civil division, 18 December 2002, appeal No. 00-21991.
Intermediaries and the role of the broker

Conduct rules

Insurance intermediaries that distribute insurance or reinsurance coverage on a principal or secondary basis must meet the integrity and professional qualification requirements set out in Articles L512-4 and L512-5 of the IC. For instance, insurance intermediaries must not have been convicted of certain offences. As far as professional qualifications are concerned, brokers need to meet certain requirements pursuant to Article R512-9 of the IC (i.e., two to four years of professional experience devoted to the production or management of insurance contracts, or a specified minimum level of higher education) or receive 150 hours of training.²⁸ In any event, brokers must have at least 15 hours of training per year.²⁹ They must also carry professional-liability and financial-bond insurance.³⁰ They can incur various sanctions, ranging from fines to imprisonment, for breach of statutory requirements, such as not being registered.³¹

Brokers and insurance companies are also bound by brokerage customs and industry practice. Legal commentators are, however, divided and cautious about their qualification as a rule of law and their possible enforcement by or against a third party.

Agency and contracting

Insurance intermediaries must be registered with the organisation in charge of the French Register of Insurance Intermediaries. Registration must be renewed annually and is subject to the payment of a fixed fee.³²

The Insurance Distribution Directive reinforced the freedom to provide services and the freedom of establishment of insurance intermediaries within the European Union by providing that the registration with their home Member State should allow them to operate in other Member States.³³

How brokers operate in practice

Traditionally, brokers provide clients with pre-contractual advice on coverage and premiums, and consequently fall under the category of insurance distributors. As such, they have certain obligations regarding pre-contractual information and advice.³⁴ These obligations have been reinforced by a decision of the Court of Justice of the European Union in May 2018, which found that even if the pre-contractual advice is given without a real intention to enter into a contract from the intermediary’s part, its actions nonetheless fall under the scope of intermediation, as does the financial advice given by an intermediary.³⁵

Brokers are, however, increasingly involved in claims handling. They may, for instance, strive to defend their clients’ interests by guiding policyholders from the time of occurrence of a loss, and assisting them during the investigation and adjustment of the loss. Brokers may also guide insurers on the choice of party-appointed adjusters.

²⁸ Article R512-9, IC.
²⁹ Article R512-13-1, IC.
³⁰ Articles L512-6 and L512-7, IC.
³¹ Articles L514-1 to L. 514-4, IC.
³² Article L512-1, IC.
³⁴ Articles L112-2 et seq. and L521-1 et seq., IC.
³⁵ Court of Justice of the European Union, 31 May 2018, C-542/16 QPC.
The extent of a broker’s involvement in the handling of a claim mainly depends on the size of the loss. For instance, a claim liable to have a major financial impact will be handled directly by the insurer, but the broker may keep it under close review.

Brokers may also act on behalf of the insurer, for example by collecting insurance premiums.

v Claims

The insured must give the insurance company notice of any claim that falls within the policy limits and scope of coverage, and provide the company with all the documents enabling it to appreciate the circumstances of the loss.

Insurance policies cannot impose a specific method of notifying claims; any clause imposing a special method is therefore invalid. The insured should notify the claim as soon as he or she is aware of it and within the time limit, if any, specified in the policy.

Pursuant to Article L113-2 of the IC, where a policy clause stipulates a specific time limit for the notifications of claims, the insurer may deny coverage of any claim reported outside the time limit in question, provided that:

a the delay in reporting has caused the insurer prejudice, inter alia, by increasing the cost of the claim;

b the specified time limit for reporting claims is not less than five days; and

c the policy’s relevant sections appear in bold print and clearly state that late reporting results in forfeiture of coverage.

Generally speaking, there is no duty on the insured to mitigate damage (except in marine insurance); nevertheless, the courts have occasionally found this duty on the basis of a breach of contract. Legal commentators have, however, remained rather cautious on this point, as the duty has neither been clearly defined nor confirmed by further court decisions. However, projects for the reform of tort law (which have not yet been adopted), inter alia, envisage modifying Article 1263 of the CC and imposing this obligation in matters other than bodily injury.

Finally, where the policy so provides in very clear print, fraudulent overstatement of losses can result in forfeiture of coverage, even if the overstatement caused no prejudice to the insurer.

Set-off

The liability insurer cannot set-off the unpaid premiums upon the indemnity it may be obligated to pay to the third-party victim. However, the insurer has a right to assert set-off, including in an insolvency context, but only if the right is asserted before the judgment opening insolvency proceedings, and under certain conditions. Accordingly, an insurer can set-off premiums owed to it by a policyholder against insurance proceeds owed by it to the policyholder.

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36 Cour de cassation, 2nd civil division, 24 November 2011, appeal No. 10-25635.
37 Cour de cassation, 1st civil division, 31 March 1993, appeal No. 91-13637.
For annual policies, the policy limit is automatically reinstated in full on the first day of the next year of insurance. Moreover, the insured or policyholder can request reinstatement of mandatory coverage. If the policy limit has not been exhausted, the remaining portion is not carried over to the next year.

In addition, insurance contracts can provide for reinstatement of the policy limit depending on changes in the risks. Such a provision is subject to a higher premium and is drafted on a case-by-case basis.

Generally speaking, insurers can stipulate mediation and conciliation clauses in their policies. Article L112-2 of the IC provides that the insurance contract must indicate how the insured can initiate a mediation. Insurance contracts relating to large risks can also contain mediation and conciliation clauses, but they do not, however, need to indicate the exact means of initiating mediation, as would have been the case with a consumer.

According to case law, if an insurance contract contains a conciliation clause or a mediation clause, the parties have to go through these processes before taking legal action.

There are two types of first instance courts in France: civil courts and commercial courts. Commercial courts differ from civil courts in that they are staffed by non-professional judges, who are usually experienced business people. There are no trials by jury in either the civil or the commercial courts.

If neither one of the parties is a commercial entity, the district court or high court has jurisdiction (depending on the amount of the claim) to rule on any disputes in first instance. Alternatively, the regional commercial court has exclusive jurisdiction if all the parties to the dispute are commercial entities (unless the contract at issue contains a jurisdiction clause that explicitly stipulates that civil courts have jurisdiction). Finally, if a claimant is a non-commercial entity but the defendant is, for its part, a commercial entity, the former can choose before which court, commercial or civil, he or she brings his or her action.

It follows from the above that insurers are accustomed to appearing before both civil and commercial courts (though mutual insurance companies must necessarily initiate proceedings or be sued before civil courts, as they are non-commercial entities).

Taking property and casualty insurance as a representative example, the principles that govern applicable law or choice of law may be summarised as follows:

- compulsory insurance contracts that correspond to a legal obligation (such as motoring insurance) are necessarily governed by French law;
insurance contracts entered into with a French resident in relation to a risk that is deemed to be located in France (according to the criteria set out in Article L310-4 of the IC) will necessarily be governed by French law, and

insurance contracts entered into with a consumer will also necessarily be governed by French law, provided the consumer has his or her habitual residence in France and the insurer carries out his or her usual business in France.

There are, however, certain conditions where the parties can elect for the insurance contract to be governed by a foreign law, namely:

a if the risk is located in France, but the insured resides or has its registered office abroad, the insurance contract can either be governed by French law or the law of the country the insured resides in;

b if the risk is not located in France, but the insured resides or has its registered office in France, the insurance contract can be governed by French law or by the law of the state where the risk is located, and

c if the risk qualifies as a large risk, as defined by Article L111-6 of the IC, the contract can be governed by any law the parties elect (rather than merely the law of the state associated with the residence of the insured and the location of the risk) – however, in this instance, if the main elements of the insurance contract are located in France, then the overriding mandatory provisions of French insurance law will apply, regardless of the governing law elected by the parties.

In the three instances listed above where the insured and the insurer elect a governing law other than French law, the governing law retained by the parties must either be identified explicitly or be self-evident in light of the other clauses of the contract or the facts of the case. If this is not the case, the governing law will be that of the state that has the closest ties with the insurance contract, which is presumed to be the law of the state where the risk is located.

Arbitration clauses in insurance contracts entered into with an insured deemed to be a consumer are null and void.

ii Litigation

Litigation stages

Generally speaking, first instance proceedings in a commercial case usually take about a year and a possible appeal will usually add another year. A possible, ultimate appeal before the French Supreme Court, the Cour de cassation (which can only be made on a point of law, rather than an issue of fact), would add another 18 months. These periods can vary depending, inter alia, on the complexity of the case, the number of parties or whether investigative measures are ordered by the court.

42 Article L181-1-1, IC.
43 Rome I Regulation, Article 6.
44 Article L181-1 Section 2, IC.
45 ibid.
46 Article L181-1-5, IC.
47 Article L181-2, IC.
48 Article R212-2 Section 10, Consumer Code.
Urgent proceedings, such as summary proceedings for interim relief and fixed-date proceedings, also exist. These proceedings can take several weeks to several months depending on the complexity of the case and the parties’ diligence.

Evidence
Proceedings before French courts do not include discovery, in a marked difference to the way evidence is produced before common law jurisdictions.

According to Article 132 of the Code of Civil Procedure (CCP), each party must produce the documents relied upon in its submissions and communicate copies thereof to the other parties. In the event that a party does not comply with this obligation, its opponents could apply to the court for a disclosure order. The court would then indicate the time limit for disclosure, if necessary on penalty of a daily fine, and, where appropriate, the method of disclosure. The judge on the merits could also choose to exclude whatever documents have not been served in due time. If a party wishes to rely on a document evidencing a transaction to which it was not itself a party, or any other document held by a third party, the court may order the production of the original or a certified copy of the said document.

Pursuant to Article 199 of the CCP, if testimonial evidence is admissible, the court shall admit statements from third parties whose first-hand knowledge can help clarify the facts at issue. Such statements can be made in writing or brought by means of an inquiry or investigation, depending on whether they are written or oral.

Costs
According to Article 695 of the CCP, costs include:

- the fees, taxes, fees or emoluments charged by the court registry offices or by the tax administration, except any fees, taxes and penalties payable in respect of documents or title deeds produced in support of the parties’ claims;
- the cost of translating documents, where translation is required by law or by an international commitment;
- allowances paid to witnesses;
- experts’ fees;
- fixed disbursements;
- emoluments of public officers;
- counsel’s fees insofar as they are regulated, including fees for counsel’s addresses; and
- expenses incurred for service of process in a foreign country.

These costs, which do not, however, include the other parties’ legal costs, are born by the losing party, once the judgment on the merits is handed down – though the court can, in its judgment (provided its decision is motivated), order that part of these costs also be borne by another party.

49 Article 133, CCP.
50 Article 134, CCP.
51 Article 135, CCP.
52 Article 138, CCP.
53 Article 696, CCP.
While the losing party will habitually be ordered to pay part of the successful party’s legal expenses, the amount usually corresponds to only a fraction of the successful party’s entire legal costs.

iii Arbitration

Format of insurance arbitrations

The parties to arbitration have wide autonomy, especially as regards the procedural rules to be followed by the arbitration proceedings, which can be agreed upon in the arbitration agreement. Arbitral proceedings must, however, comply with the mandatory guiding principles set out in the first section of the CCP. Additionally, arbitration agreements are not enforceable against all individuals, in particular non-professionals having entered into the agreement on a private basis. However, non-professionals may choose between arbitration and state courts to have their case heard.

There is a legal distinction between domestic and international arbitration; though some provisions apply to both, there are also specific provisions for each. The distinctive criterion is that of the domestic or international nature of the trade interests at stake in the dispute. In matters of reinsurance, some authors argue that the inherently complex and transborder nature of reinsurance schemes implies that arbitration on reinsurance matters is necessarily international.

Arbitration clauses can be included in contracts, before any disputes have arisen. To be valid in domestic arbitration, they must be in writing, designate the arbitrator or arbitrators, or indicate the manner in which they are to be appointed, and determine the subject matter of the dispute. In international arbitration, there are no formal requirements regarding the arbitration agreement. It is, however, recommended to specify the place and language of arbitration, the rules of arbitration to be applied and, where necessary, the governing law.

The forms of procedure (e.g., the content of the request for arbitration or the valid means of communication) should be detailed. Moreover, it is important to state: whether the arbitral tribunal may disregard strict rules of law and decide on an equitable basis; and which remedies, if any, are available against the award.

If a dispute has arisen and no arbitration clause can be identified, the parties can decide to enter into an arbitration agreement whereby they agree to submit the dispute to arbitration. In domestic arbitration, an arbitration agreement, like an arbitration clause, should designate the arbitrators or specify the manner in which they are to be appointed. In addition, arbitration agreements must, in order to be valid, indicate the subject matter of the dispute.
During the pre-arbitration phase, French courts can intervene, at the request of one of the parties, if and when a difficulty arises regarding the appointment of the arbitrators. Moreover, if the arbitral tribunal has not yet been constituted, parties to the arbitration may file a claim for urgent proceedings before a state court for temporary or protective measures. If, however, the arbitral tribunal has been constituted, only the arbitral tribunal has jurisdiction to order such measures.

French courts may have jurisdiction to hand down a judgment on the validity of arbitration clauses, provided the arbitral tribunal has not yet been constituted and the clause at issue is obviously void or unenforceable.

As a general rule, awards cannot be appealed or opposed. However, in domestic arbitration, parties have the possibility to provide in their arbitration agreement that an appeal will be possible. In that event, the appeal will aim either to obtain the reversal or the setting aside of the award, however the court of appeal can only rule in accordance with and within the limits of the arbitral tribunal’s mandate.

In the absence of any agreement on a possible appeal of the award, and in any event in international arbitration, the only possible recourse against an arbitral award is an action to have the award set aside. Contrary to an appeal, the action to set aside an arbitral award can only be brought on a limited number of grounds, some of which are shared between domestic and international arbitrations, while others are specific:

- the arbitral tribunal wrongly upheld or declined jurisdiction;
- the arbitral tribunal was not properly constituted;
- the arbitral tribunal ruled without complying with its mandate;
- due process was violated;
- the award is contrary to public policy (applies only to domestic arbitration);
- the award failed to state the reasons upon which it is based, the date on which it was made, the names or signatures of the arbitrators having made the award, or where the award was not made by majority decision (applies only to domestic arbitration); or
- recognition or enforcement of the award is contrary to international public policy (applies only to international arbitration).

These actions are, however, rarely successful as French procedural law and French courts are particularly respectful of the autonomy of arbitration.

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64 Article 1454, CCP.
65 Cour de cassation, 2nd civil division, 7 March 2002, appeal No. 00-11526.
66 Article 1448, CCP.
67 Articles 1489, 1503 and 1518, CCP. ‘Opposition’ is a form of recourse under French law, available when a judgment is rendered by default because a defendant was not properly notified of a hearing. The defendant can, in such circumstances, ‘oppose’ the judgment in question.
68 Article 1489, CCP.
69 Article 1490, CCP.
70 Article 1490, CCP.
71 Articles 1491 and 1518, CCP.
72 Articles 1492 and 1520, CCP.
Finally, in domestic arbitration, arbitral awards may be challenged by a third party whose interests are adversely affected by the award\(^\text{73}\) and may also be subject to a special remedy before the arbitral tribunal itself, called revision, but only on certain limited grounds, including fraud. In such a case, the award is re-examined by the arbitral tribunal.\(^\text{74}\)

**Evidence**

Arbitral tribunals are granted wide-ranging powers and discretion when it comes to evidence. They may hear all relevant persons or order any party to communicate all relevant documents.\(^\text{75}\)

Arbitral tribunals may order parties to perform any temporary or protective measures they deem appropriate.\(^\text{76}\)

**Costs**

There is no French statutory provision regulating arbitrators’ fees. Consequently, the arbitrators’ fees are set by the arbitrators themselves or by the arbitration institution to which the dispute is referred. Fees are mainly based on the number of hours worked and/or the amount involved in the dispute, and factors such as the complexity of the case, the reputation of the arbitrators, etc. are also taken into account.

The allocation of arbitration costs between the parties is usually decided by the arbitrators and clearly indicated in the award. Arbitration costs include the arbitrators’ fees, as well as the parties’ legal costs.

**iv Alternative dispute resolution**

French jurisdictions and French procedural law are generally in favour of alternative dispute resolution (ADR), which they have increasingly tended to promote.

Parties to any civil or commercial disputes are obligated to try and resolve their dispute amicably before initiating court proceedings.\(^\text{77}\)

Moreover, parties are always free to resort to ADR methods, such as conciliation and mediation.

Conciliation aims to bring the parties closer in order to lead them to reach an agreement. Although the ombudsman issues an opinion on the dispute, he or she is not an arbitrator and the opinion is therefore not binding in any way. Mediation on the other hand requires the third party to be neutral and to refrain from opining.

Conciliation and mediation may be either judicial\(^\text{78}\) or contractual.\(^\text{79}\) When the proceedings are contract-based, parties choose the third party that conducts them. In both instances, parties have to agree to the proceedings: there cannot be an injunction to participate.

Judicial conciliation may be conducted by the judge or by a judicial conciliator appointed by the judge.\(^\text{80}\) Like conciliation, mediation may be either contractual or judicial. Within the

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\(^{73}\) Article 1501, CCP.

\(^{74}\) Article 1502, CCP.

\(^{75}\) Article 1467, CCP.

\(^{76}\) Article 1468, CCP.

\(^{77}\) Article 56-4 Section 3, CCP.

\(^{78}\) Article 127 et seq., CCP.

\(^{79}\) Article 1528 et seq., CCP.

\(^{80}\) Article 128, CCP.
framework of a judicial mediation, subject to the agreement of the parties, the mediation procedure is conducted by a judicial ombudsman. The judicial ombudsman is independent, must possess certain skills and meet specific professional requirements. The judge sets the duration of the mediation, the remuneration of the ombudsman and may end the mediation at the request of the parties, or the ombudsman, or if the normal conduct of the mediation is compromised. When parties have reached an agreement, the judge ratifies it.

Regarding contractual mediation in insurance matters, since 2016, proceedings are handled by the insurance ombudsman. This mediation system is compulsory for insurance companies that are members of the FFA (i.e., the overwhelming majority of the French market). Insurance companies that are not members of the FFA but operate in France can participate in FFA mediation proceedings on a voluntary basis. The insurance ombudsman is independent and may intervene in relation to disputes that arise between insurers, insurance intermediaries and even consumers. Subject to the agreement of the insurer member of the FFA, the insurance ombudsman may also intervene in relation to disputes regarding professional insurance (but excluding large risks). This form of mediation is free and confidential. Parties are not bound by the decision of the ombudsman; however, if the insurer does not intend to comply with the decision, the ombudsman must be informed by letter from the general director of the insurer. Limitation periods are suspended during the mediation proceedings.

V  YEAR IN REVIEW

As far as legal developments are concerned, several 2018 decisions from the Cour de cassation are noteworthy, in that they have an impact on French insurance law or insurance-related disputes.

On 5 July 2018, the Court handed down two decisions that reiterated and clarified the principle according to which an insurer cannot successfully invoke a coverage forfeiture clause triggered by false declarations of the loss made by the insured, unless it can prove that the insured made these false declarations knowingly and in bad faith. Before these decisions, it was unclear whether the insurer was under an obligation to prove the insured’s bad faith to rely on the forfeiture clause. These decisions have now clarified the position at law on this particular issue.

In addition, on 7 February 2018, the Cour de cassation departed from its existing position regarding the fate of a contract’s limitation of liability clauses post-rescission. Until this decision, the Court’s case law held that once a contract was rescinded, none of its clauses (including possible liability limitation clauses) could later be relied upon, as the contract was deemed never to have existed. In this case, the Court reversed its position: these clauses are now deemed to ‘survive’ and remain effective, post-rescission. It follows that the party whose breach led to the rescission is now able to invoke possible liability limitation clauses that were contained in the rescinded contract. This is a significant change on the part of the Cour

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81 Articles 131-4 and 131-5, CCP.
82 Articles 131-10 and 131-13, CCP.
83 Article 131-12, CCP.
84 Cour de cassation, 2nd civil division, 5 July 2018, appeals Nos. 17-20488 and 17-20491.
85 Cour de cassation, commercial division, 7 February 2018, appeal No. 16-20352.
86 See, for instance, Cour de cassation, commercial division, 5 October 2010, appeal No. 08-11630.
de cassation, although there are limits to the ways these clauses can be relied upon; if, for instance, they are deemed to negate the very substance of a party’s contractual obligations, then they would be deemed null and void, pursuant to Article 1170 of the CC.

With regard to the insurance industry, 2018 was a noteworthy and eventful year in France, as several high-level mergers occurred or were otherwise authorised: French insurance heavyweight AXA acquired XL, and two additional mergers were authorised between AG2R La Mondiale and Matmut (two significant French mutual insurance companies) and Malakoff Médéric and Humanis (two smaller entities that specialise in health insurance and pensions).

Finally, Brexit has continued to shape the European and global insurance market as several key players that previously managed their European affairs from the United Kingdom have begun to relocate their activities on the continent to keep benefiting from the EU passport for financial services. Some global insurers and financial institutions have chosen to relocate their European offices to France, such as HSBC and Chubb.

VI OUTLOOK AND CONCLUSIONS

Insurance distributors’ duties and obligations were greatly increased in 2018 (in terms of market reviews, conflicts of interest, professional requirements, etc.) owing to the entry into force of the Insurance Distribution Directive. Moreover, Regulation (EU) No. 2016/679 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (the General Data Protection Regulation) also entered into force in 2018, generating further compliance pressure on insurers. While these obligations are too recent to have generated any case law of note at this stage, relevant decisions should start being handed down in 2019, which will no doubt be of particular interest to both insurers and the legal community, and should lead to detailed scrutiny.

The conclusion of the institutional process for the amendment of Solvency II is also expected in 2019, which should also be scrutinised closely.
Chapter 16

GERMANY

Markus Eichhorst

I INTRODUCTION

Approximately 909 foreign insurers are underwriting direct risks on the German market, either through a branch or, for the majority, by offering services from their foreign places of business. Most of these insurers are based in countries of the European Economic Area (EEA). Approximately 1,278 German underwriters add to this number. All of these underwriters together achieved a turnover related to direct insurance of €114 billion in non-life insurance and €90.4 billion in life insurance, of which €5.9 billion and €5.2 billion respectively was generated by EEA insurers. Many of the German insurers are small-capital companies or mutuals that are only active within narrow geographical limits. The Federal Financial Supervisory Authority (BaFin), the German insurance supervisory authority, lists 37 actively operating reinsurers that have their seat in Germany and seven that are seated in the EEA as at 31 December 2018.

The implementation of Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the Taking-up and Pursuit of the Business of Insurance and Reinsurance (Solvency II) into German law focused on the capital backing of insurers. Despite initial expectations that the Solvency II requirements might not come into force before 2017, on 6 March 2015 the Bundesrat (representation of the German federal states) approved the Parliament Act on the Modernisation of the Financial Supervision of Insurance Companies, which implemented the Solvency II regime into national law. The German Solvency II legislation came into force on 1 January 2016. Under the Solvency II regime, both low interest rates and capital requirements were identified by reinsurers as drivers for reinsurance solutions and by the growing number of run-off service providers as

1 Markus Eichhorst is a partner at Ince & Co Germany LLP.
2 BaFin (www.bafin.de), 2017 Statistic – Insurance undertakings and pension funds, p. 10 f.
3 In 2017, in total 86; BaFin, p. 10.
4 In 2017, in total 823; BaFin, p. 10.
5 In 2017, only three non-EEA underwriters maintained a branch in Germany, BaFin, p. 10.
6 In 2017; BaFin, p. 11.
7 In 2017; BaFin, p. 10.
9 President of BaFin Elke König's speech of 22 January 2013 (www.bafin.de/SharedDocs/Reden/DE/re_130122_neujahrspresseempfang_p.html).
drivers for run-off solutions. As required by European law, insurers may transfer portfolios to other insurers in a Member State of the European Union, which, since 2008, also applies to reinsurers (Section 166 of the German Insurance Supervision Act (VAG)). Germany is far from being a haven for run-off services, however, as German law does not recognise the English concept of ‘schemes of arrangements’ and the Federal Supreme Court held in 2012 that English court orders on the approval of these schemes are not enforceable in Germany. This fits with the German approach of being somewhat protective with regards to the position of the insured, often without any strict differentiation as to whether an insured is a consumer or a business entity.

II REGULATION

BaFin supervises insurers on behalf of the federal government. Insurers of less economic significance, and especially those that operate within only one of the federal states, may be supervised by supervisory bodies of one of Germany’s federal states. BaFin currently supervises approximately 43 per cent of German insurers. Insurers supervised by BaFin nevertheless achieve 99.9 per cent of the total earnings of both groups, which underlines its economic significance. Pension funds and domestic reinsurers are also subject to BaFin’s supervision, whereas statutory insurance institutions (statutory accident, unemployment, pension, health institutions) are not.

Insurance companies require a licence to operate. Under the single licence principle, insurers who have obtained a licence in another EEA Member State do not require a further licence to operate in Germany. These insurers may conduct business in Germany in accordance with their right to provide services under Article 56 of the Treaty on the Functioning of the European Union (TFEU) or through a branch in Germany in accordance with their right under Articles 49 to 52 TFEU. However, before commencing business from a branch in Germany, certain notification requirements must be met (Section 61 VAG and Section 169 VAG for reinsurance companies).

EEA insurers are subject to the financial and legal supervision of their home countries and, in respect of their German operations, additionally to the legal supervision of BaFin (Section 62 VAG).

In light of the Brexit negotiations it remains to be seen if and how insurance companies that have their home Member State in the United Kingdom and a licence from the Prudential Regulatory Authority (PRA) are allowed to conduct their business in Germany. BaFin stated that a ‘hard Brexit’ would cost UK insurance companies their Member State status in accordance with Section 7 No. 22 VAG. Instead the United Kingdom would be considered a third country pursuant to Section 7 No. 6 VAG. As a result, the company could no longer legally operate in Germany with a licence from the PRA pursuant to Section 61 VAG. In

12 Judgment of 15 February 2012 – IV ZR 194/09.
13 In 2017, 552 under federal supervision and 726 under supervision of the federal states; BaFin, 2017 Statistic – Insurance undertakings and pension funds, p. 11 f.
14 In 2017, €214,809,657,000 under federal supervision and €43,438,100 under supervision of the federal states; BaFin, p. 12 f.
15 Certain EU and EEA insurers, such as mutuals with low premium income, are excluded, but nevertheless require a licence pursuant to Section 110(d) VAG.
16 BaFin (https://www.bafin.de/DE/Aufsicht/Uebergreifend/Brexit/Versicherer/brexit_node.html).
order to soften the effect of a possible hard Brexit, Germany started the legislative process for a temporary legal solution included in the draft bill on Tax-Related Provisions accompanying the Withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union. Section 66(a) of this draft bill allows BaFin to declare Sections 61 to 66 and 169 VAG applicable for UK-based insurance companies that will operate in Germany until December 2020 in order to fulfil concluded contracts. It is not clear how and to what extent BaFin will use this newly created discretionary power, which has been criticised by the German Insurance Association.

Only public limited companies, mutuals or public law institutions can obtain a licence from BaFin. Documents to be submitted with the application include, *inter alia*, a business plan describing the risks that are intended to be covered, the reinsurance policy, proof of sufficient funds to cover the risks (minimum guarantee fund – the required quantum depends on the class of insurance) as well as sufficient funds to develop a business and sales organisation (organisation fund). At least two senior managers or executive directors need to demonstrate that they are sufficiently qualified and experienced to run the business.

The principle of business separation applies, which means that an insurer cannot obtain a licence for all classes of business (e.g., an insurer that has been granted a licence to cover life risks cannot obtain an additional authorisation for property risks).

Insurance supervision comprises legal and financial supervision. In respect of legal supervision, BaFin supervises whether insurers comply with all statutory requirements (Section 294 VAG). In respect of financial supervision, BaFin controls whether insurers comply with the principle of good business practice, which requires them to maintain proper accounts, consider risks under the insurance contracts and finance risks for their investments properly, maintain a proper risk management system, and keep sufficient funds (solvency). Generally, an insurer must refrain from conducting non-insurance business in order to avoid non-insurance related business risks.

Pursuant to Sections 294 and 298 VAG, BaFin can make any orders that are appropriate and necessary to avoid deficiencies or bring these to an end and, if necessary, withdraw the insurer’s licence under Section 304 VAG. The VAG sets out additional competences for BaFin, such as being able to prohibit a manager who has recklessly breached obligations from continuing to work in his or her function pursuant to Section 303 VAG.

In accordance with EU Directive 2002/92/EC of 9 December 2002, all persons who intend to distribute insurance products require a licence. This Directive has been implemented into German law in Sections 11a, 34d and 34e of the German Trade, Commerce and Industry Regulation Code, and in the Insurance Broking and Advice Regulation.

III  INSURANCE AND REINSURANCE LAW

i  Sources of law

German material insurance law is primarily set out in the Code on Insurance Contracts (VVG). The rules of the VVG initially came into force in 1908 but were considerably changed in a reform that came into effect in 2008. As a consequence of this reform, judgments on the interpretation of the VVG rules of courts and other publications need to be considered carefully to establish whether they refer to the old or the current rules.
The reform’s purpose was to modernise German insurance law, and especially to improve the position of the insured.\(^\text{17}\) Although the VVG is always focused on consumer protection, its rules also apply to non-consumer insurance contracts. The VVG’s only differentiation between consumer and some non-consumer insurance contracts is that the insurer of consumer risks cannot deviate from most of the rules of the VVG to the detriment of the insured so that the VVG provides a minimum standard of consumer protection, whereas the parties to insurance contracts on specific non-consumer risks can, to a certain extent, deviate from all VVG provisions as dealt with further below. These specific non-consumer risks that allow deviations from the provisions of the VVG pursuant to Section 210 VVG are large risks and risks covered under open policies. However, this does not mean that there are no limits for deviations even where they are generally allowed. Insofar as the VVG generally applies, it sets out the overall concepts as to what rights and obligations German law considers a fair balance between the potentially colliding interests between insurer and insured. The rules on unfair contract terms impose limits on any deviation from the overall legislative concepts even in purely business relationships without any consumer involvement. The evaluation of whether a deviation from general statutory concepts is sufficiently balanced (and, therefore, valid) often gives German courts considerable discretion. This leads to considerations in German judgments that might appear odd, especially to foreign practitioners. Judgments on the claims-made principle or costs clauses in directors’ and officers liability’ (D&O) insurance contracts are good examples (discussed below).

Large risks (as opposed to mass risks), which determine whether an insurer is generally able to deviate from provisions of the VVG that otherwise were compulsory, are – partly by reference to VAG provisions – set out in Section 210(2) VVG. The term large risks and the risks so classified have their origin in European law, and have been introduced by Article 5 of the Second Council Directive 88/357/EEC of 22 June 1988 ‘on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 73/239/EEC’. Large risks are, \textit{inter alia}:

\begin{itemize}
\item[a] railway rolling stock: all damage to railway rolling stock;
\item[b] aircraft: all damage to aircraft;
\item[c] ships (sea, lake and river vessels): all damage to river, inland waterway and sea vessels;
\item[d] transported goods: all damage to transported goods irrespective of the means of transport;
\item[e] all liabilities arising from land transport;
\item[f] aircraft liability: all liabilities arising out of the use of aircraft (including carrier’s liability); and
\item[g] liability for vessels (river, inland waterway and sea vessels).
\end{itemize}

Other risks, such as land vehicles (other than railway rolling stock), fire and natural forces, all other damage to or loss of property and general liability are only large risks if the insured’s business fulfils at least two of the following criteria: the balance sheet total is more than €6.2 million; the net turnover is more than €12.8 million; and, on average, there are more than 250 employees during the financial year.

\(^{17}\) Entwurf eines Gesetzes zur Reform des Versicherungsvertragsrechts of 20 December 2006, Bundestagsdrucksache 16/3945, p. 1.
Consequently D&O risks, although not consumer-related, may, depending on the size of the insured's business, not be qualified as large risks, and may, therefore, be exposed to the same rules as a consumer insurance contract.

Open policies, which also allow an insurer to deviate from the provisions of the VVG (within certain limits), are insurance contracts under which certain categories of risks are insured while the individual risk that is actually covered only materialises at a later stage (Section 53 VVG) (e.g., all shipments within a particular year). Transport policies are usually set up as open policies.

Marine insurance was historically not governed by the VVG. The above considerations on the VVG's general concepts and the potential consequences of any deviations in well-established marine insurance conditions for their validity are the reasons why marine insurance practitioners were opposed to initial plans of the 2008 insurance law reform to include marine insurance in the VVG. They succeeded, and marine insurance remained completely excluded from the scope of the VVG as per its Section 209. In this respect, the official explanatory statement of the legislature for the 2008 VVG reform is noteworthy as it admits the existence of a considerable legal uncertainty if the consumer-related general concepts of the VVG applied generally on marine insurance. It was felt that this might disadvantage German marine insurers, so marine insurance was totally excluded from the scope of the consumer-oriented VVG. Other purely business-related insurance contracts, such as industry property or D&O, are not excluded and are therefore exposed to courts' considerations as to whether any deviations from the consumer-oriented VVG concepts are sufficiently fair (see subsection ii).

Reinsurance contracts are also exempted from the scope of the VVG, so that the general rules of civil law set out in the German Civil Code (BGB) apply.

### Making the contract

#### Contracts under the rules of the VVG

An insurance contract, as any contract, requires a contract offer of one party and its acceptance by the other party. Usually, the insured makes the contract offer (application) by requesting from an insurer cover for certain risks, usually by filling in the insurer's forms (which refer to the insurer's general insurance terms and conditions) and by answering the insurer's questions. This, of course, requires the insured to obtain some information from the insurer on its insurance products including application forms before making the application.

Prior to the 2008 VVG reform the insurer, when willing to insure the risk, accepted the insured's application by way of providing the insured with the policy, which sets out the risks covered, the premium, other specific conditions, and the general terms and conditions. The insurance contract was concluded on the basis of the provisions in the policy and all conditions to which it referred. Unless large risks are concerned, the 2008 VVG reform modified this procedure as follows: prior to the reform it was sufficient that the insured received information on the scope of cover, premium and especially the insurer's general terms and conditions only with the insurer's acceptance of the insured's contract application. This was called the policy model, as in insurance law it was deemed sufficient that the insured received the insurer's insurance conditions only with the insurer's acceptance of the insured's insurance application, that is, together with the insurance policy – hence, policy model. In

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18 id., p. 115.
respect of non-large risks, the 2008 VVG reform requires an insurer to provide the insured with relevant information, including the insurer’s general insurance terms and conditions, prior to the insured’s contractually relevant declarations (i.e., normally its insurance application). This is called the application model. In this respect, the VVG reform intended to enable the insured to make an informed decision on whether to submit an insurance application, which requires that it received sufficient information from the insurer beforehand. Further information requirements apply, mainly in respect of risks other than large risks, which cannot be summarised here (e.g., under an information regulation).19

The insurer’s acceptance of the insured’s application can still deviate from the insured’s contract application, provided the insurer gives to the insured a conspicuous notice that the insurance certificate deviated from the insured’s application and the ways in which it did so; informs the insured of its right to object to these deviations within one month; and informs the insured that its failure to object in a timely manner is statutorily deemed as the insured’s acceptance of the deviations.

If the insurer complies with these notification requirements and the insured does not object within one month of receipt of the insurance certificate, the insurer’s deviations are deemed accepted by the insured. If, however, the insurer does not comply with its notification requirements, the insurance contract is concluded on the basis of the insured’s application.

Insurers (insofar as large risks are not affected) are exposed to further obligations prior to the conclusion of an insurance contract: they are obliged to enquire about the insured’s insurance needs, to advise on these needs and on adequate insurance solutions, and to document the contents of the advice and its reasons. Apart from the exclusion of large risks from this obligation, this does not apply if the contract is concluded through an insurance broker (Section 6(6) VVG), which then has to comply with the advice and information obligations instead. The insured may, however, waive in writing its right to be advised and informed.

If the insurer fails to comply with these obligations, it may be liable to indemnify the insured for any losses caused. Moreover, the insurer’s general insurance terms and conditions may not be validly incorporated into the contract.

Generally, the insured is entitled to withdraw from its contract application (so that the insurance contract ends retroactively) within two weeks of receipt of the insurance policy or certificate if properly advised on this right in text form (text form includes emails, which would not be qualified as written form under the law). Exceptions apply especially for insurance contracts for large risks, for some provisional cover notes and for insurance contracts of less than one month.

**Insurance contracts not subject to the VVG**

The conclusion of insurance contracts that are not subject to the VVG (marine insurance and reinsurance) is governed by the general rules of the BGB and, therefore, only require offer and acceptance without any further compliance requirements. It is sufficient to simply refer to general insurance conditions in order to incorporate them into the contract without actually providing the insurer’s terms and conditions.

19 Regulation on Information Obligations for Insurance Contracts.
**Disclosure and representation**

Pursuant to Section 19(1) VVG, the insured is under an obligation to disclose to the insurer all known circumstances prior to conclusion of the insurance contract that (1) are relevant for the insurer's decision to enter into the insurance contract with the agreed contents and (2) that the insurer requests the insured to answer specifically in text form (text form includes emails, which would not be qualified as written form under the law). This includes a prohibition to make false representations. Usually, all circumstances that the insurer requests specifically are relevant for its decision, although there may be exceptions. As a consequence of the 2008 VVG reform, the insurer can no longer expect the insured to disclose any circumstances not specifically asked for, so there is no longer any doctrine comparable to the English concept of utmost good faith (requiring the insured to disclose anything material for the risk even without any specific questions) under the rules of the VVG.

As they are not subject to the rules of the VVG, marine insurance and reinsurance contracts may still require the insured to disclose even material circumstances without any specific questions of the insurer. For example, Section 19 of the General German Marine Insurance Conditions still requires the insured to disclose all material circumstances that are relevant for the insurer's acceptance of the risk without the requirement to submit specific questions. It should also be possible to agree on similar terms for large risks falling under the provisions of the VVG, although this has not yet been tested in court.

The insurer has alternative remedies if the insured breaches this obligation, which primarily depend on the degree of the insured's misconduct and always provided that the insurer had notified the insured of the consequences of any breach:

- The insurer may (retroactively) withdraw from the contract (Section 19(2) VVG) unless the insured did not breach its disclosure or representation obligation intentionally or with gross negligence. The insured is under the onus of proving lack of intention or gross negligence.
- If the insured did not act intentionally or with gross negligence, the insurer is entitled to terminate the insurance contract within one month (which does not affect the insurer's obligation to cover any insured losses before the termination becomes effective).
- Unless the insured breaches its disclosure or representation obligation intentionally, the insurer's right to withdraw from or to terminate the contract is excluded if the insurer had concluded the contract (even with different contents) if it knew of the undisclosed circumstances. The insurer may then only request that the insurance contract be adapted to such other conditions. This effectively means that certain risks are excluded, the premium is increased, or both.
- All of these remedies will expire within one month of receipt of knowledge of the insured's infringement of its disclosure or representation requirements (Section 21(1) VVG).
- If the insurer withdraws from the contract after an insured event occurred, it is not obliged to cover the losses, unless the insured's breach of disclosure or misrepresentation obligations refers to circumstances that were neither relevant for the occurrence of the insured event nor for the insurer's determination of the insured event and the scope of its obligations under the insurance contract.
- If, however, the insured maliciously infringed its disclosure or representation obligations, the insured is not obliged to cover the loss (Section 21(2) VVG).
g. The insurer’s right to withdraw or to terminate the contract expires five years after the conclusion of the contract, unless the insured breached its obligations intentionally and maliciously, in which case it is 10 years.

h. In any case, the insurer may challenge the contract in accordance with the general civil rules applicable to a malicious deception (Section 22 of the VVG).

In summary, the consequences of the insured’s breach of its disclosure or representation obligation depend on the insured’s degree of fault and, partly, on whether the insurer would have entered into an insurance contract (even with additional risk exclusions or with an increased premium, or both) had it known the actual facts or circumstances. The following table gives an overview on the most relevant situations. It is based on the assumption that the insured’s breach of disclosure or misrepresentation obligations refers to circumstances that were relevant for the occurrence of the insured event, or for the insurer’s determination of the insured event or the scope of its obligations under the insurance contract.

<table>
<thead>
<tr>
<th>Intentional misconduct</th>
<th>Withdrawal from the contract (retroactively).</th>
</tr>
</thead>
<tbody>
<tr>
<td>No misconduct or simple negligent misconduct and the contract would not have been concluded had the insured not breached its obligations (i.e., informed the insurer as legally required)</td>
<td>Termination, which becomes effective one month after the insured’s receipt of the insurer’s termination declaration.</td>
</tr>
</tbody>
</table>

| Gross negligent misconduct and the contract would not have been concluded had the insured not breached its obligations (i.e., informed the insurer as legally required) | Adoption of the contract as of inception of the insurance contract (e.g., by way of the insurer’s request to exclude certain risks or to increase the premium, or both). |
| Gross negligent misconduct and the contract would have been concluded (with different terms) had the insured not breached its obligations (i.e., informed the insurer as legally required) | Adoption of the contract as of the current insurance year (e.g., by way of the insurer’s request to exclude certain risks or to increase the premium, or both). |

The potential affect on coverage has not yet been clarified by the courts. The retroactive adoption, if relevant risks were excluded, might have the odd result that coverage of a certain insured event might be excluded retroactively, although a simply negligent misconduct should not affect coverage at all (see box above).

Judgments on this issue have not been published. However, it seems unlikely that the courts would, in this situation, allow an insurer to avoid coverage for occurrences that occurred prior to the insurer’s demand to adopt the contract. The legal uncertainties of this situation raise doubts as to whether the legislature fully understood its somewhat complicated rules and their consequences.

The above rules provide for considerable judicial discretion in potential legal disputes and corresponding legal uncertainties in applying these rules in specific cases, which the legislature nevertheless accepted for assumed fairness considerations.

iii. Interpreting the contract

Insurance terms and conditions are to be construed objectively (i.e., by reference to the hypothetical understanding of an average insured that has no specific insurance or legal expertise). The starting point of any interpretation is the wording, its objective sense and
the systematic context in which a particular clause is contained. All relevant contractual information, including the insurance certificate, product information sheets or other product information, may serve as an interpretation aid.

The courts tend to interpret exclusion clauses (i.e., clauses that limit the coverage for certain risks or impose certain additional limitations for coverage) narrowly as the insured does not have to expect potential gaps in the coverage that the clause does not sufficiently clarify.20

Insurance conditions are usually qualified as general terms and conditions of the contract within the meaning of the civil law provisions on unfair contract terms as set out in Section 305 et seq. BGB. Pursuant to Section 305c(2) BGB, any uncertainties as to the interpretation of those general terms and conditions (including insurance conditions) are to the detriment of the party that introduced the conditions into the contract (contra proferentem). This is usually the insurer. It follows that this interpretation method is not applicable (at least not against the insurer) if it was not the insurer who introduced certain insurance conditions into the contract. This may be the case for some broker insurance conditions if the broker developed the conditions and then obtained insurance coverage under these conditions. The Federal Supreme Court confirmed this in respect of particular D&O insurance conditions of one of Germany’s leading D&O insurance brokers.21

There is a further interpretation rule that applies to the differentiation of the definition between risks and their exclusion or limitation and the insured’s obligations. Pursuant to Section 28 VVG, the parties may agree on certain obligations in the insurance contract with which the insured has to comply. The consequences of the insured’s breach of such obligations depend on the degree of its negligence, so that the insurer is not necessarily entitled to avoid coverage. Contrary to this, losses are not covered that are caused by an excluded risk (without any reference to negligence considerations). A clause phrased in a way that it seems to describe a risk and the objective scope of coverage may nevertheless be construed as an obligation of the insured. By way of example, the hull insurance conditions for inland waterway vessels (AVB Flusskasko 2000) exclude any damage or loss caused by a vessel not being fit for the voyage, ‘especially not being sufficiently equipped, manned or laden’. In a judgment of 11 February 1985,22 the Federal Supreme Court considered this to be an objective exclusion of a risk (meaning losses caused by an unfit vessel are excluded from coverage). In a judgment of 18 May 2011,23 the Federal Supreme Court changed its previous view and found that the clause is to be considered as setting out a ‘disguised obligation’. It held that the wording and systematic position of a clause are irrelevant for its qualification as either a (disguised) obligation or as an exclusion of risk. According to the Court, it matters whether the clause either describes a specific risk or whether it primarily requires a specific behaviour of the insured. Consequently, German law and practice requires a careful analysis of whether a particular clause is to be qualified as description of a risk (including limitations and exclusions) or as setting up an obligation of the insured. This analysis must not focus on the clause's wording, as the wording and systematic position of a clause (and the intention of the parties to the insurance contract) are irrelevant. The reason behind this approach is to

21 Court Order of 22 July 2009 – IV ZR 74/08.
avoid insurers circumventing the restrictive rules on avoidance of coverage for the insured’s breach of obligations, so the courts are rather sceptical about potential risk exclusion clauses that could alternatively have been phrased as a clause requiring a certain behaviour of the insured (in the above case, the behaviour to commence the voyage only with a vessel that was fit for the journey).

The concept of disguised obligations is increasingly perceived as alien to the method under which contracts are to be interpreted, and is being criticised (even by Federal Supreme Court judges). Nonetheless, the Federal Supreme Court handed down a judgment on 14 May 2014 in which it reiterated the concept of the disguised obligation. The insured sued under aircraft liability insurance. He sought cover for an accident that occurred during the start of an air show. The co-insured pilot crashed into spectators, killing two of them and leaving several injured. The insurer rejected coverage because the pilot flew without a valid licence. Under Section 4 of the Liability Insurance Conditions, ‘exclusion’ cover was excluded ‘if the pilot lacked the necessary permit, license or certificate of competence’. The Court held that the clause was a disguised obligation and not an exclusion of risk because the cover depends on the conduct of the insured. Since aircraft liability insurance is a large risk pursuant to Section 210(2)(1) VVG it seems that the Federal Supreme Court applies the differentiation to all large risks and open policies.

It has not yet been tested whether the courts would apply this differentiation method in the same way on marine insurance (the insurance of inland waterway vessels is not classified as marine insurance under the law), which is not subject to the VVG rules. Therefore, the parties should be able to freely agree on whether they want an exclusion of a specific risk or an obligation that should, as usual, be determined primarily by reference to the wording of the clauses.

**Types of terms in insurance contracts**

The law differentiates between terms that describe the risk including risk-related objective limitations, or exclusions or other objective requirements for compensation and the insured's obligations. Clauses that do not constitute contractual obligations of the insured can simply be construed under application of the rules explained above. If the requirements set up by such clauses are fulfilled, they trigger the consequences set out in the contract. The position is more complicated in respect of the insured’s contractually agreed obligations, as the consequences depend on the degree of the insured’s negligence and also partly on causation issues.

The breach of a contractual obligation is not comparable with a breach of a warranty under English law. The VVG sets out a differentiated system of remedies, depending on the specific circumstances of any case, as follows (ignoring some constellations and minor formal requirements):

- The insurer is entitled to terminate the contract unless the insured’s breach of a contractual obligation was not intentional or grossly negligent. For termination purposes, the insured is under an onus of disproving the assumption of intent and gross negligence (Section 28(1) VVG).
- The insurer is entitled to avoid coverage fully if it proves that the insured intentionally breached its contractual obligation.

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In cases of a grossly negligent breach of a contractual obligation, the insurer is entitled to reduce the contractual compensation promised under the contract in proportion to the gravity of the insured’s fault. This was one of the crucial parts of the 2008 VVG reform that abolished the ‘all or nothing’ principle, which meant that the insurer either granted coverage in full or not at all. Now, the insurer is required in cases of gross negligence to compensate the losses partly to an extent that depends on the gravity of the insured’s fault. In respect of coverage (as opposed to termination) the insured is to disprove the assumption of gross negligence if it intends to avoid these consequences.

The above does not apply if the insured proves that its breach of a contractual obligation was not causal for the occurrence or determination of the insured event, or for the determination or the scope of the insurer’s obligations under the insurance contract.

If the insured breached a contractual obligation maliciously (to be proven by the insurer), causation does not matter.

The following overview clarifies the various positions.

<table>
<thead>
<tr>
<th>Malicious intent – to be proven by the insurer</th>
<th>No coverage; no causation considerations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross negligent breach of contractual duties (either prior to or after the occurrence of an insured event) – in this respect, gross negligence is statutorily assumed, so that a party who wants to invoke an ‘intentional breach’ (the insurer) or a ‘simply negligent breach’ (the insured) has to prove this</td>
<td>The insurer may reduce the contractual compensation in proportion to the insured’s fault (which may be up to 100 per cent), unless the insured proves lack of causation. Since the 2008 VVG reform came into force, a considerable number of judgments have been published as to what percentage compensation may be reduced to in various situations, which has resulted in prejudiced case law developing.</td>
</tr>
<tr>
<td>Intentional breach – assumption of gross negligence to be disproved by the insurer</td>
<td>No coverage, unless the insured proves lack of causation.</td>
</tr>
<tr>
<td>Negligent breach – assumption of gross negligence to be disproved by insured</td>
<td>Full coverage.</td>
</tr>
</tbody>
</table>

Similar provisions apply in respect of an increase of risk caused by the insured that is prohibited under Section 23(1) VVG or an increase of risk not notified to the insurer (Section 23(2)). Depending on the gravity of the insured’s breach, the insurer may avoid coverage, reduce the compensation or terminate the insurance contract, or both (Sections 24 and 26 VVG). Section 81 VVG expressly sets out that the insurer is not obliged to make any compensation if the insured intentionally causes the insured event. If the insured causes the insured event with gross negligence, the insurer is entitled to restrict its compensation in proportion to the gravity of the insured’s negligence.

Again, these rules do not apply to marine insurance and reinsurance (Section 209 VVG). German marine insurance conditions do not have such a sophisticated system of consequences of the insured’s breach of obligations. Paragraph 23 of the DTV Hull Clauses (DTV-Kasko 1978/2004), for example, discharges the insurer from liabilities caused by a vessel that was unseaworthy when the journey commenced, unless the insured could not have avoided this with reasonable care. Therefore, any fault of the insured enables the insurer to avoid coverage fully without any need to differentiate between various degrees of negligence, so that the all or nothing principle even exists for ‘ordinary’ negligence. This exceeded and still exceeds the provisions of the VVG before the reform in 2008.

In respect of large risks in accordance with Section 210 VVG, the parties to an insurance contract can agree that gross negligence of the insured enables the insurer to avoid coverage fully as under the insurance of large risks deviations from the VVG provisions are possible.
This view was also held by the Hamburg Appeal Court in a 2018 judgment. It stated that the all or nothing principle for gross negligence can be agreed upon in an insurance of a large risk. It therefore remains to be seen whether this principle can be agreed upon for any negligence in a large risk or an open policy in accordance with Section 210 VVG. The Cargo Insurance Conditions (DTV-Güter 2000/2008) already restrict the all or nothing principle to cases of gross negligence and intent.

Any fault of a person who is deemed to be the representative of the insured is attributable to the insured. This includes any person to whom the insured entrusted the administration of the insured risk, so this person should comply with the insured’s obligations irrespective of whether he or she is the insured’s director or may otherwise legally represent the insured. As there is no easily applicable test as to whether a person is qualifies as the insured’s representative in a particular situation, there are various (non-binding) precedents to determine this. The captain of a vessel, for example, qualifies as the shipowner’s or insured’s representative in respect of a marine hull policy, but is not the representative of cargo owners under the transport policy.

Validity of clauses

Various provisions of the VVG are compulsory in a way that they cannot be derogated from to the detriment of the insured, unless large risks are concerned.

In respect of large risks and open policies, the parties are generally free to deviate from the provisions of the VVG (Section 210 VVG). However, as already mentioned in subsection i, the VVG provides for an overall legislative concept of a fair balance between the rights of the insurer and the insured. Insofar as the VVG generally applies (including large risks and open policies, and excluding marine insurance and reinsurance), an insurer is not entitled to deviate from the provisions of the VVG without any limitation in its general terms and conditions of contract. The following two judgments on D&O insurance clauses clarify the position.

In an often-quoted judgment of the Appeal Court of Munich, the Court considered whether the claims-made principle contained in D&O insurance conditions was valid as it is alien to the occurrence principle of German liability insurance practice. Claims-made liability policies define the insured event in general as the actual pursuance of a claim (with modifications) irrespective of when the event that caused such claims occurred. The occurrence principle defines as the insured event the actual occurrence that led to claims, irrespective of when these claims are pursued. As opposed to the occurrence principle, the claims-made principle might disadvantage an insured insofar as it might not be entitled to coverage if claims are only pursued against it after the expiry of the liability policy even if this policy was in place when the event occurred that caused the claims. The Appeal Court of Munich considered carefully whether this disadvantage is sufficiently balanced with the advantages the claims-made policy provided to the insured and found that this was the case. Consequently, the Court confirmed the validity of the claims-made principle. However, the reason for this was only that the policy also contained the usual clause according to which claims are even covered after the expiry of the policy if they are notified to the insurer within one year of the expiry of the liability policy, and that even claims that were caused prior to the inception of the policy are covered. Today, there is no doubt that the claims-made principle,

as defined in D&O insurance conditions, is valid. Nevertheless, the Munich judgment serves as a good example that German courts will always carefully consider whether any deviations from VVG provisions and its legislative concepts are sufficiently balanced.

D&O insurers were less fortunate in a dispute on which the Appeal Court of Frankfurt handed down a judgment on 9 June 2011. The Court considered the usual clause that the costs of legal proceedings ‘including lawyers’, experts’, witness’ and court costs are contained in the maximum amount insured’ to be invalid as it found this to deviate in an unbalanced way from the overall legislative concept of the VVG according to which an insurer is to indemnify such costs in addition to the maximum liability agreed in the insurance contract. It is doubtful whether other courts will follow this approach, although the Federal Supreme Court has not overruled this position to date. However, this judgment again underlines that German law provides for considerable uncertainties in its effort to protect consumers and business entities alike. This also confirms that marine insurance practitioners were right in their successful effort to exclude marine insurance from the scope of the VVG provisions totally, which has never been an issue in respect of reinsurance.

iv Intermediaries and the role of the broker

The VVG differentiates between the insurer’s agents and brokers. Agents are persons or entities that the insurer entrusted with the task of concluding or arranging insurance contracts (Section 59(2) VVG). Agents act on behalf of the insurer. Persons or entities that arrange insurance contracts between an insurer and an insured ‘without doing so on behalf of an insurer’ (Section 59(3) VVG) are brokers. This usually means that the insured instructs the broker to arrange coverage. Any misconduct or knowledge of the agent is attributable to the insurer, while this, in principle, is not the case for brokers. However, in 2011 the Appeal Court of Karlsruhe found that a broker’s misconduct in giving improper advice to the insured was attributable to the insurer, as the latter did not have an independent distribution system but exclusively relied on the services of brokers. If, according to the court’s reasoning, an insurer uses brokers to distribute its products, and if additionally there are no clear indications that the broker undertook to obtain coverage on behalf of the insured by choosing a suitable insurer rather than working together with one particular insurer, the broker acted as an agent would have done. The Court found that the insurer then should be treated as if the broker was an agent.

v Claims

Claims are to be notified to the insurer without undue delay. Any failure to do so is a breach of an obligation subject to the sophisticated consequences set out above, so that a breach does not necessarily release an insurer from its coverage obligation. The insurer is then required to investigate the matter and decide on coverage quickly. Although the principle of good faith is a cornerstone of German civil law, its practical effects can be seen more in the way contracts are construed, and contract terms might be invalid if they are considered to be grossly unbalanced. However, there is no particular concept of utmost good faith with particular legal consequences in German insurance law. If an insured submits a fraudulent claim, the usual civil law and insurance remedies apply: the insurer may, in exceptional circumstances, rescind the contract

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pursuant to Section 123 BGB if it is able to prove that the insured already entered into the contract with the intention to deceive the insurer. Other cases are subject to the consequences of a breach of obligations set out above, and may additionally allow the insurer to claim damages for losses reasonably suffered, especially costs for investigating the matter.

An unjustified rejection of claims or a delayed decision on coverage has no particular consequences. The insured may then simply sue the insurer. However, any obligations owed by the insured to the insurer under the insurance contract (e.g., obligation to cooperate with the insurer, and to provide any information or disclose any document the insurer considers necessary) cease as a consequence of the insurer’s rejection.

The insurer may set off any open premium claims under an insurance contract from any claims payable under such contract, even if the insured person is not the insurer’s contractual partner, and therefore does not owe the premium (Section 35 VVG).

The indemnification of the insured person leads to an automatic transfer of potential recourse rights against third parties to the insurer. The effect is comparable to an assignment from the insured person to the insurer that, however, is effected automatically simply by the insurer’s act of making the payment to the insured person. The insured is under an obligation to protect any recourse claims and to cooperate with the insurer in enforcing such claims (Section 86(2) VVG). The insured’s failure to do so may be a breach of its obligations subject to the sophisticated consequences set out above. This means that the insurer may not necessarily be able to avoid coverage as a consequence of the insured’s breach of this obligation.

The main difference between an automatic transfer of rights under the VVG and a subrogation under English law is that after the transfer the insurer is the recourse claimant, so that it may sue in its own name and also becomes a party to a recourse action.

IV  DISPUTE RESOLUTION

i  Jurisdiction, choice of law and arbitration clauses

Pursuant to Section 215 VVG, the insured is entitled to sue the insurer at the place where the insured is based. The court at the insured’s place of business is exclusively competent for claims against it. The parties are free to deviate from this in respect of large risks, although this has not yet been confirmed in judgments. In any event, Regulation (EU) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, which is applicable if a person domiciled in a Member State is sued in another Member State, prevails.

Any agreements on the applicable law are subject to Regulation (EC) No. 593/2008 of 17 June 2008 on the law applicable to contractual obligations (Rome I), which will not be dealt with as Germany directly applies this Regulation as part of European law.

Arbitration clauses are commonly (albeit not only) used in marine insurance and reinsurance contracts. They are rarely used in other insurance contracts, even if large risks are concerned. Arbitration clauses usually agreed to in marine insurance contracts may refer any disputes to an arbitration tribunal under the rules of the German Maritime Arbitration Association. Alternatives are the German Institution of Arbitration or ad hoc tribunals without any specific procedural rules. German arbitration proceedings are conducted in a similar way to usual litigation, although they should be quicker, and the arbitrator should be
more familiar with insurance concepts and, although this has rarely been discussed, would probably not have such strong reservations as regards deviations from the VVG provisions in respect of large risks as state courts sometimes have.

Alternative dispute resolution, especially mediation, is still developing in Germany, although normally on an ad hoc basis rather than as a contractually agreed requirement.

ii  Litigation and arbitration

German litigation and arbitration proceedings do not have any pretrial procedures, as there are no procedural disclosure requirements. In principle, each party is required to substantiate the facts and submit evidence without being able to obtain these facts and evidence from opponents through disclosure, although there is a duty within legal proceedings not only to object to the opponents' statements of facts flatly but to make substantiated counter submissions, and to make substantiated submissions on facts that the other party cannot know. Moreover, the judge may order the parties to submit certain documents that they consider relevant (Section 142 of the Code on Civil Procedure). Material law might also require a party to disclose information and documentation to the other party on its request irrespective of whether legal proceedings have already commenced. This is the case under insurance contracts, for example, according to Section 31 VVG, the insured is under an obligation to give any information to the insurer that it requires to determine the scope of its obligations, as well as documentation that the insured can reasonably obtain. This obligation ceases with the rejection of coverage.

Oral hearings are usually prepared by the exchange of written submissions (points of claims, points of defence, further reply submissions). The judges or arbitrators will, at the beginning of the proceedings (usually at the beginning of the oral hearing), try to induce a settlement between the parties. In this respect, they might even be quite open with their preliminary view on the facts and the merits of the case, and might hear the parties or their representatives personally. If the matter cannot be settled, the judge usually discusses the merits with the parties’ counsel and explains how he or she intends to proceed further (e.g., to hand down a judgment usually a few weeks after the closure of the hearing or to hear evidence). The judge might also order the parties to make further submissions of fact that he or she considers necessary. If the matter is not ready for a decision, the hearing will be postponed. Judgments can be appealed before the appeal courts, which, however, will only reconsider the facts determined in first instance if relevant procedural mistakes have been made that might have resulted in wrong factual determinations or if there are other indications that the court's determinations were incorrect. German appeal courts are rather reluctant to set aside a judgment for potential mistakes as to the evaluation of evidence in first instance. A further appeal to the Federal Supreme Court is only permissible if such is necessary to clarify legal questions of fundamental significance, if similar legal questions are evaluated differently by different lower courts or if lower courts deviated from the Federal Supreme Court’s findings on law as set out in its previous judgments.

The losing party is to indemnify the winning party for costs incurred for proceedings in accordance with statutory fee tariffs. The recoverable costs depend on the sum in dispute. Court costs are to be advanced by the plaintiff. By way of example, court costs for an action for payment of €100,000 in first instance amount to €3,078 and recoverable lawyers’ fees to approximately €3,750. Disbursements such as travel costs, expert fees, etc., have to be added.
The statutory fee tariffs and their effect on recoverable costs make the cost risks involved in litigation easily assessable for parties to a dispute. Similar cost principles and tariffs apply in arbitration proceedings, unless the parties agree otherwise.

V YEAR IN REVIEW

At the end of 2017 and in 2018, German courts handed down various judgments on the construction of provisions of the VVG and on consequences of the 2008 VVG reform as well as the construction of clauses in insurance contracts.

On 13 September 2017, the Munich Appeal Court held that the phrase ‘Pflichtwidrigkeit bei Ausübung der versicherten Tätigkeit’ – terminology widely used in D&O insurance conditions – excludes cover for damage resulting from acts or omissions that had no internal or external connection to the managerial duties of the director. In a case concerning a managing director who tried to establish a competing company and started to poach employees of the company he was working for, the court decided that the breach of contract did not occur in connection with the duties of the director. In the opinion of the court, the phrase clearly resembles parts of German tort law, especially Section 831 BGB. It therefore interpreted the clause in parallel to Section 831. It held that cover was limited to damage that occurred from acts or omissions that lie in the scope of the general tasks of the insured. For a director of a company, that precludes acts or omissions that do not exclusively benefit the company. The establishment of a competing company and poaching employees, on the other hand, only served the directors own financial gain and was therefore not covered by the policy.

The Düsseldorf Appeal Court also interpreted a D&O policy in 2018.29 It held that a claim arising from Section 64 of the Law on Limited Liability Companies (GmbHG) is not covered by a D&O policy. As stated in the (widely used) terms and conditions, the contract provided cover for damages on the basis of statutory liability provisions. The Court held, that the claim arising from Section 64 GmbHG entitled the company to compensation for payments made after bankruptcy of that company. In the opinion of the Court, this claim cannot be considered damages in the sense of the policy, a view previously held by the Celle Appeal Court.30 The provision did not had the nature of tort law, but was a claim of its own kind.

The Hamburg Appeal Court handed down a judgment in March 2018 concerning the contractual incorporation of the all or nothing principle for gross negligence in a carrier liability insurance.31 The plaintiff sued under combined insurance that included a carrier’s liability insurance. The insurer rejected coverage, inter alia, because the contract incorporated the all or nothing principle for intent and gross negligence. Although the behaviour of the insured was considered grossly negligent and the court accepted the incorporation of the all or nothing principle for gross negligence in general, the contract in question did not meet the requirements of a large risk or an open policy pursuant to Section 210 VVG. Therefore, deviations from the VVG were invalid and the insurer had to rely on the proportional reduction pursuant to Section 26(1) VVG.

29 Judgment of 20 July 2018 – 4 U 93/16.
30 Court Order of 1 April 2016 – 8 W 20/16.
31 Judgment of 8 March 2018 – 6 U 39/17; see also Section III.iii, above.
In another case, in March 2017, the Düsseldorf Appeal Court found that the insurer can rescind the insurance contract for malicious deception of the broker.\textsuperscript{32} The broker’s behaviour can be attributed to the insured as long as the broker is not an insurance agent of the insurer and cannot be regarded as a third party in the sense of Section 123(2) BGB. As the broker had no power of attorney he was not an insurance agent. In addition, the term ‘third party’ is to be interpreted narrowly and only applicable to persons who have no connection to the declaration recipient and, consequently, the broker.

\textbf{VI OUTLOOK AND CONCLUSIONS}

According to BaFin, the main focus of supervision in 2019 will be the challenges of digitisation and Brexit.\textsuperscript{33} Key issues related to digitisation are the interplay of market changes and supervision, the security of IT systems and private data, and the transformation of BaFin itself. In relation to Brexit, BaFin will focus on dealing with UK-based companies with licences from the PRA and the cooperation with regulatory authorities in the United Kingdom. BaFin’s reaction to Brexit is highly dependent on the results of the ongoing negotiations between the United Kingdom and the European Union. It is not clear how German legislation will change in respect of new business of UK-based insurance companies.

BaFin named the following as areas to be focused on by the German insurance market in the coming year:\textsuperscript{34} the sustainability of the investment of insurance companies and pension funds; the analysis of possible search-for-yield-behavior (the investment in riskier assets in the hope for a higher yield) of insurance companies and pension funds in their investment decisions; intensified monitoring of the premium situation of reinsurers in the non-life segment; the examination of ‘hidden’ (non-affirmative) cyber risks in insurance policies; deeper audits of stochastic valuation models of life insurance companies with the standard formula; and an in-depth examination of how insurance companies that are using the standard formula deal with economic scenario generators, examination and quality control of provisions in the solvency overview of indemnity and casualty insurance undertakings.

\textsuperscript{32} Judgment of 10 March 2017 – 4 U 191/15.
\textsuperscript{33} BaFin (https://www.bafin.de/DE/ Aufsicht/Aufsichtsschwerpunkte/aufsichtsschwerpunkte_node.html).
\textsuperscript{34} BaFin (https://www.bafin.de/DE/ Aufsicht/Aufsichtsschwerpunkte/Versicherungsaufsicht/ versicherungsaufsicht_node.html).
INTRODUCTION

The insurance market experiences constant change because of its interdependence with the economy as a whole. The Greek insurance market continues to be under pressure (as is the rest of the Greek economy), with its main characteristic being a significant and continuous drop in premium production, especially in the car insurance sector. However, local insurers are looking to switch to technology platforms that enable development and cost reduction. The EU Solvency II framework, which directly links taking new risks with efficiency and maintaining high capital adequacy, is leading companies to stable and safe paths on policies for new production, avoidance of guarantees, and complex products that usually bring higher capital requirements.

REGULATION

i Regulatory agencies and legislation

In 2008, the supervision of insurance companies was passed from the Ministry of Trade to a legal entity called the Private Insurance Supervisory Committee (PISC). Soon thereafter, pursuant to Law 3867/2010, the PISC was abolished and the Bank of Greece was appointed to regulate the private insurance sector.


ii Position of non-admitted insurers

A licence is required for insurers and reinsurers to undertake primary or reinsurance risks in Greece. The licence is granted by the Bank of Greece. The licensee is granted the right to

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1 Dimitris Giomelakis is a partner, Dimitris Kapsis is a managing associate and Nikolaos Mathiopoulos is a senior associate at Herring Parry Khan Law Office, trading as Ince & Co. The authors would like to thank George Iatridis for his assistance with writing this chapter.
provide its services in all European Union (EU) or European Economic Area (EEA) Member States. Insurers domiciled or established in other EU or EEA Member States can undertake risks in Greece by virtue of the single licence passport set by the Third Non-Life and the Consolidated Life Assurance Directives. Non-EU and non-EEA domiciled insurers and reinsurers can also undertake the relevant risks in Greece pursuant to Law 4364/2016.

iii Insurance intermediaries and their position

Insurance mediation is defined by Article 2(3) and (4) of Decree 190/2006 as any activity of introducing, proposing or carrying out other work that is preparatory to the conclusion of contracts of insurance or reinsurance, or of concluding such contracts, or of assisting in the administration and performance of such contracts, particularly in the event of a claim. The provision of information on an incidental basis shall not constitute insurance mediation if provided in the context of a professional activity other than that of assisting the customer in concluding or performing an insurance contract, of claims management and of loss adjusting of an insurance undertaking on a professional basis, and of expert appraisal of claims.

Insurance and reinsurance mediators must be registered with the professional chamber of their seat. The application for registration must be accompanied by documents evidencing that the applicant has the qualifications required by law. Employees of insurance and reinsurance companies can undertake to conduct insurance and reinsurance mediation without having to be registered with the local professional chamber, if their annual gross income deriving from the provision of mediation does not exceed €5,000. EU or EEA insurance and reinsurance mediators can operate in Greece under the single licence set by the Insurance Mediation Directive.

Act No. 86 of 5 April 2016 of the Executive Committee of the Bank of Greece introduced the Code of Conduct of insurance and reinsurance intermediaries. This Act establishes the framework of principles and rules of professional conduct of insurance and reinsurance intermediaries in their transactions with the consumers of insurance products, the insurance and reinsurance companies and the other insurance and reinsurance intermediaries.

iv Requirements for authorisation

Requirements for the insurer

An insurer domiciled in Greece must be incorporated as a société anonyme or a société européenne or a mutual association (e.g., a protection and indemnity club (for marine risks of this kind)) as provided by Law 4364/2016. The insurer’s activities must be restricted to the provision of insurance business, such as risk assessment, underwriting, risk management and solicitation of clients. The actual administration of the company must be conducted in Greece.

Requirements for the reinsurer

A reinsurer domiciled or established in Greece must be licensed, and also has to satisfy the capital and solvency requirement provided by Law 4364/2016. The reinsurer’s activities must be restricted to the provision of reinsurance business; however, if a reinsurer is incorporated as a société anonyme, it can also be a mixed financial holding company. Non-EU and non-EEA reinsurers must be licensed (Article 130 of Law 4364/2016), established in Greece, and abide by the capital and solvency requirements of Greek reinsurance undertakings.
License to conduct insurance or reinsurance business

A licence is granted according to the type of insurance for all or some of the risks, and grants the insurer the right to provide its services under the freedom of establishment (FOE) or freedom of services (FOS) regime within EU and EEA Member States, and Switzerland (with respect to non-life risks, pursuant to the bilateral agreement between the EU and the Swiss Confederation 91/370/EEC). An insurer can also undertake reinsurance risks within the scope of its primary insurance licence.

With respect to reinsurance, the licence can be granted for both life and non-life reinsurance risks, or for either of the two alone. The licensee can operate in all EU and EEA Member States under the FOS or FOE regime.

v  Regulation of directors and officers

According to Law 4364/2016, the board of directors of every Greek insurance or reinsurance company should consist of a majority of Greek citizens or citizens of other EU or EEA Member States. Any person who has been convicted of theft, embezzlement, usury, swindling, fraud, extortion, forgery, corruption, bankruptcy or smuggling, who has been declared bankrupt, or who has been a director of an insurance company that has been declared bankrupt or whose licence has been revoked because of infringement of the law, cannot be elected or appointed as chief executive officer, managing director, executive director, deputy chief executive officer, officer or board member of a Greek insurance company.

Furthermore, Law 4364/2016 provides that the members of the board of directors of an insurance or reinsurance company should have the requisite good reputation and experience to safeguard the sound and prudent management of the company. The Law also provides that the eligibility criteria of members of the board of directors of insurance or reinsurance companies and the other persons managing its activities could be subject to further specifications by a decision of the Bank of Greece.

vi  Compulsory insurance

Compulsory insurance is imposed in cases where it is essential to protect innocent third parties from damages caused by high-value risks.

A third party (i.e., a person other than the policyholder) can file a direct action if it is the person insured in a policy concluded on the account of that third party (Article 9 of Law 2496/1997); or if it is the person injured, and the insurer has undertaken to provide compulsory third-party liability cover to the person liable to compensate the third party (Article 26 of Law 2496/1997). However, with the exception of motor third-party liability claims (regulated by Law 489/1976) and claims arising from wreck removal, this right of direct action is still not in effect, as practical issues must still be resolved by means of a ministerial decision regulating which authorities shall be authorised to certify compliance with the requirements of compulsory insurance.

vii  Requirements with respect to reserves maintained by insurance and reinsurance companies

Insurers and reinsurers must conduct their business in a fit and proper manner, and comply with the regulatory obligations that have been set to safeguard their soundness. These obligations are compliant with the provisions of the EU Solvency II legislative framework enacted in Greece in 2016. In particular, insurance and reinsurance companies must form
and maintain adequate technical reserves or provisions, which must be prudently covered by investments. With respect to insurers, these investments must meet the statutory eligibility requirements, especially in terms of safety and profitability. Reinsurers, on the other hand, must abide by the prudent management requirement for investing in assets and securities. Insurers and reinsurers must also maintain a solvency margin and a guarantee fund to meet their obligations. If they fail to meet the above solvency requirements, the regulator may impose administrative sanctions, such as the submission of a plan for their short-term funding and the reorganisation of their business or a financial recovery plan, or may freeze their assets or revoke their licence and place them under compulsory winding-up proceedings.

Regarding capital requirements, each insurance and reinsurance company is obliged to comply with the Solvency II regulatory requirements. Regarding reinsurance companies, the minimum solvency margin should amount to at least €3 million pursuant to Article 267 of Law 4364/2016.

**viii Insolvency**

Insurance and reinsurance companies are placed under compulsory winding-up proceedings if their licence has been revoked on the grounds of failing to abide by solvency requirements or if the regulator has frozen their assets pursuant to Law 4364/2016. The proceedings have immediate effect in all EU and EEA Member States where the insurer is established. The liquidator is appointed by the local regulator, and has the duty to notify all persons who are entitled to insurance compensation and domiciled in other EU and EEA Member States about the proceedings and the procedure to notify their claims. Persons domiciled in Greece are invited to notify their claims and all evidence by an invitation published in national newspapers. Claims arising from compulsory third-party liability insurance are covered by the Auxiliary Fund. Claims arising from life assurance are handled by the Private Insurance Guarantee Fund (established by Law 3867/2010).

**ix Mergers**

All transactions involving a change of control of insurance and reinsurance companies have to be approved by the local regulator. In this case, the directors and officers of the acquirer will be subjected to due diligence by the Bank of Greece. An approval decision of the Bank of Greece is also necessary in the case of an insurance or reinsurance portfolio transfer.

**Financing**

There are no specific provisions in the law introducing regulations regarding the financing of an acquisition of an insurance or reinsurance company by either a person or a legal entity. Subject to the specifications of each financing scheme, corporate law restrictions, including the prohibition of loan or guarantee granting by an insurance or reinsurance company for the acquisition of its own shares by third parties, the rules on qualified holdings requirements and anti-money laundering regulations, should also be taken into account.

**x Investment**

The law does not discriminate with regard to the origin of the investment capital that may be invested in an insurance or reinsurance company. However, it should comply with anti-money laundering and counterterrorist financing legislation.
Key information documents for packaged retail and insurance-based investment products

Regulation (EU) No. 1286/2014 on key information documents for packaged retail and insurance-based investment products (PRIIPs) entered into force on 1 January 2018. This Regulation obliges the producers or sellers (such as fund managers, insurance undertakings, credit institutions or investment firms) of investment products intended to be sold to small and non-professional investors or retail investors to supply key information documents (KIDs) providing accurate, fair, clear and not misleading information about these investment products. This Regulation also provides for the civil liability of the producers or sellers of such investment products for any infringement of the Regulation where damage was suffered by retail investors as a result of compliance with a KID that is inconsistent with pre-contractual or contractual documents under the producers’ or sellers’ control or that is misleading or inaccurate.

The aim of the Regulation is to help investors to understand and compare the key features and risk-and-reward profile of such products, to establish uniform rules on transparency at EU level that apply to all participants in the PRIIPs market and thereby to enhance investors’ protection, and to rebuild their confidence in the financial market, in particular in the aftermath of the financial crisis.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Insurance contracts

Greece has a statutory legal system. Law 2496/1997, the Insurance Contract Act (ICA), sets out the regulatory contents of an insurance contract, and the obligations and rights of the insurer and the insured. Law 4364/2016 and the Greek Civil Code apply on a supplemental basis, as required.

Reinsurance contracts

There are no special regulatory or material law requirements with respect to reinsurance agreements, except Articles 168 and 169 of Law 4364/2016, which refer to finite reinsurance. The ICA does not apply directly to the reinsurance contract. Parties are free to draft and conclude the terms and conditions of their reinsurance contracts. The provisions of the ICA apply to reinsurance contracts by way of analogy, with the exception of the provisions that are not suitable for the nature and the function of reinsurance contracts.

Making the contract

Insurance contracts

According to Article 1 of the ICA (as amended), the minimum statutory or regulatory contents of an insurance contract are:

- the details of the contracting parties and the name of the person entitled to receive the insurance money (if that person is not the policyholder);
- the period for which insurance cover is granted;
- the insured risks;
- the insured sum;
- exceptions to the cover;
According to Article 2 of the ICA, the insurance contract is exclusively evidenced by a document signed by the insurer (insurance policy). The insurance policy shall state the basic elements of the insurance contract as well as the date and place of its issue. If the insurance contract is governed by general or special terms and conditions, the policy must also state that these terms and conditions apply to the contract, and a copy of the terms must be provided to the policyholder.

Article 3 of the ICA sets out the statutory or regulatory requirements aimed at the protection of the policyholder during the conclusion process of an insurance contract. The insurer bears the following notification duties:

- to supply the policyholder with the information required under law prior to the conclusion of the contract;
- to inform the policyholder in writing or via an easily legible notice appearing on the first page of the policy of:
  - any inconsistencies between the application for insurance and the policy;
  - the policyholder’s rights to object if the policy is inconsistent with the application for insurance, or the insurer failed to provide the policyholder with the information required under law or failed to communicate the insurance terms and conditions; and
  - the policyholder’s cooling-off rights;
- to provide the policyholder with separate printed specimens of the notice of objections and of exercising its cooling-off rights.

According to Article 3 of the ICA, the insurer can revoke cover if the policyholder intentionally breached its disclosure duties. Breach of these duties by negligence entitles the insurer to terminate the contract or request its variation within one month following the discovery of said breach. If the peril insured against materialises before the termination or the variation of the contract, the compensation shall be reduced in proportion to the difference between the premium paid and the premium that should have been paid if the breach of the duty to disclose had not occurred.

**Reinsurance contracts**

As mentioned in subsection i, reinsurance contracts are not regulated by law; therefore, there are no minimum statutory or regulatory requirements.

**Interpreting the contract**

Every declaration of will, including offer and acceptance during the formation of a contract, is construed according to the true intention of the parties (Article 173 of the Civil Code). Furthermore, contracts are interpreted according to the requirements of good faith and common (business) ethics (Article 200 of the Civil Code).

Implied terms may be accepted as part of a contract either by legal provisions (terms implied in law or default terms) or by contract interpretation (terms implied in fact). Terms implied in law are those provided for in the Civil Code or in other statutes that take effect in specific contract types, unless the contract stipulates otherwise. Terms implied in fact
refer mostly to supplementary contract provisions that fill gaps in the contract (i.e., provide for certain situations that are not covered by an express term of the contract or by a term implied in law). Implied terms are based upon the principle of good faith (Article 288 of the Civil Code).

Greek law requires that for the insurer to be exempted from payment, a breach must be causally connected to the loss. Article 4 of the ICA entitles the insurer to terminate the cover if the nature of the risk changes during the policy period.

The effects of a contract can be made dependent on the occurrence of future and uncertain events, which are called conditions. Conditions fall into two main categories: those that suspend the effects of the contract until the condition is met, and those that allow for the effects of the contract to occur immediately. However, upon their fulfilment, the effects of the contract will cease automatically.

iv Claims

Insurance contracts

An insurer cannot deny coverage based on late notice of claim unless there is an express provision to that effect in the agreed terms. The insurer can only claim damages. The wrongful denial of a claim could lead to a claim for bad-faith damages, owing to the moral pain and suffering caused to the insured.

Usually, the liability insurer has a right, but not an obligation, to defend a claim. Subject to the specific contractual arrangements, the notification, by either the policyholder or the insured, of the occurrence of an insured peril triggers payment under the policy provided the quantum of damages is known.

In indemnity policies, the insurer’s indemnity obligation is triggered by the notification of the occurrence of the event by the policyholder to the insurer. If a longer period is required for the assessment of the full extent of the loss, the insurer shall pay the undisputed amount without undue delay.

Reinsurance contracts

No specific law exists. Reinsurance contacts are subject to specific contractual arrangements. If a cedent fails to provide timely or sufficient notice, remedies stipulated in the contract are available.

The duty of utmost good faith implied in reinsurance contracts differs from that applicable to other commercial agreements, in that the reinsurer relies on the diligence of the insurer. If, for example, a claim in excess was notified to the reinsurer, it could result in the total release of the reinsurer, while in other commercial agreements this could only result in the recovery of a reduced amount.

A policyholder or non-signatory to a reinsurance agreement cannot bring an action against a reinsurer unless this is specifically provided in a clause in the reinsurance contract.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

The method of dispute resolution, jurisdiction and choice of law should be agreed upon by the parties in advance and in writing, but, in any case, the defendant may make an appearance without challenging the jurisdiction of the court. If an agreement provides that a court other
than the competent Greek court has exclusive jurisdiction, this agreement must be in writing. In relation to future disputes, jurisdiction clauses must be in writing and define the legal relationships to which they refer.

Most insurance policies specify the law that applies and the courts before which any dispute should be referred. Where there is some link to an EU Member State, it is important for insurers to be mindful of the impact of the Regulation (EU) No. 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (especially Articles 10 to 16 regarding jurisdiction in matters relating to insurance) (choice of court and jurisdiction) and the Rome I Regulation (especially Article 7 regarding insurance contracts) (choice of law) on the application of such provisions in policies.

ii Litigation

Most insurance disputes are referred to the courts. However, arbitration has been enjoying increasing popularity, unlike other dispute resolution mechanisms such as mediation, which is still of limited application.

**Litigation stages**

Proceedings start by way of filing a lawsuit that, apart from the names and addresses of the parties (actions *in rem* are not allowed under Greek law), also include full particulars of the claim. The claimant must, at the outset, specify the exact amount sought rather than a range or a statement that the amount sought will be notified during the proceedings.

There are three types of civil courts of first instance: courts of peace, which hear claims of up to €20,000; single-member courts of first instance, which hear claims between €20,000.01 and €250,000; and multi-member courts of first instance, which hear claims in excess of €250,000.

There is no prescribed claim form. The issue of proceedings does not interrupt the time bar; this requires that the lawsuit has also been served on the defendant.

The only available method of service is via a court bailiff instructed by the claimant to serve the lawsuit on the defendant. In cases where the defendant is domiciled in Greece, the lawsuit should be served within 30 days of its filing; where the defendant is not domiciled in Greece, it should be served within 60 days. If the defendant is domiciled in an EU Member State, the service is effected pursuant to the provisions of Regulation (EC) No. 1393/2007; for non-EU residents, the Hague Service Convention of 1965 applies.

After the lawsuit is served, the main stages of the proceedings are as follows:

a Pleadings are submitted within 100 or 130 days (depending on the case) of the date of submission of the lawsuit; supplementary pleadings are submitted within 15 days of the expiry of the above deadline. The case file is then considered closed. Within 15 days, the case is assigned to a court judge, and at the same time the hearing is scheduled within a period of no longer than 30 days. No witnesses are examined at the hearing, and the case may be heard without the parties or their lawyers being present. Following the study of the file, witnesses can be examined later if this is considered necessary by the court.

b The judgment usually takes three to 10 months to be issued. In complex cases, the court may reserve its final judgment and issue a preliminary judgment requesting additional evidence by way of, for example, expert witness or opinion.

c The final judgment is subject to appeal. There is no need for leave to appeal – all judgments are subject to appeal, either on questions of fact or on questions of law.
The appeal must be filed within 30 days of the service of the judgment, within 60 days of the service of the judgment in case the appellant is resident abroad or its address is unknown, or within two years of the date the judgment was drawn up and sealed by the court but not served on the other party (service is done by the parties).

d  A further appeal may be filed before the Supreme Court, but only on questions of law. This must be filed within 30 days of the service of the appeal court judgment, within 60 days of the service of the judgment in case the appellant is resident abroad or its address is unknown, or within two years of the day the judgment was drawn up and sealed by the appeal court but not served on the other party (service is, again, pursued by the parties).

Evidence

Generally, all documents to which reference is made in the action, or that support the claim or the defence, must be submitted together with the parties’ pleadings as outlined above.

The disclosure is not a pretrial stage. An application seeking a disclosure order can be filed, but, since the particular documents for which disclosure is sought must be prescribed in great detail, this remedy is rarely sought.

The oral debate that took place during hearings was abolished by the amendments to the civil procedural law, and has been replaced by a written procedure. The main rule, as mentioned above, is that witnesses shall no longer be examined at the hearing. If the court considers that the case has not been sufficiently clear to proceed with the issuance of the decision, it may issue an act ordering that witnesses be examined. Following the repetition of the hearing, the parties have the right to submit within eight working days their memoranda commenting on or evaluating the testimonies, or both.

An expert witness may be appointed by the court to give an opinion only if the court finds that the matter calls for expert knowledge or a party requests the appointment (Article 368 of the Code of Civil Procedure (CCP)). The number of experts appointed is at the discretion of the judge. In this case, the parties are entitled to appoint their own experts, known as technical advisers.

Costs

The rule is that the unsuccessful party pays the costs of the other party. However, the courts usually order the defeated party to pay a nominal amount, which is only a fraction of the actual costs incurred by the successful party. A trend has developed in commercial disputes to award costs on the basis of 2 per cent of the court’s adjudged amount or, if a claim is rejected, of the amount of the original claim. A defendant can, in theory, apply to the court for security for legal costs if there is an obvious risk of non-payment by the claimant if the latter is ordered to pay the costs, but this is rarely granted in practice.

iii  Arbitration

Format of insurance arbitrations

Provided there is an arbitration agreement, all disputes concerning insurance and reinsurance matters can be resolved by arbitration. The arbitration agreement must be in writing and signed by the parties to be legally binding. A signature may be substituted by the exchange
of a signed letter or fax. If the agreement is not in writing, it is only enforceable if the parties appear before the arbitrators and participate voluntarily in the proceedings without contesting the tribunal.

Domestic arbitration is governed by the rules set out in the CCP. Unless otherwise provided, domestic arbitral awards cannot be appealed, but can be annulled if certain strict requirements are met. An award can be annulled for the following reasons, among others:

- the arbitration agreement was invalid;
- the arbitration award was issued after the arbitration agreement ceased to be in force, or was against public policy or good morals;
- the arbitrators were not validly appointed or requested to be exempted from the process for serious reasons;
- the arbitrators abused the powers vested in them by law or by the parties;
- principles were violated concerning the equality of the parties, the delivery of the award and the existence of grounds for the reopening of the decision; and
- the award itself is incomprehensible or contains inconsistent provisions.

International arbitration is governed by Law 2735/1999, which introduced the UNCITRAL Arbitration Rules into national law, and is applicable in cases where Greece is the chosen venue for the arbitration.

**Procedure and evidence**

As with court litigation, the principle of civil procedure, which requires that evidence should be provided at the initiative of the parties to an action, also applies in arbitration.

**Costs**

With regard to domestic arbitration, the arbitrators’ remuneration is calculated as a percentage of the value of the claim. The award determines which party is responsible for paying the arbitrators’ fees and the costs of the arbitration. In international commercial arbitration, the allocation of costs and expenses is subject to the parties’ agreement; in the absence of an agreement, the tribunal allocates costs and fees between the parties. This allocation may be the subject of a separate decision by the tribunal.

**iv  Mediation**

Mediation in civil and commercial matters was introduced as a result of the harmonisation of Greek law with Directive 2008/52/EC. Recourse to mediation depends on (1) the parties’ will (which may be encouraged by the court), (2) a court order of another Member State or (3) imposition by the law (e.g., the Hellenic Consumers’ Ombudsman is the competent authority for the conduct of an amicable settlement of consumer disputes). The mediator’s fees are split equally between the parties, unless the parties have agreed otherwise, while each party bears its own costs.

The CCP also provides for out-of-court settlement of private disputes with the participation of the lawyers of the parties or any other third person of common choice (this is optional and is a confidential procedure).
V YEAR IN REVIEW

The debt crisis in the eurozone and the economic downturn have had a severe impact on the local insurance industry over the past eight years. The Commission for Credit and Insurance Issues of the Bank of Greece has permanently revoked the operation licences of major insurance companies and placed them in liquidation because of their failure to maintain solvency margin requirements and establish adequate technical reserves covering their deficit.

In addition, the control of major state-owned insurance companies (e.g., ATE Insurance SA) was transferred to private interests (e.g., Piraeus Bank SA) as part of a restructuring plan with the aim of strengthening their financials and improving their position towards other market competitors. In April 2017, the National Insurance Company of Greece (Ethniki Hellenic Insurance Company) was put up for sale by its parent organisation, the National Bank of Greece. In October 2018, the sale was extended after talks with a potential buyer fell through. The National Bank of Greece is expected to restart the sale in the second half of 2019.

VI OUTLOOK AND CONCLUSIONS

The debt crisis is expected to further affect Greece’s insurance and reinsurance sector in the coming years. The pressure in this sector will continue. The insurance and reinsurance intermediaries will also face considerable difficulties, especially in view of the new tax and social security contributions regime implemented in 2017, bancassurance and competition with e-shops of insurance companies.
I INTRODUCTION

The Indian insurance market was nationalised shortly after India’s independence in 1947, and remained so until the government’s industrial policy of 1991 announced the advent of a liberalised Indian economy, which included private participation in the insurance sector. In 1993, the government set up the Malhotra Committee to review the then-existing structure of the regulation and supervision of the insurance industry and to suggest reforms. The Committee recommended, inter alia, that the private sector be permitted to enter the insurance industry and that foreign insurers be allowed to enter the Indian market by forming joint ventures with Indian partners.

There was considerable delay in implementing these recommendations, and in particular a rather lengthy debate over the right level of the cap on foreign ownership, but in 1999 the Insurance Regulatory and Development Authority of India (IRDAI) (formerly, the Insurance Regulatory and Development Authority (IRDA)) was set up as an autonomous body to regulate the insurance industry and develop the insurance market, and in August 2000 private competition was permitted with a foreign ownership cap of 26 per cent.

There were growing complaints about the relatively low 26 per cent cap on foreign investment. The cap on foreign investment was intended to be raised to 49 per cent, and ultimately, after a long legislative history, on 20 March 2015, the Insurance Laws (Amendment) Act 2015 (the Amendment Act) was notified, which, inter alia, increased the foreign investment cap to 49 per cent. The Amendment Act also permitted the establishment of branch offices in India by foreign reinsurers.

India presently has 24 life insurers, 27 general insurers and six stand-alone health insurers, 26 third-party administrators, 433 insurance brokers, 29 web aggregators, four insurance repositories, and innumerable corporate agents and insurance agents. There are 10 foreign reinsurer branches in India, including the branch office of Lloyd’s of London set up under the IRDAI (Lloyd’s India) Regulations 2016 (the Lloyd’s India Regulations). In addition, at present, there are two reinsurance companies in India: the government-owned General Insurance Corporation; and ITI Reinsurance Limited, which has been granted registration by the IRDAI.

1 Neeraj Tuli is the senior partner and Celia Jenkins is a partner at Tuli & Co.
II REGULATION

i The insurance regulator

Insurance and reinsurance companies, foreign reinsurer branches and intermediaries in India are governed by the IRDAI.

ii Position of non-admitted insurers

Overseas non-admitted insurers cannot write direct insurance business in India. Non-admitted insurers who have registered with IRDAI as cross-border reinsurers can reinsure risks written by Indian insurers in accordance with the IRDAI (Re-insurance) Regulations 2018 (the Reinsurance Regulations) (see Section V). Pursuant to the Amendment Act, overseas non-admitted reinsurers are now also permitted to access the Indian market by way of branch offices set up in India and service companies set up under the Lloyd’s India Regulations.

Indian residents may purchase life insurance policies issued by an insurer outside India provided the policy is held under specific or general permission of the Reserve Bank of India. Indian residents are prohibited from purchasing insurance in respect of any property in India or any ship, vessel or aircraft registered in India with an insurer outside India without the permission of the IRDAI. Indian residents can, however, purchase health insurance policies from an insurer outside India provided aggregate remittance including amount of premium does not exceed the limits prescribed by the Reserve Bank of India under the Liberalised Remittance Scheme from time to time.

iii Position of brokers

The regulations governing the operation and functioning of insurance brokers in India were recently updated by way of the IRDAI (Insurance Brokers) Regulations 2018 (the Brokers Regulations). Only insurance brokers that are registered with the IRDAI as direct brokers, reinsurance brokers or composite brokers in accordance with the Brokers Regulations can operate as insurance brokers in India. The new Brokers Regulations have set out provisions for sale of insurance online and sale of insurance using distance marketing modes. Further, the Brokers Regulations have also set out revised norms with regard to the minimum capital requirements for insurance brokers, agreements with third-party service providers, remuneration or fee receivable by the insurance brokers and the services that a registered insurance broker is permitted to perform.

iv Requirements for authorisation

The general rule is that only licensed insurance agents and insurance intermediaries can distribute insurance products for Indian insurers. Unlicensed persons are prohibited from soliciting and procuring insurance business or providing introductions or leads.

v Regulation of individuals employed by insurers

Individuals employed by Indian insurers must be internally trained by the insurer to carry out the distribution of insurance products. Indian insurers are also permitted to use individual insurance agents that are licensed in accordance with the IRDAI (Appointment of Insurance Agents) Regulations 2016 for the distribution of insurance products.

The IRDAI has also notified the guidelines on engaging point of sales persons for life and non-life insurers, for solicitation and procurement of point of sales products designed by such insurers.
vi  The distribution of products

Only licensed or registered insurance agents and insurance intermediaries can solicit and procure insurance business for insurers. Insurers are also permitted to engage licensed telemarketers and registered web aggregators for the solicitation and procurement of insurance business, and to purchase access to the database of licensed referral companies.

In August 2017, the IRDAI notified the Guidelines on Motor Insurance Service Provider (the MISP Guidelines) to identify and regulate the role of automobile dealers in distributing and servicing motor insurance products. Pursuant to the notification of the MISP Guidelines, a duly registered motor insurance service provider (MISP) is permitted to solicit, procure and service motor insurance policies for insurers and insurance intermediaries.

vii  Compulsory insurance

The following are examples of insurance cover that are compulsory by central law:

a  under the Public Liability Insurance Act 1991: accidental cover for persons handling hazardous substances and environmental issues;
b  under the Motor Vehicles Act 1988: compulsory third-party liability insurance and compulsory personal accident cover;
c  under the Deposit Insurance and Credit Guarantee Corporation Act 1961: insurance to be taken by the banks functioning in India;
d  under the Brokers Regulations, IRDAI (Insurance Web Aggregators) Regulations 2017, IRDAI (Registration of Corporate Agents) Regulations 2015, Guidelines on Repositories and Electronic Issue of Insurance Policies of 29 May 2015, and IRDAI (Registration of Insurance Marketing Firm) Regulations 2015: professional indemnity insurance covering errors and omission, dishonesty and fraudulent acts by employees, and liability arising from loss of documents or property;

e  under the Carriage by Air Act 1972: parties are required to maintain adequate insurance covering any liabilities that may arise;
f  under the Rights of Persons with Disabilities Act 2016: an insurance scheme for employees with disabilities;
g  under the Personal Injuries (Compensation Insurance) Act 1963: employers’ liability for workers sustaining injuries;
h  under the Employees State Insurance Act 1948: insurance for employees in case of sickness, maternity and employment injury;
i  under the Payment of Gratuity Act 1972: insurance for gratuity payments to employees;
j  under the War Injuries (Compensation Insurance) Act 1943: for workers sustaining injury in war;
k  under the Marine Insurance Act 1963: insurance for marine adventures;
l  under the Merchant Shipping Act 1958: insurance on the lives of crew members;
m  under the Inland Vessels Act 1917: insurance of mechanically propelled vessels; and
n  under the Companies Act 2013: insurance of deposits accepted by companies.

viii  Compensation and dispute resolution regimes

Dispute resolution in India is broadly divided into three mechanisms: civil courts; consumer forums; and arbitration and alternate dispute resolution.
The Commercial Courts, Commercial Division and Commercial Appellate Division of High Courts Act 2015 (the Commercial Courts Act) provides for the establishment of specialised courts to adjudicate on disputes pertaining to transactions of merchants, bankers, financiers and traders.

Amendments were also made to the Arbitration and Conciliation Act 1996 (ACA) to ensure that commercial arbitrations are completed within a specified timeline and an attempt has been made to do away with the archaic system of awarding costs followed in India, and to make the costs more realistic.

Further detail on these regimes is provided in Section IV.

ix Taxation of premiums
Premiums received on account of insurance and reinsurance business attract applicable taxes, including goods and services tax. Income tax laws provide deductions to the policyholder on life and health insurance premiums paid.

x Proposed changes to the regulatory system
In 2018, the IRDAI issued an exposure draft on the IRDAI (Linked Insurance Products) Regulations 2018 and the IRDAI (Non-Linked Products) Regulations 2018, which define the revised norms in relation to the design and issuance of linked and non-linked life insurance policies by life insurers in India.

The IRDAI also issued exposure drafts on the IRDAI (Insurance Services by Common Public Service Centers) Regulations 2018 and on the IRDAI (Registration of Insurance Marketing Firm) Regulations 2018, which stipulate the proposed revised norms regarding the servicing and distribution of insurance by common public service centres and insurance marketing firms, respectively.

The IRDAI also issued the Circular on Moving towards Risk-Based Supervision of the Insurance Sector of 3 October 2018, which stipulates that the IRDAI is in the process of adopting a risk-based supervisory framework for holistic supervision of the insurance sector. It has set up an implementation committee to suggest the implementation approach for risk-based supervision and to achieve smooth transition. Insurers and insurance intermediaries have been directed to initiate steps to place greater focus on identification of risk and to build a framework that enables internal assessment of such risks and a corresponding control mechanism to mitigate risks within the organisation culture.

xi Other notable regulated aspects of the industry
The minimum paid-up equity capital for an insurer is 1 billion rupees. Any direct or indirect foreign investment in an insurer is restricted to 49 per cent; the previous requirement to obtain an approval from the government of India to increase the foreign investment in an insurer from 26 per cent to 49 per cent has been removed.

The IRDAI has also mandated that insurance companies and insurance intermediaries must be ‘Indian owned and controlled’. The Foreign Investment Rules read with the Guidelines on ‘Indian owned and controlled’ of 19 October 2015 provide that Indian ownership means that more than 50 per cent of the equity capital is beneficially owned by resident Indian citizens or Indian companies, which are owned and controlled by resident Indian citizens.

The IRDAI has released the IRDAI (Investment by Private Equity Funds in Indian Insurance Companies) Guidelines 2017 of 5 December 2017, to facilitate and regulate investment by private equity funds in insurance companies, as investors and promoters.
These Guidelines have been made applicable to unlisted Indian insurance companies and to the private equity funds who have invested in such unlisted insurance companies. These Guidelines further allow private equity funds to invest either directly in Indian insurance companies in the capacity of an investor or to invest through a special purpose vehicle in the capacity of a promoter in the insurance company.

Press reports of December 2018 indicated that the process of transfer of shares of ITI Reinsurance Limited is ongoing. At the time of writing, the regulatory approval for the transfer of shares is still pending.

There has been a significant increase in the volume of mergers and acquisition activity in the insurance sector in India. Additionally, various insurance companies have issued their initial public offerings in the past two years, and other insurance companies are looking to follow suit in the coming year.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Insurance Act 1938, the Insurance Regulatory and Development Authority Act 1999, the Marine Insurance Act 1963 and the regulations, guidelines, circulars and notifications issued by the IRDAI, govern insurance and reinsurance business.

The courts may refer to common law if there are no judicial precedents available under Indian law. Common law is, however, not binding on Indian courts.

ii Making the contract

The terms and conditions of property and engineering insurance covers are currently governed by the policy wording specified by the former Tariff Advisory Committee. Very few modifications to this policy wording have been permitted. In all other lines of insurance business, insurers are permitted to issue only those policy terms and conditions, endorsements and other ancillary documentation that have either been approved by the IRDAI in advance or filed with the IRDAI, in accordance with the prescribed product filing procedures. In addition, for health insurance policies, the IRDAI has specified a standard set of definitions, standard nomenclature for critical illness, a standard list of excluded expenses, and standards and benchmarks for hospitals in the insurance network. It has also specified a number of other conditions for health insurance policies, making these policies highly regulated.

The IRDAI (Protection of Policyholders’ Interests) Regulations 2017 require general insurance contracts to state several matters, including:

a the names and addresses of the insured and of any banks or any other person having financial interest in the subject matter of insurance, unique identification number of the product, name, code number, contact details of the person involved in the sales process;
b a full description of the property or interest insured;
c the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;
d the period of insurance;
e the sums insured;
f perils covered and not covered;
g any franchise or deductible applicable;
h premium payable and where the premium is provisional, subject to adjustment, the basis of adjustment of premium be stated;
i  policy terms, conditions, warranties and exclusions, if any;

j  action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;

k  the obligations of the insured in relation to the subject matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances;

l  any special conditions attached to the policy;

m  the grounds for cancellation of the policy, in the case of a retail policy;

n  the address of the insurer to which all communications in respect of the insurance contract should be sent;

o  the details of the endorsements and add-on covers attaching to the main policy;

p  that, on renewal, the benefits provided under the policy or terms and conditions of the policy, including the premium rate, may be subject to change; and

q  details of the grievance redressal mechanism along with the address and other contact details of the insurer or the residential address or place of residence of the policyholder is located.

Similarly, the IRDAI (Protection of Policyholders’ Interests) Regulations 2017 specifies the matters to be stated in a health and life insurance policy as well. Further, all condition precedents and warranties are required to be stated in express terms in the policy documentation.

In addition, all product literature is required to be in ‘simple language’ and ‘easily understandable to the public at large’, and all technical terms used in the policy wording are to be clarified to the insured. To the extent possible, insurers are also required to use similar wording for describing the same insurance cover or the same requirements across all their products, particularly in relation to clauses on renewal, basis of insurance, due diligence, cancellation and arbitration.

An insurance contract is one of utmost good faith, and insurers are entitled to a fair presentation of the risk prior to inception. The Indian Marine Insurance Act 1963 obliges an insured to make a full and frank disclosure prior to inception, and the Supreme Court has stated that this includes by way of the proposal. There is an argument that an insurer may limit the insured’s duty by limiting the questions asked in the proposal form unless the proposal form contains a statement that has the effect of negating any restriction of the disclosure obligation by reference to the questions asked. The IRDAI (Protection of Policyholders’ Interests) Regulations 2017 also impose an obligation on the insured to disclose all material information.

If there has been a misrepresentation or non-disclosure of a material fact, then an insurer may avoid the policy ab initio. Unless the misrepresentation or non-disclosure was fraudulent, the premium must be returned to the policyholder.

iii  Interpreting the contract

In general terms, the statutory framework may be said to favour insurers more than insureds, but the regulatory framework and the interpretation of applicable law is perhaps more favourable to insureds. For example:

a  the courts and consumer forums have held that if there is any ambiguity in the terms and conditions, then these shall be construed in favour of the insured;
b the Insurance Act 1938 restricts the ability of insurers to call a life insurance policy into question after three years from inception on any grounds, including fraud;

c the IRDAI (Protection of Policyholders’ Interests) Regulations 2017 provide, among other obligations, that insurers must follow certain practices at the point of sale of the policy as well as at the processing or claims stage so that:
• the insured can understand its terms properly;
• insurers have proper procedures and mechanisms to hear any grievances of the insured;
• the policy terms are clearly stated (e.g., warranties, conditions, insured’s obligations, cancellation provisions, conditions precedent);
• certain claims procedures are followed to expeditiously process claims; and
• insurers pay interest at a rate of 2 per cent above the prevalent bank rate in cases of delayed payment, etc.;

d following the IRDAI (Health Insurance) Regulations 2016 (the Health Regulations), general insurers and health insurers are ordinarily required to renew a health insurance policy except on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the insured. Renewal cannot be denied on grounds such as an adverse claims history. Moreover, according to the Guidelines on Product Filing Procedures for General Insurance Products issued by the IRDAI in February 2016, in a general insurance policy, the insurer can cancel the policy mid-term only on grounds of fraud, misrepresentation and moral hazard;

e the IRDAI has also directed that all health insurance policies offer portability benefits whereby policyholders are given credit for the waiting periods already served under previous health insurance policies with that insurer or any other Indian insurer; and

f pursuant to the Health Regulations, the IRDAI is also monitoring wellness benefits provided to policyholders under health insurance policies by mandating that such policies clearly stipulate the manner of calculation, accrual, redemption and carrying forward of such benefits.

Another feature of the insurance sector concerns government-owned insurers, which are considered instruments of the state and are thus expected to act justly and reasonably.

iv Intermediaries and the role of the broker

Insurance brokers, corporate agents, web aggregators, referral companies, insurance marketing firms and insurance agents are granted a licence for a fixed period of three years, following which the licence may be renewed for a further three years at the discretion of the IRDAI.

Insurance brokers and web aggregators are required to exclusively carry on the distribution of insurance products, while corporate agents may have a main business other than the distribution of insurance products, and newly introduced insurance marketing firms are allowed to sell or service other financial products.

If a corporate agent has a main business other than insurance distribution, then it is not permitted to make the sale of its products contingent on the sale of an insurance product or vice versa. Corporate agents were previously restricted to acting for a maximum of one life insurer and one general insurer, however, following the notification of the IRDAI (Registration of Corporate Agents) Regulations 2015, they are permitted to adopt an open architecture under which they can act for up to three life insurers, three general insurers and three health insurers.

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The IRDAI’s regulations specify separate codes of conduct for each insurance intermediary that governs the conduct expected of each intermediary while performing their functions. Breach of the respective code of conduct could lead to suspension or cancellation of their licence or certificate of registration.

The regulatory limits on the commission or remuneration payable to insurance agents and insurance intermediaries for the solicitation and procurement of insurance business continue to remain under the IRDAI (Payment of Commission or Remuneration or Reward to Insurance Agents and Insurance Intermediaries) Regulations 2016 (Commission Regulations), as amended from time to time. However, insurers are now permitted to make other payments in the form of rewards to insurance agents or insurance intermediaries.

Insurance agents and insurance intermediaries are also prohibited from offering rebates to customers on the premium or commission receivable.

All insurance brokers are required to be part of the Insurance Brokers Association of India.

v Claims

Insurance policy terms and conditions are meant to specify the requirements for notification of claims or circumstances that may give rise to a claim. Although it is common for these clauses to be expressed as conditions precedent to the insurer’s liability to make payment of the claim, the IRDAI’s Circular of 20 September 2011 said that insurers cannot reject claims on the basis of delayed notification if the delay was unavoidable unless the insurer is satisfied that the claim would have been rejected in any event. However, judicial decisions have taken a different approach in that the rejections of claims on the ground of delayed notification have been upheld. The position is not settled and the Supreme Court in 2017 in the case of Gurshinder Singh v. Sriram General Insurance Co Ltd referred this question to a three-judge bench.2 Pending the disposal of this matter, a three-judge bench of the Supreme Court in Sonell Clocks v. NIA,3 observed that the rejection of the claim on the ground of delayed notification is ‘not a technical matter but sine qua non [an indispensable condition] for a valid claim to be pursued by the insured, as agreed upon between the parties’.

Insurance policy terms and conditions are also meant to expressly state the insurer’s grievance redressal procedure and the applicable dispute resolution provisions for differences or disputes arising under the policy. While there are no specific regulatory requirements in this regard, it is common for retail policies to give exclusive jurisdiction to the Indian courts and commercial lines policies to contain express arbitration provisions.

General insurance policies are usually annually renewable policies with the entire premium being paid in advance, and it is not common to offer these policies on a long-term basis or to provide for premium payments in instalments. Life insurance policies usually have policy terms of at least 10 years and, unless a single premium is payable in advance, it would usually be payable at regular intervals during the policy terms. All life insurance policies are required to contain express provisions and conditions for reinstatement of the policy in the event of discontinuance of premium payments.

2 SLP (C) No. 24370/2015.
3 (2018) 9 SCC 784.
IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses
Policyholders have a statutory right to sue for relief under an insurance policy in Indian courts, and Indian law shall be applicable. This right cannot be abridged by the terms of the insurance policy or otherwise.

It is common for retail policies to be subject to the exclusive jurisdiction of Indian courts and for commercial lines policies to contain arbitration clauses.

ii Litigation
An insured can approach a civil court or (if the dispute qualifies) a consumer court. An insurer can only approach a civil court. Both civil and consumer courts have territorial and pecuniary jurisdiction, so actions before them need to be brought keeping in mind the geographical location pertaining to the cause of action or the place where the defendant resides and the value of the claim.

The consumer courts follow a three-tier hierarchy that comprises, in ascending order, the district forums, followed by the state consumer dispute redressal commissions (the state commissions), followed by the National Consumer Dispute Redressal Commission (NCDRC). There are 626 district forums, which can accept claims up to a value of approximately US$28,570; and there are 36 state commissions, which can accept claims of between approximately US$28,570 and US$143,000, and appeals against the decisions of the district forums. At the apex lies the NCDRC, which accepts matters with a value of over US$143,000 and appeals against the decisions of the state commissions. A decision of the NCDRC on matters with a minimum value of US$143,000 can be challenged before the Supreme Court (the country’s highest court). The Consumer Protection Bill 2018 has been introduced in Parliament, which, \textit{inter alia}, proposes the enhancement of these pecuniary limits to US$143,000 for the district forums, US$1,430,000 for the state commissions and above US$1,430,000 for the NCDRC.

Similarly, the broad ascending hierarchy of the civil courts comprises around 600 district courts, 24 high courts and the Supreme Court, which only hears appeals and cases from the lower courts that involve breaches of fundamental rights. Four of the 24 high courts (Delhi, Bombay, Madras and Calcutta) have original jurisdiction to hear matters of a civil nature over a certain pecuniary value. One of the high courts (Delhi) has jurisdiction to hear matters involving pecuniary values of US$286,000 and above. The district courts under them do not hear matters involving values higher than that limit. The remaining district courts have an unlimited pecuniary jurisdiction, and are the competent courts of first instance to hear any insurance dispute falling within their territorial jurisdiction. The Commercial Courts Act has led to the establishment of commercial courts at the district level and commercial division, and commercial appellate division benches within the high courts. These commercial courts are specially assigned to hear insurance and reinsurance matters, among other disputes. The pecuniary jurisdiction of these courts is disputes that have a value of US$4,285 and above. There is no right to a hearing before a jury, and cases are decided by judges.

Unless otherwise expressly provided in law, an appeal lies from every decree passed by a court exercising original jurisdiction to the court authorised to hear appeals from the decisions of such court, unless such decree has been passed with the consent of the parties.

As a general rule, an appeal will lie if there is a substantial question of law involved. Facts established at the lower court are not normally disturbed.
In civil disputes, the usual sequence is that the decision of a district court is appealable before a single judge of a high court. The single judge’s decision can be appealed before a division bench of the high court. The final stage of appeal is before the Supreme Court.

The limitation period for filing an appeal ranges from 30 to 90 days depending on the stage of appeal, and delays can be condoned at the court’s discretion for sufficient cause shown and reasonable reasons resulting in such delay.

The Code of Civil Procedure 1908 (CPC) governs the method of instituting and trying civil suits. The Commercial Courts Act provides, for the first time, for summary judgment in a suit. Under this Act, plaintiffs can apply for summary judgment in a suit after summons have been served upon a defendant. If the court is convinced that the defendant has no real prospect of succeeding in a claim, it may grant a summary judgment. In other circumstances, the court may pass conditional orders allowing a defendant to defend the suit after payment of a deposit or on such other terms as the court may deem fit.

The CPC allows either party to the action to apply to the court for an order directing the other to make discovery. The court will consider the relevance of the documents requested for the dispute to be determined, and direct the discovery of a particular document or type of document accordingly. The CPC also allows a party to give notice to the other party in whose pleadings or affidavits a reference is made to any document to produce the document for inspection. Non-compliance with a discovery order can lead to the dismissal of the action or defence, as the case may be. The CPC also allows a court to summon any person, even if that person is not a party to the proceedings, and direct him or her to produce any document, material or testimony regarding the dispute, and to do so in person at the court.

Indian courts have held that the position under Indian law relating to privilege is similar to that under English law. In this regard, the Bombay High Court has effectively recognised privilege over documents created in contemplation of litigation. As regards documents prepared in the course of settlement negotiations or attempts, it is common for parties to mark them ‘without prejudice’, but they are not expressly protected as privileged documents under the Evidence Act, and as a matter of practice are commonly produced before courts.

Courts have the power to require witnesses who are within their jurisdiction to give evidence and to issue an arrest warrant if a witness refuses to comply. A court cannot compel the attendance of a witness outside its jurisdiction, and thus cannot impose any penal consequences for non-attendance. The CPC allows a court to issue a commission for the examination of a witness outside its jurisdiction and allows it to issue a commission for the examination of a person resident outside India. If the person whose attendance as a witness is deemed necessary by the court is a party to the action and this person fails to attend or give evidence, the court may, in considering the absence of this person, dismiss the plaint or the defence, as the case may be.

Courts may award the successful party its costs, but the award is at the court’s discretion. It is common for costs awards to be made in favour of a successful party, but the level of costs awarded is rarely sufficient to cover the actual costs incurred. The Supreme Court has commented that costs awards are too low, and therefore do not serve as a deterrent to discourage vexatious litigation. Referring to a statutory upper limit of US$47.04 for costs awards in the case of vexatious litigation, the Supreme Court suggested that Parliament should consider raising the limit to US$1,568. The Commercial Courts Act attempts to rectify the situation, as it amends the CPC to permit courts to grant actual costs to a successful party.
In view of the low level of costs awarded, there are, as yet, no material advantages in making a pretrial offer in civil litigation. However, in view of the changes to the law, this situation may change.

In addition, Section 89 of the CPC embraces a provision for the settlement of disputes outside court. All cases that are filed in court need not necessarily be decided by the court itself. Considering the time taken for legal proceedings and the limited number of judges available, it has become imperative to resort to an alternative dispute resolution (ADR) mechanism with a view to end litigation between parties at an early date. The ADR mechanism as contemplated by Section 89 is arbitration, conciliation or judicial settlement, including settlement through a Lok Adalat (a mode of ADR) or mediation. There is usually a mediation cell associated with each court.

iii Arbitration

The ACA is based on the UNCITRAL Model Law. The ACA preserves party autonomy in relation to most aspects of arbitration, such as the freedom to agree upon the qualification, nationality and number of arbitrators (provided this is not an even number), the place of arbitration and the procedure to be followed by the tribunal. The principle of party autonomy has recently been confirmed by the Supreme Court in a number of cases. The decisions restrict the scope of the Indian courts to intervene in respect of those arbitrations where the seat is non-Indian.

The Arbitration and Conciliation (Amendment) Act 2015 amended the ACA. This Act makes the ACA a preferred reference for settlement of commercial disputes, as it not only sets out strict timelines for completion of the arbitral proceedings but also permits parties to choose to conduct arbitration proceedings in a fast-track manner, with the award being granted within six months. In addition to the foregoing, a cost regime with regard to providing the costs of arbitration proceedings to a successful party has also been set out.

The ACA expressly bars the courts from intervening in an arbitral proceeding except to the extent this is provided for in the Act itself. For example:

a where a party files an action before a court in spite of an arbitration agreement, the other party can apply to that court to refer the dispute to arbitration instead;
b a party can apply to a court for interim remedies;
c a party can seek the court's assistance for the appointment of an arbitrator if the other party refuses to cooperate in the process;
d a party can seek the court's assistance for recording evidence; and
e the court can set aside an award in an arbitral proceeding where it has been passed following material errors of jurisdiction or in prejudice of the public interest. The court's power is limited in this regard, and it cannot interfere in the reasoning given for arriving at the award.

iv ADR

The ACA recognises arbitration and conciliation as valid forms of ADR.

v Mediation

The courts may direct the parties to refer their disputes to ADR with the parties’ consent. There are a number of mediation cells associated with the courts. The mediator is either selected by the parties or by the court. The mediator acts as a facilitator to encourage parties
to settle their disputes. However, unlike arbitration, the mediation process is not binding on either party. The Commercial Courts Act contemplates compulsory mediation between the parties prior to filing of a suit unless urgent interim relief is sought.

V YEAR IN REVIEW

The Indian insurance sector has witnessed significant changes over the past year. As mentioned in Section II, the following regulations have been introduced:

a The Reinsurance Regulations, which repeal the IRDAI (General Insurance – Reinsurance) Regulations 2016 and IRDAI (Life Insurance – Reinsurance) Regulations 2013. They also amend, to the relevant extent, the IRDAI (Registration and Operations of Branch Offices of Foreign Reinsurers Other than Lloyd’s) Regulations 2015 and the Lloyd’s India Regulations. The Reinsurance Regulations prescribe the new order of preference to be followed by insurers for the placement of reinsurance business. They also provide that insurers may adopt alternative risk transfer solutions, subject to the prior approval of the IRDAI.

b The Brokers Regulations, which replaced the previous IRDA (Insurance Brokers) Regulations 2013. They prescribe the revised norms for the setting up and functioning of insurance brokers in India.

c The IRDAI (Linked Insurance Products) Regulations 2018 and the IRDAI (Non-Linked Products) Regulations 2018, which define the revised norms in relation to the design and issuance of life insurance policies by life insurers in India. The IRDAI has released an exposure draft on these regulations.

d The IRDAI (Insurance Services by Common Public Service Centers) Regulations 2018 and the IRDAI (Registration of Insurance Marketing Firm) Regulations 2018, which stipulate the proposed revised norms regarding the servicing and distribution of insurance by common public service centres and insurance marketing firms, respectively. The IRDAI has released exposure drafts on both sets of regulations.

In addition, in light of the order issued by the High Court of Delhi in the matter of United India Insurance Company Limited v. Jai Parkash Tayal,4 the IRDAI issued a direction on 19 March 2018 prohibiting insurers from rejecting a claim under a health insurance policy based on exclusions concerning ‘genetic disorder’. In addition, the IRDAI issued the Circular on the Mental Healthcare Act 2017 on 16 August 2018 to make provision for medical insurance for the treatment of mental illness mandatory, on the same basis as is available for the treatment of physical illness.

The Supreme Court, by way of an order in S Rajasekaran v. Union of India and Ors of 20 July 2018,7 made it mandatory for insurers to provide long-term third-party liability insurance cover with respect to new vehicles sold from 1 September 2018. Following this, the IRDAI issued the Circular on Implementation of the Directions of the Hon’ble Supreme Court of India in the matter of WP No.295/2012 of Shri S Rajasekaran v. Union of India and Ors of 28 August 2018 to prescribe the norms to general insurers regarding issuance of long-term motor insurance policies.

VI OUTLOOK AND CONCLUSIONS

The Indian insurance industry has seen significant growth and development in recent years. The removal of the requirement to seek approval from the Indian government to increase the foreign investment cap from 26 per cent to 49 per cent in insurers and insurance intermediaries is one of the factors that has led to an increase in the quantum of economic investments in existing Indian players, along with various foreign players exploring options of setting up insurance joint ventures in India. Moreover, there has been a noteworthy increase in the number of players in the reinsurance space, whereby several foreign reinsurers have recently been permitted to set up branches in India. Lloyd’s of London has set up a branch office in India under the Lloyd’s India Regulations. Further, with insurers being permitted to issue products under the ‘use-and-file’ process, there has been an increase in product development and innovation in India.

However, these significant, and frequent, changes to the regulatory environment have led to a state of flux in the insurance industry. For instance, with the notification of the Reinsurance Regulations, Indian insurers are expected to make changes to their reinsurance programmes, which is bound to affect reinsurers both in and outside India.

Various regulatory amendments have been made in the past year and further amendments are expected. For instance, a committee set up by the IRDAI, in its final recommendations, suggested setting up a core sandbox committee with dedicated personnel to monitor and supervise digital innovations, facilitate the roll-out of experiments and provide the ecosystem required for this experimentation. In addition, in order to make available a standard health product across the industry, the IRDAI has issued Draft Guidelines to suggest the wordings for standard mediclaim policies.
INTRODUCTION

Indonesia is a country with many citizens, and where the interest of those citizens in insurance is very low. There are many people there, especially those in the lower-middle classes, who do not have insurance.

However, the development of insurance in Indonesia has been quite good. Based on the list of insurance companies released by the Financial Services Authority (OJK) on 31 December 2015, there are 137 insurance companies that consist of:

- 76 general insurance companies;
- 50 life insurance companies;
- six reinsurance companies;
- three mandatory insurance companies; and
- two social insurance companies.

By 30 September 2017, investment reached 505.57 trillion rupiahs – a 22.42 per cent increase compared with December 2016 (which totalled 412.98 trillion rupiahs). By 30 September 2017, insurance and reinsurance premium income reached 183.45 trillion rupiahs (71.1 per cent of the projection set by the OJK for the period up to 31 December 2017).

The OJK is an independent institution, free from interference from other parties, which has the function, duty and authority to regulate, supervise, inspect and investigate, as given in Article 1 point 1 of Indonesian Act No. 21 of 2011 on the Financial Services Authority (Indonesian Act 21/2011).

REGULATION

When running its business, an insurance company must conform with Indonesian Act No. 40 of 2014 on Insurance (Indonesian Act 40/2014) and Financial Services Authority Regulation (OJK Regulation) No. 69/POJK05/2016 (OJK Regulation 69/2016) on the implementation of insurance companies, shariah insurance companies, reinsurance companies, and shariah reinsurance companies. Indonesian Act 40/2014 applies to all types of insurance, including reinsurance and shariah insurance.

Article 1 point 15 of Indonesian Act 40/2014 states that ‘Insurance Company [refers to] general insurance companies and life insurance companies.’

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1 Aldi Andhika Jusuf and Amir Rahmat Akbar Pane are managing partners, and Rico Ricardo is an associate, at AP Advocates. The information in this chapter was accurate as at April 2018.

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As an institution with a supervisory function, the OJK has the authority to issue business licences in the financial services sector, including insurance, as given in Article 8 paragraph 1 of Indonesian Act 40/2014: ‘Each party [that] shall undertake insurance business must first obtain a business licence from the Financial Services Authority.’

The OJK also has the authority to approve new insurance products to be issued in the market. Therefore, all insurance products marketed in Indonesia are in compliance with OJK standards. Indeed, Article 28 paragraph 1 of OJK Regulation No. 23/POJK05/2015 on Insurance Products and Marketing Insurance Products (OJK Regulation 23/2015) states that: ‘Any new insurance product to be marketed shall be reported to OJK to obtain a letter of approval or letter of record’.

When a product has been approved by the OJK, the product has been verified by the OJK.

i Insurance agreement and the parties

Article 246 of the Indonesian Commercial Code states:

Insuarance is an agreement, in which the insuring party commits to the insured party by obtaining premium, to pay compensation for a loss due to a loss, damage or un-obtained profit, which may be suffered due to an uncertain event.

Where agreements made under Indonesian law adhere to the consensual principle, the agreement exists at the time the agreement is closed or one second after the deal is reached.

An insurance agreement expires when:

a the time period is up;
b a journey or travel ends (for transportation);
c an event is followed by claim;
d an agreement is terminated; or
e an agreement is nullified.

Regarding the parties in the insurance agreement, the legal system in Indonesia recognises the existence of three parties: the insurer, the insured and the underwriter.

ii Legal basis of insurance law


Indonesian Civil Code

The Indonesian Civil Code is a legal basis for all agreements, including insurance agreements. Article 1313 of the Indonesian Civil Code states: ‘An agreement is an act pursuant to which one or more individuals bind themselves to one another.’

Article 1320 Indonesian Civil Code states:

*In order to be valid, an agreement must satisfy the following four conditions:*
1. there must be consent of the individuals who are bound thereby;
2. there must be capacity to enter into an obligation;
3. there must be a specific subject matter;
4. there must be a permitted cause.

Article 1338 of the Indonesian Civil Code gives that: ‘All valid agreements apply to the individuals who have concluded them as law. Such agreements are irrevocable other than by mutual consent, or pursuant to reasons stipulated by the law. They must be executed in good faith.’

**Indonesian Commercial Code**

Articles 246–302 of the Indonesian Commercial Code regulate insurance agreements and insurance that is provided therein.

**Indonesian Act 21/2011**

Indonesian Act 21/2011 regulates the OJK, as an institution that has functions, duties and regulatory and supervisory powers over the financial services industry. Act 21/2011 also instructs the OJK to establish regulations on consumer protection of the financial services sector, as given in Article 31 of Indonesian Act 21/2011: ‘Further provisions on the protection of consumers and society shall be regulated by OJK Regulation.’

**OJK Regulation 1/2013**

As stipulated in Article 31 of Indonesian Act 21/2011 (see above), OJK Regulation 1/2013 was established to regulate the rights and obligations of business actors (insurers) and consumers (the insured), and the prohibitions of business actors (insurers) in marketing their products.

The scope of consumer protection stipulated in OJK Regulation 1/2013 is set out in Article 1 point 3: ‘Consumer protection is the protection of consumers with the scope of behaviour of business finance service actors.’

Furthermore, there are several principles that must be obeyed by every person who makes insurance coverage (see below).

iii  **Principles of insurance in Indonesia**

The principles of insurance used in legal provisions in Indonesia and recognised worldwide are as follows.

**Utmost good faith**

Article 251 of the Indonesian Commercial Code states:

*Every incorrect or false notice, or every concealment of facts known by the Insured party, even though made in good faith, the nature of which is such that the agreement concerned would not have been made, or would not have been made under the same conditions if the insuring party learnt the factual situation of all these matters, shall render the insurance concerned void.*
Insurable interest

Article 268 of the Indonesian Commercial Code states that ‘insurance may cover all interests which can be denominated in terms of money, which may be subject to risk and which are not excluded by law.’

Indemnity

The principle of indemnity is the balance between the amount of compensation and the loss actually suffered by the insured.

Subrogation

Article 284 of the Indonesian Commercial Code states:

The insuring party having paid compensation for losses in respect of insured goods shall obtain all rights possessed by the insured party towards third parties in respect of such losses; and the insured party concerned shall be responsible for all actions which may potentially damage the rights of the insuring party towards such third parties.

Contribution

Article 278 of the Indonesian Commercial Code states:

If in one and the same policy, even though on different days by several insuring parties an amount exceeding the actual value is covered, then the parties concerned shall jointly, proportionately to the amounts respectively signed by them, be only liable for the actual insured value.

This provision shall also be applicable if several insurances are concluded for the same goods on the same date.

III   LIFE INSURANCE POLICY

Insurance policy

Article 255 Indonesian Commercial Code states that ‘insurance must be made in writing in the form of a deed, indicating the name of policy.’ Whereas, in OJK Regulation 23/2015, policy is defined in Article 1 point 6:

The insurance policy is a certificate of insurance agreement or other document equivalent to an insurance agreement, as well as other documents that constitute an inseparable part of the insurance agreement, which is made in writing and contains an agreement between the Insurer and the policyholder.

Article 11 of OJK Regulation 23/2015 regulates the standard contents of the insurance policy:

[The] insurance policy must contain [the following] at least:

a  when the enactment of coverage takes place;
b  description of the agreed benefits;
c  method of premium payment;
d  grace period for premium payment;
The insurance policy must include the fact that there are rights and obligations for the insurer and the insured, with regard to premiums and claims. The premium is a right for the insurer and an obligation for the insured.

Article 1 point 7 of OJK Regulation 23/2015 states:

Premium is amount of money specified by the insurer and approved by the policyholder to be paid under an insurance agreement or a set amount of money under the provisions of the laws and regulations underlying the compulsory insurance programme to benefit.

The claim is the right of the insured and an obligation for the insurer, and claims are the achievements of insurance companies. This is because the insurer pledges the insured party in the insurance policy over the payment of claims when the insured party suffered losses that are covered by the insurance policy.4

ii Life insurance

According to Mr HMN Purwosutjipto, life insurance can be interpreted as mutual agreement between the insured and the insurer where they are bound together during the course of coverage. The insured pays the premium to the insurer, to pay the amount of money that has been promised to the beneficiary, if the person whose soul is insured is dead or the agreed period of time is over.5

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Article 1 point 1b of the Indonesian Act 40/2014 states:

*Insurance is an agreement between two parties, namely the insurance company and the policyholder, which became the basis for the acceptance of premiums by insurance companies in exchange for provide payment based on the death of the insured or a payment based on the life of the insured with a predetermined amount of benefits and/or based on the results of fund management.*

However, in Article 302 of the Indonesian Commercial Code life insurance is defined as: ‘The life of a person may be insured for the benefit of the person concerned, either for a lifetime or for a period of time determined in the agreement concerned.’

From the aforementioned, we can conclude that an indemnity principle as described above is not applicable for life insurance. This is because it is difficult to determine the amount of compensation that is owed after the death of a person. Human life has not just economic value, but also other values that cannot be measured with money, such as religious and social values. 6

The legal basis for the implementation of Life Insurance in Indonesia is regulated in Articles 302–308 of the Indonesian Commercial Code.

In addition to the parties mentioned above (insurers, insured and underwriters), there is an additional party in life insurance: the beneficiary.

Article 303 Indonesian Commercial Code states that: ‘A concerned party may enter into insurance even without the acknowledgment or permission of the person whose life is insured.’

**IV DISPUTE RESOLUTION**

If a dispute claim is submitted by the insured, the first step is to refer to the insurance policy. 7 One of the standard contents of an insurance policy is to contain the settlement of the dispute (choice of forum) as intended in Article 11n of OJK Regulation 23/2015: ‘[a] clause of dispute settlement which among others contains settlement mechanism in court and outside court and chosen place of dispute settlement’.

An insurance policy is the deed of agreement between the insured and the insurers that arranges everything, including the case of dispute and how the dispute was resolved. However, in the Indonesian Law System a *pacta sunt servanda* principle of civil law applies, as intended in Article 1338 paragraph 1 of the Indonesian Civil Code: ‘All valid agreements apply to the individuals who have concluded them as law.’ Therefore, the implementation of all insurance claims, up to dispute settlement, must follow the provisions contained in the insurance policy, Indonesian law or other regulations.

**i Internal dispute resolution**

Article 32 paragraph 1 of OJK Regulation 1/2013 states: ‘The financial services business actor must have and implement the service mechanism and complaint settlement for the consumer.’

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As intended in Article 1 point 12 of OJK Regulation No. 1/POJK07/2014 on Alternative Dispute Settlement Institutions in the Financial Services Sector (OJK Regulation 1/2014):

*Complaint is the expression of consumer dissatisfaction caused by the loss or potential of financial loss to the consumer which is allegedly occurred by mistake or negligence of financial services institution in the placement of fund activity by consumer at financial service institution and/or utilisation of service and/or product of financial services institution.*

However, if a complaint has been issued and one of the party is dissatisfied with the result, then the complaint turns into a dispute and the parties can resolve the dispute through external dispute resolution.

Article 1 point 13 of OJK Regulation 1/2014 states:

*Dispute is a conflict between the consumer and the financial services institution in the placement of funds by the consumer at the financial services institution and/or the utilisation of services and/or products of the financial services institution after going through the process of completion of complaint by the financial services institution.*

A dispute may arise between the insurer and the insured if the insured is not paid the total sum as agreed. The total sum insured is amount of money that the insurer is obliged to pay to the insured in case of their death, in accordance with the agreement contained in the insurance policy.8

If disputes regarding the total sum insured cannot be resolved by internal dispute resolution, then the insured can apply for the dispute to be resolved by external dispute resolution.

### ii External dispute resolution

**Indonesian Meditation and Arbitration Agency (BMAI)**

The BMAI is a legal entity that takes the form of an independent and impartial union. It provides services for the settlement of claims disputes (claims for compensation or benefits) regarding insurance between members of the insurance company and the insured.9

The BMAI was established based on the Joint Decree of four Ministers:

- Coordinating Minister for Economic Affairs No. KEP45/M.EKON/07/2006;
- Governor of the Bank of Indonesia No. 8/50/KEPGBI/2006;
- Minister of Finance No. 357/KMK012/2006; and

Although the BMAI is insurance dispute settlement institution, not all insurance disputes can be solved through the BMAI.

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10 ibid, page 13.
There are several conditions for disputes to be resolved by the BMAI: 11

a) disputes involving insurance claims of up to 500 million rupiahs for general insurance and 300 million rupiahs for life insurance and social insurance;

b) where internal efforts have been sought by the company to resolve disputes, but have failed;

c) disputes that are not related to premium pricing, related policies with interest rate and fees, actuarial standards and generally accepted provisions;

d) disputes that are not related to criminal offences, with complaints filed more than six months after the verdict of rejection by the insurance company;

e) disputes that have not been resolved amicably;

f) disputes that are not commercial; and

g) the dispute has never been brought to court or arbitration and is not being investigated by the authorities.

The insurance dispute settlement is conducted by the BMAI in three stages: the mediation stage, the adjudication stage and the arbitration stage.

**Mediation**

The settlement of an insurance claims dispute received by the BMAI will be handled by a mediator, who will strive for the insured and the insurer to reach an agreement to settle the dispute amicably and reasonably for both parties.

Article 1 point 6 of BMAI’s Decree No. 008/SK-BMAI/11.2014 on Regulation and Procedure of Mediation (BMAI’s Decree 008/2014) states that ‘[The] mediator is a permanent employee of BMAI authorised to conduct investigation and dispute mediation process submitted by the applicant to BMAI.’

The first steps to start the mediation process are given in Article 8 of BMAI’s Decree 008/2014:

*The applicant must fill out and submit the dispute resolution application form (FPPS) provided by BMAI as the basis of the BMAI to investigate a dispute, in accordance with Appendix – 04 of this Decree.*

Article 9 paragraph 1 of the BMAI’s Decree 008/2014 states that ‘[The] FPPS must be filled and submitted by the applicant to BMAI within six months [once] the respondent submits the final rejection letter to the applicant and [if] during the period of six months there is no response/refutation from the applicant.’

The duration for dispute settlement through the BMAI is regulated in Article 16 of the BMAI’s Decree 008/2014: ‘Regarding to the purpose of the institution to resolve the dispute ‘quickly’, then the settlement of dispute under the mediation process must be finished within 30 days from the date of signing of the complete agreement letter of mediation.’

Article 16 paragraph 2 of BMAI Decree 008/2014 states that: ‘The duration referred to [in] paragraph 1 of this Article can be extended for a maximum period of 30 days, with the consent of the parties.’

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Article 17 paragraph 1 of BMAI Decree 008/2014 states:

“If the dispute can be completed through mediation, [the] mediator shall record in writing all the settlement requirements reached by the parties, then the parties shall sign the settlement agreement, in accordance with Appendix - 08 of this Decree.

If the dispute is resolved by mediation, then the mediator must record all the terms of the settlement reached by the parties, then the parties will sign the dispute resolution agreement. However, if the dispute cannot be resolved through mediation, then the parties may proceed to the next stage of adjudication.

**Adjudication**

Before the adjudication process begins, the parties will sign an adjudication agreement provided by the BMAI, which contains the terms and conditions of the adjudication procedure.

Article 17 paragraph 2 of BMAI Decree 008/2014:

“If the dispute cannot be settled through mediation, the mediator will ask the applicant whether the applicant wishes to proceed to the adjudication and if the applicant agrees, the mediator requests the applicant to complete the dispute resolution application form to adjudication (FPPSAj) (Attachment - 09 of This Decree) to the chairman of BMAI for approval.

Article 2 paragraph 3 of BMAI Decree 008/2014:

*Disputes that can be resolved through BMAI adjudication are only disputes that meet the following requirements:*

- *disputes in the field of insurance or related to insurance system;*
- *disputes concerning rights which, by law and other regulations, are fully controlled by the parties;*
- *disputes which, according to the laws and regulations, can be held amicably; and*
- *disputes that have taken the mediation of BMAI but the parties have failed to reach the settlement agreement, and have not pursued other legal remedies outside the BMAI.*

In the settlement of insurance disputes the adjudication council consists of three people.

Article 1 paragraph 2 of BMAI Decree No. 009/SK-BMAI/112014 on Regulation and Procedure of Adjudication of Indonesian Mediation and Arbitration Agency (BMAI Decree 009/2014) states that the ‘adjudicator is an individual who meets the requirements as an adjudicator who is appointed by the board of BMAI according to regulations and procedures of adjudication of BMAI’.

Adjudication aims to conduct a judicial review of the opinions made by the mediator on a case before the opinion or decision is submitted to the parties concerned.12

Article 20 paragraph 1 of BMAI Decree 009/2014 states: ‘The adjudication investigation deadline is maximum of 60 days from the establishment of the adjudication council.’

However, with the authority of the adjudicator council and with the consent of the parties, the duration of investigation can be extended for maximum of 30 days.

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 Arbitration
Disputes that cannot be completed in mediation or adjudication and whose value of disputes exceeds the deferred range of indemnification amount shall be processed by arbitration. The arbitration award shall be final and binding on the parties and may not be requested by appeal, cassation or other legal action.

For dispute settlement through the BMAI, the mediation and adjudication are free. At the arbitration stage, the cost incurred depends on the amount of the disputed claim.

iii Financial Services Authority (OJK)
The OJK gives the opportunity for financial service consumers of the OJK to ask questions, request information, and submit complaints to its financial customer care service.

Article 40 paragraph 1 and Article 40 paragraph 3 of OJK Regulation 1/2013:

Consumers may submit a complaint indicating a dispute between the financial services business actors and the customer to the Financial Services Authority, in this case a member of the board of commissioners in charge of education and consumer protection.

The following requirements must be met if the applicant wants to resolve the dispute through the OJK:

a the applicant must be business service personnel in the field of banking, capital market, pension fund, life insurance, financing, pawn company, or guarantee (maximum settlement of 500 million rupiahs; (Article 41a1 of OJK Regulation 1/2013);

b the financial services business actor has made a settlement effort but the consumers may not accept such settlement, or it has passed the time limit stipulated in the Financial Services Authority Rule (Article 41c of OJK Regulation 1/2013);

c the complaint being filed is not in process or has been terminated by an arbitration or judicial institution, or another mediating agency (Article 41d of OJK Regulation 1/2013);

d the complaint is private in scope (Article 41e of OJK Regulation 1/2013);

e the proposed complaint has never been facilitated by the OJK (Article 41f of OJK Regulation 1/2013); and

f the filing of the settlement of the complaint shall not exceed 60 weekdays from the date of the letter of completion of the complaint delivered by the business service to the consumers (Article 41g of OJK Regulation 1/2013).

The role of the OJK in the dispute resolution of the insurance is to helping the applicant to meet the requested party. However, the OJK is not a mediator or conciliator but a facilitator and is only allowed to facilitate and supervise the settlement process of disputes.

14 Loc cit.
Article 42 OJK Regulation 1/2013 states:

The granting of complaint settlement facility carried out by the Financial Services Authority as intended to in Article 41 is an effort to bring consumers and financial services business actors to review the issues fundamentally in order to obtain a settlement agreement.

This is because, in the end, the dispute arising between the insurer and the insured can only be solved by agreement between the insured and the insurer.

Article 45 OJK Regulation 1/2013 states the following:

(1) The implementation of the facilitation process until the signing of the deed of agreement is conducted within 30 week days since the consumer and financial services business actors signed a facilitation agreement as referred to in Article 44.

(2) The duration of the facilitation process as referred to in paragraph (1) may be extended to the next 30 (thirty) working days based on the agreement made by the consumer and financial services business actors.

iv Litigation

If the insured is still not satisfied with the decision of the BMAI, then he or she can take the civil lawsuit to court.15 Within the Indonesian legal system, insurance disputes are breach of contract where the dispute will be resolved in a district court. Suit is filed to the court where the defendant’s domicile resides (the actor sequitur forum rei principle), as given in Article 118 paragraph 1 of the Revised Indonesian Regulation (HIR):

Civil lawsuit, which scope of the district court’s jurisdiction, must be filled with a letter of request signed by the plaintiff or by his/her authority according to the Article 123, to the head of the district court in the area of the defendant’s residence or if not known where he/she lives, his/her actual domicile.

If the suit is complete, then the court, through its bailiff, will summon the parties and start the trial.

In Indonesian law, there are several trial stages that must be passed:

a mediation;
b statement of claim;
c defendant’s response;
d rejoinder;
e counterclaim;
f evidence and witness;
g closing argument; and
h judicial decision.

Three judges, consisting of one chairman and two judge members are in charge of examining and deciding cases. The dispute resolution process through trials takes more time than other dispute resolution alternatives.

If the judges have decided the case and the defeated party is dissatisfied, then the party can apply a regular legal remedy (appeal, cassation or opposition) or an extraordinary legal remedy (civil request or third-party request).

v Indonesian National Arbitration Body (BANI)

Article 1 point 1 of Indonesian Act No. 30 of 1999 on Arbitration and Alternative Dispute Resolution (Indonesian Act 30/1999) states: ‘Arbitration is a way of solving civil disputes outside the district courts based on the arbitration agreement made in writing by the parties to the dispute.’

The main requirement for parties to be able to use arbitration as a possible dispute settlement is an agreement between the parties in advance. Choosing arbitration as a choice of forum must be stated in insurance policy as given in Article 1 point 3 of Indonesian Act 30/99:

*Arbitration agreement is an agreement in the form of an arbitration clause contained in a written agreement made by the parties before a dispute arises, or a separate arbitration agreement made by the parties after the dispute arises.*

Article 60 Indonesian Act 30/99 states that: ‘[An] arbitration award shall be final and binding legal force on the parties.’

The arbitration award is independent, final and binding, so the chairman of the court is not allowed to examine the reasons or considerations of the national arbitration award.

Regarding the execution of the arbitral award, basically the parties have to implement the decision voluntarily. Nevertheless, the arbitral award can be enforced. This may be done by such decision being submitted and registered to the district court, or by submitting the original or authentic copy of the arbitration award by the arbitrator or his or her proxy to the district court within 30 days of the arbitration award being pronounced. Article 61 of Indonesian Act 30/99 states:

*In case the parties do not implement the arbitration award voluntarily, the award shall be implemented based on the chairman of district court order upon the request of one of the parties.*

V YEAR IN REVIEW

From January to October 2017, the BMAI handled 60 disputes from hundreds of dispute reports that were entered between the insurer and the insured. The number of cases handled in 2017 was more than in the previous year, where the results of mediation and adjudication handled by the BMAI amounted to 36 cases.

The increase in cases is based on the fact that many of the insured who have an insurance dispute chose to use the path of litigation to resolve their disputes.

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For several reasons, the insured are still reluctant to resolve insurance disputes using mediation and arbitration measures that are free of charge. First, BMAI regulations state that the individual applicants are required to follow by themselves all dispute resolution processes, and are not allowed to appoint any parties to represent them. Applicants may be accompanied by a companion, but the companion does not have the right to speak except with the permission of the mediator.\(^{19}\)

Second, those with commercial insurance are generally not classified as the poor who deserve legal assistance in the view of the legal aid legislation.\(^{20}\)

Third, the BMAI is not considered to be sufficiently independent and impartial. This can be seen from the large number of complaints that do not continue mediation.\(^{21}\)

VI OUTLOOK

Referring to data released by the OJK, the value of claims and benefits paid by life insurance companies from January 2017 up to September 2017 reached 49.62 trillion rupiahs. That number is 18.2 per cent less when compared to the same period in the previous year, which reached 58.65 trillion rupiahs.\(^{22}\)

The claim is the point when the insurer decides if there is good faith and whether the insurance company will pay compensation to the customer in the case of loss or accident. Therefore, the claim process from the start to the payment of a claim is clear proof of what the insurance company promised to its customers.\(^{23}\) A high claim ratio shows that the performance of Indonesian insurance companies is good. It fosters public trust for insurance. This can be proven based on a higher life insurance premium income compared to the previous year.

Based on statistics on insurance released by the OJK, life insurance premium income reached 114.8 trillion rupiahs by August 2017, an increase of 36.4 per cent compared to the same period in 2016, which totalled 84.12 trillion rupiahs.\(^{24}\)

In addition to the good performance of the insurance industry, legal certainty will also foster the trust of the people regarding insurance. Indonesia has OJK Regulation 1/2013 as a regulation that protects the rights of the insured as consumers of the financial services sector (issued by the OJK as an institution with a supervisory function in insurance industry). Furthermore, the OJK also issued OJK Regulation 23/2015, that regulates the standard contents of the insurance policy, showing, basically, that the insurance policy is an agreement or engagement between the insurer and the insured, in which the rights and obligations of each party have been regulated.\(^{25}\) In the end, all actions including payment of claims (total sum insured) and dispute resolution refer to the policy.

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\(^{20}\) Loc cit.

\(^{21}\) Loc cit.


Chapter 20

IRELAND

Sharon Daly, Darren Maher, April McClements and Gráinne Callanan

I INTRODUCTION

The UK’s decision to leave the European Union has resulted in a number of financial services firms engaging with the Central Bank of Ireland (the Central Bank) to discuss potential moves and authorisation, ranging from UK firms looking to re-establish themselves in advance of Brexit in a country with guaranteed access to the single market to a number of branches of UK entities in Ireland considering their future corporate structures post-Brexit.

The efficiency of Irish domestic regulators, well-established prudential regulation and a young, well-educated English-speaking workforce has cemented Ireland’s status as a thriving hub for the insurance industry in the EU.

The moves come as the possibility of a no-deal Brexit arises, despite a ‘standstill’ transition agreement being struck between the EU and the UK government in March 2018, which was arguably designed to avoid such relocations.

II REGULATION

i The insurance regulator

The Central Bank has responsibility for the authorisation and ongoing supervision of insurance and reinsurance undertakings, insurance intermediaries and captives.

The supervisory role of the Central Bank involves ongoing review and assessment of an undertaking’s corporate governance, risk management and internal control systems. The Central Bank’s administrative sanctions regime provides it with a credible tool of enforcement and acts as an effective deterrent against breaches of financial services law.

In order to facilitate this supervisory process, insurance and reinsurance undertakings are obliged to submit annual and quarterly returns to the Central Bank in respect of their solvency margins and technical provisions. The Central Bank is also empowered to conduct regular themed inspections across the industry. There are certain requirements that regulated firms under the Central Bank’s supervision must comply with on an ongoing basis, including the Corporate Governance Requirements for Insurance Undertakings 2015, the Corporate Governance Requirements for Captive Insurance and Reinsurance Undertakings 2015, the Consumer Protection Code 2012, the Fitness and Probity Standards, the Minimum Competency Regulations 2017 and the Minimum Competency Code 2017.

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1 Sharon Daly, Darren Maher, April McClements and Gráinne Callanan are partners at Matheson.
ii Requirements for authorisation

To operate as an insurance undertaking in Ireland, an entity must either be authorised and regulated by the Central Bank or authorised by another EU regulator, which in turn enables it to avail of the single passport regime.

As to the process applied by the Central Bank when reviewing a licence application made pursuant to European Union (Insurance and Reinsurance) Regulations 2015 (the Irish Regulations), which transposed the EU Directive 2009/138/EC (Solvency II) into Irish law, the applicant first has a preliminary meeting with the Authorisations Team of the Central Bank. Thereafter, the application proceeds through the submission of a detailed application and business plan to the Central Bank.

Broadly, subject to the applicant satisfying the requirements of the Central Bank in respect of minimum capital requirements and any additional preconditions or undertakings specified in the letter of authorisation in principle issued by the Central Bank, the applicant will be issued with a formal final certificate of authorisation.

A reinsurance provider can also establish a special purpose reinsurance vehicle (SPRV), which can streamline the authorisation process and is subject to less rigorous supervision by the Central Bank in comparison with fully regulated insurers.

The ongoing regulatory requirements of regulated firms under the Central Bank's supervision include, where applicable:

- ensuring it retains authorisation from the Central Bank;
- maintaining technical reserves and required solvency margin;
- submitting quarterly and annual returns in respect of minimum capital requirements;
- ensuring compliance with the relevant corporate governance codes and guidance, as published by the Central Bank;
- ensuring compliance with the general good requirements contained in the Consumer Protection Code (in the case of Irish resident undertakings); and
- ensuring compliance by all directors, executives and staff with the fitness and probity regime.

iii Regulation of individuals employed by insurers

As part of an application for authorisation, the Central Bank reviews both the proposed corporate governance structures and the individuals who are to be appointed to key roles within the insurance and reinsurance undertaking. This is to ensure that the undertaking has the necessary people, skills, processes and structures to successfully manage its insurance and reinsurance business.

All proposed directors and senior management will have to apply to the Central Bank for prior approval to act as part of the Central Bank’s Fitness and Probity regime. Forty-six senior positions are prescribed as pre-approval controlled functions (PCFs), including the positions of director, head of finance and head of compliance. PCFs are a subset of Controlled Functions (CFs) – in other words PCFs are by definition also CFs.

Unlike CFs, the prior approval of the Central Bank is required before an individual can be appointed to a PCF, to ensure that a person performing a PCF has a level of fitness and probity appropriate to the performance of that particular function. The individual must complete an online individual questionnaire that is endorsed by the proposing entity and then submitted electronically to the Central Bank for assessment.
The main implication of being appointed to a PCF role is that a person must comply on an ongoing basis with the Fitness and Probity Standards introduced by the Central Bank Reform Act 2010 and confirm this in writing to the Central Bank.

Where a person comes within the Minimum Competency Framework (as defined in subsection vi), qualifications may be necessary but generally no set exams are mandatory. The Central Bank is required to set out a specification for each PCF role that might include a qualification (see Appendix 4 of the Minimum Competency Code 2017), and the PCF holder must meet that specification.

iv The distribution of products
Once an insurance and reinsurance undertaking holds the relevant authorisation, it is entitled to market and sell both its services and contracts in Ireland. However, the manner in which insurance and reinsurance contracts can be marketed and sold to the consumer is subject to a number of general good requirements contained in the Consumer Protection Code 2012 (published by the Central Bank); Consumer Protection Act 2007; Sale of Goods and Supply of Services Act 1980; European Communities (Unfair Terms in Consumer Contracts) Regulations 1995; and the European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004.

v Taxation of premiums

Non-life insurance companies
Non-life insurance business carried on by a company is taxed at the standard rate of 12.5 per cent corporation tax. While profits liable to taxation are generally recognised in accordance with relevant accounting treatment, particular accounting treatment applies to certain aspects of the insurance business such as: the realisation of non-financial investment assets; treatment of equalisation or catastrophe reserves; and taxation of captive insurers (which is similar to the treatment of non-captives).

Life assurance companies
There is a divergence in the tax treatment of life assurance companies, depending on whether its life assurance business was contracted before or after 1 January 2001. Business contracted prior to 1 January 2001 is taxed on investment return as apportioned between policyholders and shareholders, with the policyholder’s share taxed at 20 per cent on an annual basis and the shareholder’s share taxed at 12.5 per cent corporation tax rate. Conversely, for business contracted after 1 January 2001, income and gains within the fund are not liable to tax for the term of the policy. Exit taxes arise on payments made to certain classes of Irish policyholders. The exit tax rates applicable are 25 per cent where the policyholder is a company and opts to make an election or 41 per cent in all other cases. Policyholders that are not resident in Ireland and can provide a declaration to that effect are exempt from paying tax in Ireland. The insurer's income from business contracted after 1 January 2001 is liable to tax at the standard corporation tax rate of 12.5 per cent.

Reinsurance companies
Reinsurance business is taxed in the same manner as non-life insurance businesses at the standard 12.5 per cent corporation tax rate. The distinction between business contracted before or after 1 January 2001 in respect of life assurance businesses does not apply to
reinsurance companies. However, it is possible to establish SPRVs on a tax-neutral basis, provided they qualify under Section 110 of the Taxes Consolidation Act 1997. SPRVs are liable to tax at 25 per cent; however, this is charged on the company’s net taxable profit, which, by virtue of specific tax-deductible expenditure, can be maintained at a very low level.

vi  Changes to the regulatory system
The Financial Services and Pensions Ombudsman Act 2017 (the 2018 Act) came into force on 1 January 2018. The 2018 Act amalgamates the Financial Services Ombudsman and the Pensions Authority into the Office of the Financial Services and Pensions Ombudsman (FSPO). The 2018 Act strengthens the functions of the FSPO and extends the limitation period for bringing complaints to the FSPO.

The limitation period for consumer complaints in respect of long-term financial services has been extended from six years to: (1) six years from the date of the conduct giving rise to the complaint; (2) three years from the date on which the person making the complaint first became aware or ought to have become aware of that act or conduct; or (3) a longer period, as may be permitted by the FSPO.

Significantly, the 2018 Act applies retrospectively although it is limited to conduct complained of after 2002. Therefore, the FSPO can investigate conduct complained of before the enactment of the 2018 Act owing to the extended limitation period, in circumstances where such complaints would have been previously refused as a result of being statute barred. However, the service to which the complaint relates must also not have expired or have been terminated more than six years before the date of the relevant complaint.

On 24 January 2019, the FSPO published 228 legally binding decisions from 2018. The FSPO stated that the aim in publishing the decisions was to enhance transparency of its powers and services. It can now award compensation of up to €500,000. It can also direct a regulated provider to rectify the conduct that is the subject of a complaint, and there is no limit on the value of the rectification that can be directed. The vast majority of complaints are successfully resolved at mediation.

The EU (Non-Financial and Diversity Information Disclosure) Regulations 2017 (the 2017 Regulations) came into operation on 21 August 2017 and apply in respect of all financial years commencing on or after 1 August 2017. The 2017 Regulations introduce two distinct obligations based on different qualifying criteria: non-financial reporting and diversity reporting. It is possible for a company to fall within the scope of both reporting regimes. The 2017 Regulations apply to companies that:

- qualify as a large company under Section 280H of the Companies Act 2014 (the Act);
- have an average number of employees that exceeds 500; and
- is an ineligible entity under the Act, meaning an undertaking that:
  - has transferable securities admitted to trading on a regulated market of any Member State;
  - is a credit institution; and
  - is an insurance undertaking, or is another type of undertaking specified in the Act, for example, an investment company.

The non-financial statement should contain information relating to environmental matters, social and employee matters, respect for human rights, and bribery and corruption matters, to the extent necessary for an understanding of the development, performance, position
and impact of the company's activity relating to these matters. A brief description of the company's business model, policies and an analysis of the non-financial key performance indicators relevant to the particular business should also be included.

The 2017 Regulations were amended, with effect from 17 October 2018, by the European Union (Disclosure of Non-Financial and Diversity Information by certain large undertakings and groups) (Amendment) Regulations 2018 (the 2018 Regulations). Most of the amendments introduced are technical in nature, designed to clarify perceived ambiguities in the drafting of the 2017 Regulations. There is now a requirement for non-financial information to be included in the director’s report (in the Company’s audited financial statements), or, in certain circumstances, in a separate statement.


The Minimum Competency Framework has been introduced to incorporate the implementation of the Insurance Distribution Directive (IDD), the Markets in Financial Instruments Directive II, the associated European Securities and Markets Authority Guidelines, and the European (Consumer Mortgages Credit Agreements) Regulations 2016.

The Minimum Competency Framework sets out certain minimum professional standards for persons providing financial services, in particular, persons exercising a controlled function on a professional basis. The revised framework aims to ensure that consumers obtain a minimum acceptable level of competence from staff acting for and on behalf of regulated firms in providing advice and information and associated activities in connection with retail financial products. The main changes under the revised Minimum Competency Framework relate to the qualification and experience requirements of the staff of financial services providers. All staff carrying out a relevant function must now:

a. have a recognised qualification (as defined in the Minimum Competency Code 2017);
b. comply with the grandfathering provisions; or
c. comply with the new entrants’ provisions, which includes participating in a training process.

Staff are also required to complete annual continuing professional development training, and regulated firms are required to maintain written records of this training and review their staff’s development and experience needs. Additional standards must be complied with where staff exercise a controlled function involving:

a. MiFID services and activities;
b. mortgage credit;
c. insurance and reinsurance undertakings and insurance intermediaries; and
d. design of retail financial products.

Regulated firms are now required to conduct an annual review of their staff’s development and experience needs. The Minimum Competency Code 2017 requires regulated firms to provide a certificate of such qualifications, if requested to do so by a consumer.
The EU Regulation on Packaged Retail and Insurance-Based Investment Products (PRIIPs) (the PRIIPs Regulation),\(^2\) supplemented by the PRIIPs Regulatory Technical Standards 2017 (RTS),\(^3\) came into effect on 1 January 2018. The PRIIPs Regulation is a key piece of legislation, which aims to enable retail investors to understand and compare the key features and the potential risks and rewards of investment products, funds and investment-linked insurance policies.

PRIIPs introduce the obligation to provide a key information document (KID), which is a pre-contractual fact sheet that will inform retail investors of the main features, risks, reward profile and costs associated with a product in a clear and accessible manner. The form and content of the KID is standardised by the RTS in order to facilitate the comparison of similar products and coordinate disclosure requirements across the European insurance market. The wide definition of PRIIPs under the PRIIPs Regulation means that all manufacturers and financial intermediaries that distribute PRIIPs to retail investors fall within its scope. However, certain products, including non-life insurance products and pension products, are specifically excluded from its application and entities subject to the Undertakings for Collective Investment in Transferable Securities are not obliged to comply with PRIIPs until 1 January 2020.

Data protection is governed by the Data Protection Acts 1988 to 2018 (DPA), as amended from time to time, and the General Data Protection Regulation (GDPR),\(^4\) which came into force on 25 May 2018 (together with other EU Regulations, Directives, Decisions and Guidelines on data protection and data privacy, and guidance issued by the Irish Data Protection Commission (DPC) and the European Data Protection Board).

The GDPR is directly effective in Ireland, meaning that the Irish parliament did not have to implement national legislation for the GDPR to become law. However, the GDPR allows EU Member States to introduce national law derogating from some of its provisions and this has been done in Ireland through the DPA. It introduces a number of derogations, including an exemption, subject to suitable safeguards for data subject rights, to the general prohibition on the processing of data concerning health where the processing is necessary and proportionate for insurance and pension purposes.

Many of the principles relating to the processing of personal data under the GDPR are broadly the same as those set out under the EU Data Protection Directive\(^5\) (which was repealed by the GDPR). However, the GDPR enhances the EU data protection framework in a number of ways, including enhancing data subject rights and transparency, greater penalties for breach, and extraterritorial effect in certain circumstances. It also introduced the principle of accountability pursuant to which controllers and processors must be able to demonstrate compliance with their respective obligations under the GDPR.

With regard to enforcement of data protection laws, the DPA introduces enhanced powers for the DPC, and the government has significantly increased the DPC’s budget in recent years. The DPC has indicated that it will continue to proactively undertake initiatives to build awareness of the GDPR, and has increased its staff numbers accordingly. These

\(^2\) No. 1286/2014.
\(^3\) Delegated Regulation 2017/653.
\(^5\) Directive 95/46/EU.
developments reflect a commitment to enforcing compliance with the GDPR, and suggest that the DPC will be in a strong position to take action against controllers and processors that breach the rights of individuals under the GDPR.

vii  Capital requirements

Insurance undertakings regulated by the Central Bank are required to meet the capital and solvency requirements set out under Solvency II and the Irish Regulations.

Irish-authorised insurance undertakings are required to establish and maintain technical provisions in respect of all insurance and reinsurance obligations towards policyholders and beneficiaries of insurance and reinsurance contracts. The value of technical provisions must correspond to the current amount an undertaking would have to pay if it were to transfer its insurance and reinsurance obligations immediately to another insurance undertaking. The Irish Regulations set out detailed provisions for the calculation of technical provisions.6

In accordance with Solvency II, Irish-authorised insurance undertakings are also required to establish and maintain a further solvency margin as a buffer, to ensure their assets are sufficient to cover their liabilities. The Solvency II capital requirements are calculated based on the specific risks borne by the relevant insurer and are prospective in nature (i.e., each insurer must make the relevant calculations at least once a year to cover both existing business and the new business expected to be written over the following 12 months). Solvency II imposes a solvency capital requirement (SCR) and a lower minimum capital requirement (MCR).

An insurance undertaking may calculate the SCR based on the formula set out in the Irish Regulations or by using its own internal model approved by the Central Bank. The SCR should amount to a high level of eligible own funds, thereby enabling the undertaking to withstand significant losses and ensuring a prudent level of protection for policyholders and beneficiaries. The MCR should be calculated in a clear and simple manner, corresponding to an amount of eligible, basic own funds, below which policyholders and beneficiaries would be exposed to an unacceptable level of risk if the undertaking was allowed to continue its operations.

An insurance undertaking must have procedures in place to identify and inform the Central Bank immediately of any deteriorating financial conditions. As such, the SCR and MCR provide for clear channels by which the Central Bank can monitor the financial state of insurance undertakings. In the event of a breach of the capital requirements, the Central Bank will employ an escalating ladder of supervisory intervention, allowing for the implementation of a recovery plan by an insurance undertaking, as approved by the Central Bank. Where there is a breach of the SCR or MCR, compliance must be re-established within six months or three months respectively, otherwise the Central Bank may restrict the free disposal of the assets of the undertaking and ultimately withdraw its authorisation.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Statute

In general terms, insurers retain significant freedom of contract; however, this has been tempered in recent years by legislation enacted to comply with EU law in the area of consumer protection including the Unfair Terms in Consumer Contracts Directive 1993/13/EC and the Distance Marketing of Financial Services Directive 2002/65/EC.

In circumstances where the insured is a consumer, the insurer must also comply with the Consumer Protection Code 2012 and Consumer Protection Act 2007. The Sale of Goods and Supply of Services Act 1980 is also applicable to insurance contracts.

With the exception of the transposition of EU legislation, there have been very few substantive legislative amendments to the law in this area in recent years. The Marine Insurance Act 1906 remains the most recent codification of general principles of insurance law.

The Law Reform Commission (LRC) has, however, recommended reforms to consumer insurance law and published a draft bill in July 2015. The LRC recommendations were largely incorporated into the Consumer Insurance Contracts Bill 2017 (the 2017 Bill), which was referred to the Select Committee on Finance, Public Expenditure and Reform, and Taoiseach in February 2017. The 2017 Bill is at the third stage before the Dáil, however, there is no clear timeline for implementation.

The definition of a consumer in the 2017 Bill is quite broad and includes individuals and small businesses with a turnover of less than €3 million (provided that these persons are not a member of a group having a combined turnover greater than €3 million). This is the definition used for the purpose of complaints to the FSPO and under the Central Bank’s Consumer Protection Code 2012.

The European Union (Insurance Distribution) Regulations 2018 (as amended) (IDR) transposed the IDD into Irish law with effect from 1 October 2018. The IDD creates a minimum legislative framework for the distribution of insurance and reinsurance products within the European Union, and aims to facilitate market integration and enhance consumer protection.

The IDR introduces general consumer protection principles for all insurance distributors to act honestly, fairly and professionally, and in accordance with the best interests of the customer. Insurance distributors may not incentivise or remunerate their employees in a manner that would conflict with their duty to act in the customers’ best interests. In addition, insurance intermediaries are required to disclose the nature of any remuneration received in relation to an insurance contract to the customer.

Insurance undertakings and intermediaries that manufacture any insurance product for sale to customers are required to implement product oversight and governance procedures prior to distributing or marketing an insurance product to customers. A target market must be identified for each product to ensure that the relevant risks to that target market are identified, assessed and regularly reviewed.

Common law

The law in relation to insurance contracts in Ireland is primarily governed by common law principles, the origins of which can be found in case law.
Making the contract

**Essential ingredients of an insurance contract**

Insurance contracts are governed by the general principles of contract law, common law and the principle of good faith. There are no specific rules for the formation of an insurance contract beyond these general duties. There is no statutory definition of a contract of insurance under Irish law, and the legislation does not specify the essential legal elements of an insurance contract. As a result, the courts have considered it on a case-by-case basis.

The common law definition of an insurance contract is of persuasive authority. The main characteristics of an insurance contract were set out in the leading Irish authority, *International Commercial Bank plc v. Insurance Corporation of Ireland plc*, and are as follows:

a. generally, the insured must have an insurable interest in the subject matter of the insurance policy;
b. payment of a premium;
c. the insurer undertakes to pay the insured party in the event of the happening of the insured risk;
d. the risk must be clearly specified;
e. the insurer will indemnify the insured against any actual loss (indemnification); and
f. the principle of subrogation is applied, where appropriate. This is generally not appropriate in relation to life assurance or personal injury policies.

There is no difference between an insurance contract and a reinsurance contract.

In the context of consumer policies, the 2017 Bill proposes to reform the area of insurable interests. Section 5 of that Bill provides that an insurer cannot reject an otherwise valid insurance contract on the basis that the insured does not or did not have an insurable interest. Where the contract of insurance is also a contract of indemnity, the insured must have an interest, however, it does not need to extend past a factual expectation of an economic benefit from preserving the subject matter or loss on its destruction damage or loss. In addition, an insurer may not refuse liability under a contract on the basis that the name of the person who may benefit is not specified in the policy.

An insurance policy will usually comprise a proposal form, policy terms and conditions, and supporting documentation provided to the insurer by the insured. The policy will typically contain express terms defining the cover being provided, exclusions to cover, excess, conditions or conditions precedent and warranties.

**Information provided to the insurer at placement**

The information provided to the insurer at placement depends on the risk and the requirements of the insurer in question; however, there has been a trend towards very short proposal forms that do not request detailed information about the risk. It was anticipated this would change in line with the changes in the UK driven by the Insurance Act 2015; however, it remains to be seen whether there will in fact be a significant change in Ireland.

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Utmost good faith, disclosure and representations

Parties to contracts of insurance are subject to the duty of utmost good faith. As a result, the insured or proposer has a duty prior to renewal or inception to disclose all material facts. The remedy for breach of the duty is avoidance.

A material fact is one that would influence the judgement of a prudent underwriter in deciding whether to underwrite the contract; and, if so, the terms (such as the premium) on which it might do so.

The duty goes beyond a duty to answer questions on a proposal form correctly; however, the courts have confirmed that the questions posed on the proposal form will inform the duty. There is no requirement to show inducement under Irish law.

Misrepresentation is closely related to non-disclosure and attracts the same remedy. To rely on misrepresentation, the insurer must establish that there has been a representation of fact made by the insured that is untrue. Misrepresentations can be fraudulent, reckless or innocent. The common law position is that a misrepresentation is fraudulent if made with knowledge of its falsity or without belief that it was true or with reckless disregard as to whether it was true or false.

In practice, many insurance policies contain ‘innocent non-disclosure’ clauses that prevent the insurer from avoiding the policy for an innocent non-disclosure or misrepresentation.

In respect of consumer insurance only, the 2017 Bill proposes to replace the duty of disclosure with a duty to answer specific questions honestly and with reasonable care. The questions posed by the insurer should identify the material risk and the relevant information actually to be relied upon by the insurer. There is no duty to provide additional information on renewal unless specifically requested by the insurer. The 2017 Bill also proposes that in cases of innocent or negligent non-disclosure and misrepresentation, the principal remedy should be to adjust the payment of the claim taking account of the carelessness of the insured and whether the breach in question affected the risk. The 2017 Bill retains avoidance as a remedy for fraudulent breaches on public policy grounds.

Recording the contract

Insurance contracts are generally required to be evidenced by a written policy. There are various legislative provisions that impose mandatory requirements concerning the form and content of insurance contracts, some of which are derived from EU law. The 2017 Bill proposes to consolidate the essential requirements concerning the form of consumer insurance contracts in a single general legislative framework.

iii Interpreting the contract

General rules of interpretation

Insurance contracts are subject to the same general principles of interpretation as other contracts. The Supreme Court has confirmed in two judgments, Analog Devices v. Zurich Insurance and ors and Emo Oil v. Sun Alliance and London Insurance Company, that the principles of construction as set out by Lord Hoffman in ICS v. West Bromwich Building Society should be applied to the interpretation of insurance contracts.

In summary, interpretation is the ascertainment of the meaning that the document would convey to a reasonable person having all the background knowledge that would reasonably have been available to the parties in the situation in which they were at the time of
the contract. The background or ‘matrix of fact’ should have been reasonably available to the parties and includes anything that would have affected the way in which the language of the document would have been understood by a reasonable person. The previous negotiations of the parties and their declarations of subjective intent are excluded from the admissible background. The meaning that a document (or any other utterance) would convey to a reasonable person is not the same thing as the meaning of its words. The meaning of the document is what the parties using those words against the relevant background would reasonably have been understood to mean. The ‘rule’ that words should be given their ‘natural and ordinary meaning’ reflects the common-sense proposition that it is not easy to accept that people have made linguistic mistakes, particularly in formal documents. However, if it could nevertheless be concluded from the background that something must have gone wrong with the language, the law does not require judges to attribute to the parties an intention that they plainly could not have had.

The court will apply an objective approach to determine what would have been the intention of a reasonable person in the position of the parties.

Where a contractual term is ambiguous, the interpretation less favourable to the drafter is adopted using the contra proferentem rule.

**Incorporation of terms**

In general, there are no mandatory provisions that are implied by the law or regulation in insurance policies, although the following exist:

- implied restrictions contained in motor insurance policies;
- provisions in the Criminal Justice (Drug Trafficking) Act 1996 concerning minimum disclosure requirements; and
- professions whose professional bodies set professional indemnity insurance requirements. For example, practising solicitors, accountants and architects are required to have appropriate professional indemnity cover.

The all-important element in the declaration usually contained in a proposal form is the phrase that makes the declaration the ‘basis of the contract’. In making the proposal the basis of the contract, the proposer warrants the truth of his or her statements and, in the event of a breach of the warranty, the insurer can repudiate liability under the policy without reference to issues of materiality. However, basis of the contract clauses are considered to be very draconian by the courts and there is a judicial reluctance to enforce these clauses. The 2017 Bill proposes to abolish basis of the contract clauses in consumer insurance policies.

**Types of terms in insurance contracts**

Typically, insurers in the Irish insurance market have standard policy conditions for each product that have developed over time. These policy conditions are influenced by industry norms as well as Irish judicial decisions in cases involving contractual clauses. Further, most Irish insurers and reinsurers underwriting international business are familiar with London market terms (International Underwriting Association and Lloyd’s Market Association).

A policy will typically include express terms defining:

- coverage: the extent of the insurer’s potential liability to the insured;
- exclusions: matters expressly excluded from cover;
- excess: the initial amount of any loss that the insured must bear themselves;
- conditions precedent to cover, for example notification provisions; and
warranties: statements of fact or continuing intention by the insured in relation to the risk underwritten, such as a warranty that certain precautions will be taken in respect of particular activities.

Warranties are construed very strictly by the courts in circumstances where the breach discharges the insurer from liability from the date of breach (irrespective of whether the breach is material to the loss) and they are thus considered to be draconian. The 2017 Bill proposes to abolish warranties in consumer insurance contracts and replace these with suspensive conditions.

Almost all insurance policies list terms of the contract as conditions. The effect of a breach of condition in an insurance policy depends on whether that condition is a condition precedent to liability. Breach of a condition precedent entitles the insurer to decline cover for a claim in the event of a breach without the necessity to demonstrate that the insurer has suffered any prejudice. The remedy for breach of a bare condition is in damages. The courts will not construe an insurance condition as a condition precedent unless it is expressed as a condition precedent, or the policy contains a general condition precedent provision.

‘Follow the fortunes’ and ‘follow the settlements’ clauses are common in reinsurance agreements.

iv Intermediaries and the role of the broker

Conduct rules

In order to undertake insurance and reinsurance distribution activities in Ireland, a person must be registered as an insurance and reinsurance intermediary pursuant to the IDR.

The IDR removed ‘insurance policies’ from the definition of investment instruments within the Investment Intermediaries Act 1995 (IIA), which means that certain intermediaries who were previously required to be registered under both the IIA and the IDR are now no longer required to be authorised under the IIA as well and have contacted the Central Bank to revoke their IIA registration.

Insurance and reinsurance distribution involves work undertaken in connection with entering into contracts of insurance and reinsurance, work undertaken prior to entering into such contracts, introducing persons to insurance and reinsurance undertakings or other insurance and reinsurance intermediaries with a view to entering into such contracts, or assisting in the administration and performance of such contracts (including loss assessing and dealing with claims under insurance contracts).

In fulfilling its statutory role, the Central Bank operates a robust authorisation process that requires applicants to demonstrate compliance with the authorisation standards set out in the legislation described above. Before the Central Bank will authorise an insurance or reinsurance mediator and enter it into the register, the applicant must satisfy the Central Bank that:

a the directors satisfy the Minimum Competency Framework as published by the Central Bank;

b the undertaking holds certain minimum levels of professional indemnity insurance;

c senior management and key personnel possess the requisite knowledge and ability; and

d the undertaking will implement internal procedures for the proper operation and maintenance of client premium accounts.
Agency and contracting

The general law on agency applies equally to insurance intermediaries in Ireland. An insurance intermediary means a person who, for remuneration, undertakes or purports to undertake insurance distribution. As discussed previously, any person carrying on insurance distribution activities in Ireland is required to comply with the requirements of the IDR.

The wide definition of insurance distribution under the IDR captures the activity of nearly all insurance agents who assist a customer in entering into an insurance contract with an insurance undertaking or provide services which are complimentary to an insurance product subject to specific exemptions.

An insurance intermediary can at different times act as agent of either client or the insurer.

Generally speaking, an agent is one who is authorised by a principal to enter into binding contractual relationship with a third party. For example, an insurance intermediary may only handle premium rebates due to consumers where there is an express agreement to act as the agent of the relevant insurance undertaking.

An agent’s authority to act on behalf of the principal may be actual or apparent. Actual authority may be expressed or implied and is most commonly expressed in an agreement. Apparent or implied authority exists where the principal’s actions or words would lead a reasonable person to believe that the agent was authorised to act.

An agent’s duties are typically to the principal alone although this may not always be the case in an insurance context and depends on the nature of the party undertaking the activity. An insurance agent will be deemed to be acting as the agent of the insurer when he or she completes, or assists the proposer to complete, a proposal for insurance with the insurer (from whom the agent holds an appointment). In these circumstances, the insurer is responsible for any error or omission in the completion of the proposal. Similarly, an insurer will be responsible for any act of its tied agent with regard to a contract of insurance offered or issued by that insurer.

An independent insurance intermediary may act on behalf of both their client and the insurer (e.g., although acting for client, it will be the agent of the insurer when collecting premium).

The agent is entitled to remuneration from the principal as well as an indemnity from the principal for any expenses or losses incurred in action for the principal.

There are numerous types of insurance intermediaries in insurance law. For example, an insurance broker typically works independently from insurance companies when advising customers on the range of insurance products available on the market. Insurance brokers guide clients in selecting the most appropriate insurance product for their needs by obtaining quotes from a number of insurance companies and assessing the suitability of the various products for the individual customer. There is no defined number of insurance companies that the broker must review as part of its fair analysis of the market. In practice, it will be reviewed on a case-by-case basis and will depend on many factors such as the number of providers offering insurance products in that market.

On the other hand, a multi-tied insurance intermediary is an intermediary that has a limited number of exclusive arrangements in place with a small number of insurance undertakings, whereas a tied insurance intermediary is an intermediary that has an exclusive arrangement in place with the insurer.

Outsourcing is permitted provided that the insurance intermediary otherwise has an appropriate level of substance, such as a full-time Irish resident senior management team.
Generally, any functions of an insurance intermediary may be outsourced intra-group or to a third party provided that appropriate oversight and control is retained by an Irish registered intermediary.

Any outsourcing must not: (1) materially impair the insurance intermediary’s system of governance; (2) cause an undue increase in operational risk; (3) impair the supervisory monitoring of compliance with obligations; or (4) undermine the continuous and satisfactory service to policyholders.

**How brokers operate in practice**

Intermediaries act as agents on behalf of insurance undertakings and are typically appointed by an insurance undertaking under the terms of a distribution agreement or claims administration agreement. An intermediary must be registered with the Central Bank as an authorised insurance intermediary (in accordance with the legislative provisions referenced above) before being permitted to advise consumers on insurance products and carry out other specified activities on behalf of insurance companies (e.g., loss-assessing and claims administration). Important requirements for registered intermediaries in Ireland include:

a. ensuring the proper maintenance and reconciliation of designated client premium accounts;

b. ensuring that the undertaking has sufficient professional indemnity insurance cover; and

c. ensuring that senior management are sufficiently experienced to manage the business and to carry on activities on the intermediary’s behalf.

**Claims**

**Notification**

Notice requirements will vary depending on whether the policy in question is claims-made or losses-occurring. Claims-made policies typically require insurers to be notified of circumstances that may give rise to a claim within a short period of the insured becoming aware of the circumstances, and usually the policy will require notification of the circumstances and claims as soon as reasonably practicable. Some policies will specify time limits for notification.

Where the notice requirements are stated to be a condition precedent to cover, the insurer will be entitled to decline cover for a breach of these requirements without needing to establish that it has suffered prejudice as a result of the breach. If the notice requirement is not stated to be a condition precedent and is a bare condition, the only remedy available to an insurer for breach of a condition is damages.

The courts are reluctant to allow insurers to decline claims on the basis of a technical breach of notice conditions, particularly where that breach is failure to notify a circumstance. The test applied by the courts is objective, however the court will consider whether the insured had actual knowledge of the circumstance that allegedly should have been notified to the insurers. The knowledge of the insured is a subjective test.

**Good faith and claims**

While much of the case law regarding the duty of good faith is focused on the pre-contractual duty, the duty continues post-contract and is a mutual duty. There is, however, no common law duty on the insured to disclose changes in the risk insured during the policy period (although the contract may contain a requirement to this effect).
Once a contract of insurance has been concluded, the relationship between insurer and insured is predominantly governed by the terms of the policy and typically the policy will impose obligations on the insured in relation to matters such as payment of premium, notification of claims and claims cooperation.

The consequence of making a fraudulent claim is avoidance and the policyholder also forfeits the premium paid under the insurance contract.

As noted above, the duty of good faith is mutual in nature; however, in practice breach of the duty by the insurer is rarely ever pursued because the only remedy for breach of the duty of good faith is avoidance of the contract. There are no statutory rules that relate to the time in which a claim should be settled by an insurer, although provisions on claims settlement are included in the Central Bank's Consumer Protection Code 2012. In addition, the 2017 Bill proposes that, in the case of consumer insurance contracts, the insurer should be under a duty to handle claims promptly and fairly, and the insured should be entitled to damages where an insurer unreasonably withholds or delays payment of a valid claim.

**Set-off and funding**

As per Regulation 20 of the European Communities (Reorganisation and Winding-up of Insurance Undertakings) Regulations 2003, the right of creditors to demand set-off of their claims against the claims of the insurance undertaking where set-off is permitted by the law applicable to the insurance undertaking's claim is not affected by winding-up proceedings against the insurance undertaking. However, a creditor must be in a position to demonstrate mutuality of claims between the parties in order to be able to rely on statutory set-off.

**Reinstatement**

The principle of indemnity has, to an extent, been eroded by insurers offering policies on a 'new for old' or 'reinstatement as new' basis, without any deduction for betterment or wear and tear, particularly in the areas of property damage and motor insurance.

A policy written on a reinstatement as new basis is subject to the principle of indemnity in that the insured cannot recover more than his or her loss. The sum insured in the policy is the maximum sum payable by insurers, but not necessarily the amount paid. If the work of reinstatement is not carried out, or is not carried out as quickly as is reasonably practicable, the insurer is only liable to pay the value of the property at the time of the loss.

**Dispute resolution clauses**

Insurance policies often contain a dispute resolution clause enabling either party to refer a contractual dispute to a particular dispute resolution forum before proceeding to litigation. Arbitration clauses are the most common in this regard; however, mediation has developed into a common form of dispute resolution.

**IV  DISPUTE RESOLUTION**

**i  Jurisdiction, choice of law and arbitration clauses**

Any dispute arising under an insurance or reinsurance contract that contains an arbitration clause must be referred to arbitration. If court proceedings are brought and there is an
arbitration agreement, the proceedings may be stayed in favour of arbitration. In circumstances where there is no arbitration clause in the contract, subject to the terms of the contract, the dispute will be brought before the Irish courts.

Mediation is also a common form of dispute resolution in Ireland, and since the introduction of the Mediation Act 2017 on 1 January 2018 solicitors are required to advise their clients on the merits of mediation as an alternative dispute resolution (ADR) mechanism prior to issuing court proceedings. In addition, to issue proceedings, the Mediation Act requires the solicitor to swear a statutory declaration confirming that such advice has been provided and this declaration must be filed with the originating document in the relevant court office.

Choice of forum, venue and applicable law clauses in insurance and reinsurance contracts are generally recognised and enforced by the courts in Ireland. However, where the insured is domiciled in an EU Member State, the following European regulations may limit the application of these provisions in insurance contracts:

a. Regulation (EC) 44/2001 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (Brussels I Regulation);
b. Regulation (EU) 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (Recast Brussels Regulation), which replaces the Brussels I Regulation in respect of proceedings and judgments in proceedings commenced after 10 January 2015;
c. Regulation (EC) 593/2008 on the law applicable to contractual obligations (Rome I Regulation); and
d. Lugano Convention (L339, 21/12.2007) on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

ii Litigation

Litigation stages

The jurisdiction in which proceedings are brought depends on the monetary value of the claim: the District Court deals with claims up to a value of €15,000 and the Circuit Court deals with claims up to a value of €75,000 (€60,000 for personal injuries cases).

Claims with a value in excess of the Circuit Court jurisdiction are heard by the High Court, which has an unlimited monetary jurisdiction.

The Commercial Court is a division of the High Court that deals exclusively with commercial disputes. The Court retains the discretion to refuse admission to the commercial list, for example where there is delay. Proceedings are case-managed and tend to move at a much quicker pace than general High Court cases. Insurance and reinsurance disputes may be heard in the Commercial Court if the value of the claim or counterclaim exceeds €1 million; and the Court considers that the dispute is inherently commercial in nature.

Insurance disputes before the courts are heard by a judge sitting alone and not a jury.

A Court of Appeal was established in 2014 to deal with appeals from the High Court. The Court of Appeal hears appeals from the High Court except when the Supreme Court believes a case is of such public importance that it should go directly to the highest court in the state.
Evidence
Except in the most limited circumstances evidence is to be given orally. Where the attendance of a witness is required at the trial of an action, the lawyer for either party can issue a witness summons on an individual resident in Ireland. If the person required to give evidence is out of the jurisdiction, it is not possible to require attendance through service of a summons. In such circumstances, it is possible to apply to take evidence on commission, or use letters rogatory, or in some cases, where the witness is in the United States, rely on a procedure under Title 28 of the United States Code 1782 to compel a witness in the US to give evidence or produce documents in proceedings before the Irish courts.

Where a party intends to rely on the oral evidence of a fact or expert witness at trial, a witness statements or expert reports must be served on the other party at least 30 days before the trial of the action.

Costs
The general rule is that costs follow the event (i.e., the loser pays). However, there is a growing body of case law, mainly emanating from the Commercial Court, that suggests that if the litigation is complex, the court should engage in a more detailed analysis and should not just award full costs to the winning side if the plaintiff has not succeeded in all claims.

Where the parties cannot agree on the costs incurred during the proceedings, the matter will be referred to taxation, where the taxing master will review the bill of costs and decide on the appropriate figure to be awarded to a party for its costs. The successful party will normally recover approximately 60 per cent of its recoverable costs known as party and party costs. These will usually be approximately 50 per cent to 75 per cent of the total costs incurred by the party in the litigation.

There are a number of tools that a defendant can use to put the plaintiff ‘on risk for costs’ including lodgements, tenders and Calderbank offers. In essence, all of these involve the defendant offering a figure to settle the matter; if the plaintiff rejects the offer and is then awarded a lower amount at the hearing of the action, the plaintiff is penalised for costs.

Arbitration
Where an insurance or reinsurance contract contains an arbitration clause, the dispute must be referred to arbitration. This rule does not apply to insurance contracts with consumers where the value of the claim is less than €5,000; and the agreement has not been individually negotiated.

The United Nations Commission on International Trade Law (UNCITRAL) Model Law has applied to all Irish arbitrations since the introduction of the Arbitration Act 2010 on 8 June 2010. This Act introduced increased finality to the arbitral process by restricting the basis for appealing awards and decisions, and reducing the scope for court intervention or oversight.

The High Court has powers for granting interim measures of protection and assistance in the taking of evidence, although most interim measures may now also be granted by the arbitral tribunal under the 2010 Act. Once an arbitrator is appointed and the parties agree to refer their dispute for the arbitrator’s decision, then the jurisdiction for the dispute effectively passes from the court to the arbitrator.
A contract that does not contain a written arbitration agreement is not arbitrable and is specifically excluded from the application of the 2010 Act. The arbitration agreement must be in writing whether by way of a clause in the substantive contract or by way of separate agreement. While Section 2(1) of the 2010 Act stipulates that these clauses should be in writing, this provision has been given a broad interpretation to include an agreement concluded orally or by conduct as long as its content has been recorded in writing.

Article 34 of the 2010 Act deals with applications to the court for setting aside an award. The grounds on which a court can set aside an award are extremely limited and correspond with those contained in Article V of the New York Convention, which requires the party making the application to furnish proof that:

- a party to the arbitration agreement was under some incapacity or the agreement itself was invalid;
- the party making the application was not given proper notice of the appointment of the arbitrator or of the arbitral proceedings or was otherwise unable to present his or her case;
- the award deals with a dispute not falling within the ambit of the arbitration agreement;
- the arbitral tribunal was not properly constituted; or
- the award is in conflict with the public policy of the state.

Arbitration can be a more expensive option than litigation in circumstances where the arbitrator and the venue must be paid for while access to the courts is subject only to the payment of stamp duty, which is relatively modest in comparison with the costs of arbitration. Arbitration may be a favourable option, particularly for insurers, however, as the courts are traditionally seen as pro-insured in insurance disputes, given the draconian provisions in insurance contracts. There is also the benefit of confidentiality of the dispute in arbitration.

iv ADR

Mediation is the most common form of ADR for insurance disputes.

v Mediation

The role of the courts

As discussed above, the Mediation Act 2017 (which came into effect on 1 January 2018) requires solicitors to advise their clients of the merits of mediation as an ADR mechanism in advance of issuing court proceedings. Prior to issuing proceedings, the Act requires the solicitor to swear a statutory declaration confirming that such advice has been provided, and this declaration must be filed with the originating document in the relevant court office when issuing proceedings.

The courts cannot compel the parties to mediate disputes; however, in the High Court and Circuit Court, a judge may adjourn legal proceedings on application by either party to the action, or of its own initiative, to allow the parties to engage in an ADR process. When the parties decide to use the ADR process, the rules provide that the courts may extend the time for compliance with any provision of the rules. A party failing to mediate following a direction of the court can be penalised in costs.
V YEAR IN REVIEW

i Brexit
As mentioned in Section I, Brexit has resulted in a number of financial services firms considering re-establishing themselves in Ireland, including UK firms and branches of UK entities.

ii Developments related to litigation funding
Third-party professional litigation funding is not generally permitted. In July 2018, in the case of *SPV Osus Ltd v. HSBC Institutional Trust Services (Ireland) Ltd*, the Supreme Court called on the legislature to urgently reform the area, failing which the Supreme Court itself may intervene.

The High Court has previously made clear that after-the-event insurance (ATE) is valid; therefore, ATE insurance is the only valid third-party funding.

iii Representative actions in consumer litigation
The European Commission has published a draft Directive that proposes a new type of EU-wide collective redress mechanism for consumers. This would allow a ‘qualified entity’ to take a representative action before a Member State court on behalf of a group of consumers that has been affected by a breach of consumer protection laws, to seek redress for the affected group. This would increase litigation risk for industry sectors that are subject to EU regulation, including insurers. The draft Directive will require further consultation in the European Parliament and the European Council, and is likely to be amended prior to publication in the Official Journal. It is anticipated that it will be adopted prior to the next EU Parliament elections, scheduled for May 2019.

iv Civil Liability Amendment Act 2017
The Civil Liability Amendment Act 2017 came into effect in late 2018. The Act empowered the courts to make awards in catastrophic injury cases by way of periodic payments, rather than as a lump sum. The aim of the legislation is to ensure continuity of payment throughout the life of the plaintiff.

v The Insurance (Amendment) Act 2018
The Insurance (Amendment) Act 2018 came into force in July 2018, which amends and extends the scope of the law in relation to insolvent insurers.

vi Payment protection insurance
Following the UK Supreme Court decision in *Plevin v. Paragon Personal Finance Limited*, a further redress scheme in respect of payment protection insurance (PPI) is underway in the UK. On 26 June 2018, a judgment was handed down in the Manchester County Court in the case of *Doran v. Paragon Personal Finance* (unreported). The amount awarded in this case was higher than the amount that would have been awarded under the Financial Conduct Authority guidelines for a case similar to the *Plevin* case, and that would have been awarded by the Financial Ombudsman. It is possible, particularly in light of the changes to the limitation period for claims to the Financial Services and Pensions Ombudsman in relation to long-term financial products, that there could be further litigation in relation to the sale of PPI in Ireland.
Emerging risks
There was an increase in cybersecurity threats and data breaches in 2018. A regulated online sphere, in the context of cybersecurity and data privacy, is, therefore, becoming more important. It follows on from this that the flow of data between states and the control that governments should exercise over this data is an important consideration in 2019. The enforcement of the GDPR is also important in this context.

VI OUTLOOK AND CONCLUSIONS
The UK Part VII transfer under the Financial Services and Markets Act 2000 (the UK Act) has been a key part of UK insurers’ Brexit contingency plan, enabling transfers of EU and EEA insurance business between the UK and Ireland through a court-sanctioned legal transfer process. To date, many UK Part VII insurance transfers have been completed, with more to be completed later in 2019.

Compared to 2018 levels, despite the uncertainty caused by Brexit, trade wars and protectionism, we anticipate an increase in the levels of insurance industry mergers and acquisitions (M&A) activity in the second half of 2019. While the lack of clarity about specific proposals under Brexit may be a short-term inhibitor of insurance M&A in the first half of 2019, proposed transactions that have been put on hold in the wake of Brexit are expected to continue and increase post-Brexit.

Technology has been identified as a key driver of M&A activity. Insurtech investments are also expected to lead to a more innovative approach, with examples of insurers buying insurtech start-ups increasing in 2018.

Cloud computing is gaining more significance in the insurance market. In light of this, a focus on upgrading talent in this area is likely to be a key focus in 2019. Insurers will also be expected to modernise and personalise their policies, as a result of increased customer expectations. Some products will become more reliant on data from connected devices.

We expect an increase in 2019 in Irish companies taking out cybersecurity cover and potentially related coverage disputes. In the next few years, we also anticipate litigation from insureds challenging claims decisions made by automated claims processing systems and on the interpretation of rights conferred by the GDPR on individuals in relation to automated decision-making.
I

INTRODUCTION

The Israeli insurance market is an expanding and evolving environment, and one that presents new challenges to all those involved. In this area, the focus of both the legislature and the relevant regulator is on the protection of the individual consumer. Courts of law have traditionally followed suit with this public policy, although, in recent years, a slight shift can be perceived towards a more balanced construction of insurance policies.

II

REGULATION

i

The insurance regulator

The insurance market is regulated by the Commissioner of Capital Markets, Insurance and Savings, appointed by the Minister of Finance. Two bodies advise the Commissioner: a four-member advisory committee and the Advisory Council, which has 15 members, of whom no more than six may be government employees.

The Commissioner is competent to resolve disputes between insurers and assureds. In practice, it will refrain from assuming this role in fact-laden cases. Its decision may be appealed to the district court.

ii

Licensing

Writing insurance requires a licence. Foreign insurance companies cannot write insurance business in Israel, but Israeli citizens may buy insurance abroad. Writing reinsurance business, however, does not require a licence and foreign insurers are therefore free to do so.

The Commissioner is authorised to license a foreign company if the latter is registered in Israel and subject to regulation in the country of origin.

In a unique act, the Israeli government enacted a regulation in December 1951 exempting Lloyd’s underwriters from the stipulations of the Law of Controlling Insurance Service. The practical effect of this is that Lloyd’s underwriters are permitted to write business directly in Israel.

With the objective of increasing competition in the insurance industry to lower premiums for consumers, the Commissioner reduced the minimal capital requirements for establishing new insurance companies in Israel. As a result, two new insurance companies commenced business in 2018, and it is anticipated that additional insurance companies will be registered in 2019, some of these digital.

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1 Harry Orad is a founding partner at Gross Orad Schlimoff & Co.
iii Compulsory insurance

Israeli law imposes compulsory insurance requirements on professionals or individuals in several areas, including the following:

a The capital market: insurance requirements are imposed on investment advisers and distributors; investment portfolio managers, mutual fund managers and trustees; provident funds and their managing companies; and underwriting companies. This compulsory insurance ensures protection of clients against negligent acts and omissions and infidelity of employees.

b Bodily injury coverage: Israeli law imposes compulsory insurance requirements for the coverage of bodily injury in clinical trials on human subjects (insurance requirements are imposed on the clinical trial sponsor).

c Motor accidents: the Israeli Road Accident Victims Compensation Law provides compensation for all victims of motor accidents on a no-fault basis. Compulsory insurance by all vehicle owners provides the source of compensation. Where such insurance was not placed, the injured party will receive compensation from a joint fund that receives a share from all premiums paid to insurers in the market. The joint fund will then have subrogation rights against the party that failed to take out insurance as required by law. In addition, sport events organised by registered sports authorities and organisations are subject to compulsory accident insurance. Schoolchildren are covered by compulsory personal injury insurance.

d Banks: there is no statute that compels banks to acquire compulsory insurance; however, the Commissioner of Banks has issued a directive that requires banks to acquire employee dishonesty insurance.

e Aviation: new regulations that will come into effect in June 2018 impose compulsory insurance on operators of commercial aircraft to, from or in Israel, in respect of passengers, baggage and cargo; third parties; and acts of hostility, war or terror.

f Organised sport activities are subject to compulsory accident insurance.

g School children are covered by compulsory accident insurance by the local authorities.

iv Directors’ and officers’ insurance

Directors’ and officers’ (D&O) insurance, although not mandatory, has become a prerequisite for most high-ranking directors and officers. Israeli courts have, in recent years, strictly applied reporting duties, and demanded accurate, full, updated reporting. The Business Judgement Rule has been adopted by the Supreme Court and courts are hesitant to intervene in decisions of boards of directors that comply with the requirements of the Business Judgement Rule.

Recent years have seen an increase in the number of claims, derivative claims and class actions in respect of breach of duties by directors and officers. Most of these end in settlements in which insurers play an important role.

The Israeli Companies Law prohibits the indemnification (as well as insurance and exemption) of a director or officer in respect of the following matters:

a breach of fiduciary duty towards the company, unless committed in good faith and with reasonable grounds to believe that the action would not prejudice the company’s interests;

b acts committed intentionally or recklessly;

c acts committed with the intention of gaining unlawful personal benefit; and

d fines and penalties, including civil fines and monetary levies.

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III  INSURANCE AND REINSURANCE LAW

i  Sources of law
The Israeli legal system is fundamentally a common law regime, without jury. However, throughout the years, civil law statutes have been enacted that adopt principles from various jurisdictions in Europe and elsewhere. The Insurance Contract Law (ICL) was passed in 1981, adopting principles of consumer protection. In conjunction with this, the Control of Financial Services (Insurance) Law was passed, which provides regulatory provisions for the market. The law applies to all types of insurance other than reinsurance, marine, aviation and insurance of diamonds or valuable metals.

ii  Making the contract
The ICL does not specify a unique format for execution of the insurance contract. However, it does specify particular rules aimed at reinforcing consumer rights and imposing limitations on insurers, remedies and power. These rules aim to moderate the typical imbalance of power between the insurer and insured.

iii  Duty of disclosure
The ICL imposes an explicit duty on the insured to answer the insurer’s questions in full and truthfully, when presented in writing in respect of a material matter. A material matter is defined by the Law as one that could affect a reasonable insurer’s willingness to assume the risk in general or to assume it under the terms specified by the policy.

The Law further stipulates that fraudulent concealment of a matter that the insured was aware of as being a material matter is regarded as an untruthful and incomplete answer. Israeli courts have interpreted this in conjunction with the questions posed by the insurer on the proposal form: a subject not mentioned in a proposal form has been deemed as immaterial and therefore, there can be no positive duty of disclosure regarding such a subject and no sanction for non-disclosure.

iv  Interpreting the contract
An insurance contract is interpreted according to the (revised) Article 25 of the Law of Contracts and case law, which clarified rules of interpretation of insurance policies, such as *Cohen v. Migdal Insurance Company* and *MS Aluminium Products v. Arie Insurance Company*.

The stages of interpreting a policy are as follows:

a  The first stage is based on the subjective intention of the parties to the specific policy. If possible, the parties’ intentions will be ascertained literally from the language of the insurance contract. Otherwise, for the subjective intention, the court will look at external circumstances, such as communications exchanged between the parties.

b  Second, if the subjective intention of the parties cannot be ascertained, then the court will seek the objective intention of the parties, namely the intention of reasonable and honest parties with respect to the policy in question. The objective intention can be ascertained, for example, from common practice among other insurers in the relevant type of insurance.

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2 CA 4688/02.
3 CA 453/11.
A policy construction that gives it force and effect is preferable over one that voids the policy provisions.

Only if the court cannot ascertain the subjective or objective intention of the parties will the court interpret ambiguities in the policy against the drafter (usually the insurance company).

Courts also refer to the doctrine of the reasonable expectations of the insured, but only if there are several reasonable interpretations and one of them meets the reasonable expectations of the insured. This is generally used together with other rules of interpretation.

v Warranties and conditions precedent

The ICL provides no basis for the doctrines of warranties and conditions precedent as implemented in common law countries. The Israeli law has adopted a proportionate remedy principle regarding both breach of contract terms and breach of duty of disclosure. The significance of this principle is that other than in cases of fraud, there is no automatic exemption of the insurer from liability.

Where the insurer alleges breach, the court will consider its extent and effect, and is authorised to reduce liability proportionately according to the ratio of the actual premium and the higher premium that would have been charged had the insured disclosed the material matter or had the insurer known that the policy condition would not have been adhered to.

The insurer bears the burden of proof that full disclosure or non-adherence to the condition would have had an effect on underwriting.

Furthermore, the ICL negates remedies where the breach of the duty of disclosure or the policy condition did not affect the risk.

vi Intermediaries and the role of the broker

The licensing of insurance brokers is regulated by law, requiring a licence, which follows on from practical training and examinations. The licensing is in three areas of expertise: general insurance, marine and pension insurance brokerage.

The licence may be granted to an individual or to a corporation.

The activities of insurance agents are regulated by law. An insurance agent is defined as ‘one who engages in insurance brokering between the insured and insurers, and as a liaison between the insurer and the insured’. It is considered an agent of the insurer with regard to the negotiations leading up to the formulating of the insurance contract, unless appointed in writing by the insured as an agent of the insured. As the agent of the insurer, any fact brought to its knowledge regarding a material matter will be considered as known by the insurer for the purpose of the insured’s duty of disclosure.

Payment of premium to the agent is also considered as payment to the insurer.

The agent is considered the insurer’s agent for the purpose of receiving notice of the identity of the insured and the beneficiary, unless the insurer informed the insured and the beneficiary in writing that notification must be sent to a different recipient.

The presumption that the insurance agent is the agent of the insurer serves as an obstacle that insurers must surmount to be allowed to rely on policy terms.
In Clal Insurance Company Ltd v. Mussa Ally the court ruled that the insured was not deemed as receiving a copy of the policy terms as the document had been sent to the agent and not to the policyholder. The fact that the agent in that case was a close relative of the policyholder did not suffice to overcome this obstacle. Furthermore, the insured had signed the section in the proposal form appointing the agent as his own agent. However, the court ruled that in the absence of clear-cut evidence that the insured fully understood the meaning of this waiver, the legal presumption prevailed and the agent remained the agent of the insurer. As a result, the court did not allow the insurer to rely on stipulations in the policy making cover conditional upon the insured taking measures to alleviate the risk. The court ruled that as the policy had not reached the hands of the policyholder, the insurer had not fulfilled the duty to ensure that the policyholder was fully aware of these conditions and the consequences of non-compliance.

vii Claims

Notification

The ICL provides that the insured must notify the insurer of the insured event immediately after becoming aware of its occurrence. However, as with the approach to breach of policy terms or the duty of disclosure, the law does not sanction late notification with automatic dismissal of the claim. The burden of proof in this respect is on the insurer, who must prove substantive damage as a result of the failure to notify on time. To meet this burden, it is not sufficient to show a theoretical possibility that damage may be sustained by the insurer. In any case, the claim will not be dismissed but reduced proportionately with regard to the extent of the damage caused by the delay. Furthermore, as with the majority of the provisions of the ICL, the above are reinforced as the Law mandates that these provisions cannot be modified by agreement unless such modification is in favour of the insured. The practical effect of these provisions is that, as a rule, insurers cannot rely on a ‘late notification’ argument unless their rights were significantly prejudiced as a result of such late notification. These provisions have been the subject of discussion in numerous Israeli court cases wherein the courts have consistently ruled that an insurer that wishes to benefit from the remedy provisions must show that its rights were actually prejudiced by the insured’s non-compliance with the duty to notify.

The burden of proof borne by the insurer is not a light one. It must prove actual damage as a result of breach of the notification duty. Statements to this effect were made in several cases including Hassneh Insurance Co v. Asulin, where the burden imposed on the insurers to prove actual damage was emphasised.

In Wile v. Phoenix Insurance Co, the court again ruled that it is not sufficient for the insurer to merely prove the breach of the notification duty, rather, actual damage as a result of the breach must be shown to have occurred.

International Bank v. Prudential Insurance Co was an extreme case. The bank advised insurers of the court claim against it only after it had already lost the case in court. Prudential refused to indemnify the bank, dismissing the claim based on the argument of late notification. The bank filed suit and the court ruled in favour of the bank holding that

4 CA 2626/01.
5 CA 215/91.
6 CA 1438/02.
7 CF 7/88.
Prudential had not proved any damage as a result of the late notification. The court stated that the bank had defended the claim against it in a comprehensive and highly professional manner. Furthermore, the court ruled that the insurers had breached their duty to act in good faith by raising such ‘technical arguments’.

**Good faith and claims**

Section 27 of the ICL provides that the insurance benefits will be paid within 30 days of the day on which the insurer is in possession of the information and documents required for the ascertainment of his or her liability. However, insurance benefits not disputed *bona fide* will be paid within 30 days of the day on which a claim is submitted to the insurer, and they may be claimed separately from the remainder of the benefits. (See subsection x, below.)

**Insurer’s duty to issue a coverage position letter**

Coverage position letters have been the basis of limitations on insurers’ practical rights and scope of defence in Israeli courts, where the coverage position letter did not meet the regulator’s requirements. These requirements have been adopted by the courts as legally binding in the framework of the insured–insurer relationship. The Supreme Court added that insurers’ obligations also apply to a third party that is entitled to direct privity with the insurer.

The first directive on the subject, issued in 1998, required the insurer to specify all grounds for denial of coverage, sanctioning failure to do so by precluding the insurer from raising any new argument in future litigation. The Commissioner cited the insured’s right to receive all details to be able to seek advice regarding possible legal relief on the basis of the insurer’s position as the rationale for this sanction.

Later, a variation on the original directive was issued, clarifying that arguments based on events subsequent to the coverage position letter, or based on grounds that could not have reasonably been known to the insurer when issuing the coverage position letter, would be allowed to be introduced at a later stage.

The courts afforded the directives the power to limit the scope of insurers’ rights to evoke defence arguments beyond those cited in the coverage position letter:

- *a* the insurer is obliged to effectively investigate the circumstances of the loss or claim to form its coverage position as soon as possible after receipt of the claim;
- *b* the coverage position must be provided to the insured in writing, within 30 days of receipt of information and documents required from insured;
- *c* where coverage is declined (whether wholly or partially), all grounds for this position must be detailed therein;
- *d* the insurer is precluded from raising any argument on circumstances, conditions or exclusions that were not mentioned in the coverage position letter; and
- *e* the insurer will be able to broaden its defence only in rare cases where the circumstances material to its updated coverage position were not known and could not reasonably have been known. Such cases would certainly include intentional behaviour aimed at concealing material facts from the insurer.
viii Reinstatement

Reinstatement clauses are common in property insurance and provide coverage beyond the scope of the ICL. Reinstatement (i.e., ‘new for old’) is an additional cover and is subject to a time limit that may cause friction with the insurer. This type of cover was analysed in the precedential ruling in Phoenix Insurance Co Ltd et al. v. The Deborah Hotel et al.\(^8\)

The meaning of a reinstatement clause in the policy is that in consideration of a higher premium, the insured reinstates the damaged assets at a new value; that is, at the current price, without reduction for wear and tear, etc. The option to choose reinstatement instead of compensation for the damage is in the hands of the insured, not the insurer.

Both conditions are found in the reinstatement clause of the policy in question – namely the limited time to complete the reinstatement and the insurer’s liabilities for payment of expenses after the reinstatement is actually carried out – and are a fundamental part of reinstatement value insurance accepted in the insurance industry.

Precisely because of the restrictions in the clause, in relation to both the completion of reinstatement and payment only after the insured has covered his or her expenses, accepted behaviour and good faith requires the insurer not to create obstacles for the insured to exercise his or her rights under the policy. The matter in question of this ruling created a vicious cycle whereby it was not possible to begin the reinstatement procedure before the insurer approved its scope and details. The parties turned to arbitration to settle the argument; however, this process was not activated because of the position of the insurer, which was that it could be activated only after the reinstatement period. It was ruled that the insurer’s position was inconsistent with the spirit of the policy and not the conventional way that insurers should fulfil their obligations. Therefore, the Supreme Court ruled that under the circumstances there was no justification for denying the insured’s request to extend the period of reinstatement.

The condition that reinstatement costs are due (beyond compensation for the actual damage) only after the insured covers his or her expenses independently and only after the reinstatement is complete is a basic condition for the implementation of reinstatement insurance.

The time limit will not apply where the insurer is found to have unlawfully denied insurance benefits and so prevented the insured from reinstating the damaged property. In Hadar Insurance Co Ltd v. Ehad Ha’am Food and Investments Ltd\(^9\) the insurer claimed that the insured failed to reinstate the equipment in the allotted time and therefore was not entitled to reinstatement values. The Supreme Court rejected the insurer’s argument, ruling that by detaining the insurance benefits for the actual damage, the insurer prevented the insured from reinstating the equipment and therefore could not invoke the time limit condition against the insured.

ix Dispute resolution clauses

The insertion of dispute resolution clauses is not widely accepted in standard policies, as this is considered an infringement of the insured’s rights to take up matters with the courts.

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8 CA 191/80.
9 CA 7298/10.
New legislation

The amended Section 28 to the ICL stipulates that in personal insurance (life, auto, home, health – but not liability) the court is obliged to award, and in non-personal insurance the court may award, an additional interest award of up to 20 times the basic interest rate, when an insurer did not indemnify the insured the amounts not in dispute in good faith on the appropriate date (in long-term care insurance – up to 10 times). If the court decides not to apply this special rate, it should explain the reasons for its decision.

Section 27 provides that the insurance benefits will be paid 30 days after the insurer received all information and documents required to ascertain the insurer’s liability under the insurance contract. For insurance benefits that are not in dispute, the payment should be made within 30 days of the date the insurance claim was notified to the insurer. If this Section is breached, the insurance benefits will accumulate the above-mentioned interest. According to a Supreme Court precedent, the 30-day period will be calculated from the date the insured notified the insurers regarding the insured event.

Insurance Arbitration Institute

A new bill proposed by the Ministry of Finance in 2018 stipulated the establishment of an Insurance Arbitration Institute and compulsory arbitration of insurance claims in this Institute (except for claims by big companies (according to turnover and number of employees) and claims against third parties). If, and to what extent, this proposed bill will be approved is yet to be determined.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

As a rule, insurance contracts, other than those concerning reinsurance, marine, aviation, diamonds and precious metals are subject to Israeli law. Jurisdiction is local and the competent court is determined by the amount claimed – up to 2.5 million shekels with the lower court and above this amount with the district court, as first instances.

ii Right of appeal

There is an automatic right of appeal against judgments of the court of first instance to the appeal court within 45 days. As a rule, the appeal court will not intervene on points of fact unless a severe and obvious error is clearly evident.

Leave to appeal is required to allow access to a second appellate instance and to appeal interim decisions. As a rule, the appellate court will only allow such appeals in exceptional cases. With regard to appellate judgments, the petitioner must show severe injustice or that the issue is one of importance to the public. The petition for leave to appeal must be filed within 30 days of handing down of the subject decision.

Most district courts will now complete hearing of an appeal within three years. At the Supreme Court, however, a case may take much longer.

The courts distinguish between lawyers’ fees and costs, and are authorised to award either or both to the winning party. Lawyers’ fees are usually awarded as a percentage of the judgment.
### iii Arbitration

Arbitration is very similar to a court process – evidence is brought, and discovery and testimony can be compelled by the arbitrator by using the court’s mechanism. Rules of evidence do not apply where parties have not agreed otherwise.

The essential difference between arbitration and a court process concerns the options for appeal, amendment or annulment of a judgment, which for arbitration are rare and very difficult to obtain compared with a court judgment. There is, in essence, no route to appeal against an arbitral judgment except where the parties initially agreed to allow an appeal, this being limited to ‘a fundamental error in application of the law which causes significant miscarriage of justice’. A motion for the annulment of a judgment will be allowed only in cases where the arbitration suffers from a serious procedural flaw as listed in the Law of Arbitration. Arbitration is significantly more expensive and time-consuming than mediation. (See Section III.x.)

As stipulated by the Commissioner, an insurance policy may not include a clause binding the insured to arbitration, in case of a future dispute. This clause is considered to be prejudicial to insured’s rights. This stipulation does not apply when the insured specifically agreed to the arbitration clause.

### iv Alternative dispute resolution

Mediation is the most common form of alternative dispute resolution and a recent amendment to the Civil Procedure Rules mandates referral of all litigants in all claims for over 75,000 shekels (excluding damages for victims of motor vehicle accidents) to hold a meeting with a mediator to discuss holding mediation talks. This is a general rule and not specific to insurance cases. This is a precondition for continuing to trial but the court is not authorised to penalise parties for not agreeing to mediation or for not making an offer to settle.

A positive incentive for early settlement is afforded by rules regarding payment and refund of court charges. Court charges are levied on monetary claims at the rate of 2.5 per cent of the claim. Half of the court charges is paid on filing the claim and the second half is paid only if the case goes to trial. Furthermore, the first half of the court charges will be refunded automatically to parties that settle before three pretrial hearings have been held and the court is authorised to refund the entire charges paid if a resolution is reached, at any stage, by mediation or arbitration.

Mediation will normally be conducted by a lawyer with experience in the field or a relevant expert and will take much less time as meetings are held with the parties and the lawyers, with no need for testimony or any discussion of formalities, such as admissibility of evidence or discovery issues. It is also possible to have confidential discussions with the mediator, *ex parte*, which are effective in sounding out an objective party's point of view without the risk of unnecessarily revealing evidence to the counterparty.

### V SUBROGATION

#### i Stricter rules

Subrogation by insurers is seemingly a simple matter of transferring rights from the insured to the insurer regarding the insured damage, against third parties. However, as depicted in
a ruling by the Supreme Court in Lloyd’s Underwriters and IEC v. Ashdod Port (December 2014),\(^\text{10}\) as outlined below, the subrogating insurers may have to make additional efforts to prove the elements of the claim in order to ensure the full transfer of rights and benefits.

**Background**

The Israel Electrical Company purchased equipment from Siemens in the amount of tens of millions of dollars for a new power production installation. While being unloaded at the Ashdod Port, the crates were dropped and damaged by impact. Siemens later determined that several units must be replaced and others should undergo repair.

**Subrogation**

Under Israeli law, subrogation is contingent on the insurer establishing all of the following conditions:

\[\text{a} \quad \text{the obligation to pay insurance benefits on the basis of a valid policy;}\]
\[\text{b} \quad \text{actual payment of insurance benefits on the basis of this obligation;}\]
\[\text{c} \quad \text{proof of the insured’s right for compensation from a third party in relation to the insured event or damage.}\]

Regarding the reviewed case, all these conditions seem to exist. The district court dismissed the subrogation claim and held that the insurers’ considerations in regards to the payment were ‘unreasonable’. The court found that the insurers failed to conduct an independent assessment of the damage and accepted Siemens’ conclusions blindly, even though they were obviously an interested party.

The Supreme Court upheld the decision, specifically in regard to the fact that the insurance policy covered impact damage only and that no investigation had been carried out to determine whether indeed all the damage was caused by impact and not by other unrelated causes.

**Review and comments**

The Supreme Court judgment emphasises the fact that in order to preserve and ensure the prospects of subrogation, the insurer must invest efforts, beyond those necessary to determine coverage, in order to investigate and preserve evidence necessary for the future subrogation claim. The insurer must invest independent efforts to determine the exact nature of the damage and cannot rely on the advice of an interested party, such as the manufacturer or supplier of the damaged product.

**ii Subrogation by a foreign insurer**

Subrogation in Israel stems from Section 62 of the Insurance Contract Act 1981, which transfers any rights that the insured may have for remedy in relation to the insured loss to the insurer upon payment of the insurance benefits. In VIG – Vienna Insurance Group v. Sharon Drainage and River Authority (October 2015),\(^\text{11}\) VIG filed a subrogation claim in Israel, and the action was denied by the district court. The court ruled that Section 62 grants the subrogation right.

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\(^{10}\) CA 12/7287.

\(^{11}\) CA 53025-11-14; appeal (dismissed) 8044-15 (January 2017).
to an insurer, meaning an insurer registered by law in Israel and subject to local regulations. The court ruled that the rationale behind this was to grant rights of subrogation only to the companies that were also obliged to act within the confines of local regulatory rules.

This ruling was not the first of its kind in recent years in the lower courts; however, the appeal to the Supreme Court on this case was denied, creating a precedential binding rule, precluding foreign insurers from availing themselves of the right of subrogation in Israel.

Comments

According to Section 72 of the Insurance Contract Act 1981, Section 62 is the only section of the law that applies to reinsurers. As a result, we hold the view that a foreign insurer wishing to insure risks in Israel and retain subrogation rights must do so via a local insurer as a fronting company who would later exercise the subrogation right. Alternatively, as suggested in the VIG case, a recovery claim should be filed in the name of the insured, who may then remit proceedings to the foreign insurer.

Our view is that the legal position of Lloyd’s underwriters in Israel is different to other foreign insurers because they are permitted to write insurance business in or from Israel on the basis of being exempt from the requirements of the Insurance Supervision Law.

VI YEAR IN REVIEW

i Civil procedure reform

The Rules of Civil Procedure were significant reformed in 2018 and will come into effect from September 2019. The overriding objective of this reform, as with the Lord Woolf reform in England, is to enable the court to deal with cases justly and at a proportionate cost, while improving the efficiency and speed with which they are dealt with. The new procedure places severe time constraints on litigants while expanding the court’s discretion regarding case management.

The reformed Rules of Civil Procedure are expected to accelerate proceedings owing to stricter time limits for preliminary proceedings and defence. The new rules warrant the particular attention of the claims departments of insurers, who will have to review claims handling procedures to meet the new requirements.

ii Reduction of interest rates

With respect to bodily injury claims, in calculations of future loss, the fixed annual interest rate was 3 per cent for many years. Owing to the very low inflation rate, several courts have implemented a 2 per cent rate that substantially increases the compensation. However, not all courts have fully adopted this new figure and are waiting for the decision of the Supreme Court. The eventual decision is especially important for insurers’ risk calculations and liability reserves.

iii New codification of insolvency and rehabilitation

In March 2018, the Israeli parliament approved the new Insolvency and Rehabilitation Law 2018. The Law will come into force on 15 September 2019.

One of the main changes in this Law is the definition of insolvency, which now includes two alternative tests: the cash-flow test and the balance test.

The main relevant issue regarding D&O insurance is the provision in the Law relating to the directors’ and the CEO’s liability in case of insolvency, as defined under the Law.
iv Cyber technology

The new Regulations for the Protection of Privacy (Information Security), enacted in 2017, became effective in May 2018. The Regulations establish, for the first time in Israel, a specific arrangement regarding protection of databases, including establishing organisational procedures and risk management enhancement steps in the management of databases. They also include a duty to report any severe data breach to the Database Registrar, and the Registrar may instruct that notification be given to the data subjects who may be affected.

In addition, the EU General Data Protection Regulation, which also became effective in May 2018, applies to Israeli companies that either target the European Union (by offering goods or services to individuals from EU Member States) or monitor the behaviour of individuals from EU Member States (e.g., by tracking them online).

There are also new duties attached to directors and officers of companies regarding cyber-risk management and reporting, which should be included in the company and D&O insurance.

v D&O insurance

The new Insolvency and Rehabilitation Law, described in subsection iii, imposes liability on the directors and on the CEO of the company in any case where these individuals knew or could have known that the company is insolvent, and did not take reasonable measures to mitigate the scope of the insolvency. In such a case, the directors and CEO could be held liable towards the corporation for the losses sustained by the creditors, as a result of their failure to prevent or mitigate such losses. Certain provisions of the law provide a safe harbour defence for the directors and CEO, however, the law prohibits the corporation from granting them exemption or indemnification.

Insurers that write D&O policies in Israel may wish to address the extended duties of directors and CEOs under the law.

VII OUTLOOK AND CONCLUSIONS

The Israeli insurance market will continue to be very competitive, dictating a soft market, especially in personal lines insurance. It is expected that the high level of competition and developments in technology will lead to creative new products in the market and increase in sales of direct insurance.

Insurtech is very developed in Israel. Israeli insurance companies are looking at ways to transform parts of their activities to digital formats such as sale of policies, underwriting information and handling of claims, in particular in personal insurance. As a result of the growing competition, digital search engines compare terms and costs of insurance offers by competing insurance companies, to present tools to the consumer to find the most suitable insurance.

A new Commissioner of Insurance was appointed in 2018 and, although his vision is still unknown, it is certain he will encourage the market to make digital and technological improvements.
Chapter 22

ITALY

Alessandro P Giorgetti

I INTRODUCTION

Italy has the world’s eighth-largest economy, made up of small and medium-sized companies producing high-technology and high-quality products. The economy slowed over the first half of 2018 as exports and industrial production weakened in association with the government’s economic politics that created conditions for higher interest rates. However a drop in energy prices helped to contain inflation, more than in the rest of the eurozone, which should support Italian exports despite Brexit.

According to the European Commission’s 2018 autumn forecast, the economy was set to grow by approximately 2.1 per cent in 2018 before moderating to 1.9 per cent in 2019, even if a recovery of exports and higher public spending are expected to lift real GDP to 1.2 per cent. Those positive expectations have been confirmed by the latest assessments released by the Italian National Institute of Statistics for the third quarter of 2018, which indicated that GDP decreased by 0.1 per cent compared to the previous quarter but increased by 0.7 per cent compared to the third quarter of 2017, maintaining the moderate employment rate increase. The unemployment rate fell to 10.5 per cent in 2018, and is expected to drop to 10.2 per cent in 2019.

The insurance market should benefit from both the expected national increase in exports and the challenges posed by the European General Data Protection Regulation (GDPR) implementation in May 2018, which introduced a stringent requirement to prevent and handle data breaches, imposing large fines for unprevented data breaches. However, due to the nature of the administrative and punitive sanctions, those fines could not be legitimately insured in Italy.

In contrast with the non-life insurance market, Italian life insurers are steadily recovering from the downturn recorded in the past two years and recorded premium income growth in all classes, particularly Classes I and III (unit and index-linked policies).

It is evident that, despite the difficulties in relaunching the national economy, Italy remains a fertile ground for insurance underwriters, and provides interesting opportunities for prudent insurers and reinsurers especially in the newly developing cyber and data protection insurance markets.

1 Alessandro P Giorgetti is the managing partner at Studio Legale Giorgetti.
2 The National Institute of Statistic’s (ISTAT) Economic Outlook was published on 21 November 2018. ISTAT is an active member of the European Statistical System, coordinated by Eurostat.
II REGULATION

i The insurance regulator

Decree-Law No. 95 of 6 July 2012 dissolved the Italian Private Insurance Regulatory Authority (ISVAP) and replaced it with the Institute of Insurance Supervision (IVASS), a department of the Bank of Italy. Despite its total integration into the Bank of Italy structure, IVASS maintained a degree of logistical and decision-making autonomy.

On 1 January 2013, IVASS took over all functions previously carried out by ISVAP, including the supervision of intermediaries and the distribution of insurance products for better coordination between the control and regulation of the financial promoters. The register of insurance experts and the Italian Information Centre have been taken away from the insurance regulator's competence and passed on to the Concessionaire for Public Insurance Services.

In accordance with the law, the pro tempore senior deputy governor of the Bank of Italy is also the president of IVASS.

Other governing organs of the supervisory body are the Council and the integrated Directorate made up of directors of the Bank of Italy and IVASS advisers. The president promotes and coordinates the activities of the Council, which is responsible for the overall administration of the institute. The Directorate is competent to direct public body activities and adopt strategic decisions. IVASS should establish more focused supervisory controls on life and non-life insurance companies to bring down insurance costs and, consequently, premiums.

Having implemented a new regulation concerning its organisational structure, IVASS became quite active. In 2013, it issued the very first set of rules for the management of insurance services offered online. These norms implemented the provisions introduced by Article 22, Paragraph 8 of Development Decree No. 179 of 18 October 2012. This regulation lays down rules and minimal requirements to promote more effective management of insurance e-commerce or services offered electronically through insurance portals or the website of insurance and reinsurance companies.

IVASS then provided for imposed administrative fines and the application of disciplinary sanctions in respect of insurance and reinsurance intermediaries and the rules of functioning for the Guarantee Committee supervising the sanction proceedings. The regulatory activity of IVASS continued, introducing the obligation for intermediaries to adopt a certified electronic mail address along with the invitation (thus a measure 'not legally binding') to use an advanced electronic signature in all contracts. Furthermore, this Regulation introduced an obligation for intermediaries to facilitate electronic payment, and specified that intermediaries should make the electronic documentation and information package available to customers who have chosen to receive them. In respect of insurers, this regulation established the prohibition of requiring documentation that is already in their

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3 Decree-Law No. 95 (the Spending Review Decree) was subsequently amended and converted into Law No. 135 of 7 August 2012. The government, which originally also considered dissolving the Commission for the Supervision of Pension Funds (COVIP), the regulator for pension funds, at the very last minute introduced an amendment to the Spending Review Decree and chose to keep COVIP, as its dissolution would not have reduced government expenditure.

4 IVASS address: 21 Via del Quirinale, Rome.

7 Regulations Nos. 1 and 2.

8 Regulation No. 3.
possession having been obtained on the conclusion of a previous contract. This ban does not apply if the documentation in question is no longer valid. IVASS then regulated the receivership of insurance companies.9

In 2014, IVASS intervened to regulate the obligations of adequate due diligence and anti-money laundering registrations on the part of insurance companies and insurance intermediaries,10 as well as regulating occupational requirements of insurance and reinsurance intermediaries respectively, with the goal of promoting insurance intermediaries’ professional requirements, particularly taking into account the increasing spread of insurance relations to be handled electronically and concerning the internal identification of the organisational units responsible for administrative proceedings.11

After 2016, the year in which the EU Solvency II Directive (Solvency II) came into effect, IVASS concentrated its regulatory activity more on insurers’ profitability and capitalisation, followed by a letter to the market on 10 August 2016 better illustrating how to determine the capital requirement using the standard formula, as well as the look-through approach dictated by Regulation No. 28/2016.

This trend continued throughout 2017, with Regulation No. 34/2017 on the corporate governance provisions relating to the valuation of assets and liabilities other than technical reserves and their assessment criteria, and Regulation No. 35/2017 concerning the adjustment required for the loss-absorbing capacity of technical reserves and deferred taxes in the determination of the companies’ Solvency Capital Requirement.

In 2018, IVASS concentrated its regulatory efforts on companies’ internal compliance and the distribution of insurance products. The following are particularly relevant to insurance companies: Regulation No. 38 laying down provisions on the system of governance of 3 July 2018 and Regulation No. 42 laying down provisions on the external audit of public disclosure related to the Solvency and Financial Condition Report of 2 August 2018. IVASS also issued two regulations regarding the implementation of Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (the Insurance Distribution Directive): Regulation No. 40/2018 laying down provisions on insurance and reinsurance distribution, with particular attention to the areas of training and professional education as well as the promotion and placement of insurance contracts by means of distance communication techniques; and Regulation No. 41/2018 on the pre-contract information duties of the insurance distributors, which shall apply to all insurance contracts, except tailor-made products that do not need any pre-contract information.

ii Position of non-admitted insurers

Only admitted insurers are entitled to provide insurance. More precisely, according to legislation, the admitted insurers should meet the existing requirements for authorisation, and have the minimal share capital or guarantee fund fully paid up in cash.

iii Requirements for authorisation

In general, only public companies, cooperatives and mutual insurance companies, or equivalent European or foreign companies, can apply to IVASS for an authorisation. Lloyd’s
syndicates are the sole exception, and they have been specially authorised because of their particular historical status and in accordance with the fundamental freedoms of the Treaty on the Functioning of the European Union.

New insurance and reinsurance companies that wish to undertake or start a new business in Italy can do so only after being authorised or licensed by IVASS through an order (if the undertaking has its head office in Italy), or by an acknowledgement of the formal communication made by the company along with confirmation of the supervisory authority of the state where the company has its registered office.

The order or the acknowledgement of the formal communication must be published in the Official Gazette, and the newly authorised or licensed insurance company may start underwriting insurance or reinsurance only after publication.

An insurance company that applies for authorisation must submit a number of documents to IVASS. The most important are:

a. A certified copy of the memorandum and articles of association showing the insurance classes that the insurer will underwrite, and stating whether it also intends to offer reinsurance. It is forbidden to set up a company whose sole object is the exclusive pursuit of insurance business abroad.

b. Evidence that the memorandum and articles of association have been deposited with the Registrar of Companies and that the incorporation has taken place in accordance with the Civil Code provisions or the applicable local laws.

c. A scheme of operations and a technical report drawn up pursuant to the ISVAP regulations, including the names of the persons charged with administration, management and internal control and corporate governance functions, as well as the names of the natural or legal persons who directly or indirectly have controlling interests or qualifying holdings in the company, with an indication of the amount of each holding.

d. Proof that the company has a share capital or guarantee fund, fully paid up in cash, sufficient to meet the liabilities of the intended business plan, and proof that the company possesses the minimum organisation fund required by ISVAP Orders Nos. 97/1995 or 98/1995, or both, fully paid up in cash.

e. For foreign companies, proof of the appointment of a general representative who must be domiciled at the address of the branch. If a company is appointed as general representative then the registered office must be within the territory of Italy.

If the application is incomplete or IVASS's requests for further information are not met, authorisation is usually denied. It is also refused if no proof is given that the share capital or guarantee fund has been fully paid up, or that the organisation fund is actually and immediately available to the company.

12 Royal Decree No. 262 of 16 March 1942 in Official Gazette No. 79 of 4 April 1942.
Equally, the authorisation or licence is denied if any persons charged with the administration, management and internal control functions do not meet the prescribed requirements, or if the scheme of operations does not satisfy the financial needs and the technical rules for the correct management of an insurance business.

A major role in the authorisation process is played by the laws, regulations and administrative provisions of any state to which the company or one or more of its shareholders is subject, and any difficulties in meeting such requirements may delay the application or even entail a final refusal.

An IVASS order refusing the authorisation is notified to the company by means of a registered letter with advice of receipt within six months of the date of the complete application with all documents required by law or with the additional documents and information requested by the authority. If six months elapse with no response received by the applicant company, then the authorisation will be considered refused.

iv Other notable regulated aspects of the industry

In accordance with the Private Insurance Code, an insurance company’s minimum share capital or guarantee fund, fully paid up in cash, must be not less than:

\( a \) for companies intending to pursue life assurance: €5 million;
\( b \) for companies intending to pursue non-life insurance:
- €5 million for insurance classes 10, 11, 12, 13, 14 and 15;
- €2.5 million for insurance classes 1, 2, 3, 4, 5, 6, 7, 8, 16 and 18; and
- €1.5 million for insurance classes 9 and 17;
\( c \) for companies intending to pursue life assurance, personal accident and sickness insurance simultaneously:
- €5 million for life assurance; and
- €2.5 million for the pursuit of personal accident and sickness insurance; and
\( d \) for cooperative companies, the minimum share capital is reduced to half the listed amounts.

On 1 January 2016, Solvency II came into effect and took over from Directives 2002/12/EC and 2002/13/EC on solvency margin requirements for life and non-life insurance. Solvency II is based on three pillars:

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13 The directors, officers, statutory auditors and general directors must all meet the prescribed requirements of probity, independence and trustworthiness according to the relevant Civil Code provisions, Article 4 of Ministerial Decree No. 186/1997 and Ministerial Decree No. 162/2000, to ensure sound and prudent management of the insurance or reinsurance company. Article 36 of Decree-Law No. 201 of 6 December 2011 addressed the issue of ‘interlocking directorates’, introducing the prohibition for an individual to be member of two or more boards of insurance companies, financial institutions or banks.

14 Italian law provides for statutory and free reserves not corresponding to particular underwriting liabilities or to adjustments of asset items. Currently, the reserves are considered and regulated by the Private Insurance Code. Foreign insurance companies operating in Italy under the freedom of establishment system shall comply with the provisions on technical reserves that apply to companies with a registered office in Italy. The adequacy level of the reserves is a source of major concern for the Italian regulator.

15 Legislative Decree No. 209 of 7 September 2005, as amended by Legislative Decree No. 130 of 30 July 2012.
a the calculation of minimum financial requirements to cover risks, which outlines the formula that European insurance companies must use to calculate their capital reserves to cover risks;
b governance and risk management, which analyses the requirement that insurance companies must provide for adequate risk management and the potential for good governance; and
c transparency rules, for proper information disclosure to the market and to the relevant authorities, for the purpose of proper protection of consumers and insurers.

With the introduction of Solvency II, and IVASS Regulation No. 24/2016 in June of the same year, insurers are now free to choose the most appropriate investment instruments, subject to the precondition that their immediately available capital is adequate to cover the risk underlying the investment.

Mergers and transfers of insurance portfolios that involve insurance companies operating in Italy are subject to IVASS’s prior agreement, but if the merger may result in the company having a position of market dominance, the Italian Antitrust Authority might also have to give its preliminary authorisation. The sole financial requirement is that the incorporating company or the new company resulting from the merger has the necessary solvency margin, taking into account the merger and the consolidated liabilities.

In the case of a merger, the entire operation, the relevant arrangements, and the new memorandum and articles of incorporation must be presented to and reviewed by the insurance regulator, which can make observations to ensure conformity with the law and to guarantee the insured.

There are no restrictions regarding investments in or the acquisition of an insurance or reinsurance company, provided that the funding of the operation does not breach any anti-money laundering provision or public policy. In the event of a merger resulting in the setting up of a new company with its head office in Italy, the new company must be authorised before it can legitimately underwrite insurance, whereas if one of the parties in the merger has its head office in another EU Member State, IVASS’s agreement to the operation can only be given after the relevant home supervisory authority has approved the merger.

While reviewing the merger, and the new memorandum and articles of incorporation, IVASS performs a limited background investigation of the officers and directors of the acquirer or of the new company to ensure that they all respect the Civil Code provisions and meet the applicable legal requirements.

If an insurance or reinsurance company enters into serious financial difficulties, Articles 245 to 265 of the Private Insurance Code provide for the administrative compulsory winding up of insolvent or financially troubled insurance and reinsurance companies.

With respect to reinsurance companies domiciled in Italy, the current regulatory requirements with respect to reinsurance ceded shall be found in Directive 2005/68/EC of 16 November 2005 on reinsurance, which amended Directives 73/239/EEC and 92/49/EEC and Directives 98/78/EC and 2002/83/EC, although the relevant provision at law has not yet been formally enforced in Italy.

On 10 March 2010, ISVAP published Regulation No. 33 on reinsurance, which implemented the provisions of the Private Insurance Code as modified by the adoption of the EU Reinsurance Directive (2005/68/EC). The regulatory framework is complex, with its 143 articles detailing and providing for the exclusive conduct of reinsurance activities by companies with a registered office in Italy or Italian branches of companies with registered
offices abroad (or both); the procedures for authorising such activities; and companies that have a registered office in Italy and authorisation exclusively to conduct reinsurance activities to carry on such activities in other EU Member States under the applicable regulations on freedom of establishment and freedom to provide services.

In Italy, only licensed or accredited reinsurers can provide reinsurance. Therefore, there is no need for collateral to allow a deduction from the liabilities stated on the reinsured company’s statutory financial statement. However, collateral might become necessary with a retrocessionaire of the reinsurer that is neither licensed nor accredited. In this case, the retrocessionaire must provide some form of collateral to allow a deduction from the liabilities stated on the Italian reinsured company’s statutory financial statement.

v The distribution of products

The distribution of insurance products is usually done through intermediaries, but in rare and limited cases insurance can be acquired directly from the insurer at the registered office agency.

During the distribution, a number of rules to protect consumers and unsophisticated customers must be respected. In particular, Article 182 of the Private Insurance Code obliges IVASS to ensure compliance with the principles of clarity, recognition, transparency and fairness of advertising and information on the conformity of the insurance contract with the advertising and in the pre-contract negotiations (with the information notice) and the execution of the insurance contract (policy conditions). The old secondary legislation providing for all those topics has been substituted by an organic and organised set of rules contained in IVASS Regulations Nos. 40 and 41 of 2 August 2018 (see Section II.i).

For some life products, such as pension funds, and some life policies, the index-linked products are subject to the supervision and control not only of IVASS but also of the Commission for the Supervision of Pension Funds.

vi Intermediaries

Among the principal duties of the Italian regulator is the supervision of insurance intermediaries, which to operate legitimately must be listed on the Sole Register of Insurance and Reinsurance Intermediaries (RUI).

The RUI was set up by the Private Insurance Code, implementing Directive 2002/92/EC on insurance mediation, and is mainly governed by ISVAP Regulation No. 5 of 16 October 2006. According to the regulations, any insurance and reinsurance intermediation activity is reserved solely to persons who have passed the ISVAP/IVASS national exam and consequently have been listed on the RUI.

Based on the Private Insurance Code, the RUI is divided into five sections as follows, and no intermediary may be recorded in more than one section:

- Section A for insurance agents;
- Section B for brokers;
- Section C for direct canvassers of insurance undertakings;
- Section D for banks, financial intermediaries as per Article 107 of the Consolidated Banking Law, stock-broking houses and the Italian Post Office’s banking division (Bancoposta); and
- Section E for the collaborators of the intermediaries registered under Sections A, B and D conducting business outside the premises of such intermediaries.
ISVAP attached to the RUI a list of intermediaries having their residence or head office in EU Member States. This special section contains information on natural persons and companies licensed as insurance and reinsurance intermediaries in other EU or EEA Member States who have also been authorised by the regulator to pursue insurance mediation in Italy based on the freedom of establishment or freedom of services.

vii Compulsory insurance

A number of special laws impose compulsory insurance to be undertaken with private insurance companies.\textsuperscript{16}

At other times, the private insured must instead take out an insurance contract with a public insurer, such as the National Institute for the Insurance of Accidents at Work,\textsuperscript{17} or take out a mutual insurance contract with a private insurer through a public contracting entity.\textsuperscript{18}

Finally, an obligation to take out an insurance contract can be found in some national collective labour contracts stipulated between the trade unions, representing the employees, and the Industrial Association, representing all their members who will adopt the negotiated national collective labour contracts for the specific industry.\textsuperscript{19}

Decree-Law No. 138 of 13 August 2011, converted into Law No. 148 of 14 September 2011, introduced compulsory insurance. According to the Law, all professionals had to take out a professional indemnity insurance contract by 13 August 2012, with the exception of physicians and lawyers.

\textsuperscript{16} Motor insurance was introduced in Italy by Law No. 990 of 29 April 1969 in Official Gazette No. 2 of 3 January 1970. It was subsequently modified, and the most recent amendment was introduced by Decree-Law No. 179 of 18 October 2012, which provided that a compulsory motor insurance contract for motor vehicles and boats cannot be tacitly renewed and cannot be underwritten for a period longer than a year; any eventual policy clauses in contrast with this provision are deemed to be null and void.

\textsuperscript{17} Domestic accidents compulsory insurance was introduced in Italy by Law No. 493 of 3 December 1999, which imposes, as of 31 January 2013, the obligation to take out a contract of compulsory insurance with the National Institute for the Insurance of Accidents at Work for persons between 18 and 65 years who work full-time in the family house. The policy costs around €1 per month.

\textsuperscript{18} Typical examples of this are:

\textit{a} The Law on Hunting No. 157 of 11 February 1992, according to which hunters must obtain insurance coverage for civil liability arising from the use of firearms for hunting, with a €1 billion limit per claim, with a sub-limit of €750 million per injured person, and €250 million for damage to animals and things; or for personal accidents related to hunting, with a limit of at least €100 million for death or permanent disability. This insurance is provided through the National Federation of the Hunters.

\textit{b} The obligation to pay a small premium to the Italian Gas Committee for the policy it annually draws up against the risks arising from the use or abuse of the gas distributed via networks or pipelines by the different national public utilities companies regardless of whether they are publicly or privately owned.

\textsuperscript{19} For example, the national collective labour agreement for managers and executives, according to Article 18(7)(a), (b) and (c), obliges the enterprises party to a collective contract to take out, for the benefit of their employees, executive insurance against professional and extra-professional accidents.
For physicians, the duty to undertake errors and omissions insurance became effective on 15 August 2014, whereas for lawyers the obligation became effective after the Department of Justice issued a decree reforming the legal profession and a subsequent decree determining the minimum requirements for mandatory professional indemnity insurance for lawyers.

**viii Taxation**

The taxation of premiums and life policy revenues in Italy is a complex matter that cannot be discussed in detail in this chapter. In brief, premiums are not subject to value added tax but to an insurance tax that varies for each class of insurance in accordance with the fixed percentage set forth by Law No. 1216 of 29 October 1961.

Similar to any capital gain, financial yields resulting from life insurance contracts and capitalisation are subject to the substitutive tax provided for in Article 26 ter of Decree No. 600 of 29 September 1973. The tax due is up to 20 per cent of the capital gain, but was reduced to 12.5 per cent for the portion of income that related to the period between the date of subscription or purchase and 31 December 2011.

The Italian State Agency, through Ministerial Circular No. 41/2012, clarified that, according to Article 83 of Decree No. 68 of 29 March 2012, financial yields resulting from life insurance contracts and capitalisation of foreign insurance policies are also subject to the substitutive tax provided for in Article 26 ter of Presidential Decree No. 600 of 29 September 1973, even if paid by foreign insurers to persons residing in Italy.

**ix Regulation of individuals employed by insurers**

All employees are subject to a collective contract negotiated at national level between the most representative trade unions and the national association of the employers (in the case of the insurance market, the National Association of Insurance Companies). The national collective contract can then be integrated using a specific collective contract negotiated between the local trade unions and the representative of a specific insurance company or group of insurance agents.

Although the national collective contract for insurance employees expired at the end of June 2013, the binding effects of the contract were extended while the parties were negotiating.

On 22 February 2017, the National Association of Insurance Companies and the trade unions reached an agreement on the new contract terms and economic conditions for management employees.

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20 In Official Gazette No. 116 of 19 May 2016, the Regulation governing the training period for access to the legal profession in accordance with Article 41, Paragraph 13 of the Law of 31 December 2012, No. 247 (Decree No. 70 of 17 March 2016) was published.


22 Percentages can vary enormously, from a minimum of 0.05 per cent for insurance stipulated on ships registered in Italy up to a maximum of 21.25 per cent for any insurance other than fire, theft, liability, machinery breakdown, personal accident, cargo and marine insurance (i.e., credit or bond insurance is subject to this rate).
The national collective labour contract for the employees of insurance agencies was concluded on 8 July 2014 for the agents of the Generali/Ina Group, and on 20 November 2014 for insurance agents in free management.23

Furthermore, a national collective labour contract (see subsection vii) is integrated into all applicable labour laws. Of particular importance are Legislative Decree No. 626/1994 dealing with the safety and health of workers at work, the Jobs Act24 and the two delegated implementing Decrees approved by Parliament on 20 February 2015 (respectively, redundancies and contracts, and social safety nets). The Jobs Act and the two Decrees came into force on 1 March 2015.

III INSURANCE AND REINSURANCE LAW

i Sources of law

In Italy, the source of insurance and reinsurance law is statutory. Case law precedents are not binding, and the very same issue could receive different treatment from one court to the next.

The principal written statutes to be considered are:

- the Private Insurance Code;
- the Civil Code;
- the special legislation dealing with compulsory insurance;25 and
- regulations issued until 21 December 2012 by ISVAP and from that date onward by IVASS.

ii Making the contract

The rules providing for insurance contracts and their drafting are all contained in the Civil Code.

The contract is not concluded until the two parties agree on the extension of the risk, and on the premium to be paid for the shifting of the risk from the insured onto the insurer.

The conclusion of the contract is a complex succession of events where the prospective insured will propose a risk, usually by completing a proposal form prepared by the insurer, who will evaluate the risk and quote the premium. In completing the proposal, the prospective insured must answer truthfully and completely to avoid being sanctioned for wilful non-disclosure according to Article 1892 of the Civil Code or negligent non-disclosure according to Article 1893 of the Civil Code.26 Case law indicates that all information that is

23 National collective labour contract for employees of insurance agencies under free management (20 November 2014).
24 Legislative Decree No. 34 of 20 March 2014, converted with amendments into Law No. 78 of 16 May 2014: ‘Urgent measures to promote employment and to raise the simplification of formalities for enterprises’.
26 Wilful non-disclosure, which can also be committed by omitting to state or represent, according to Article 1892 of the Civil Code, is sanctioned with the loss of the right to recover any indemnity under the policy, whereas in the case of negligent non-disclosure, according to Article 1893 of the Civil Code, the right to recover is reduced in proportion to the premium that would have been charged if the true situation had been known and the premium that was actually charged. See Cass Civil No. 3165 of 4 March 2006; Cass Civil No. 7245 of 29 March 2006; Cass Civil No. 16769 of 21 July 2006; and Cass Civil No. 5849 of 13 March 2007.
requested by the insurer in the proposal form must be deemed essential, and a non-disclosure or false statement in response to a query automatically qualifies the misrepresentation as wilful.\textsuperscript{27}

When the risk is of an industrial or technical nature, a survey is sometimes undertaken. This provides better understanding of the risk, but might pose substantial problems should the insured have made a misrepresentation. In fact, case law indicates that any on-site visit and survey might override the false or omitted declarations in the proposal form, as the insurer or its agent (the surveyor) should have checked and realised the differences between the proposed risk and the real risk.

Finally, it is important to mention the IVASS circular letter to the market of 5 November 2013 concerning the long-term property insurance reintroduced by Law No. 99/2009. IVASS, as a result of numerous protests made by insurers complaining about companies’ refusal to grant them an early termination of insurance contracts of multi-annual duration, invited all insurance companies, by 31 December 2013, to ‘specifically and with adequate graphic evidence’ indicate in the policy whether the insured benefited from a discount because of the policy’s long duration and the fact that, owing to the discount applied, the policyholder cannot exercise the right of early withdrawal from the contract for the first five years of the contract.

As mentioned in Section II.i, in accordance with IVASS Regulation No. 41/2018, as of 1 January 2019, all negotiations for standard contracts shall be accompanied by a pre-contract information package, except tailor-made insurance that only requires the completion of the proposal form.

\section*{Interpreting the contract}

While the insurance contract may be concluded orally, according to Article 1888 of the Civil Code, there must be written proof of its existence.

Usually this prevents potential controversies regarding the object of the insurance or the scope and extension of the contract, and clearly excludes from the insurance any contractual terms that are not expressly incorporated into the policy wording. Notwithstanding this, there are some cases where the policies are badly drafted and the wording can pose problems. If a problem of interpretation arises, the contract will be interpreted using the general interpretation rules that are provided in the Civil Code for all contracts,\textsuperscript{28} which mainly relate to the will of the parties and good faith.

Furthermore, depending on whether the insurance contract has been prepared by the insurer as a \textit{pro forma} contract or whether the policy wording has been duly and totally negotiated between the parties, there will be some substantial differences in the interpretation and enforcement of the contract.

In the first case, whenever the insurer prepares policy wording or forms designed to uniformly regulate a number of contractual relationships principally with non-professionals, the basic rule is to interpret \textit{contra proferentem} (i.e., the wording shall be interpreted against the party who prepared the policy wording). Furthermore, any added clause or cancellation that modifies the original policy text shall prevail in accordance with Article 1342 of the Civil Code.

\textsuperscript{27} See Cass Civil No. 3165 of 4 March 2003; Cass Civil No. 4862 of 12 May 1999; and Cass Civil No. 10086 of 12 October 1998.

\textsuperscript{28} See Articles 1362 to 1371 of the Civil Code.
In addition, there are terms that are considered legal but onerous for the party against which these are drafted. These clauses are not binding on a party that has not accepted them and signed twice in accordance with Article 1341 of the Civil Code. This is usually to regulate the contractual terms stipulating a specific and particularly short period to comply with the contract provision, or that modify the court jurisdiction as per the general rules of law or create foreclosure terms. Notwithstanding a listing of clauses, this procedure was judicially extended to insurance underwritten on a claims-made basis, because although a legitimate contract, it deviates from the loss-occurrence basis chosen by the legislature as the typical way in which insurance shall operate.\(^{29}\) This decision created the key question of whether claims-made clauses are legitimate or not. The United Sections of the Court of Cassation, with Judgment No. 22437 of 24 September 2018, decided that claims-made clauses delimit the object of the contract but do not limit the liability, and in view of their non-vexatious nature, do not require double approval in accordance with Article 1341 of the Civil Code. The Court also affirmed that the contractual model based on the claims made is part of the historical background of civil liability insurance and while it represents a derogation from the ‘loss occurrence’ scheme provided for in Article 1917(1) of the Civil Code, it is nonetheless permitted pursuant to Article 1932 of the Civil Code. The legitimacy of the clause is also confirmed by legislation through the reform of the National Health Service implemented by the Gelli-Bianco Law. The Court also recalled its Judgment No. 9140 of 6 May 2016 and affirmed that the claims-made clauses are legitimate as they safeguard the interests of both the insured and insurer, hence the judge, case by case, will ensure that there is no asymmetry between the parties, or mechanisms that determine ‘temporal gaps in the insurance coverage’.

Under Italian law, there are no warranties, but rather conditions precedent or essential conditions. These must be marked and appropriately addressed in the policy so that the insured’s attention is directed to the condition.

In setting the terms of an insurance contract, the parties, according to Article 1322 of the Civil Code, are free to negotiate the content of the insurance provided that a risk does exist, and that the terms do not breach internal public policy\(^{30}\) or have an illicit scope.\(^{31}\) Usually there are general conditions providing for all contracts falling within a specific class of business (professional indemnity), particular conditions for a specific group of insured (engineer’s professional indemnity), and special conditions that should provide only for that particular contract and that are quite often condensed in a summary at the beginning of the policy document.

\(^{29}\) The Joint Sections of the Court of Cassation with judgment No. 9140 of 6 May 2016 superseded the rigid approach set forth by its prior judgment No. 5264 of 23 December 2005, according to which claims-made clauses were deemed to be unfair contract terms and therefore invalid, and affirmed that the validity of claims-made clauses shall have to be assessed case by case, keeping in mind the specificity of the insurance contract scope and the factual elements of the case. However, the Supreme Court did not provide clear directions about the criteria that should support a validity test. Consequently, until this aspect is clarified by future case law, it would be prudent to have the insured accepting claims-made clauses in writing (by double signature) pursuant to Articles 1341 and 1342 of the Civil Code.

\(^{30}\) In the past, the nullity of kidnap and ransom insurance was grounded on ISVAP Regulation No. 246 of 22 May 1995 on the grounds that this type of insurance was inviting criminals to kidnapping insured persons with the aim of obtaining the indemnity payment. Today, Article 12 of the Private Insurance Code provides the same prohibition.

\(^{31}\) It is forbidden to insure any crime. For example, a clause insuring a cargo of drugs against the peril of fire or against loss following a police seizure would be null.
iv Claims

When an insured-against event occurs, the insured shall notify the loss to all insurers and start salvage to minimise the extent of the loss.

Article 1913 of the Civil Code provides that, unless the insured entity has already had notice of the occurrence of the loss, notice must be given within three days of the loss event. A lack of notice or late notice does not permit the insurer to deny liability unless prejudice has been suffered, and in this case the denial shall be proportional to reflect the prejudice suffered.

For all non-liability insurance, the insured event or the loss occurrence triggers the insurer’s indemnity obligations if the insured knew of the event or occurrence, or the insured should have known of the event or occurrence. If the insured does not make a timely notification or does not enforce its right to the indemnity within two years of the loss event, any right under the policy will be covered by the statute of limitation.

A slightly different approach is adopted by Article 1917 of the Civil Code on liability insurance contracts underwritten on a claims-made basis, where the element triggering the insurance guarantee is a third-party claim against the insured made by way of a registered letter or service of a writ of summons.

Once notified of the claim, the liability insurer can decide to defend the third-party claim on behalf of the insured. The duty remains until the liability insurer has exhausted the policy limits, in which case it shall be obliged to defend until the end of the proceeding. The duty to defend also triggers a sub-limit for defence costs equal to one-quarter of the policy limit. If the judgment or arbitration award exceeds the policy limit, the defence costs are apportioned between the insurer and the insured according to their respective interests.

Third parties are not usually privy to the insurance contract, and have no right to make a claim and enforce it in a court of justice. In exceptional and very limited cases, when the policyholder or insured entity remains inactive where there is a risk that the right to indemnity will be time-barred, a third party may, through subrogation, assume the rights of the insured and claim the insurance coverage. Not even the policyholder can act unless expressly delegated to do so in the policy or by a proxy of the insured.

Further exceptions to the aforementioned rule are found in the special provisions of Law No. 990/69 on compulsory motor accident insurance and Article 149 of the Private Insurance Code (see Constitutional Court judgment No. 180/2009).

No specific sanction is provided for wrongful denial of a claim, but because litigation usually follows, the court might award interests for late payment (provided for by Legislative Decree No. 231 of 9 October 2002) either from the date on which the indemnity was due to the date of final settlement or (in accordance with the newly modified Article 1284 of the Civil Code) from the date of the lawsuit service to the date of final settlement.

Quite often in Italian policy wording there is a provision for the loss adjustment of the claim whereby the parties or their experts should negotiate the amount of the loss and the level of the indemnity. More often than not these clauses not only focus on the pure quantification of the loss, but also authorise experts to resolve any controversy about the

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32 In accordance with the provisions of Article 2900 of the Civil Code.
33 See Article 17, Paragraph 1 of Law No. 162, dated 2 November 2014.
34 While the legal interest rate currently stands at 0.5 per cent, the interest for late payment provided for by Legislative Decree No. 231 of 9 October 2002 currently stands at the European Central Bank annual interest rate plus 7 per cent.
warranties or the increment of the risk, or even to determine if a misrepresentation of the risk took place. Whenever this occurs, case law indicates that the loss adjustment process has turned into a real arbitration\textsuperscript{35} with all the connected problems of challenging and voiding the outcome of the ‘informal arbitration award’.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

The parties are free to choose the jurisdiction and the applicable substantive law, and to include an arbitration clause to derogate the ordinary court jurisdiction unless the clause would be in conflict with the law.

An example, according to which the freedom of the parties is limited, is in their choice of international jurisdiction, which in relation to the insurance shall be made in accordance with the provisions of Section 3 (Articles 10–16) of Council Regulation (EC) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, or territorial jurisdiction within Italy when the insured is a consumer.\textsuperscript{36} A particular situation arising from this Regulation is the concurrent jurisdiction of the state of residence of the victim of a motor accident, which can be traced back to the Court of Justice of the European Union, in judgment No. 6 dated 13 December 2007-C463,\textsuperscript{37} interpreting the old Regulation (EC) No. 44/2001 on jurisdiction in civil and commercial matters.

ii Litigation

Litigation proceedings include first instance trial, an appeal and possibly a final appeal to the Court of Cassation for procedural faults or errors in the application of the law in the second instance judgment.

In accordance with Article 2697 of the Civil Code, the burden of proof rests with the party seeking to enforce the right in court, and the defendant must prove his or her case only after the claimant has fully proved the claim.

The insured or claimant must prove that the insured event occurred, the premium had been paid and the insurance contract existed. While the loss occurrence can be proved by witnesses or other means, the insurance and the premium payment shall be proved in writing.\textsuperscript{38}

\textsuperscript{35} \textit{Inter alia}, see Cass Civil No. 1081 of 18 January 2011.

\textsuperscript{36} In this sense, Cass Civil No. 9922 of 26 April 2010 affirmed that Article 1469 \textit{bis}, Paragraph 3, No. 19 of the Civil Code is procedural in nature and applies in cases started after it entered into force, even if relating to disputes arising from contracts stipulated before, and affirmed that the rule, in disputes between a consumer and a professional, establishes the exclusive jurisdiction of the courts of the place where the consumer has his or her residence or elected domicile.

\textsuperscript{37} In this binding precedent the Court affirmed that the injured party may sue, with direct action, the foreign motor liability insurer before the judges of the states where he or she resides, provided that direct action is provided for by the national law (and in Italy it is so provided for) and provided the insurer has a domicile within the territory of an EU Member State.

\textsuperscript{38} According to Article 1888 of the Civil Code, the insurance contract must be proven in writing, whereas Article 2721 of the Civil Code excludes the admissibility of testimonial proof of contracts when their value exceeds the sum of €2,58. However, the judge may allow the testimony beyond the limit above, taking into account the quality of the parties, the nature of the contract and any other relevant circumstance.
Legislative Decree No. 28 of 4 March 2010, implementing EU Directive No. 52 of 2008, imposes mediation for civil and commercial controversies. The Italian Constitutional Court declared the Decree unconstitutional for its abuse of power; therefore, the government issued Decree-Law No. 69 on 21 June 2013 (converted into Law No. 98 on 9 August 2013), which restored the mediation process as a condition of admissibility but limited it to any proceedings in the areas listed in Article 5, Paragraph 1 of Legislative Decree No. 28/2010. Among the different conflicting issues listed are:

- insurance contracts;
- medical malpractice;
- directors’ and officers’ liability; and
- banking and financial contracts.

The proper service of the writ of summons imposes a term of 90 days between the date of service and the first hearing. If the defendant wishes to join a third party or to counterclaim, it must make an application 20 days before the scheduled hearing, otherwise the defendant will lose the opportunity, and may only oppose and resist the claim when appearing at the first hearing, which is either scheduled on the writ of summons or postponed *ex officio* by the court to meet the court calendar.

In the first hearing, the judge checks that all the necessary parties are present. Following this, the court may issue default orders against parties that have failed to attend and, if a duly summoned party to proceedings fails to attend, the court might consider some of the factual allegations and the documents produced as uncontested and ground his or her decision on such evidence. After that the discovery phase opens and the parties will have:

- 30 days from the date of the hearing to amend the defences;
- 30 days to present any further evidence that might be necessary to support the case – again, discovery is limited to what the parties consider relevant and the documents affecting the case usually are not produced in court; and
- 20 days to rebut, object to and oppose the opponent’s discovery.

The dates of all hearings are set *ex officio* by the judge depending on his or her workload.

When all the defences are lodged in court, they are discussed by the judge who will determine which evidence is relevant for the case, and hence admissible; in the same court order, the judge will decide if independent expertise is necessary, and if it is, he or she will fix a specific date to swear in the court expert, and to give instructions about the scope and object of the expert testimony. One independent expert is appointed by the court and one by each of the parties, and the court-appointed expert will lodge a written report to which the parties have a right of reply. If one or both parties disagrees with the court-appointed expert, the latter might be called to the hearing to answer questions or to draft a supplement to the report.

Depending on the number of witnesses and questions, the evidentiary proceedings will be divided into one or more hearings scheduled generally every quarter.

Once the discovery is over, the case enters into the decision phase with a hearing where the court receives the parties’ arguments. From that date, two terms start to run: 60 days to lodge the last written defence, and a further 20 days to rebut the final defences of the opponents.

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39 See Official Gazette No. 53 of 5 March 2010.
40 Constitutional Court judgment No. 272/2012 in the Official Gazette of 12 December 2012.
Exceptionally, at the end of the discovery the court might elect to follow a fast-track proceeding pursuant to Article 281 of the Civil Procedure Code. In this proceeding, the parties shall lodge a short brief with the court 10 days before the hearing for arguments and, at the hearing after having given the arguments, the judge will listen to their oral pleadings and issue a decision, the reasoning for which will be explained in writing at the time of the publication of the judgment. In general, the decision process of a court takes from three to 14 months; however, much will depend on the complexity of the arguments raised by the parties and the court’s workload. Typically, the entire litigation lasts from two to three years in first instance, and a little less at first appeal and before the Court of Cassation.41

In litigation, costs follow the event; therefore, the losing party shall bear on top of its own costs the successful party’s costs and court costs, including the cost of expertise, the court duties and the register tax on the judgment.42 This is the general rule, but the courts have the opportunity to expressly apportion the litigation costs between the two parties, and in insurance contract litigation, the most common reason to derogate from the rule is that the policy wording was unclear, and that the insured had good grounds to believe that he or she had a viable and legitimate claim.

The Supreme Court of Cassation, in its leading precedent No. 1183 of 19 January 2007, declared that punitive damages were alien to the Italian legal system and, therefore, contrary to internal public policy. Thus it is not permissible to insure against punitive or exemplary damages in Italy, even if it is possible to do so legitimately for punitive damages awarded in other jurisdictions.

For the very same reasons, no punitive or exemplary damages can be awarded against an insurer who challenged in court a claim made under one or more of its policies.

Since 1 January 2015,43 a series of tasks previously carried out on paper and in person must be done electronically and remotely (the Electronic Civil Process).

In fact, with the Electronic Civil Process, lawyers can:

a consult case court files online;
b receive telematics communications from judicial offices, and serve defences and judgments directly upon other lawyers;
c execute electronic payment of unified court duties; and
d file defences, writs and pleadings along with the supportive documents packed into a specific ‘electronic envelope’ that is automatically electronically controlled and recorded by the national software system.

Despite a number of courts experiencing technical problems and interpreting the new rules differently, the technical instrument should guarantee a faster proceeding with less administrative personnel. The overall time between the service of summons and the issuing of judgments decreased from 1,075 days in 2015 to 840 in 2017, with a minor decrease to 817 days in 2018.

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41 Usually an appeal lasts two years, and the Court of Cassation proceeding between one year and 18 months.
42 The register tax is a proportional tax, usually 3 per cent of the court award; in the case of rejection of the claim, a fixed fee is usually charged.
43 Decree Law No. 132/2014, as converted into Law No. 162/2014, provides rules to speed up the proceeding, granting the possibility of moving away from the usual and general burdensome rite to a faster, albeit summary, rite of cognition (new Article 183 bis Civil Procedure Code), and introduces measures for the efficiency and simplification of the executive process along with a reduction in the judges’, magistrates’ and public prosecutors’ vacations.
### iii Arbitration

There are two forms of arbitration: formal arbitration, where the award has the nature of a court judgment; and informal arbitration, whose award has the nature of a contract and therefore can only be challenged for error, illegality, fraud, duress or excess of power in making the award.

The differences in the procedural and evidentiary requirements between the two formats are substantial. While the formal arbitration procedure is regulated by the Civil Procedure Code and the decision is rendered in accordance with the strict rule of the law, informal arbitration is not regulated and the parties can decide their own rules in the arbitration clause.

It is somewhat rare to encounter clauses in Italian policy wording that provide for formal arbitration for a number of reasons, including the risk of lack of independence of one or more of the arbitrators, and the costs of such procedures. Formal arbitration can, however, guarantee a first instance decision in a relatively short time (between six months and one year in the vast majority of the cases), as against the lengthy proceedings in a court of law (between two and 10 years).

Informal arbitrations are, however, quite common in property and business interruption insurance. Here, too, the costs of the procedure are usually high and reflect the work done in the loss-adjustment process.

### iv Alternative dispute resolution

Alternative dispute resolution clauses, apart from contractual expertise clauses, do not feature in Italian insurance contracts.

In a contractual expertise clause, the parties provide referral to one or more third parties, chosen for their particular technical competence, the task of formulating a technical appreciation, evaluation or economic appraisal. It follows that, if the parties have referred to experts the determination of a value of the relevant things, the extent of the damage suffered or the indemnification, the adjustment they make shall determine the value not in the abstract, but with reference to the specific loss event.

The expert opinion can be attacked and challenged only through the typical actions for annulment, actions for breach of contracts, or both.

### v Mediation and mandatory assisted negotiation

Article 5 of Legislative Decree No. 2 of 4 March 2010 includes a list of disputes subject to compulsory mediation. Among other controversies, the law mentions disputes relating to insurance contracts, and to compensation for damage caused by the circulation of vehicles, by medical malpractice, and because of the liability of directors and officers. If the case was litigated without prior recourse to mediation, the judge had to suspend the litigation and grant the parties a term of six months to mediate.

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45 A contractual expertise clause is typically included in fire or theft insurance policies to determine the insured item or items lost due to a fire or theft.
46 A contractual expertise clause is typically included in personal accident or medical costs insurance to determine the accident, the disability sustained and the costs of medical care.
47 A contractual expertise clause is typically included in business interruption clauses to evaluate the indemnity consequent to the loss of earnings net of the deductible period.
The Constitutional Court, with ruling No. 272 of 6 December 2012, declared Legislative Decree No. 2 of 4 March 2010 unconstitutional for excess of legislative delegation, insofar as it provided for the compulsory nature of mediation. Following this binding precedent, mediation remained available to resolve insurance disputes, but because it was no longer compulsory it was little used and the rate of successfully mediated disputes, which was already low when the procedure was compulsory, dropped even further after the Constitutional Court judgment.

This situation was reversed by the Decree Law No. 69/2013, which reintroduced compulsory mediation for a number of types of controversies, including claims for medical malpractice, professional errors and omissions, damages for libel and slander, insurance, banking and financial contracts. Two novelties have been introduced by the new legislation: only mediation entities or bodies present within the territory of the judge competent to hear the eventual subsequent litigation can legitimately run a mediation; and the parties shall be assisted by a lawyer during the compulsory mediation sessions.

Decree Law No. 132/2014, as converted into Law No. 162/2014, introduced a new form of alternative dispute resolution as a condition of admissibility of any lawsuit, including payment of debts up to €50,000, but limited to any proceedings that are not listed in Article 5, Paragraph 1 of Legislative Decree No. 28/2010 (mandatory assisted negotiation). With this new alternative dispute resolution, the parties, with the assistance of one or more lawyers acting as facilitator, should try to negotiate a solution to their existing controversy within three months. If the assisted negotiation fails, the parties can then legitimately act in court to have the judge resolve the dispute.

V YEAR IN REVIEW

The year 2018 was not characterised by many legal changes but Legislative Decree No. 68 of 21 May 2018 implemented the Insurance Distribution Directive. On the regulatory side, a number of notable changes have been introduced by:

a IVASS Regulation No. 37/2018 concerning the criteria and terms to be followed by undertakings for compulsory discounts in motor vehicle liability insurance;

b IVASS Regulation No. 38/2018 laying down provisions on the system of governance;

c IVASS Regulation No. 39/2018 concerning the procedure for applying administrative sanctions and implementing provisions;

d IVASS Regulation No. 40/2018 laying down provisions on insurance and reinsurance distribution;

e IVASS Regulation No. 41/2018 laying down provisions on transparency, disclosure and design of insurance products;

f IVASS Regulation No. 42/2018 laying down provisions on the external audit of public disclosure related to the Solvency and Financial Condition Report;

g IVASS Measure No. 76/2018 amending the IVASS Regulations Nos. 9/2017, 23/2008 and 24/2008 to adapt them to the implementation in Italy of the Insurance Distribution Directive; and

Letter of 3 October 2018 to the insurers and reinsurers having the head office in the United Kingdom pursuing business in Italy under the right of establishment or the freedom to provide services, asking them to:

- send adequate information on an individual basis about the impact of Brexit to their Italian policyholders and beneficiaries, according to the guidelines contained in an Opinion of the European Insurance and Occupational Pensions Authority of May 2018;\(^\text{49}\)
- publish similar information on their internet site; and
- give appropriate instructions to their distribution networks about the information to provide to their current and potential customers.

VI OUTLOOK AND CONCLUSIONS

In 2019, the Italian economy will continue to grow but less than expected owing to the general economic climate, and the increasing political uncertainties that will characterise Italian politics until the next European elections in May 2019.

The 2017 systemic actions,\(^\text{50}\) with reference to compulsory motor insurance, in an attempt of further limiting judicial fraud, along with the enhanced efficiency of the judicial system through the amalgamation of small courts and the introduction of the Electronic Civil Process, and the slow but steady development of alternative dispute resolution methods, should continue to benefit the insurance market throughout 2019.

Domotics (home automation) and new health insurance are currently rarely sold, but those products are expected to take off in the next few years to counter new risks posed by the internet of things at home and the constant reduction of resources available to the National Health Service.

The trend of a reduction in premiums for medium- to long-term insurance policies continues to slow down even if the average price for motor insurance on an annual basis decreased (by less than 0.3 per cent). Interestingly this last trend seems unrelated to the black box discounts as only 20.6 per cent of the stipulated contracts contains clauses for reducing the premium owing to the presence of the black box. No significant changes are expected in relation to black box installation in 2019.

As mentioned in Section I, life insurers were starting to recover from the past two years and were looking towards 2019 for record premium income growth in all classes, but

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\(^{50}\) Law 124/2017 introduced changes concerning motor liability insurance, including:

- The obligation to contract the granting of significant discounts if a driver has installed a black box in his or her car. This includes details of the interoperability and portability of the black boxes.
- The introduction of specific information obligations for insurance companies.
- Discounts in favour of the consumer who accepts certain conditions.
- Compensation for temporary disability damage that now, regardless of the extent of permanent disability, shall be determined by way of the daily amount for the absolute temporary disability foreseen for minor injuries.
- Prohibition of tacit renewal, at the request of the insured, with regard to contracts stipulated for accessory risks (e.g., fire and theft), if the accessory policy was stipulated in conjunction with the motor insurance.
particularly for Classes I and III (unit and index-linked policies). Life insurance penetration in Italy is 6.1 per cent (premiums/GDP) compared with the European average of 2.6 per cent. However, despite this positive development, the economy’s performance in the last quarter of 2018 and the prospects for 2019 threaten to hamper this progress.

In connection with the implementation of the GDPR in May 2018, IVASS became active in supervising insurance market awareness about the new legislation requirements, and especially the processes put in place to prevent data breaches and the eventual subsequent notifications and remedial action. In particular, aside from the more traditional interventions upon insurance and reinsurance companies, IVASS continued to monitor the risks involved in the use of new technologies by the Italian and EU intermediaries based in Italy and circulated to the market the 16 February 2018 letter in which the Regulator, after having reviewed the current measures and processes adopted by insurers and intermediaries for the acquisition and storage of data, recommended that the insurance market adopt a number of recommended measures, including the review and reform of their existing insurance policies in order to cover cyber risk and associated remedial costs.

On 1 October 2018, the Insurance Distribution Directive became fully applicable, imposing on intermediaries and all subjects that are part of the insurance distribution chain better oversight and governance of the insurance products by way of more transparent and complete pre-contractual information about the specific insurance product to be distributed, more transparent checks of conflicts of interests, and a continuous education of the persons involved in the insurance distribution.

In conclusion, the insurance market and, as a consequence, the reinsurance market, are expected to benefit from all these changes throughout 2019.
I INTRODUCTION

The Japanese life and non-life insurance markets are very competitive, involving a large number of companies. Although Japanese insurance companies are providing individual annuities in response to the expanding demands of an ageing population, the falling birth rate in Japan has had the effect of reducing demand for life and non-life insurance coverage. Accordingly, major Japanese insurance companies are seeking business opportunities overseas to expand their presence in the worldwide market, which has larger room for growth. At the same time, in their domestic strategies and with a view to streamlining, Japanese insurance companies have promoted mergers and acquisitions, which has led to their integration into some larger insurance groups, and they have sought more cost-effective sales channels for insurance contracts. To achieve a synergistic effect through integrated group management, insurance companies are undertaking cross-selling by sharing the clients of companies in the same group to ensure easy access thereto. Further, the style of solicitation has been diversified for efficiency and to respond to the needs of customers. Traditionally, sales of life insurance were made face-to-face by employees of life insurance companies that undertook solicitation activities on behalf of a sole insurance company. However, the use of agents, including bancassurance (that is, the selling of insurance products by a bank liberalised in December 2007) and those undertaking solicitation activities on behalf of multiple insurance companies, and direct marketing through several channels, which did not occur in the past, are becoming more common. As with the life insurance market, the non-life insurance sales channels are diverse.

As for the reinsurance market, there are two domestic reinsurance companies and a number of branches of foreign reinsurers in Japan. Non-life insurance companies also underwrite reinsurance. Japanese non-life insurance companies play an important role in the world’s reinsurance market.

II REGULATION

i The insurance regulator

Insurance business is regulated under the Insurance Business Act (IBA), whereby the Financial Services Agency (FSA) takes the main role as the insurance regulator. Under the IBA, the Japanese Prime Minister (PM), who has the authority to supervise the entities or
persons that conduct insurance business and related business in Japan, delegates most of his or her authority (excluding certain important powers such as granting or cancelling insurance business licences) to the Commissioner of the FSA. The Commissioner further delegates a part of his or her authority to the directors of the Local Finance Bureau of the Ministry of Finance (LFB).

The FSA and the LFB have the authority to (1) demand reports from and inspect insurance companies, licensed branches of foreign insurers (licensed branches), small-amount and short-term insurance (SASTI) providers, subsidiaries thereof, service providers subcontracted by any insurance company, certain major shareholders of insurance companies, insurance holding companies, and insurance agents and brokers; and (2) take administrative action against insurance companies, licensed branches, SASTI providers, certain major shareholders of insurance companies, insurance holding companies, and insurance agents and brokers.

The FSA stipulates detailed regulations under the IBA. Additionally, the Comprehensive Guidelines for the Supervision of Insurance Companies and SASTI Providers (the Guidelines), set by the FSA, contain basic concepts, evaluation criteria and other guidelines relating to the supervision of insurance companies and SASTI providers, which should be observed when doing insurance business in Japan.

ii Position of non-admitted insurers

Insurance and reinsurance activities are only permitted to be undertaken by insurance companies, Japanese branches of foreign insurers and SASTI providers that have obtained licences in Japan. Foreign insurers not licensed in Japan under the IBA and without branch offices in Japan cannot conclude domestic risk insurance contracts (i.e., insurance contracts for persons resident or domiciled in Japan, or with property located, or vessels and aircraft registered, in Japan), with the exception of certain insurance contracts, such as:

- reinsurance;
- insurance covering international freight;
- overseas travel insurance; and
- insurance for which prior permission from the FSA has been received by the policy applicant.

iii Position of insurance intermediaries

Under the IBA, the persons or entities permitted to act as agents or intermediaries for the conclusion of an insurance contract are limited to the following:

- life insurance solicitors, such as life insurance agents, and officers and employees of life insurance providers;
- non-life insurance solicitors, such as non-life insurance agents, and officers and employees of non-life insurance providers;
- small-amount and short-term insurance solicitors; and
- insurance brokers.

Life insurance agents, officers and employees of life insurance providers, non-life insurance agents and SASTI solicitors must register with the PM through the LFB.

Unlike non-life insurance, from an insurance regulatory perspective, the officers (excluding officers with authority of representation, company auditors and members of audit committees) and employees of licensed life insurance providers are required to register.
Since these intermediaries listed above, except for brokers, are entitled to act as intermediaries for the conclusion of insurance contracts on behalf of insurance companies, licensed branches and SASTI providers, they are responsible for loss incurred by customers because of improper actions of intermediaries during the solicitation of insurance.

Brokers are independent from insurance companies. If a customer incurs loss because of the improper action of a broker, insurance companies are not responsible for the loss and the broker must indemnify the customer for the loss. Therefore, to ensure the resources to indemnify customers against loss, the IBA requires brokers to:

- deposit a security deposit with the deposit office;
- conclude a contract with a security provider stipulating that a required amount of security deposit be lodged by the security provider for the account of the broker, by order of the PM; or
- conclude a broker’s liability insurance contract (in this case, brokers are required to ensure the resources of at least ¥20 million by the means listed in points (a) or (b), or both).

iv Requirements for authorisation

Japanese insurance companies

Insurance companies must obtain from the PM either a life insurance business licence or a non-life insurance business licence.

The applicant must submit a licence application with the required attachments to the PM through the FSA. The required attachments include:

- the applicant’s:
  - articles of incorporation;
  - statement of business procedures;
  - general policy conditions; and
  - statement of calculation procedures for insurance premiums and policy reserves;
- a business plan;
- documents explaining the status of recent assets, profits and losses; and
- documents relating to the applicant’s subsidiaries.

To protect the public interest, the PM can impose conditions on licences or revise their conditions.

Japanese branches of foreign insurers

For a foreign insurer to conduct insurance business in Japan, its Japanese branch must obtain from the PM either a life insurance business licence or a non-life insurance business licence.

The procedures for foreign insurers to obtain a licence are similar to those for Japanese insurance companies.

SASTI providers

SASTI providers must register with the PM through the LFB. The registration application and its required attachments are similar to those for a licence application.
v  The distribution of products
No person or entity is allowed to distribute insurance products, other than insurers themselves, their agents and brokers.

vi  Other notable regulated aspects of the industry

Permitted activities and subsidiaries
Insurance companies and licensed branches can carry out only the following types of business under the IBA:

a  underwriting insurance and management of assets (typical business);
b  incidental business, for example:
   • representing the business or performing services on behalf of other insurance companies and other entities carrying out financial business;
   • guarantees of obligations;
   • handling private placements of securities; and
   • derivative transactions; and
c  business permissible under the IBA and other laws (e.g., certain securities trading business and trust business concerning secured bonds).

Insurance companies cannot hold subsidiaries other than those set out in the IBA, including:

a  companies that engage in financial business (e.g., insurance companies, banks, securities companies and trust companies);
b  companies that engage in business that is dependent on the business of their parent insurance companies and their subsidiaries;
c  companies that engage in business that is incidental or related to financial business;
d  companies that explore new business fields; and
e  holding companies whose subsidiaries are limited to companies listed in points (a) to (d).

Since this rule was applicable to subsidiaries inside and outside Japan, and as major Japanese insurance companies tended to seek business opportunities overseas to expand their presence in the worldwide market as there is larger room for growth, it was pointed out that Japanese insurance companies, upon acquiring foreign insurance companies, found their competitive position impaired because they were forced to sell certain subsidiaries not qualified under the IBA. For this purpose, the reforms of the IBA in March 2012, and May 2014, loosened the restrictions on the business engaged in by subsidiaries of foreign financial institutions acquired by Japanese insurance companies, subject to approvals having been obtained. However, the approved foreign subsidiaries should be sold within five years after the date of the acquisition unless the insurance companies obtain approval from the PM to extend this period. This affords Japanese insurance companies greater flexibility in expanding overseas.

Neither insurance companies nor their subsidiaries can acquire or hold, on an aggregated basis, more than 10 per cent of the total voting rights of all shareholders of any other company in Japan, except companies that can be held as subsidiaries by insurance companies, as mentioned above. The Anti-Monopoly Law imposes similar restrictions.
Ownership
A shareholder of a Japanese insurance company or insurance holding company that holds more than 5 per cent of the total voting rights must file a notification with the LFB or (in certain cases) the FSA, and file a report each time there is a change to the notification. If the person or entity is to acquire directly or indirectly (through other entities) at least 20 per cent of the total voting rights of a Japanese insurance company (or 15 per cent in certain cases) (major shareholder threshold), they must obtain prior authorisation from the FSA. The IBA provides a certain review standard for the authorisation to ensure sound and appropriate management of the insurance company’s business.

Acquisitions of SASTIs must be pre-approved by the LFB when the major shareholder threshold is surpassed.

Further, the acquirer or holder must file an *ex post* notification with either the FSA or LFB respectively, if either (1) the person or entity acquires more than 50 per cent of the total voting rights of a Japanese insurance company or SASTI provider; or (2) the number of voting rights held becomes equal to or less than 50 per cent, or less than the major shareholder threshold.

With respect to insurance holding companies, the following must obtain prior authorisation from the PM: a company that intends to become a holding company with an insurance company as its subsidiary; and a person who intends to establish such a holding company.

In the case of SASTI providers, pre-approval is required from the LFB.

After becoming an insurance holding company, notification is necessary when the company makes an insurance company its subsidiary.

The holding company must file a notification if an insurance company or a SASTI provider ceases to be its subsidiary.

Approval requirements
Under the IBA, insurance companies must obtain approval for the following:

*a* transactions that are not generally conducted in the ordinary course of business (such as a transfer of insurance contracts, transfer of insurance business or entrustment of insurance business); and

*b* corporate actions that involve:

- a reduction of the capital of stock insurance companies;
- entity conversion of a stock insurance company into a mutual insurance company (and vice versa); or
- a merger, company split or liquidation.

Issuance of any equity triggers an *ex ante* notification obligation only when the insurance company increases its stated capital with such an issuance of equity. Debt security also requires an *ex ante* notification, but only if it is in the form of bonds with share warrants.

Capital requirements and solvency margin requirements
Japanese insurance companies must hold more than ¥1 billion in either (1) stated capital (in the case of a stock company); or (2) total amount of *kikin* (the funds held by a mutual insurance company, equivalent to the capital held by stock companies) including a reserve for redemption of *kikin* in the case of a mutual company.
The IBA provides for a solvency margin ratio as a standard to assess the soundness of an insurance company’s business. The solvency margin ratio is calculated by dividing the total amount of stated capital, kikin, reserves and other amounts by the amount available to cope with possible risks, exceeding the standard predictions that may occur because of insurance accidents. Insurance companies must maintain a solvency margin ratio of at least 200 per cent. In practice, however, all insurance companies maintain a higher ratio. The formula for calculating the solvency margin ratio is as follows:

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\text{Solvency margin ratio (\%) = \frac{\text{the total amount of margin} \times 100\%}{\text{the total amounts of risk} \times 1/2}
\]

The group solvency margin requirement on a consolidated basis has been applicable to an insurance company and insurance holding company since the fiscal year end of 31 March 2012, which means the solvency margin ratio of a group with an insurance company or insurance holding company at the top should be calculated on a consolidated basis (i.e., the insurance holding company and its subsidiary or the insurance company and its subsidiary).

Similar ongoing requirements apply to licensed branches and SASTI providers.

### III INSURANCE AND REINSURANCE LAW

#### i Sources of law

**IBA**

The IBA and related regulations provide for the supervision and regulation of the insurance and reinsurance business. The definition of an insurance business under the IBA includes insurance and reinsurance activities. Therefore, the IBA regulates insurers and reinsurers in the same way.

**Insurance Act**

The Insurance Act generally regulates insurance contracts entered into after 1 April 2010.

#### ii Making the contract

**Essential ingredients of an insurance contract**

While the IBA does not define what constitutes an insurance contract, an insurance contract under the Insurance Act is defined as an insurance contract, a mutual aid contract or any other contract in whatever name, under which both:

- one party undertakes to pay financial benefits (limited to the payment of money in life insurance contracts, and fixed benefit accident and health insurance contracts) to the other party, subject to a certain event occurring; and
- the other party undertakes to pay insurance premiums (including mutual aid premiums), the calculation of which is based on the possibility of a certain event occurring.

Life insurance is defined as an insurance contract in which insurers will pay financial benefits with respect to the survival or death of individuals, where an interest is clearly eligible to be insured. Non-life insurance is defined as an insurance contract under which the insurer agrees to indemnify the loss that may arise from specific accidents. The subject matter of a non-life insurance contract must be an interest that may be measured by an amount of money (i.e.,
Japan

an insurable interest). The insurable interest must be held by the insured. In this way, non-life insurance is distinguished from gambling. In practice, whether the insured holds insurable interest is decided on a case-by-case basis, so that those in need of cover are not unduly restricted from accessing sufficient cover.

There is no definition of a contract of reinsurance in either the Insurance Act or the IBA. However, a contract of reinsurance is a type of non-life insurance.

Information provided to the insurer at placement

Under the Insurance Act, applicants are required to provide material information that is related to the possibility of an accident or loss to the extent specified by an insurance company at the time of placement (Article 4).

Utmost good faith, disclosure and representations

As stated above, policyholders and the insured are obliged to disclose material facts that are specifically requested by an insurer in relation to the insurance, at the time of concluding an insurance contract (the duty of disclosure). In this regard, under Japanese law, the duty of disclosure is generally considered not as a representation of utmost good faith, but rather as a legal mechanism to correct information asymmetry so that the insurers can have adequate information held only by policyholders or the insured.

Recording the contract

To avoid being exposed to a moral hazard, insurance companies have introduced a system for recording certain insurance contracts with the Life Insurance Association and the General Insurance Association, and share the information of the insurance contracts between the members of those associations for reference in conclusions of insurance contracts and claims handling, or for checking the overinsurance.

Interpreting the contract

General rules of interpretation

Generally, it is understood that an insurance policy should be interpreted in a uniform manner so that insurance contracts between a number of policyholders are read as the same, and policyholders and the insured under the same insurance policy are treated equally. Accordingly, the intentions or understanding of an individual policyholder are not considered in the interpretation of insurance contracts.

Incorporation of terms

Policy conditions

While insurance policies are not required to be in writing, insurance contracts are generally concluded with policy conditions predetermined by the insurance company and approved by the FSA, or, instead of the approval, certain types of insurance contracts can be sold either:

- by giving prior notification to the FSA; or
- by stating in the statement of business procedures that the insurance company can create or change the insurance contracts without any prior notification to the FSA.
A person who wants insurance coverage submits an insurance application form to an insurance company, and if the insurance company accepts his or her application, an insurance contract is concluded and the terms of the policy conditions become binding between them.

Under the Insurance Act, there are several types of provisions that include discretionary provisions, compulsory provisions and unilateral compulsory provisions in favour of the insured or policyholders. When an insurance policy excludes or sets out a provision that conflicts with discretionary provisions, the insurance policy supersedes the discretionary provisions. With respect to compulsory provisions, parties are not allowed to conclude insurance policies that contradict the compulsory provisions and any contradicting policy provisions are null and unenforceable. Further, unilateral compulsory provisions make invalid and unenforceable any provisions in the policy that are less favourable to the insured or policyholders than the unilateral compulsory provisions. That said, however, unilateral compulsory provisions in favour of the insured or policyholders are not applicable to certain commercial lines of insurance, including:

a marine insurance;
b insurance concerning aircraft or air cargo;
c insurance concerning nuclear facilities; and
d business activities insurance.

It is often the case that reinsurance is interpreted as ‘business activities insurance’.

Policy conditions consist of both:

a general policy conditions in which the basic terms of the insurance policy are stipulated; and
b special policy conditions by which the terms of the general policy conditions are amended or supplemented.

**Insurance certificate**

Under the Insurance Act, if an insurance contract is concluded, the insurance company must deliver an insurance certificate to the policyholder, where the policy conditions do not exclude the application of this provision. The insurance certificates set out basic information, including the insurance premium, insurance period, risks covered, insured amount and policyholder’s name.

**Types of terms in insurance contracts**

General policy conditions commonly include clauses relating to the following matters:

a scope of the insurance and exclusions;
b limit of the insurance company’s liability;
c commencement and termination date of the insurance;
d calculation of the amount of the insurance claim;
e procedure for payment of the insurance claim;
f duty of disclosure;
g duty of notification;
h insurance subrogation;
i invalidity, expiry or termination of the insurance contract; and
j resolution of disputes and governing law.
Warranties

As stated above, under the Insurance Act, policyholders and the insured are bound by the duty of disclosure. Where a policyholder or insured party has breached the duty of disclosure or misrepresented matters subject to the duty of disclosure because of malicious intent or gross negligence, the insurance providers can cancel the insurance contract, provided, however, that the insurance providers cannot terminate the insurance contract for breach of the duty of disclosure, if their insurance agent either:

a prevented the insured or policyholders from disclosing material facts; or

b advised the insured or policyholders not to disclose material facts or to misrepresent material matters.

As a result, upon the cancellation, the insurer will not be liable for damage caused by insurance accidents that arise from matters not notified because of the breach of the duty of disclosure (Articles 4, 28, 37, 55, 66 and 84 of the Insurance Act). However, the insurer is still liable for damage caused by insurance accidents that are not relevant to the matters subject to the duty of disclosure. Since the provisions above are categorised as unilateral compulsory provisions in favour of the insured or policyholders, policy terms less favourable to the insured or policyholders are invalid and unenforceable.

Conditions and conditions precedent

Where the insurance policy imposes, as a policy condition, a duty of notice on policyholders and the insured to the effect that when there are any changes in the subject matter of the duty of disclosure that relate to the increase of risk, then the policyholders and the insured are required to give notice to insurers (the duty of notice upon increase of risk). Where the policyholders or the insured have breached the duty of notice upon increase of risk, because of malicious intent or gross negligence, the insurers can cancel the insurance contract. As a result, upon the cancellation, the insurer is not liable for damage caused after the increase of the risk. However, the insurer is still liable for damage caused by accidents that are not relevant to the increased risk (Articles 29, 31, 56, 59, 85 and 88 of the Insurance Act). Since the above provisions are categorised as unilateral compulsory provisions, policy terms less favourable to the insured or policyholders are invalid and unenforceable.

As stated above, policy conditions should not contradict the compulsory provisions or unilateral compulsory provisions in favour of the insured or policyholders, and if they do so, they will be unenforceable. Major compulsory provisions and unilateral compulsory provisions, and simple explanations thereof, are provided in the following paragraphs. In addition, if any of the terms set out in the Insurance Act are omitted from insurance contracts or reinsurance contracts, they will be implied by the Insurance Act.

Retrospective insurance

According to Articles 5, 39 and 68 of the Insurance Act, an insurance contract is null and void if either (1) the policyholder is aware that any accident to be covered by the insurance has already occurred; or (2) an insurance company is aware that an accident to be covered by the insurance will never occur.
**Overinsurance**

According to Article 9 of the Insurance Act, in relation to non-life insurance, if an insured amount exceeds the value of the object insured, a policyholder can cancel the excess part of the insurance contract, unless either (1) the excess is caused by the malicious intent or gross negligence of the policyholder; or (2) there is an agreement regarding the value of the object insured.

**Right to reduce insurance premiums because of decreasing insurance value**

If a non-life insurance value is reduced in a significant way, the policyholder can claim for reducing insurance premiums at the level of reduced insurance value (Article 10 of the Insurance Act).

**Right to reduce insurance premiums because of decreasing insurance risk**

If an insurance risk is reduced in a significant way, the policyholder can claim for reducing insurance premiums at the level of reduced insurance risk (Articles 11, 48 and 77 of the Insurance Act).

**Extinguishment of the insured objects after the occurrence of covered damage**

In relation to non-life insurance, insurers must pay insurance reimbursements if the insured objects are extinguished after the covered damage has occurred (Article 15 of the Insurance Act).

**Statutory lien for liability insurance**

In relation to liability insurance, those damaged by covered accidents are entitled to obtain a lien over claims for insurance reimbursements. Therefore, the insured are allowed to exercise their claim against the insurer only with the consent of those damaged by covered events or to the extent that they have indemnified those damaged by covered events.

In addition, liability insurance claims against insurers cannot be transferred, subject to a pledge or sequestered, except in certain cases (Article 22 of the Insurance Act).

**Insurance subrogation**

In relation to non-life insurance, if an insured can claim against another person with respect to the loss covered by the insurance and an insurance company has paid the insurance claim, the insurance company will be subrogated to the rights held by the insured against the other person to an extent that does not prejudice the rights of the insured, but only to the extent of the amount paid (Article 25 of the Insurance Act).

**Right to cancel by the insurer**

An insurer can cancel the insurance contract when (Articles 30, 57, and 86 of the Insurance Act):

- a policyholder commits fraud or tries to commit fraud against the insurer; or
- where there is a material issue that adversely affects the insurer's trust in the policyholder, making it difficult for the insurer to maintain the insurance contract with the policyholder.
Legal effect of cancellation

The cancellation of insurance contracts is only effective going forward, and the insurer is not then liable for further cases when the insurance contract is cancelled (Articles 31, 59 and 88 of the Insurance Act).

Right to cancel by the insured

In certain circumstances, when the insured is not the same person as the policyholder, the insured can cancel the insurance contract (Articles 34, 58 and 87 of the Insurance Act). This applies to non-life accident and health insurance, life insurance, and fixed-benefit accident and health insurance.

iv Regulations on insurance solicitation

Conduct rules

The solicitation of insurance should be conducted in an appropriate manner in accordance with the rules provided under the IBA and the Guidelines, including:

a persons carrying out insurance solicitation should provide information and an explanation of important items necessary for the customers to determine whether to conclude an insurance policy;

b no false statement should be made with respect to important items;

c policyholders and the insured should not be encouraged to make a false statement, or be prevented or discouraged from disclosing a material fact to insurers; and

d no discounts or rebates on insurance premiums or any other special benefits should be offered to policyholders or insured parties.

The Life Insurance Association of Japan provided clarification of ‘special benefits’ (referred to in point (d) above) in its Voluntary Guidelines on 8 March 2017, in response to a request by the FSA. In light of this, special benefits include not only prepaid payment instruments under the Payment Services Act, such as e-money, book coupons and coupons for goods, but also points that can be exchanged for money or e-money even if they do not fall under prepaid payment instruments. Moreover, it also stated that whether other types of benefits are included under special benefits should be assessed based on the range of usage of the services, and whether the economic value and contents of the services exceed social norms.

Obligations to provide information

In the past, regulations on the provision of information were worded as negative obligations under the IBA. However, the 2014 amendment of the IBA, which entered into force on 29 May 2016 with the related Cabinet Order and other Ministry Ordinance, imposes positive obligations. Under the revised IBA, persons carrying out insurance solicitation must provide their customers with the contents of insurance contracts and other helpful information for policyholders. Details of the exact information required to be supplied under this obligation are delegated to subordinate regulations.
Obligation to check intentions of customers

Insurance companies and solicitors are required to confirm the intentions of customers when soliciting insurance. This rule expects insurance solicitors to:

a. understand the motivation and purposes behind new customers seeking insurance policies (i.e., the risks that the customer has identified and would like to cover by purchasing insurance);

b. offer insurance policies that are suitable for such purposes;

c. provide explanations of the policies to customers; and

d. prior to the conclusion of insurance contracts offer opportunities for the customers to confirm that the insurance policies are in line with their original purposes, or in cases where there are differences between them, to explain the differences and the reasons for the differences.

Unlike other major requirements for insurance solicitation, detailed requirements are not provided for this obligation; instead, the supervisory authority anticipates that insurance solicitors will adopt innovative approaches and come up with reasonable and appropriate measures depending on the types of insurance policies and solicitation channels.

Restrictions on consignment

Under the IBA, consignment of insurance solicitations is allowed only where they are made directly by the insurance companies, for the purpose of ensuring the appropriateness of the solicitation by means of direct control by the insurance companies.

However, the direct consignment rule is not applicable where (1) an insurance company consigns insurance solicitations to another insurance company, (2) both of the insurance companies belong to the same group, (3) the insurance solicitation is carried out by insurance solicitors (e.g., insurance agents) of the consigned insurance company, and (4) they obtain authorisation from the PM. This will enhance the cost-effective group management of insurance companies.

Regulations on multi-tied agents

Multi-tied agents have often professed to be ‘impartial and neutral’ advisers to customers, but there have been cases in which some have recommended insurance policies from which they derive greater benefits, such as policies involving a high commission and policies provided by an insurer who has a financial interest in the multi-tied agent. Concerns have been raised about a lack of transparency in the sales processes of multi-tied agents and, further, that multi-tied agents have been known to make misleading representations, suggesting they are acting for customers rather than insurance providers. To address these concerns, IBA regulations were introduced that require multi-tied agents to explain why they are recommending certain insurance policies above others that are available to them. There are two ways to select an insurance policy. One is to select a policy in line with the customer’s stated needs. In such cases, multi-tied agents should select, from the insurance policies they handle, policies aligned with the customer’s stated needs and explain how the recommended policies fulfil the customer’s requirements. For example, if customers request a life insurance policy with a low premium, multi-tied agents should select a low-premium life insurance policy from the products they handle. The other is to select insurance policies based on the multi-tied agent’s own interests. In such cases, the multi-tied agent may recommend insurance policies regardless of the customer’s requirements but should frankly disclose to the customer why
they have recommended such products. For example, if the multi-tied agent’s policy selection is motivated by a financial interest held by the insurer, or a high commission, this must be disclosed to the customer. The above rule does not apply to insurance brokers who act on behalf of customers. Insurance brokers have a fiduciary duty to provide the best advice to customers, therefore they must not select policies on the basis of their own self-interest.

**Regulations on telemarketing**

Insurance companies and intermediaries engaging in telemarketing solicitation are required to establish solicitation procedures, including measures to address anticipated problems that may arise when dealing with clients who are solicited via telephone, and to identify problems at an early stage, as well as to provide appropriate education, control and guidance to the persons making telephone calls. In addition, insurance intermediaries utilising telemarketing should focus on:

- establishing scripts for discussions;
- ensuring there is a ‘do not call’ registry;
- recording telephone conversations;
- analysing the reasons for complaints and sharing with the persons making the telephone calls measures to prevent such complaints; and
- conversation monitoring by personnel who are not party to the conversations, with a view to implementing appropriate measures to address any problems identified by the monitoring.

**Claims**

**Notification**

Under the Insurance Act, notifications of loss are required where policyholders or the insured perceive the loss, thereby giving insurers the opportunity to investigate the accident and determine the loss, or to prevent further extension of the loss. In the event of a default of this notice obligation, the insurance company may:

- be indemnified for any damage that it incurs because of the delay; or
- deduct an amount equivalent to any loss caused by failure of this notice from insurance moneys.

**Good faith and claims**

It is generally understood that the parties to an insurance agreement should act in good faith so as not to harm the other parties, although there are no explicit rules that are specifically applicable at the stage of making an insurance claim.

**Set-off and funding**

A right to set off mutual debts and credits is generally recognised in Japan if certain conditions are met (Article 505 of the Civil Code). These conditions include the satisfaction of both obligations that are due.

Payment of insurance reimbursements must be forthcoming after a reasonable period required for investigations (Articles 21, 52, and 81 of the Insurance Act).
**Reinstatement**

A basic and very common policy condition of life insurance is a provision that allows policyholders to reinstate an insurance contract in abeyance because of non-payment of an insurance premium. Detailed conditions, effects and procedures are not regulated by law.

**Dispute resolution clauses**

Arbitration clauses in insurance and reinsurance agreements are enforceable in Japan. Although arbitration clauses are not commonly provided in insurance policies, reinsurance contracts often stipulate the clauses in relation to disputes between ceding companies and reinsurance companies.

**IV DISPUTE RESOLUTION**

**i Jurisdiction, choice of law and arbitration clauses**

Claims for insurance reimbursement against an insurance company must generally be filed in the jurisdiction of the debtor’s residence, unless expressly provided in the insurance policy (Article 5 of the Code of Civil Procedure of Japan). Insurance policies sometimes stipulate the choice of forum and venue as the headquarters of the insurance company or, simply, Japan. These arrangements are valid and enforceable in Japan, subject to the FSA approval and notification requirements for the policy conditions, provided that they are not prejudicial to consumers’ interests under the Consumer Contract Act, which does not apply to commercial lines (including reinsurance contracts).

Choice of law is often stipulated in non-life insurance policies, and is also valid and enforceable in Japan, subject to the FSA approval and notification requirements for the policy conditions. If not, it is assumed that Japanese law applies to both life and non-life (except for marine) insurance contracts. A choice of foreign law may be void in insurance policies with consumers under the Consumer Contract Act.

Although arbitration clauses are not commonly provided in insurance policies, reinsurance contracts often stipulate these clauses in relation to disputes between ceding companies and reinsurance companies. Generally, arbitration clauses in insurance and reinsurance agreements are enforceable in Japan.

**ii Litigation**

Japan’s litigation system essentially consists of three stages: district courts (first instance), high courts (courts of appeal) and the Supreme Court (court of final appeal). Depending on the complexity of the case and the actions of the other party, it might take a year or more until the conclusion of a case in the court of first instance. In addition to this, if either of the parties refuses to accept the judgment of the court of first instance, it may appeal the case to a higher court, and again to the Supreme Court. Anticipated costs also depend on the situation and include the costs of translation into Japanese, since documents filed in a Japanese court must be in Japanese.

According to litigation practice in Japan, if a policyholder files an action for an insurance claim, he or she must prove all of the following facts:

a existence of a valid insurance contract;

b occurrence of an insurance event during the insurance period;

c occurrence and quantum of loss; and

d causal relationship between the insured event’s occurrence and the loss.
iii Arbitration

Parties are entitled to agree to submit disputes to arbitration even after occurrence of a dispute; however, an arbitration agreement is required to be in writing for a Japanese court to dismiss a file that is subject to an arbitration agreement, where either party has filed a lawsuit in a Japanese court.

Under the Arbitration Act, parties are free to agree on the procedure to be followed by the arbitral tribunal in conducting the arbitral proceedings, subject to the provisions relating to acts against the public order.

iv Alternative dispute resolution

In October 2010, the Financial Alternative Dispute Resolution System under the IBA was introduced in Japan. Under this System, insurance companies and reinsurance companies are required to do the following:

a conclude a contract with the designated institution for dispute resolution designated by the FSA; and

b comply with the procedure of the designated institution for dispute resolution to resolve insurance or reinsurance complaints, or disputes arising from insurance business.

However, insurance companies and reinsurance companies are guaranteed the right of access to a court. The Life Insurance Association of Japan, the General Insurance Association of Japan, the Insurance Ombudsman, and the Small Amount and Short Term Insurance Association of Japan are the designated institutions for dispute resolution in insurance business.

In addition, there are some alternative dispute resolution (ADR) forums for insurance complaints and disputes, such as:

a the Japan Centre for the Settlement of Traffic Accident Disputes;

b the Automobile Liability Insurance and Mutual-aid Dispute Settlement Mechanism; and

c the Dispute Resolution Committee established by the National Consumer Affairs Centre of Japan.

v Mediation

For mediation, the court will form a mediation panel consisting of one judge and two other persons to settle disputes amicably; however, this procedure is not commonly used in insurance claims.

V YEAR IN REVIEW

The FSA encourages financial business operators to establish and publish (1) policies regarding customer-oriented business conduct and (2) key performance indicators (KPIs), for assessing the degree of implementation of its Principles of Customer-Oriented Business Conduct (the Principles). At the end of September 2018, 259 insurance companies and other related companies adopted the Principles and published their policies on customer-oriented business conduct. Few companies published KPIs; however, an increasing number are publishing both their policies and KPIs.

The Principles comprise the following:

a formulating and announcing policies regarding customer-oriented business conduct;

b pursuing the customers’ best interests;
appropriately managing conflicts of interest;
clarifying commissions;
providing important information in a comprehensible manner;
providing suitable service for customers; and
outline to adequately motivate the employees.

The FSA announced that customers could select good financial business operators by comparing their KPIs.

VI OUTLOOK AND CONCLUSIONS

Japan is expected to be subject to the Financial Action Task Force fourth round of anti-money laundering and counter-terrorist financing mutual evaluations in 2019. The FSA published the Guidelines for Anti-Money Laundering and Combating the Financing of Terrorism in February 2018 and the Current Status of Anti-Money Laundering and Combating the Financing of Terrorism in August 2018. In these publications, the FSA has requested financial institutions in Japan, including insurance companies, to improve their measures against money laundering and terrorism financing using a risk-based approach. These institutions are devoting substantial resources to this end.
I INTRODUCTION

As at 30 September 2018, there were 24 life insurers and 30 non-life insurers (14 domestic insurance companies and 16 foreign insurance companies) in Korea. The gross profits earned by the life insurers during the first three quarters of 2018 was 4.39 trillion won, which is an increase of 6 per cent from the same period in 2017 (3.6 per cent of the average profit rate for invested insurance assets), and the gross profits earned by non-life insurers during the first three quarters of 2018 was 2.92 trillion won, a drop of 8.2 per cent from the same period in 2017 (3.4 per cent of the average profit rate for invested insurance assets).

The reinsurance market in Korea has stagnated after years of growth. The operating profit in the first half of 2018 dropped by 13.8 per cent due to large-scale incidents in and out of Korea, such as the Iranian oil tanker casualty in the East China Sea, the fire on board a car carrier at the Incheon Port, and fires at factories in China and Greece. Apart from Korean Re, all 10 reinsurers are foreign companies, the first entrant being Singapore’s Asia Capital Re, which entered the Korean reinsurance market in September 2016. Korean Re’s market share is going down with the increasing competition from foreign reinsurers. In 2018, the domestic life insurance market ranked eighth and the non-life insurance market ranked eleventh in the world in terms of revenue.

Both life insurers and non-life insurers experienced a difficult year in 2018. The outlook for 2019, however, is promising: while the life insurance market is still under pressure to inject more capital amid the adoption of the new International Financial Reporting Standard 17 (IFRS17), the non-life insurance market is anticipating a positive year with higher auto insurance premiums and weaker competition.

II REGULATION

i The regulatory authorities

The Financial Services Commission (FSC) and the Financial Supervisory Service (FSS) regulate the insurance industry. The FSC prepares financial policies and systems (i.e., it legislates and amends the development plans and regulations of insurance business); monitors, inspects and sanctions financial institutions, including insurance companies; and approves the establishment of financial institutions, including insurance companies. The FSC regulates insurance business in accordance with the Insurance Business Law (IBL) and the Insurance Supervision Regulations.

1 S W Park is a partner at Law Offices Choi & Kim.
The FSS is the executive arm of the FSC. It records the current status of insurance contracts and the financial status of insurance companies, monitors insurance companies’ business operations, and sanctions insurance companies. The FSS also directly inspects and supervises insurance companies and their employees, including insurance brokers.

ii  Position of non-admitted insurers
The IBL regulates the requirements for being in insurance business, and if such requirements are not satisfied, the FSC will not issue a licence. An insurer may not conduct insurance business without a valid business licence, the failure of which could result in imprisonment for up to five years or fines of up to 30 million won (Article 200-1 of the IBL).

iii  Position of brokers
According to Article 89-1 of the IBL, insurance brokers must be duly registered with the FSC to perform the intermediate execution of insurance contracts. As insurance brokers are involved in the execution of insurance contracts, in many aspects they are similar to insurance agents. However, insurance brokers differ from insurance agents (who act on behalf of a particular insurance company) in that they liaise with multiple insurance companies. Article 92 of the IBL prohibits insurance brokers from being affiliated with one particular insurance company. Accordingly, insurance brokers have no authority to execute insurance contracts or collect insurance premiums on behalf of insurance companies.

iv  Requirements for authorisation
Any person or entity wishing to perform insurance business should obtain a licence from the FSC, and Article 6 of the IBL details the requirements to obtain the licence. In particular:

a  The minimum capital requirement for an insurance company with a comprehensive insurance business licence is 30 billion won (for an insurance company with a selected insurance business licence, the minimum capital requirement can be adjusted in accordance with the Presidential Decree for the IBL, provided that the amount exceeds 5 billion won). For an insurance company that markets or solicits by telephone, mail or computer communication only, the minimum capital requirement is reduced to two-thirds of the above.

b  An insurance company should have a professional workforce and a suitable infrastructure (e.g., IT facilities). In cases where an insurance company outsources some of its work (e.g., review of insurance contracts, maintenance of IT facilities, investigation of insurance fraud), the outsourced work must also be done in compliance with the same requirement.

c  An insurance company’s business plan should be reasonable, and should not be contrary to public policy.

d  An insurance company’s principal shareholders should not be disqualified for any grounds under Article 13-1 of the IBL. They should also have the financial soundness and ample funding capacities without any record of harming the economic order.

A foreign insurance company seeking to obtain an insurance business licence in Korea must meet the following requirements:

a  it should have operating funds equivalent to (or more than) the above-mentioned minimum capital requirements for domestic insurance companies;
it should be in the same insurance business area in a foreign country in accordance with
the law of that respective jurisdiction as the insurance business area it seeks to enter in
Korea;

c its assets and financial and business soundness should be adequate to operate business
insurance in Korea, and it should be recognised internationally; and

d it should satisfy the requirements of points (b) and (c) relating to domestic insurance
companies.

In order to obtain a licence, an insurance company may first apply for a provisional licence
upon which the FSC may place conditions. The company should indicate the type of
insurance that it would offer under its company name. Companies not in the business of
offering insurance may not use words in their company names or logo that may show or
imply that they are an insurance company. Companies cannot operate both life insurance and
non-life insurance business at the same time.

v Distribution of insurance products
According to Article 2-1 of the IBL, the term ‘insurance product’ means a contract stipulating
the payment of insurance money and other benefits to an insured in the event that an incident
for which the insured is protected against occurs.

According to Article 2-1 of the IBL, an insurance product can be any of the following:

a life insurance product: a contract that promises to pay stipulated money and other
benefits to an individual in relation to the survival or death of an individual;

b non-life insurance product: a contract that promises to pay stipulated money and other
benefits to an insured for a loss (including any loss resulting from non-performance of
contractual liabilities or statutory duties and obligations) resulting from a contingency
(excluding a disease, an injury and nursing thereof provided for in point (c)); and

c type 3 insurance product: a contract that promises to pay stipulated money and other
benefits to an insured for any disease, injury or nursing thereof for the purpose of
guaranteeing any risk.

vi Compulsory insurance
While most insurance contracts can be freely entered into between private parties, there are
some types of insurance that must be purchased mandatorily. In particular, when a party is
planning to be involved in an act that may cause damage to others, that party may be required
to purchase insurance to ensure that it has the capacity to reimburse the damage.

The IBL does not have a separate section that compels the execution of insurance
contracts. A party involved in a specific act or business, should check whether purchasing
insurance is mandatory by reviewing the relevant laws.

vii Taxation of premiums
Under Article 26-1-11 of the Value-Added Tax Act, insurance business is exempt from value
added tax (VAT); thus, no VAT should be imposed on the payment of insurance premiums.
For the same reason, an insurance company that collects insurance premiums does not include
any VAT in the premiums. Accordingly, when an insured pays an insurance premium, no
VAT will be imposed, and an insurance company is also not obliged to pay any VAT.

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In cases where an insurance policyholder purchases insurance under which his or her spouse or dependents are insureds, part of the paid insurance premium can be deducted from his or her income for the purpose of calculating his or her income tax.

When receiving death insurance money, if the insurance policyholder and the insured are not identical, the insurance money may be subject to inheritance tax or gift tax.

Insurance companies are obliged to pay corporate tax. For an insurance company whose net taxable income is less than 200 million won, the applicable tax rate is 10 per cent; for insurance companies whose net taxable income is between 200 million won and 20 million won, the applicable tax rate is 20 per cent; and for insurance companies whose net taxable income is greater than 20 billion won, the applicable tax rate is 22 per cent.

According to Article 9 of the Education Tax Act, insurance companies are obliged to pay education tax in an amount equivalent to 0.5 per cent of their net taxable income arising from, inter alia, stocks, bonds and foreign exchange derivatives.

Prior to November 2015, insurance companies were obliged to pay education tax on a quarterly basis. However, the law was amended to lower insurance companies' burden of taxation, and since November 2015, insurance companies have been obliged to pay education tax only once a year.

III INSURANCE AND REINSURANCE LAW

i Sources of law
The Korean Commercial Code (KCC) includes regulations that cover insurance in general, and its general provisions (e.g., on party autonomy) will also apply. In addition, various special laws, such as the IBL, the Automobile Accident Compensation Act, the Act on the Indemnification for Fire-Caused Loss and the Purchase of Insurance Policies, and the Depositor Protection Act, apply to insurance contracts.

It is common for insurance companies to draft general conditions and standard contractual terms in advance, and to adopt the same when executing insurance contracts (standard terms and conditions). The standard terms and conditions are binding on parties to insurance contracts, but if the parties agree otherwise on particular conditions, to the extent that those particular conditions apply, the standard terms and conditions would not apply.

ii Making the contract
The major elements of insurance contracts include the insurance money and insurance premium amounts, the risks covered by the insurance (the grounds for payment of the insurance money), insurers' obligations, insurance periods, exclusion clauses and the governing law clauses.

The insurers are obliged to inform the insureds of the ‘material information’ about the policy. Material information refers to information that has a grave impact on the insureds' interests such that, if made known to the insureds, it could influence their decision on whether or not to sign the contract. Examples of material information include, for car insurance, information about the main driver to be covered; and for casualty insurance, exemption clauses for climbing and hand-gliding or other similarly dangerous activity, or exemption for driving without a licence. Insurers must provide the insured with the insurance policy and explanation thereof at least by the time of the insured's subscription. In cases where the insurer's obligation of explaining and notifying the terms of the insurance policy is breached, the insurer cannot argue that those terms are included in the insurance contract.
Insurance policyholders and the insureds are obliged to inform insurers of ‘important matters’. Important matters are those that, if they had been known to the insurer at the time of execution of the insurance contract, would have resulted in the insurer not executing the contract under the same terms. Examples of important matters include, for fire insurance, the materials of an object, the structure of the object and the circumstances surrounding the object; for car insurance, a car’s model and the purpose of the car; and for life insurance, an insured’s gender, age and medical history.

A breach of the obligation to notify in an insurance contract is considered to be, for important matters, failure to notify or insufficient notice, committed intentionally or in gross negligence. Intentional breach by a person refers to a failure to notify when he or she is aware of the important matter that has not been notified or the notice was intentionally untruthful. Grossly negligent notice means that a person has failed to acknowledge the importance of the matter to be notified or he or she was unaware the matter was important.

In cases where the obligation of notifying important matters is breached, an insurance contract may be terminated by an insurer and the burden of proof for establishing the breach rests with the insurer. However, if the policyholder can prove that the breach has no causal relationship with the occurrence of an insured accident, the insurance money can be claimed. In addition, in cases where an insurer knew about the important matters that were not notified or, through its own fault, was ignorant of the important matters, the insurer would not be permitted to terminate the insurance contract.

iii Interpreting the contract
When interpreting insurance contracts, if there is a conflict between the standard terms and conditions and any particular conditions, the latter should prevail. The standard terms and conditions should also be interpreted impartially in accordance with the doctrine of good faith, and they should not be interpreted differently for different insurance policyholders. In cases where the standard terms and conditions are not clearly written, they should be interpreted against the insurer, and the exclusion clause of the standard terms and conditions should be narrowly defined.

iv Claims
Upon the occurrence of an insured accident, the relevant insured and the beneficiary of the relevant insurance can claim for the applicable insurance money. The statute of limitations for the right to claim payment of insurance money is three years (Article 662 of the KCC). The insurers’ right to claim payment of insurance premiums is two years (Article 662 of the KCC). When an insurance policyholder, an insured or a beneficiary notices the occurrence of an insured accident, it should be immediately notified to the relevant insurer. If any loss was caused or increased by the policyholder’s, insured’s or beneficiary’s failure to notify the occurrence of the insured accident, the insurer shall not be liable for compensation for the increased loss.

When a policyholder or an insured notices that the likelihood of the occurrence of an insured accident greatly increases during the insurance period, this information should be notified to the insurer, and if the duty to notify is neglected, the insurer may terminate the insurance contract. In cases where the increased likelihood of the occurrence of an insured accident is because of wilful or gross negligence on the part of a policyholder, insured or beneficiary, the insurer can terminate the insurance contract.
If a peril insured against has occurred because of bad faith or gross negligence on the part of a policyholder, insured or beneficiary, the insurer is not liable to pay the insurance money (Article 659-1 of the KCC). If a peril insured against has been caused by war or other public disturbances, the insurer is not liable to pay the insurance money unless agreed otherwise (Article 660 of the KCC).

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

When a dispute arises in relation to an insurance contract in Korea, it can be resolved through court proceedings, arbitration or financial dispute mediation by the FSS. However, there is no court exclusively designed to resolve insurance disputes, and there is no arbitral institution or procedure that exclusively deals with insurance disputes. Thus, insurance disputes must be resolved in the civil court or through arbitration proceedings in the same way as other general cases.

When a Korean court finds that a dispute has substantial connection with Korea, it has international jurisdiction over the dispute. More specifically, under Korean law, the Korean court has jurisdiction to hear a case when the policyholder’s residence or the insurance company’s principal place of business is located at the place where the Korean court has jurisdiction; this can be changed by the parties’ agreement. Arbitration cases are generally resolved through arbitration proceedings at the Korean Commercial Arbitration Board (KCAB).

When the parties have expressly or impliedly agreed to a governing law, that law shall apply. In other words, the parties’ agreement on the governing law will be considered valid. In cases where there is no agreed governing law, the applicable governing law shall be determined pursuant to the Korean Private International Act.

FSS-conducted financial dispute mediation is available to resolve disputes arising between customers and financial institutions (e.g., insurance companies) that are subject to FSS supervision.

According to Article 51 of the Act on the Establishment, etc. of Financial Services Commission, the Financial Disputes Mediation Committee (FDMC) was established to examine and decide on issues and conflicts between interested parties with respect to insurance. Accordingly, when there is a conflict with respect to insurance between an insurance company and other interested parties, the parties may request the FDMC to handle the case.

Once a case is submitted to the FSS, the head of the FSS may examine the case by requesting an insurance company to submit a report on the insurance company’s business or assets, or any other relevant documents; and by summoning the concerned parties and requesting their testimonies. In accordance with Article 53-2 of the Act on the Establishment, etc. of Financial Services Commission, the head of the FSS may recommend that the parties settle the matter amicably. In the event that the case is not settled amicably, in accordance with Article 53-3, the case may be submitted to the FDMC. After reviewing the case, the FDMC may issue a mediation order and request the parties to accept the same. If the parties accept the mediation order, it will have the same effect as a reconciliation decision issued by a court (Article 55). The parties may not accept the mediation order or file a lawsuit in the middle of mediation proceedings.
ii Litigation

The judiciary system comprises three levels: the first instance courts, the Appellate Court and the Supreme Court. Legal proceedings are commenced by a plaintiff's submission of a complaint to a first instance court with competent jurisdiction, and the plaintiff will submit relevant supporting documents along with the complaint. While it is not required to notarise documents to be submitted to the court, powers of attorney and certificates of corporate nationality (which need to be submitted in cases where a foreign corporate entity is a party to the litigation) must be notarised.

A plaintiff will be required to pay stamp tax and service of process fees when commencing a lawsuit, and stamp tax will take up a substantial portion of the court costs. Stamp tax is calculated in accordance with a formula set by Korean law based on the claim amount. In cases where the plaintiff is not a Korean resident and does not have an office in Korea, the Korean court can order, ex officio or pursuant to the defendant's application, the plaintiff to provide security for legal costs. The amount of security for legal costs will be calculated in accordance with the rules set forth by the Supreme Court based on the total legal costs (including attorneys' fees) that will be incurred at each level of court. The recoverable attorneys' fees have slightly increased after the amended rules took effect on 1 April 2018. As the defendant is entitled not to respond to the complaint until the plaintiff has paid the security for legal costs, it is general practice that plaintiffs pay security for legal costs in order to continue with the proceedings. The winning party can recover its legal costs (albeit not fully) from the losing party.

While the time frame is subject to change depending on the complexity of a case, it generally takes eight to 10 months from the commencement of the proceedings for the first instance court to render its judgment. In cases of appeal proceedings, it generally takes six to eight months until the Appellate Court's judgment. Finally, it takes approximately one to two years until the Supreme Court renders its judgment.

iii Arbitration

In arbitration proceedings through the KCAB, parties will appoint one or multiple arbitrators from among the arbitrators recommended by the KCAB. While arbitration proceedings through the KCAB do not differ much from court procedures, in international arbitration proceedings where a foreign company or foreign personnel are involved, the parties can choose the language to be used in the proceedings. An arbitral award will have the same effect as a judgment, and arbitration proceedings will not be as costly as court proceedings. Moreover, an arbitral award is rendered more promptly than a court judgment.

In 2016, the KCAB amended its International Arbitration Rules (the Rules) to secure autonomy and fairness of arbitration tribunals and to promote effectiveness of international arbitration. The amended Rules came into effect on 1 June 2016. The Rules are not markedly different from the previous version, with the exception of the procedure for an emergency arbitrator. By appointing an emergency arbitrator, parties can now ask for immediate preservation and temporary injunction even before the constitution of an arbitration tribunal.

Korea is a party to the UN Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the New York Convention). Thus, an arbitral award duly delivered by the KCAB can be recognised and enforced in other countries that are party to the New York Convention, and foreign arbitral awards rendered by other countries that are parties to the New York Convention will be recognised and enforceable in Korea. Further, Korean courts
will even recognise arbitration awards rendered in foreign countries that are not party to the New York Convention by applying standards similar to those used to determine the enforceability of foreign judgments in Korea.

iv  Mediation

A typical mediation procedure is conducted by a court. Mediation can be held upon the parties’ application or at the court’s discretion during legal proceedings, and a case may be referred to the Mediation Committee whereby parties will come to a reasonable level of agreement. Mediation decisions, once finalised, have the same legal effect as court judgments. In cases where parties are unable to come to an agreement through mediation, they can continue with court proceedings and resolve the matter through a court judgment.

V  YEAR IN REVIEW

On 17 April 2018, the Amendment of the Act on the Establishment of Financial Services Commission was put into effect. In accordance with the Amendment, if a person applies for mediation to the FSS in an insurance dispute, the time-bar on the person’s claim will stop running. The time-bar will then start running again when the person accepts the mediated proposal or when the mediation proceedings end without a resolution. This Amendment was enacted to promote mediation for insurance-related disputes and to respond to criticism that the short length of the time-bar for an insurance claim was inadequate to protect the rights of the legitimate insurance consumers.

Meanwhile, the International Accounting Standards Board has decided to postpone the implementation of IFRS17 by one year to 2022. As interest rates keep declining, however, insurers are still under pressure to inject capital before the implementation of IFRS17, and the need for the government to take measures and put in policies to ease the financial burden on insurers.

VI  OUTLOOK AND CONCLUSIONS

According to an Issue Analysis Report published by the Korea Insurance Research Institute on 21 May 2018, the average age of a person obtaining a life insurance policy is rising, as a result of the aging population, relatively slower growth in the income of younger generations and the increase in the number of micro-households. These changes are expected to continue and insurers will be under pressure to diversify business, and come up with a variety of insurance products and strategies to cope.
I INTRODUCTION

The insurance industry in Malta has experienced appreciable growth over the past 15 years and has been delivering excellent results. The insurance sector forms an integral and important part of the Maltese financial services industry, which currently contributes just over 12 per cent of Malta’s gross domestic product. It has gradually evolved from a small number of local set-ups to approximately 63 insurance and reinsurance undertakings, of which 41 underwrite risks situated outside Malta. Another 495 foreign insurers based in the European Union are underwriting direct risks in Malta, making use of their ‘passporting’ rights on a services or establishment basis. In recent years, the financial services single regulator, the Malta Financial Services Authority (MFSA), has introduced a number of innovative corporate structures including: protected cell companies; incorporated cell companies; and reinsurance special purpose vehicles set up either as stand-alone structures or as cells of securitisation cell companies.

With Brexit looming on the horizon, Malta is expected to be the only remaining EU Member State to offer protected cell legislation. A protected cell company (PCC) allows for the creation of separate and segregated cells. The individual cells do not have separate legal personality, and business is written through the PCC. This allows each cell to utilise the PCC’s passport licence to write business directly throughout the European Union. The legal segregation of the cells means that the assets and liabilities of each cell are ring-fenced from each other, with each cell having a distinct pool of assets and liabilities that remain separate from the assets and liabilities of other cells and from the core of the PCC. A cell is only required to satisfy its own notional solvency capital requirements, and the cells are not required to individually satisfy the minimum capital requirements that can be satisfied by the PCC as a whole. Also, there may be situations where a PCC may permit its cell or cells to utilise a part of the excess capital held by the core to meet their capital requirements under the EU Solvency II regime (Solvency II).

Another company cell structure is the incorporated cell company (ICC). The structure is based on corporate principles that are similar to the PCC structure. However, in an ICC structure, each incorporated cell of an ICC is deemed to have a separate legal personality that

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1 Edmond Zammit Laferla is a partner and Petra Attard is a senior associate at Mamo TCV Advocates.
2 Companies Act (Cell Companies Carry on Business of Insurance) Regulations, 2010, SL 386.10.
is distinct from that of the core and the other incorporated cells. As a direct consequence of this important distinguishing feature, each incorporated cell would be required to satisfy own funds and solvency capital requirements in its own right.

A securitisation cell company can be set up to assume risks as a reinsurance special purpose vehicle from a ceding undertaking through reinsurance contracts or utilised to assume risks through similar arrangements. The assets and liabilities of each cell would be segregated from those of other cells, and those assets are not available to creditors of other cells.

II REGULATION

i The insurance regulator

The MFSA is the single regulator for both insurance undertakings and intermediaries. The Authorisation Unit is tasked with the approval process including, *inter alia*, approval of applications, acquisitions and disposals, and appointment of key function holders, directors and senior management of licensed financial services entities. The Insurance and Pensions Supervision Unit is responsible for prudential matters, while the Conduct Unit is responsible for conduct of business issues.

The Insurance Business Act (IBA) and the Insurance Distribution Act (IDA), together with the Regulations, Insurance Rules and Insurance Distribution Rules issued by the MFSA under the respective Acts, create the legal and prudential framework for regulating insurance business and insurance intermediaries activities in Malta. The IBA is largely modelled on UK statute and implements Solvency II.

The Maltese legal and regulatory regime is fully compliant with Solvency II. Local authorised firms are, however, permitted to adopt the proportionality principle in a number of areas (e.g., system of governance, risk management, supervisory reporting and public disclosure).

ii Position of non-admitted insurers

In Malta, only admitted insurers are entitled to conduct insurance activities. The regulatory regime prohibits the performance of insurance business or insurance distribution activities in or from Malta by unauthorised firms. Exceptionally, reinsurance treaties, contracts covering ‘large risks’, or contracts of insurance entered into with the approval of the MFSA or the minister responsible can be underwritten by a non-admitted insurer through a broker licensed in terms of the IDA.

EU and EEA insurers and intermediaries authorised by their home Member State are able to ‘passport’ into Malta, on a freedom of establishment (branch) or freedom of services basis. The MFSA has a secondary regulatory role primarily on conduct and marketing issues.

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5 Established by the Malta Financial Services Authority Act (Chapter 330, Laws of Malta).
6 Chapter 403, Laws of Malta.
7 Chapter 487, Laws of Malta.
iii Position of brokers

Insurance intermediaries such as insurance agents, insurance brokers and tied insurance intermediaries are required to be authorised by the MFSA. Introducers are not required to seek authorisation; however, the activities they may carry out are limited to making introductions to insurers and insurance agents and brokers. In addition, the Insurance Distribution Directive (IDD), which came into force on 1 October 2018, has also introduced the concept of ancillary insurance intermediaries (AIIs) (see Section III.iv).

iv Requirement for authorisation

The MFSA may grant authorisation to a company with its head office in Malta to carry on insurance business in or from Malta, or to a company whose head office is in a country outside Malta to carry on insurance business in or from Malta.

The following are prerequisites for the granting of a licence under the IBA:

a submission of application to the MFSA in the prescribed application form;
b submission of a scheme of operations to the MFSA in the prescribed form;
c satisfaction of the prescribed minimum own funds requirement;
d company’s objects are limited to insurance business and operations arising directly therefrom;
e all qualifying shareholders, controllers and persons who will effectively direct the business are fit and proper to ensure its sound and prudent management; and
f disclosure of any close links.

The documents and information required for the enrolment of an insurance broker or insurance agent broadly follow that of insurers.

The duration of the approval process depends on whether the undertaking is being established as a direct insurer, in which case the MFSA is to consider an application within six months; or a reinsurer or captive, in which case the time period imposed is reduced to three months. The approval process for intermediaries is to be concluded within three months.

Insurers and reinsurers are to hold eligible own funds covering the Solvency II capital requirements, which are calculated using the standard formula or using a full or partial internal model as approved by the MFSA. Insurers and reinsurers must also hold eligible basic own funds to cover the minimum capital requirement.

Insurance intermediaries are required to satisfy applicable own fund requirements. Brokers and agents are to maintain own funds equivalent to €58,250 or 4 per cent of the annual gross premiums receivable, whichever is the higher. The minimum own funds required to be held by insurance managers ranges from €17,000 to €58,250 depending on whether the insurance manager is managing solely captive insurers or whether it has been granted a binding authority to enter into insurance contracts on behalf of the insurers.

v Regulation of individuals employed by insurers

Persons occupying senior management posts, members of the board of directors of an insurer or insurance intermediary and key function holders must all be approved by the Authorisation Unit within the MFSA, prior to being appointed. Enrolled insurance intermediaries must have an individual who is registered in the managers, brokers or agents register, as the case may be.
vi The distribution of products
The distribution of products in Malta is carried out both through intermediaries or directly from an insurer at its principal office or at one of its branches. The implementation of the IDD has introduced additional requirements to both insurer and intermediaries carrying on distribution activities, the aim of which is additional consumer protection. The distribution of products is further regulated by the Conduct of Business Rulebook, which is applicable to insurers and intermediaries, as well as European insurance undertakings carrying on insurance business in Malta through the Freedom of Establishment regime. The Rulebook also implemented the conduct of business provisions set out in the IDD.

As of 1 January 2018, producers and distributors of packaged retail investment and insurance products (PRIIPs) are required to comply with the EU Regulation on key information documents for PRIIPs,8 which obliges those who produce or sell investment products to provide investors with key information documents.

vii Compulsory insurance
A number of sector-specific laws impose compulsory insurance cover to be undertaken. These include sea vessels, third-party cover for motor vehicles and aircraft. Several professionals are also required to take out a professional indemnity cover. These include accountants, notaries, engineers, trustees and healthcare professionals.

Furthermore, under the IDA, one of the continuing obligations of licensed insurance agents and brokers is to maintain a professional indemnity insurance cover or some other comparable guarantee.

viii Compensation and dispute resolution regimes
Where an insurer or intermediary is unable to satisfactorily resolve a customer complaint, an eligible customer (natural person or micro enterprise) may lodge a complaint with the Office of the Arbiter for Financial Services.9

In the case of insolvency of an insurer, recourse by a qualifying person10 can be made to the Protection and Compensation Fund,11 the objectives of which are to affect payments of claims remaining unpaid by reason of the insolvency of an insurer and to affect compensation to victims of road traffic accidents.

ix Taxation of premiums
Stamp duty in the amount of €0.11 for every €100 or part thereof of the sum assured is payable by the insured on policies of insurance (other than life insurance policies). The minimum

9 The Office was introduced on 18 April 2016 by the Arbiter for Financial Services Act (Chapter 555, Laws of Malta). Prior to that complaints were addressed to the Consumer Complaints Manager within the MFSA.
10 A qualifying person is: (1) an insured of the insolvent insurer eligible for protection; (2) a person other than the policyholder, to whom payment in respect of any sums falling due under the policy could have been made in accordance with the policy (e.g., beneficiary); or (3) a person to whom the insolvent insurer is liable to pay any sum or other consideration in respect of the insured's legal liability to such person under the policy of insurance (e.g., third party). In the case of general business protected risks, payments shall be made to every qualifying person who is an individual and to every non-corporate body or association of persons if all such persons are individuals.
11 Set up by the Protection and Compensation Fund Regulations 2003.
duty chargeable is generally €13. Duty on life insurance policies that are not renewable every year is payable where the policyholder is resident in Malta or incorporated in Malta at the rate of €0.10 for every €100 or part thereof. The minimum duty chargeable is generally €11.65.

Insurance policies issued by Maltese insurers insuring risks that are situated outside Malta are exempt from Maltese stamp duty or any other form of Maltese insurance premium tax. Furthermore, policies of aviation, marine cargo, marine hull or boat, and export credit and suretyship are exempt from the payment of stamp duty, even where the risk is deemed to be situated in Malta.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Maltese legal system has foundations in both English common law and civil law. The basis of insurance law is general contract law. There is no generic insurance contract law. However, in 2005, a number of amendments were added to the Maltese Civil Code aimed at regulating life insurance contracts.

Case law precedents are not binding and courts are free to interpret the law, which could result in the same issue being treated differently by the courts.

The elements of contract law are governed by civil law doctrine contained in the Civil Code. The IBA and IDA, and the Rules and Regulations issued thereunder by the MFSA, also deal specifically with compulsory insurance.

ii Making the contract

Essential ingredients of an insurance contract

A contract of insurance means an agreement in which an insurer agrees, for a consideration, to pay to or for the account of the insured a sum of money or other consideration, whether by way of indemnity against loss, damage or liability or otherwise, on the happening of a specified event with respect to which there is an element of uncertainty as to when or whether it will take place.

The rules of contract law apply to contracts of insurance and reinsurance. Hence, for a contract to be valid the following essential elements must be satisfied:

- the parties must have capacity to contract;
- there must be the consent of the parties;
- there must be a certain element that constitutes the subject matter of the contract; and
- there must be a lawful consideration.

Together with the Civil Code elements, Maltese jurisprudence has established the importance of the common law principles of insurable interest and utmost good faith in contracts of insurance.

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12 Chapter 16, Laws of Malta.
13 See, inter alia, the Motor Vehicles Insurance (Third-Party Risks) Ordinance (Chapter 104, Laws of Malta).
14 Article 2(1), IBA.
**Recording the contract**

Generally speaking, a contract can be concluded verbally; however, the IBA requires a written policy document to be issued by the insurer to the policyholder.

**iii Interpreting the contract**

**General rules of interpretation**

Insurance and reinsurance contracts are subject to the same general rules of interpretation that apply to other contracts, as provided for in the Civil Code. Where the terms of an agreement are clear and words in the agreement are attributed the meaning attached to them by usage at the time of the agreement, there shall be no room for interpretation. Where the literal meaning differs from the common intention of the parties as clearly evidenced by the whole of the agreement, preference shall be given to the intention of the parties. In case of any doubt, the agreement shall be interpreted against the obligee (insurer) and in favour of the obligor (insured).

**Types of terms in insurance contracts**

It is common practice for an insurance policy to include clauses relating to policy limits, excess amounts and other general exclusions, indemnity limit and period of insurance, warranties, conditions precedent and consumer complaints’ process.

**iv Intermediaries and the role of the broker**

The IDA regulates insurance brokers, insurance agents, tied insurance intermediaries and insurance managers. Insurance distribution activities means the activities of introducing, proposing or carrying out other work preparatory to the conclusion of contracts of insurance, or of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim.

Insurance agents are persons appointed by an insurer to be its agent with the authority to enter into contracts of insurance on its behalf. Insurance brokers are those who acting with complete freedom as to their choice of insurers, bring together persons seeking insurance and insurers, who carry out work preparatory to the conclusion of insurance and reinsurance contracts and who assist in the administration and performance of such contracts, in particular in the event of a claim.

Tied insurance intermediaries (TIIs) are defined as persons carrying on insurance intermediary activities for or on behalf of one or more insurers in the case of insurance products that are not in competition. These persons may collect premiums or amounts intended for the policyholder; however, they cannot make any insurance commitments towards or on behalf of the public. Insurance brokers are prohibited from appointing tied insurance intermediaries but can set up branches and appoint introducers. Under the IDD, insurance brokers are now permitted to appoint AIIs.

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15 However, the Civil Code specifically requires that a number of agreements be concluded in writing, either by means of a private writing or public deed.
16 Article 1002, Civil Code.
17 Article 1003, Civil Code.
18 Article 1009, Civil Code.
19 Article 2(1), IDA.
An AII is not considered to be an insurance intermediary but a specific type of intermediary operating under specific conditions (e.g., a travel agent, car rental company or motor vehicle dealer). The activities of AII s are described as the activities of persons who, for remuneration, take up or pursue insurance distribution activities on an ancillary basis, acting under the full responsibility of authorised undertakings, for the products that concern them, provided that all of the following conditions are met:

a the principal professional activity of the natural or legal persons does not comprise insurance distribution activities;

b the natural or legal persons only carry out insurance distribution activities in relation to certain insurance products that are complementary to a good or service; and

c the insurance products concerned do not cover long-term insurance business or liability risks, unless that cover complements the good or service that the natural or legal persons provide as their principal professional activity.

Insurance managers can provide services to either an insurer or an insurance broker. In the former case, an insurance manager can accept an appointment from an insurer to manage any of its business and may have the authority to enter into contracts of insurance on behalf of the insurer. Insurance managers may also accept an appointment from an insurance broker with certain limitations specified in the law.

Claims

Notification

The procedure for filing insurance claims is typically set out in the insurance contract itself. It is common practice for contracts of insurance and reinsurance, especially liability policies, to require that the insured notifies his or her insurer of a claim within a given time frame, for the claim to be valid. Prompt notification of an event that may or is likely to give rise to a claim is usually included in the contract as a condition precedent.

In terms of the Civil Code, the prescriptive period for filing a judicial action for damages for breach of contract is typically five years. If the damages are in tort, the prescriptive period is two years, which may be extended if the action for compensation is related to a personal injury. The aforementioned time periods may be suspended or interrupted in certain cases as prescribed by law.

Good faith and claims

The insured is required to provide the insurer with full, complete and correct information both pre-contractually and claims stage. Providing false information will result in the denial of claim, cancellation ab initio of the policy and could give rise to criminal liability for insurance fraud.

Set-off, funding and reinstatement

Article 1166(c) of the Civil Code grants the insurer an automatic right of subrogation on payment of an indemnity. Nonetheless, a subrogation clause is included in most insurance contracts. Upon payment of an insurance claim by the insurer, the insurer may claim indemnity from a third party for the loss covered by the insurance contract. An act or omission on the part of the insured that could prejudice the insurer's subrogation rights may forfeit policy coverage.
IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses
Choice of law in insurance contracts is regulated by the Rome I Regulation (Rome I), where parties to an insurance contract that falls within the ambit of Article 7(3) of Rome I are provided with a limited list of applicable laws.\(^\textit{20}\)

The provisions of Article 7(3) of Rome I are in conflict with the applicable provisions of the Civil Code. Malta has not introduced any further legislation following the coming into force of Rome I pursuant to Article 7(3)(2). Despite the fact that, to date, there has been no judgment delivered by the Maltese courts that has resolved this conflict, it has been argued that Article 7(3)(1) of Rome I should prevail over the provisions of Civil Code with respect to the choice of law applicable to contracts of life insurance.

ii Litigation
The procedure regarding the institution of court proceedings is regulated by the Code of Organisation and Civil Procedure.\(^\textit{21}\) Generally speaking, court proceedings are initiated by the filing of a sworn application, with the defendant having 20 days from date of service to file a sworn reply. An application to appeal a judgment delivered by a court of first instance is to be filed within 20 days of delivery of the judgment.

iii Arbitration
There are two forms of arbitration, mandatory arbitration and voluntary arbitration.\(^\textit{22}\) Motor vehicle claims, not arising in connection with a claim for damages for personal injuries, are subject to mandatory arbitration, provided that the value does not exceed €11,646.87 in the event that the dispute arises from:

\begin{itemize}
  \item a collision between vehicles;
  \item involuntary damage to property involving vehicles; or
  \item any such claim against:
    \begin{itemize}
      \item an authorised insurer;
      \item an assurance company;
      \item an approved underwriter; or
      \item the liable person in accordance with the Motor Vehicles Insurance (Third-Party Risks) Ordinance (Chapter 104, Laws of Malta).
    \end{itemize}
\end{itemize}

Arbitration proceedings are governed by the Arbitration Act, which provides rules for both domestic and international arbitration. International arbitration is governed by the UNCITRAL Model Law, which is implemented by the First Schedule to the Arbitration Act.

In the case of mandatory arbitration, the parties may appeal to the Court of Appeal in certain limited circumstances contemplated under the Arbitration Act. However, in the case of voluntary arbitration, if the parties to the insurance contract would have expressly excluded the right of appeal, the decision of the arbitrator will be final and no appeal to the Court of Appeal can be made.


\(^{21}\) Chapter 12, Laws of Malta.

\(^{22}\) Arbitration Act, Chapter 387, Laws of Malta.
iv Alternative dispute resolution

Besides arbitration, mediation and conciliation, eligible customers (natural persons or micro enterprises) may file a complaint with the Arbiter for Financial Services. The Office of the Arbiter is required to invite the claimant and the financial service provider to resolve the dispute through mediation. When the mediation proves unsuccessful or the parties do not wish to pursue this option, the Office of the Arbiter will proceed with the investigation and decision on the complaint.

v Mediation

Mediation is seldom resorted to by the parties to an insurance contract. Mediation is regulated by the Mediation Act. Mediation can be resorted to either voluntarily, following an order of the court or by law. The applicable forum is the Malta Mediation Centre.

V YEAR IN REVIEW

The year 2018 was interesting and challenging. Insurers now have a clear idea of their Solvency II requirements and how this has affected their operations and profitability. Malta has seen sustained growth in PCCs, especially among market players wishing to improve their economies of scale and streamline their operations. The insurance industry in Malta was also impacted by Brexit in that a number of insurers and intermediaries carrying on insurance business in the United Kingdom through the EU passporting regime have either chosen to redomicile in Gibraltar or set up undertakings in the United Kingdom while UK insurers and intermediaries seeking to retain their EU passport licence have had to set up operations in an EU Member State, with Malta being one of the preferred jurisdictions.

The MFSA's pragmatic approach is being seen in the way the principle of proportionality is being adopted within the insurance market. It has been possible to see how the proportionality principle can be applied while ensuring that policyholders remain protected.

The IDD was implemented in 2018, which brought more onerous requirements on product oversight, training, disclosures and amendments to sales process for manufacturers and distributors of insurance products. The requirement of producing an insurance product information document, and the need to satisfy the knowledge and ability requirement and continuing professional training and development, were some of the hot topics following the implementation of the IDD.

The General Data Protection Regulation also came into force in 2018 and the insurance industry had until 25 May 2018 to comply with its provisions.

VI OUTLOOK AND CONCLUSIONS

The industry is constantly exploring ways of reinventing itself, including using digitisation to remain ahead of competition. The utilisation of insurtech and blockchain technology has attracted much interest, and the government has been proactive in making Malta one of the first jurisdictions to introduce legislation regulating distributed ledger technology platforms, virtual financial assets and initial coin offerings. Investor protection remains a top priority for the MFSA and insurance and reinsurance companies are, for the time being, prohibited from dealing in virtual currencies for their clients or their own accounts.

23 Chapter 471, Laws of Malta.
I INTRODUCTION

The Mexican market operates under the framework set forth by the Insurance and Surety Companies Law (LISF), effective since 4 April 2015, and its implementing regulation. The LISF incorporated standards of the EU Solvency II Directive into the Mexican legal framework, requiring insurance companies to adjust and bear the cost and effects of these standards in their operations. The Mexican market has been in a continuous process of adjustment, negotiating with regulators, adapting to this framework, adding costs to the operation of insurance companies, reducing margins, and creating regulatory and consolidation pressure. Unfortunately, the LISF has not improved insurance penetration in Mexico, nor financial inclusion. The regulatory framework of the LISF continues lagging behind in terms of regulations required to implement some of the reforms introduced by the LISF. However, progress was made in the second half of 2018, as the National Commission of Insurance and Bonds (CNSF) finally licensed insurance companies to operate the new surety insurance line of business.

Despite Mexico being the second-largest Latin American market with an advanced regulatory regime, the lack of penetration continues to be a cause for concern, as well as a magnet for potential opportunities – even though this ‘potential’ has been mentioned as a factor to target the Mexican market for the past 25 years and has yet to deliver.

The complexity of new risks and the increase in additional lines of business that are capital-intensive or require added capacity, such as catastrophic insurance, have increased the use of reinsurance to cope with the ongoing concerns in underwriting and capacity, and a system that permits ‘fronting’ activities has mainly been relying on reinsurance to grow and face these new risks and challenges, rather than developing its local capacity. There are no indications of changes to these scheme going forward.

The high reliance on reinsurance with a system based on fronting arrangements creates enormous challenges when adjusting and settling certain claims. Trends in the Mexican market have translated into a malaise within the Mexican insurance market with foreign reinsurers, regarding the manner in which claims are being handled and resolved. There is growing concern from certain reinsurers and markets, and their respective advisers, regarding measures that are considered to be abusive in their use of the claims control clause. Such problems are

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1 Yves Hayaux-du-Tilly is a partner at Nader, Hayaux & Goebel. The author is grateful to Juan Pablo Sainz of Nader, Hayaux & Goebel for his assistance in preparing this chapter.
typical of fronting arrangements. There are ongoing conversations with reinsurance markets to
explore the manner in which the reinsurance market may change its current practices affecting
the long-standing working relationship between cedants and reinsurers.

II REGULATION

i The insurance regulator

Insurance and reinsurance operations in Mexico are regulated by both the Ministry of the
Treasury and Public Credit (SHCP) and the CNSF. The SHCP has authority to interpret,
implement and execute the provisions of the LISF for administrative purposes. The CNSF
has authority to grant and revoke authorisations to incorporate and operate insurance
companies in Mexico, and to register reinsurance companies with the General Registry of
Foreign Reinsurance Companies to take Reinsurance and Rebonding from Mexico (the
Reinsurance Registry), to take reinsurance from Mexican insurance companies. The CNSF
is also responsible for supervising the operation of insurance and reinsurance companies and
has authority to supervise, investigate and issue regulations applicable to the operations of
Mexican insurance and reinsurance companies. All the applicable regulations issued by the
CNSF are compiled in a single regulatory circular (the Circular).

ii Position of non-admitted insurers

Article 20 of the LISF provides that only those entities duly licensed by the Mexican federal
government through the CNSF to operate as insurance companies may undertake active
insurance operations within Mexican territory.²

If a non-licensed insurance company operates in Mexico on a non-admitted basis and
carries out active insurance operations in Mexico, it shall be deemed to be breaching Mexican
law and the transaction shall be null and void. Furthermore, such conduct would constitute
criminal liability on the part of: (1) the non-admitted foreign insurer; (2) the insurance
intermediaries (broker or agent); and (3) the officers, managers, directors, representatives and
agents of the entities referred to in (1) and (2).

iii Position of brokers

As a general rule, insurance companies may only pay brokerage fees to insurance brokers
duly authorised as such by the CNSF. There is a licence to act as an individual agent and
another for entities to act as insurance brokers. To obtain the licence to act as an agent or
broker, the individual or entity must file an application with the CNSF, which must comply
with the requirements set out in the Regulation of Insurance and Surety Brokers (the Brokers
Regulation). The legal provisions applicable to insurance brokers are contained in Chapter
32 of the Circular.

Reinsurance intermediaries are entities licensed to provide reinsurance intermediation
services (Article 106, LISF). To incorporate and operate a reinsurance intermediary, the prior
authorisation of the CNSF is required, and to obtain the authorisation an application must
be filed with the CNSF. The application must comply with the requirements set out in the

² Article 20, Paragraph 2 of the LISF defines ‘active insurance operations’ as those in which, upon the
occurrence of a future and uncertain event agreed upon by the parties, one party agrees to directly or
indirectly indemnify or pay an amount of money to the other party, in exchange for a premium.
Rules on the Authorisation and Operation of Reinsurance Intermediaries (the Intermediaries Rules). Reinsurance intermediaries must be incorporated as limited liability stock companies and have their corporate domicile in Mexican territory. The legal provisions applicable to reinsurance intermediaries are contained in Chapters 9, 32 and 35 of the Circular.

iv Requirements for authorisation

Pursuant to the LISF, to incorporate and operate an insurance company in Mexico, an application must be filed with the CNSF. The application must comply with the requirements set out in Article 41 of the LISF. The CNSF has discretional authority to grant or deny the authorisation. These authorisations are regulated in Chapter 2 of the Circular.

An insurance company must start operations within three months of receiving the relevant authorisation from the CNSF. Before starting its operations, the CNSF must carry out an inspection visit and confirm that the insurance company has the infrastructure, procedures and systems required to operate according to Article 47 of the LISF.

Under the LISF, Mexican insurance and reinsurance companies and foreign reinsurance companies registered with the Reinsurance Registry may cede or take risks in reinsurance to and from Mexican insurance companies. Pursuant to the Circular, foreign reinsurance companies may not take reinsurance in Mexico when they intend, or when they effectively carry out, on a majority or exclusive basis, reinsurance operations with Mexican insurance companies with whom they have financial or business ties. Although it is not clearly explained in the LISF, the ‘majority or exclusive’ operations referred to in this provision relate to the global reinsurance activities undertaken by foreign reinsurance companies, and not only their reinsurance activities in Mexico. The reason for this provision is to prevent the proliferation of captive reinsurance companies.

Insurance companies authorised in Mexico are allowed to carry out reinsurance operations in the same lines of business in which they have a licence to take insurance. However, a licence to exclusively operate reinsurance business can also be obtained. There are currently only two Mexican insurance companies authorised to exclusively operate reinsurance: Reaseguradora Patria and Der Neue Horizont Re.

The registration of foreign reinsurance companies with the Reinsurance Registry is governed by the LISF and the Circular. To register with the Reinsurance Registry, foreign reinsurance companies must file an application with the CNSF in the terms set forth in Article 107 of the LISF and Chapter 34.1 of the Circular. The CNSF may grant or deny this registration on a discretionary basis. The registration of foreign reinsurance companies is valid until 31 December of the year of registration and must be renewed every year.

v Regulation of individuals employed by insurers

Title 3, Chapter 1, Section II of the LISF and Chapter 3.7 of the Circular provide basic requirements of experience, expertise and knowledge in finance, law, administration or insurance for the eligibility of directors, officers and statutory examiners within an insurance company, and also prescribe which individuals may not be appointed as such. Insurance companies must give notice to the CNSF on any such appointment and provide sufficient evidence to the CNSF that the individual complies with the requirements under the LISF to serve in the relevant capacity. The insurance company must maintain a file for each individual with supporting documentation and evidence of their qualifications and representations and annually confirm to the CNSF that its directors and officers comply with the requirements set forth in the LISF and the Circular to serve in their respective positions.
vi The distribution of products

Pursuant to the LISF and Chapter 4 of the Circular, standard-form contracts, collective and group contracts and surety insurance must be registered with the CNSF.

Insurance products registration must comply with the following documentation (contractual documentation):

a. general conditions and model contracts, containing the general and particular conditions under which the insurance product will be commercialised;

b. a technical note, containing the technical and financial hypothesis for the calculation of the premium and the ongoing risk reserve;

c. a legal opinion, certifying that the insurance product complies with all applicable legal provisions; and

d. a ‘congruency opinion’ that certifies that both the technical note and the legal opinion are consistent.

Insurance companies may use, sell and distribute insurance products immediately upon their registration. The CNSF may at any time suspend the registration of an insurance product if, in its opinion, the insurance product does not comply with applicable laws and regulations.

The LISF requires that standard-form insurance contracts are filed with the National Commission for the Defence and Protection of Financial Services Consumers (Condusef), for their registration with the Standard-Form Contracts Registry.

vii Compulsory insurance

The main difference between compulsory insurance and other insurance products, other than the fact of the insurance coverage being required by law, is that compulsory insurance contracts shall continue in full force and effect until their termination, and may not be terminated, even when the corresponding premium is not paid when due or within the cure period set forth under the LISF. Compulsory insurance premiums may not be paid in instalments.

Compulsory insurance includes social security (e.g., life, health and disability), which is mandatory for employers with respect to their employees; professional liability insurance to practise certain professions; and automobile insurance to circulate on roads and highways under federal jurisdiction, and in some of the states of Mexico.

viii Taxation of premiums

Insurance companies are subject to income tax and value added tax. Income tax is levied at 30 per cent on insurance companies’ accrued income less authorised deductions. The Income Tax Law provides special rules for deductions applicable to insurance companies.

Value added tax is levied at 16 per cent on all insurance services paid for by customers, except for agricultural insurance, mortgage and financial guaranty insurance, and life insurance.

Mexican reinsurance companies receive the same tax treatment as insurance companies. Income tax is applicable to foreign reinsurance companies when they receive premiums from a Mexican resident or from a foreign resident with a permanent establishment in Mexico. The income tax is calculated by applying a 2 per cent withholding rate on the gross amount paid to reinsurers with no deductions.

The person paying the premium to the reinsurers must withhold and pay the income tax at the applicable rate. Depending on the jurisdiction in which the reinsurance company...
is incorporated, there might be a double taxation treaty that applies to the payment of premiums to foreign reinsurance companies and that supersedes the general provisions referred to herein.

Insurance and reinsurance brokers are subject to the same taxes and to the same rates as insurance companies but are not subject to special deductions applicable to insurance companies.

**ix  Other notable regulated aspects of the industry**

Insurance companies must maintain a minimum paid-in capital stock. That minimum paid-in capital stock is regulated in Chapter 6 of the Circular.

The following are the (approximate) minimum paid-in capital requirements for each line of business applicable for 2019, until new capital requirements are issued by the CNSF, which should be before June 2019:

- **a** Life: 37.90 million pesos.
- **b** Pensions: 155.68 million pesos.
- **c** Accidents and health:
  - personal accident or medical expenses: 9.47 million pesos; and
  - health, including personal accident or medical expenses: 9.47 million pesos.
- **d** Property and casualty:
  - one line: 28.43 million pesos;
  - two lines: 37.9 million pesos;
  - three or more lines: 47.38 million pesos;
  - mortgage insurance: 67.83 million pesos; and
  - financial guarantee insurance: 184.59 million pesos.

Insurance companies authorised exclusively for reinsurance operations are required to maintain 50 per cent of the applicable minimum paid-in amount, as listed above.

**III  INSURANCE AND REINSURANCE LAW**

**i  Sources of law**

Mexican insurance and reinsurance companies are governed by the LISF. The LISF was published in the Official Gazette of the Federation (DOF) on 4 April 2013 and entered into effect on 5 April 2015, repealing the General Insurance and Mutual Companies Law, which had been in effect since 1935.

The Insurance Contract Law (LCS), enacted by Decrees dated 29 December 1934 and 1 January 1935, also published in the DOF on 31 August 1935, is applicable to all insurance contracts subject to Mexican law, except for maritime insurance, which is governed by the Navigation and Maritime Commerce Law published in the DOF on 1 June 2006.

Reinsurance contracts are governed by the applicable law expressly agreed by the parties in the contract. Generally, the parties agree on Mexican law as the law governing the reinsurance contract.

**ii  Making the contract**

Article 1 of the LCS defines insurance contracts as agreements in which an insurance company agrees to indemnify or pay for damages, or to pay an amount of money on the occurrence of a risk covered under the terms of the contract, in exchange for the payment of a premium.
The reinsurance contract is not a regulated contract, which generates many disputes in practice. The reinsurance contract is defined in Article 2, Section XXV of the LISF, as the contract in which an insurance company assumes totally or partially a risk that is covered by another insurance company, or the liability exceeding the amount insured by the direct insurer.

Article 25 of the LISF provides a general classification of insurance contracts as follows:

a. Life.

b. Accidents and health, including:
   • personal accidents;
   • medical expenses; and
   • health.

c. Property and casualty, including:
   • civil liability and professional;
   • maritime and transportation;
   • fire;
   • agriculture and livestock;
   • automobiles (motor insurance);
   • credit insurance;
   • surety insurance;
   • mortgage insurance;
   • financial guarantee insurance;
   • earthquake and other catastrophic risk;
   • miscellaneous; and
   • risks declared by the SHCP as specialty risks.

**Essential elements of an insurance contract**

Under the LCS, insurance policies must contain:

a. the name and address of the contracting parties and the signature of the insurance company;

b. a description of the insured asset or person;

c. a description of the risks insured;

d. the effective date of coverage and its duration;

e. the amount insured;

f. the insurance fees or premium; and

g. any other clauses required by law or agreed by the parties.

It is common to find the following clauses in insurance policies:

a. coverage limits and exclusions;

b. form and terms under which the premium must be paid;

c. insured’s right to be informed about commissions paid to intermediaries;

d. insured’s right to revise the policy if its terms differ from the agreed terms;

e. competence of Condusef and choice of jurisdiction clause; and

f. special clauses required for specific lines of business.
Utmost good faith, disclosure and representations

The duty of utmost good faith is an implied principle applicable to all insurance contracts. This duty demands diligent and honest conduct from both parties, including the duty of the insured to disclose to the insurer any fact that may help the underwriter to evaluate the risks and determine the premium.

Interpreting the contract

General rules of interpretation

To the extent that the terms and conditions of the agreement are clear and there is no question as to what the intent of the parties was, the insurance policy must be interpreted in accordance with its terms:

a. if the terms of the insurance policy seem contrary to the evident intent of the parties, the intent of the parties shall prevail over the terms of the insurance policy;

b. if the insurance policy is generic in its terms, its interpretation must be limited to the purposes of the insurance policy;

c. if the insurance policy permits various interpretations, it must be interpreted in the most convenient manner for the insurance policy to be effective;

d. the terms and conditions of an insurance policy, including those terms that are not clear, must be interpreted in a manner that is consistent with the interpretation of the insurance policy as a whole;

e. if the terms of an insurance policy that may have different meanings must be interpreted in a manner consistent with the nature and purposes of the insurance policy;

f. if it is impossible to construe the insurance policy using the rules set out above, the insurance policy must be construed in favour of the interpretation that provides reciprocity of interests between the parties.

Incorporation of terms

Compliance with the LCS is mandatory, therefore any agreement contrary to the LCS is null and void, unless otherwise permitted under the LCS. Taking this into account, it is implied that insurance contracts are subject to the provisions of the LCS.

Intermediaries and the role of the broker

Conduct rules

Pursuant to Article 106 of the LISF, only reinsurance intermediaries are authorised to provide reinsurance intermediation services. Authorisation from the CNSF is required to incorporate and operate a reinsurance intermediary. In order to obtain this authorisation, an application must be filed with the CNSF. The Intermediaries Rules set forth the requirements and information that the application for authorisation must contain. A reinsurance intermediary must be incorporated as a limited liability company with a residence in Mexico.

Agencies and contracting

As a general rule, intermediation of insurance products may only be carried out by insurance brokers certified and licensed by the CNSF. Insurance companies may only pay commission arising from the sale of insurance policies to insurance brokers.
How brokers operate in practice

To carry out brokerage services in Mexico, insurance brokers must be authorised by the CNSF. To this end, an application must be filed with the CNSF. The requirements and information that the application must contain is set forth in the Brokers Regulation. The authorisation may be granted to:

a. individuals acting as employees of an insurance company or independent individuals operating with a service agreement with an insurance company; and
b. limited liability companies incorporated under Mexican law.

The authorisation to act as an insurance broker is granted for three years for individuals (renewable at the request of the insurance broker) and, in the case of legal entities, the CNSF can grant the authorisation for an indefinite period.

Article 12 of the Brokers Regulation lists entities and individuals that cannot participate, directly or indirectly, in the capital stock of an insurance broker legal entity; these include Mexican insurance companies and financial entities subject to approval by the corresponding Mexican authority; foreign governments or authorities; and foreign financial entities.

Claims

A claim is triggered on the occurrence of a peril covered by the policy. Insurable interest is required to make a valid claim and demand payment under a policy.

The statute of limitations of claims is two years after the date of the occurrence of the loss, except for life insurance, where it is five years (Article 81, LCS). The statute of limitations can be interrupted for the following reasons:

a. on appointment of experts as a result of a loss;

b. if a claim is filed with the specialised unit of the corresponding insurance company or Condusef;

c. by initiating an action or proceeding before competent courts, on service of process to the insurance company; or

d. by the express acknowledgment of the rights of the insured or its beneficiaries by the insurance company.

Good faith and claims

The LCS establishes the obligation of the insured (1) to give timely notice of the occurrence of the casualty; (2) regarding property and casualty insurance, to prevent or reduce the damage; and (3) not to modify the status of the assets. If, when acting in good faith, the insured omits to give timely notice of the occurrence of the casualty or to carry out reasonable actions to prevent or reduce the damage, or modifies the status of the insured asset, the insurance company may reduce the indemnity in proportion to the damage that could have been mitigated or avoided by the insured. If the insured were to act fraudulently, the insurance company would be released from its obligations under the policy.

The consequences of bad faith may:

a. trigger the right to terminate the insurance contract;

b. allow the parties to recover premiums paid or request payment of damages and loss of profit; and

c. release the parties from their obligations under the insurance contract.
Set-off and funding
The parties can set off mutual debts and credit as long as both are due and payable.

Reinstatement
The LCS does not regulate reinstatement, but it may be included in the insurance contract. Reinstatement generally operates when the insured pays the outstanding premiums, provided the risk has not changed.

If any risk takes place prior to reinstatement of the insurance contract, the insured is not entitled to obtain any compensation, since he or she was not covered by the insurance.

Dispute resolution clauses
Clauses regarding choice of forum, jurisdiction and applicable law are valid and enforceable in Mexico in insurance and reinsurance contracts. Furthermore, the parties in insurance and reinsurance contracts can convene to solve potential disputes through an arbitration. Mexico is a contracting state of the Hague Convention on Choice of Court Agreements (2005) and of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the New York Convention 1958).

IV DISPUTE RESOLUTION
i Jurisdiction, choice of law and arbitration clauses
The parties in a reinsurance contract are free to agree the terms and conditions of the contract as long as they do not breach any mandatory legal provision or go against public policy. Arbitration clauses are enforceable in insurance and reinsurance agreements. The terms and conditions of an insurance contract are subject to and shall comply with the LCS, which is mandatory; any agreement contravening the LCS shall be null and void.

ii Litigation
Insurance and reinsurance disputes are regulated by the Code of Commerce. If one of the parties breaches a contract, the non-defaulting party can initiate ordinary commercial proceedings. This judicial process has four basic stages: filing of the claim by the plaintiff and response from the defendant; submission and presentation of evidence of any kind; pleadings; and award.

The parties can appeal any ruling to a higher tribunal, unless the aggregate amount is less than 633,075.88 pesos.

Each party pays its own litigation costs and the losing party may be required to indemnify the winning party, including for attorneys’ fees, subject to certain established thresholds and the decision of the court.

iii Arbitration
The insured and the respective beneficiaries can file claims with the insurance company, Condusef and Mexican courts.

Claims filed with Condusef or before a competent court interrupt the statute of limitations.
Condusef can act as a mediator in disputes resulting from an insurance contract if the amount in dispute is less than 6 million Mexican investment units (approximately 37.47 million pesos). Condusef can also act as an arbitrator if the dispute is not solved in a mediation process; however, the parties can choose a third party as an arbitrator.

The foregoing does not affect the right of the parties to bring a legal action before Mexican courts.

As mentioned in Section III.v, Mexico is a contracting state of the New York Convention and agreements to submit disputes arising from reinsurance policies to arbitration are valid, and the respective awards can be enforced by Mexican courts.

The Mexican chapter of the International Insurance Law Association, the Mexican Insurance and Bonding Law Association (AMEDESEF), together with the Arbitration Centre of Mexico (CAM), created the Mexican chapter of the Insurance and Reinsurance Arbitration Society (ARIAS Mexico). ARIAS Mexico, managed by the CAM with the technical assistance of AMEDESEF, promotes arbitration to resolve insurance and reinsurance disputes.

Reinsurance claims can be resolved in judicial proceedings through arbitration or through other alternative dispute resolution mechanisms, such as mediation and conciliation.

iv Mediation
There is an important increase in mediation as an alternative mechanism for settling international reinsurance disputes and claims involving Mexican cedants and the London market. Mediation has proven to be an efficient alternative.

v Alternative dispute resolution
Even though Article 17 of the Mexican Constitution refers to means of alternative dispute resolution, there is no federal regulation regarding alternative dispute resolution processes. However, several states have enacted specific laws on this matter.

The most popular alternative dispute resolution procedures are arbitration and mediation (see subsections iii and iv).

V YEAR IN REVIEW
i The insurance sector
According to the CNSF, as at September 2018, the Mexican insurance sector comprises 97 insurance companies licensed to operate in Mexico, of which 57 are subsidiaries of foreign insurance companies, and more than 250 foreign reinsurance companies registered with the Reinsurance Registry, including Lloyd’s of London. Ten atomic pools (nuclear insurance pools) were also registered with the Reinsurance Registry to take reinsurance in Mexico. Direct premiums in the insurance and surety sectors increased had by 3.3 per cent by the end of September 2018 compared to the same period in 2017. The overall annual growth in the Mexican insurance industry from January to September 2018 was 3.3 per cent in real terms. From the total amount of premiums by the end of September 2018, 98.4 per cent came from direct insurance and only 1.6 per cent from reinsurance.

By the end of September 2018, life insurance had increased by 8.5 per cent in real terms compared to the previous year; health insurance increased by 7.2 per cent; and property and casualty increased by 4 per cent, without including motor insurance, which decreased by 11.8 per cent.
The penetration of insurance with respect to Mexico’s gross domestic product is 2.3 per cent, which was below the level of 2.7 per cent penetration that was expected for 2018. The Mexican Association of Insurance Institutions, together with the CNSF, are working on a strategy to increase penetration to 3.4 per cent by 2020.

There was also substantial M&A activity during 2018, driven mostly by international transactions with effects on the Mexican market.

ii  Lloyd’s
In January 2018, Probitas Syndicate 1492 opened a representative office in Mexico, becoming the first Lloyd’s syndicate with a physical presence in the country. Probitas aims to coordinate its strategy in Latin America from its Mexico office. Taking into account the constant conflicts arising from inadequate placement of reinsurance policies in Mexico, having a local team of underwriters will contribute to a more efficient and transparent operation for the benefit of the Lloyd’s market and the local cedants. Two Mexican groups, Grupo Nacional Provincial and Reaseguradora Patria, currently have investments in Lloyd’s.

iii  Change in government
As a result of the federal elections in July 2018, the National Regeneration Movement (MORENA) took control of Congress and its presidential candidate Andrés Manuel López Obrador won by a landslide, taking office on 1 December 2018. As a result of the changes in government, Ricardo Ernesto Ochoa Rodríguez was appointed president of the CNSF replacing Norma Alicia Rosas Rodríguez. All vice presidents and certain senior officers of the CNSF resigned from their positions. This has created uncertainty and added pressure to the CNSF, which already had a very heavy workload.

We expect that there will be inefficiencies on the part of the CNSF in 2019 as a result of the process of appointing new vice presidents and senior officers, and there will be a period of adjustment as those individuals adapt to their new positions. As this change of government has wide-reaching implications, the public policies of the CNSF, and consequently the impact on the insurance industry, are yet to be determined. However, the insurance industry is feeling some of the effects, mostly as a consequence of the austerity regime being imposed on the public administration, which includes the cancellation of private medical insurance for public officers and the reduction of other fringe benefits in public officers’ compensation packages.

iv  Case concerning a foreign insurer
During 2018, the CNSF cancelled, for the first time, the registration of a foreign reinsurer with the General Registry of Foreign Reinsurance Companies for non-economic reasons arising from an alleged breach of regulation by a Mexican cedent. The CNSF argued that both the cedent and the foreign reinsurers must comply with the duties that the law impose to the cedent and that in case of breach by the cedent of its obligations under applicable Mexican law and regulations, the reinsurer may also be deemed liable. This criterion has raised concerns from foreign reinsurers that have implemented internal control and compliance measures to ensure that cedent companies comply with their legal obligations in their reinsurance transactions to avoid potential liability, including the cancellation of their registration that would prevent them from taking risk from Mexican cedents. The foreign insurer appealed the
ruling cancelling its registration before the CNSF, and the CNSF subsequently considered that it did not breach Mexican laws and regulations and reinstated its registration with the General Registry.

VI OUTLOOK AND CONCLUSIONS

i Regulatory
There will continue to be regulatory challenges arising from the implementation of Solvency II standards. The likely changes in public policy may also have an important impact on regulatory changes. This presents an opportunity to conduct significant changes to the regulation to effectively increase penetration, by maintaining operational costs at reasonable levels to permit growth and ensuring that Mexican operations are attractive to investors. We expect a shift in the priorities of the regulators towards protection to customers and expansion of insurance protection to the general population.

There is extensive interest in developing insurtech potential, while coping with compliance and regulatory challenges, including a strict regime that is not very well adapted from the banking sector on anti-money laundering regulation, and the data protection and privacy regulation. New risks require new products and present new challenges. There continues to be appetite from funds to work alongside insurance companies to exploit the role of insurance companies as institutional investors. The challenges have been clearly identified, and with the exception of a few insurance companies actively investing in private equity, venture capital and other securities, such as development trusts and real estate trusts, the insurance industry has not fully embraced its potential as a key institutional investor; and at the same time, regulators have not amended the regulations to enhance and give incentives for this purpose. We expect important changes to the investment regime of insurance companies aligned with the interest of the new government to finance long-term infrastructure projects.

As mentioned in Section I, the CNSF finalised the licensing process for the operation of new surety insurance companies. It remains to be seen what impact – if any – surety insurance will have on the market.

ii Case law
More litigation is anticipated, which will result in court precedents on insurance matters. The most relevant development continues to be the evolution of the concept of moral damages that has been regarded as a similar terms to that of punitive damages, with important focus on the insurance industry.

The contra proferentem principle in insurance continues to be reinforced, impacting the manner in which cases are being argued before the courts. Ongoing cases are contributing to the judicial interpretation of the exclusion of the risk of terrorism (terrorism exclusion clause or endorsement) in insurance policies. Some of these cases are related to violent acts that took place in the context of demonstrations and protests against the government that occurred in January 2018, as a consequence of a substantial rise in the price of petrol. These cases are relevant to the insurance industry as the Mexican precedents do not reflect international market practices.

iii Reinsurance claims
Despite the Mexican market expression of concerns on certain practise of reinsurers arising from an increase in disputes originated by inconsistencies of applicable laws and regulations
governing reinsurance contracts and, in particular, abuse in the application of claim control clauses, concrete actions to resolve these practices that are damaging the credibility of, and confidence in, reinsurers, continue being long due and pending.

As previously identified, one of the main sources of conflicts is caused by the recurrent use of fronting arrangements in a legal framework where the insurance company maintains its liability before the insured despite the fact that, technically, it is just fronting the risk. Issues such as lack of understanding or even neglect of Mexican law, and the respective failure to review the effect that Mexican law has in relation to the English wording used in some placements through fronting arrangements, raises inconsistencies between the insurance or reinsurance policies and Mexican law, and to growing differences in the manner in which reinsurance companies handle claims in prejudice of the insurance company that placed the business. Despite various efforts, the regulators in Mexico have not approved a mechanism to effectively address the effects of international money laundering regulations in local placements and limitations of liability under reinsurance programmes.

There is an opportunity to effectively use and promote alternative dispute resolution mechanisms in Mexico specialised in insurance and reinsurance claims, including mediation and arbitration and the use of the Mexican chapter of the Insurance and Reinsurance Arbitration Society (ARIAS Mexico), by including arbitration clauses in insurance and reinsurance agreements to resolve disputes in arbitration, as a consequence of the ongoing conflicts arising in reinsurance contracts, and also to prevent certain situations in global insurance programmes. However, the reinsurance market is still generally reluctant to include mediation and arbitration clauses in reinsurance policies.

iv  Distribution

Despite continued efforts from the CNSF and the Association of Mexican Insurance Companies to expand insurance offers to small and medium-sized companies, which contribute around 52 per cent of the national GDP, and enforcing automobile insurance and other mandatory insurance products, there has been limited success. This is an area in which we also expect changes in the strategy of the CNSF as a consequence of the change of government.

Bancassurance continues to develop and is one of the most important areas of growth within the industry. With very few exceptions, most banking groups operating in Mexico have transferred their insurance business and operations to insurance groups and entered into exclusive distribution arrangements. During 2018 that trend continued and further developments with innovative approaches will be launched during 2019. Various projects aiming to exploit the untapped, and therefore underserved, health insurance market will be launched during 2019. These projects will be closely monitored and their success will certainly attract other players.

v  Further consolidation

The market will be attentive to the new government policies and their impact in the insurance industry to adjust their strategy towards Mexico. Depending on these, we may see consolidation, growth or a combination. There is expectation that the new government policies have a positive impact in the surety market and a negative impact in the medical expenses line of business.
vi Product development

Parametric insurance products for catastrophic risks were developed during 2018 and are expected to be available on the Mexican market in 2019.

The appetite of the Mexican insurance market for capacity to underwrite the new energy-related risks has been invigorated by the developments in the reform of the energy sector and new players operating in Mexico. These developments include environmental risks, exploration and production of hydrocarbons, upstream, midstream and downstream. The complexity and size of the Mexican market demands new and innovative products to cover new risks such as cyber risk, as well as health and medical coverage insurance, professional liability, directors and officers, and errors and omissions policies. There has also been growth in asset management-related products and services.
I INTRODUCTION

New Zealand has an established insurance market comprising a number of local and overseas general insurers and life insurers. A small number of global reinsurers have branches in New Zealand, although the majority of risk is reinsured overseas.

The core principles of insurance law in New Zealand are sourced from long-standing English common law authorities, supplemented by a combination of New Zealand statute law and voluntary code.

II REGULATION

i The insurance regulator

The Reserve Bank of New Zealand (RBNZ) is the prudential regulator and supervisor of all insurers and reinsurers carrying on insurance business in New Zealand, and is responsible for administering the Insurance (Prudential Supervision) Act 2010 (IPSA).

The Companies Office and the Financial Markets Authority (FMA) also have roles. The Companies Office administers and regulates companies law, and the FMA administers and regulates persons subject to the Financial Service Providers (Registration and Dispute Resolution) Act 2008 (FSPA) and the Financial Advisers Act 2008 (FAA) (which can include insurers and insurance intermediaries).2

ii Regulation and authorisation

IPSA

The IPSA requires each person who carries on insurance business in New Zealand to be licensed as an insurer.3 Whether an insurer ‘carries on insurance business in New Zealand’ (a concept that encompasses both insurers and reinsurers) is a question of fact that must be decided having regard to all of the insurer’s circumstances.

To obtain a licence, an insurer must apply to the RBNZ and provide information to establish that it meets certain requirements, including those relating to solvency and credit

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1 Tom Hunt and Marika Eastwick-Field are partners at Russell McVeagh. The authors would like to thank and gratefully acknowledge the assistance of Ling Yan Pang, Nicole Browne and Che Ammon.

2 As discussed in Section II.ix, the Financial Services Legislation Amendment Bill passed its third and final reading by Parliament on 4 April 2019; however, at the time of writing, it has not received royal assent, passing it into law.

3 IPSA, Section 15.
rating, risk management, corporate governance, compliance with anti-money laundering legislation, and that the insurer is able to satisfy ongoing prudential requirements (including that the insurer holds, and has the ability to maintain, a minimum amount of capital in accordance with solvency standards set by the RBNZ).  

Overseas insurers may be eligible for exemptions from parts of the licensing requirements if they are supervised by a recognised overseas regulator and they meet certain standards in their home jurisdictions.

There are also specific rules that allow Lloyd’s to obtain a licence on behalf of all Lloyd’s underwriters.

**FPSA**

Insurers must register on the Financial Service Providers Register (FSPR) in accordance with the FPSA. Insurers that provide services to retail clients are also required to be members of an approved dispute resolution scheme.

**Companies Act 1993**

As corporate entities carrying on business in New Zealand, insurers must be registered with the Companies Office. This requirement also applies to insurers that are incorporated outside New Zealand but that carry on business in New Zealand.

### iii Position of non-admitted insurers

As mentioned in subsection ii, owing to the requirement that each person who carries on insurance business in New Zealand must be licensed, non-admitted insurers are effectively prohibited from operating in New Zealand. In addition, the IPSA also places restrictions on the use of certain words including ‘insurance’, ‘assurance’, ‘underwriter’, ‘reinsurance’ or any word that has the same or a similar meaning. Subject to some limited exceptions, it is an offence for a person to carry on any activity in New Zealand (either directly or indirectly) using a name or title that includes a restricted word unless the person is licensed or permitted to do so under the IPSA.

### iv Position of brokers

Brokers are primarily regulated under the Insurance Intermediaries Act 1994 (IIA), the FPSA and the FAA.

The IIA governs insurance intermediaries and brokers. It is primarily focused on ensuring that the risk of the default or insolvency of the intermediary or broker falls on the insurer rather than the insured. The IIA does not impose any registration requirements and no regulator has specific jurisdiction for monitoring compliance with the IIA. The IIA’s obligations are, instead, most commonly raised in civil disputes between insurers, insureds and insurance intermediaries. If an entity is an insurance intermediary, certain deeming provisions apply in relation to payments made to or received by that intermediary in order to bind the insurer in the event of default by the intermediary. Obligations on brokers are more onerous and include duties in relation to payments due to the insured and operating of client broking accounts.

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4 IPSA, Part 2, Subpart 1.
5 IPSA, Section 219.
The FSPA and the FAA impose regulatory requirements on brokers who fall within the definitions of financial adviser, broker and financial service provider (in each case, as determined by the activities that the broker undertakes). Brokers that are subject to the requirements of the FSPA must be registered on the FSPR and belong to an approved dispute resolution scheme if they act as a financial service provider for retail clients. The FSPR enables the public to check that financial service providers are registered, along with certain other details including the types of financial services that they are registered to provide. Brokers that are subject to the FAA must comply with certain disclosure and conduct obligations, which vary depending on the types of services that they provide.

v Regulation of individuals employed by insurers

Individuals employed by insurers are regulated by the IPSA to a limited degree. Directors of licensed insurers are required to certify that any new director, the chief executive officer, chief financial officer and appointed actuary (who may or may not be an employee of the insurer) are fit and proper persons to hold their respective roles (and the criteria on which the certification is based must be specified in the insurer’s fit and proper policy). The RBNZ has powers to take action against persons appointed to these roles that it views as being inappropriate to be involved in the management or governance of an insurer. The RBNZ may also apply to the district court for a person to be banned from participating in an insurance business in relation to certain wrongdoings.

Employees of insurers that provide financial advice are regulated under the FAA and FSPA. However, the extent to which these employees are regulated depends on the type of financial advice they offer and whether the insurer is a qualifying financial entity (QFE). Insurers that are registered on the FSPR and that employ a number of financial advisers may apply to the FMA to become a QFE. Obtaining QFE status enables an organisation to streamline the registration, disclosure, dispute resolution and supervision arrangements that will apply to its financial advisers. In return, the insurer takes responsibility for its advisers’ compliance with the regulatory regime.

vi Compulsory insurance

Unlike some jurisdictions, there is no compulsory motor vehicle or workers compensation insurance in New Zealand. The government operates a ‘no fault’ accident compensation scheme for personal injury by accident suffered by any New Zealand resident or visitor to New Zealand. The scheme is administered by the Accident Compensation Corporation under the Accident Compensation Act 2001, and is funded through levies and taxation. No private legal proceedings can be brought for personal injury covered by the scheme, and there is therefore only limited need for personal injury liability insurance.

Where residential buildings and personal property are insured against fire, the property is also deemed to be insured against earthquake and other natural disaster under the Earthquake Commission Act 1993. The insured pays a premium for this cover to the Earthquake Commission through the insurance company.

6 IPSA, Section 37.
7 IPSA, Section 222.
8 As discussed in Section V.ii, there is currently a public inquiry into the Earthquake Commission’s operational practices.
The Maritime Transport Act 1994 imposes certain insurance requirements in respect of oil pollution liabilities and for offshore marine installations.

vii Compensation and dispute resolution regimes
As discussed in subsection iv, insurers that provide services to retail clients are required by the FSPA to be a member of an approved dispute resolution scheme.9 There are four approved schemes, though most insurers are members of the Insurance and Financial Services Ombudsman Scheme (the IFSO Scheme),10 which focuses primarily on insurance.

The IFSO Scheme is free to access for the insured and can consider complaints from consumers and small businesses up to NZ$200,000 (unless the insurer agrees to a greater amount). It cannot make a determination in relation to commercial insurance policies.

Insurers are also required to have an internal dispute resolution process. This process must have been exhausted before a dispute can be brought to the IFSO Scheme. If a dispute is brought to the IFSO Scheme, it will be investigated, and attempts will be made to resolve the dispute through negotiation or mediation (or both). If this process fails, then the ISFO Scheme can make a determination on the dispute that will be binding on insurers, but not on consumers or small businesses who may seek redress through an alternate dispute resolution process or through the courts.

viii Taxation of premiums
In general, a person carrying on an insurance business is subject to income tax in the same manner as any other taxpayer in business. Income and deductions will generally be recognised using ordinary tax principles, but with the overlay of specific statutory rules. As such, insurers are generally subject to income tax on insurance premiums received.11

For tax purposes, New Zealand distinguishes between two categories of insurers: general insurers and life insurers. General insurance is defined as insurance that is not life insurance. New Zealand has specific statutory rules addressing:

- the income tax treatment of a general insurer’s outstanding claims reserves, which seek to align income tax treatment with financial reporting and actuarial practice;
- certain premiums derived by non-resident general insurers (addressed below);
- the calculation of the income of life insurers, which require separate calculations to reflect two bases of taxable income:
  - a shareholder base (representing income derived for the benefit of shareholders); and
  - a policyholder base (representing income derived for the benefit of policyholders);
- the timing of recognition of the income of life insurers, which seeks to address the timing and allocation issues inherent with life insurance products, particularly in respect of participating life policies; and
- certain life insurance premiums paid to underwriters at Lloyd’s of London (addressed below).

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9 FSPA, Section 11.
10 As of February 2019.
11 As of February 2019, companies are subject to an income tax rate of 28 per cent.
Where a non-resident general insurer derives a premium with a New Zealand source that is not attributable to a fixed establishment of the insurer in New Zealand, 10 per cent of the gross premium is income of the insurer. This income is given separate treatment for income tax purposes and the insurer is not permitted any deductions against this income. Therefore, this is the net amount subject to tax. If the non-resident general insurer does not file a return and pay the relevant New Zealand tax, New Zealand deems certain persons to be agents of the insurer and requires the agent to file a return and pay the tax. Under these rules the person paying the premium may be liable for the non-resident insurer’s tax liability. Similar rules also apply to certain life insurance premiums derived by underwriters at Lloyd’s of London. If those rules apply, 10 per cent of the gross premium is income of the insurer, the insurer is not permitted deductions against that income and the person paying the premium may be required to calculate the income tax payable, file a tax return and pay the insurer’s tax liability.

Insurance premiums are generally subject to New Zealand’s goods and service tax (GST) (currently at a rate of 15 per cent), with the exception of premiums for life insurance. The provision of life insurance is not subject to GST (either because it is exempt or because it is zero-rated for GST purposes, depending on the particular circumstances). Some other exceptions can also apply, for example in relation to certain credit-related insurance contracts.

Proposed changes to the regulatory system

In 2017, draft legislation (the Financial Services Legislation Amendment Bill) was introduced to Parliament to repeal and replace the current FAA regime. The Bill is aimed at simplifying and streamlining the regime. The proposed amendments include replacing the current types of financial advisers with three new types (financial advisers, financial advice providers and nominated representatives), permitting the provision of robo-advice to retail customers, requiring anyone who provides financial advice to be licensed (and introducing a fit-for-purpose licence structure), imposing conduct and competence obligations on anyone who provides financial advice and creating shorter, simplified disclosure requirements. Under the Bill, anyone giving financial advice will need to be engaged by a ‘financial advice provider’ and either a ‘nominated representative’ under the Financial Markets Conduct Act 2013 or a ‘financial adviser’ registered under the FSPA. The Bill passed its third and final reading by Parliament on 4 April 2019. It is now due to receive royal assent, after which it will become legislation. Given that the Bill is still to be enacted into law, the FMA has decided to grant an exemption to enable the provision of personalised robo-advice. Persons seeking to rely on the exemption must apply to the FMA.

The RBNZ is also undertaking a comprehensive review of the IPSA, although, as of April 2018, work on this review is suspended. The focus of the review was on the adequacy and effectiveness of the current regulatory tools over the insurance sector in New Zealand. In particular, the review was to give priority to the scope of the IPSA, overseas insurers, financial strength requirements and regulatory mechanisms. The work on this review was suspended from April 2018, although the RBNZ has stated that this will be reviewed regularly and work will resume in due course. The review, if and when it recommences, will take into account recommendations from the 2017 International Monetary Fund’s assessment of observance.

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of the insurance core principles in New Zealand, which indicated that the RBNZ’s powers should be extended in order to further develop observance initiatives and ensure that policyholders are adequately protected.

A review of insurance contract law is underway (see Section V.iii) and this will include consideration of the existing regulation of brokers and intermediaries under the IIA.

x Other notable regulated aspects of the industry

Under the IPSA, approval must be obtained from the RBNZ in relation to a change of control, or change in corporate form, of any licensed insurer.13 This allows the RBNZ to consider the same matters as when it first licenses an insurer to ensure the change in control or corporate form will not affect the insurer’s ability to operate effectively.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Insurance law in New Zealand is governed by a combination of common law, statute and voluntary code.

The foundation for insurance law is the general law of contract, supplemented by insurance-specific principles, such as the doctrine of utmost good faith and the principle of indemnity.

Marine insurance is treated as a distinct subset of insurance law and is governed by the Marine Insurance Act 1908. There is no equivalent code in New Zealand relating to non-marine insurance. However, there are a number of statutes that are relevant to the terms of non-marine insurance, including the Life Insurance Act 1908, the Insurance Law Reform Acts of 1977 and 1985, and the Fair Trading Act 1986 (FTA).14

Members of the Insurance Council of New Zealand (ICNZ) also agree to adhere to the Fair Insurance Code, which is expected to be updated in 2019. The ICNZ currently has 30 members.15 The Code sets a minimum standard of service for insurers, describes the responsibilities owed between the insurer and the insured, and encourages professionalism in the insurance industry.

ii Making the contract

Essential ingredients of an insurance contract

The IPSA defines a contract of insurance as a contract involving the transference of risk and under which the insurer agrees, in return for a premium, to pay to or for the account of the policyholder a sum of money or its equivalent, whether by way of indemnity or otherwise, on the happening of one or more uncertain events.16 This definition generally accords with the position at common law.

An insurance contract generally requires an insuring clause, and must identify the property or liability to be insured and the scope of the indemnity. This information is customarily set out in the policy schedule (which contains details specific to the particular

13 IPSA, Sections 26 to 27.
14 As discussed in Section V.iii, as at March 2019 some of the provisions of these statutes are being reviewed.
16 IPSA, Section 7.
insured) and the policy wording (which sets out further details as to the nature and scope of the insurance cover, as well as claims conditions and other provisions relevant to the insurance).

**Recording the contract**

Insurance contracts are usually recorded in a written document or combination of documents (usually a policy schedule signed or stamped by the insurer, together with a document containing the policy wording). However, the only express legislative requirement is found in the Marine Insurance Act 1908, which requires that a contract of marine insurance is signed or sealed by the insurer.17

**Regulation of contractual terms**

The Life Insurance Act 1908 contains provisions relating to the assignment of life insurance policies, in relation to life policies taken out by or for the benefit of minors, and protecting the surrender value of life insurance policies if premia are not paid.

The Insurance Law Reform Act 1977 limits an insurer’s ability to avoid a policy because of misstatements by the insured, or to decline a claim in reliance on certain types of exclusions or because of non-compliance with time limits for making a claim. It also provides that arbitration clauses in insurance policies (other than those entered into by the insured in trade) are not binding on the insured.

The Insurance Law Reform Act 1985 abolishes the common law requirement for an insurable interest in policies of life insurance and indemnity (other than where the Marine Insurance Act 1908 applies). It restricts the application of ‘average’ clauses in policies for dwelling houses and allows purchasers of land and fixtures to have the benefit of the vendor’s insurance during the period between the contract of sale and settlement.

In March 2015, the FTA was amended to prohibit unfair contract terms in standard form consumer contracts. These prohibitions apply to a limited extent to consumer insurance contracts (although the legislation recognises that there are some terms that are necessary to protect the insurer and that will therefore not be considered unfair, such as provisions that identify the subject matter or risk insured, impose obligations of good faith, specify the sum insured or applicable deductible, or describe the basis on which claims are settled).

As mentioned, a review of insurance contract law is underway, which is discussed in Section V.iii.

**Statutory charge under Law Reform Act 1936**

Pursuant to the Law Reform Act 1936, any insurance that is available to meet liability to pay damages or compensation is charged (to the amount of the claim, subject only to the policy limit) in favour of the claimant from the time of the event giving rise to the claim.18 The courts have held that the effect of the charge is to prevent an insurer from advancing defence costs to the insured where to do so would erode the amount of insurance proceeds subject to the charge.19

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17 Marine Insurance Act 1908, Section 24.
18 Law Reform Act 1936, Section 9. This is also part of the review of insurance contract law – see Section V.iii.
The court decisions that clarified the application of this legislation and its impact on defence costs have resulted in significant changes to the structure of liability policies in recent years. Whereas it was previously common to issue liability policies with aggregate limits of cover for both defence costs, and damages and compensation, it is now common for insureds to purchase separate or additional defence costs cover.

**Prohibited insurance**

Certain types of insurance are prohibited by statute. For example, insurance that purports to indemnify a person for liability to pay a fine or infringement fee under the Health and Safety at Work Act 2015, or the Employment Relations Act 2000, is unlawful and of no effect.

The Companies Act 1993 contains restrictions on a company’s ability to effect insurance for its (and its related companies’) directors and employees.\(^{20}\) A company must be authorised by its constitution, and have the prior approval of its board, before effecting the insurance. A company cannot effect insurance for its directors and employees in respect of criminal liability (e.g., fines) or defence costs in respect of criminal proceedings unless the director or employee is acquitted. The directors who vote in favour of effecting the insurance must certify that the cost of the insurance is fair to the company.

Similar restrictions apply under the Financial Markets Conduct Act 2013 (in respect of conduct regulated by financial markets legislation) to ‘specified persons’ (e.g., issuers, offerers and licensees) that are not companies subject to the Companies Act 1993.\(^{21}\)

**Information provided to the insurer at placement**

The insured is subject to a general duty to disclose any material fact to the insurer.\(^{22}\) The insured’s duty of disclosure extends beyond the answering of questions specifically asked by the insurer. Failure to disclose material facts can entitle the insurer to avoid the policy. However, where an insured discloses facts that reasonably point toward the existence of further relevant facts, the insurer may be treated as having waived disclosure if it did not make further enquiries.\(^{23}\)

This duty of disclosure is codified in respect of marine insurance in the Marine Insurance Act 1908, which also expressly states that the following circumstances do not have to be disclosed in the absence of enquiries: circumstances that diminish risk; circumstances that are known or presumed to be known to the insurer; and any circumstance that is superfluous to disclose by reason of any express or implied warranty.\(^{24}\)

The House of Lords has confirmed that the duty of utmost good faith is an extra-contractual duty and therefore cannot give rise to common law damages.\(^{25}\) While the Contract and Commercial Law Act 2017 imposes a general right to damages for misrepresentation (which could provide a pecuniary remedy for a breach of the duty of

\(^{20}\) Companies Act 1993, Section 162.

\(^{21}\) Financial Markets Conduct Act 2013, Sections 526 to 530.


\(^{24}\) Marine Insurance Act 1908, Section 18.

utmost good faith), such remedies are unlikely to be available for breach of a simple failure to disclose unless it can be established that there was a positive misrepresentation that there was nothing further to disclose.

As noted above, the Insurance Law Reform Act 1977 precludes an insurer’s right to avoid a policy for misstatement by the insured unless the misstatement was substantially incorrect and material (and, in the case of life insurance policies, made either fraudulently or within three years of the date that the policyholder dies or the contract is sought to be avoided).

The scope of the insured’s duty of disclosure, and the consequences of non-disclosure, are part of the review of insurance contract law in New Zealand.

iii Interpreting the contract
General rules of interpretation

There are no special rules that apply to the interpretation of insurance contracts. Accordingly, insurance agreements are interpreted according to the general law of contract, which aims to ascertain the meaning that the document would convey to a reasonable person having all the background knowledge that would have been reasonably available to the parties at the time they entered into the agreement.

The ordinary and natural meaning of the language at issue will be a ‘powerful, albeit not conclusive’ indicator of what the parties meant, but might not be determinative if the wider or commercial context reliably shows otherwise.

The New Zealand position on the admissibility of pre-contractual communications and post-contractual conduct represents a departure from the long-standing position in England and Wales. In *Gibbons Holdings Ltd v. Wholesale Distributors Ltd*, the Supreme Court held that mutual conduct of parties after the formation of a contract could be used to construe the agreement. In *Vector Gas Ltd v. Bay of Plenty Energy Ltd*, the Supreme Court considered the extent to which preliminary negotiations could be used to aid the interpretation of a contract. The controversial decision, which resulted in four separate judgments, drew criticism for introducing undue uncertainty into contractual interpretation. While the decision in *Firm PI 1 Ltd v. Zurich Australian Insurance* re-emphasises the focus that will be given to the express wording of the particular contract, the New Zealand courts retain a greater ability than their UK counterparts to take into account pre-contractual communications as an aid to interpretation.

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28 *Investors Compensation Scheme Ltd v. West Bromwich Building Society* [1998] 1 WLR 896 (HL) at 912 per Lord Hoffman.
Intermediaries and the role of the broker

Agency/contracting

Brokers generally act as agents of the insured. However, as a result of statutory reform in the Insurance Law Reform Act 1977, a person acting for the insurer during the negotiation stage within the scope of their actual or apparent authority remains an agent of the insurer throughout that process.33 The insurer is subsequently deemed to be imputed with notice of all matters material to the contract of insurance known to this representative concerned in the negotiations before the insurance proposal is accepted.34

Commissions

Typically, a broker, who is the effective cause of placement of the risk, is entitled to remuneration on a commission basis. In practice, the amount of commission is typically agreed with the insurer (not the insured) and brokers deduct the commission from the amount of premium before passing it on to the insurer.

iv Claims

Notification

Insurance policies in New Zealand commonly include express requirements for prompt notice of claims to be given to the insurer. However, where an insurance contract prescribes a time limit within which notice of any claim must be given, the time limit will only apply where the insurer has been prejudiced by the insured’s delay (and will not be binding in respect of time limits for notification following death in life insurance policies).35 Unless the policy provides otherwise, there is no particular form in which notice must be given.

Good faith and claims

An insured is under a general duty not to make fraudulent claims. It is accepted that an insurer is under a duty to admit liability and to pay promptly, failing which there is a liability in damages for breach of an implied term of the contract to the extent that the delay is the fault of the insurer.36 In Young v. Tower Insurance Ltd, the court confirmed that a duty of good faith on the part of the insurer is implied in every insurance contract. While the court did not delineate the full scope and limits of that duty, at a bare minimum it requires the insurer to disclose all material information that the insurer knows or ought to have known and to act reasonably, fairly and transparently (in both cases, including the initial formation of the contract, and during and after the lodgement of a claim), and to process the claim in a reasonable time.37

33 Insurance Law Reform Act 1977, Section 10(1); see also Nairn v. Royal Insurance Fire & General (New Zealand) Ltd (1990) 6 ANZ Insurance Cases 60-010(HC).
34 Insurance Law Reform Act 1977, Section 10(2).
IV  DISPUTE RESOLUTION

i  Jurisdiction, choice of law and arbitration clauses

Many insurance contracts contain express jurisdiction and choice of law clauses. Some insurance contracts also contain provisions requiring any disputes to be determined by arbitration rather than by the courts. These provisions in retail insurance contracts will not be binding on an insured under the Insurance Law Reform Act 1977, unless the parties have agreed to submit a dispute to arbitration after the dispute has arisen. As discussed in Section II.vii, dispute resolution schemes, such as the IFSO Scheme, are available for retail insurance clients where disputes are not resolved through the insurer’s internal dispute resolution processes.

There are no specific limits on an arbitrator’s jurisdiction. The district court has jurisdiction to hear civil claims where the quantum does not exceed NZ$350,000. Claims that exceed NZ$350,000 are heard in the High Court.

ii  Litigation

Litigation stages
Proceedings are usually commenced by the filing and service of a statement of claim and notice of proceeding (although other processes are also available, depending on the nature of the claim). Following the filing of pleadings, the parties are usually required to complete discovery. Written briefs of evidence will then be exchanged, before a hearing at which witnesses will give evidence (and be cross-examined) and legal argument will be presented.

An unsuccessful party may, subject to the rules applicable to the court, appeal a judgment to a higher court. In some cases, this will require obtaining leave of the court.

Evidence
In civil cases, evidence is often given by way of a signed written brief of evidence (which is either taken as read or forms the basis of the oral evidence given by the witness at trial). The opposing party will have an opportunity to cross-examine the witness.

A party to proceedings can call expert witnesses. Experts must adhere to a code of conduct and may be required to confer prior to the hearing.

Costs
Generally, costs follow the event; that is, the unsuccessful party will be required to pay the costs of the successful party. Costs are often ordered on a ‘scale’ basis in accordance with applicable rates set out in the relevant rules of the court, although the court has the ability to award increased or indemnity costs in certain circumstances.

iii  Arbitration

Format of insurance arbitrations
The Arbitration Act 1996 provides the framework for the arbitration of disputes held in New Zealand. Certain provisions of the Arbitration Act 1996 apply automatically to all arbitrations governed by the Act, whereas the application of other (more procedural) rules depends on whether the arbitration is a domestic or international arbitration and whether the parties have chosen to exclude or adopt those rules.
**Procedure and evidence**

The Arbitration Act 1996 provides that parties are free to agree on the procedure of the arbitral tribunal. Failing such agreement, the tribunal has the power to conduct the proceedings in the manner considered appropriate.\(^38\) Many arbitrations in New Zealand are run in a manner very similar to court proceedings.

If the place of arbitration is outside New Zealand, with an international arbitral institution, the independent rules that govern the proceedings of that institution will apply.\(^39\)

**Costs**

Under the Arbitration Act 1996, unless the parties agree otherwise, the costs and expenses of the arbitration can be fixed by the tribunal in its award. In the absence of an award on costs, each party will bear their own expenses and will share the cost of the arbitral tribunal in equal parts.

**iv Alternative dispute resolution**

Mediation is a commonly utilised disputes resolution process in New Zealand whereby parties seek to resolve their dispute by agreement with the assistance of an independent facilitator. The District Court Rules 2014 also encourage parties to attempt to resolve disputes by agreement by utilising the judicial settlement conference process available through the courts.

**V YEAR IN REVIEW**

**i Regulatory supervision**

The year 2018 saw an increased focus by regulators on conduct and culture in the financial services industry generally, in light of the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry. In parallel with a similar review of New Zealand’s retail banks, the RBNZ and the FMA have been undertaking a review of the conduct and culture within life insurers. A report was released in January 2019, with individual feedback given to each reviewed life insurer. The report set out the regulators’ findings in respect of life insurers, focusing on customer outcomes, conduct and culture governance, conduct and culture risk management, and issue identification and remediation. Insurers have until 30 June 2019 to develop a plan to address the feedback and report back to the RBNZ and the FMA.\(^40\) As a result of these reports, the government announced a consultation on the regulation and conduct of financial institutions (to be released by May 2019), with legislation to be introduced in the second half of 2019.\(^41\)

In November 2018, CBL Insurance Limited (CBL) was placed into liquidation on application by the RBNZ, on grounds including that CBL was in breach of its required

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38 Arbitration Act 1996, Schedule 1, Clause 19.
solvency regime and had failed to comply with the RBNZ’s directions. An independent review of the RBNZ’s supervision of CBL has been commissioned to identify lessons for the RBNZ and implications for the insurance regulatory regime. The review aims to provide an independent and expert perspective on how best to strengthen the regulatory and supervisory framework for the future, and in particular will (1) identify any shortcomings and positives in the RBNZ’s supervisory practices and its critical judgements, (2) identify any constraints or areas for enhancement in the legislative and regulatory framework in which the RBNZ was operating, and (3) help key stakeholders and the wider public understand the RBNZ’s role and activities as a prudential supervisor.

Separately, the FMA released a report in July 2018 on ‘replacement business’ in the life insurance industry by QFE providers, where policies were shifted from one provider to another.42 This report found that there were significant discrepancies in processes among the individual QFEs, and that generally there was insufficient acknowledgement that replacement business represents conduct and customer risks for businesses that need to be managed effectively.

ii Natural disaster

Natural disasters and climate change continue to be a major factor in the insurance industry. The ICNZ has announced that insurers have spent more than NZ$226 million in recoveries from extreme weather in 2018. This makes 2018 just short of the record set in 2017 of NZ$242 million, and is seen as an indicator of the increasing frequency and intensity of storms in New Zealand. The ICNZ refers to the need to adapt to the changing climate in order to reduce the costs of adaptation and impact of these weather events.43

The effects of the Canterbury earthquakes in 2010 and 2011 are still ongoing. The Canterbury Earthquakes Insurance Tribunal Bill was introduced to Parliament in August 2018 and, at the time of writing, is before the Governance and Administration Committee. This Bill establishes a tribunal to provide speedy, flexible and cost-effective services to help resolve insurance claims in relation to the Canterbury earthquakes between policyholders and insurers, and insured persons and the Earthquake Commission.

On 12 November 2018, a public inquiry into the Earthquake Commission’s operational practices and its approaches to claims outcomes in relation to the Canterbury earthquakes, and subsequent events including the Kaikoura earthquake in 2016, was announced. The inquiry is to report back by 30 June 2019.

The Fire and Emergency New Zealand Act 2017 (the FENZ Act) was passed in July 2017, consolidating the New Zealand Fire Service, the National Fire Authority and rural fire authorities into one organisation: Fire and Emergency New Zealand (FENZ). Controversially, given the global move away from funding emergency services through levies on insurance, FENZ is funded solely by levies on insurance premiums. The new levy regime broadens the levy base to include any contract that insures property against physical loss (rather than being limited to insurance against fire damage) and is expected to see a general increase in insurance


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costs. The FENZ Act came into force on 1 July 2017 (and existing levies have already been increased), but after criticism from the insurance industry the new levy regime has been further delayed until 1 July 2019.

iii  Insurance contract law review

In May 2018, the Ministry of Business, Innovation and Employment (MBIE) released an issues paper as part of its review and proposed reform of New Zealand’s insurance contract law. The proposed key objectives of the review are to ensure insurers and insureds are able to transact with confidence at all points in the life cycle of an insurance policy, and that interactions between insurers and insureds are fair, efficient and transparent at all points in the life cycle of an insurance policy. The review also includes the existing legislation in relation to insurance. Submissions on the issues paper closed on 13 July 2018. It is anticipated that the MBIE will be releasing an options paper with more specific details of proposed reform in 2019.

iv  Liability for hiring replacement vehicles

The scope of potential claims under motor vehicle insurance policies was expanded in 2018 in *Blumberg v. Frucor Beverages Limited.* In this case, a ‘not-at-fault’ driver lost the use of their vehicle as a result of an accident caused by an ‘at-fault’ driver. The High Court found that an at-fault driver (and, therefore, the driver’s insurer) should bear the reasonably incurred costs of hiring a replacement vehicle while the vehicle of a not-at-fault driver is being repaired.

VI  OUTLOOK AND CONCLUSIONS

New Zealand is likely to see considerable legislative changes in insurance regulation and insurance contracting in the short term. Given the RBNZ and FMA report on life insurers, a key focus moving forward will be on conduct regulation, consumer protection and confidence in the insurance sector.

New opportunities for technology-based innovation (insurtech) are also expected to have a considerable impact on the insurance market over the next year. However, given the regulatory changes anticipated in New Zealand, monitoring and full participation in these developments will be important for all participants in the insurance industry.

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45  *Blumberg v. Frucor Beverages Limited* [2018] NZHC 1876.
I INTRODUCTION

The Portuguese insurance and reinsurance market is based on a developed industry, and is supported by:

a. an established insurance tradition and market acceptance;

b. a relevant display of compulsory insurances; and

c. the presence of large national and international financial groups in the sector, and of several of the major international insurance companies and insurance intermediaries in the market.

Life insurance distribution is still mostly performed through banks, acting as intermediaries. Despite this, life insurance, investment products and pension funds schemes have been gathering more acceptance and relevance in the market.

With regard to non-life insurance, compulsory insurance products make up the bulk of the operations. They mainly concern civil liability products; however, there are large portfolios of health, damage and loss insurance products in the market, mainly placed through banks and big retailers, acting as intermediaries or under the connected contract exemption.

Despite this, new products have become more popular, such as bond insurance, investment products and cyber insurance products.

The legal framework enjoys some stability and benefits from acts being updated and adapted fairly frequently. The Insurance and Reinsurance Access and Exercise Legal Framework Act (the Insurance Legal Framework), which is the main piece of legislation, entered into force in 2016 (last updated in 2018); and the Insurance Contract Legal Framework Act (ICLF), which establishes the general framework on insurance contract execution and performance, entered into force in 2009 and was last updated in 2015. Notwithstanding this, the market operators and the legal framework are adjusting to several pieces of EU legislation that became applicable from the second half of 2017 to the second half of 2018, in particular: Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 (the Insurance Distribution Directive (IDD)), and Regulation (EU) No. 1286/2014 of the European Parliament and of the Council of 26 November 2014 on key information documents for packaged retail and insurance-based investment products (the PRIIPs Regulation).
II REGULATION


The general provisions on prudential and market behaviour regulation are set forth in the Solvency II transposing act and the Insurance Legal Framework.

The Portuguese Insurance and Pension Funds Supervisory Authority (ASF) is the main supervisory and regulatory authority related to prudential and market conduct rules compliance by insurance and reinsurance undertakings and intermediaries, covering both the access and the pursuit of insurance and pension funds distribution in Portugal, or in EU territory when the activity is pursued by Portuguese companies and persons.

The ASF is also the supervisory and regulatory authority concerning market conduct rules for insurance-based investment products and open pension funds distribution.

Although the Ministry of Labour, Solidarity and Social Security supervises the distribution of provident and mutual benefit products similar to insurance products, where they are provided by authorised provident and mutual benefit institutions, the ASF shares the supervision over provident and mutual benefit institutions whose quotas or financing funds surpass the amounts determined in the new Mutual Benefit Institutions Code approved under Decree-Law 59/2018 of 2 August 2018.

i Position of non-admitted insurers

Only authorised insurance undertakings and authorised provident and mutual benefit institutions can provide insurance and similar products in Portugal.

According to the Insurance Legal Framework, the provision of insurance products or insurance schemes by non-authorised insurers is a crime punishable by a sanction of up to five years in prison or a fine.

Furthermore, the company that commits the infraction may be subject to compulsory administrative liquidation, and the company and the persons involved may be subject to a five-year prohibition on insurance activities.

ii Position of brokers

Insurance and reinsurance mediation was governed by Decree-Law 144/2006 of 31 July 2006 (the Insurance Mediation Law), and by the ASF’s Regulation 17/2006-R of 29 December 2006, both implementing the rules set forth by Directive 2002/92/EC (the Insurance Mediation Directive), although the market commenced the gradual implementation of the IDD rules transposed through the Insurance and Reinsurance Distribution Legal Framework (IRDLF), approved through the Law No. 7/2019 of 16 January.

The legal and regulatory framework establishes three types of insurance mediators: brokers, who are fully independent insurance mediators; agents, who are insurance mediators that pursue mediation in the name of and on behalf of one or more insurance undertakings; and insurance intermediaries, who are ‘tied insurance mediators’ as defined under the Insurance Mediation Directive.

The different types of mediators are subject to different rules pertaining access to the market, namely those regarding prudential requirements and authorisation procedures, as well as regarding market conduct.
iii Requirements for authorisation

The ASF is responsible for the authorisation and registration of Portuguese insurers, reinsurers and brokers, as well as for the authorisation and registration of foreign insurers, reinsurers and brokers established or providing services in Portugal, and some provident and mutual benefit institutions.

Authorisation is required for any creation or implementation measure. There are several prudential conditions that must be complied with in order for the authorisation to be provided, covering the type of company, system of governance, funds, fit and proper requirements and other aspects.

The ASF authorises insurers to render services regarding specific types of cover. Therefore, insurers must appoint the types of cover that they propose to distribute, and prepare the application and respective submission documents accordingly. Insurers may request alterations to their authorisation, which, if minor, do not require further authorisation, although they may require a notification to the ASF.

EU insurers, reinsurers and brokers enjoy EU passporting rights, which provide a simplified procedure for access to the Portuguese market and other EU markets via freedom of establishment and freedom to provide services rights.

EU companies providing services in Portugal under the right of establishment or freedom of services (FOS) are subject to market behaviour rules set forth in Portuguese law, as well as other general interest conditions concerning compulsory insurance provisions, such as claims handling procedures and other aspects of insurance distribution. Most of the prudential regulation rules are set forth by the principal company legal and regulatory framework, although the ASF must be notified of relevant alterations that may have an impact on Portuguese market sustainability or the conditions for the rendering of services in Portugal.

However, EU companies accessing the Portuguese market under FOS must appoint a claims representative who must reside or be established in Portugal, and, when providing motor liability insurance, EU companies must also become associated with the Portuguese Green Card Bureau.

iv The distribution of products

Portugal has only approved the laws, regulations and administrative provisions necessary to comply with the IDD in 2019. Nevertheless, the market commenced adjusting to the preliminary IDD transposition draft law (the IDD Draft Law) released by the ASF in 2018.

The IDD Draft Law authorises the ASF to approve and publish the regulations deemed necessary in order to duly and fully transpose the IDD, but no draft regulation has been disclosed so far.

The IDD Draft Law and the IRDLF establish new rules concerning insurance products approval, adequacy assessment and distribution, and information requirements, including information on intermediaries’ fees and the obligation to deliver the insurance product information document. They also set new rules regarding authorisation procedures and requirements, system of governance, fit and proper requirements, and conflict of interest rules.

Finally, the IRDLF alters the previously existing connected contract exemption (CCE), setting less restrictive rules for the applicability of the new ancillary insurance intermediaries exemption conditions set forth in Article 1(3) of the IDD.
v Compulsory insurance

The non-life insurance market in Portugal is based on compulsory insurance products. There are dozens of compulsory insurance products, including classes (as defined under Solvency II) for accident; fire and natural forces; other damages to property; motor vehicle liability; and suretyship.

Under the Insurance Legal Framework and the ICLF, compulsory insurance products distributed in Portugal are subject to the applicable Portuguese legal and regulatory provisions concerning the compulsory insurance.

The insurer must deliver the terms and conditions of any compulsory insurance in the Portuguese language, unless the parties agree that it shall be worded in another language and the policyholder requires the delivery of the policy in another language.

The ASF has the power to issue standardised policies and command any insurer to comply with these standardised policy terms. Insurers are obliged to register the general terms and conditions of any compulsory insurance products with the ASF, which in return must declare whether the terms and conditions are compliant with the applicable rules.

Furthermore, insurers offering compulsory insurance distribution in Portugal by way of FOS are required to appoint, register with the ASF and divulge the identity of a claims representative and a client ombudsman, both of which must be resident or established in Portugal.

vi Compensation and dispute resolution regimes

Under the Insurance Legal Framework, the ASF is responsible for any mitigation, recovery or liquidation process concerning insurance and reinsurance companies. Despite this, there is no general compensation regime for the event of an insurer or a mediator bankruptcy.

Nonetheless, there are several applicable compensation and dispute resolution regimes concerning specific insurance products, such as motor insurance and accidents at work and occupational diseases insurance, which cover any payments owed by the insurer to the insured person or company, the beneficiary or the injured party.

Regarding motor insurance, the Portuguese Motor Insurance Legal Framework, approved under Decree-Law 291/2007 of 21 August 2007, established the Motor Insurance Guarantee Fund, to which all insurers that provide motor insurance in Portugal must contribute. It is responsible for compensating for damage suffered by the injured persons whenever the person liable for the damage caused by a motor vehicle is unknown, fails to comply with the obligation to enter into a valid compulsory motor insurance or, for some reason, is exempt from this obligation.

Insurers do enter into non-binding compensation regimes, in order to expedite claim-handling and payment. The most relevant example is the Insured Person Direct Liquidation Protocol (the Liquidation Protocol), applicable, under certain requirements, when the persons involved in a motor vehicle accident between two vehicles duly covered by motor insurance contracts agree on the circumstances of the accident, and under which the insurer of the injured party directly compensates the damage suffered and subsequently obtains reimbursement from the insurer of the liable persons.

As established under the Liquidation Protocol, any dispute arising between insurers concerning the interpretation and execution of the compensation regime shall be committed to arbitration.

The existing general and mandatory dispute resolution regimes are applicable to disputes opposing insurers and policyholders, insured persons, beneficiaries or injured parties, and, as such, will be addressed below.

vii Proposed changes to the regulatory system
There is an ongoing discussion regarding the necessity of a new financial supervisory and regulatory structure, and the general principles and positions that should be followed on this matter.

For the time being, there are no final decisions on a new financial supervisory and regulatory structure. The current structure comprises three authorities, the ASF, the CMVM and the Bank of Portugal, and a consultation and coordinating entity, the National Council of Financial Supervisors. The Financial Supervision Reform Working Group favours the substitution of the current sectorial supervision with a twin-peaks supervision model, where insurance, banking and securities market behaviour supervision would be assumed by a single authority.³

The CMVM’s supervisory and regulatory functions pertaining to market conduct rules for insurance-based investment products and open pension funds distribution have been transferred to the ASF, which also has supervisory and regulatory responsibilities for some significant provident and mutual benefit institutions. Considering these proposed changes, it is expected that the ASF will regulate insurance distribution, particularly concerning insurance-based investment products, open pension funds, and provident and mutual benefits in 2019.

III INSURANCE AND REINSURANCE LAW
i Sources of law
The Portuguese legal framework is based on statutory law. There are no binding case law precedents, and customary law is subject to highly restrictive requirements.

There are several insurance contracts ruled under specific statutes, such as motor liability, bond and credit, and marine insurance contracts. Despite this, the basic insurance law framework is set out in the ICLF as amended, approved under the Decree-Law 72/2008 of 16 April 2008, which establishes the general rules regarding insurance contracts, specific rules applying to damages and personal insurance, and several special rules applying to certain covers.

The ICLF shall apply to any insurance contract regulated under specific legislation, and, whenever the ICLF does not cover the subject matter, the Civil Code and the Commercial Code shall apply.

There are also several ASF and CMVM regulations establishing relevant provisions concerning insurance contracts, notably the ASF regulations on compulsory insurance standardised policies.

ii Making the contract

The ICLF does not define the concept of an insurance contract, although it expressly determines that should be a contract through which the insurer undertakes to perform the agreed obligation (which might be a pecuniary charge) in the event of a specified uncertain future event (although Portuguese law admits past events to be covered, under very strict requirements). The policyholder undertakes the obligation to pay the premium (which will always consist of a pecuniary charge that can be paid through cash, bank cheque, postal order or payment services transactions).

The making of the contract commences with the provision of legally and regulatory compliant pre-contractual information to the policyholder, as well as any information and clarifications that might be necessary for the policyholder to comprehensibly understand the contract. Whenever the insurer is distributing an investment product, it must also provide the policyholder with the key information document.

The policyholder is required to file and deliver to the insurer a contractual proposal with the information considered necessary by the insurer. In contrast to other countries’ legislative frameworks, according to the ICLF, the policyholders are subject to a pre-contract obligation to provide the insurer with any information that the policyholder is aware of and can reasonably find relevant for the insurer to evaluate the risks to be covered, regardless of whether this information is expressly requested by the insurer.

Whenever the policyholder delivers to the insurer or the broker the filed contractual proposal and any other required information and documents, the insurer has 14 calendar days to accept, deny or require any further information or documents. The omission of any action determines the contract to be considered accepted.

After the contract is entered into by the parties, the insurer is required to issue and deliver the insurance policy to the policyholder immediately (or in 14 calendar days, when the insurance is a ‘mass-insurance’ contract), worded under specific legal and regulatory requirements, comprising all the contractual terms. The policyholder has 30 calendar days to submit any complaint regarding the insurance policy. After this period has elapsed, the insurance policy is considered to validly reflect the parties’ agreement, and this assumption can only be challenged with written documents containing divergent information.

The Insurance Legal Framework requires the insurer to number the contracts and maintain an insurance and investment products electronic register, containing information on the parties and in the contract itself.

iii Interpreting the contract

Although the contract may be concluded in any form the parties choose, the insurer must always issue and deliver the insurance policy, which will serve as the basis for the contract interpretation. Nevertheless, insurance contracts are normally construed under general terms and conditions proposed by the insurer.

Insurance contract interpretation should be based on the insurance policy and should be construed objectively, with the meaning that a normal policyholder in the conditions of the specific policyholder would give to the terms. However, under the rules applicable to general terms and conditions, dubious terms shall be interpreted in the most favourable way for the policyholder.

Insurance policies usually contain three sets of terms and conditions: general terms, special terms (setting specific rules on certain covers, premium payments or other items of the contract) and particular terms (‘schedule’), which comprehend the concrete aspects of the
insurance contract, such as the identity of the policyholder, insured persons and beneficiaries, the premium amount or calculous method, the insured good, the insurance period or the insured amount. Special and particular terms cannot change the nature of the cover as determined by the insurance type.

General terms and conditions declared null in judicial courts are registered and divulged so that claimants and insurers are informed of the judicial interpretation. Although there is no case law precedent in Portugal, decisions involving insurance contracts clauses are considered by insurers when drafting new terms and conditions.

iv Intermediaries and the role of the broker

Portuguese Law allows for three types of registered insurance mediators, as well as non-registered intermediaries acting under the Insurance Mediation Directive CCE.

Insurance mediators can act on behalf of the insurer or on behalf of the policyholder. When doing so, the mediator must comply with the information obligations that the party he or she represents is subject to.

Alongside this, the Insurance Mediation Law provides a number of conduct rules for insurance mediators, such as:

a. the obligations to provide information to clients, insurers and the ASF;

b. the prohibition to intermediate the conclusion of insurance contracts that fail to comply with any legal or regulatory rules;

c. the obligation to act accordingly with the orders received, namely from the policyholder, and to render accounts;

d. the obligation to keep a record of the contracts that he or she has intermediated; and

e. a prohibition on imposing an insurance contract crossed sale.

The intermediary is subject to the anti-money laundering (AML) prevention obligations set forward in EU and Portuguese law and, as such, must comply with the applicable customer due diligence measures.

Although an intermediary does not necessarily assume the representation of one of the parties in the insurance contract, whenever it acts in the name of the insurer or of the policyholder, any communication that might be delivered to it is considered to have been delivered directly to the party it represents.

In the event of a false representation, the actions performed by or through the intermediary are deemed contractually ineffective, although the insurer can ratify the performed actions. Despite this, the ICLF establishes that an insurance contract entered into through an intermediary that has presented itself as acting in the name of an insurer can be binding to the insurer, provided that there are objectively valid and acceptable reasons to sustain the policyholder’s belief in the intermediary’s good faith and legitimacy, and if the insurer has in any way contributed to the formation of such conviction.

v Claims

Under the ICLF, the policyholder, the insured person and the beneficiary must present any claim to the insurer within eight calendar days of becoming aware that the insured event has occurred, or in a wider period determined in the insurance contract.

The claimant must state the causes, circumstances and consequences of the event, as well as render to the insurer any clarifications that it might request.
The ICLF does not establish a specific consequence for failure to present the claim in the given period, but the insurance contract may establish the reduction of the due instalment according to the damage suffered by the insured because of the delay. The contract may also determine the exclusion of coverage whenever the delay is wilful and causes significant damage to the insurer. However, these contractual terms cannot be opposed (1) when the insurer has taken knowledge of the event or (2) in any circumstances, to injured persons in order to prevent payment of instalments due under civil liability compulsory insurances contracts.

The insurer must pay within 30 calendar days of having determined the causes, circumstances and consequences of the claim. To ensure correct and fair claim handling and overall market behaviour by the insurer, Portuguese law imposes the obligation to create, register, implement and divulge claim and complaint policies.

There are also several provisions established in the law to guarantee that the policyholders, insured persons, beneficiaries and injured persons are aware of their rights, with emphasis on motor insurance or life insurance products and schemes registers.

The ICLF determines that the pre-contractual document and the insurance policy must indicate the claim presentation procedures and channels, as well as the procedures and channels for presenting complaints regarding claim handling by the insurer.

Insurers also have an obligation to appoint a client ombudsman to serve as an appeal instance regarding claim-handling disputes.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

The general rules on international jurisdiction are set out in Articles 10 to 16 of EU Regulation No. 1215/2012 of the European Parliament and of the Council of 12 December 2012, on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (recast).

Portuguese law states that the injured party whose damages are covered by a liability compulsory insurance can always bring actions directly against the insurer or be joined in proceedings held against the insured. These possibilities are extended to liability non-compulsory insurance when the insured has previously informed the injured party on the existence of the insurance, and the injured party and the insurer have commenced negotiations.

In some cases (e.g., insurance contracts covering large risks), the parties are allowed to commit the dispute to a different jurisdiction, although the requirements for a valid choice of jurisdiction are narrow.

The general rules on choice of law are set out in Article 7 of the Rome I Regulation, and in Articles 5 to 10 of the ICLF.

Insurance contracts covering large risks are governed by the law chosen by the parties, or, in the absence of choice, by the law of the country where the insurer has its habitual residence, unless the contract is manifestly more closely connected with another country, in which case the law of that country shall apply.

Other insurance contracts are governed by the law chosen by the parties, although the parties can only choose from certain specified laws.

In the absence of a valid choice of law, the insurance contract shall be governed by the law of the Member State in which the risk is situated at the time of conclusion of the contract.
There are three provisions of the ICLF that establish rules of the upmost importance with regard to choice of law:

a. the ICLF determines that consumer protection mandatory rules are to be considered as overriding mandatory provisions;
b. compulsory insurance is governed by Portuguese law; and
c. regardless of whether they are covered by Portuguese law, insurance contracts offering cover that is forbidden in Portugal are null.

When contracts are submitted under Portuguese law, the ICLF allows the parties to commit the dispute to arbitration, whatever the type of insurance, cover or claim.

ii Litigation

Most disputes arising from an insurance contract interpretation or execution demand a judicial review of the circumstances and, therefore, demand a declarative proceeding to be held.

Portuguese law establishes specific proceedings and jurisdiction for claims against public and private persons or entities regarding their liability for acts and omissions in the exercise of state authority. Other civil proceedings are regulated under the general provisions of the Portuguese Civil Procedure Code. Nonetheless, all declarative proceedings are adversarial and comprehend mandatory mediation phases held by the trial judge.

Generally, the burden of proof relies on the plaintiff and written evidence does not bear higher evidential value than other types of evidence. However, written evidence tends to supersede oral evidence.

The parties can appeal the decisions before the higher court and, under certain circumstances, before the Supreme Court of Justice. Final decisions are directly enforceable.

Portugal has successfully diminished the duration of proceedings by creating the CITIUS platform, an internet platform through which proceedings actions concerning almost all civil proceedings must be performed. Despite this, civil proceedings are still perceived as costly for natural persons. To reduce the negative impact, the law establishes higher court costs for mass litigators and establishes that the winning party can demand that the losing party reimburse the incurred costs.

iii Arbitration

Law 63/2011 of 14 December 2011 establishes the general rules on voluntary arbitration. Parties can submit disputes arising from insurance contracts to arbitration, although the arbitration, when applied to consumers, cannot diminish consumers’ procedural guarantees as provided by state proceedings.

A valid arbitration clause prevents the parties from submitting the dispute to state jurisdiction if they fail to agree on the submission, and the arbitration decision is enforceable, although the parties can appeal the decision before state courts.

Insurance arbitration is fairly well developed in Portugal. The most representative private insurance arbitration centre is the Centre for Insurance Information, Mediation, Ombudsman and Arbitration (CIMPAS), which settles disputes concerning motor insurance, and, up to certain claim amounts, multi-risk and civil liability insurance. It may settle disputes arising from other types of insurance, with the exception of large-risk insurance. In addition, it does not settle disputes arising from events that have not occurred in Portugal or that have resulted death or permanent disability.
The arbitration is always preceded by a mandatory mediation phase, which is usually expedited (three to six months until the final decision), and the arbitration fees are settled as 3 per cent of the claim amount.

iv Alternative dispute resolution
The most significant alternative dispute resolution (ADR) system is the client ombudsman, which serves as a voluntary instance to which policyholders, insured persons, beneficiaries and injured parties can appeal claim-handling decisions and actions taken by the insurers.

Any insurer that provides services in Portugal must create, implement, register and divulge a client ombudsman policy, and appoint a client ombudsman habitually resident or established in Portugal.

Other than the client ombudsman, the law and the insurance market have established, developed and implemented arbitration and mediation systems that have been increasingly embraced by insurance claimants.

v Mediation
Law 29/2013 of 19 April 2013 establishes the general rules on civil and commercial mediation. Under its provisions, parties can only submit to mediation disputes concerning material interests, and the submission of disputes to mediation is always based on free and informed consent by the involved parties, that the parties can retract at any time and by any cause. Nevertheless, if the parties agree on the mediation, the decision is enforceable through state courts.

Voluntary mediation is developing in Portugal as consumers become more aware of the existence of state-held and private mediation centres, such as the mediation centre provided by justices of the peace and CIMPAS.

Portuguese declarative proceedings have a mandatory mediation phase, led by the trial judge before the trial hearings.

V YEAR IN REVIEW
The Portuguese insurance and reinsurance market grew consistently throughout 2018, although it had to adjust to the Fourth Anti-Money Laundering Directive (4th AML Directive), the PRIIPs Regulation, the IDD and the General Data Protection Regulation, in a time-consuming and resource-intensive process that is still underway.

The exposure of insurance companies to foreign financial markets and the broad restructuring of European insurance companies and banks has continued to determine portfolio sales and mergers and acquisitions (M&A) operations between insurance undertakings. This is expected to continue in the coming years and will result in more concentration in the Portuguese market.

The insurance industry is based on mandatory insurance products and banking operations-related insurance products, which means that many of the most relevant life insurance companies in the Portuguese market are part of larger financial corporate groups and have banks as their main distributors.

Regarding non-life insurance companies, the main players have a large number of compulsory insurance products.
The relevance of compulsory insurance products and the concentration of the market on non-life insurance brings some risks – the Portuguese Competition Authority has initiated proceedings against five insurance undertakers for alleged constitution of a cartel aimed at market share and price-fixing.

VI OUTLOOK AND CONCLUSIONS

The year 2018 was exceptionally challenging for insurance undertakings and distributors as regards to their respective adjustments to the EU and Portuguese insurance legal and regulatory frameworks, in a process that will continue throughout 2019.

As mentioned in Section V, the implementation of the 4th AML Directive, the PRIIPs Regulation, the IDD and the GDPR have introduced significant changes to insurance undertakings and distributors market-behaviour rules, requiring demanding operations, policies, procedures, terms and conditions, marketing strategies and documentation, and distribution arrangements, which means they must be reviewed and restructured.

In addition, the prudential and market-behaviour supervisory and regulatory powers of the ASF will require the authority to accommodate the supervision and regulation of new matters previously subjected to the CMVM or the Ministry of Labour, Solidarity and Social Security.

Therefore, market operators will have to continue to adjust to the regulatory provisions during 2019.

However, despite the above, the Portuguese insurance market is consistently growing and attracting international players. M&A activity and portfolio sales are expected to continue throughout 2019. There are also expected to be innovations regarding insurtech, namely risk management, predictive models, fraud prevention, and marketing strategies and procedures.
I INTRODUCTION

In the past, the Spanish insurance and reinsurance industry was very fragmented and weak, and did not have the financial capacity to cover the risks of the market. Consequently, the risks were largely ceded abroad and local insurers fronted for foreign carriers. This changed slowly following an extensive restructuring and consolidation in the 1980s, and there are now Spanish players competing in the international market.

This financial weakness led to the creation of the Insurance Compensation Consortium, a wholly state-owned entity whose main task is to cover what are known as extraordinary risks.

The legal system endeavours to protect consumers while participants on equal negotiating terms are not subject to the otherwise mandatory insurance provisions concerning those risks classified as large risks.

Generally speaking, the insurance industry is heavily regulated and supervised.

II REGULATION

i The insurance regulator

Law 20/2015 of 14 July, on regulation, supervision and solvency of insurance and reinsurance entities (Law 20/2015) entered into force on 1 January 2016. At the same time, the Regulation and Supervision of Private Insurance Act 2004, was abrogated, except for a few provisions that are still in force.

Responsibility for the day-to-day regulation of insurance and reinsurance business conducted in Spain is delegated to the Directorate-General for Insurance and Pension Funds (DGIPF), which is a division of the Ministry for the Economy and Business.

The main focus of the DGIPF is control of insurance activities, solvency, the competence and suitability of the directors and certain other senior managers, the appropriateness and robustness of the systems and controls that the insurer has in place for the conduct of its business, the administrative protection of the insured, beneficiaries, injured third parties and participants in pension plans through the attention and resolution of complaints, and the inspection and sanction of certain infractions.

Other areas such as policy terms and wordings, technical issues and the rate of premiums and commissions are more lightly regulated and are not subject to authorisation or filing, although the DGIPF may require insurers to submit this information at any time.

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1 Jorge Angell is the senior partner at LC Rodrigo Abogados.
European Economic Area (EEA) insurers operating in Spain either by way of establishment or providing services are subject to the disciplinary power of the DGIPF in coordination with the relevant EEA supervisory authority.

ii  Position of non-admitted insurers

Policies issued by non-authorised insurers are null and void by law. However, the effects can differ from the general civil rules on nullity of contracts: if no loss has occurred, the insured is not required to pay the agreed premium or has the right to recover any premium paid. However, if a loss that would otherwise have been covered had the policy been valid occurs before the premium is returned, the non-authorised insurer may keep the premium, but would be required to pay an indemnity, the quantum of which would be determined in accordance with the void policy terms. The insured may also claim any other relevant damages sustained by reason of the void policy. Both the company and the directors or officers that permitted the policy to be issued shall be jointly and severally liable for those obligations.

iii  Position of brokers

Insurance and reinsurance brokers are wholly independent intermediaries between purchasers of insurance and reinsurance, on the one hand, and insurers and reinsurers, on the other.

Insurance and reinsurance brokers are required to be registered in the administrative register that covers insurance and reinsurance intermediaries, reinsurance brokers and senior management, which is administered by the DGIPF. It is not an authorisation proper, but a formal requirement to be able to carry out their activity. See Section III.v.

iv  Requirements for authorisation

Insurers or reinsurers based in the EEA who are duly authorised to write business in their countries will be entitled to carry out business in Spain under either the freedom of establishment regime (as a branch) or the freedom to provide services regime (FOS) subject to complying with the EU notification procedure. In both cases, they must abide by the regulations dictated by Spain, as the host Member State, for reasons of the general good, as well as the applicable regulatory rules. To set up an insurance branch, it is necessary that the DGIPF, after the EU appropriate notification procedure has been completed and all other applicable requirements have been met, enters the branch office on the Administrative Register of Insurance Entities. Further, the branch office must be recorded with the Companies Register.

However, reinsurance companies willing to write business in Spain may do so both by setting up a branch in Spain or under the FOS regime without being required to obtain any prior administrative authorisation or give any prior notification to the DGIPF.

Foreign insurers and reinsurers other than EEA companies are required to obtain an authorisation from the Ministry for the Economy and Business if they wish to set up a branch in Spain.

v  Regulation of individuals employed by insurers

Generally, individuals employed by insurers are subject to the same rules as any other employee, namely the Workers’ Statute 2015 and the relevant collective bargaining agreement, if any.
There is a specific collective agreement for insurance and reinsurance companies. The system is highly protective of employees although the rules have been somewhat relaxed by the current government.

vi The distribution of products
EEA insurers who write business in Spain under the FOS regime may distribute their products through brokers and underwriting agencies, with the exception of local agents because the agent’s activities could lead to the conclusion that the insurer has a permanent presence in Spain, in which case it would have to comply with the rules on establishment. This is not incompatible with the insurer equipping itself with some form of infrastructure in the host Member State to render the services in question (expert adjusters, legal advice, canvassers, a permanent structure for collecting the premiums or receiving notices of claims, etc.).

EEA insurers operating under the FOS regime may advertise their services in Spain in the same way that Spanish insurers can, and are subject to the same regulation and supervision.

vii Compulsory insurance
There are a number of forms of compulsory insurance including third-party motor insurance, air navigation, 10-year building cover, travel insurance and professional liability (for auditors, lawyers, engineers, architects, etc., if they practise in professional firms). Civil liability insurance is required to own or use certain properties (e.g., recreational and sports boats and personal watercraft); to keep potentially dangerous animals (e.g., dogs); to obtain authorisation for certain business activities (e.g., sea transportation, travel agencies, public shows and leisure activities, exploration, prospecting and exploitation of hydrocarbons, installation or maintenance services of telecommunications equipment or systems); and for many other activities.

viii Compensation
The Insurance Compensation Consortium (ICC) is in charge of the winding up of insurance companies with the ICC undertaking the role of liquidator, in the cases set forth by Law 20/2015 and by the ICC Statute approved by Royal Legislative Decree 7/2004 of 29 October, as amended.

The main goal of the winding-up proceedings as handled by the ICC is the timely payments of the creditors’ rights under the relevant insurance policies (the insured, beneficiaries and injured third parties). The ICC purchases the creditors’ rights in accordance with the foreseeable net liquidation balance without having to wait for the winding-up procedure to be completed. Payments are made with the ICC’s resources and then the ICC is subrogated to the creditors’ rights. Any recoveries will belong to the ICC. This is a significant improvement on ordinary insolvency proceedings.

ix Dispute resolution regimes
Section 97 of Law 20/2015 provides for dispute resolution mechanisms in insurance matters. These are litigation, arbitration (subject to certain limitations in the case of consumers), and mediation. See Section IV.

In addition, pursuant to Section 97, insurers are required to receive and resolve any claims and complaints of the insured. Insurers operating under the FOS regime are not
required to set up a customer service department in Spain. It would be sufficient to provide to the insured full details of the insurance broker or the underwriting agency (i.e., the place where such complaints can be sent).

The insurer may appoint a customer ombudsman – either an entity or recognised independent expert – who shall handle and resolve the claims and complaints submitted to it. If this is the case, the policy must provide the address and the email of the customer ombudsman. The DGIPF should be informed of this appointment.

The insurer or the customer ombudsman must respond to a complaint within two months from the date it is filed. After this period has elapsed, if the insured’s claim or complaint is not answered or is dismissed, the claimant can submit a complaint to the complaints service of the DGIPF. The policy must indicate the insured’s right to proceed in this way.

x Taxation of premiums

There is an insurance premium tax (IPT) that currently amounts to 6 per cent of all premiums collected in Spain in non-exempt lines. The IPT is ultimately paid by the insured but the insurer is required to collect and deliver it to the Treasury. For this purpose, the insurer must file returns on a periodical basis (monthly plus one annual summary).

The following transactions are exempt from the IPT:

a those related to the compulsory social security insurance and collective insurances for alternative systems to pension plans and pension funds;

b life insurance;

c capitalisation operations based on actuarial techniques;

d reinsurance operations;

e surety;

f export credit insurance;

g insurance operations related to international transport of goods or passengers;

h insurance operations related to international shipping or air travel, with the exception of private navigation or aviation for leisure purposes;

i insurance operations of medical care assistance and disease; and

j operations related to insured prevision plans.

Insurers are also required to pay to the ICC a levy or surcharge of 0.15 per cent on all premiums for the insurance of risks located in Spain other than premiums for life and export credit insurance, which is intended for the financing of the winding up of insurance companies.

Finally, insurers are required to collect from the insured and turn over to the ICC a tariff (in fact a premium) for the coverage of extraordinary risks. This tariff is paid on certain lines only.

The levies and tariffs payable to the ICC are ultimately payable by the insured but the insurer is directly liable to the ICC.

xi Proposed changes to the regulatory system

In January 2016, the European Council adopted the Insurance Distribution Directive (Directive 2016/97/EU) (IDD). EU Member States were required to transpose the IDD into their national law and apply it by 23 February 2018. However, the European Commission agreed to postpone the application date to 1 October 2018. Spain, however, has not yet
transposed the IDD to its legislation. In May 2018, the Draft Bill on the Distribution of Private Insurance and Reinsurance was submitted to Parliament. However, the early call for elections and the dissolution of the legislative chambers on 5 March 2019 by the Prime Minister caused the legislative process to expire. It is expected that the new Act will be approved in the summer 2020. It will replace the Private Insurance and Reinsurance Mediation Act 2006 (PIRMA).

III INSURANCE AND REINSURANCE LAW

i Sources of law

Pursuant to the provisions of Section 1 of the Civil Code, the sources are the law, custom and the general principles of jurisprudence, in that order, with certain peculiarities.

The criteria repeatedly laid down by the Supreme Court when interpreting and applying the law, custom and the general principles of jurisprudence will complement the legal order. Only that judicial trend constituting solid doctrine may be regarded as a precedent. Courts cannot depart from their previous decisions without sound reason.

The main substantive insurance and reinsurance rules are contained in the Insurance Contract Act 1980 (ICA). Reinsurance is regulated as a type of casualty insurance and is not subject to the otherwise mandatory provisions of the ICA. Spanish case law on reinsurance is scarce and the existing case law focuses mainly on the legal autonomy between the underlying insurance contract and the reinsurance contract from the perspective of the insured, who has no right of action or claim against the reinsurer.

The inherent complexity of the matter is enhanced by the relative inexperience of courts in reinsurance matters.

Marine insurance is regulated by the Maritime Navigation Act 2014, which abrogated the former rules contained in the Commerce Code.

ii Making the contract

**Essential ingredients of an insurance contract**

The basic principle of Spanish contract law is party autonomy, hence the parties are free to establish the conditions they may deem convenient provided these do not infringe upon the law, public morals and public policy (Section 1255, Civil Code). There are areas in which party autonomy is severely restricted, namely with regard to consumers.

The contract exists from the moment one or several persons undertake to give something or render some service to another or others (Section 1254, Civil Code). Contracts are concluded merely by consent (Section 1258, Civil Code) and consent is expressed by the convergence between the offer and the acceptance about the thing and the consideration, which are to constitute the contract (Section 1262, Civil Code).

Where contracts between distant persons are concerned, there is consent when the offerer learns about the acceptance or, it having been sent by the accepter, the offerer could not ignore it in good faith. In connection with agreements entered into by automatic devices, there is consent from the moment the acceptance is manifested (Section 54, Commerce Code and Section 1262, Civil Code).
**Utmost good faith, disclosure and representations**

The general principle for the interpretation of insurance contracts, as with any other contract, is good faith. The principle of utmost good faith means to behave loyally and truthfully towards the other party, and it is particularly relevant where insurance contracts are concerned, as case law has consistently proclaimed. Reinsurance contracts are also based on this principle. The duty of utmost good faith is a continuing one.

Prior to the conclusion of the contract, the policyholder is subject to the duty to disclose to the insurer, pursuant to the questionnaire submitted by the insurer, all the circumstances known by the policyholder that may be relevant for the evaluation of the risk. The policyholder will be relieved from said duty if the insurer does not submit a questionnaire or, submitting it, there are circumstances that may be relevant for the evaluation of the risk but are not covered in the questionnaire.

It follows that the policyholder is not under the proactive duty to disclose all material facts that may have a bearing on the evaluation of the risk, but only those the policyholder is asked about by the insurer.

In the event of ‘inaccuracies’ (misrepresentations) or ‘reservations’ (concealment or non-disclosure) in the information provided when completing the questionnaire or proposal form, the remedies available will depend on when the insurer becomes aware of the inaccuracies or reservations.

If the insurer becomes aware of the inaccuracies or reservations before the loss takes place, it will be entitled to rescind the contract within one month of learning about the misrepresentation or reservation. In this event, the insurer may keep the premium for the period in course, save that it acted in bad faith or with gross negligence (an event that is difficult to imagine). If the loss occurs before the rescission is notified or if the misrepresentation or non-disclosure is discovered after the loss takes place, the insurer will no longer be entitled to rescind the contract but solely to reduce the indemnity in the same proportion to that existing between the premium actually collected and the premium that would have been collected had the real risk been disclosed to it. However, if the policyholder acted in bad faith or with gross negligence (to be proved by the insurer), the insurer will be released from its obligation to indemnify.

**iii Recording the contract**

The insurance contract and any amendments or supplements must be formalised in writing, whether on paper or by another durable medium that enables it to be stored, easily retrieved and reproduced without changing the contract or the relevant information.

Further, the insurer has the duty to hand out the insurance policy or at least a provisional document attesting coverage to the policyholder. This is for purposes of proof only. It is standard practice to write down insurance contracts.

The reinsurance contract need not be executed in policy form or generally in writing to be valid. In practice, however, written form is customary in the market.

**iv Interpreting the contract**

*General rules of interpretation*

Along with utmost good faith, which is the general principle for the interpretation of insurance contracts, a foundational concept of Spanish contract interpretation law is that the contract should be construed upon its own terms (i.e., literally, provided the terms reflect the common
intent of the parties). If the terms appear to contradict the evident intent of the parties, the common intent will prevail and should be looked for. When looking for the intent, actions before, during and after the contract was concluded may be taken into consideration. In other words, if the intent of the parties flows clearly from the terms of the contract then those terms will be applied and no interpretation will be required (Section 1281, Civil Code and Section 57, Commerce Code, and related case law). In addition, there are a number of subsidiary rules of construction.

Ambiguous clauses may not be construed in favour of the drafter of the contract. In the case of contract with consumers, which are characterised as an ‘adhesion’ contract by case law, courts apply the contra proferentem rule and normally will find in favour of the insured.

The Law on Standard Contract Terms applies to both consumers and non-consumers.

**Incorporation of terms**

Terms implied by statute are fairly common under Spanish civil law. Notably, this is the case of contracts for sale. There are some limited cases in insurance law (data protection rules, protection for extraordinary risks in connection with certain lines) and virtually none with regard to reinsurance contracts.

The courts could imply and incorporate terms when interpreting, construing or integrating the contract, but this is rare. Incorporation by usage (of principles such as ‘follow the fortunes’ or ‘follow the settlements’) would be feasible in principle under Section 1258 of the Civil Code, subject to evidence and consistent observance in the relevant market.

**Types of terms in insurance contracts**

A fundamental distinction is whether the insurance contract involves a large risk, or a mass or consumer risk. Large risks are defined in Section 11 of Law 20/2015 by a combination of different lines of insurance and financial thresholds.

Generally, all the provisions of the ICA are mandatory, unless the law itself provides otherwise. However, clauses that benefit the insured shall be permissible and valid. The fundamental effect of an insurance contract involving a large risk is that the parties are free to agree as they wish, subject to the general limits to party autonomy and to the fundamental principles of insurance; hence, they are not subject to the otherwise mandatory provisions of the ICA.

Aside from contracts involving large risks, the conditions of the insurance contract must be written in a clear and precise way, and signed by the insured (there are special rules for electronic contracts). Further, clauses that limit or restrict the rights of the insured must be highlighted and written in bold letters, and explicitly accepted by the policyholder or insured (Section 3, ICA). Otherwise, the clause may be null and void. It is a requirement to include a statement that the policyholder or insured has read the limitative clauses, if any, and agrees to them. In addition, Section 8 of the ICA, as amended by Law 20/2015, provides that the policy must describe, in a clear and comprehensible manner, the guarantees and covers and the applicable exclusions and limitations, which must be highlighted.

On the other hand, contractual clauses limiting or restricting the insured’s rights, or exclusions contained in the policy that by nature do not delimit and specify the coverage afforded by the insurer, cannot necessarily be raised against the third party who has the right to claim directly from the insurer (in the context of civil liability policies). Clauses specifying the risk are those relating to the subject matter or object of the insurance, the sum insured, the period of insurance and the geographic scope, etc. The rest may be limitative clauses.
or exclusions. In these cases the insurer may recover from the insured but cannot oppose the third party’s claim on the basis of such clauses. Case law (e.g., decision of the Supreme Court of 30 November 2011, RJ\2012\3519) has drawn a subtle (and not always clear) distinction between clauses delimiting cover and clauses delimiting the rights of the insured or providing for exclusions. Occasionally, these exclusions have been described as delimiting cover objectively and therefore, theoretically, they could be raised against the third party. A key exercise is therefore to examine each contract on a case-by-case basis. This is particularly true in the case of motor insurance, for example.

Extreme care should be taken when incorporating legal concepts and principles from other jurisdictions into Spanish policies. These principles may mean little or nothing in Spain and, even worse, they can lead to misinterpretations.

Parties to a reinsurance contract are not subject to the otherwise mandatory provisions of the ICA. Therefore, party autonomy fully operates subject to the general limits to party autonomy (the law, public morality and public policy).

**Warranties, conditions precedent and conditions**

Warranties and conditions precedent do not have the same meaning and effect in Spain as those envisaged in English law.

Under Spanish law, a condition precedent (e.g., ‘it is a condition precedent to liability under this policy that the insured notifies the insurer’) is not a condition proper although there are similarities. Technically, there will be a condition proper (suspensive) if the effects of the contract depend on a future and uncertain event, or on an event that has actually taken place without it yet being known to the parties. In the first case the contract cannot go into operation until after the event; in the second case, the obligation is effective from the day on which it was undertaken, but it cannot be enforced until the event is known. In any case, the occurrence of the event must not be subject to the will of any of the parties. In this sense, a condition will be void if the occurrence of an event depends on the exclusive will of the other party (Section 1115, Civil Code).

A court could also find the condition precedent to be limitative in nature (of the rights of the insured), if it has not been adequately singled out in the contract and accepted specifically in writing by the policyholder, and thus could set it aside. Alternatively, it could take the view that the clause is detrimental to the insured and, for this reason, null and void. The Law on Standard Contract Terms could also be applicable to the extent the terms of the contract are imposed by one contracting party to the other. Under this Law, for these clauses to be valid, the party that adheres to the agreement must accept them explicitly. Otherwise the contract may be deemed null and void.

However, there is no reason why a well-drafted clause, providing for these conditions, should not be valid and enforceable, if incorporated into an insurance contract involving a large risk where the parties are not bound by the otherwise mandatory provisions of the ICA.

**v Intermediaries and the role of the broker**

**Conduct rules**
The operations of insurance and reinsurance intermediaries are subjected to the PIRMA, as amended. As mentioned in Section II.xi, the Draft Bill on the Distribution of Private Insurance and Reinsurance, which will transpose the IDD into Spanish law, is pending the approval by Parliament.
The IDD regulates the activities of insurance intermediaries, insurance companies, their employees and ancillary insurance intermediaries, as well as online distribution. In summary, the IDD:

a. lays down the information that must be given to consumers before they sign an insurance contract;

b. imposes certain conduct of business and transparency rules on distributors;

c. clarifies procedures and rules for cross-border business; and

d. contains rules for the supervision and sanctioning of insurance distributors if they breach the provisions of the IDD.

The PIRMA applies to intermediation activities between insurance policyholders or insureds and insurance entities. It also applies to distribution activities carried out by insurance companies through channels other than insurance intermediaries (direct marketing, internet, etc.).

The PIRMA does not include direct sales of insurance products, when these activities are carried out by an insurance company or its employees.

Intermediation activities include the presentation, proposal or fulfilment of tasks prior to entering into an insurance or reinsurance contract, the actual entry into the contract, and subsequent assistance necessary for the administration and implementation of those contracts, particularly in the event of losses and claims (Section 2.1, PIRMA).

The PIRMA classifies insurance and reinsurance intermediaries into three categories: insurance agents, insurance brokers and reinsurance brokers.

**Commission**

An insurance agent acts on behalf of the insurer (one or several insurers), promoting and concluding insurance contracts in exchange for a remuneration characteristically on a continuing and stable basis. The commission is the usual remuneration of the agent. The commission is set at a percentage of the premium, which varies depending on the line of business and type of the insurance.

An insurance broker acts for the insured and must provide independent, professional and impartial advice to the insured parties demanding risk coverage of their persons, goods, interests or liabilities. They are independent actors. The broker’s remuneration may be paid by both the client and the insurance company.

The PIRMA allows remuneration agreements on a freedom of contract basis between insurers and insurance brokers, in the form of a commercial commission for their mediation services, as long as the remuneration does not affect the independence of the broker. Any remuneration linked to rappels, subsidies or total volume of operations is totally prohibited for brokers.

The broker can enter into a written commission contract with the client in relation to a particular insurance operation, and issue a professional fee invoice to the client for the services rendered.

The disclosure of remuneration is limited. Only in cases where the insurance broker is paid both a fee by his or her client and a commission by the insurer must the amount of the commission and the name of the relevant broker be stated in the premium receipt.

Reinsurance brokers are remunerated by reinsurers on a freedom-of-contract basis between the broker and the reinsurer in the form of commissions on premiums, or other forms of remuneration.
**Agencies and contracting**

Insurance agents can be bound by an agency contract with one or several insurance companies and act under their direction and supervision. Insurance agents are classified as exclusive insurance agents and tied insurance agents.

An exclusive insurance agent is considered to be an extension of the insurance company, which is administratively liable for the agent’s actions that infringe upon the legislation on insurance intermediaries. This should be understood notwithstanding the agent’s civil and criminal liability for his or her own actions. Insurance companies have to register the agents in their own agent registry. This registry is controlled by the DGIPF. Exclusive agents must also have the required knowledge and ability.

The tied insurance agent may be linked to several insurance companies, in which case, the express consent of the first insurance company with which he or she concluded the first agency agreement is required. Tied insurance agents must pass training courses as set out by the DGIPF relating to financial matters and private insurance, and must have sufficient financial capacity to respond to their customers’ claims in the event of professional negligence (there are exceptions to this requirement).

**How brokers operate in practice**

In practice, brokers operate in much the same way as in the United Kingdom and other jurisdictions, particularly where international brokers are involved. Generally speaking, they are the dealmakers and coordinate the parties involved (the insured, underwriter, reinsurer, etc.). Spanish brokers authorised to operate in Spain may also conduct business in other EEA Member States by means of the EU single passport provided that they have disclosed to the DGIPF their intention to do so.

Insurance brokers act for the insured and must provide objective advice according to the criteria laid down by PIRMA. Reinsurance brokers normally act for the cedent although their commission is paid by the reinsurer.

**vi Claims**

**Notification**

As a general rule, insurance claims must be reported within seven days of the moment the insured knew about the loss (Section 16, ICA). A longer term can be agreed for the benefit of the insured. Shorter terms could be agreed in the case of a large risk. In practice, however, many policies insert imprecise wording of the type ‘as soon as possible or practicable’ or similar, which conceivably could be longer than the statutory seven days.

The late notification of the loss would not *per se* entitle the insurer to rescind the contract, but only to claim damages, if any (Section 16, ICA). As an exception to the general rule, the prompt notification of the loss can be made a condition precedent to liability of the insurer if the risk in question concerns a large risk.

The law does not provide for the case of reinsurance. It will depend on the agreement of the parties.
**Good faith and claims**

The policyholder or the insured have the duty to provide all information available on the circumstances and consequences of the loss. The breach of this duty with gross negligence or bad faith on the part of the insured would release the insurer from its obligation to indemnify (Section 16, ICA).

The foregoing provision is connected with the general duty of salvage in casualty and property insurance, which is to be understood as the duty to diminish or minimise the loss (Section 17, ICA). If the insured breaches that duty, the insurer will be entitled to reduce the indemnity in the relevant proportion taking into account the significance of the damages derived from the breach and the degree of fault of the insured. If the insured had the intent to prejudice the insurer, the latter will be released from its obligation to indemnify.

Once the loss has occurred, and within five days of the notification of the loss, the insured or the policyholder is required to send a list of the existing objects at the time of the loss and of the objects saved, and an estimate of loss, to the insurer. The insured is required to prove the pre-existence of the objects. However, the policy itself will constitute a presumption in favour of the insured where no further evidence could reasonably be provided. The insured must also provide all relevant information on the circumstances of the loss at the request of the insurer. The insurer is bound to pay the indemnity at the end of the investigations and adjustments necessary to establish the existence of the loss and the quantum thereof, if any. If the parties disagree on the quantum, expert adjusters designated by the parties will sort out the issue.

The law provides nothing about the reporting of facts and circumstances that could eventually give rise to a claim. Policies usually require the reporting of facts and circumstances and attach certain legal consequences to such reporting.

As a general rule, Section 19 of the ICA excludes from cover losses caused by the insured acting in bad faith. This is also the first standard exclusion in all insurance policies.

Case law has ruled that the fraudulent or bad faith exclusion in an insurance policy cannot be raised against an injured third party. In such a case, the insurance company is left to recover the losses from the insured.

As regards reinsurance claims, fundamental principles of the reinsurance contract, particularly in the case of treaty reinsurance, have traditionally been the community of risk created by the contract and the follow the fortunes principle in the frame of the utmost good faith, which also compels the reinsured to protect the interests of the reinsurer.

The ICA does not make any reference to follow the fortunes or follow the settlements principles, nor does there appear to be any case law offering guidance in this regard. The former Section 400 of the Commerce Code, which dealt with fire insurance and was abrogated by the ICA, did provide that the reinsurer was to follow the settlements of the insurer but did not specify either the requirements or the consequences thereof.

The effects of a follow the settlements clause are, therefore, uncertain. It is commonly held in Spain that this clause would compel the reinsurer to accept and be bound by the settlements reached by the insurer provided the insurer is, in effect, liable under the direct policy and the risk is covered by the reinsurance contract. It would also be possible to contend that the reinsurer is not bound if the settlement is not concluded in a businesslike manner (namely in the event of *ex gratia* payments), but there are no authorities confirming this.
IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Jurisdiction

Insurance disputes related to consumers (mass claims) are normally resolved by litigation in court. Within the Spanish territory, any disputes arising out of the contract between the insurer and the insured must be referred to the courts for the domicile of the insured (Section 24, ICA). Any agreement to the contrary shall be deemed null and void.

Also of relevance are the special jurisdictional rules set forth in Council Regulation (EU) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (the Brussels I Regulation recast).

With regard to insurance contracts involving a large risk, the parties are free to refer the dispute to the courts of their choice.

Choice of law

The parties to an insurance contract involving a large risk may freely choose the governing law and are not subject to the otherwise mandatory provisions of the ICA.

In the event of conflicts of laws, Regulation (EC) No. 593/2008 of the European Parliament and the Council of 17 June 2008 on the law applicable to contractual obligations (Rome I) applies to insurance contracts concluded as from 17 December 2009. The Rome Convention 1980 applies to insurance contracts concluded before that date and to those countries that opted out of the Regulation (Denmark), but its rules do not apply to insurance contracts covering risks located in the territories of the Member States of the European Union.

Arbitration clauses

The Arbitration Act (AA) approved by Law 60/2003 of 23 December, as amended, recognises the freedom of parties to submit to arbitration any disputes related to matters that they can freely dispose of in accordance with the law.

For insurance, this general principle was confirmed by Section 97.4 of Law 20/2015, both with regard to large and mass (consumer) risks, although the latter with qualifications. In the event of mass risks (consumers), any disputes between insurers and consumers may be referred to the Consumers Arbitration System as set out in the consolidated text of the Law on the Protection of Consumers and Users. Insurance disputes concerning large risks tend to be (but are not always) resolved by arbitration. The parties to a contract involving a large risk are free to submit their disputes to arbitration having regard to the general rules set forth in the AA.

The parties to a reinsurance contract are free to refer the dispute to the courts of their choice, or to arbitration or any other alternative dispute resolution method.

ii Litigation

Litigation stages

Generally, the Spanish civil litigation system is more adversarial than inquisitive. The civil first instance courts are the competent courts to hear insurance disputes.

A civil proceeding starts with the filing of the statement of claim with the Register of the Court. The claimant should attach to the statement of claim all documents on which the claimant bases his or her claim, or designate the private or public records where this
documentary evidence may be found. The defendant has the same burden regarding the
documents related to his or her defence. Therefore, the parties should disclose all the evidence
they have at the beginning of the process in order to avoid procedural ‘ambushes’.

The main steps of the proceedings include pleadings (claim, defence and, eventually,
counterclaim and response to the counterclaim), the case management conference and the
trial.

In the ordinary procedure for claims exceeding €6,000, which is the main declaratory
procedure, once the defendant has been served with the claim, the defendant has 20 working
days to file his or her defence, and a counterclaim, if any. In the latter case, the claimant will
then have 20 working days to respond to the counterclaim.

The defendant is required to set out his or her defence arguments following the order
of the claim (accepting or rebutting the corresponding arguments) and to file all of the
documents in his or her possession supporting his or her defence (this rule also applies to the
counterclaim and the answer to the counterclaim).

The parties must disclose to their opponents in the pleadings phase those documents
they rely on.

After the allegations (pleadings) phase has been completed, the court will call the
parties to a case management conference (CMC), which should take place within 20 days.
This term is rarely, if ever, observed in practice. The purposes of the CMC are reaching a
settlement if possible, sorting out any procedural technicalities and submitting the evidence
the parties intend to avail themselves of (namely the documents filed with the pleadings,
witnesses and expert witnesses). If the court deems that the controversy relates solely to points
of law or the parties only produce documentary evidence with their respective allegations,
the lawsuit could be called to an end and judgment passed on the issue. If not, the court will
fix a date for the trial where all evidence submitted and admitted is to be taken (testimonies,
interrogatories, etc.) and then the parties’ attorneys will orally summarise their conclusions.
The time frame to trial is variable, from three to 10 months, depending on the nature and
complexity of the case. Judgments should be handed down within 20 days of the trial. This
term is almost never observed in practice.

Parties are entitled to appeal against any adverse court decision. An appeal can be
lodged on questions of fact or of law.

In some limited cases (where, for instance, the amount involved exceeds €600,000
or the matter involves a special legal interest) there is a further and final appeal to the
Supreme Court. There is also a special appeal to the Constitutional Court in the event that
constitutional rights are violated by the courts.

Evidence

Each party bears the burden of proving those facts supporting the position that they are
defending in the proceedings.

The courts have wide discretion when assessing evidence, subject to reasoning founded
on the applicable law and the relevant facts.

Evidentiary means are interrogation of the parties, public documents, private
documents, experts’ reports, judicial examination and witnesses. Further, any means for
reproducing words, images and sounds, as well as instruments for the storage and retrieval
of data, words, figures, and mathematical operations carried out for accounting purposes or
others relevant for the proceedings, can be presented as evidence.
Costs

The general rule is that the losing party pays the costs of the other party, unless the court appreciates that the case presented serious factual or legal doubts.

If the claim is admitted in part, each party pays its own costs and half of the common costs, if any (e.g., experts designated by the court), unless there is merit to impose these on the party that in the court’s view litigated recklessly.

Costs are capped in that they cannot exceed one-third of the total quantum of the claim. If the nature of the claim does not permit it to be quantified, then the claim for these sole purposes will be valued at €18,000, unless the court decides otherwise in light of the complexity of the case.

iii  Arbitration

Format of insurance arbitrations

The AA lays down rules for arbitrations, both domestic and international. The AA is strongly influenced by the UNCITRAL Model Law of 1985, as amended.

Procedure and evidence

The main principles of an arbitration procedure are the following:

a  The essential principles of the procedure are the right of the parties to be heard, the right of the parties to contradict each other and equal standing. The parties can agree to have the dispute resolved under legal principles or based on equity (fairness and justice). They may set out the procedural rules (ad hoc arbitrations). Parties may entrust the administration of the arbitration to an institution, in which case its rules will apply.

b  The taking of evidence upon motion of the parties or the arbitrators. The arbitrators may reject irrelevant evidence or that which is not admissible under the law. Witnesses, experts and third parties participating in the proceedings will be able to use their own language both in oral and written evidence (in which case interpreters will be provided).

c  The arbitrators may order interim or provisional measures (injunctions).

d  The procedure may involve jurisdictional cooperation; the intervention of the courts is limited to certain support and control functions (inter alia, appointment of arbitrators, taking of evidence, interim measures notwithstanding the power of arbitrators to grant them, recognition and enforcement, and annulment of awards).

e  The award must be issued within six months of the statement of defence, unless the parties agree to extend the term. The late issuance of the award does not constitute per se a ground for annulment, without prejudice to the arbitrators’ liability.

f  The award must be in written form and must always be reasoned, even if it is solely based on fairness and equity, unless the parties reach a settlement and agree that it be reflected in the form of an award.

g  With regard to the annulment of an award, the grounds on which an award can be challenged in court with the intent to vacate it in full or in part are rather limited (Section 41, AA).

Costs

The general rule is that subject to the agreement of the parties, the arbitrators shall decide in the award on the allocation of costs (Section 37.6, AA). In the case of institutional arbitrations, the arbitrators will follow the institution’s rules on costs.
iv  Mediation

The role of the courts

Although mediation as a form of resolving civil and commercial disputes has a long history, in its current form, method and approach, it is fairly new in Spain. The Mediation in Civil and Commercial Matters Act was approved by Law 5/2012 of 6 July. Section 97.3 of Law 20/2015 recognises the freedom of parties to submit their disputes to a mediator in the terms provided by Law 5/2012.

Mediation can either result from the agreement of the parties or be suggested by the court hearing the dispute. Mediation is free and voluntary and nobody may be compelled to continue in the mediation procedure and conclude an agreement. The mediator must be impartial and independent.

The parties will have to notarise the agreement reached if they need to enforce it in court. The Spanish notary public will previously have to verify the fulfilment of the requirements under the Mediation Act and that its content is not contrary to the law. This will add some red tape to the procedure.

The court’s intervention is limited to the enforcement of the mediation agreement, or to homologate (endorse) the agreement when it has been reached in the course of litigation.

V  YEAR IN REVIEW

The following events were of particular interest for the insurance sector in 2018.

The new Data Protection and Digital Rights Guarantees Act (approved by Organic Law 3/2018) was published in the Spanish Official Gazette on 6 December 2018, effective from 7 December. The new Law adapts Spanish legislation to the General Data Protection Regulation (Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016), applicable since 25 May 2018, and completes its provisions. In addition, the new Law recognises certain new ‘digital rights’ for citizens, namely, the right to rectify data on the internet, the right to update any information on digital media, the right to privacy and use of digital devices at work, the right to digital disconnection from work, among others. This Law repeals the Data Protection Act 1999.

On 16 April 2018, the Resolution of 28 March 2018 was published, which approves the surcharges in favour of the ICC for the coverage of extraordinary risks, the coverage clause to insert in ordinary insurance policies and the information to be provided by insurers regarding the policies included in the extraordinary risks coverage regime. The Resolution has been in force since 1 July 2018.

VI  OUTLOOK AND CONCLUSIONS

The approval of the new Law on Distribution of Private Insurance and Reinsurance, which will replace the Private Insurance and Reinsurance Mediation Act 2006 (see Section II.xi), will be an important development in the next two years. In addition, a regulatory sandbox will be implemented in Spain with the goal of facilitating innovation in and development of financial services, in line with existing regimes in the United Kingdom, the Netherlands and Denmark.
I INTRODUCTION

The Swedish insurance industry comprises approximately 350 companies, investing more than 4.5 trillion kronor in the Swedish and global economy. Approximately 135 of these companies are non-life insurance companies. The market is dominated by the four largest non-life insurance companies, which together represent more than 80 per cent of the market based on premium income. The life insurance market, however, does not provide for the same concentrated dominance; the four life insurance companies reporting the highest premium income together represent around 45 per cent of the market.

The reinsurance market can be divided into non-life and life reinsurance. There is currently no Swedish company authorised by the Swedish Financial Supervisory Authority (SFSA) to conduct business as a reinsurance company (i.e., a company licensed to conduct reinsurance activity only). Instead, the reinsurance market in Sweden is dominated by large international reinsurers.

About 50 insurance companies on the Swedish market are members of Insurance Sweden, an industry organisation working to promote good business conditions. Together these insurance companies account for more than 90 per cent of the Swedish insurance market.

II REGULATION

i Applicable regulation

Regulation of insurance and reinsurance companies

Insurance and reinsurance companies are regulated through the Insurance Business Act implementing the Solvency II Directive (2009/138/EC) into national law. The Insurance Business Act set out the framework for:

a authorisation;

b operation within another Member State of the European Economic Area (EEA);

1 Peter Kullgren is a partner, Anna Wahlbom is a senior associate and Jakob Andersson is an associate at Hamilton Advokatbyrå KB.
2 http://www.svenskforsakring.se/statistik/branschstatistik/forsakringsforetag/.
3 http://www.svenskforsakring.se/statistik/branschstatistik/forsakringsforetag/marknadsandelar-for-liv-och-skadeforsakring/.
5 SFS 2010:2043.
In addition, insurance and reinsurance companies are subject to certain requirements under the Insurance Business Ordinance, and the SFSA's regulations and general guidelines.

**Regulation of insurance and reinsurance intermediaries**

On 1 October 2018, the Swedish Insurance Distribution Act entered into force implementing Directive (EU) 2016/97 (the Insurance Distribution Directive (IDD)) into national law. The Insurance Distribution Act changed the market for insurance and reinsurance intermediaries through its extended scope of application, by also including insurance and reinsurance companies' distribution. The Insurance Distribution Act sets out the framework for:

- authorisation;
- operation across borders;
- operational requirements;
- information requirement and suitability assessment;
- additional requirements when distributing insurance-based investment products;
- additional requirements when distributing certain pension insurance products; and
- supervision.

In addition, insurance and reinsurance intermediaries are subject to certain requirements under the Insurance Distribution Ordinance, and the SFSA's regulations and general guidelines.

**ii Regulating body**

The SFSA supervises both insurance and reinsurance companies' and insurance intermediaries' compliance with applicable requirements in Sweden. However, it does not supervise insurance business carried out under legislation other than the Insurance Business Act and the Act on Undertakings of Foreign Insurers and Institutions for Occupational Retirement Provision in Sweden, such as state social insurance schemes regulated through the Social Insurance Code.

The SFSA maintains a register covering all companies authorised to conduct insurance and reinsurance, and insurance intermediary activities in Sweden. The register includes the following information related to undertakings that have authorisation:

- name, contact details, corporate ID and identification number at the SFSA;
- date and type of authorisation;
- details of cross-border business; and
- details of employees conducting insurance mediation.

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6 SFS 2011:257.
7 SFS 2018:1219.
8 SFS 2018:1231.
9 SFS 2010:110.
iii Requirement for authorisation

Insurance and reinsurance companies

Insurance and reinsurance business can only be carried out in Sweden with the authorisation of the SFSA. In order for the SFSA to grant authorisation the applicant must satisfy the following requirements under the Insurance Business Act:

- it must be incorporated as an entity that can be authorised (e.g., a limited liability company or a mutual insurance company);
- it must have articles of association or statutes that comply with applicable legislation;
- it must comply with the requirements under the Insurance Business Act and other applicable regulations;
- if it is a limited liability company, its qualified owners must be deemed fit to exercise significant influence on its management;
- its proposed board of directors, chief executive officer, any deputies for these positions and key function holders must be deemed fit and proper to perform their respective duties; and
- it cannot have a close link (i.e., be part of the corporate structure) that prevents the SFSA from exercising effective supervision.

As part of its application the applicant is required to provide a wide range of information to the SFSA, such as its articles of association, business plan, corporate governance policies and, when applicable, internal rules on anti-money laundering.

The SFSA normally reaches a decision within five months of the completed application being submitted. However, the review period may be extended if additional information is required from the applicant during this period.

It is possible under the Insurance Business Act to apply for an advanced ruling by the SFSA on whether the intended business requires authorisation.

Insurance intermediaries

Insurance intermediary activities generally require authorisation from the SFSA. However, a few exemptions apply. Authorisation can be granted to both individuals and entities. A separate requirement for authorisation applies under the Insurance Distribution Act depending on whether the applicant is an individual or an entity.

An individual must satisfy the following requirements:

- not be underage (i.e., under 18 years old), disqualified to conduct business, bankrupt or in receivership;
- not have a criminal record for financial crime – he or she must have proven good care in financial affairs;
- have suitable knowledge of the intended business;
- comply with requirements on continuous professional training and occupational development;
- possess adequate liability insurance;
- be suitable to conduct insurance intermediary activities; and
- not have a close link that prevents the SFSA from exercising effective supervision.
An entity must satisfy the following requirements:

a. not be in bankruptcy or liquidation;
b. possess adequate liability insurance;
c. not employ as members of the management and any deputies thereof those that have a criminal record for financial crime – they must have proven good care in financial affairs (in addition, they must possess sufficient knowledge and competence to be part of the management in an entity conducting insurance distribution activities and, in general, be considered suitable to conduct such business);
d. ensure that employees carrying out insurance and reinsurance distribution activities on its behalf comply with the requirements in points (a) to (d) of the previous list applying to individuals; and

e. not have a close link that prevents the SFSA from exercising effective supervision.

The SFSA is required to reach a decision on authorisation within three months of the completed application being submitted. If authorisation is granted, the individual or entity is required to register with the Swedish Companies Registration Office before commencing any insurance intermediation activities.

Insurance and reinsurance companies are not required to seek separate authorisation for the distribution of their insurance products. However, they are required to comply with the applicable requirements under the Insurance Distribution Act.

iv Exemptions from authorisation

Entities domiciled and authorised to conduct insurance and reinsurance business in another EEA Member State are not required to seek authorisation from the SFSA. These entities can conduct insurance and reinsurance business in Sweden through the establishment of a branch or agency, or based on the freedom to provide services.

Entities domiciled and authorised to conduct insurance and reinsurance intermediary activities in another EEA Member State are not required to seek authorisation from the SFSA. These entities can conduct business in Sweden through a branch, other permanent presence or based on the freedom to provide services.

Although exempted from authorisation, both EEA insurers, and insurance and reinsurance intermediaries, are required to complete a notification process before conducting any insurance business or intermediary activities in Sweden. The SFSA supervises business carried out in Sweden by EEA insurers and insurance intermediaries.

v Non-EEA insurance and reinsurance companies and insurance intermediaries

Non-EEA insurers and reinsurers can only conduct insurance business in Sweden through a local branch or agency after obtaining authorisation from the SFSA. The same applies when a non-EEA insurance intermediary wishes to conduct activities in Sweden through a branch or permanent presence.

However, non-EEA insurers and reinsurers may apply for authorisation with the SFSA to conduct marketing activities in Sweden for insurance for which the risk is situated therein, if these activities are conducted through mediation by an insurer authorised in Sweden, and both parties are part of the same group or have entered into a cooperation agreement.

The SFSA will supervise the business carried out in Sweden by a non-EEA insurer or reinsurer, or insurance intermediary.
vi  Restrictions on ownership and control
Ownership in insurance and reinsurance companies is subject to restrictions under the Insurance Business Act that may impact the authorisation process and may affect the companies in a merger and acquisition. An acquirer must obtain the approval of the SFSA before:

a. acquiring, directly or indirectly, 10 per cent or more of the share capital or voting rights of an insurance or reinsurance company (qualified holding);
b. increasing its direct or indirect holdings to, or above, 20 per cent, 30 per cent or 50 per cent of the share capital or voting rights of an insurance or reinsurance company; or

c. increasing its holdings in a way in which the insurance or reinsurance company becomes a subsidiary.

The SFSA will approve the acquisition if the acquirer is deemed fit and proper to exercise significant influence over the management of the insurance or reinsurance company, and the acquisition is financially sound.

The SFSA is required to provide its decision on an application for acquisition within 60 business days of the day the application is deemed complete. If the acquirer is required to submit additional information in order for the SFSA to reach a decision, the assessment period can be extended.

Furthermore, a direct or indirect owner is required to notify the SFSA in writing if it decides to dispose of a qualified holding or reduce its holdings below any of the thresholds listed above.

Acquisitions or increases in holdings of non-EEA insurers authorised to conduct business in Sweden are not subject to the SFSA’s approval. However, the SFSA must be notified of proposed acquisitions and changes in control of these insurers. See subsection iii for more information about applicable requirements on ownership and control in the authorisation process.

There are no similar restrictions on ownership and control for entities authorised to conduct insurance or reinsurance intermediary activities.

vii  Proposed changes to the regulatory system
Life insurance companies manage approximately 75 per cent of the total assets on the local occupational pension market. Insurance companies that conduct business covering both occupational pension and life insurance (mixed insurance activities) have been given the possibility to apply a transitional rule to their occupational pension business, through which they can apply a number of pre-Solvency II requirements, until the end of 2022 (as currently suggested). The time period under which the transitional rule is intended to apply is a result of Directive (EU) 2016/2341 on the activities and supervision of institutions for occupational retirement provision (IORP II), which is expected to enter into force in Sweden on 1 May 2019.

How the implementation of IORP II will affect the Swedish insurance industry is still unclear, especially as it has been suggested that insurance companies conducting mixed insurance activities will be provided with an opportunity to transform their business into an occupation pension company, which would mean a change in form and applicable regulatory regime.
III INSURANCE AND REINSURANCE LAW

i Sources of law
The Insurance Contracts Act\textsuperscript{11} is the main source of law in Sweden when it comes to provisions covering insurance contracts. The provisions of the Insurance Contracts Act are mandatory for the benefit of the policyholder, its assignee and the insured, unless otherwise expressly stated in the Act.

The Insurance Contracts Act includes provisions on both non-life and life insurance contracts as well as special requirements in relation to group insurance contracts. In relation to each type of insurance contract (life and non-life), the Act outlines the main applicable requirements for the insurance contract, such as:

\begin{itemize}
  \item[a] the insurer’s duty to provide information;
  \item[b] the policyholder’s disclosure obligations;
  \item[c] rights under the insurance contract;
  \item[d] limitation of the insurer’s liability;
  \item[e] premium payments;
  \item[f] claims management; and
  \item[g] statute of limitations.
\end{itemize}

Specific national legislation applies to contracts covering motor vehicle liability insurance and patient insurance.

In contrast to insurance contracts, reinsurance contracts are not specifically regulated under Swedish law, which means that the contracting parties enjoy a great degree of flexibility when entering into them. Although not specifically regulated, general requirements following from the Contracts Act apply,\textsuperscript{12} as well as general principles of contract law.

ii Making the contract
The Insurance Contracts Act does not provide any requirements governing how an insurance contract should be concluded with the policyholder. However, generally it is concluded as a result of an insurance seeker applying for insurance cover with an insurer or through an insurance intermediary, and receiving an offer that is subject to acceptance by the insurance seeker.

There is no codified principle of utmost good faith under Swedish insurance law, although the contracting parties have a general duty of loyalty. Although this principle is not codified, it is to some extent reflected in the Insurance Contracts Act through the provisions governing the insured’s pre- and post-contractual duty to disclose information to the insurer.

In relation to reinsurance contracts, a duty of utmost good faith can be implied under a ‘follow the fortunes’ clause, as it involves a unique business partnership between the cedant and the reinsurer.

There are ongoing discussions in the Swedish insurance industry regarding for how long an insurance contract can be recorded as a result of the General Data Protection Regulation (2016/679/EU) (GDPR) entering into force on 25 May 2018. At the time of writing, no market standard has been published.

\textsuperscript{11} SFS 2005:104.
\textsuperscript{12} SFS 1915:218.
iii Interpreting the contract

The provisions of the Insurance Contracts Act are mandatory for the benefit of the policyholder, its assignee and the insured, unless otherwise expressly stated in the Act. Consequently, a court will set aside a clause in the insurance contract that is in violation of the mandatory provisions of the Act.

If the wording of an insurance contract does not explicitly contradict the provisions of the Insurance Contracts Act, the court may still at its own discretion set aside any contractual clause that it deems to be manifestly unreasonable. However, such decisions are rare in insurance cases.

The Insurance Contracts Act does not cover any provisions on mandatory clauses to be covered by the insurance contract, only general information regarding its form and content. Although insurance companies are free to set the content of their respective insurance contracts the wording of the Insurance Contracts Act is usually incorporated. Commonly found clauses are:

- applicable definitions;
- policy period;
- insured interests;
- claims trigger;
- geographical scope;
- premium payments;
- dual insurance coverage;
- exclusions and limitations of coverage (e.g., for increase in risk, acting with gross negligence and breach of applicable safety requirements);
- statute of limitations; and
- terms and conditions.

As described in subsection i, reinsurance contracts are not regulated under Swedish law, which means that how these contracts should be concluded between the cedant and the reinsurer is also not regulated. According to accepted market practice, the following clauses are generally found in reinsurance contracts:

- disclosure requirements (e.g., regarding the cedant’s underwriting activities);
- right of the reinsurer to inspect the records of the cedant company;
- ‘follow the fortunes’ and ‘follow the settlement’ clauses;
- claims cooperation or claims control clauses;
- premium levels and premium payments;
- profit commission;
- provisions on portfolio transfers;
- statute of limitations; and
- choice of law and dispute resolution mechanisms.

iv Intermediaries and the role of the broker

As described in Section II, insurance intermediary activities in Sweden can be conducted by an entity or an individual authorised by the SFSA, an ancillary insurance intermediary or a tied insurance intermediary. It is quite common in Sweden for insurance companies to use tied insurance intermediaries (e.g., banks), for which they are liable for any damage inflicted as a result of the intermediary activities.
Insurance intermediaries are required to act in accordance with conduct rules as stipulated in the Insurance Distribution Act. Generally, insurance intermediaries are required to conduct their business in accordance with good insurance distribution practice and with due consideration of the customer’s interests. Furthermore, an insurance distributor must act honestly, fairly and professionally. If an insurance intermediary is part of the Swedish Insurance Intermediaries Association (SFM) and InsureSec – an organisation established by SFM and the larger Swedish life insurance companies using intermediaries for insurance distribution – additional industry regulations apply with the purpose of facilitating adequate advice on insurance coverage. InsureSec also established a disciplinary forum for its registered members in the event of violations of industry regulations.

On the Swedish market, insurance products are distributed by the insurance companies themselves and through different types of insurance intermediaries. In practice, it is common for insurance seekers to ask insurance intermediaries for advice on suitable insurance cover and on which insurance company provides an insurance contract that matches its needs.

v Claims

A claim of insurance coverage under an insurance contract can be made as a result of an insured event. The definition of an insured event as well as information about how to make a claim are usually covered by the conditions of the insurance contract. An insurance contract can also provide for a time period under which a claim must be notified to the insurance company. The remedy for a late notice is a reduction of indemnification, which is proportionate to any loss incurred by the insurer as a result of the late notice.

The ultimate deadline to notify a claim to the insurer is regulated by the statute of limitations under the Insurance Contracts Act. The statute of limitations for an insured to bring legal proceedings against the insurer is within 10 years of the date when the claim was triggered, according to the insurance contract. If a claim has been notified within that time, the insured has at least six months to bring legal proceedings from the date of receipt of the insurer’s final decision.

The insured bears the burden to prove that an insured event has occurred under the insurance contract and the insurer generally has the burden to prove whether, for example, an exclusion applies or whether the indemnification should be reduced as a result of the insured’s breach of the insurance contract. The burden of proof is lower for consumers claiming indemnification.

With regard to non-consumer (business) insurance, the insurer is allowed to include a clause in its insurance policy stipulating that it is entitled to deny a claim if the insured has failed to notify the insurer within one year of the occurrence of the insured event.

An insurer furthermore has the right of subrogation to the insured’s claim for damages resulting from loss, if the claim is covered by the insurance contract and has been indemnified by the insurer.

Insurance companies usually have internal procedures for the management of disputes relating to insurance claims (e.g., a review committee). If a dispute cannot be resolved by the insurer, different dispute resolution forums are available. Information about applicable dispute resolution forums is generally covered by the insurance contract and may differ depending on the type of insurance and whether the insured person is a natural or legal person.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Clauses regarding choice of jurisdiction, competent court and applicable law are normally both recognised and enforceable. Nevertheless, these clauses must comply with Regulation (EC) No. 593/2008 on the law applicable to contract obligations and Regulation (EU) No. 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

Arbitration clauses in insurance and reinsurance contracts are both common and enforceable, with the exception of consumer insurance (save for certain types of group insurance).

ii Litigation

There is no specific litigation procedure for insurance disputes. Accordingly, insurance disputes are litigated in the same way as any other commercial dispute, namely in general courts, governed by the Swedish Code of Judicial Procedure. The general courts are organised in a three-tier system: district courts, courts of appeal and the Supreme Court.

Swedish litigation proceedings can be summarised as follows in non-complex matters. Upon filing a summons application and a statement of defence, the parties will typically file one additional submission with the court. The purpose of the preliminary hearing is to resolve any ambiguities as regards, for instance, what the disputed facts of the case are. Subsequent to the preliminary hearing, the parties will be required to submit a complete list of evidence and respond to any issues raised during the hearing. The main hearing will usually be held six months after the preliminary hearing. Conclusively, it normally takes at least one year from the submission of the summons application until the award is rendered.

In complex matters, involving additional written submissions by the parties and sometimes further preliminary hearings, the length of the proceedings is considerably longer – usually two to three years.

A review permit is required in order to appeal a decision reached by a district court or a court of appeal. Generally, the deadline to appeal a decision is three weeks from when the decision has been rendered or, where applicable, when it has been served. A leave to appeal will only be granted if any of the following conditions apply:

a there is reason to believe that the district court has come to an erroneous conclusion;
b it is not possible to assess the correctness of the district court’s decision;
c it is important to establish an award that may provide guidance to Swedish courts; or
d any other extraordinary reason.

However, a court of appeal’s decision is only appealable in the event of points (c) and (d), above. Consequently, the Supreme Court rarely grants leave to appeal.

The principle of oral proceedings is most frequently applied in litigation proceedings in Sweden, in contrast to depositions, which are rare.

There is no discovery or disclosure of documents phase in Swedish litigation. Accordingly, there is no general obligation to disclose documents. Nevertheless, a party is able to request the court to order a counterparty or a third party to disclose specific documents if certain criteria are met.
The law applies a loser-pays principle (with exceptions), therefore the winning party is entitled to full compensation from the losing party for reasonable litigation costs (costs for counsel, experts, witnesses and the party’s own costs, etc.). By default, the successful party is also entitled to interest.

### iii Arbitration

Arbitral proceedings are governed by the Swedish Arbitration Act. The UNCITRAL Model Law on International Commercial Arbitration has, to a large extent, influenced this Act. Similarly to litigation proceedings, there are no specific arbitral proceedings for insurance arbitrations. Arbitral proceedings in Sweden are commonly governed by the Arbitration Rules of the Arbitration Institute of the Stockholm Chamber of Commerce (SCC), available on its website.\

Generally, arbitration is more expedient than litigation. For instance, in 2017 more than 50 per cent of the awards under the SCC Arbitration Rules were rendered within 12 months of the time of registration of the case.

Another important difference between arbitration and litigation is that the former allows for greater flexibility as regards evidence. As mentioned in subsection ii, there is no discovery phase in litigation and depositions are rarely used. However, the parties in an arbitration are free to implement a discovery phase, as well as depositions.

The cost of arbitration consists of arbitrators’ fees and, under the assumption that the arbitral proceedings are governed by the SCC rules, fees to the institute and possible expenses. The costs can be determined by using a ‘calculator’ on the SCC website.

### iv Alternative dispute resolution

If a dispute between an insurer and a customer cannot be resolved, the customer can refer the matter to the National Board for Consumer Disputes.\(^1\)

Furthermore, the following boards deal with specific types of claims:

- the Board for Personal Insurance;
- the Board for Legal Protection Insurance;
- the Board for Counsel Expenses; and
- the Board for Bodily Injury Liability Insurance.

Although a ruling by one of the boards listed above is not legally binding, insurance companies commonly reconsider their decisions in accordance with a ruling.

Finally, disputes can also be handled by the courts or arbitral tribunals, as applicable.

### v Mediation

The district courts have a general obligation to attempt to negotiate a settlement between the parties in any commercial dispute, including insurance disputes. These negotiations are always held during the preliminary hearing but also frequently in the main hearing.

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16 [https://www.arn.se/om-arn/Languages/english-what-is-arn](https://www.arn.se/om-arn/Languages/english-what-is-arn).
V YEAR IN REVIEW

During 2018, the insurance and reinsurance market was subject to a number of regulatory changes; however, none was as invasive as Solvency II, which entered into force in 2016.

On 1 January 2018, rules following from Regulation (EU) No. 1286/2014 of the European Parliament and of the Council of 26 November 2014 on key information documents for packaged retail and insurance-based investment products (PRIIPs) came into effect, which affected Swedish life insurance companies, among others. The Regulation’s aim is to enable retail investors to understand and compare the key features and risks of the PRIIPs.

Another regulatory change of a more general nature, which affected insurance and reinsurance companies to a wide extent, is the GDPR, which came into effect on 25 May 2018. As a result of the GDPR, insurance companies have been required to review their procedures for, among other things, the collection, processing and recording of personal data.

The most significant regulatory change during the past year was the new Insurance Distribution Act, implementing the IDD into national law, which came into effect on 1 October 2018. While the IDD’s predecessor, the Insurance Mediation Directive (2002/92/EC), only applied to insurance intermediaries, the IDD was expanded to cover insurance companies’ distribution of insurance products. This change has resulted in additional requirements being placed on insurance and reinsurance companies when it comes to, for example, the knowledge and competence of the employees carrying out insurance and reinsurance distribution activities on the entity’s behalf.

One topic that has been widely debated in Sweden before and during the implementation of the IDD is whether the provision of advice, in relation to investments under an insurance contract, should be regulated under the IDD or as an investment service under MiFID II (2014/65/EU). This is currently subject to the Supreme Court’s decision in a dispute regarding the scope of an insurance intermediary’s liability insurance. The Supreme Court requested a preliminary ruling from the Court of Justice of the European Union, which came in May 2018. Stipulating that the provision of advice regarding investments under an insurance contract should be regarded as insurance intermediary activities and regulated accordingly. However, a decision has not yet been reached by the Supreme Court. In the meantime the Swedish legislature has concluded that the provision of advice regarding investments under an insurance contract should be regarded as insurance distribution, thus falling within the scope of the Insurance Distribution Act.

Throughout 2018 only one notable transaction was recorded, which was the sale of the Swedish life insurance company Danica Pension Försäkringsaktiebolag (publ) (Danica Pension) to Polaris and Acathia Capital. The transaction is expected to be finalised during the first half of 2019, as it requires supervisory approval before closure. Danica Pension was established in 1999 as a Swedish subsidiary to Danica Pension in Denmark.

VI OUTLOOK AND CONCLUSIONS

The Swedish insurance and reinsurance market has, during the past couple of years, been subject to substantial regulatory changes affecting different aspects of the insurance business.

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17 This case covers the relationship between the predecessors to the IDD and MiFID II, namely the Insurance Mediation Directive and MiFID I (2004/39/EC). However, it is also relevant in relation to the application of the IDD and MiFID II.
Although it is likely that there will be fewer regulatory changes in the year ahead, insurance and reinsurance companies must continue to improve and refine their business in order to ensure compliance with applicable requirements and market practice.

It is expected that both insurers and insurance intermediaries will increase their presence on the web by providing automated advice in the insurance field. The SFSA has already today taken a more active role in this area by investigating pros and cons, risks and legal requirements.

There are also developments in the area of insurtech, although they are not believed to progressing as quickly as in the fintech sector. In general, the Swedish insurance industry and the products provided are very traditional, which means it will take some time before there are developments mirroring those in the fintech area.
INTRODUCTION

The Swiss insurance and reinsurance market is very diverse. All types of companies are represented, from globally operating all-liners to locally based providers of customised solutions. However, the Swiss insurance market does not consist solely of large, internationally orientated companies; in addition to a broad midfield, a large number of small, locally established companies are characteristic of Switzerland’s insurance landscape. Some of these companies were founded as social self-help organisations and are run on cooperative lines to this day.  

In 2017, the total number of insurance companies under supervision was 204 (of which 48 were branches of foreign insurance companies). The total number of reinsurers was 55 (of which 27 were reinsurance captives).

REGULATION

The regulatory body in Switzerland is the Swiss Financial Market Authority (FINMA), which regulates banks, insurers, insurance intermediaries, collective funds and the financial markets. The insurance sector of FINMA (including reinsurance) is dealt with by approximately 100 employees. For social insurance businesses (such as mandatory health and accident insurance as well as occupational pension funds), the Swiss Federal Office of Social Insurance is the competent regulator.

As Switzerland is not a member of the European Union (EU) or the European Economic Area (EEA), the freedom of services regime and the possibility to apply for local passporting rights do not apply. Although there are bilateral treaties between the European Union and Switzerland in place, there is no single passport of licences between EEA Member States and Switzerland. The only exception is the bilateral treaty between Switzerland and the Principality of Liechtenstein, where both countries give each other freedom of services in insurance matters. In addition, the Agreement between the EU and Switzerland concerning direct insurance of 10 October 1989 is in place, which lays down the conditions necessary...
and sufficient to enable insurers whose head offices are situated in an EEA Member State to establish branches in Switzerland and vice versa. This Agreement is particularly important for determining the jurisdiction in which an insurance activity is given.\(^5\)

Insurance supervision is regulated by the Insurance Supervisory Act (ISA) and the respective Insurance Supervisory Ordinance (ISO). According to Article 2 of the ISA, the following insurance undertakings fall under the supervision of FINMA: Swiss insurance companies that have their seat in Switzerland and carry out direct insurance or reinsurance business; and foreign insurance companies (without their seat in Switzerland) that conduct insurance activities in Switzerland (and are therefore doing Swiss business).

Business is considered to be Swiss business if the policyholder or any of the insureds is domiciled in Switzerland or if the insured property is located in Switzerland.\(^6\) Whether the product is physically distributed in Switzerland is irrelevant.

Exempt from supervision are foreign insurance companies (i.e., companies that have their seat abroad) if they only operate reinsurance in Switzerland\(^7\) or write as primary insurer the following risks in relation to marine, aviation and international transport: risks lying abroad (irrespective of whether the policyholder or the insured is domiciled in Switzerland), and war risks.\(^8\)

If none of the above-mentioned exceptions apply, the insurance company is subject to Swiss supervision and needs to obtain approval from FINMA before it commences insurance activities.\(^9\) If a foreign insurance company does not intend to apply for authorisation it is, apart from the above-mentioned exceptions, only permitted to write business in Switzerland as a reinsurer. Policies would then have to be issued by a Swiss licensed fronting company, and the foreign insurance company would act as a reinsurer and be exempt from Swiss supervision.

Insurance intermediaries also fall under the supervision of FINMA. The law basically draws a difference between those that are affiliated with insurance undertakings and those that are not (i.e., brokers). Both fall under the supervision of FINMA, but only non-affiliated intermediaries need to be registered in the register of insurance intermediaries.\(^10\) The supervision of FINMA only relates to the intermediary’s activities in Switzerland; activities of the intermediary performed abroad are not supervised by FINMA even if the intermediary is based in Switzerland.\(^11\)

An insurer or reinsurer seeking approval to carry out insurance or reinsurance activities has to submit an application to FINMA together with a business plan.\(^12\) The application and the business plan are based on a number of standardised forms.

With regard to taxation, the Swiss tax authorities levy Swiss federal stamp duty at a rate of 5 per cent on insurance premiums. This does not apply to reinsurance premiums, and there are certain exceptions for primary insurance as well (such as cargo, health, life and accident insurance). VAT is not levied on insurance or on reinsurance premiums.

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\(^5\) Cf. Article 8.2 of this treaty.
\(^6\) Article 1(1) ISO.
\(^7\) Article 2(a) ISA.
\(^8\) Article 1(2) ISO.
\(^9\) Article 3(1) ISA.
\(^10\) Articles 42 and 43 ISA.
\(^11\) Article 182 ISO.
\(^12\) Article 4(1) ISA.
III  INSURANCE AND REINSURANCE LAW

i  Sources of law

Switzerland is a civil law country and, as such, the law recognised as authoritative is statutory law passed by the competent legislature, which may be at the cantonal or federal level depending on what is provided for in the Federal Constitution of the Swiss Confederation. The legislation for private insurance is in the competence of the federal state.\(^{13}\)

The key source of private insurance contracts is the Federal Act on Insurance Contracts (ICA). Complementary to that, the Swiss Civil Code and the Code of Obligations (CO) have to be considered. The ambit of the ICA is limited by its Article 100, according to which reinsurance contracts are not regulated by the ICA but by the CO. In an international context the Federal Act on Private International Law Act (PILA) has to be consulted to determine the relevant governing law.

In a broader sense, insurance law is composed of not only these core provisions, but also of the law of special subjects. Examples include, but are not limited to, consumer protection law, data protection law and the law against unfair competition.

ii  Making the contract

Conclusion of the contract

Where an offer is made by the insured and no time limit is set, it remains binding on the offerer for 14 days.\(^{14}\) If the insurance requires a medical examination, the application period is extended to four weeks.\(^{15}\)

The conclusion of an insurance contract necessitates mutual consent with respect to the essential terms and the expression thereof by the parties.\(^{16}\) For this reason, an insurance contract is reached if the parties agree that by the occurrence of a specified event the insurer has to deliver a specific performance and, in return, the insured has to pay the premium.

Pre-contractual duty of disclosure and representations

In the ambit of the ICA, Swiss law differs from the risk-declaration paradigm adhering to the doctrine of utmost good faith and its associated subdivision of representations and non-disclosure.

The insurer is responsible for obtaining the necessary information to assess the risks.\(^{17}\) With respect to the relevant risk factors, a customer only has to disclose information that the insurer explicitly requests in writing.

However, the principle of utmost good faith is relevant in the field of reinsurance business. The insurer is obliged to disclose all information needed by the reinsurer to make its underwriting decision (e.g., tariffs, contract terms or underwriting guidelines).\(^{18}\)

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13  Article 98(3) Federal Constitution of the Swiss Confederation.
14  Article 1(1) ICA.
15  Article 1(2) ICA.
16  Article 1(1), Article 2(1) and Article 18(1) CO.
17  Article 4(1) ICA.
Further, the concept of ‘warranty’ as such is not known to Swiss law. What appears to best correspond with this concept are the duties that insureds take on at the conclusion of a contract for loss avoidance. However, the infringement of this duty only has an effect if it has an impact in a concrete insured event.\(^\text{19}\)

**Recording of the contract**

**Freedom of formality**

Article 11 of the CO states the freedom of formality. Thereafter, the CO does not require parties to follow a specific form to achieve legally binding contracts unless the law provides otherwise. Since neither the CO nor the ICA demand observance of form, insurance contracts can be effected orally or even without using words by consenting behaviour. However, the insurer has to inform the insured before or at the conclusion of the contract about the identity of the insurer and the essential terms of the insurance contracts (i.e., the insured perils, the premiums as well as the inception and termination of the insurance contract).\(^\text{20}\)

**Decisiveness of the insurance policy**

On conclusion of an insurance contract, the ICA commits the insurer to issue an insurance policy that records the parties’ rights and obligations. Thereby, the policy performs the function of an instrument of evidence, and in conjunction with the insurer’s signed offer it gives certain alleviations in recovery proceedings for premiums.\(^\text{21}\)

Pursuant to Article 12 of the ICA, the policyholder has to claim correction within four weeks in the event that the policy deviates from the original contract terms. In cases of default, the insurance policy has constitutive effect in the sense that its purport shall be deemed approved.

**iii Interpreting the contract**

Article 18 of the CO provides that the genuine will of the parties to the contract is key to any interpretation. Accordingly, a judge has first and foremost to establish the parties’ real intent, which might differ from their written legal act.

If a court cannot ascertain the parties’ intentions or if there is no consensus, the court will resort to the parties’ presumptive intent. The court thereby establishes objectively how the parties, considering all circumstances, could and should have understood the contract’s contested clause or clauses in good faith.\(^\text{22}\)

In interpreting the contract, a judge avails himself or herself of different means and rules. The primary instrument with precedence over the other means relates to the wording used by the parties. All the circumstances under which the contract has been concluded also need to be considered. For that reason, the judge particularly takes into account the

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\(^{19}\) Article 29 ICA.

\(^{20}\) Article 3 ICA.

\(^{21}\) Stephan Fuhrer, op cit. 17, No. 3.96.

purpose of the contract and the parties’ interests in the performance thereof;\textsuperscript{23} the history of the contractual negotiations and the conduct of the parties before entering into the contract (historical interpretation);\textsuperscript{24} and usages in the specific field.

Findings based on these means of interpretation are subject to further rules of interpretation. The most important are as follows:

\textit{a} The ‘principle of trust’, which is particularly important. Based on this principle a statement made by one party is to be interpreted from the addressee’s objective point of view.

\textit{b} Contract provisions. These provisions should be interpreted with regard to the place they occupy in the contract’s structure and the purpose they serve within that structure (systematic interpretation).

\textit{c} Swiss statutory rules. Statutory provisions of Swiss contract law are divided into two types: mandatory and supplemental rules. Where the contract regulates an issue, but the meaning of the contract’s provisions is unclear, the parties can be presumed to have ascribed to their agreement the same meaning as that resulting from supplemental law.\textsuperscript{25} This rule of interpretation does not extend to mandatory statutory provisions, as these will apply in any event and take precedence over the contract’s terms.

\textit{d} The interpretation in \textit{dubio contra stipulatorem}. Wording that can be understood in good faith in different ways will normally be interpreted in accordance with the understanding of the party that did not draft the disputed provision.\textsuperscript{26} For insurance matters, this rule is specifically reflected in Article 33 of the ICA.

The field of direct insurance agreements essentially consists of the practice of two types of contract terms: those in separate agreements; and the insurers’ general standard terms and conditions (GTCs). The latter only take effect if they are being specifically referred to on the occasion of concluding the contract and only insofar as no other specific individual agreement exists.\textsuperscript{27}

The admissibility of GTCs in insurance contracts is further subject to Article 8 of the Federal Act Against Unfair Competition (UCA). According to that norm, GTCs shall be deemed abusive where they create a significant and unjustified disparity between contractual rights and obligations to the detriment of consumers in a manner that breaches the principle of good faith. This norm empowers the courts to review the content of GTCs in business-to-consumer contracts and to void any clauses that do not meet the requirements of Article 8 of the UCA.

\textbf{iv Intermediaries and the role of the broker}

Pursuant to Article 40 of the ISA, insurance intermediaries refers to all persons offering or concluding insurance or reinsurance contracts. This extends to agents, brokers and independent insurance advisers as well as the sales force of insurance companies.

\textsuperscript{23} Federal Supreme Court judgments, reported at BGE 129 III 702, at p. 707; and at BGE 119 II 368, at p. 373.
\textsuperscript{24} See, for instance, the Federal Supreme Court judgment, reported at BGE 114 II 265, at p. 267.
\textsuperscript{25} Gauch et al, op cit. 21, No. 1230.
\textsuperscript{26} Federal Supreme Court judgments, reported at BGE 119 II 368, at p. 372, and Federal Supreme Court Judgment No. 4C.215/2002 of 11 November 2002, consid. 2.4.
\textsuperscript{27} Gauch et al, op cit. 21, Nos. 1128 et seq. and 1138 et seq.
Switzerland

As a consequence, all intermediaries falling under the provision of Article 40 of the ISA are subject to the supervision of FINMA. However, only insurance intermediaries that are not affiliated with an insurance company legally, financially or in any other capacity (in essence that means brokers) are subject to registration.\textsuperscript{28} Affiliated insurance intermediaries, on the other hand, are free to register (tied agents). Rules as to the question of when affiliation is assumed can be found in Article 183 of the ISO. Especially noteworthy are Letters (a) and (b) of Paragraph 1, which state that no registration is required if the majority of the commissions the intermediaries receive during a calendar year are predominately from one or two insurers; and if the intermediaries receive compensation or other financial advantages from insurers that do not conform to customary compensation for insurance intermediation, and that therefore could affect their independence.

From a regulatory point of view, brokers are obliged to disclose to potential customers at first contact various information (i.e., the broker’s or the insurer’s identity, persons that can be held liable for negligence or information regarding the processing of personal information).\textsuperscript{29} Many Swiss brokers are members of the Swiss Insurance Brokers Association,\textsuperscript{30} which has its own conduct rules.\textsuperscript{31} These rules set out ethical standards, the duties of the broker (providing risk analysis, drafting of policies, customer support and assistance in claims handling), and his or her relationships with the insured and the insurer.

The qualification of intermediaries as either tied agents or brokers has an impact on their duties while contracting. The relation between broker and customer is deemed a mandate under Swiss law that provides a duty of care of the brokers for the customer’s interest in a comprehensive manner. Failing to do so may lead to liability. Since this liability arises in connection with commercial activities conducted under official licence, any exclusion thereof may apply at most to slight negligence.\textsuperscript{32} To cover these claims, brokers are, under regulatory law, obliged to have professional indemnity insurance or similar financial security.\textsuperscript{33}

The loyalties and duties of a tied agent as against a prospective client are far more limited. Since agents are to assign to the legal sphere of the insurer, the duty to advise ranges only over their own products. Market expertise is not required. Unlike with brokers, a breach of a duty of care may be attributed to the insurer, which can be held liable for it.\textsuperscript{34}

\textbf{v} \hspace{1cm} \textbf{Claims}

The insured has to inform the insurer about an event covered by the policy as soon as he or she becomes aware of the incident and the resulting claims.\textsuperscript{35} Unless otherwise agreed, there is no procedure that has to be followed. Negligent delay in providing this information entitles the insurer to reduce claims to the extent that the loss could have been avoided or mitigated in the case of timely notification.

\textsuperscript{28} Article 43(1) ISA.

\textsuperscript{29} Article 45 ISA.

\textsuperscript{30} See www.siba.ch.


\textsuperscript{32} Article 101(3) CO.

\textsuperscript{33} Article 44 ISA.

\textsuperscript{34} Article 34 ICA.

\textsuperscript{35} Article 38(1) ICA.
At the insurer’s request, the beneficiary must disclose all circumstances relevant to the course or the future development of the incident in question. Deliberate misrepresentation or concealment of such facts that could diminish or suspend an insurer’s obligations void the coverage. Further, an insurer is released from its obligations if the insured does not report a loss with the intent to ameliorate his or her position.

In the event of a partial loss, both the insurer and the policyholder may terminate the insurance policy.

Insurance payments are due four weeks after the date the insurer received sufficient information to legitimate a claim under the policy. Should there be outstanding premiums, the question of set-off arises. In line with Article 120 of the CO, where two persons owe each other sums of money, and provided that both claims have fallen due, each party may set off their debt against their claim (i.e., a person who has undertaken an obligation in favour of a third party may not set off that obligation against that party). However, there is an exception in direct insurance for the account of third parties. In this case, the insurer can set off claims for outstanding premiums against the beneficiary even though the latter is not the debtor of the premium.

As regards dispute resolution clauses, jurisdiction and arbitration clauses are permitted and often found in insurance and reinsurance contracts, the latter particularly in reinsurance contracts. Mediation clauses are legally possible, although in practice are very rare.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Jurisdiction

In a domestic context, the court at the domicile or registered office of the defendant or at the place where the characteristic performance must be rendered has jurisdiction over actions related to contracts. For actions arising out of the commercial or professional activity of an establishment or branch, the court at the defendant’s domicile or registered office or at the location of the establishment has jurisdiction. However, in disputes concerning consumer contracts for actions brought by the consumer, the court at the domicile or registered office of one of the parties has jurisdiction.

International disputes in Switzerland are ruled by the PILA and international treaties, as applicable. In the European field, the Lugano Convention is of particular importance. The Convention includes a special chapter concerning insurance disputes. The consumer-related norms in Article 15 et seq. do not apply.

36 Article 39 ICA.
37 Articles 39 and 40 ICA.
38 Article 42 ICA.
39 Article 41 ICA.
40 Article 122 CO.
41 Article 18(3) ICA.
42 Article 31 of the Civil Procedure Code.
43 Article 12 CPC.
44 Article 32 CPC.
45 Convention of 30 October 2007 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.
Jurisdiction clauses have to be in line with the body of law applicable according to the situation. In purely domestic situations, the Civil Procedure Code (CPC) has to be consulted. International disputes demand the consideration of the PILA or international treaties. In European matters, the Lugano Convention is again relevant.

**Choice of law**

Choice of law under consumer contracts is prohibited.\(^{46}\) In all other cases, parties may diverge from the general rules.\(^{47}\) However, provisions of Swiss law – the application of which, owing to their particular purpose, is compulsory irrespective of the governing law designated by the parties – remain unaffected.\(^{48}\) Relevant case law in this respect has yet to be established.

**ii Litigation**

**Stages**

The cantons may designate a special court (as in Zurich, Berne, Aargau and St Gallen) that has jurisdiction as sole cantonal instance for commercial disputes (the commercial court). Commercial proceedings are considered insurance matters with a value in dispute of at least 30,000 Swiss francs and involving parties registered in the Swiss Commercial Registry or in an equivalent foreign registry.\(^{49}\) If only the defendant is registered and the value in dispute is reached, the claimant may choose between the commercial court and the ordinary court.\(^{50}\) In Zurich, the ordinary courts are the district courts and, for proceedings where the sum in dispute is less than 30,000 Swiss francs, the single-judge courts. All these courts have the function of trial courts.

Appeals in line with Article 308 et seq. of the CPC are admissible against final decisions of ordinary courts if the value of a claim in the most recent prayers for relief is at least 10,000 Swiss francs.\(^{51}\) These appeals may be filed on grounds of incorrect application of law or incorrect establishment of the facts.\(^{52}\)

No internal cantonal remedy is given for commercial court decisions – that is, the remedies mentioned only apply if claims are filed with the ordinary courts.

Commercial court and high court final decisions are subject to appeal to the Federal Supreme Court if the dispute value is at least 30,000 Swiss francs.\(^{53}\) With respect to allegations of infringement of federal law, the judges’ cognition is not limited. Factual findings of a prior instance may only be overruled if they are obviously wrong.\(^{54}\)

\(^{46}\) Article 120(2) PILA.  
\(^{47}\) Article 116 PILA.  
\(^{48}\) Article 18 PILA.  
\(^{49}\) Article 6(1) CPC.  
\(^{50}\) Article 6(2) CPC.  
\(^{51}\) Article 308 CPC.  
\(^{52}\) Article 310 CPC.  
\(^{53}\) Article 74 Federal Supreme Court Act.  
\(^{54}\) Article 105(2) Federal Supreme Court Act.
Evidence
Testimonies, physical records (documents), inspections, expert opinions, written statements, and questioning and statements of the parties are all admissible evidence. Testimonies, expert opinions and physical records form the primary type of evidence in insurance proceedings. Statements of the parties are of minor importance.

Costs
Procedural costs include court and party costs that the unsuccessful party must bear. In both cases, the courts mostly award costs by reference to a cantonal tariff. The courts have discretion to amend the amount payable under the tariff by reference to a number of factors, such as the complexity of the case, the number of hearings and the number of documents processed.

The fee agreement between clients and lawyers can be made without regard to cantonal tariffs and provisions. It is most common to agree on an hourly rate. Lump-sum agreements are admissible as long as such fee is in line with the estimated services being rendered by the lawyer.

The limits within which success fees are allowed are unclear under Swiss law. However, it can be stated that these fees are permitted if there is an agreed hourly fee (which must cover the lawyer’s costs), and an incentive payment comes only in addition to the hourly rate, and is not of predominant significance to the extent that conflicts of interest could arise.

Funding the process
A person is entitled to legal aid if he or she does not have sufficient financial resources and the case does not seem to be devoid of any chances of success. 55

If the person seeking aid wins, the losing party pays the successful party’s legal fees. If the person seeking aid loses, his or her legal fees will be paid by the canton. An indemnity for the opposing party, if any, still has to be paid by the person seeking aid. 56 Rendered legal aid must be reimbursed as soon as the beneficiary is in a position to do so. 57

The costs of a lawsuit can be insured by means of legal assistance insurance, although such insurance in Switzerland usually provides a waiting period of three months or more.

Third-party funding is lawful in Switzerland, and is not specifically regulated.

iii Arbitration
Although it would be permissible to provide an arbitration clause in an insurance policy, this is not seen very often. However, arbitration clauses sometimes appear in directors’ and officers’ liability insurance and other financial lines of business policies.

A special form of arbitration is compulsory in legal assistance insurance where the insurer and policyholder have different opinions in respect of the measures to be used for the handling of the claim. 58

In reinsurance matters, arbitration is the usual means to resolve potential disputes. Swiss arbitration is, however, not very often seen, but usually arises in retrocession agreements. If

55 Article 117 CPC.
56 Article 122 CPC.
57 Article 123 CPC.
58 Article 169(1) ISO.
the parties agree on Swiss arbitration, they usually prefer *ad hoc* rather than institutional arbitration. If the reinsurance contract does not provide in detail the type of proceedings they would like to follow, the arbitrators will decide how they will proceed\(^59\) and will normally refer to the UNCITRAL Arbitration Rules. In *ad hoc* arbitration, arbitrators usually work on an hourly rate basis.

The role of the courts is limited in international arbitration. The arbitral panel renders its own procedural orders, provides precautionary measures and takes evidence on its own.

The influence of the national courts is limited to those cases where its assistance is necessary (i.e., where one party does not comply with precautionary orders\(^60\) or where evidence can only be taken with the assistance of the courts).\(^61\) Further intervention of the national courts could be for the appointment, removal or replacement of an arbitrator in the event that one of the parties defaults.

The grounds for appeal against awards in international arbitration are very much restricted. The only remedy would be an appeal to the Federal Supreme Court, and the grounds for appeal would be limited to a violation of fundamental procedural rights as follows:\(^62\)

\begin{itemize}
  \item[a] the sole arbitrator was designated or the arbitral tribunal was constituted in an irregular way;
  \item[b] the arbitral tribunal wrongfully accepted or declined jurisdiction;
  \item[c] the arbitral tribunal decided on points of dispute that were not submitted, or it left undecided prayers for relief that were submitted;
  \item[d] the principle of equal treatment of the parties or the right to be heard was violated; or
  \item[e] the award is incompatible with public policy.
\end{itemize}

Where no party has its domicile or a business establishment in Switzerland, the parties may exclude any challenge to the arbitral award (or confine the exclusion to specified grounds for challenge) by an explicit declaration in the arbitration agreement or in a subsequent written agreement.\(^63\)

**iv Alternative dispute resolution**

Methods for alternative dispute resolution (including mediation) are rarely used in the wording of primary insurance policies.

In reinsurance contracts, the parties are usually obliged to try to settle their claims amicably or go to a mediator before they initiate arbitration. However, the binding effect and consequences of a breach of this obligation are not very clear, apart from the fact that the obligation could not prevent one party from initiating arbitration without having followed the required methods laid down in the reinsurance contract.

\(^{59}\) Article 182(2) PILA.
\(^{60}\) Article 183(2) PILA.
\(^{61}\) Article 184(2) PILA.
\(^{62}\) Article 190(2) PILA.
\(^{63}\) Article 192(1) PILA.
v Mediation

Mediation is not very established in commercial matters (including insurance and reinsurance), and there are no known mediation centres in Switzerland. If the parties intend to go to a mediator they would do so abroad (particularly in England, the United States or Singapore).

The Swiss courts do not encourage parties to go to mediation. However, some judges (in particular in the Zurich and Berne Commercial Courts) prefer to summon parties to a hearing and try to convince them to settle the claim.

V YEAR IN REVIEW

The Swiss Federal Council’s plan to completely revise the ICA (after it was amended in 2006) ultimately raised too many controversial issues, and it was requested to prepare a partial revision, which was presented on 28 June 2017. At the time of writing, it is uncertain whether this revision will enter into force. The revised bill will extend the right of injured parties to directly claim against insurers only partially (the original bill provided a general possibility for direct claims). An amendment of considerable significance relates to the recourse possibilities of insurers. This amendment would also be in line with a 2018 ruling of the Federal Supreme Court that facilitated the recovery rights of insurers against liable parties.64 Previously, their right of recourse was restricted; for instance, the insurer covering damage was not able to take recourse against the responsible person if it was only liable based on strict liability or if it was contractually liable but did not act through gross negligence.65 The revised ICA will provide for a norm that leads to full subrogation rights by putting insurers into the shoes of the insureds and, thus, also enabling property insurers to take recourse actions in matters such as those mentioned above (see the Article 95c of the ICA).

VI OUTLOOK AND CONCLUSIONS

Switzerland has long been an important centre for the reinsurance industry for a variety of reasons. The trend of moving reinsurance business to Switzerland was originally started by companies with large exposures in the United States. The process is known in Switzerland as ‘redomestication’, as under Swiss corporate law it is possible to move a foreign domiciled company into Switzerland without dissolving it. Currently, Brexit and its effect on the insurance industry is being widely discussed.

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64 Federal Supreme Court judgment of 7 May 2018 (Case No. 4A_602/2017).
Chapter 32

**TURKEY**

*Pelin Baysal and Ilgaz Önder*

I INTRODUCTION

i Nature of the insurance and reinsurance market

There are 62 active insurance companies incorporated in Turkey, consisting of 39 non-life insurers, 18 life and pension insurers, four life insurers and one reinsurer. Reinsurance cover is mostly provided to Turkish insurance companies by foreign reinsurers.

The premiums collected in 2018 amounted to approximately 48.3 billion lira, an increase of 17.3 per cent compared with the previous year. Of this aggregate value, approximately 41.9 billion lira was derived from non-life insurers, whereas approximately 6.4 billion lira was derived from life insurers. These values include the premiums collected from both inside and outside Turkey.

Insurance sales in Turkey are conducted via direct sales, agencies, bancassurance and brokers. Agencies had the biggest share in 2016, with their total sales accounting for over 60 per cent of the total, and worth around 25 billion lira. This significant amount of sales is because of the strong presence of agencies in Turkey; there were more than 15,000 actively operating agencies as at 2015.

Agency sales are followed by bancassurance sales. Bancassurance grew from 17 per cent to 22 per cent from 2008 to 2016, exceeding 8.8 billion lira in total sales. In 2015, bancassurance became the main life-insurance distribution channel in Turkey. Banks function as agents bringing together insurers and clients, demanding simple and low-cost products from trusted financial institutions.

In recent years, foreign investors’ interest has grown significantly with the stabilisation of the economy, the efforts to comply with the laws and regulations of the European Union, and the considerable insurance potential in Turkey. The foreign share in the insurance sector...

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1 Pelin Baysal is a partner and Ilgaz Önder is an associate at Gün + Partners.
4 [https://www.tsb.org.tr/resmi-istatistikler.aspx?pageID=909](https://www.tsb.org.tr/resmi-istatistikler.aspx?pageID=909); see also Turkey Insurance Sector Report, October 2018, prepared by Allianz Sigorta AŞ ([http://www.odd.org.tr/folders/2837/category1/docs/2322/T%C3%BCrkiye%20Sigorta%20Sekt%C3%B6r%C3%BCKer%C3%B6R%20Raporu%20Ekim%202018.pdf](http://www.odd.org.tr/folders/2837/category1/docs/2322/T%C3%BCrkiye%20Sigorta%20Sekt%C3%B6r%C3%BCKer%C3%B6R%20Raporu%20Ekim%202018.pdf)).
at the end of 2013 totalled 61.29 per cent of active insurance companies.\textsuperscript{7} Statistics reveal that 76 per cent of the reinsurance market is dominated by foreign reinsurance companies, whereas the remaining coverage is provided by one active reinsurance company established in Turkey.

The premium to gross domestic product (GDP) ratio in Turkey is low, demonstrating potential for growth in the future.\textsuperscript{8} The ratio of gross premiums, which has increased by 19 per cent since 2012, constitutes only 1.5 per cent of GDP.\textsuperscript{9} The goal of the insurance sector is to generate up to 63 million lira in premiums by 2023.\textsuperscript{10} Despite growing awareness of insurance, the Turkish insurance market is still under-penetrated and there is a significant lack of legal and practical experience, particularly with respect to various types of policies, including directors’ and officers’ liability insurance, employee infidelity, commercial crime and various aspects of complex policies, such as all-risks construction and engineering policies.

\textbf{ii The legal landscape for insurance and reinsurance disputes}

Enforcement through the Turkish court system is a lengthy process. Subject to a monetary limit, insurance disputes are handled by general first instance commercial courts. Lack of sufficient experience and specialisation, coupled with the inadequacy of the legislative provisions of the old Commercial Code (replaced by the new Turkish Commercial Code (TCC) as of 1 July 2012), as well as case law leads, in addition to other hurdles of Turkish litigation, to a considerable level of uncertainty with respect to the outcome of court proceedings.

Out-of-court settlements are therefore frequently used. Courts cannot force parties to settlement or alternative dispute resolution but are required to remind them of their options at the end of the preliminary examination. Apart from arbitrary and voluntary settlement prospects, the legislature introduced a mandatory mediation preceding the court litigation (see Section IV.vi for more information about mediation).

In 2007, a voluntary insurance arbitration system was introduced. The total number of disputes settled by the Insurance Arbitration Commission reached 129,448 as at 31 December 2017,\textsuperscript{11} and 195,775 as at 30 September 2018.\textsuperscript{12} This dramatic and constant increase over the past years clearly reveals that arbitration is becoming more popular. Traffic insurance and car insurance disputes accounted for approximately 98 per cent of the applications.\textsuperscript{13}

\begin{itemize}
\item \textsuperscript{7} Insurance Union of Turkey, ‘Statistics of Foreign Insurance and Reinsurance Companies’, 12 February 2014.
\item \textsuperscript{11} http://www.sigortatahkim.org.tr/E-BULTEN-32.html.
\item \textsuperscript{12} http://www.sigortatahkim.org.tr/E-BULTEN-35.html.
\item \textsuperscript{13} http://www.sigortatahkim.org.tr/files/isttstk35.pdf.
\end{itemize}
II REGULATION

i The insurance regulator

The insurance regulatory agency in Turkey is the Insurance Undersecretariat of the Treasury (the Undersecretariat).

An insurance company in Turkey can only operate in the form of a joint-stock company or, in the case of mutual insurance funds, a cooperative company. Before incorporation, insurance companies must obtain approval from the authority. They must also apply to the Undersecretariat for licensing in each insurance licence class. Companies that fail to apply for an insurance licence within one year of their incorporation will lose their right to use ‘insurance’ in their commercial names, as well as being subject to criminal and administrative penalties.

An insurance company is not allowed to be active in both the life and non-life insurance divisions or in any sector not related to insurance.

The minimum paid share capital of an insurance company is 5 million lira, paid in cash.

A foreign insurance company can only operate in Turkey by opening a branch, by incorporation of a company in Turkey or by acquisition of shares of a local insurance company. However, the Undersecretariat, according to its Circular No. 2007/5, does not consider it to be an ‘operation’ conducted in Turkey if the foreign reinsurance company, without engaging in any marketing activities in Turkey, merely receives – and accepts – a proposal from the local insured or broker to underwrite a risk in Turkey.

Insurable interests of residents in Turkey must be insured by insurance companies established in Turkey with a limited number of exceptions, such as the import and export of freight, ship chartering and life insurance. Non-compliance with the above conditions shall be subject to criminal sanctions including imprisonment and fines. Because of the above restrictions, fronting arrangements are frequently made with local insurance companies.

There are a considerable number of areas of compulsory insurance in Turkey, particularly for hazardous activities. The most widespread type of compulsory insurance is cover for motor vehicles. In addition, earthquake insurance for private dwellings, third-party liability for passengers on intercity and international transport, medical malpractice, professional indemnity insurance for independent auditors and those providing services to banks are other types of compulsory insurance.

In 2015, to enhance working conditions and ensure workers’ safety after the mining disaster in Soma (Manisa), which is Turkey’s worst-ever industrial accident resulting in the deaths of 301 miners, the Council of Ministers introduced compulsory personal accident insurance for miners. Furthermore, in 2015, the amendment to the Regulation on the Tracing of Compulsory Insurance specifically stipulated that those insurance companies authorised to provide insurance services covering an area of compulsory insurance, cannot refrain from issuing compulsory insurance and cannot amend insurance policies in such a way that excludes risks related to the compulsory insurance.

The Insurance Act provides security funds as a precaution for losses to be indemnified because of compulsory liability insurance. For instance, injured persons can resort to the fund for physical injuries if the injury cannot be attributed to anyone or those responsible for the injury are uninsured, or for physical injuries and pecuniary damages in the event the insurance company is bankrupt or its licence is cancelled owing, for instance, to insolvency.

Various activities including transactions related to the commencement of operations; voluntary windings-up or mergers and acquisitions; acquisition by another company with its assets and liabilities; and the transfer of insurance portfolio are all subject to authorisation by the Ministry of Treasury and Finance.
II  Taxation

Insurance company transactions remain exempt from VAT but are subject to a banking and insurance transaction tax (BSMV) and fire insurance tax. Save for the specific exemptions, the general rate of BSMV is determined as 5 per cent of the insurance companies’ transactions and the fire insurance tax, levied at 10 per cent, shall apply to insurance premiums collected on fire insurance purchased for movable and immovable properties within municipal boundaries and adjacent areas.

III  INSURANCE AND REINSURANCE LAW

i  Sources of law

Turkey adopts a continental law system, and legislation is the principle and primary source of law. The provisions of the Turkish Code of Obligations shall be applicable on the insurance contracts where the Insurance Chapter of TCC is silent. The principles of freedom of contract apply subject to the mandatory and protective measures of these Codes. Accordingly, the Council of Ministers is entitled to stipulate compulsory insurance in the interests of the public good, the execution of which cannot be rejected by the insurance companies upon the request of the intended insured.

Although court decisions are in principle not binding, in giving their judgments, local courts tend to rely heavily on the judgments of the Court of Appeal. However, established and consistent case law is lacking with regard to analysis and interpretation of insurance terms and conditions in most of the disputes, especially if the dispute requires technical or engineering expertise; because such disputes are mostly resolved by means of out-of-court settlements.

Turkish law does not explicitly contemplate reinsurance contracts. With the exception of the special provisions under Agriculture Insurance Act No. 5363, the only and main provision that particularly concerns reinsurance agreements is included in the TCC. Insurance companies may reinsure the risk on whatever terms and conditions are deemed fit and necessary (Article 1403). Despite the wording of this particular provision and the fact that there is no other provision that directly concerns reinsurance agreements, many academics take the view that the reinsurance agreements are ultimately subject to the mandatory pro-insured provisions governing insurance agreements. Therefore, in addition to the general rules of contract law, insurance law provisions in the TCC would, to the extent possible, apply to reinsurance relations by analogy. It is, however, not clear to what extent and how provisions of insurance law in each case would apply to reinsurance.

The Insurance Act and subsidiary legislation provide the regulatory framework of the insurance and reinsurance industry.

ii  Making the contract

Insurance contracts are defined in the TCC as:

[A] contract under which the insurer undertakes, in exchange for a premium, to indemnify a loss caused by the occurrence of a danger or risk, harming an interest measurable in monetary terms of a person concerned or to effect payment or to fulfil other performances based on the lifetime or upon occurrence of certain events in the course of the lifetime of one or several persons.

The insurer must issue an insurance policy, recording the mutual rights, obligations (including default and special provisions) and general conditions predetermined by the Undersecretariat...
and signed by the insurer. Written form is not a condition for validity but a regulatory requirement, as a tool for evidencing the content and scope of the coverage, for the protection of the insured.

In this respect, the Insurance Act requires insurance contracts to be drafted in Turkish and devoid of any words in a foreign language. Similarly, the Law on Compulsory Usage of Turkish Language among Commercial Entities, an old law that is still in force and taken into account by the courts, also requires all private law contracts to be drafted in Turkish. The courts, according to the recent precedents, apply this requirement for the contracts concluded with the entities established under the laws of foreign states. There is no concrete consequence of violation of this requirement; however, use of foreign language, depending on the circumstances, may cause the exclusions incorporated into the contract or insurance policy to be deemed void or interpreted to the detriment of the insurer.

The following can be identified as the main elements of insurance to be taken into account when drafting the contract or insurance policy, apart from formal requirements.

**Insurable interest**

The Code refers to an ‘interest measurable in monetary terms’. According to established doctrinal views and practice, an insurable interest in indemnity insurance consists of proprietary, intellectual or personal rights and receivables that are measurable in monetary terms and capable of enforcement by legal action.

With respect to life insurance, the TCC provides that the policyholder can take out insurance on its own life or on the life of another person (person subject of the risk) against death or survival. In the case of insurance on the life on another person, it is required that the beneficiary has an interest in the survival of that person.

Lack of insurable interest not only at the time of the conclusion of the contract but at any stage will result in invalidity of the contract. Provisions to the contrary will render the insurance contract invalid.

**Risk**

The definition of the TCC includes ‘risk’, namely danger that leads to harm to the insured interest. The TCC also explicitly refers to the obligation of the insurer to ‘carry the risk’.

Accordingly, depending on the type of the insurance contract, the risk is transferred to the insurer as soon as the premium paid or the contract is concluded.

The insurer’s obligation to indemnify is subject to the occurrence of the identified risk and the occurrence of a loss as a result of the occurrence of the risk. However, if the risk occurs because of intentional acts of the insured, the insurer shall be released from liability and shall not reimburse the premiums paid.

As insurance and reinsurance contracts are contracts of utmost good faith, one of the statutory duties of the policyholder is the duty of disclosure and not to misrepresent facts known or reasonably expected to be known to him or her before the conclusion of the contract.

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15. Under Article 1429 of the TCC, the common rule is stipulated as ‘Unless otherwise agreed, the insurer shall pay losses arising from the negligence of the insured, the insured, the beneficiary and the persons for whose acts these persons are legally liable.’
The TCC imposes a duty of disclosure on the insured at three different stages, namely, before the conclusion of the contract, during the contract and at the time of occurrence of the risk.

Regarding the duty of disclosure before policy inception, the TCC provides that the policyholder is under a duty to disclose important facts that are, or should be, known to him or her. The TCC also provides that questions asked verbally or in writing by the insurer are presumed to be important unless proven otherwise.

The TCC, after confining the duty of the policyholder to the questions in a list provided by the insurer, explicitly provides an exception where facts were concealed in bad faith. In cases of non-compliance with the duty of disclosure before policy inception, the TCC provides alternative rights for withdrawal of the policy or asking for a change in the premium, both to be used within 15 days of becoming aware of the non-disclosure of important facts. When the request for a change in the premium has not been accepted within 10 days, the insurance will terminate automatically.

When breach of the duty of disclosure has been discovered after the occurrence of the risk, a reduction on the insurance indemnity will be made according to the degree of negligence of the policyholder in its failure to disclose, provided that the negligence has the potential to affect the occurrence of the risk or the amount of the indemnity. When the policyholder acted wilfully, the insurer has no liability for insurance indemnity provided that there is a connection between the non-disclosure and the occurrence of the risk. When there is no connection, the indemnity shall be paid taking into consideration the proportion of the paid premium and the premium that should have been paid if the circumstances had been disclosed.

**Insurance sum**

The insurance sum is subject to the limit of the insured value and the actual loss in indemnity insurance. The TCC forbids agreeing on an insurance sum exceeding the value of the insurable interest.

**Insurance premium**

The TCC provides that ‘unless otherwise contracted, liability of the insurer starts at the time of actual payment of the premium or the first instalment’.

Compliance with the payment schedule is crucial for the insured in order to retain coverage because, subject to certain notification prerequisites, the TCC provides the insurer with the opportunity to avoid the insurance contract without any legal consequence if the insured or policyholder fails to pay the premium instalments.

**Interpreting the contract**

General principles concerning interpretation of contracts in civil law also apply to insurance contracts, especially the principles of utmost good faith and honesty. When ambiguity or contradictions exist in the wording, interpretation in favour of the insured prevails because the primary duty of providing proper wording is on the insurer. The principles of protection of the insured and keeping the insurance contract alive are dominant. One of the main points to be considered in the interpretation is the principle of balance between the risk carried by the insurer during the term of the contract, the premium collected and the interests.
**Incorporation of terms**

Each and every insurance contract should refer to a set of general conditions, which are approved by the Undersecretariat. Apart from the general conditions, it is possible to incorporate special provisions according to needs of the insured within the framework of the mandatory provisions under the TCC; however, insurers should ensure that there is no ambiguity when interpreting the contracts.

The Insurance Act provides that the insurer should not content itself with merely writing down the risk covered under the contract; it must also expressly mention the exclusions. If exclusions are not mentioned by the insurer, they shall be deemed to be part of the insurance coverage.

The TCC provides that, in case of any discrepancy between the policy and the insured’s proposal form, the terms and conditions included in the policy that do not exist in the proposal form shall be deemed invalid.

The insurer, when negotiating and concluding the insurance contract, is under a strict duty to enlighten the insured about the details of the coverage; in the absence of which, the insured is entitled to rescind the insurance contract owing to the undesired terms incorporated into the insurance policy within 14 business days.

**Types of terms in insurance contracts**

Special provisions of insurance contracts have to be drafted in accordance with the standard general terms approved by the Undersecretariat and the mandatory provisions of the TCC. Non-compliance with mandatory provisions may render the contract or the relevant contract provision invalid. There are various legal provisions that cannot be contracted out contrary to the interests of the policyholder, the insured or the beneficiary.

**Warranties – conditions precedent**

Sanctions attached to certain warranties or conditions precedent to cover do not necessarily give the terms the intended effect and may be caught by semi-mandatory or mandatory provisions of the TCC. Where a condition or warranty relates to the duties already provided for by the TCC, such as the duties of disclosure and notification before and during the contract (regarding any increase in the risk) and upon the occurrence of the insured-against event, then semi-mandatory provisions that cannot be amended contrary to the interests of the policyholder, the insured or the beneficiary with respect to such duties and sanctions are highly likely to be applicable. These provisions prevent the insurer from simply rejecting cover on the basis of non-compliance and subject sanctions to various conditions, such as a causal link between the failure in compliance and the occurrence of the risk or the amount of indemnity.

The TCC introduces a specific provision in that regard and provides that where the insurance contract provides for partial or entire avoidance of the contract by the insurer for non-compliance with the contractual duties by the insured (where the sanction of non-compliance with such duties has not already been specifically provided for in the TCC – as explained above), avoidance shall not take effect unless the non-compliance is based on fault. Where non-compliance is based on fault, the right to avoid the policy will cease when it has not been used within one month of learning of the circumstances. Also, the insurer will have no right to avoid the policy unless the non-compliance had any effect on the occurrence of the risk and the extent of the obligations of the insurer.
iv  Intermediaries and the role of the broker

Position of brokers

According to the definition of the Insurance Act, a broker is the person who acts independently and impartially to appoint the insurance companies for contracting insurance policies.

Pursuant to the new Regulation on Insurance and Reinsurance Brokers (the Brokers Regulation) enacted in mid 2015, and which superseded the previous regulation regarding brokers, brokers must obtain a brokerage licence from the Undersecretariat. (This prerequisite was also stipulated in the previous Brokers Regulation.)

How brokers operate in practice

There are various obligations and prohibitions set out for brokers in the Brokers Regulation. For instance, brokers must conduct extended research when appointing insurers, and while they can conclude protocols with insurance and reinsurance companies, they are prohibited from engaging in any other business. Brokers are also prohibited from preparing insurance policies and similar documents.

Under the new Brokers Regulation, the requirements on equity capital and assets have also been amended. A legal entity broker’s minimum capital is set as 250,000 lira and 50,000 lira for any additional type of insurance.

Agencies and contracting

Agencies operate on behalf of insurers, on the basis of a contractual relationship between them and the insurance company.

Agencies also need to be incorporated as joint stock or limited liability companies and obtain the approval of the Undersecretariat, and shall be registered on the Agency Registry indicating whether or not the agencies are granted power to conclude contracts and collect premiums. The approval shall be then promulgated by the Turkish Union of Chambers and Commodity Exchanges.

In April 2013, insurance agencies were prohibited from engaging in business other than agency work in the insurance sector.

v  Claims

Duty of disclosure

Apart from the disclosure duties regarding the conclusion of the contract (as set forth in subsection ii, ‘Risk’), the TCC provides for the duty of immediate notification of the increase of the risk during the term of the contract and provides that the insured and the policyholder must refrain from acts that would increase the amount of insurance indemnity by way of aggravating the risk or current conditions. When the increase has been learned subsequently, the policyholder must notify the insurer within 10 days of learning at the latest.

The insurer has the right to terminate the policy or request premium difference within one month of becoming aware of the increase in the risk. When the non-disclosure was wilful, the insurer will keep the paid premium. When payment of the premium difference has not been accepted within 10 days, the policy will be deemed terminated.

When the increase has been learned of after the occurrence of the risk, the insurance indemnity will be reduced according to the gravity of negligence in the failure to disclose, provided that the non-disclosure is of such gravity that it may affect the amount of the insurance indemnity or the occurrence of the risk. When the policyholder was intentional in
its non-disclosure, the insurer has the right to terminate the policy, provided that there is a
connection between the increase in the risk and the occurrence of the insured event. In such
cases, the insurer will not pay any indemnity and not return the paid premium. When there
is no connection, however, the insurer must pay the indemnity, taking into consideration the
proportion of the paid premium and the premium that should have been paid.

When the risk has occurred before the right of termination has taken effect or within
the period for use of the right of termination, insurance indemnity must be paid taking into
consideration the ratio between the paid premium and the premium that should have been
paid, provided that there is a link between the increase and the occurrence of the risk.

The policyholder also has a duty of disclosure at the occurrence of the risk that relates
to the disclosure of the facts affecting the occurrence of the loss.

In the case of liability insurance, the TCC provides that the policyholder has a duty to
immediately notify the insurer upon learning of the occurrence of the risk, and in the case
of property insurance, the policyholder must notify the insurer without delay. As regards
third-party liability policies, the TCC introduces a new duty on the insured to also notify
events that may give rise to his or her liability within 10 days of learning of the event. When
the notification of occurrence of the risk has not been made or the policyholder was late in
his or her notification, a reduction will be made in the indemnity according to the degree
of negligence in the failure to disclose, provided that the failure caused an increase in the
insurance indemnity.

**Good faith and claims**

Even though the insured’s interest is covered in exchange for the payment of premiums, he or
she must still take appropriate precautions and not negligently cause further losses or aim to
achieve enrichment upon the occurrence of the risk.

In the event that risk materialises or that materialisation of risk becomes highly
probable, the policyholder must, as long as circumstances permit, take measures to prevent
the loss or the increase in its likelihood, to mitigate the loss, and to protect the insurer’s rights
of recourse against third persons.

**Set-off and funding**

The insurer is entitled to deduct the premium due from the indemnity amount or the fixed
sum to be paid with the exception of liability insurance. Set-off may be applicable even in the
event where the insured and the beneficiary are different persons.

**IV DISPUTE RESOLUTION**

**i Choice of jurisdiction**

The Turkish Civil Procedure Code, applicable to local disputes, restricts the freedom of choice
of local jurisdictions to agreements between merchants and agreements between public legal
entities. Insurance agreements with no foreign element concluded with those who do not
qualify as merchants shall therefore be subject to the jurisdiction rules provided for in the
Civil Procedure Code and cannot be contracted out. Accordingly, the courts of the place
where the insurable interest or risk is located are vested with jurisdiction, as an alternative
to the courts of the respondent’s domicile and the place of performance agreed under the
contract.
The Code on International Civil Procedure, regulating conflict of laws, provides with respect to insurance contracts involving a foreign element that the following jurisdiction rules cannot be avoided by contract: (1) claims against insurers are subject to the jurisdiction of the courts at the insurer's principal place of business or the place of incorporation of the insurer's branch or Turkish-incorporated agent that concluded the contract; and (2) where the claim is against the policyholder, the insured or the beneficiary, the courts that have jurisdiction are the courts of its domicile in Turkey. Therefore, parties cannot agree on courts of a foreign country for the resolution of insurance disputes.

Regarding the choice of arbitration in insurance and reinsurance contracts, see subsection iv.

ii Choice of applicable law
Unlike jurisdiction agreements, there is no specific restriction on the law applicable to insurance contracts. The main limitation to the application of foreign law would generally be the existence of a foreign element and Turkish public policy. The general approach under Turkish law is that mandatory rules are not necessarily matters of public policy. Where, however, the insured is not a merchant but a real person, consideration of public policy and the law on 'standard contract terms' protecting the weaker party of the contract may prevail for the sake of protection of the insured.

The requirement of the existence of a foreign element, however, is controversial. In a decision of the Court of Appeal in an insurance case filed by an insured, it was concluded that the choice of a foreign law between two Turkish parties, by itself, would suffice for the fulfilment of the 'foreign element requirement' even if there is no foreign element with respect to the dispute.

Reinsurance agreements with a foreign element are much less likely to be subject to the above restrictions of applicable law although there would obviously be issues of back-to-back cover where different rules could potentially apply to the local insurance.

iii Litigation
Claims to be pleaded directly towards the insurer
With regard to liability insurance, the TCC provides that third parties are entitled to direct their claims to the third-party liability insurer of the person responsible for the loss.

Notification before the pleading
The insured shall notify the loss that is thought to be within the insurance coverage as soon as possible. Maturity of the indemnity payment arises upon conclusion of the insurer's investigations into the scope of the indemnity and, in any case, 45 days after notification of the occurrence of the risk. The investigation of the insurer must be concluded within three months of notification.

Stages of litigation
Insurance disputes are, in principle, dealt with by the first instance commercial courts.

Stages of litigation before the commercial courts are as follows:

a The parties submit a written submission of their claim, defence, rebuttal and rejoinder, and evidence.
A preliminary hearing date is set, where issues such as case conditions (e.g., existence of the judiciary power of the court, disputes on capacity to file and pursue a lawsuit, and allocation of a security if necessary) and preliminary objections (jurisdiction, division between the civil and commercial courts, existence of an arbitration agreement) are to be resolved. The judge shall carry out the required procedure to collect the parties’ evidence. At the preliminary hearing, the judge will also encourage the parties to settle or resort to mediation. In this stage, the parties can amend their evidence and assertions only if the counterparty gives its consent.

The courts almost always revert to court-appointed expert examinations even in legal matters. Hearings are held on the disputed elements of the case, where the court can hear witnesses and obtain expert reports.

Upon assessment of all evidence and facts, the court delivers a short judgment followed by a reasoned judgment. According the new Turkish judicial system, which was introduced on 4 February 2011 by the Civil Procedural Code and became operational for judgments rendered after 20 June 2016, the appeal procedure is to be conducted by a two-tier system comprised of regional appellate courts and the Supreme Court. Accordingly, the decisions of first instance courts concerning a dispute amounting to no less than 3,110 lira can be appealed before the regional appellate courts. Decisions of the regional appellate courts can be appealed before the Supreme Court, provided that the dispute amounts to no less than 41,530 lira.

Despite being operational since 2016, the positive effects of the judicial system are yet to be seen. It is expected to decrease the workload of the appellate courts and accelerate the appeal stage. For this purpose, the Ministry of Justice, referring to European Commission for the efficiency of justice guidelines, implemented new measures on 3 September 2018 for judicial time management and set target lengths for judicial proceedings for the first instance courts. The target for each individual proceeding was made available to parties on 1 January 2019.

Mediation was introduced as a compulsory remedy to be resorted to before filing a lawsuit in commercial matters to decrease the workload of the judicial bodies (see subsection vi).

This would also enable the Supreme Court to evaluate the merited issues of a dispute and prepare more diligent reasoning for their awards, which may hopefully develop case law where law or practice are ambiguous. This is particularly important for insurance law, because the Supreme Court has not, thus far, provided guiding principles for complex insurance disputes that often require a considerable effort to interpret the facts and contracts in order to solve a wide range of issues (e.g., deductibles, exclusions, subrogation).

Evidence

Under Turkish civil law, the adversarial system prevails.

The burden of proof of the existence of the contractual relationship, the occurrence and amount of the loss lies with the insured. The insurer, on the other hand, must prove the lack of cover and application of exemptions. Every transaction exceeding 2,500 lira must be proven by a deed. Witness evidence would only constitute supportive evidence.

Turkish courts frequently refer disputes to a court-appointed panel of experts, even in legal matters. As a novelty, the parties are granted the opportunity to submit expert evidence.

16 Article 341 of the CCP
17 Article 361 of the CCP
views subject to the questions of the judge and the parties (without any common-law-style cross-examination procedure) as supportive evidence without the need to obtain a judge’s order in this regard. Neither expert reports ordered by the court nor expert views submitted by the parties are binding for the judgment.

Costs
Of the claimed amount, 6.831 per cent must be paid as court fees. One-quarter of this amount must be paid to the court in advance by the claimant. Court fees and court expenses (the most significant of which are expert fees – approximately 3,000 to 4,500 lira per expert examination) are recoverable in the event of the case being found in favour of the claimant. The court orders legal fees in favour of the winning party (or to the extent of acceptance by the court of the claimed amount) in accordance with an official tariff. The parties cannot recover actual fees they may have paid to their lawyers. Lawyers’ fees ordered by the court belong to the lawyers unless agreed otherwise between the lawyers and their clients.

Claimants who are of foreign citizenship may also be obliged to submit a warranty to the court, the amount of which shall be determined by the court, subject to exemptions provided by bilateral and multilateral agreements (such as the Hague Convention on Civil Procedure).

iv Arbitration
Pursuant to Law No. 6570 dated 29 November 2014, the Istanbul Arbitration Centre was established and parties have the opportunity to refer disputes, in addition to ad hoc arbitrations and conventional arbitration institutions, to the Centre or to the Insurance Arbitration Commission, whose functions are explained below. The Centre presents an efficient alternative to court litigation, as the costs are low and the length of proceedings is short.

Arbitration clauses
Parties can refer to arbitration for the resolution of insurance disputes by inserting an arbitration clause into the insurance and reinsurance agreement or concluding a separate arbitration agreement between themselves. As mentioned in subsection i, provisions of the Civil Procedure Code apply to parties in arbitration in local disputes, whereas the International Arbitration Act applies if there is a foreign element in the dispute, particularly in disputes between local insurers and foreign reinsurers where the place of arbitration is Turkey.

Insurance Arbitration Commission
The Insurance Act foresees an institutional arbitration proceeding irrespective of the existence of an arbitration clause. Even if the insurance company is not a member of the arbitration system, the insured shall benefit from the relevant arbitration procedure regarding the disputes arising from compulsory insurance.

18 Umar, Bilge; HMK Şerhi sayfa 801 vd.
21 Drafted in consideration of the UNCITRAL Model Law on International Commercial Arbitration, the International Arbitration Act is applicable to those disputes involving a foreign element.
Format of insurance arbitrations

The Commission may appoint a tribunal consisting of a minimum of three arbitrators specialised in life or non-life insurance in cases of arbitration based on the Insurance Act. However, where the disputed amount is equal to or above 15,000 lira, it is compulsory to form a tribunal. The tribunal decides by majority.

Procedure and evidence

The requirement for application to the Commission is a partial or total rejection of the insurance claim.

Applications may not be filed with the Commission regarding disputes that have been referred to a court or to the Arbitration Committee for Consumer Problems.

The application to the Commission shall be first examined by rapporteurs. Applications that cannot be settled by rapporteurs are referred to the insurance arbitrators. Arbitrators have to issue their awards within four months, at the latest, of the date they have been commissioned.

In addition to the procedure of arbitration adopted by the Civil Procedure Code, the arbitrator may consider the case on submitted documents only. Unless otherwise agreed, the tribunal or the sole arbitrator can decide on the provisional injunctions or evidence determination.

Costs

Attorneys’ fees ordered in favour of the party whose request is partially or wholly accepted are one-fifth of the attorneys’ fees that would be rendered if the dispute had been resolved before the state court.

The application fee is determined by the Undersecretariat and varies from 50 lira to 300 lira, depending on the amount of the dispute. 22

The fees of arbitrators are paid by the Commission. Arbitrators shall decide on the additional costs as regulated under the Civil Procedure Code.

Awards

Most of the awards rendered in 2018 by the Commission concerned car insurance policies, compulsory traffic insurance, property insurance and life insurance policies. Compared with court judgments, the awards contain more comprehensive examinations and reasoning.

v Alternative dispute resolution

Complaints of the insured

If the insured has a complaint arising from interpretation of the regulations or conduct of an insurance company, it can apply to the Insurance General Directorate, incorporated under the Undersecretariat.

vi Mediation

Mediation was recognised in Turkish law for the first time by the Mediation Act, which entered into force in June 2013. With the amendment of the TCC, which entered into
force on 1 January 2019, mediation became a compulsory remedy for all commercial claims (including insurance disputes) that had to be resorted, leaving filing a lawsuit before the state courts as a last resort.

The compulsory mediation for commercial disputes under the TCC is designed to be finalised within six weeks, and this can be extended by two weeks if deemed necessary by the mediator.

In the event of a settlement at the end of mediation, the parties may request an annotation regarding the execution of the agreement from the court at the place of jurisdiction. The annotation gives the agreement the power of a court judgment.

V YEAR IN REVIEW

One of the main hot topics continues to be the private pension scheme that became compulsory for employees and public servants. The government is encouraging private pension systems and annuity products by providing contributions to the premiums paid by the policyholders and introducing compulsory pension schemes. With the amendment of the Personal Pension Savings and Investment System Law, employees under 45 were automatically included in the pension system, the premium for which is deducted from the insured's salary. The latest finance news, however, reports that this product has not been as successful as hoped, as 60 per cent of the insureds opted to abandon the scheme shortly after their automatic inclusion. The compulsory enrolment has been applied to businesses gradually based on the number of employees. As of 1 January 2019, businesses consisting of five or more employees are included in the scheme.

Building completion insurance policies, credit insurance policies and short-term trade credit for small and medium-sized enterprises (SMEs) were introduced in 2015 as products, serving the purpose of limiting the effects of economic slowdown and currency volatility. The Undersecretariat issued a communiqué on 24 December 2018 to be effective as of 1 January 2019, which set the guidelines and tariffs to be adopted by insurance companies for credit insurance foreseen for SMEs.

In the last quarter of 2018, the Ministry of Treasury and Finance announced the New Economic Programme, which outlines that 2019 to 2021 will be years of fiscal discipline accompanying a rebalancing of the economy to overcome rapid inflation and reduce the budget deficit. Within the scope of this programme, Berat Albayrak, the Minister of Treasury and Finance, announced that the Turkish reinsurance market will undergo a transformation as, thus far, it has failed to provide sufficient cover for every type and magnitude of risk. This is why building completion insurance policies, among others, have not gained momentum until now.

The legislature is reported to be contemplating a new law that envisages a state-owned reinsurance company and a national pool to boost the investment environment.

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23 Law No. 4632.
VI OUTLOOK AND CONCLUSIONS

According to the European Commission’s Turkey 2018 Report, ‘Turkey has a good level of preparation in the area of financial services. Some progress was made, particularly in making it compulsory for employers to automatically enrol employees in pension schemes.’ The Report also states that, while banks continued to dominate the financial sector, the size of the much smaller insurance sector (including private pensions) increased to 4 per cent.

The government has an objective to be the 10th-biggest economy in the world by 2023, aiming to generate US$2 trillion worth of gross national product. In line with this objective, the government is focusing on the insurance sector, among others. Because of the increase in foreign investment and developments in the Turkish economy, it is expected that the insurance sector will gain momentum in the coming years.

Newly emerging risks, disasters that have been experienced and the economic climate are important motives when shaping the underlying legislation and insurance tools. In that vein, in 2018 the Undersecretariat aimed to enhance insurance regulations to incentivise participants in the insurance market and to develop new products that will create opportunities for insurance companies. Ultimately, this endeavour was limited to compulsory motor liability insurance and individual pension schemes. More progress may be made in 2019. Efforts to align Turkish regulation with EU insurance regulation are expected to continue.

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The Association of the Insurance, Reinsurance and Pension Companies, for instance, has been in constant communication with the Ministry of Treasury and Finance in order to integrate the York-Antwerp Rules 2016 into the TCC, which will take place in 2019.

The endeavours of the Undersecretariat and the Ministry of Treasury and Finance in earlier years to boost the economy, with the support of the insurance sector, failed to attract the desired attention of stakeholders, as in the case of building completion insurance, which aimed to provide relief to the construction sector. In March 2018, the Association of the Insurance, Reinsurance and Pension Companies, in response to a complaint submitted by individuals whose request to obtain building completion insurance was rejected by insurance companies, had to explain that insurance companies cannot provide any reinsurance coverage for such risks. Similar difficulties in obtaining insurance and reinsurance cover have been reported in other sectors, such as textiles and chemicals. However, as mentioned in Section V, the transformation of the local reinsurance market, which would include a state-owned reinsurance company as envisaged by the New Economic Programme, is seen as a constructive solution.

30 https://www.tsb.org.tr/images/Documents/York%20Antwerp%20Kurallar%C4%B1%202016%20Hat%C4%B1rlatma%202018.pdf.
Chapter 33

UNITED ARAB EMIRATES

Sam Wakerley and John Barlow

I INTRODUCTION

i The insurance and reinsurance market

The United Arab Emirates (UAE) insurance market is the largest in the Gulf Cooperation Council (GCC). Nevertheless, there are generally low levels of insurance penetration, which presents both challenges and opportunities within the market.

There are effectively three separate insurance jurisdictions in the UAE: the onshore UAE market; the Dubai International Financial Centre (DIFC) and the Abu Dhabi Global Market (ADGM), of which the latter two are largely wholesale offshore reinsurance centres. The onshore insurance market is largely dependent on reinsurers and significant capacity is now available in the DIFC.

There is also a growing Islamic insurance market within the UAE. Takaful insurance is an alternative system of cooperative Islamic insurance that is found within the region. Takaful insurance is primarily subject to the same UAE laws as non-Takaful insurance, although there are some differences, for example relating to policy content.

ii The legal landscape for insurance and reinsurance disputes

The UAE’s ‘onshore’ legal system

The onshore legal system is founded upon civil law principles with a statutory code as the primary source of law. The court system is heavily influenced by shariah law and operates in the UAE’s official language of Arabic. The legal framework of the justice system operates via two systems: a federal judiciary presided over by the Federal Supreme Court in Abu Dhabi and local judicial departments at the local government level, such as the Dubai courts. There is no system of binding precedent although the doctrine of jurisprudence constante does apply, meaning that decisions of higher courts can be persuasive on lower courts. In addition, the doctrines of reservation of rights and without prejudice correspondence are not expressly recognised under the law. There is also no general doctrine of privilege (whether legal advice privilege or litigation privilege), although the impact of this is minimised by the absence of any obligation of mandatory disclosure. However, the laws governing lawyers’ conduct in the UAE prohibit lawyers from disclosing confidential information provided by their client without the client’s consent.

1 Sam Wakerley and John Barlow are partners at HFW.
3 An analysis of DIFC and the ADGM insurance laws are beyond the scope of this chapter.
4 Insurance Authority Board Resolution No. 4 of 2010.
**DIFC and ADGM courts**

While the onshore courts operate a civil law system, the UAE is home to a series of free zones governed by their own regulations. In the case of the DIFC and the ADGM, these financial free zones have their own civil laws (i.e., non-criminal) and their own common law courts to administer those laws. The DIFC and ADGM court systems are predominantly based on English common law, and substantive civil law and procedure. In relation to binding precedent, which is applicable in the DIFC and ADGM courts, the body of case law continues to grow. In the event that the law is silent, the DIFC and ADGM judiciary has the power to call upon English common law precedent to help determine disputes. In contrast to the UAE onshore court system, the doctrine of privilege and the doctrine of reservation of rights and without prejudice correspondence are recognised concepts in the DIFC and ADGM courts.

**II REGULATION**

**i The insurance regulator**

The onshore insurance market is regulated by the Insurance Authority (IA), which oversees all insurance business in the country (i.e., insurers, brokers and other insurance service providers). Although the IA was established in 2007, and remains in its infancy, there has been a steady increase in regulation, creating a robust framework in which to operate. The scope of IA governance includes insurance and reinsurance companies and licensed insurance intermediaries located or operating in the UAE in order to ensure the protection of customers located or operating in the UAE.

In addition to the IA, there are separate dedicated regulators for the health insurance sector in some of the individual emirates; at present, these are the Dubai Health Authority, the Department of Health of Abu Dhabi and the Sharjah Health Authority.

Further, the Dubai Financial Services Authority and the Financial Services Regulatory Authority, respectively, regulate DIFC- and ADGM-based insurers. Each regulator has its requirements for the authorisation and regulation of companies offering insurance services.

**ii Position of non-admitted insurers**

The law prohibits non-admitted insurers. Any insurer conducting insurance business in the UAE must be licensed by the IA. This prohibition applies to all types of insurance business and is contained in the UAE Insurance Law. The DIFC and ADGM also prohibit non-licensed insurers operating within their jurisdictions.

There are no express legal provisions restricting insurance fronting transactions. Therefore, as long as the insurer is in compliance with applicable prudential limitations in local regulations, there is no provision preventing it from ceding 100 per cent of a given written risk (i.e., fronting the risk), either to a local reinsurer or a foreign reinsurer. In practice, however, reinsurers may impose stricter terms and conditions.

5 Federal Law No. 6 of 2007 on Establishing the Insurance Authority and the Regulation of its Operations as amended by Federal Law No. (3) of 2018.

6 Article 26 of Federal Law No. 6 of 2007 provides that: ‘It is not permissible to carry out insurance with an insurance company outside the state on property in the state, or on the liabilities arising from the same. It is not permissible either to broker for insuring such property or liabilities except with a company registered in accordance with the provisions hereof.’ In practice, the Insurance Authority prohibits any insurance products from being provided by foreign insurers irrespective of the type of risk being insured.
iii  **Position of brokers**

In 2018, the IA passed an Insurance Consultant Resolution,\(^7\) which is expected to result in a significant decrease in the number of insurance consultants and brokers in the UAE. Key regulations of the Insurance Consultant Resolution include the prohibition of persons from practising the profession of an insurance consultant or broker unless he or she obtains a licence from the IA.\(^8\) A licence is valid for one year and renewable annually.\(^9\) Further, a sole insurance consultant or broker whose application is accepted must submit to the IA a professional indemnity insurance policy providing cover of 1.5 million dirhams.\(^10\) A corporate insurance consultant or broker must submit to the IA a professional indemnity insurance policy providing cover of 3 million dirhams.\(^11\)

iv  **Requirements for authorisation**

Insurance and reinsurance activities may be exercised within the UAE by any of the following:\(^12\) a public joint-stock company, listed on a UAE stock exchange and with UAE nationals owning at least a 51 per cent stake in the company; a branch of a foreign insurance company; or an insurance agent.

In relation to branches of a foreign insurance company, the parent company of a branch office must be able to meet risk exposures in the UAE.\(^13\) Companies that fail to comply with their solvency margins and minimum guarantee fund requirements will be liable to an administrative fine of 150,000 dirhams.\(^14\)

Insurers based in the DIFC and ADGM are generally prohibited from insuring risks situated in the onshore UAE market; however, this prohibition does not apply to reinsurance providers.

v  **Regulation of individuals employed by insurers**

The IA must approve individuals working in certain roles, including directors, chief executive officers, compliance officers, finance officers and money laundering reporting officers of an insurer or broker. In addition, an insurer regulated by the IA must circulate the Instructions concerning the Code of Conduct and Ethics, which must be observed by insurance companies operating in the UAE,\(^15\) to its employees, and develop internal professional codes of conduct for the company and its employees.\(^16\)

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\(^7\) Resolution of the Insurance Authority Board Chairman No. 12 of 2018 On the Law of Licensing and Registration of Insurance Consultants.

\(^8\) id., Article 2.

\(^9\) id., Article 9.

\(^10\) id., Article 10.1.

\(^11\) id., Article 10.2.

\(^12\) Article 24 of the Federal Law No. 6 of 2007 on Establishing the Insurance Authority and the Regulation of its Operations as amended by Federal Law No. (3) of 2018.

\(^13\) The method for calculating the solvency requirements is included in Article 4 of the Insurance Authority Board of Directors Chairman Resolution No. 14 of 2018 On Applying the Solvency Requirements.

\(^14\) No. 3 of Cabinet Resolution No. 7 of 2019 Concerning the Administrative Fines Imposed by the Insurance Authority.

\(^15\) Insurance Authority Board Resolution No. 3 of 2010.

\(^16\) Article 3(12) of the Insurance Authority Board Resolution No. 3 of 2010.
vi  Distribution of products

Insurance products can only be distributed in the UAE by insurers and insurance brokers and consultants licensed by the IA, or banks licensed in the UAE via bancassurance arrangements between a locally licensed insurer and the bank.

vii  Compulsory insurance

Third-party liability insurance in respect of motor vehicles is compulsory. Health insurance is also compulsory in Dubai and Abu Dhabi.

viii  Compensation and dispute resolution regimes

Complaints

The IA mandates that each insurance company must maintain a register of complaints from its clients, and should investigate each complaint within 15 days of the date of its submission. Any decision should be included within the Complaint Register. The IA inspectors have access to the Complaint Register to verify the information. Each complainant (whether it is the insured or the beneficiary) may appeal decisions to the IA if the insurance company rejects their complaint. An insurer may be fined 50,000 dirhams if it delays in providing clarifications regarding complaints received by the IA.

Dispute resolution

The IA has the mandate to form specialised dispute resolution committees that can settle disputes arising out of insurance contracts. The IA has granted extensive powers to the new dispute resolution committees, including the power to compel the production of documentation as necessary, to seek the assistance of experts and witnesses, and to adopt any alternative measures required for the settlement of disputes. Either party may appeal the decision of the IA committee to the individual emirate’s court of first instance within 30 days. However, once this period has elapsed, the decision of the committee becomes final and binding.

17 Insurance Authority Board of Directors Decision No. 12 of 2018 Concerning the Regulation on Licensing and Registration of Insurance Consultants and Organisation of their Operations.
18 Bancassurance arrangements are permitted in the UAE under Insurance Authority Board of Directors Decision No. 13 of 2018.
20 Dubai Health Insurance Law No. 11 of 2013; Abu Dhabi Health Insurance Law No. 23 of 2005.
21 Article 10 of the Insurance Authority Board Resolution No. 3 of 2010.
22 Cabinet Resolution No. 7 of 2019 Concerning the Administrative Fines Imposed by the Insurance Authority.
23 Article 110(2) of Federal Law No. 6 of 2007 on Establishing the Insurance Authority and the Regulation of its Operations as amended by Federal Law No. (3) of 2018.
25 ibid.
There is no pre-action protocol or procedure for insurance complaints. Insurers are required to handle claims (which must always be in accordance with applicable legislation and the provisions of insurance policies) as follows:

a. insurers must issue a decision in relation to all insurance claims;
b. if a claim is fully or partially rejected, insurers must provide the insured with reasons for the rejection in writing;
c. in the event of a dispute between the insurer and the insured, an insured may submit a written complaint to the IA, which may request further clarification from the insurer; and
d. if the insured disputes the clarification provided by the insurer, the insured may refer the matter to a specialised insurance committee.

ix Taxation of premiums
On 1 January 2018, the UAE introduced value added tax (VAT) at the rate of 5 per cent. All insurance and reinsurance premiums are subject to VAT with the exception of life insurance. During the implementation of VAT, many issues arose with regard to insurance policies that had been entered into before 1 January 2018, but provided coverage after this date. These issues are still subject to debate.

The Federal Tax Authority (FTA) has confirmed that reinsurance placed with a reinsurer located outside the UAE shall be treated as an imported service and the reinsurance premium payable by the insurance company will be subject to VAT under the reverse charge mechanism. This does not apply to life reinsurance.

x Proposed changes to the regulatory system
There are a number of regulatory reforms being considered by the federal authorities at the time of writing, most notably in relation to life insurance. These potential reforms are considered in more detail in Section V.

III INSURANCE AND REINSURANCE LAW

i Sources of law
Insurance is regarded as a commercial activity and, in theory, is governed by the UAE Commercial Code. Under the Commercial Code, the hierarchy of laws is as follows:

a. the Commercial Code;
b. the agreement of the parties (i.e., the policy);
c. rules of commercial customs and practices (with specific or local customs and practices superseding general practices); and
d. the Civil Code, insofar as it does not contradict the general principles of the commercial activity.

27 Federal Decree-Law No. 8 of 2017 on Value Added Tax.
29 Federal Law No. 5 of 1985.
However, the substantive provisions of insurance law are contained in the Civil Code\textsuperscript{30} and therefore, in practice, the insurance provisions of the Civil Code\textsuperscript{31} are applied by the courts, despite the above-mentioned hierarchy.

Marine insurance law is set out in the Maritime Code.\textsuperscript{32} It can be helpful to consider these provisions in the context of non-marine insurance in the event that the Civil Code and the other insurance laws do not address a particular issue.

Many policies written in the UAE still incorporate London market wordings. In the event that UAE law is completely silent on a point, it can be instructive to consider the relevant English law on the basis that it may represent commercial custom, although the extent to which a UAE court will be guided by English law is limited.

Further, the principles of shariah law can also be relevant when considering insurance law. Although there is a presumption that where there is a codified provision of UAE law dealing with an issue, that provision is considered to be compliant with shariah courts may nevertheless look to shariah principles for guidance in interpreting and applying the law.

\section*{ii Making the contract}

\textit{Essential ingredients of an insurance contract}

Under the law, insurance is a contract whereby the insured and insurer cooperate in addressing an insured risk or event. The insured pays to the insurer a specified sum or periodical instalments (i.e., the premium) and, in return, if the specified risk materialises, the insurer is bound to make payment.\textsuperscript{33} The general provisions in relation to formation of contracts under the Civil Code\textsuperscript{34} will apply to insurance contracts, insofar as they do not contradict those specific provisions in the insurance sections of the Civil Code.

Although not explicitly stated, there must be a fortuity (i.e., there must be an element of risk or uncertainty).

\textit{Transfer of risk when the uncertain event occurs}

The policy will typically specify that there will be a transfer of risk when the uncertain event occurs. However, as a basic principle, in first-party insurance, the transfer of risk will occur when the risk or the event set out in the contract materialises.\textsuperscript{35}

In the case of liability insurance, the obligations of the insurer only arise when the injured third party makes a claim against the insured.\textsuperscript{36} This can include a legal judgment awarded against the insured, although it has been held in certain cases that this is not strictly required.\textsuperscript{37}

\begin{thebibliography}{9}
\bibitem{30} Articles 1026 to 1055 of the Civil Code.
\bibitem{31} Along with the Insurance Law and the Insurance Authority Board Resolution No. 3 of 2010.
\bibitem{32} Articles 399 to 420 of the Maritime Commercial Code (Federal Law No. 26 of 1981).
\bibitem{33} Article 1026(1) of the Civil Code.
\bibitem{34} id., Articles 125 to 148.
\bibitem{35} id., Article 1026(1).
\bibitem{36} id., Article 1035.
\bibitem{37} Court of Cassation Judgment No. 281 of 1993.
\end{thebibliography}
**Requirement of insurable interest**

There is no express concept of insurable interest; however, the Maritime Code contains a prohibition on anyone benefiting from a policy of insurance unless they have a ‘lawful interest’ in the peril not occurring.\(^{38}\) It is likely that this provision would apply equally to non-marine insurance.

Taking out a contract of insurance without an insurable interest, albeit undefined, would be akin to gambling, which is prohibited under shariah law.

**Utmost good faith**

Parties to an insurance policy are obliged to perform their obligations in a manner consistent with the requirements of good faith.\(^{39}\) There is also an express obligation on an insurance company to carry out its business on the basis of absolute good faith.\(^{40}\)

In cases of non-marine insurance, if the insured misrepresents or fails to disclose matters, or fails to carry out an obligation under the policy, and the insurer can prove that the insured did so in bad faith, the insurer is entitled to retain the premium in addition to requiring that the policy be cancelled.\(^{41}\)

In cases of marine insurance, the position is the same as in non-marine if the insurer can prove bad faith of the insured. However, even if bad faith cannot be proved (but misrepresentation, for example, can be proved) in relation to a marine insurance policy, an insurer is still entitled to retain half of the premium, as well as requiring that the policy be cancelled.\(^{42}\)

To give a degree of protection to insureds, there is an obligation on the insurer to include all of the necessary questions relating to material facts, required by the insurer to assess the risk, within the proposal form. The proposal form must also set out the consequences on coverage of giving incorrect or inaccurate information.\(^{43}\)

**Recording the contract**

A contract of insurance is recorded by way of a written document. Insurance policies are required to be in Arabic although may be accompanied by a translation. In the event of a discrepancy between the translations, the Arabic version will prevail. Failure to issue a policy in Arabic can result in a fine of 50,000 dirhams. The Director General may exempt some insurance policies from being written in Arabic.\(^{44}\)

As a result of the enactment of the Electronic Transactions and E-Commerce Law,\(^{45}\) contracts between parties can be executed electronically; for example, contracting by ‘click-to-accept’ (where an insurer indicates their consent to the insurance contract by ticking a box online). The Electronic Transactions and E-Commerce Law permits such electronic documentation as evidence.

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38 Article 368 of the Maritime Code.
39 Article 246(1) of the Civil Code.
40 Article 3 of the Insurance Authority Board Resolution No. 3 of 2010.
41 Article 1033 of the Civil Code.
42 Article 388 of the Maritime Code.
43 Article 6 of the Insurance Authority Board Resolution No. 3 of 2010.
44 No. 3 of Cabinet Resolution No. 7 of 2019 Concerning the Administrative Fines Imposed by the Insurance Authority.
45 Federal Law No. 1 of 2006.
The content of insurance policies is governed by the IA Board Resolution No. 3 of 2010, which sets out a number of requirements, including that the policy must clearly describe the subject matter, the insured sum, the extent of cover and the claim procedure. In addition, the policy must include all terms and conditions governing the contract, be bound in such a way that does not permit removal of pages, and must set out page numbering in the policy and any attachments. The Maritime Code also contains certain specific requirements for the content and recording of marine insurance policies, including that the insurer or a representative must sign the policy.

iii Interpreting the contract

General rules of interpretation

The starting point for interpreting a policy is that clear words will be given their direct meaning with no scope for any other interpretation. If the words are clear, they cannot be departed from. However, where there is ambiguity or scope for interpretation, enquiries can be made into the intentions of the parties. Any doubt arising in cases of ambiguity will be resolved in favour of the obliging party. This is caveated in the case of contracts of adhesion (e.g., standard form insurance policies) and it is not permitted to construe ambiguity against the adhering party (i.e., the insured).

Finally, there is a presumption of contractual interpretation that a specific or special condition, or term, will override or supplement a standard or general clause.

Incorporation of terms

As a general rule, an insurance policy must contain all of the terms and conditions that pertain to it. However, there are a number of notable terms that have additional requirements.

For example, clauses in the policy exempting the insurer from liability must be written in bold characters, in a different print colour and initialled by the insured. Failure to comply with this requirement can lead to a fine of 50,000 dirhams.
An arbitration agreement is void unless it is contained within a special agreement, separate from the general printed conditions of the policy.\textsuperscript{56}

The following provisions in an insurance policy are void:

\begin{itemize}
\item \textit{a} any provision excluding cover for a breach of the law, other than a felony or deliberate misdemeanour;
\item \textit{b} a late notification provision in the event that there is a reasonable excuse for the delay; and
\item \textit{c} any arbitrary provision, breach of which was not causative of the occurrence of the incident insured against.\textsuperscript{57}
\end{itemize}

A party’s obligations under the contract (i.e., the policy) can extend beyond what is expressly contained within the contract to include an obligation to also do that which is related to the contract via law, custom or the nature of the transaction.\textsuperscript{58}

\textit{Types of terms in insurance and reinsurance contracts}

UAE law does not specifically distinguish between types of terms in the same way as may be found under English law (e.g., conditions, terms, innominate terms), nor are conditions precedent or warranties expressly recognised.

The applicability and enforceability of a term under UAE law will depend upon its effect. Any term that purports to permit an insurer to avoid cover (e.g., a condition precedent) will be subject to the formalities for exclusion clauses as referred to above and may be void if it does not comply.

Similarly, any arbitrary term, breach of which would have had no effect on the cause of the incident insured against, will also be void. In that regard, breach of a warranty in a policy will not automatically allow an insurer to avoid cover. The breach of the warranty must have been causative of the loss.

\textit{iv Intermediaries and the role of the broker}

\textit{Conduct rules}

There is no legal requirement to conduct insurance or reinsurance business through an insurance broker. Where an insurance broker is involved, insurance brokers in the UAE must be authorised by the IA, which prohibits insurance companies from dealing with brokers in respect of UAE insurance business not licensed by them.\textsuperscript{59} With regard to intermediaries acting in the life insurance business, there are plans to introduce legislation requiring such intermediaries to be licensed by the IA.\textsuperscript{60}

\begin{itemize}
\item \textsuperscript{56} Article 1028(d) of the Civil Code; Article 7(2) of the Insurance Authority Board Resolution No. 3 of 2010
\item \textsuperscript{57} Article 1028 of the Civil Code.
\item \textsuperscript{58} id., Article 246(2).
\item \textsuperscript{59} Article 26(4) of the Resolution of the Board of Directors of the Insurance Authority No. 15 of 2013 concerning insurance brokers regulation (the Insurance Authority Brokers Regulations).
\item \textsuperscript{60} Article 9(1) of draft Circular No. (12) of 2017 regarding Life Insurance and Family Takaful Business in the UAE.
\end{itemize}
United Arab Emirates

Agency and contracting
A broker is an independent intermediary which mediates insurance or reinsurance contracts between the insured and reinsured, and the insurer and reinsurer, and is paid a commission from the insurer and reinsurer. UAE law does not distinguish between placing brokers and producing brokers. UAE insurance law distinguishes between a broker and an agent. The first acts independently as an intermediary; the latter acts directly and exclusively as intermediary for one insurer or reinsurer. Both categories are separate and a broker cannot act as agent and vice versa.61

How brokers operate in practice
Brokers that are established and authorised in the UAE must comply with the IA Brokers Regulations. A broker is not permitted to act as both insurance broker and reinsurance broker for the same customer and the same transaction.62 Reinsurance brokers are not directly regulated under the law, provided they do not carry on business activities in the UAE (i.e., their business activities are conducted outside the UAE or offshore within the DIFC and ADGM). Therefore, generally, a reinsurance broker’s functions and duties will be determined by the contractual arrangements between it and the reinsured, a producing broker or the reinsurer, as the case may be.

Claims
Notification
The procedure for providing notice of a claim will usually be set out in the insurance policy itself. Article 7(5) of the IA Board Resolution No. 3 of 2010 states that insurers must explain the procedures the insured must follow in the event the insured risk has occurred in order to receive the entitled compensation. The content of the notice will typically require a summary of the claim or circumstance, quantum information sufficient for insurers to assess coverage and any supporting documents. The IA provides that the procedures the insured has to follow upon the occurrence of the risk have to be clearly indicated on the policy.63

There are no specific consequences for late notification in relation to insurance contracts. Instead, the general position regarding a breach of contract will apply. In the event that a policy is breached, the insurer may seek damages or refuse to pay a claim under the policy (depending on the insurance policy itself). However, if the insured has a reasonable excuse for the delay, a term in the insurance policy that provides that late notification means an insured’s rights shall lapse under an insurance policy, will be void.64 Further, arbitrary clauses are void (e.g., where a breach did not cause the occurrence of the incident insured against); this could include breach of a notification provision.65

In relation to the handling of claims subsequent to notification, the IA has provided further clarity through Federal Law No. 3 of 2018 on the Amendment of Certain Provisions of Federal Law No. 6 of 2007. For example, if an insured fails to provide all information requested by insurers following notification, this can amount to a reason to deny the claim.

61 Article 3(3) of the Insurance Authority Brokers Regulations.
62 id., Article 3(4).
63 Article 9(1) of the Insurance Authority Board Resolution No. 3 of 2010.
64 Article 1028(b) of the Civil Code.
65 id., Article 1028(e).
in circumstances where the information is required to ascertain the incident or the extent of
the loss\textsuperscript{66} and where the insured has no reasonable excuse for the delay.\textsuperscript{67} Subsequently, the
IA has granted extensive powers to the new dispute resolution committees, including the
power to compel documentation as necessary.\textsuperscript{68} Either party may appeal the decision of the
IA committee to the individual emirate's court of first instance within 30 days. However,
once this period has elapsed, the decision of the committee becomes final and binding (see
Section II.viii).

The limitation period for issuing legal proceedings under insurance contracts is three
years from the occurrence of the incident, or from the date of the insured having knowledge
of that occurrence.\textsuperscript{69} The limitation period in respect of marine insurance is generally two
years from the date of the incident (with specific provisions dealing with claims in relation
to vessels and cargo), or where a third party makes a claim against the insured.\textsuperscript{70} Further,
limitation is suspended under marine insurance by 'registered letter or delivery of other
documents relating to the claim',\textsuperscript{71} or a 'legal excuse'.\textsuperscript{72}

**Good faith and claims**

Parties to contracts (including insurance contracts) governed by UAE law are subject to the
obligation to perform the contract in good faith; this includes an obligation on the insurer
to exercise good faith in paying claims.\textsuperscript{73} It follows that it may, theoretically, be possible
for the insured to claim damages for breach of this duty of good faith when adjusting and
settling claims (i.e., this would be similar to punitive bad faith claims), to claim damages for
consequential losses flowing from the insurer's breach, or both.

**IV DISPUTE RESOLUTION**

i **Jurisdiction, choice of law and arbitration clauses**

UAE courts have jurisdiction over insurance-related claims brought against UAE nationals
and entities or foreign legal entities with a domicile or place of residence in the UAE.\textsuperscript{74} Any
agreement to the contrary is void.\textsuperscript{75} Articles 31 to 41 of the Civil Procedures Law includes a
series of circumstances that will determine which court within the UAE has jurisdiction over,
for example, the conclusion of a contract or the performance of a contract. Article 37 relates
specifically to insurance where a dispute relates to insurance, jurisdiction is vested in the court
or where the beneficiary has its residence or of the location of the property.

\textsuperscript{66} Article 9(6) of the Insurance Authority Board Resolution No. 3 of 2010.
\textsuperscript{67} Article 1028(b) of the Civil Code.
\textsuperscript{68} Article 110(2) of Federal Law No. 3 of 2018.
\textsuperscript{69} Article 1036 of the Civil Code.
\textsuperscript{70} Article 399(1) of the Commercial Maritime Code.
\textsuperscript{71} id., Article 399(3).
\textsuperscript{72} id., Article 399(1) and (2).
\textsuperscript{73} Articles 246 and 1034 of the Civil Code, Article 3(2) of the Insurance Authority Directive (Code of
Conduct for Insurance Companies issued by the Insurance Authority (Insurance Authority Resolution
No. 3 of 2010)).
\textsuperscript{74} Article 20 of Federal Law No. 11 of 1992 (the Civil Procedures Law).
\textsuperscript{75} id., Article 24.
In theory, UAE law recognises choice of law clauses. However, the courts will not apply laws that are contrary to shariah or public policy (a concept that is broadly construed). Moreover, there are specific matters where a court will not uphold a foreign choice of law clause, for example real property or contracts entered into or performed in the UAE. In practice, foreign choice of law provisions will likely be ignored by a UAE court.

The parties can also choose arbitration as the method of dispute resolution. In June 2018, Federal Law No. 6 of 2018 on Arbitration (the Arbitration Law) came into force. This repealed and replaced Articles 203 to 218 of the Civil Procedures Law. Article 8 states that if a dispute brought before a court is covered by an arbitration agreement, the court must dismiss the action, unless the court finds that the arbitration agreement is void or unenforceable. In addition, Article 7(6) of the IA Code of Conduct and Ethics states that non-compulsory insurance policies may incorporate an arbitration clause. The arbitration clause must be signed and printed as a separate agreement from the general terms and conditions incorporated in the policy. (See subsection iii.)

With regards to the ADGM, Section 16(2)(e) of the ADGM Courts Regulations state that the ADGM Court of First Instance shall have jurisdiction as is conferred on it by any request, in writing, by the parties.

Under Article 5(A)(2) of Dubai Law No. 16 of 2011, parties situated outside the DIFC can now select exclusive or non-exclusive DIFC courts’ jurisdiction to hear disputes. Parties may decide on DIFC jurisdiction either before the conclusion of their contract (i.e., before any potential dispute arises) or after the dispute has arisen by jointly agreeing in writing to refer a dispute to the DIFC courts. If there is any connection between a claim and the DIFC, the DIFC courts are generally amenable to accept jurisdiction, regardless of whether the underlying contract has a DIFC governing law and jurisdiction provision. Parties may opt out of the jurisdiction of the DIFC courts in favour of the local courts under Article 13(1) of DIFC Law No. 10 of 2005. Our experience is that, in practice, any choice of opting out requires careful wording. Disputes as to whether the DIFC courts or onshore Dubai courts have jurisdiction are resolved via the Joint Judicial Committee – a seven-member committee constituted of four judges from the onshore Dubai courts and three from the DIFC courts.76

ii Litigation

Litigation stages

Litigation is divided into three stages:

a) Court of First Instance;

b) Court of Appeal; and

c) the Federal Supreme Court (colloquially referred to as the Court of Cassation).

Substantive proceedings are commenced in the UAE court by the filing of a statement of claim, along with a power of attorney (POA) issued in favour of a local advocate and the appropriate court fee. Once these are filed, the court will schedule a hearing date and the defendant will be served with the claim.

Separate hearings for the defendant to submit its POA and its defence, and for any further submissions, will be scheduled and held until the court considers that it has enough information either to appoint a court expert or pass judgment.

76 Dubai Decree No. 19 of 2016.
Either party has an automatic right to appeal judgments of the Court of First Instance to the Court of Appeal. Appeals to the Supreme Court from the Court of Appeal can only be made on points of law (in accordance with the specific grounds set out in the Civil Procedure Code).

A judgment creditor should apply to the Execution Court in order to enforce a judgment against a defendant.

**Evidence**

A party is required to present evidence that it relies on in support of its claim or defence and there is no obligation to disclose documents that are relevant or helpful to the other party. The court may be asked to order the specific disclosure of a document. Oral witness testimony is possible on application to the court, but is uncommon.

Where causes of action are based on documentary evidence and there is a dispute about the validity of a document, copies of the original documents may be produced. Denying documents on the basis that they are copies is no longer acceptable, and the party seeking to deny documents will be required to prove that the documents are ‘invalid’ or were not in fact authored by the party to whom they are attributed.

All submissions to the court, including documentary evidence, must be filed in Arabic. Any supporting evidence in any other language will need to be translated and certified by a legal translation company registered and certified with the Ministry of Justice. However, if the official language of the defendant is not Arabic, the claimant shall be bound to attach to the notice a certified translation in English, unless there is an earlier agreement between the parties to attach the translation in another language.

Experts are appointed by the court from a panel of experts according to their particular specialisation to provide an opinion required for deciding a case (particularly for technical matters). As litigation in the UAE is characterised by exchanges of written submissions with little advocacy, experts are an essential part of the litigation process. The parties may also agree to use a particular expert from the panel. If appointed, the expert will set a meeting with the parties and allow the parties to submit further documents in addition to those already submitted to the court (including the parties’ own expert evidence). Once the expert has filed his or her report, the parties are given the opportunity to comment on it.

While the opinion of the expert is not binding on the court, the court will usually follow the recommendations in the expert’s report. Significantly, the factual findings of an official document (which are those in which a public official or person employed in public service certifies what has taken place before him or her or what he or she has been informed of by the parties concerned within the limit of his or her authority and jurisdiction, such as a police report) are binding upon the court.

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77 Article 158 of the Civil Procedure Code.
78 id., Article 173.
81 Article 5(3) of the Civil Procedure Code.
82 Federal Law No. 7/2012 on the Regulation of Expertise before the Judicial Authorities.
83 Article 90(1) of the Law of Evidence.
84 Articles 7 and 8 of the Law of Evidence.
**Costs**

Only nominal legal costs are recoverable by a successful party (often in the region of 5,000 dirhams) at each stage of proceedings. Court filing fees and expert fees are, however, recoverable as part of the final (successful) judgment awarded by the court.

**Arbitration**

*Format of insurance arbitrations*

As mentioned in Section III.iii ‘Incorporation of terms’, in respect of insurance contracts, the arbitration clause must be set out in a separate agreement signed by both parties. Ad hoc arbitration is also recognised.

Arbitration proceedings in the UAE (i.e., onshore) are governed by the Arbitration Law, which is based on the UNCITRAL Model Law. The original arbitration provisions of the Civil Procedure Code were not based on the UNCITRAL Model Law and were underdeveloped in comparison to the DIFC and the ADGM arbitration laws (which are also modelled on the UNCITRAL Model Law). Both international and domestic arbitral awards must be ratified by the UAE courts before they can be enforced.

*Procedure and evidence*

There are a number of arbitration centres and institutions, both onshore and offshore. Onshore centres and institutions include the Dubai International Arbitration Centre, the Abu Dhabi Commercial Conciliation and Arbitration Centre, and the Centre for Amicable Settlement of Disputes in Dubai. There are also other domestic arbitration centres in Sharjah and Ras Al Khaimah. Examples of offshore institutions include the DIFC-LCIA Arbitration Centre and the ADGM Arbitration Centre. Each institution will have its own procedural rules that will apply insofar as they do not contradict the mandatory rules of the Civil Procedure Code or the offshore law as applicable.

The UAE has been party to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards (1958) since 2006. While there has been some uncertainty around the enforcement of arbitral awards in the UAE under the Convention, UAE courts have more readily recognised enforcement of foreign arbitral awards in recent years. UAE arbitral awards should also be enforceable in other Convention signatory states.

**Costs**

Arbitrators can award costs at their discretion. A party may apply to the courts to vary the tribunal’s assessment of costs; however, the usual position is that the unsuccessful party pays the successful party’s costs.

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85 As per Article 1028(1)(d) of the Civil Code.
86 Article 55 of the Arbitration Law.
87 For example, see Case No. 693 of 2015 where the Court of Cassation recognised for enforcement a London-based arbitration award.
iv Mediation
Mediation is a voluntary process and, as such, parties can opt to mediate disputes with several centres offering mediation services within the UAE, such as the Abu Dhabi Commercial Conciliation and Arbitration Centre, and the Centre for Amicable Settlement of Disputes in Dubai.

V YEAR IN REVIEW
i Regulation
In 2018 and early 2019, the IA issued new circulars and decisions relating to, among other things, reporting requirements for insurers, financial solvency requirements for Takaful insurance companies and branches of foreign insurance companies, and bancassurance arrangements.

Under the new reporting requirements, insurance companies must provide their audited annual financial reports to the IA in Arabic and English in the form specified in the Circular. This provision extends to financial solvency requirements for branches of foreign insurance companies; all branches of foreign insurance companies are now obliged to disclose the value of the net assets of their parent company.

In the health insurance sector, Executive Council Resolution No. 18 of 2018 and Dubai Decree 17/2018 created the Dubai Health Insurance Corporation (DHIC), which will manage and supervise health insurance in the emirate. The DHIC will also manage government health insurance programmes.

The implementation of VAT caused issues for many insurers, particularly those offering consumer-line policies. The transitional provisions of the VAT laws require insurers to account to the FTA for premiums paid for insurance services taking place from 1 January 2018, even if the policy began prior to 1 January 2018.

ii Life insurance
The UAE has one of the most developed life insurance markets in the region, and it is continuing to grow. In April 2017, the IA introduced draft Circular No. 12 of 2017 regarding Life Insurance and Family Takaful Business in the UAE, with the aim of raising the bar for the regulation of life insurance and family Takaful products. The regulations contained in the Circular were intended to secure market conduct with the various entities that provide and facilitate the provision of life insurance products in the UAE, and place significant focus on regulating the commission structure, disclosure obligations owed to the client and protecting policyholder values. As outlined in Section VI, it is expected that the final version will be published in 2019.

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88 See Circular No. 51 of 2018 on 2019 Reporting Requirements for All Insurance Companies Operating in the UAE.
89 See Insurance Authority Board of Directors Decision No. 14 of 2018.
90 See Insurance Authority Board of Directors Decision No. 13 of 2018.
91 Article 80 of Federal Decree-Law No. 8 of 2017 and Article 70 Cabinet Decision 52 of 2017.
iii Dispute resolution
The powers of the IA are set to increase with the establishment of the IA Disputes Resolution Committee in 2019. This committee will have powers to settle disputes arising out of insurance contracts. The Court of First Instance has also confirmed that insurance-related disputes will not be accepted by the local UAE courts unless they have first been considered by the specialised committee.

iv Arbitration
As mentioned in Section III.iii and Section IV.i, the Arbitration Law states that if a dispute brought before a court is governed by an arbitration agreement, the court must dismiss the action, unless the court finds that the arbitration agreement is void or unenforceable. In addition, Article 7(6) of the IA Code of Conduct and Ethics states that non-compulsory insurance policies may incorporate an arbitration clause. The arbitration clause must be signed and printed as a separate agreement from the general terms and conditions incorporated in the policy.

VI OUTLOOK AND CONCLUSIONS
It is likely that the IA will continue its proactive approach to the regulation and management of insurance disputes. We expect that the Cabinet will implement the IA’s life insurance regulations, which were originally proposed in 2016, during the course of 2019. These regulations will place an upper limit on commission paid to financial advisers selling offshore bonds (a form of lump sum investments) and fixed-term contractual savings plans. The regulations will stipulate that commissions will be paid over the term of the product rather than as an upfront cost. There are also new provisions regarding the transparency of information provided to customers, so that they are aware of fees and commissions. This is intended to give investors more clarity on how their insurance-based investments, savings and life products are structured.

Further, innovation in the insurance industry will be driven by technological development in 2019. This development extends to the supervision of the industry, as the IA is in the process of establishing a sophisticated electronic financial database on the insurance industry that would facilitate its supervision of the sector in accordance with international best practices. Developments in business technology, and the fintech and cybersecurity sectors, will require insurers to offer products and services to keep up to date with the market. We anticipate that the upcoming Board of Directors Resolution concerning electronic insurance regulations (which will include provisions regulating information on websites, transparency and security) will regulate all electronic insurance operations practiced by licensed insurers, brokers, agents and Health Insurance TPA companies in the UAE.
I INTRODUCTION

The United States insurance market is one of the largest financial markets in the world. In 2017, US insurers underwrote approximately US$1.37 trillion in life and non-life direct premiums, accounting for just over 28 per cent of the global insurance industry. To put that number in perspective, the US$1.37 trillion in underwriting amounted to roughly 7.07 per cent of the total US gross domestic product. Yet even these premiums fail to capture the full scale of the US insurance market. In 2017, the total cash and invested assets of US insurers reached US$5.48 trillion. As such, the US insurance market plays a significant role in the global economy.

In 2017, the US insurance market included US$597.1 billion in life and health insurance premiums, including annuities. This dynamic and highly competitive segment of the marketplace includes more than 1,000 insurance companies competing to underwrite a wide variety of products.

The 2017 US insurance market also wrote US$558.2 billion in premiums in the property, casualty and specialty markets, including, among others, comprehensive general liability, directors’ and officers’ insurance, errors and omissions insurance, and workers compensation coverages. Competition within the highly fragmented property and casualty market is significant, with approximately 2,600 different insurance companies competing for business.

The underwriting of US reinsurance is also robust, with net premiums written to unaffiliated reinsurers totalling approximately US$48.9 billion in 2017. Reflecting the
heightened complexity of reinsurance offerings, lower demand for reinsurance products, and intense international competition, this market is concentrated in substantially fewer companies than the direct-side market.\textsuperscript{10}

Given the scope of the US market, it should come as no surprise that legal advisers specialising in insurance and reinsurance law span a broad range of specialties including insurance litigation and counselling; claims handling; regulatory compliance; professional and management liability; insurer liquidation and insolvency; and reinsurance disputes. The following sections provide a basic introduction to the language and practice of insurance law within the US market.

\section*{II REGULATION}

Historically, US insurance and reinsurance companies were solely regulated at the state level. In 1944, however, a US Supreme Court decision raised doubts about state-level insurance regulation. In response, in 1945, the US Congress enacted the McCarran-Ferguson Act,\textsuperscript{11} which declared ‘that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.’\textsuperscript{12} Since passage of the McCarran-Ferguson Act, regulation of insurance and reinsurance companies is primarily performed at the state level with additional federal regulation applying only to certain topics.\textsuperscript{13}

\subsection*{i State-by-state regulation}

\textit{State insurance departments and commissioners}

In the US, insurance companies obtain their charter from one domiciliary state, which is the primary regulator of the solvency of the insurance company. However, in general, an insurance company must also obtain a licence in each state in which it intends to issue policies. (Non-admitted or ‘surplus lines’ insurers are an exception to that rule, and are addressed below.) An insurer’s business practices, like marketing, are regulated separately by each state in which the insurer is licensed, and the laws and rules regarding these practices vary from state to state.

All 50 states have an insurance regulatory department, generally led by a chief insurance regulator. State insurance departments are generally funded by fees and taxes on insurance companies, including fees for licensing and examinations.

\textsuperscript{10} id. at 10.  
\textsuperscript{11} 15 U.S.C. § 1011 et seq.  
\textsuperscript{12} id. § 1011.  
\textsuperscript{13} This chapter does not address the US health insurance market. That market is primarily regulated by the federal government. For example, in 1965, the US Congress passed the comprehensive health insurance plans known as Medicare and Medicaid; in 1974, the US Congress passed the Employee Retirement Income Security Act, which placed employee benefit plans (including health plans) primarily under federal jurisdiction, and the HMO Act, which set standards for federally qualified health maintenance organisations; in 1996, the US Congress passed the Health Insurance Portability and Accountability Act, which established minimum federal standards for the availability and renewability of health insurance; lastly, in 2009, the US Congress passed the Affordable Care Act, a set of comprehensive health insurance market reforms.
The National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC) operates to coordinate insurance regulatory efforts across the states. The NAIC is a private, voluntary association of chief insurance regulators from the 50 states, the District of Columbia and five US territories. The NAIC is funded by assessing fees for its services and publications. Although the NAIC lacks any actual regulatory authority, it is the leading voice with respect to the state-based insurance regulatory system in the US.

Issues subject to state regulation

Insurance regulations in the US are generally intended to protect both consumers and the public by regulating insurer business practices while monitoring their solvency. The goal is twofold; first, to regulate the terms of insurance contracts to maintain fairness between the insurance company and the consumer, and second, to assure that the insurance company will be available to pay the valid claims of consumers when they are presented.

In practice, these goals are met through regulations on a variety of topics, outlined below.

Company licensing

Insurance companies are generally required to obtain licences from state insurance regulatory authorities before transacting insurance in a given state. Once granted, the insurance licence specifies which lines of insurance the company is permitted to sell within the state. Because licensing is done on a state-by-state basis, approval by one state does not carry over into any other state. Licence applications submitted to states other than an insurance company’s domicile generally are called ‘expansion applications’.

Typically, states require certain minimum levels of capital and policyholder surplus in order to obtain a licence. The amount of capital and surplus will depend on the type and volume of business the insurance company intends to write. In addition to capital requirements, state regulators reviewing an insurance company’s licence applicant evaluate the company’s management, business plan, and market conduct.

Producer licensing

Individuals or companies that sell, solicit, or negotiate insurance in the US must be licensed as a ‘producer’ in each state in which the individual or company operates. This includes insurance agents and insurance brokers.

The requirements for licensing of producers vary from state to state, and producers typically have to meet separate licensing requirements for each state in which they sell insurance. In most states, the producer licensing process includes an examination and a background check. The process for licensing resident producers can be different from the process for licensing non-resident producers.

Rate and product regulation

In the US, individual states regulate both the types of products certain insurance companies can offer and the rates those insurance companies can charge for their products. The level and specificity of product and rate regulation varies from state to state.

14 The most important exception is for surplus lines.
Generally, all states require that rates not be inadequate, excessive or unfairly discriminatory. On the whole, states do not set mandatory rates. Instead, insurance companies choose the rates they intend to use in a given state in which they are licensed, and then inform the state of the chosen rates, with justification.

For commercial lines within the property and casualty insurance market, states take a variety of approaches to regulating insurance rates. Some states require that rates be filed with the state and approved prior to use. Other states require only that rates be filed with the state. Finally, certain states have no filing requirements at all.

With respect to insurance product regulation, state regulators often require pre-approval of certain life and property and casualty insurance products offered in their individual state to assure that offered products can be readily understood by consumers. That pre-approval process includes, among other things, a review of policy forms and marketing materials.

Markets conduct regulation
States also regulate the business of insurance by prohibiting insurance companies from engaging in unfair, deceptive, or anticompetitive conduct. To enforce these regulations, states perform market conduct examinations of licensed or admitted carriers and producers. States also use enforcement actions to compel insurance companies to adhere to specific standards with respect to the interactions between the companies and consumers or policyholders. In some states, enforcement actions may also be brought by the state attorney general under laws outside of insurance-specific regulations.

Solvency and accreditation
All 50 states and the District of Columbia have adopted financial reporting laws that require insurance companies to file quarterly and annual financial statements on the forms authored by the NAIC. Likewise, insurance companies must calculate their risk-based capital in accordance with procedures set by the NAIC.

These coordinated financial requirements are part of the NAIC’s accreditation programme. Accreditation is a certification issued to a state insurance department once it has demonstrated that it has met and continues to meet a variety of legal, financial, and organisational standards as determined by the NAIC. Accreditation is necessary so that when an insurance company is domiciled in an accredited state, the other states in which the insurance company is licensed or writes business can be assured that the domiciliary state is adequately monitoring the financial solvency of that company. As at January 2019, all 50 states plus the District of Columbia and Puerto Rico are accredited.

Financial examinations
Each of the 50 states and the District of Columbia require insurance companies operating within their state or territory to submit to a full financial examination at least once every five years. These examinations are designed to verify the companies’ financial statements.

Uniform standards, including the NAIC Model Law on Examinations and the NAIC’s Financial Condition Examiners Handbook, apply to financial examinations by almost all 50 states. These standards specify both when a financial examination is to be conducted and the guidelines and procedures to be used by the state in its conduct of the financial examination. Generally, states use a risk-focused approach to financial examinations. Insurance companies that operate in multiple states are subject to financial examination by each state. These multiple financial examinations, however, are coordinated to some extent for group examinations.
Credit for reinsurance and collateral requirements

Historically, most US states required unauthorised reinsurers (reinsurers not licensed or accredited in a ceding insurer’s domicile) to post 100 per cent collateral for any reinsured liabilities in order for the ceding insurer to get full financial statement credit for its reinsurance placements. This allowed state-based insurance regulators to indirectly regulate transactions with reinsurers outside its jurisdiction.

In recent years, a number of states have reduced collateral requirements for certain approved non-admitted reinsurers. As at December 2018, 48 states have passed legislation to implement revised reinsurance collateral provisions focused on the solvency risk of reinsurers as opposed to their admitted status. Additionally, in September 2017, the US and the European Union announced that they had formally signed a bilateral covered agreement regarding the regulation of insurance. The agreement calls for an end to collateral and local presence requirements for EU and US reinsurers. It also affirms the US system of state regulation of insurance by effectively limiting the application of EU and US prudential measures to the worldwide operations of EU and US insurers.

Under the terms of the agreement, US-based insurers are subject to the prudential supervision of the EU only to the extent of their operations in the EU, and vice versa. The agreement also eliminates collateral and local presence requirements for EU and US reinsurers. The agreement encourages supervisory authorities in the US and the EU to exchange information regarding insurers and reinsurers that operate in both markets. Over the 60-month implementation plan, the US and the EU will identify and roll back inconsistent or pre-empted legislation. Finally, the agreement establishes cross-conditionality between provisions as an enforcement mechanism, to ensure equal compliance and equal benefits.

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15 NAIC Statement on Covered Agreement on Reinsurance Consumer Protection Collateral, available at https://www.naic.org/cipr_topics/topic_covered_agreement.htm (last visited 15 January 2019). The NAIC has approved seven countries as qualified jurisdictions: Bermuda, Germany, Switzerland, United Kingdom, France, Ireland and Japan. Reinsurers that are licensed and domiciled in these jurisdictions are eligible for reduced reinsurance collateral requirements. id.; see also NAIC List of Qualified Jurisdictions, available at http://www.naic.org/documents/committees_e_reinsurance_qualifed_jurisdictions_list.pdf (last visited 15 January 2019).


18 id.

19 id.


On 11 December 2018, the US and the UK announced that they had reached terms on a similar bilateral covered agreement, which includes the same material terms as the US and EU agreement, and follows the same implementation plan.\(^\text{22}\)

**Insurance insolvency**

Insurance company insolvencies are exempt from federal bankruptcy law. Instead, the rehabilitation and liquidation of insurance companies has been specifically delegated to the states. Thus, domiciliary state laws establish the process for the receivership or liquidation of an insolvent insurance company.

Notably, the insolvency clause standard in almost all US reinsurance contracts may require the reinsurer to indemnify an insolvent insurer’s estate for the full amount of any covered claim allowed in the proceeding, despite the fact that the estate in liquidation may actually pay only a fraction of the allowed amount to its policyholder.

\(\text{ii Federal regulation of insurance}\)

Although states are the primary source of insurance regulation in the US, the federal government also plays a role with respect to certain regulatory issues.

**Direct federal programmes**

In a number of hard-to-place insurance markets, the US federal government has stepped in to provide direct insurance or reinsurance support. Under these programmes, federal regulation either pre-empts or directly supports private insurance, supplanting the states’ regulatory role for the specific insurance market.\(^\text{23}\) Examples of direct federal insurance involvement include terrorism risk insurance,\(^\text{24}\) flood insurance\(^\text{25}\) and crop insurance.\(^\text{26}\)

**Liability Risk Retention Act**

In 1986, the US Congress enacted the Liability Risk Retention Act of 1986 (LRRA). The LRRA allowed for the formation of risk retention groups (RRGs), which are entities through which similar businesses with similar risk exposures create their own insurance company


\(^{23}\) The examples cited herein of direct US federal government participation in insurance markets are illustrative and not exhaustive.

\(^{24}\) Initially enacted in 2002, the Terrorism Risk Insurance Act of 2002 (TRIA), Pub. L. 107–297, 116 Stat. 2322, was reauthorised in 2007 and expired on 31 December 2014. On 12 January 2015, HR 26, the ‘Terrorism Risk Insurance Program Reauthorization Act of 2015’ was signed into law. This legislation extended the federal terrorism reinsurance program established by the TRIA until 31 December 2020.


\(^{26}\) The Federal Crop Insurance Corporation was initially created by the US Congress in 1938 (codified at 7 U.S.C. § 1501) in response to the economic difficulties brought to the US farming industry by the Great Depression. In 1980, the programme was expanded through the Federal Crop Insurance Act, Pub. L. 96–365.
in order to self-insure their liability (but not property) risks. RRGs are only required to be licensed as an insurance company in one domiciliary state. Once licensed, an RRG is exempted from most insurance regulations for any other state in which the RRG operates.

**Federal Insurance Office**

The Federal Insurance Office (FIO), an organisation within the US Treasury Department, is responsible for monitoring all aspects of the insurance industry in order to identify issues or gaps in the regulation of insurance companies that could lead to a systemic crisis in the insurance industry or the US financial system. While the FIO does not have any express regulatory authority over the insurance industry, it is responsible for coordinating international insurance agreements, monitoring access to affordable insurance for traditionally underserved communities and reporting to the US Congress about vital issues in the insurance industry.

**Financial Stability Oversight Council**

The Financial Stability Oversight Council (FSOC) identifies and responds to risks to the financial stability of the US. The FSOC has the authority to subject a ‘non-bank financial company’, including an insurance company, to supervision by the Federal Reserve if it determines that the company is a ‘systemically important financial institution’ (SIFI) through a multistage determination process. Once a company is identified as an SIFI, it is subject to enhanced prudential standards, including specific reporting requirements, risk-based capital requirements, liquidity requirements, risk management requirements, leverage limits and credit exposure limits. The FSOC previously designated three insurers as SIFIs, but none of them remain subject to Federal Reserve supervision.27

**Nonadmitted and Reinsurance Reform Act – surplus lines and reinsurance**

All 50 states allow issuance of surplus lines business by unlicensed or non-admitted insurance carriers. Generally, consumers must use a specially licensed insurance broker and demonstrate that they are unable to find the specified coverage through the admitted market. Once the exceptional need is demonstrated, the risk can be placed with non-admitted carriers.

In situations where the risk placed with a surplus lines carrier is located in multiple states, the exclusive taxing authority with respect to surplus lines and non-admitted insurance policies is in a policyholder’s ‘home state’. In addition, surplus lines insurance is subject only to the regulatory requirements of the policyholder’s home state (except for workers’ compensation business) and large commercial insurance purchasers that meet certain conditions may directly access the surplus lines market.

With respect to reinsurance, if an insurer’s domicile recognises credit for reinsurance for the insurer’s ceded risk, then no other state may deny the credit for reinsurance, provided that the domiciliary state is NAIC-accredited, or has solvency requirements substantially similar to those required for NAIC accreditation. The laws and regulations of non-domiciliary states are also pre-empted to the extent that they (1) restrict or eliminate the right to resolve reinsurance disputes pursuant to reinsurance contractual arbitration provisions, (2) require that a certain state’s law shall govern the reinsurance contract, or (3) attempt to enforce

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a reinsurance contract on terms different than those set forth in the reinsurance contract itself. Finally, the exclusive authority to regulate the financial solvency of a reinsurer is in the reinsurer's domiciliary state.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Each state has both statutory and common law applicable to insurance issues. State common law is a significant source of law for the purpose of resolving disputes. In broad terms, it applies to issues such as legal duties, the interpretation of contracts, procedure and damages. Individual state statutes applicable to insurance, though they vary in breadth and focus, generally regulate insurance companies operating within the state. Common state statutes include provisions requiring companies to be licensed or barring insurers from acting or marketing their products in a deceptive manner.

Under the US Constitution, federal statutes may pre-empt state statutes and laws where they overlap. Thus, a federal statute may pre-empt inconsistent state laws. Federal common law, while fairly narrow in scope, impacts insurance and reinsurance companies indirectly. One example is federal common law relating to the application of the Federal Arbitration Act, which guides decisions on whether policyholders or cedents are bound to arbitrate a dispute with insurers or reinsurers.

ii Making the contract

The requirements for the creation of an enforceable insurance or reinsurance contract mirror those of most written contracts – offer, acceptance, consideration, legal capacity and legal purpose. In practical terms, an application or submission and the tender of the initial premium represent the offer to contract. Acceptance is generally demonstrated through execution of the policy or agreement. Without an offer and acceptance, there is no meeting of the minds and no contract.

Insurance and reinsurance contracts are negotiated and placed both directly and through intermediaries. In either case, prospective policyholders or cedents provide the information requested by the insurance carrier or reinsurer for the placement. If necessary, the insurance carrier or reinsurer's underwriter can (but is not necessarily required to) seek more information. At all times, the prospective policyholder or reinsured generally is under an obligation to disclose all material information relating to the risk being covered.

Following the agreement on terms, the insurance or reinsurance contract is documented. In most individual consumer insurance markets, the insurance policy is initially crafted by the insurance company. In other instances, a manuscript policy may be negotiated.

iii Interpreting the contract

Because of variations among state laws, there are no overarching rules of insurance contract interpretation. In general, the rules of interpretation applicable to commercial contracts apply to insurance policies. State or federal courts that interpret contract provisions typically try to determine the objective intent of the parties. Unambiguous insurance policy provisions are generally enforceable. While these principles apply generally to reinsurance agreements as well, it is important to note that reinsurance disputes are typically viewed through the prism of industry custom and practice. Indeed, in reinsurance arbitrations the arbitrators’ charge
is often to view the parties’ agreement as an ‘honourable engagement’ and they are often directed to interpret the contract without a need to follow strict rules of law and with a view to effecting the purpose of the contract in reaching their decision.

iv  Intermediaries and the role of the broker

Insurance intermediaries, including agents and brokers, play a key role in the US insurance and reinsurance markets. Currently, there are more than 2 million individuals and more than 500,000 businesses licensed to provide insurance services in the US.\(^{28}\)

There are a number of types of agents and brokers. Broadly speaking, a general insurance agent contractually represents the insurance company and is authorised to accept risks and issue policies, a soliciting agent has authority to seek insurance applicants, but has no authority to bind an insurance company, and a broker is a licensed, independent contractor who represents insurance applicants and ceding insurers in the negotiation and purchase of insurance or reinsurance.\(^{29}\)

The conduct of insurance intermediaries is regulated through state statutes and laws. Typically, an agent or broker has a duty to faithfully carry out the instructions of its client. Depending upon the circumstances, a heightened ‘fiduciary duty’ may also apply.

v  Claims

The laws regarding insurance and reinsurance claims issues vary from state to state. The key issues include notice, good faith and dispute resolution.

With respect to notice, both insurance and reinsurance claims generally require that a policyholder or cedent provide reasonably timely notice of claims or other information. For insurance claims, timely notice is considered a condition precedent to coverage in many states and, in the absence of reasonably timely notice, a claim may not be covered. For reinsurance claims, in some jurisdictions, unless timely notice is stated to be a condition precedent in the reinsurance contract, a reinsurer seeking to avoid a claim on account of late notice must prove that it was economically prejudiced.

Both insurance and reinsurance claims may involve issues of good faith and fair dealing. Insurance companies, for their part, must respond to the claims of their policyholders consistent with contractual good faith and fair dealing requirements. In reinsurance, the duty of utmost good faith applies to both cedents and reinsurers. Thus, while cedents must fully disclose all material information about the ceded risk, for most lines of business reinsurers have a concomitant duty to ‘follow the fortunes’ of their cedents, which requires indemnifying cedents for all businesslike, good faith, reasonable claim payments.

IV  DISPUTE RESOLUTION

i  Jurisdiction, choice of law and arbitration clauses

A few key issues relating to insurance and reinsurance dispute resolution are (1) the forum in which a suit can or must be brought, (2) the law that will govern the dispute and (3) the dispute resolution process. In that regard, some insurance policies and most reinsurance


\(^{29}\) Depending upon the facts, a broker may also act for the insurance company or reinsurer.
contracts contain provisions relating to jurisdiction, choice of law or arbitration, either separately or together within a single dispute resolution clause. A typical forum clause, for example, requires any lawsuit related to the policy or contract to be filed in a given state or federal court. Similarly, a typical choice of law clause dictates which jurisdiction's laws 'shall' apply to disputes arising out of the contract. Finally, a typical arbitration clause states that all disputes regarding the contract shall be resolved by arbitration and, in most instances, spell out certain procedures applicable to the arbitration process.

Where those issues are not spelled out in the applicable contract, state and federal courts use a variety of legal rules for determining whether the chosen forum for a lawsuit is appropriate and choosing which state's law will apply. Arbitration, however, is a matter of contract or agreement; thus, a party that did not or has not agreed in its contract to arbitrate a dispute typically cannot be forced to do so.

**ii  Litigation**

The judicial system is made up of two different court systems: the federal court system and the state court systems.

In the federal system, there are three levels of courts: the district courts, which are the federal trial courts; the interim appellate courts, called the circuit courts of appeal; and the US Supreme Court, the final appellate court. Only two types of cases are heard in the federal system. The first is cases dealing with issues of federal law. The second is cases between citizens of two different states or between a US citizen and a foreign entity, provided the amount in dispute meets a minimum threshold. In total, there are 94 US district courts throughout the 50 states. There are 13 US circuit courts of appeal, each with separate jurisdictional coverage. There is one Supreme Court. Notably, the right to appeal to the Supreme Court typically is not automatic; the Supreme Court must agree to hear the case.

Typically, state court systems are made up of two sets of trial courts: trial courts of limited jurisdiction (probate, family, traffic, etc.) and trial courts of general jurisdiction (main trial-level courts). Most states also have intermediate appellate courts. All states have one final appellate state court.

Each state has its own rules of evidence for cases tried in its courts. Each state likewise has its own rules of procedure for cases progressing through its court system. The federal district courts, however, have a unified set of evidence rules and a unified set of rules of procedure.

Except in certain limited circumstances, the general rule in the US is that each party pays its own costs of litigation.

**iii  Arbitration**

The most widely used alternative dispute resolution process is arbitration. There are numerous types of insurance and reinsurance arbitrations. The differences between each type generally relate to the following: the number of arbitrators; arbitrator selection procedures; arbitrator neutrality; and the arbitration hearing procedure.

Generally, US insurance and reinsurance arbitrations are conducted before either one arbitrator or three arbitrators. The selection process varies; in some instances, there is a process managed by an independent third party for selection of the entire panel, in other instances, the parties choose and organise the selection process. Two prominent and independent
groups that certify arbitrators and in varying degrees organise insurance and reinsurance arbitrations in the US are the American Arbitration Association and the AIDA Reinsurance and Insurance Arbitration Society.

Typically, in the single-arbitrator process, the arbitrator is neutral and often has expertise in the particular type of dispute. Where the arbitration panel consists of three arbitrators, the general process is that arbitrators are either all neutral, or the parties each appoint a single arbitrator and follow a process for selection of a neutral umpire. In the latter process, it is common for both parties to be able to communicate with their appointed arbitrator prior to the hearing, but in the end, party-appointed arbitrators are expected to rule based on their view of the merits of the dispute. Although there are grounds to vacate or modify an arbitration award under the Federal Arbitration Act (or similar state statutes) and the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (also known as the New York Convention), unless there is a prior agreement otherwise, arbitration decisions are considered binding.

In most instances, arbitrators are not bound by strict rules of evidence during the hearing. It is also common for witnesses appearing at an arbitration hearing to be questioned by the presenting party's attorney, the opposing party's attorney and the arbitration panel.

Finally, the general rule is that each party pays its own costs for insurance and reinsurance arbitrations. However, insurance and reinsurance contracts may specify otherwise.

iv Mediation
Most state and all federal courts have adopted mediation processes designed to encourage dispute resolution without a trial. In general, the process is voluntary and the mediator is an independent third party without court affiliation. However, in a number of states, parties in commercial disputes are required to participate in at least one mediation or settlement conference prior to moving forward with trial. In addition, parties to an insurance dispute will often agree to retain a private mediator to help resolve one or more issues.

v Alternative dispute resolution
A range of dispute resolution techniques are used. Beyond arbitration and mediation, alternative dispute resolution procedures include early neutral evaluations, peer review and mini-trials. A number of industries – including the construction, maritime, and securities industries – have adopted these procedures to handle intra-industry claims.

V YEAR IN REVIEW

There were significant developments for the US insurance industry in 2018. While a comprehensive review of developments in the industry exceeds the scope of this chapter, the following is a sampling of the key emerging issues and events that will be on the minds of insurers throughout 2019.

i American Law Institute adopts the first Restatement of the Law, Liability Insurance
In May 2018, the American Law Institute (ALI) approved a final draft of the first-ever Restatement of the Law, Liability Insurance. The Restatement describes itself as a set of
guidelines designed to help courts navigate liability insurance law issues. While the ALI has historically published Restatements covering many different areas of the law, the Liability Insurance Restatement is controversial.

Critics of the project argue that the Restatement sought to change the law rather than describe the current law. For example, during the drafting process, directors of insurance departments from Idaho, Illinois, and Michigan each wrote to the ALI and expressed concern that the proposed Restatement did not reflect the laws of their jurisdictions, or the laws of insurance as they generally understood it. Similarly, in April 2018 the governors of South Carolina, Maine, Texas, Iowa, Nebraska and Utah wrote to the ALI and expressed the view that the proposed Restatement departed from established legal principles governing liability insurance contracts and disputes. In May 2018, however, the project was approved by the ALI membership.

Following the project’s approval, certain state insurance regulators have continued to express their concern. The National Conference of Insurance Legislators, for example, objected that the Restatement intruded upon the ‘constitutionally protected legislative prerogatives’ of the states to regulate insurance. In July 2018, the state of Ohio formally rejected the Restatement of the Law, Liability Insurance, stating in legislation that it ‘does not constitute the public policy of this state and is not an appropriate subject of notice’. US insurance professionals will be carefully monitoring how other jurisdictions and courts of law react to the Restatement over the next year.

ii New York and New Jersey reach divergent conclusions on the ‘unavailability exception’ to pro rata allocation

The appropriate manner for allocating losses arising from long-tail liabilities, such as environmental contamination or asbestos bodily injuries, is a contested insurance coverage issue. Generally, US courts have recognised two distinct methods for allocating loss. Under the ‘all sums’ allocation method, policyholders can seek coverage for all of their losses under any triggered insurance policy. Under the pro rata allocation method – which is based on the fact that some liability policies provide coverage for loss occurring ‘during the policy period’ – losses that span multiple policy periods are allocated based on each insurer’s relative time on the risk.

In 2017, the highest courts of three states – New York, New Jersey and Connecticut – were asked to address the extent to which pro rata allocation requires policyholders to bear the costs associated with periods where they could not have obtained insurance to cover their liabilities because it was unavailable. In 2018, the highest courts in New York and New Jersey handed down their decisions, reaching different conclusions. In March 2018, the New York Court of Appeals closed the door on the ‘unavailability exception’ to pro rata allocation in

Keyspan Gas East Corporation v. Munich Reinsurance America, Inc.\textsuperscript{33} In that case, the insured sought coverage for clean-up costs associated with environmental contamination at five natural gas plants under its control that occurred gradually over many decades beginning in the early 1900s. The insurers argued that their liability was limited to their \textit{pro rata} share of the damage based on their respective time on the risk, but the insured argued that the insurers should also bear the costs associated with any policy periods when insurance coverage for environmental contamination was generally ‘unavailable’. The New York Court of Appeals sided with the insurers, unanimously finding that ‘because “the very essence of \textit{pro rata} allocation is that the insurance policy language limits indemnification to losses and occurrences during the policy period” the unavailability rule cannot be reconciled with the \textit{pro rata} approach’.

However, in June 2018, the New Jersey Supreme Court affirmed New Jersey’s unavailability exception to \textit{pro rata} allocation in \textit{Continental Insurance Co et al v. Honeywell International Inc}.\textsuperscript{34} The case arose from Honeywell’s production of asbestos-containing products for more than 60 years, from 1940 until 2001. The insurance policies providing coverage from 1940 to 1986 did not contain exclusions for asbestos-related liabilities, but the policies from 1986 until 2001 did. Under New Jersey law, the policies were subject to \textit{pro rata} allocation, but the parties disagreed over how the court should treat the periods where asbestos-related liabilities were excluded. The majority found that the unavailability exception was a matter of established law in New Jersey, and that while it ‘would not hesitate to revisit’ this approach if it proved inefficient or unrealistic, this case ‘does not present a compelling vehicle to reconsider our precedent on allocation’.\textsuperscript{35}

Insurance professionals in the US will now monitor how the Connecticut Supreme Court decides \textit{RT Vanderbilt Company, Inc v. Hartford Accident and Indemnity Co},\textsuperscript{36} a case that also involves long-tail liabilities subject to \textit{pro rata} allocation and the question of how to treat periods where insurance was purportedly unavailable to cover the risk. A decision is expected in 2019.

\textbf{iii} New York Court of Appeal’s guidance impacts review of facultative reinsurance certificates

A contested reinsurance issue in US courts is whether the ‘reinsurance accepted’ section in a facultative reinsurance certificate unambiguously caps the amount the reinsurer is obligated to pay for both loss and expenses incurred by the ceding company. In December 2017, the New York Court of Appeals ruled that ‘[u]nder New York law generally . . . there is neither a rule of construction nor a presumption that a per occurrence liability limitation in a reinsurance contract caps all obligations of the reinsurer, such as payments made to reimburse the reinsured’s defense costs.’\textsuperscript{37} The Court further explained that under New York law, a court must not ‘disregard the precise terminology that the parties used and simply assume . . . that any clause bearing the generic marker of a “limitation of liability” or “reinsurance accepted” clause was intended to be cost-inclusive’.\textsuperscript{38} Instead, reviewing courts should

\textsuperscript{33} Keyspan Gas East Corporation v. Munich Reinsurance America, Inc, et al, APL-2016-00236 (NY).
\textsuperscript{35} id. at 61.
\textsuperscript{36} RT Vanderbilt Company, Inc v. Hartford Accident and Indemnity Co, et al, PSC-16-0445 (CT).
\textsuperscript{38} id. at *6.
interpret certificates by ‘look[ing] to the language of the [certificate] above all else’, and that ‘even modest variations on the face of a written agreement can alter the meaning of a critical term’.39

In 2018, the United States Court of Appeals for the Second Circuit twice applied this rule to interpret facultative reinsurance certificates. First, in the May 2018 case of Global Reinsurance Corp v. Century Indemnity, the Second Circuit remanded a case involving a facultative reinsurance certificate back to the lower court ‘for consideration in the first instance of the contract terms at issue, employing standard principles of contract interpretation’.40 Quoting the New York Court of Appeals, the Second Circuit stated that the district court ‘should “construe each reinsurance policy solely in light of its language and, to the extent helpful, specific context”’.41

Second, in the September 2018 case of Utica Mutual Ins Co v. Clearwater Ins Co, the Second Circuit referenced the New York Court of Appeal’s decision and held that a ‘naked’ limitation on liability or reinsurance accepted clause – that is, one that does not say that the reinsurer’s obligations are ‘subject to’ the amount of liability – ‘does not inherently cap the reinsurer’s liability’ and ‘says nothing about whether that liability cap is expense-supplemental or inclusive’.42 However, because the reinsurance certificates had a ‘follow-the-form’ clause, the court found that the reinsurer’s obligations ‘must track’ the cedent’s obligations on the underlying policies.43 Since the underlying policies at issue were ‘expense-supplemental’, the court ruled that ‘the . . . certificates likewise are expense-supplemental’.44

VI OUTLOOK AND CONCLUSIONS

The US insurance and reinsurance markets continued to grow and evolve in 2018. As this growth and evolution will no doubt continue in 2019 and beyond, industry executives, representatives and practitioners will need to stay abreast of these changes in order to respond in a timely manner to new and emerging issues.

39 id. at *5 (citation and quotation marks omitted).
40 Global Reins Corp of Am v. Century Indem Co, 890 F.3d 74, 77 (2d Cir. 2018).
41 id. (citation omitted).
42 id. at *14. However, the Second Circuit also stated if the facultative certificate does say that the reinsurance is ‘subject to’ the amount of liability, then the reinsurer’s obligations ‘would be expense-inclusive and would therefore be capped at’ the stated limit. id. at 13.
43 id. at *15.
44 id.
Appendix 1

ABOUT THE AUTHORS

JAKOB ANDERSSON
*Hamilton Advokatbyrå KB*

Jakob Andersson is an associate in Hamilton’s dispute resolution practice and has experience in a number of dispute-related matters, in particular insurance claims and professional liability. Prior to working at Hamilton, Jakob served as a law clerk at the Stockholm District Court.

ALDI ANDHIKA JUSUF
*AP Advocates*

Aldi Andhika Jusuf is a managing partner at AP Advocates. He specialises in business law, commercial law and corporate law. However, he has also taken cases in the areas of criminal law and corporate crime. In addition to being an advocate and a member of the Indonesian Bar Association, Aldi also has an AKPI licence as an Indonesian administrator and receiver.

During his 12 years as an advocate, Aldi has handled cases of national and multinational companies engaged in financial services including insurance and banking, and other companies engaged in oil and gas; mining; telecommunication; the automotive mobile industry; medical and pharmacy; media; investment; shipping; and contractual matters within the scope of non-litigation and litigation (such as labour, insurance, bankruptcy and investment disputes). Aldi has also handled general corporate matters, corporate actions (such as IPOs, rights issues, obligations and M&A transactions worth trillions of rupiahs), and establishment of investment companies.

JORGE ANGELL
*LC Rodrigo Abogados*

Jorge Angell is the senior partner of LC Rodrigo Abogados, and specialises in corporate and commercial law, insurance and reinsurance law, private international law, litigation and arbitration. He graduated in law in 1971. He is a member of the Madrid (Spain) and Lima (Peru) Law Societies.

He frequently acts as an expert in Spanish law before foreign courts, especially English and US courts, and as arbitrator and party counsel in domestic and international arbitrations. He is listed in the arbitrators’ roster of the Arbitration Court of the Chamber of Commerce and Industry of Madrid, of the Madrid Law Society and of the Arbitration Court of the Chamber of Commerce of Lima. He is a member of ICC Spanish National Committee, the London Court of International Arbitration and the European-Latin American Arbitration Association.
He is currently the Chairman of the Reinsurance Working Party of the International Insurance Law Association (AIDA). He is a member of the following LPD Committees of the IBA: Business Organisations, Insurance, Litigation (co-chair for 2006 to 2007) and Arbitration. He is also a member of the FDCC and current International Rep for Spain, vice chair of the International Activities Committee and former vice chair of the Reinsurance, Excess and Surplus Lines Section. He is also a member of the Professional Liability Underwriting Society; SEAIDA (the Spanish section of AIDA); and the Credit Insurance Working Party of AIDA, as well as an adjunct member of the International Association of Claim Professionals; and a member of the Defence Research Institute and the Spanish Arbitration Club.


He speaks Spanish and English fluently.

PETRA ATTARD
Mamo TCV Advocates
Petra Attard is a senior associate in the corporate and insurance law practice group of Mamo TCV Advocates. She regularly assists clients in the insurance industry on corporate and regulatory matters, advising on corporate governance matters, compliance and regulatory matters, product structuring, financing and M&A transactions.

BRUNO BALDUCCINI
Pinheiro Neto Advogados
Bruno Balduccini has been a partner since 2001 in the corporate practice of the Pinheiro Neto Advogados office in São Paulo. His fields of expertise are banking regulations, business law, corporate law, financing, investments, M&A, exchange controls, credit cards, insurance and reinsurance. In addition to his practice at Pinheiro Neto Advogados, he has been a standing member of the São Paulo Lawyers Institute since 2004, where he participates in the banking law committee. Mr Balduccini graduated with an LLB from the Pontifical Catholic University of São Paulo (1992), and holds a master’s degree in international banking law from Boston University (1998). He was admitted to the Brazilian Bar Association in 1993. Mr Balduccini was a foreign associate at Sullivan & Cromwell in New York for one year between 1998 and 1999. Mr Balduccini has been consistently named a leading lawyer by Chambers Latin America, Chambers Global, Latin Lawyer, The Legal 500, Who’s Who Legal and Advocacia 500.

JOHN BARLOW
HFW
John Barlow advises insurers and reinsurers of financial institutions in connection with their fidelity, computer crime, D&O, PI/Civil Liability and cyber liability programmes, and
About the Authors

**John** has handled and settled many of the most significant claims to find their way into the London insurance and reinsurance market over the past two decades.

John also heads up HFW’s regulatory team in Dubai, which assists insurers, brokers and MGAs wishing to establish a presence in the DIFC. John and his team’s work includes advising on set ups and compliance and guides clients from the initial approach to the Dubai Financial Services Authority to the obtaining of the required licence.

In addition to his claims handling experience and dispute resolution, John has considerable experience in the development of leading financial institution insurance products that encompass the coverage of exposures of IFAs, banks, investment banks and sovereign financial institutions. John has developed market leading products in connection with bank operational risk programmes, including products that address regulatory capital issues for banks, traders and commodities companies.

John has considerable experience of political risk, trade credit, trade finance, sovereign guarantee and protracted payment insurances, as well as the development of captive insurance programmes.

**PELIN BAYSAL**

*Gün + Partners*

Pelin Baysal has been with Gün + Partners since 2006 and has been a partner since 2013. She is chair of the firm’s insurance and reinsurance, and corporate and M&A practices, and co-chair of the firm’s dispute management practice.

She has acted as party counsel in and advised on numerous commercial and corporate disputes before the Turkish courts and ICC arbitration, involving M&A disputes, shareholder disputes, joint-venture disputes, distribution agreements, compensation cases, white-collar crimes, insurance disputes, D&O liability disputes, and enforcement of foreign court judgments and arbitral awards.

Pelin advises numerous reinsurers and insurers on all forms of insurance under Turkish law and advises on litigation and arbitration, and coverage issues on policies including general third-party liability, professional third-party liability, credit insurance, fire all risks, mechanical breakdown, construction all risks, D&O and bankers blanket bond policies. She also advises insurance and reinsurance companies on regulatory matters.

In addition, she is the only listed lawyer from Turkey in *Who’s Who Legal: Insurance & Reinsurance*. The publication, which is based upon an independent survey of general counsel and private practice lawyers, profiles the foremost practitioners in the insurance and reinsurance community. They noted that Pelin Baysal is highly sought after by clients, who commend her ‘sharp and comprehensive analysis’ as well as ‘the clarity of her advice’ when it comes to insurance disputes.

**NEIL BERESFORD**

*Clyde & Co LLP*

Neil Beresford is a specialist in high-value Colombian litigation. He has worked in Colombia for almost 20 years and runs cases in almost every jurisdiction including civil courts, administrative courts, criminal courts, the Constitutional Court, arbitration tribunals, the Controller’s Office, the Superintendence of Industry and Commerce, and the Prosecutor’s Office.
Neil works with international reinsurers doing business in Colombia and also with Colombian companies doing business abroad. He has worked with Colombian insurers on the structure of global property programmes for multilatina corporations.

In recent years, Neil’s practice has focussed on the Controller’s Office. He is also representing insurers and reinsurers in a long-running insurance dispute relating to the Central Bank of Colombia and its role in the collapse of the UPAC lending system in the 1990s.

Neil is actively involved in the development of Colombian insurance and reinsurance law and speaks regularly on the subject.

NICOLAS BOUCKAERT
Kennedys
Nicolas Bouckaert is a partner at Kennedys, whose Paris office he co-founded in October 2017. He is qualified as a French avocat à la cour and a solicitor in England and Wales, having studied in England (University of Oxford and University of York) and trained at a magic circle firm in London.

Nicolas is regularly instructed in complex and international disputes, both before French courts and arbitration tribunals. He acts for leading insurers and reinsurers, brokers, major policyholders and manufacturers. His practice includes coverage disputes (insurance and reinsurance), defence work, subrogation claims and general commercial litigation. It spans several key industry sectors (aerospace, construction, real estate, finance and manufacturing), with a particular focus on product and professional liability. Nicolas also has significant experience of complex court-appointed technical investigations, specifically relating to industrial risks.

Nicolas is one of the co-authors of The International Comparative Legal Guide to Insurance & Reinsurance and the FARAD Private Life Insurance Handbook (2nd ed.). He is bilingual in English and French, and also speaks Italian. He is a member of the International Insurance Law Association (AIDA), the Association for the Management of Risk and Assurance of Enterprise (AMRAE) and the Franco-British Lawyers Society (FBLS).

GRÁINNE CALLANAN
Matheson
Gráinne Callanan is a partner in the financial institutions group and leads Matheson’s Cork office. Gráinne advises a wide range of leading domestic and international financial institutions doing business in and from Ireland, including life and non-life insurance and reinsurance companies, captive insurers and intermediaries on corporate transactions, regulatory and compliance and corporate governance.

Gráinne has extensive expertise in the areas of new authorisations, portfolio transfers, cross-border mergers, corporate restructurings, distribution arrangements and health insurance. She has advised on a wide range of innovative transactions in the insurance market in recent times and has advised clients on a number of significant acquisitions of closed books of life insurance businesses.

Gráinne lectures at the Law Society of Ireland and the Insurance Institute of Ireland. Gráinne is also a member of the Cork Financial Services Forum.
MICHAEL T CAROLAN
Troutman Sanders LLP
Michael T Carolan is a partner in Troutman Sanders’ insurance and reinsurance group, where he concentrates his practice on litigating, arbitrating, and resolving domestic and international disputes involving reinsurance, complex insurance coverage and brokers’ liability. He also counsels clients on regulatory issues, business and settlement strategy, insolvency and liquidation issues, and bad faith exposures. Michael has represented company and intermediary clients across the life, health, and property and casualty markets in litigation and arbitration in state and federal courts as well as a variety of US and foreign arbitral settings. He has also written on reinsurance issues related to credit default swaps and financial products. Michael received his JD from the George Washington University Law School in 2006.

CHEN JUN
AnJie Law Firm
Chen Jun is a partner at AnJie Law Firm. She has great experience in insurance compliance. She serves as legal counsel to many insurance institutions, such as Anbang Insurance Group Co, Ltd, China Joint Property Insurance Co, Ltd, Sunshine Property Insurance Co, Ltd, China Huanong Property & Casualty Insurance Co, Ltd and Generali China Insurance Co, Ltd. She also specialises in the utilisation of insurance funds.

Chen Jun practises in insurance and reinsurance, and corporate compliance. Her educational background includes Heilongjiang University, School of Law (LLM) and Southwestern University of Finance and Economics, School of Economics (LLB).

SIMON COOPER
Ince Gordon Dadds LLP
Simon Cooper has over 33 years’ experience of advising clients in the London and international insurance and reinsurance markets. He has extensive experience of acting in large-scale disputes in the English Commercial Court and appellate courts, in ad hoc arbitrations and in overseas jurisdictions. Many of these disputes have involved multiple parties and complex issues of fact and law. He also has comprehensive experience of mediation and other forms of alternative dispute resolution.

Mr Cooper’s practice has included most areas of non-marine insurance and reinsurance, including PI and cyber, property, and space risks. He is recommended in various guides including Chambers Guide (in which he is recognised as a Notable Practitioner) and The Legal 500. He is a member of the IUA clauses subcommittee and edited the second edition of Reinsurance Practice and the Law. He writes and lectures frequently on insurance and reinsurance law.

SHARON DALY
Matheson
Sharon Daly is a partner and heads the commercial litigation insurance team, which is described by The Legal 500 as ‘second to none’ with Sharon being personally commended for her ability to respond creatively to complex disputes.
Sharon and her team have been involved in some of the most significant commercial litigation before the Irish courts in the past 10 years, including defending a major financial institution in a multibillion, multi-jurisdictional dispute arising from investment in Bernard L Madoff’s business. Sharon also acted for insurers in the largest property damage dispute to come before the Irish courts in relation to the liability of hydroelectric dams and flood damage arising therefrom.

Sharon and her team advise a wide range of clients on insurance issues including coverage, policy disputes and defence of large complex claims. Sharon and her team also advise on regulatory issues for insurers and support commercial transactions for insurers buying and selling their businesses.

As a member of the Matheson’s Brexit Advisory Group and a council member of the Dublin Chamber of Commerce, Sharon is working with government and other key stakeholders to encourage UK-based multinationals to relocate to Dublin in order to facilitate the growth of Dublin as a leading global business centre, building on Brexit and beyond.

MIGUEL DUARTE SANTOS

Gouveia Pereira, Costa Freitas & Associados, Sociedade de Advogados, SP, RL

Miguel Duarte Santos is a managing associate at Gouveia Pereira, Costa Freitas & Associados, Sociedade de Advogados, SP, RL – GPA Law Firm, working in the areas of insurance, banking, finance and securities law.

He specialises in insurance and banking law, with eight years of experience advising and representing insurance companies, claims representatives and insurance brokers (national and foreign) on the applicable supervisory and regulatory provisions of the Fourth Anti-Money Laundering Directive, the General Data Protection Regulation, consumer protection, complaints management, conclusion of distance contracts, and other applicable legal and regulatory frameworks.

Miguel also advises on the drafting, conclusion and performance of insurance contracts and ensures the judicial follow-up of legal actions and arbitration proceedings concerning life and non-life insurance, as well as capitalisation operations.

He has significant experience in assisting national and international companies on access to the Portuguese insurance market, namely on the authorisation procedures via freedom of establishment and freedom to provide services rights, as well as on the relevant legal and regulatory provisions for the rendering of the insurance activity.

Miguel has also published several scientific papers on related areas.

JOHN DYKSTRA

Maples Group

John Dykstra is a partner in the Cayman Islands office of the Maples Group. He specialises in structured finance, investment funds and corporate and commercial transactions, with an emphasis on catastrophe bond transactions and other insurance-linked securities, CLO transactions, securitisations, derivatives, structured debt and repackagings. John is recommended for insurance and reinsurance by Who’s Who Legal and is noted in Chambers Global and The Legal 500 for catastrophe bond transactions.
MARIKA EASTWICK-FIELD

*Russell McVeagh*

Marika Eastwick-Field is a commercial litigation specialist with particular expertise in insurance, banking and financial markets, real estate and construction.

Marika represents clients in a variety of commercial disputes, both in the courts and in arbitrations. She also advises on a range of contentious and non-contentious matters including contract, company and securities law, banking, leasing and insurance.

MARKUS EICHHORST

*Ince & Co Germany LLP*

Markus Eichhorst joined Ince & Co in 2001 and specialised in insurance and shipping disputes. He became a partner in 2008. He was called to the bench in 2010 and worked as a judge for two years before he returned to Ince & Co Germany LLP. He has significant experience in negotiating, litigating and arbitrating insurance, commercial and shipping disputes, such as marine and non-marine coverage disputes under P&I, D&O and other liability policies as well as property insurance policies. Mr Eichhorst is an officer of the insurance committee of the International Bar Association. He is especially recommended for arbitration and mediation in the *Best Lawyers* survey 2013.

ANTOINE FONTAINE

*Bun & Associates*

Antoine Fontaine is Bun & Associates’ practice leader for the insurance, labour, tax and regulatory reform practice groups. He holds a PhD in insurance law and has developed unmatched expertise in Cambodia’s insurance sector, providing comprehensive advice to multinational companies on their insurance portfolio and counselling to foreign insurance companies on their market entry. He notably advised the first insurance broker, the first insurance agent, the first and the latest fully privately owned life insurance company, the latest general insurance company and the first three micro-insurance companies on their market entry.

He has worked in Cambodia for 18 years. He co-founded Bun & Associates after working for AXA Insurance as legal research expert, the French Embassy in Cambodia and leading French law firm, Gide Loyrette Nouel. Since 1999, he has been lecturing in universities around South East Asia and has published several articles on South East Asian legal systems. He still lectures on insurance law at the Royal University of Law and Economics in Phnom Penh.

Mr Fontaine is described by *Chambers and Partners Asia-Pacific* 2017 as continuing to be a key name for work in the insurance sector. He is a member of the Paris Bar and the former chair of the French Cambodian Chamber of Commerce, and has been appointed as the French Foreign Trade Adviser by the French prime minister and legal counsel of the French Embassy in Cambodia. He is fluent in French and English, and conversant in Khmer.
ANDRÉS GARCÍA
Clyde & Co LLP

Andres García is a Colombian-qualified associate at Clyde & Co. Andrés graduated from Los Andes University in Bogotá and holds a master's degree in administrative law from Pontifical Xavierian University and an LLM from University College London.

Before joining Clyde & Co, Andrés practised at Palacios Lleras (2010–2013) and Arrieta Mantilla y Asociados (2015–2017), two of the most prestigious boutique law firms in Colombia, where he acquired a wide experience in commercial and administrative litigation.

DAVID GERBER
Clayton Utz

David Gerber is a partner in the Sydney office of Clayton Utz. He is a specialist insurance lawyer with experience in both general and life insurance, including reinsurance. In 2014, he was named a ‘Rising Star’ for insurance and reinsurance in Expert Guides: Insurance and Reinsurance. According to Best Lawyers, for the past six years he has been selected by his peers for inclusion in The Best Lawyers in Australia in the area of insurance law. From 2016 to 2019, he has been ranked by The Legal 500 Asia Pacific as one of Australia’s ‘Leading Individuals’ in insurance. In 2019, Chambers and Partners ranked Mr Gerber as a Band 4 Insurance practitioner in the Asia-Pacific region.

Mr Gerber helps clients both with their corporate insurance issues and resolving disputes, including insurance coverage disputes. This includes advice on policy interpretation, insurance claims, indemnity and risk issues, insurance regulation, product development and distribution, captives, reinsurance, portfolio transfers, the insurance aspects of major projects, M&A and other commercial transactions, and regulatory investigations. He also acts for the insurance industry in corporate restructuring and insurance-linked securities transactions, regulatory engagement and enforcement matters, and has advised local and international clients on regulatory compliance.

He holds bachelor of arts and bachelor of laws degrees from the University of Natal, South Africa. He is admitted to practise in the Supreme Court of New South Wales and the High Court of Australia, and is an Advocate of the High Court of South Africa.

LARS GERSPACHER
gbf Attorneys-at-law Ltd

Lars Gerspacher is a partner at gbf Attorneys-at-law Ltd and focuses his activities on the areas of insurance and reinsurance law, aviation and maritime law, and transport and trade law.

He is on hand to advise and give support to his clients whenever needed, conduct international proceedings and represent clients in litigation or arbitration in various lines of business (such as marine, aviation, D&O liability, E&O, fidelity and other financial lines). He also specialises in policy drafting and regulatory work for the insurance and reinsurance industries, where he advises upon any aspect of regulation by the Swiss Financial Market Authority. He handles authorisations in Switzerland and Liechtenstein, including the drafting and submission of required business plans to the competent regulators. In particular, he advises reinsurers in re-domesticating their business to Switzerland.

Mr Gerspacher is recognised in, among others, Who’s Who Legal: Insurance & Reinsurance as one of the leading practitioners in the above-mentioned fields.
About the Authors

DIMITRIS GIOMELAKIS
Herring Parry Khan Law Office, trading as Ince & Co

Dimitris Giomelakis joined Ince & Co in January 2009 from Vgenopoulos & Partners Law Firm, where he was an associate for four years. He graduated from the Law School of Athens and qualified as a lawyer in 2004. He holds an LLM from the University of Hamburg, a master's degree in European studies from the University of Hamburg, and a master's degree in law and economics from the University of Rotterdam.

He has carried out court-related work on a wide variety of matters covering all aspects of shipping, commercial, insurance and labour disputes, and has advised Greek and foreign clients on disputes before Greek courts and arbitration tribunals. His contentious practice extends to extrajudicial and judicial disputes with government authorities.

ALESSANDRO P GIORGETTI
Studio Legale Giorgetti

Alessandro P Giorgetti is a graduate of Milan State University, where he studied private international law. He both graduated and was admitted to the Milan Bar in 1983. He subsequently studied commercial law at Robinson College, Cambridge University. He is a member of the special Bar for the High Courts in Italy.

Mr Giorgetti practises insurance and reinsurance law, and has acted as principal consultant or litigator in some of the major Italian cases.

He works in English, French and Italian. He is an active member of the International Association of Defense Counsel, of which he has been a past international vice president; the Defence Research Institute; and the International Bar Association. Mr Giorgetti also belongs to the Association of Fellows and Legal Scholars of the Center for International Legal Studies in Salzburg, and he has been listed since 2007 in Who's Who Legal: Product Liability and since 2008 in Who's Who Legal: Insurance & Reinsurance.

He has authored several articles, and the book Il contenzioso di massa in Italia, in Europa e nel Mondo – Profili di comparazione in tema di Class Action ed Azioni di Gruppo, ed. Giuffé (2008), comparing mass litigation and collective redress procedures around the world.

He is a regular lecturer in Italy and abroad on insurance, professional liability and personal injury law.

DIÓGENES GONÇALVES
Pinheiro Neto Advogados

Diógenes Gonçalves has been a partner in the litigation group of Pinheiro Neto Advogados’ São Paulo office since 2007, practicing in litigation and insurance and reinsurance. He graduated from São Paulo University in 1995 and holds a postgraduate degree in civil procedure law from the University of Milan, Italy (1997) and an LLM degree in civil procedure law from the University of São Paulo Law School, Brazil (2002). As part of his international professional experience, he was a foreign associate at Villa Manca Graziaidei in Italy in 1997. He is currently the coordinator of the litigation group at Pinheiro Neto Advogados, and a member of the São Paulo Lawyers Institute, the International Association of Defence Counsel, Insuralex and the Association of Foreign Insurance Companies. Mr Gonçalves has been consistently named a leading lawyer by Chambers Latin America, Chambers Global, Latin Lawyer, The Legal 500, Who’s Who Legal and Advocacia 500.
YVES HAYAUX-DU-TILLY

Nader, Hayaux & Goebel

Yves Hayaux-du-Tilly is a partner of the Mexican independent law firm Nader, Hayaux & Goebel, the only Mexican law firm with an office in London.

Yves specialises in insurance and reinsurance, both in contentious and non-contentious matters. Yves currently represents the following Mexican affiliate insurance companies on an ongoing basis in transactional work, mergers and acquisitions, product development and general regulatory, corporate governance and compliance-related matters: AXA Seguros Mexico, Assurant Daños Mexico, Assurant Vida Mexico, BUPA Mexico, Cardif Mexico Seguros de Vida, Cardif Mexico Seguros Generales, Dentegra Seguros Dentales, Der Neue Horizont Re, Genworth, Grupo Nacional Provincial, Grupo Sudamericano de Inversiones (Grupo SURA), LandAmerica Mexico (in liquidation), Mapfre Asistencia, MetLife Mexico, Panamerican Life Mexico, Seguros Azteca, Seguros Principal, Principal Pensiones, Prudential Seguros Mexico and Zurich Mexico.

Yves also represents Mexican and foreign insurance and reinsurance companies, and has experience in arbitration and mediation.

Yves is former chairman, vice chairman and board member of the Mexican chapter of International Insurance Law Association (AIDA), former vice chairman of Ibero–Latin American Committee of AIDA (CILA), and was responsible for establishing the Mexican chapter of the Insurance and Reinsurance Arbitration Society (ARIAS Mexico). He is also a member of the presidential council of AIDA and honourary member of the Commercial Bar Association.

Yves is a co-founder of the Mexican Chamber of Commerce in Great Britain.

CRAIG HINE

Clayton Utz

Craig Hine is a senior associate in the Sydney office of Clayton Utz. He is a specialist insurance lawyer with experience in both general and life insurance.

He has experience assisting clients with both corporate insurance issues and dispute resolution. His experience includes advising on insurance and risk issues in commercial transactions, advising on insurance placements and policy wordings, advising on licensing, the distribution of insurance products and other regulatory compliance issues, and conducting insurance litigation in the Federal Court of Australia.

Mr Hine holds bachelor of applied finance and bachelor of laws degrees from Macquarie University, Australia, and a master of laws degree from the University of Sydney, Australia. He is admitted to practise in the Supreme Court of New South Wales and the High Court of Australia.

RALPH HOFMANN-CREDNER

Wolf Theiss Rechtsanwälte GmbH & Co KG

Ralph Hofmann-Credner has more than 15 years of experience in the insurance industry. He has in-depth expertise in advising on policy wording and on general terms and conditions for (new) insurance products, as well as in contested insurance matters, such as coverage and dispute resolution, including recourse claims. He has specialised expertise in handling complex insurance-related cross-border litigation cases in Austria and across the CEE/SEE
region for the global insurance industry. He is appointed by Lloyd’s of London and by Lloyd’s Insurance Company SA as General Representative for Austria, and he is admitted to the Austrian Bar and enrolled with the Solicitors Regulation Authority as a (non-practising) solicitor in England and Wales. In addition, he regularly lectures on insurance law at various institutions.

TOM HUNT
Russell McVeagh
Tom Hunt is a talented corporate finance and debt capital markets lawyer with extensive experience acting for both banks and borrowers in New Zealand and overseas.

Tom has extensive experience advising his client base of banks, corporates and other financial market participants on all aspects of financial services regulation. He is regarded as a leading expert on the AML/CFT Act and also has particular expertise in relation to financial adviser legislation, and all aspects of the prudential regulation of banks and insurers.

CELIA JENKINS
Tuli & Co
Ms Celia Jenkins handles the firm’s non-contentious practice, and specialises in product development, regulatory issues and corporate and commercial work.

Ms Jenkins has been involved in drafting, vetting and advising on insurance contract wording and ancillary documentation across a range of business and product lines, and has reviewed more than 1,150 policies including ULIPs, term life, whole life, rural-oriented, health-oriented (for stand-alone health insurers and life insurers), personal accident, pension, gratuity, superannuation, leave encashment, travel, home contents, D&O, various E&O, marine and aviation liability policies, medical complications liability, POSI and trade credit.

Ms Jenkins also advises insurers, intermediaries and third-party service providers on structuring and drafting commercial arrangements, database and service provider payments, credit management, distribution channels management, rebating, and also on larger commercial issues such as restructuring of existing joint ventures, entry strategies, investments in exchange traded funds and pension funds.

Ms Jenkins also assists insurers and insurance intermediaries in dealing with disciplinary actions by the insurance regulator. In addition, Ms Jenkins advises overseas insurers and reinsurers and Indian financial companies on a range of corporate issues in relation to investments in the insurance space, and also advises clients on restructuring options, foreign direct investment issues and joint ventures in the intermediary space.

DIMITRIS KAPSIS
Herring Parry Khan Law Office, trading as Ince & Co
Dimitris Kapsis joined Ince & Co in January 2009 from his own law office, where he advised on a wide range of shipping, corporate and insurance matters. He graduated from the Law School of Athens, and holds an LLM in legal aspects of marine affairs and commercial law. He qualified as a lawyer in 1994. He advises major local and international shipping companies on both dry and wet matters, including litigation and dispute resolution. He acts for clients on due diligence for the establishment of foreign companies in Greece as well as incorporation and organisation of Greek companies, finance, taxation, security and competition issues.
He has also substantial experience in S&P transactions, M&A transactions, corporate acquisitions, investment transactions, all legal aspects of commercial contracts, and in matters related to the assigning of public contracts by means of public tenders, including the preparation and submission of administrative and judicial objections and appeals.

THOMAS J KINNEY

*Troutman Sanders LLP*

Thomas J Kinney is an associate at Troutman Sanders in the insurance and reinsurance group. His practice involves litigation, arbitration, and counselling on a wide variety of insurance and reinsurance issues, and includes pre-dispute advice as well as insurer and reinsurer representation in complex disputes. Tom received his JD from the George Washington University Law School and his BA, with honours, from the University of New Hampshire. Prior to joining the firm, Tom clerked for the Honourable Noel T Johnson and the Honourable William C Nooter of the District of Columbia Superior Court.

SIGRID MAJLUND KJÆRULFF

*Kammeradvokaten / Poul Schmith*

Sigrid Majlund Kjærulff represents both Danish and international clients in the insurance industry and the public sector. Having worked in the insurance industry as a claims manager, Sigrid is focused on matters involving the defence of liability, policy-based disputes and coverage issues including financial lines, product liability, administrative liability and public liability, particularly workers’ and patients’ compensation and related legal areas such as contract law. Sigrid’s practice spans dispute resolution in the High Courts of Western and Eastern Denmark, and the city courts.

PETER KULLGREN

*Hamilton Advokatbyrå KB*

Peter Kullgren is a partner in Hamilton’s banking and finance practice, and assists Swedish and foreign financial companies, banks, insurance companies (both direct insurance and reinsurance), insurance intermediaries, brokerage firms, funds and payment service providers. Peter’s specialist expertise and experience in both financial markets and regulatory affairs means that he is qualified to assist his clients in the best possible way.

LI DAN

*AnJie Law Firm*

Li Dan is a senior counsel at AnJie Law Firm. Li Dan has worked for seven years in Beijing Tongzhou District People’s Court and five years in Beijing Third Intermediate People’s Court. She has an abundance of experiences in trials of civil and commercial cases. Li Dan is distinguished by her ability and extensive experiences in the trials of civil and commercial cases. During her tenure as a judge, she independently heard over 800 civil cases and 2,000 commercial cases and participated in the trials of over 3,000 cases.

Li Dan practices in insurance and reinsurance, and litigation and arbitration. Her educational background includes Renmin University of China (LLM), City University of Hong Kong (LLM) and Southwest University of Political Science and Law (LLB).
DARREN MAHER
Matheson

Darren Maher is a partner and head of the financial institutions group at Matheson. He has advised a wide range of leading domestic and international insurance and reinsurance companies on all aspects of insurance law and regulation, including establishment and authorisation, development and distribution of products, compliance, corporate governance and reorganisations including cross-border mergers, schemes of arrangement, portfolio transfers, and mergers and acquisitions. Darren is a member of the firm’s Brexit Advisory Group, and is advising a significant number of the world’s leading financial services firms on their plans to establish a regulated subsidiary in Ireland in order to maintain access to the EU Single Market in advance of the Brexit date.

Darren frequently publishes articles in insurance and reinsurance publications and is co-author of the Irish chapter of PLC’s *Cross-border Insurance and Reinsurance Handbook*. Darren lectures at the Law Society of Ireland and the Insurance Institute of Ireland.

NIKOLAOS MATHIOPOULOS
Herring Parry Khan Law Office, trading as Ince & Co

Nikolaos Mathiopoulos joined Ince & Co in January 2017 from Thenamaris (Ships Management) Inc, where he worked for three-and-a-half years as a legal counsel. He had previously worked for Timagenis Law Firm, where he was an associate for eight-and-a-half years. He graduated from the Law School of Athens and qualified as a lawyer in 2003. He holds an LLM in maritime law from the University of Southampton, an LLM in civil law from the University of Athens and an LLM in commercial and corporate law from University College London.

He has experience in litigation before the Greek courts as well as in arbitration proceedings under LMAA rules. His main area of expertise is maritime and commercial law, but he is also familiar with all aspects of Greek civil and administrative laws and procedures. He advises shipping companies, P&I clubs and classification societies.

APRIL MCCLEMENTS
Matheson

April McClements is a partner in the insurance and dispute resolution team. She is a commercial litigator and specialises in insurance disputes.

April advises insurance companies on policy wording interpretation, complex coverage disputes (in particular relating to financial lines policies), D&O claims, cyber, professional indemnity claims, including any potential third-party liability, and subrogation claims. April also manages professional indemnity claims for professionals, including insurance brokers, architects and engineers, for a variety of insurers.

April has been involved in obtaining High Court approval for various insurance portfolio transfers or schemes of arrangement arising from reorganisations or mergers and acquisitions involving life, non-life and captive insurers. April also works in the area of general commercial litigation with a particular focus on contractual disputes, most of which are litigated in the Commercial Court. She is also a strong advocate of ADR and has acted for clients in mediation and arbitration.
April is a member of the Law Society of Ireland, the Insurance Institute of Ireland and the British Insurance Law Association. She has contributed to various industry publications and has participated in seminars as a speaker on insurance issues. She is a lecturer on the Law Society of Ireland Insurance Law Diploma course.

WILLIAM C O’NEILL

*Troutman Sanders LLP*

William C O’Neill is a partner in Troutman Sanders’ insurance and reinsurance group. Bill is recognised as a top insurance and reinsurance attorney in *Chambers USA*, Euromoney’s *Guide to the World’s Leading Insurance and Reinsurance Attorneys* and *Who’s Who Legal: Insurance & Reinsurance*. He regularly handles arbitrations and litigations involving many lines of business, including property and casualty, life, trade credit and health insurance. In the past several years, he has successfully taken significant life, property and casualty, and health disputes through hearing and final award, while resolving numerous additional disputes on favourable terms short of hearing. Bill often counsels clients regarding business, strategy and regulatory matters. Bill received his JD from Cornell Law School in 1997.

ILGAZ ÖNDER

*Gün + Partners*

Ilgaz Önder has been a senior associate at Gün + Partners since 2013. His practice focuses on insurance and reinsurance, corporate and M&A, and dispute management.

He mainly concentrates on commercial litigation in various fields, including insurance and reinsurance, where civil law and criminal law often overlap. Within the scope of his practice, Ilgaz not only assists clients in disputes subject to adjudication, but also oversees debt collection procedures following high-profile disputes. He provides the clients with legal advice on employment law and in-depth analysis of business immigration.

HARRY ORAD

*Gross Orad Schlimoff & Co*

Harry Orad began his legal career as a commercial lawyer specialising in corporate and property law. He also served as a municipal court justice. In 1983 he joined the highly acclaimed National Fraud Unit of the Israeli Police, rising to the rank of chief superintendent, where he investigated complex financial institution fraud and white-collar crimes. Since 1986 Harry has specialised in insurance and reinsurance law. He drafted some of the first D&O policies in Israel and later redrafted these policies to comply with new legal provisions. He has lectured on corporate governance issues in Israel and abroad. Between 1988 and 1989, Harry worked in London as a consultant to one of the major insurance law firms. Harry’s expertise in insurance law includes D&O liability, banking insurance (bankers blanket bonds), financial institutions, crime insurance, credit insurance, product liability, and pollution and contamination.

Harry has acted for underwriters and insurers worldwide on complex financial insurance matters, and has been inducted into the Hall of Fame of *The Legal 500*. 
ROBERTO PANUCCI FILHO

Pinheirão Neto Advogados

Roberto Panucci Filho is an associate in the corporate practice of the Pinheiro Neto Advogados office in São Paulo. His fields of expertise are banking and insurance regulation, financing, M&A, corporate law, business law and foreign exchange controls. He also has a strong background in corporate and commercial litigation. Mr Panucci earned his bachelor’s degree (LLB equivalent) from the University of São Paulo (2008) and holds a master’s degree in contract law from the University of São Paulo (2014) and an LLM from Columbia University (2015). He was admitted to the Brazilian Bar Association in 2009. Mr Panucci was a foreign associate at Paul, Weiss, Rifkind, Wharton & Garrison LLP in New York for one year between 2015 and 2016. Mr Panucci has been recommended by Chambers Latin America, The Legal 500 and Advocacia 500.

S W PARK

Law Offices Choi & Kim

S W Park joined Choi & Kim in 2002. He mainly handles marine casualties, bill of lading and charter-party disputes and insurance matters. He has represented most of the major P&I clubs, foreign and domestic shipping companies and insurance companies, and the International Oil Pollution Compensation Fund.

He was admitted to the Korean Bar in 1999. He gained a BA from Seoul National University (1994) and an LLM from King’s College London (2009–2010), and attended the Judicial Research and Training Institute, Korean Supreme Court, from 1997 to 1999.

He is a member of the Korean and Seoul Bar Associations.

MONA PATEL

Ince Gordon Dadds LLP

Mona Patel is a partner within Ince & Co LLP’s corporate practice. She is a transactional corporate and commercial lawyer with over 14 years’ experience. Working for both UK and international clients, in the insurance sector she has acted for insurers, brokers and claims handlers. Over the years she has advised on a number of cross-border acquisitions, disposals, joint ventures, management buyouts and buy-ins, and restructurings including applicable regulatory issues (e.g., authorisation, Section 178 applications and approval/controlled functions). She also has a broad commercial practice assisting insurance as well as commercial clients with their commercial contracts and intellectual property.

Ms Patel also works for clients in a number of other business and industry sectors including energy, shipping, aviation, international trade, e-commerce and technology.

AMIR RAHMAT AKBAR PANE

AP Advocates

Amir Rahmat Akbar Pane is a managing partner at AP Advocates. He specialises in litigation. His experience in litigation spans a wide range of criminal and civil law. Amir also participates in developing legal education by holding law seminars in cooperation with relevant parties. He is a member of the Indonesian Bar Association.
RICO RICARDO  
*AP Advocates*  
Rico Ricardo joined AP Advocates as an associate, and is actively involved in various legal cases in the areas of litigation (civil and crime) and non-litigation.

PETER ROGAN  
*Ince Gordon Dadds LLP*  
With over 35 years of experience, Peter Rogan has advised on all areas of insurance with a focus on reinsurance, marine, professional indemnity and political risks. He has been involved in many of the major market issues over the years and developed a strong reputation for sensible strategic advice in relation to large disputes.

Peter has been distinguished as a leading insurance and reinsurance lawyer by *Chambers and Partners*, *The Legal 500 UK* and *Who's Who Legal*, and he has been named Global Insurance & Reinsurance Lawyer of the Year in the 2012 *Who's Who Legal* Awards.

Over the years, Peter has handled countless arbitrations and mediations and uses the experience gained from these and from his role as senior partner to develop his arbitration and mediation practice, in respect of which he has already taken a number of appointments.

Peter is a founder member of ARIAS UK and an ex-chairman of the Insurance Committee of the International Bar Association. Peter regularly chairs and speaks at conferences both in London and abroad.

RICARDO ROZAS  
*Jorquiera & Rozas Abogados*  
Ricardo Rozas is a partner at Jorquiera & Rozas Abogados. He is very experienced in marine and non-marine insurance and reinsurance topics, including assisting the global reinsurance market on a regular basis and in some of the biggest cases in Chile’s insurance history. Among other things, he advises in all the related areas, including but not limited to policy coverage advice, liability defence and assessment, wordings and policy structures, and dealing with the Chilean compulsory adjustment procedure and the Chilean regulator. He also focuses on the industrial sector in respect of property or business interruption and liability covers, and has broad experience in a variety of complex disputes and litigation with both local and international dimensions.

Mr Rozas has been awarded with the ILO Client Choice Awards 2011, selected for inclusion in *Who's Who Legal: Insurance & Reinsurance* (2011–2016 and 2019), and recommended among ‘Leaders in their Field’ for *Chambers Latin America* 2014. He is a past chair of the maritime and land transport committee of the International Bar Association (IBA). In addition, he is member of the insurance committee of the IBA; of the maritime committee of the International Bar Association; of the Latin American Maritime Law Institute; of the International Association of Insurance Law; and of the Chilean Maritime Law and Bar Associations.

He graduated from the School of Law of the Catholic University of Chile (LLB) and holds an LLM from Southampton University, United Kingdom. He is a regular speaker at different insurance and transport conferences around the world, and is author of several publications.
RAQUEL RUBIO  
*Clyde & Co LLP*

Raquel Rubio has worked on high-value Colombian litigation for the past 12 years. She has extremely close ties with the Colombian insurance and reinsurance market, and experience of almost every jurisdiction in Colombia, from the civil courts to the Constitutional Court, the Prosecutor’s Office, the Superintendence of Industry and Commerce, and the Controller’s Office.

Raquel advises global corporations doing business in and out of Colombia. She is currently advising a Colombian energy company on issues arising from a wind farm development in Central America. Last year, she advised a Colombian insurer on its Hurricane Harvey exposures.

Raquel has particular experience before the Controller’s Office. She is involved in almost 20 active cases, including a US$6 billion corruption investigation which is the largest case ever heard in Colombia.

Raquel is actively involved in the development of Colombian insurance and reinsurance law and was a speaker at the 2018 Fasecolda conference in Cali.

TADASHI SAKEMI  
*Nishimura & Asahi*

Tadashi Sakemi is an associate at Nishimura & Asahi and was admitted to practise in 2016. Tadashi’s areas of practice include insurance, structured finance and real estate transactions.

KAYLEIGH STOUT  
*DAC Beachcroft LLP*

Kayleigh Stout is a coverage and defence lawyer, who advises the insurance and reinsurance markets on losses and disputes worldwide. Working in Portuguese and Spanish, she advises primarily on Latin American and European losses involving traditional and renewable energy, construction, aviation, infrastructure and environmental sectors.

DUNCAN STRACHAN  
*DAC Beachcroft LLP*

Duncan Strachan advises on litigation defence and coverage issues across Latin America, including in the key jurisdictions of Brazil, Colombia, Chile, Mexico, Ecuador, Argentina and Venezuela. He is fluent in Spanish and also works in written Portuguese. Regularly dealing with large and complex cases across Latin America, the Caribbean and the United States, Mr Strachan manages exposures on behalf of the London and Miami reinsurance markets.

His Latin American expertise covers the energy industry, the utilities sector, financial services and aviation losses. Commentators mention that ‘The way he deconstructs an argument is very analytical’. They continue: ‘He is fully aware of commercial realities and is someone I would describe as a safe pair of hands.’

As well as his broad international experience, Mr Strachan advises clients on commercial disputes in the United Kingdom and Europe. He advises on general liability, construction disputes, product liability claims, and D&O and cyber wordings.
SHINICHI TAKAHASHI

Shinichi Takahashi is a partner at Nishimura & Asahi and is qualified to practise in Japan and New York. Shinichi’s areas of practice include insurance, banking, capital markets, and structured finance and securitisation.

His transactions include advising insurers regarding the revisions of policy wording following the introduction of the new Insurance Act; acquisition by a US life insurer of another US life insurer with a substantial Japanese business; conversion of a Japanese branch of a foreign insurer to a Japanese corporation; advising insurers in Japan on various coverage issues, including those related to the Great East Japan Earthquake in 2011 and the flood in Thailand in 2012; advising a Japanese subsidiary of a Chinese company on its insurance business licence application; and advising Japanese and non-Japanese insurers and reinsurers on reinsurance trading, including drafting reinsurance contracts and resolving reinsurance disputes.

ROGER THALMANN

Roger Thalmann practises in particular in the fields of insurance and reinsurance law, and transportation and corporate law, with a special interest in liability matters. His work includes both consulting and litigation.

He received his law degree from the University of Zurich. Before joining gbf Attorneys-at-law Ltd, he worked at a district court in the canton of Zurich. He speaks German, English, Italian and French.

HENRIK NEDERGAARD THOMSEN

Henrik Nedergaard Thomsen is a partner and heads the insurance team at Kammeradvokaten / Poul Schmith. Henrik has 30 years’ experience working nationally and internationally with the insurance sector and the public sector focusing on the defence of liability and coverage issues, including professional liability, product liability, property, energy, offshore, administrative liability, public liability and national indemnity.

Henrik’s dispute resolution practice encompassed both litigation and national and international arbitration including more than 150 cases before the Danish Supreme Court, and he is a certified arbitrator. Henrik is author and co-author of several articles regarding litigation, insurance and reinsurance, and product liability. He is recognised as a leading individual by The Legal 500.

ABRAHAM THOPPIL

Abraham Thoppil is a partner in the Cayman Islands office of the Maples Group. He has been involved with Cayman Islands reinsurance, insurance and alternative risk transfer products, and insurance M&A transactions. His experience includes working with insurance managers,
brokers, hedge fund sponsored reinsurers and domestic insurers. He also has assisted with the legislative drafting process relating to a number of Cayman Islands laws. Abraham has been recommended for insurance and reinsurance by *The Legal 500*.

**NEERAJ TULI**

*Tuli & Co*

Mr Neeraj Tuli is the firm’s senior partner. Before setting up Tuli & Co in 2000, Mr Tuli was a partner at Kennedys in London. Mr Tuli’s contentious work and coverage advice ranges across a wide variety of policies including trade and credit, MD, BI, CPM, E&O, D&O, CGL, Product Liability, Public Liability, DSU, ALOP, EAR and CAR. He has handled litigation and arbitration in India, London, Paris, New York, San Francisco, Hong Kong, Singapore and Papua New Guinea, and is currently managing claims on behalf of insurers and reinsurers in India, the United States, Chile, the United Kingdom, Germany, Ireland, Finland, Italy, Japan, Kuwait, Dubai, Australia and New Zealand.

Mr Tuli also acts as an arbitrator and was appointed on behalf of one of India’s largest public sector manufacturing and engineering companies in relation to two energy disputes with a Russian enterprise, where his co-arbitrators are both English QCs.

Mr Tuli is recognised as a leading lawyer for product liability, and a leading lawyer for insurance and reinsurance in India. He has been invited to be the first president of the Insurance Law Association of India being formed in association with the British Insurance Law Association, and he is a member of the Confederation of Indian Industry’s National Committee on Dispute Resolution.

**ALEXIS VALENÇON**

*Kennedys*

Alexis Valençon is a partner at Kennedys and co-founder of its Paris office. He is an insurance and reinsurance specialist with extensive expertise in complex litigation and arbitration. He advises leading French and foreign insurance and reinsurance companies, brokers, major policyholders, manufacturers, and industrial companies on a broad range of issues, ranging from insurance and reinsurance disputes (litigation and arbitration) to product liability, financial lines, construction and professional liability. He also assists his clients in complex court-appointed investigations relating to industrial risks, drafting insurance contracts that comply with French law and setting up activities in France.

He teaches judicial procedure and insurance litigation at the Paris Insurance Institute and at the Law Faculty of Le Mans University. He is also regularly invited to speak at conferences and colloquiums on matters of (re)insurance law and litigation. He is one of the co-authors of the *Lamy Assurances* (France’s leading textbook on (re)insurance law) and regularly contributes to various international reference books on (re)insurance law and product liability.

Alexis is a member of the International Insurance Law Association (AIDA), Association for the Management of Risk and Assurance of Enterprise (AMRAE), the International Bar Association (IBA), the French Arbitration Committee (CFA) and the Professional Association of Reinsurers operating in France (APREF).

Alexis has a postgraduate degree in industrial property (Paris Panthéon-Assas University); a postgraduate degree in criminal law (Bordeaux University); a master’s degree in
political science (McGill University, Canada and Melbourne University, Australia); a master’s degree in private law (Bordeaux University); and a bachelor’s degree in private law (Alcalà de Henares University, Spain). He speaks French, English and Spanish.

ANNA WAHLBOM
Hamilton Advokatbyrå KB

Anna Wahlbom is a senior associate in Hamilton’s banking and finance practice, and assists Swedish and foreign financial companies, banks, insurance companies (both direct insurance and reinsurance), insurance intermediaries, funds and payment service providers. Anna’s experience as a former in-house legal counsel at one of Sweden’s life insurance companies qualifies her to assist clients in an in-depth manner regarding legal matters and especially in matters of regulatory implementation.

SAM WAKERLEY
HFW

Sam Wakerley is head of insurance for HFW in the Middle East. He has been based in the Dubai office since 2005 and handles a wide range of disputes work with a particular specialisation in insurance and reinsurance claims. He has advised on some of the region’s largest energy, marine, property, liability, construction and PI insurance/reinsurance claims. Sam also advises on shareholder, JV and other commercial disputes. His work involves general advisory work, supervising local court litigation, DIFC court work, English High Court work, arbitration and mediation.

Sam is consistently recommended in both The Legal 500, Chambers and Partners, and in the International Who’s Who of Insurance and Reinsurance Lawyers. In Chambers Global (2017) Sam Wakerley is described by clients as ‘clear, concise and very tactical; he can see the bigger picture without omitting the details’. He is well recognised as a leading insurance practitioner in the jurisdiction, and he has gained prominence advising insurers and reinsurers regarding high-profile building fires. One client said: ‘If I have a big thing he’ll always be very responsive. It’s great to have someone like him who can get the job done very quickly’ (Chambers Global (2019)).

WAN JIA
AnJie Law Firm

Wan Jia is a senior lawyer at AnJie Law Firm. Wan Jia has extensive experience in the field of insurance and reinsurance law services. She has represented parties in a great number of insurance disputes before Shanghai High People’s Court, Jiangsu High People’s Court and other high-level people’s courts. She has also rendered legal services to insurance issues valued at over 1 billion yuan.

Wan Jia practises in insurance and reinsurance, and litigation and arbitration. Her educational background includes the College of William & Mary (LLM), Zhongnan University of Economics and Law (LLB), and Huazhong University of Science and Technology (bachelor of engineering).
WANG XUELEI  
*AnJie Law Firm*

Wang Xuelei is a partner at AnJie Law Firm. He has great experience in litigation and arbitration. He represents different insurance companies in insurance subrogation dispute cases, property all risks insurance dispute cases, personal life insurance dispute cases, liability insurance dispute cases and some other non-insurance contentious cases.

Wang Xuelei practices in insurance and reinsurance, and litigation and arbitration. His educational background includes Shijiazhuang University of Economics, School of Law (LLB).

KEITA YAMAMOTO  
*Nishimura & Asahi*

Keita Yamamoto is a counsel at Nishimura & Asahi and was admitted to practise in 2001. Keita’s practice areas include insurance, banking and financial regulation.

His recent experience includes cross-border acquisition by a Japanese life insurer and regulatory defence work for a Japanese bank against overseas regulators.

YU DAN  
*AnJie Law Firm*

Yu Dan is a partner at AnJie Law Firm. She has great experience in insurance compliance. She serves as legal counsel to many insurance institutions such as the People’s Insurance Company (Group) of China Limited, Taikang Life Insurance Co, Ltd, PICC Property and Casualty Company Limited, PICC Life Insurance Company Limited, China Life Property & Casualty Insurance Co, Ltd, and China United Property Insurance Company Limited. She also specialises in the utilisation of insurance funds.

Yu Dan practises in insurance and reinsurance, and corporate compliance. Her educational background includes Wuhan University, School of Law (LLB).

EDMOND ZAMMIT LAFERLA  
*Mamo TCV Advocates*

Edmond Zammit Laferla is a partner with Mamo TCV Advocates and is part of the corporate and insurance law practice group. His areas of specialisation include all aspects of corporate, civil and commercial litigation, and he regularly assists clients in a variety of related matters. Edmond provides advice to local and foreign clients on various corporate matters, including corporate governance. He has also been involved in privatisation procedures, and in the negotiation and drafting of major contracts. He assists clients with respect to validity and enforceability of agreements and arrangements related to commercial and corporate issues. Edmond is also regarded as one of the leading lawyers in the insurance practice area and provides legal support to a number of local and foreign insurance players by providing advice on insurance-related matters, including litigation, and regulatory and compliance issues.

ZHAN HAO  
*AnJie Law Firm*

Zhan Hao is the managing partner of AnJie Law Firm. He specialises in litigation and arbitration of insurance and reinsurance cases, M&A relating to insurance companies,
establishment of domestic and foreign-funded insurance organisations in China, utilisation of insurance funds and insurance compliance, etc. He also has great experience in antitrust filings with MOFCOM, defence of investigation on monopoly agreements (cartels) and abuse of dominance, antitrust private litigation, antitrust compliance, antitrust analysis from an economic perspective and anti-unfair competition. As an arbitrator of CIETAC and an experienced litigator, Zhan Hao has handled many complicated cases, some of which were heard by the Supreme People's Court.

Zhan Hao practises in the following areas: insurance and reinsurance, antitrust and dispute resolution. His educational background includes Tehua Research Centre (post-doctoral researcher, economics); Peking University, School of Law (PhD, economic law); China-EU Jurisdiction and Law Cooperation Programme (officially selected and supported by the government to study in the United Kingdom, France, Belgium, Germany, Denmark and Spain); and Wuhan University, School of Law (LLM and LLB).


ZHANG XIANZHONG
AnJie Law Firm

Zhang Xianzhong is a partner at AnJie Law Firm. He has great experience in the utilisation of insurance funds. He also represents some private equity funds to invest in car parking projects, wholesale market products, outdoor media advertising projects and others. He also represents a security company in its investment in a company in Tianjin for first-class development of land, an asset company in its investment of insurance funds in public housing project supported by Jiangsu Nanjing government, an insurance company in its purchase of office buildings, obtaining land-use rights, relevant construction work and other projects.

Zhang Xianzhong practises in utilisation of insurance funds, corporate M&A and PE investment, real estate, and telecommunications and the internet. His educational background includes Temple University, USA (LLM) and China University of Political Science and Law (LLB).
CONTRIBUTORS’ CONTACT DETAILS

ANJIE LAW FIRM
19F, Tower D1, Liangmaqiao Diplomatic Office Building
No. 19 Dongfangdonglu
Chaoyang District
Beijing 100600
China
Tel: +86 10 8567 5988
Fax: +86 10 8567 5999
zhanhao@anjielaw.com
zhangxianzhong@anjielaw.com
wangxuelei@anjielaw.com
yudan@anjielaw.com
junchen@anjielaw.com
wanjia@anjielaw.com
lidan@anjielaw.com
www.anjielaw.com

BUN & ASSOCIATES
29 Street 294
PO Box 2326
Phnom Penh
Cambodia
Tel: +855 23 999 567
Fax: +855 23 999 566
fontaine@bun-associates.com
www.bun-associates.com

AP ADVOCATES
Jakcentral Gondangdia Lama Building
No. 25
Jl. RP Soeroso No. 25 Menteng
Jakarta Pusat
Indonesia
Tel: +62 21 392 2232
aldijusuf@apadvocates.com
amirpane@apadvocates.com
ricoricardo@apadvocates.com
www.apadvocates.com

CLAYTON UTZ
Level 15
1 Bligh Street
Sydney
New South Wales 2000
Australia
Tel: +61 2 9353 4000
Fax: +61 2 8220 6700
derber@claytonutz.com
chine@claytonutz.com
www.claytonutz.com

CLYDE & CO LLP
The St Botolph Building
138 Houndsditch
London EC3A 7AR
United Kingdom
Tel: +44 20 7876 5000
Fax: +44 20 7876 5111
neil.beresford@clydeco.com
raquel.rubio@clydeco.com
andres.garcia-arias@clydeco.com
www.clydeco.com
Contributors’ Contact Details

DAC BEACHCROFT LLP
The Walbrook Building
25 Walbrook
London EC4N 8AF
United Kingdom
Tel: +44 20 7894 6876
dstrachan@dacbeachcroft.com
kstout@dacbeachcroft.com
www.dacbeachcroft.com

GBF ATTORNEYS-AT-LAW LTD
Hegibachstrasse 47
8032 Zurich
Switzerland
Tel: +41 43 500 48 50
Fax: +41 43 500 48 60
gerspacher@gbf-legal.ch
thalmann@gbf-legal.ch
www.gbf-legal.ch

GOUVEIA PEREIRA, COSTA FREITAS & ASSOCIADOS,
SOCIEDADE DE ADVOGADOS,
SP, RL
Palácio Sotto Mayor
Rua Sousa Martins, 1, 6º Andar
1050-217 Lisbon
Portugal
Tel: +351 213 121 550
Fax: +351 213 121 551
miguel.santos@gpasa.pt
www.gpasa.pt

GROSS ORAD SCHLIMOFF & CO
Gibor Sport Building
7 Menachem Begin Road
Ramat Gan 5268102
Israel
Tel: +972 3 6122 233
Fax: +972 3 6123 322
harry@goslaw.co.il
www.goslaw.co.il

GÜN + PARTNERS
Kore Şehitleri Cad 17
Zincirlikuyu 34394
Istanbul
Turkey
Tel: +90 212 354 00 00
Fax: +90 212 274 20 95
pelin.baysal@gun.av.tr
ilgaz.onder@gun.av.tr
https://gun.av.tr

HAMILTON ADVOKATBYRÅ KB
Hamngatan 27
101 33 Stockholm
Sweden
Tel: +46 70 868 48 31 / +46 76 883 09 31
/ +46 701 82 51 08
peter.kullgren@hamilton.se
anna.wahlbom@hamilton.se
jakob.andersson@hamilton.se
www.hamilton.se

HFW
Level 8, Building 6
Emaar Square, Sheikh Zayed Road
PO Box 53934
Dubai
United Arab Emirates
Tel: +971 4 423 0555
Fax: +971 4 425 7941
sam.wakerley@hfw.com
john.barlow@hfw.com
www.hfw.com
INCE GORDON DADDS
Ince Gordon Dadds LLP
Aldgate Tower
2 Leman Street
London E1 8QN
United Kingdom
Tel: +44 20 7481 0010
Fax: +44 20 7481 4968
peterrogan@incegdlaw.com
simoncooper@incegdlaw.com
monapatel@incegdlaw.com

Ince & Co Germany LLP
Grosse Elbstrasse 47
22767 Hamburg
Germany
Tel: +49 40 38 086 0
Fax: +49 40 38 086 100
markus.eichhorst@incelaw.com

Herring Parry Khan Law Office, trading as
Ince & Co
Livanos Building
47–49 Akti Miaouli
Piraeus 185 36
Greece
Tel: +30 210 455 1000
Fax: +30 210 429 3318
dimitris.giomelakis@incelaw.com
dimitris.kapsis@incelaw.com
nikolaos.mathiopoulos@incelaw.com

www.incegdlaw.com

KAMMERADVOKATEN / POUL SCHMITH
Vester Farimagsgade 23
1606 Copenhagen V
Denmark
Tel: +45 20 45 10 65 / +45 50 77 84 14
hnt@kammeradvokaten.dk
smk@kammeradvokaten.dk
www.kammeradvokaten.com

KENNEDYS
31 rue de Lisbonne
Paris 75008
France
Tel: +33 1 84 79 37 80
alexis.valencon@kennedyslaw.com
nicolas.bouckaert@kennedyslaw.com
www.kennedyslaw.com

LAW OFFICES CHOI & KIM
10th Floor Gwanghwamun Building
92 Saemunan-ro
Jongno-gu
Seoul 03186
Korea
Tel: +82 2 732 5577
Fax: +82 2 735 6866
swpark@choikim.com
www.choikim.com

LC RODRIGO ABOGADOS
Calle de Lagasca, 88 – 4th floor
28001 Madrid
Spain
Tel: +34 91 435 54 12
Fax: +34 91 576 67 16
jangell@rodrigoabogados.com
www.rodrigoabogados.com

JORQUIERA & ROZAS ABOGADOS
Av Isidora Goyenechea 3250, 4th floor
Las Condes
Santiago 7550083
Chile
Tel: +56 2 580 9300
Fax: +56 2 580 9311
rrozas@jjr.cl
www.jjr.cl

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MAMO TCV ADVOCATES
Palazzo Pietro Stiges
103 Strait Street
Valletta VLT 1436
Malta
Tel: +356 2540 3000
Fax: +356 2124 4291
edmond.zammitlaferla@mamotcv.com
petra.attard@mamotcv.com
www.mamotcv.com

MAPLES GROUP
PO Box 309, Ugland House
South Church Street
Grand Cayman KY1-1104
Cayman Islands
Tel: +1 345 949 8066
Fax: +1 345 949 8080
john.dykstra@maples.com
abraham.thoppil@maples.com
www.maples.com

MATHESON
70 Sir John Rogerson’s Quay
Dublin 2
Ireland
Tel: +353 1 232 2119 / 2398 / 2638 / 2050
Fax: +353 1 232 3333
sharon.daly@matheson.com
darren.maher@matheson.com
april.mclements@matheson.com
grainne.callanan@matheson.com
www.matheson.com

NADER, HAYAUX & GOEBEL
Paseo de los Tamarindos 400-B, 7th floor
Bosques de las Lomas
05120 Mexico City
Mexico
Tel: +52 55 4170 3000
Fax: +52 55 2167 3099
Salisbury House
29 Finsbury Circus
London EC2M 5QQ
United Kingdom
Tel: +44 2037 40 1681

NISHIMURA & ASAHI
Otemon Tower
1-1-2 Otemachi
Chiyoda-ku
Tokyo 100-8124
Japan
Tel: +81 3 6250 6200
Fax: +81 3 6250 7200
s_takahashi@jurists.co.jp
ke_yamamoto@jurists.co.jp
t_sakemi@jurists.co.jp
www.jurists.co.jp

PINHEIRO NETO ADVOGADOS
Rua Hungria, 1100
São Paulo 01455-906
Brazil
Tel: +55 11 3247 8681 / 8967 / 6362
Fax: +55 11 3247 8600
bbalduccini@pn.com.br
dgoncalves@pn.com.br
rpanucci@pn.com.br
www.pinheironeto.com.br
RUSSELL McVEAGH
Level 30, Vero Centre
48 Shortland Street
PO Box 8
Auckland 1140
New Zealand
Tel: +64 9 367 8000
Fax: +64 9 367 8163
marika.eastwick-field@russellmcveagh.com

Level 24, Dimension Data House
157 Lambton Quay
PO Box 10–214
Wellington 6143
New Zealand
Tel: +64 4 499 9555
Fax: +64 4 499 9556
tom.hunt@russellmcveagh.com

www.russellmcveagh.com

STUDIO LEGALE GIORGETTI
Via Fontana 28
20122 Milan
Italy
Tel: +39 2 54 57 734 / 923
Fax: +39 2 55 18 02 82
giorgetti@giorgettilex.com
www.giorgettilex.com

TULLI & CO
7A Lotus Towers
Community Centre
New Friends Colony
New Delhi 110 025
India
Tel: +91 11 4593 4000
Fax: +91 11 4593 4001
neeraj.tuli@tuli.co.in
celia.jenkins@tuli.co.in
www.tuli.co.in

WOLF THEISS RECHTSANWÄLTE GMBH & CO KG
Schubertring 6
1010 Vienna
Austria
Tel: +43 1 51510 5630
Fax: +43 1 51510 665630
ralph.hofmann-credner@wolftheiss.com
www.wolftheiss.com

TROUTMAN SANDERS LLP
401 9th Street NW, Suite 1000
Washington, DC 20004
United States
Tel: +1 202 274 2863
Fax: +1 202 274 2994
michael.carolan@troutman.com
william.oneill@troutman.com
thomas.kinney@troutman.com
www.troutman.com