ACKNOWLEDGEMENTS

The publisher acknowledges and thanks the following law firms for their learned assistance throughout the preparation of this book:

ANJIE LAW FIRM
BIRD & BIRD ADVOKATPARTNERSELSKAB
BUN & ASSOCIATES
CLAYTON UTZ
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NISHIMURA & ASAHI
PINHEIRO NETO ADVOGADOS
RUSSELL McVEAGH
SEDGWICK, DETERT, MORAN & ARNOLD LLP
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PREFACE

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 the emerging markets of Brazil, Russia, India and China 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.

Looking back on the past year, market estimates suggest that total economic losses from natural and man-made disasters will be at least US$158 billion, significantly higher than the US$94 billion losses in 2015. Insured losses from 2016 will also be higher, at around US$49 billion compared with US$37 billion in the previous year. Earthquakes (in Taiwan, Japan, Ecuador, Italy and New Zealand), hail and thunderstorms and Hurricane Matthew were responsible for the largest insurance losses, with the latter causing devastation across the east Caribbean and south-eastern US. The US, Europe and Asia all experienced heavy flooding, while wildfires sparked the biggest ever loss for Canada’s insurance industry. Tragically, approximately 10,000 people lost their lives in disaster events in 2016.

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. I hope that you find this fifth edition of The Insurance and Reinsurance Law Review of use in seeking to understand them and I would like once again to thank all the contributors.

Peter Rogan
Ince & Co
London
April 2017
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.

During 2016, both the definition of a ‘fraudulent claim’ and the remedies available to insurers battling against such claims, were radically reformed through a combination of new legislation and new guidance from the highest court in the land.

### 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 very recently, the insurer’s remedy in respect of each of these categories was ‘forfeiture’ of the entire claim – the ‘fraudulent claims rule’. The essence of the rule is that, if an assured presents a claim that is in whole, or in part, fraudulent, the assured will forfeit the entirety of the claim. Since the Supreme Court’s 2016 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 assured 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 remedies do not apply to a fraudulent claim by a dishonest third party against an innocent assured 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.

These different types of fraud and the remedies available are discussed further below.
Wholly invented claims

These are claims in respect of which the loss has either been deliberately brought about by the assured’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.

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 assured 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*, 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*, an assured claimed for loss of rent in relation to a property divided up into 13 flats, each of which had been sublet. The assured 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:

- the exaggeration was more than trivial;
- the assured was dishonest – exaggeration of itself did not establish dishonesty; there had to be an intention to deceive the insurer, or recklessness; and
- 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*, 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.

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4 *Danepoint Ltd v. Underwriting Insurance Ltd* [2006] Lloyd’s Rep IR 429.
**Fraudulent devices**

In *Agapitos v. Agnew; The Aegeon*, the Court of Appeal held that if an assured 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. In its landmark 2016 decision in *Versloot Dredging v. HDI-Gerling; 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 assured’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.

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 assured 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 assured’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.’

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7 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.
8 *Versloot Dredging v. HDI-Gerling; The DC Merwestone [2016] Lloyd’s Rep IR 468.*
ii 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 assured will receive no sanction for dishonesty during the legal process; simply that the court rules of procedure now 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.

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.’

In the 2004 case of *Sony Computer Entertainment v. Ball*,10 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*,11 for example, following a 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.

Striking out

The question for the *Supreme Court in Fairclough Homes Ltd v. Summers*12 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’.

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9 Manifest Shipping Co Ltd v. Uni-Polaris Shipping Co Ltd; The Star Sea [2001] 2 WLR 170.
Adverse costs consequences

It is a long-established principle in England that a losing party usually 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 over recent years that they will express their disapproval of dishonest claims in adverse costs orders. For example, in *Sulaman v. Axa Insurance Plc*, 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.

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.

Conclusion

There were two landmark Supreme Court decisions in 2016 in relation to fraudulent insurance claims. Following those decisions, the common law remedy of forfeiture is still available to insurers where the assured 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 assured has presented a genuine claim but used a fraudulent device – what was

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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 assureds but also to dishonest third parties bringing claims against innocent assureds. A range of penalties are available and the courts are increasingly willing to use them. Finally, in what has been a dramatic year in the development of English law on fraud, 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.
Chapter 2

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 2016, there were 29 registered life companies (including both direct insurers and reinsurers) in Australia with combined assets of A$225.5 billion \(^2\) and 109 authorised general insurers (including both direct insurers and reinsurers, but not including Lloyd’s Australian operations) with combined assets of A$120.5 billion. \(^3\) There are currently 38 registered health insurers in Australia. \(^4\)

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 Australian financial services industry. It is also responsible for administering the Financial Claims Scheme in the Insurance Act 1973 (the Insurance Act). \(^5\)

The Australian Securities and Investments Commission (ASIC) is the corporate regulator in Australia. It monitors and promotes market integrity in the Australian financial system. ASIC also has functions and powers related to consumer protection that are conferred on it by or under the Corporations Act 2001 (Corporations Act), the Australian Securities and Investments Commission Act 2001, the Insurance Contracts Act 1984 (Insurance Contracts Act) and the Life Insurance Act 1995 (Life Insurance Act). \(^6\)

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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’ in Australia if the person or body corporate is not an authorised general insurer.  

A body corporate may apply in writing to the APRA for authorisation to carry on insurance business in Australia. 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 in Australia 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) or undertake liability under such a policy.  

A body corporate may apply in writing to the APRA for registration to carry on life insurance business in Australia. 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.  

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.  

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 in Australia, 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 in Australia 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 in Australia. A body corporate may apply to the APRA for registration as a private health insurer.  

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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.
health insurance regime 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 of Australia through an agent or broker in Australia, except where the insurance business of the insurer is solely a business of reinsurance.  

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:

- **a** contracts for which the policyholder is a ‘high-value insured’ (as defined by the regulations);
- **b** contracts for specified atypical risks;
- **c** contracts for other risks that cannot reasonably be placed in Australia; and
- **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.

**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 Financial Ombudsman Service (FOS) is an independent body that resolves disputes between its members, who 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 to the FOS. The FOS 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 FOS administers and monitors compliance with the General Insurance Code of Practice 2014 (the Code), which is applicable to general insurers writing certain domestic and personal classes of insurance who are signatories to the Code.

The Superannuation Complaints Tribunal (SCT) is an independent tribunal established to deal with complaints related to superannuation. Such complaints may relate to life insurance acquired through superannuation. The SCT is required to act in accordance with the Superannuation (Resolution of Complaints) Act 1993.

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. 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.

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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 UK. 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 that:

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

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.\(^\text{20}\)

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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\(^{17}\) *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 in Australia. 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. 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.

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.

The Insurance Contracts Act also modifies the common law rights of life insurers in relation to misrepresentations, non-disclosures and misstatements of age. A court may disregard avoidance in certain circumstances.

**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. 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.
iii Interpreting the contract

General rules of interpretation

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

a. words and phrases are to be given their ordinary and natural meaning unless they have a technical meaning or the sense in which they are used suggests that such a meaning is inappropriate;

b. the context in which words appear is to be taken into account;

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 received 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 Australian 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.

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. 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.

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.

29 L & M Electrics Pty Ltd v. SGIC (Qld) (1985) 3 ANZ Ins Cas 60-641, 78, 946.
33 Insurance Contracts Act, Section 54(2).
34 Insurance Contracts Act, Section 54(1).
Insurance brokers who are members of the National Insurance Brokers Association (NIBA) are also bound to comply with the Insurance Brokers Code of Practice. 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’s code of practice. The NIBA’s 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.

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), 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), such failure may be remedied by Section 54 of the Insurance Contracts Act.

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.

35 Insurance Contracts Act, Section 40(1).
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.36 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.37

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 in Australia.

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.

ii Litigation

Litigation stages, including appeals

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.

36 See, for example, ACE Insurance Ltd v. Moose Enterprise Pty Ltd [2009] NSWSC 724 (Justice Brereton, 31 July 2009).
37 See, for example, Akai Pty Ltd v. The People’s Insurance Co Ltd (1996) 188 CLR 418.
**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 such manner as 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
Mediations are 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 FOS or the SCT.

V YEAR IN REVIEW
i Regulatory changes
Most of the recent regulatory changes have been in relation to life insurance as part of the industry-wide reforms announced at the end of 2015. Those reforms were announced in response to a report released in response to the Financial System Inquiry established by the Commonwealth government.

Regulatory changes for the life insurance industry have most recently targeted:

a remuneration practices that may lead to poor consumer outcomes, in particular the payment of upfront commissions and conflicted remuneration in connection with the sale of life insurance – these remuneration practices are banned under the Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016, which passed the Senate on 9 February 2017; and

b best practice standards, including in relation to the handling of claims, for life insurers and others involved in the delivery of retail life insurance through the introduction of a Life Insurance Code of Practice.

ii Key case
In *CGU Insurance Ltd v. Blakeley & Ors*38 the High Court of Australia cleared the way for third-party claimants to directly pursue the insurer of insolvent or bankrupt defendants, including by joining the insurer to a proceeding in the formative stages.

The appointed liquidators in the winding up of Akron Roads Pty Limited (Akron) commenced proceedings against various directors of Akron for breaches of insolvent trading provisions, including a company, Crewe Sharp Pty Limited (Crewe), which was alleged to be a shadow director of Akron. One of the directors and Crewe sought, but were denied, indemnity under a professional indemnity insurance policy Crewe held with CGU. The liquidators sought to join CGU to the proceedings, notwithstanding that the liquidators and Akron had no direct rights against CGU pursuant to the insurance policy. Ultimately, the High Court was required to determine whether the first instance court had jurisdiction to hear the claim and grant the relief sought by the liquidators against CGU.

As to whether the first instance court relevantly had jurisdiction, it was necessary for the High Court to decide whether there was a ‘justiciable controversy’ between the liquidators and CGU. The High Court decided that there was, on the basis that the proceeds of the insurance policy would have ultimately become payable to them by operation of Section 562 of the Corporations Act and Section 117 of the Bankruptcy Act (which, in effect, requires that insurance proceeds paid to an insolvent or bankrupt insured be paid to any

38 *CGU Insurance Ltd v. Blakeley & Ors* [2016] HCA 2.
third-party claimant in respect of whom the proceeds have been received, in priority to other creditors). The effect of these statutory provisions and CGU’s denial of indemnity was to create a relevant ‘justiciable controversy’.

In light of this judgment, a party who has a claim against an insolvent or bankrupt defendant where the defendant may be covered by insurance may pursue the claim against the insurer directly, if the practical outcome is going to be that the party would ultimately become the beneficiary of any insurance proceeds.

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 is likely to remain the focus of regulators in the near future.
Chapter 3

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. In a few cases, insurers cover both North Africa and the Middle East from an Austrian office. The perception and reality may indeed be that Austria serves not only as a local market, but also as a gateway into larger insurance markets than itself.

On 11 March 2016, the Austrian Insurance Association (VVO) published its annual report for 2015, which reflects a premium volume of €17.445 billion generated by Austrian licensed insurers of local direct contractual insurance businesses, whereas insurance payments for the same period amounted to €15.379 billion.2

The Austrian insurance industry employs 26,750 people, whereby the VVO3 represents the interests of all private insurance companies active in Austria. The VVO is also registered in the Austrian lobbying register.4 Membership in the VVO is voluntary and, according to the homepage of the VVO, currently consists of 125 members.

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. It is a mixed coinsurance and reinsurance pool, with no government participation. The primary objective is to offer affordable property cover against risks arising from an insured event triggered by terrorism. The Terrorpool acts as reinsurance, with the direct writing insurer issuing a separate terrorism policy and then ceding the business to the Terrorpool. The pool 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. However, the majority of the members of the VVO belong to the pool. A members’ share of the pool is calculated in proportion to their market share in property insurance, and all property lines (industrial, commercial and private) other than transport insurance are covered.

1 Ralph Hofmann-Credner is a counsel at Wolf Theiss Rechtsanwälte GmbH & Co KG.
2 The full annual report is available at the download area of the VVO: www.vvo.at/vvo/vvo.nsf/sysUNID/xB605261887C09BC0C1257FA200404CD7.
3 www.vvo.at.
4 www.lobbyreg.justiz.gv.at/edikte/it/iredi18.nsf/suche!OpenForm&subf=e.
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)\(^5\) grants a licence upon application and fulfilment of preconditions. A European Economic Area (EEA) insurance company holding a licence and situated outside Austria does not require a further or domestic insurance licence. Such 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.

After completion of the preparatory and implementation work for the transposition of the Solvency II Directive\(^6\) the revised Insurance Supervision Act 2016 came into force on 1 January 2016 (VAG 2016).\(^7\)

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 based on the German Insurance Contract Act from 1908, which was introduced in Austria in 1939 and reinstalled in 1958 as the VersVG 1958 with only minor changes. As a result, the provisions of Austrian and German insurance contract law remained almost identical for decades, and the Austrian courts and practitioners often resorted to German case law and doctrine for advice. However, since an in-depth reform of the German Insurance Contract Act in 2008, which introduced substantial changes that were not adopted in Austria, the two legal systems have started to drift apart. This has caused new developments in case law and doctrine in Austria. In future, these changes have to be borne in mind when comparing Austrian and German case law and literature.

The VersVG is, in general, applicable both in consumer and non-consumer contracts without distinction. It aims at protection of 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).

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5 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.
7 An English translation of the VAG 2016 is available online: www.fma.gv.at/download.php?d=825.
In addition, general insurance terms and conditions play a key role in Austrian insurance law. Model insurance terms are published by the VVO, and although these are not binding, they are usually adopted by insurers and incorporated into insurance contracts with no, or only minor, changes. Interestingly, and unlike in Germany where the German Insurance Federation has published model terms for directors and officers (D&O) liability insurance, such model terms have not been published by the VVO. Therefore, one may come across German D&O wordings that are simply adopted for Austrian law.

Although court judgments in Austria are, in general, only binding on the parties involved in a dispute, case law plays an important role, especially in the interpretation of provisions of the VersVG, and general terms and conditions. Furthermore, the courts of lower instance have to 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 (OGH), which is the highest instance in civil and criminal matters.

ii 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 such offer of the insured shall be binding for a maximum period of six weeks unless a longer period has been individually negotiated between the insurer and the insured.

In larger corporate insurance programmes, usually an intermediary or an in-house broker is involved in negotiating the wording with the insurer. The negotiations sometimes create a back-and-forth process between them.

The insurer is obliged to furnish the 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 after 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.

The VersVG (Sections 16 et seq. of the VersVG) stipulates 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, he or she is only obliged to reveal facts that he

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8 Model insurance terms and conditions in German can be found on the homepage of the VVO: www.vvo.at/vvo/vvo.nsf/sysPages/suche.html?OpenDocument&searchText=Musterbedingungen.
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 his or her information obligations, then the insurer is entitled to rescind the contract within one month after gaining knowledge of the violation of the information obligation. However, the right of recession depends on various factors, such as:

a. the degree of fault of the insured;

b. the relevance of the information;

c. to what extent the information has been specifically asked for by the insurer; and

d. whether the insurer was already familiar with or has waived his or her right to be informed about the relevant circumstances.

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:

a. the name, head office address and legal form of the insurance undertaking and, where appropriate, the branch by which the contract will be concluded;

b. the term of the insurance contract;

c. the method of paying the premium and the duration of premium payments;

d. the circumstances under which the insured is entitled to revoke or withdraw from the contract; and

e. if the prospective insured is a natural person:
   • the law applicable to the contract or, when the parties are free to choose, the law that the insurer proposes to use; and
   • the name and address of the supervisory authority of the insurance undertaking or of another body to which complaints about the insurance contract can be addressed.

A failure of the insurer to comply with the information requirements under the VAG 2016 entitles the insured to rescind the contract (in general within two weeks after receipt of the required information, the policy and a copy of the insurance conditions along with a notification about the right of rescission of the contract).

In addition, the new provision in Section 252(8) stipulates a general prohibition on misleading statements by an insurer. Under this provision, all information addressed to an insured, or distributed by an insurer in such a way that an insured will gain knowledge thereof, must be unambiguous, not misleading and provided *bona fide*. In addition, the name of the supervisory authority must not be named in a way that indicates that the offered insurance products or services have been authorised by that supervisory authority. This new provision shall hinder misleading commercial practices, including distribution of misleading
information in advertising. According to Section 252(9), the FMA is empowered to publish a regulation with a non-exhaustive list of practices that are in any event considered to be misleading.

### iii 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 OGH 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 OGH 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. The insured is simply granted the right to rescind from the insurance contract according to Section 5b of the VersVG. There is no differentiation between consumer and business contracts in this regard.

### iv Intermediaries and the role of the broker

In Austria, 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 Commercial Information System (GISA)) that replaced the former 14 local professional registers for insurance intermediaries. 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.

In Austria, brokers play a key role in generating business for insurers. 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 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. In practice, an insurer would investigate insurance fraud where indications for incorrect information arise and a reasonable amount of a loss is concerned.

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 after 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 after 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 a period of 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 insurer that a lawsuit must be filed within a period of one year and that otherwise the insured’s claim will be time-barred.
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 aircrafts). 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 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 would be 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, this is the case: according to the Statute on Private International Law (Article 35a), 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.

### Litigation

The state court system in civil proceedings consists of a maximum of three domestic stages (i.e., without preliminary ruling procedures). A lawsuit is filed with the court of first instance in which a case is heard in general by a single sitting judge. With the exception of minor cases, an appeal may be raised in every case to the court of higher instance sitting as a court of appeals with a bench of three professional judges (in some cases, such as employment law cases, lay judges may sit in first instance). A further appeal may be filed with the OGH 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 third-party expert and analysing any documents filed (in German language, or filed in another 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. Therefore, there is no need to prove one’s legal position in court, but parties will try to argue towards their legal position on a certain legal question that the courts shall ultimately decide.

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 the winning party and its attorney. Certain types of litigation funding by third parties exist, and taking out legal expense insurance is quite common for 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. One may differentiate between arbitration and an expert procedure, which may be viewed as a kind of arbitration, and which is rather common (see below).

If the parties do not stipulate a specific procedure (be it individually negotiated or by reference to the rules of an arbitral institution), Austrian law contains a number of default provisions regulating the most important procedural aspects. For example, Austrian 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 Austrian 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 the VVO publishes model conditions that are commonly used by insurers. 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 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 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. Thereby, 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.

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. Of course, the FMA could also handle such a complaint on a voluntary basis. An online complaint form is available on the FMA website.27

The VVO has established its own permanent point of contact for complaints or legal questions and concerns in relation to insurance contracts.28 If an email is sent describing the facts at hand, the VVO will contact the insurer to enquire about the status of a claim.

v Mediation

Austrian courts recognise mediation proceedings. However, in practice, mediation does not play a key role. As far as we are aware, mediation is commonly accepted by parties pursuing an insurance claim. So far, Austrian law does not stipulate that a party must go through mediation before filing a lawsuit in a contested insurance matter.

V YEAR IN REVIEW

Referring to a decision of the European Court of Justice,29 the OGH ruled in autumn 2015 that an insured may benefit from an unlimited right of withdrawal from a life insurance contract in the event that the insurer did not inform the insured or only partly informed him or her (e.g., by stating an incorrect period of time) to withdraw from the contract after completion. While insurers wish to repay to such insureds only the surrender value of the contract, the Austrian Consumer Protection Association commenced an in-depth analysis of consumers in 2016 and consequently initiated test cases against Austrian life insurers demanding the repayment of all premiums paid plus 4 per cent interest per annum.30

25 OGH 5 November 2014, 7 Ob 148/14m.
VI OUTLOOK AND CONCLUSIONS

It is to be expected that during 2017 further court decisions dealing with the (re)payment obligations of life insurers in the event of the right to withdraw from contracts will be released and become final and binding, which will result in more legal clarity for insured consumers as well as for life insurers.
I INTRODUCTION

Bermuda’s insurance market is characterised by innovation, with the island having led – and continuing to lead – the development of many of the concepts and structures now central to the industry worldwide. Its international insurance industry began in 1947 with the founding by CV Starr of the American International Company Limited, and in the 1960s the island created the concept of ‘captive insurers’. Throughout the 1960s and 1970s, Bermuda continued to focus on the captive insurance industry, developing concepts such as group captives, ‘rent-a-captives’,2 and segregated account companies,3 in addition to the traditional single-parent captive. In the mid-1980s, the first of the excess liability insurers were formed on the island, and in the early 1990s, the concepts of structured reinsurance were developed, along with transformer4 vehicles, thus marking the beginning of the ‘convergence’ of the capital and insurance markets. The development of the property catastrophe reinsurance market followed, being particularly notable for the waves of capital flowing into the island following the major insured events and capacity crises of 1993 (Hurricane Andrew), 2001 (World Trade Center terrorist attacks) and 2005 (Hurricanes Katrina, Rita and Wilma). Throughout, the island has also seen the development of life insurers and reinsurers, and a very diverse array of general business insurers outside the property catastrophe lines. The overall result is a highly developed captive as well as commercial insurance and reinsurance market, with a sophisticated and adaptable regulatory framework.

Most recently, Bermuda has seen particular growth in the development of ‘sidecar’ vehicles, catastrophe bonds (cat bonds) and other insurance-linked securities (ILS) products,5 along with a corresponding growth in the development of investment funds focusing on such products. The creation in 2009 of a new class of special purpose insurer (SPI), designed to accommodate sophisticated, fully funded insurance transactions, has provided the framework

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1 Christian Luthi and Michael Frith are directors at Conyers Dill & Pearman Limited.
2 A ‘rent-a-captive’ is a captive insurance company established and licensed by a sponsor who then ‘rents’ its capital, its insurance licence and its capacity to operate to various participants.
3 Segregated accounts companies are operated through ‘cells’ whose assets and liabilities are ring-fenced and legally or contractually protected from the creditors of other cells and the general creditors of the company.
4 Insurance transformers are entities (typically, special purpose vehicles) that transform one type of financial risk into another; for example, the transformation of risks under insurance or reinsurance contracts into risks under credit derivative agreements and vice versa.
5 See Section VI, infra.
for these highly sophisticated ILS structures to flourish, with SPIs now comprising a substantial number of all new insurers on the island and rapidly becoming the predominant vehicle of choice for the majority of global ILS issuances.6

The development – and maintenance – of each of these insurance and reinsurance products has been supported by a characteristically risk-based regulatory approach from the local insurance regulator, the Bermuda Monetary Authority (BMA), as well as the natural development of a sophisticated service provider network and physical infrastructure. Speed to market is one of the hallmarks of the island’s industry, with the BMA overseeing one of the most efficient licensing processes of any major global insurance centre, and that advantage has been preserved even throughout the most recent period of regulatory development driven by the impact of the European Solvency II Directive (Solvency II) and Bermuda’s successful bid for full Solvency II equivalence.

Beyond the regulatory environment, Bermuda enjoys a sophisticated legal system based on English common law. Its court of first instance is the Supreme Court of Bermuda, which adjudicates civil and commercial disputes with a value of over US$25,000. In 2006 a commercial division of the Supreme Court was established. The division’s jurisdiction encompasses most commercial and corporate matters and expressly includes claims or counterclaims relating to insurance and reinsurance and arbitration.7 Matters in the Supreme Court will be determined by a single judge sitting alone. There are four commercial judges, two permanent (including the Chief Justice), and two part-time who sit as acting puisne judges. The first-tier appellate court is the Court of Appeal, a panel of three justices of appeal who sit in quarterly sessions and hear appeals from the Supreme Court. The second and final court of appeal is the Judicial Committee of the Privy Council, which is ordinarily composed of a panel of five judges who are members of the Supreme Court of England and Wales or are senior judges from Commonwealth jurisdictions.

II REGULATION

The insurance licensing and regulatory regime in Bermuda is primarily composed of the Insurance Act 1978 and the regulations promulgated thereunder (the Insurance Act).8 The Insurance Act applies to any person carrying on insurance business in or from within Bermuda. It does not generally distinguish between insurers and reinsurers; companies are simply registered (licensed) under the Insurance Act as ‘insurers’. The Insurance Act uses the defined term ‘insurance business’ to include reinsurance.

The Insurance Act distinguishes between three regulatory categories of insurance business: long-term business, special purpose business and general business. Long-term business consists of life, annuity, and accident and disability contracts. Special purpose business can be any fully funded insurance business under which an insurer fully funds

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6 SPIs comprised 20 of 64 total new insurer registrations for 2015. Source: Bermuda Monetary Authority insurer registration statistics for year ended 31 December 2015.
7 Rules of the Supreme Court 1985, Order 72 Rule 1(2). In particular see Rule 1(2)(v) and (xi).
8 Provisions of the Companies Act 1981 are applicable to insurance and reinsurance companies and other legislation such as the Segregated Accounts Companies Act 2000 will be applicable in the case of segregated accounts companies and the Life Insurance Act 1978 will have application in connection with providers of long-term business who write policies governed by Bermudian law.
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its liabilities to its insureds through the proceeds of a debt issuance, cash, time deposits or another financing mechanism. General business is any insurance business that is not long-term or special purpose business.9

The regulation of those matters pertaining to the Insurance Act is the responsibility of the BMA. The nature of regulation under the Insurance Act is a combination of self-regulation, filings of statutory financial statements and certifications as to compliance with the applicable statutory requirements, together with review and investigation by the BMA in specified circumstances.

All persons seeking to carry on insurance business in or from within Bermuda are required to be registered (licensed) under the Insurance Act.10 In the usual course, a person seeking to carry on insurance business in Bermuda will incorporate a Bermudian company to write such business, and it is that company that is registered as an insurer. It is also possible (although much less common), for an overseas insurer to form a branch operation to carry on insurance business in Bermuda. In such a case, the overseas company will apply to be licensed in the same way as a Bermuda-incorporated company, with the BMA imposing such conditions as it sees fit on the licence issued to take account of the characteristics of that branch operation.

When considering whether to approve an application, the BMA is bound by the Insurance Act11 to consider whether the applicant and its directors and officers are fit and proper persons to be engaged in ‘insurance business’ and, in particular, whether they have, or have available to them, adequate knowledge and expertise. The BMA has the discretion to approve or decline any registration application or to impose conditions if it feels it is appropriate to do so, and is required to exercise its discretion in the public interest.

Applications for all new insurers are filed with the BMA and are considered within one week of being filed. The application must include a brief business plan, setting out the pertinent details of the proposed business, capital structure and management of the company, along with five-year pro forma financial projections and other ancillary documents.12 The same application process is applicable to all classes of insurer.13

i Classification of insurers

There are six classes of general business insurer (Classes 1, 2, 3, 3A, 3B and 4), and five classes of long-term business insurer (Classes A, B, C, D and E). SPIs are not further divided by class.14

The classification system reflects the risk-based regulatory approach of the Insurance Act. Class 1 and Class A insurers are at one end of the regulatory scale, and are companies wholly owned by one person and carrying on insurance business consisting only of insuring the risks of that person or its affiliates (i.e., single-parent captives). Given those risk characteristics, these insurers are subject to the least rigorous regulatory oversight of all the classes of general and long-term business insurers.

9 Insurance Act 1978, Section 1(1).
10 Insurance Act 1978, Section 3.
11 Insurance Act 1978, Section 5 and Schedule, Minimum Criteria for Registration.
12 Insurance Act 1978, Sections 4(7), 4A(4) and 4EA(3).
13 Ibid.
Class 3B and Class 4 general business insurers are very large commercial insurers, writing in excess of US$50 million of net premium. Classes C, D and E long-term business insurers are also considered to be commercial insurers, with the class determined based on value of the insurer’s total assets (the higher the value, the higher the class). In each case, these companies are at the opposite end of the regulatory scale to the captive sector, and are subject to the most rigorous regulatory oversight of all the classes of general and long-term business insurers. We refer to such companies as ‘commercial insurers’.

SPIs are restricted to writing fully funded business and necessarily involve sophisticated participants only, and they are regulated accordingly. As such, they are subject to less extensive regulatory oversight.

**ii Solvency and capital requirements**

All insurers’ statutory assets must exceed their statutory liabilities by an amount greater than or equal to a prescribed minimum solvency margin. This margin varies depending on the class of their registration. For general business insurers it is calculated by reference to net premiums written and loss reserves posted, while for long-term insurers it is calculated by reference to the value of the insurer’s total assets. For SPIs, the solvency margin requirement is simply that the insurer’s assets must exceed its liabilities.\(^{15}\)

As part of the BMA’s successful effort to obtain full third-country equivalence for Bermuda under the developing Solvency II regime in Europe, all commercial insurers are also now required to maintain available statutory capital and surplus at a level equal to or in excess of their enhanced capital requirement (ECR). The ECR applicable to qualifying insurers is established by reference to either the appropriate Bermuda Solvency Capital Requirement (BSCR) model (standard mathematical models used to determine an insurer’s capital adequacy) or a BMA-approved internal capital model.

While not specifically set out in the Insurance Act, the BMA has also established a target capital level (TCL) for each insurer subject to an ECR equal to 120 per cent of its ECR. While qualifying insurers are not currently required to maintain their statutory capital and surplus at this level, the TCL serves as an early warning tool for the BMA and failure to maintain statutory capital at least equal to the TCL will likely result in increased BMA regulatory oversight.\(^{16}\)

For each insurer subject to an ECR, the BMA has introduced a three-tiered capital system designed to assess the quality of capital resources that a company has available to meet its capital requirements. The new system classifies all capital instruments into one of three tiers based on their ‘loss absorbency’ characteristics. Highest quality capital is classified as Tier I capital; lesser quality capital is classified as either Tier II capital or Tier III capital.

All general business insurers are also required to maintain an appropriate level of liquidity to their assets, keeping the value of their ‘relevant assets’ at not less than 75 per cent of the amount of their ‘relevant liabilities’. ‘Relevant assets’ will include items such as cash and time deposits, quoted investments, unquoted bonds and debentures, investments in first mortgage loans on real estate, investment income due and accrued, accounts and premiums receivables, reinsurance balances receivable and funds held by ceding reinsurers. Other assets not generally considered to be ‘relevant assets’ may nonetheless be approved as such by the

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\(^{15}\) Insurance Returns and Solvency Regulations 1980.

BMA in appropriate circumstances, on application by the insurer. ‘Relevant liabilities’ are total general business insurance reserves and total other liabilities less deferred income tax, sundry liabilities (i.e., those not specifically defined) and letters of credit and guarantees.17

iii Long-term business fund (long-term insurers only)
A long-term insurer must maintain accounts in respect of its long-term business separate from any accounts kept in respect of any other business, and all receipts of its long-term business shall form part of its long-term business fund. The long-term business fund is a legally segregated pool of assets whose use is restricted under the Insurance Act. No payment may be made, directly or indirectly, out of the long-term business fund for any purpose other than the company’s long-term business except insofar as the payment can be made out of any surplus certified by the company’s approved actuary to be available for distribution other than to policyholders.18

iv Dividend and return of capital restrictions
Where an insurer fails to meet its minimum solvency margin or (general business insurers only) its minimum liquidity ratio on the last day of any financial year, it is prohibited from declaring or paying any dividends during the next financial year without the prior approval of the BMA. Any insurer that fails to comply with its ECR is also prohibited from declaring and paying any dividends until the failure has been rectified.19

The restrictions on declaring or paying dividends and distributions under the Insurance Act are in addition to the solvency requirements under the Companies Act 1981, which restricts a company from declaring or paying a dividend or a distribution out of contributed surplus unless there are reasonable grounds for believing that the company is, and after the payment of the dividend or distribution will be, able to pay its liabilities when they become due and that the realisable value of that company’s assets will, after payment of the dividend or distribution, be greater than the sum of its liabilities.20

No general business or long-term insurer may reduce its total statutory capital, as set out in its previous year’s financial statements, by 15 per cent or more unless it has received the prior approval of the BMA. Total statutory capital includes the amount paid in with respect to the issue of its shares as well as all contributed surplus.21

SPIs are not subject to return of capital restrictions.

v Principal representative and other statutory service providers
The Insurance Act requires every insurer to appoint a resident principal representative and to maintain a principal office in Bermuda. The principal representative must be knowledgeable in insurance and will be responsible for arranging for the maintenance and retention of the statutory accounting records and for making the annual statutory financial return. Certain minimum records are required to be maintained at the principal office (e.g., premium registers, loss registers and general records on reinsurances). The principal representative has

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17 Insurance Returns and Solvency Regulations 1980.
19 Insurance Act 1978, Section 31B.
20 Companies Act 1981, Section 54.
21 Insurance Act 1978, Section 31C.
a statutory duty to report to the BMA when he or she considers there to be a likelihood of
the insurer becoming insolvent or upon becoming aware or having reason to believe that the
insurer has failed or defaulted in various other matters set out in the Insurance Act.22

Every general business insurer (other than Class 1 insurers) must also appoint an
individual approved by the BMA to be its ‘loss reserve specialist’, and is required to submit
annually (triannually, in the case of Class 2 insurers) an opinion of its approved loss reserve
specialist with its statutory financial return in respect of its loss and loss expense provisions.23

Every long-term business insurer must appoint an approved actuary, who must opine
on the insurer’s statutory financial return.24

SPIs are not subject to any requirement to obtain a loss reserve or actuarial opinion.

Every insurer must appoint an independent auditor (based in Bermuda), approved by
the BMA, to report on the company’s statutory financial statements. The auditor is required
to state whether, in the auditor’s opinion, it was reasonable for the directors to certify the
statutory ratios and whether the declaration of statutory ratios complies with the requirements
of the Insurance Act.25

SPIs may (and commonly do) apply to the BMA to waive the requirement that they
prepare audited statutory financial statements, and the BMA is generally willing to grant such
waivers.26

vi Head office requirements

Every commercial insurer in Bermuda (Classes 3A, 3B, 4, C, D and E) must also maintain
a head office in Bermuda. In determining whether this requirement is met, the BMA will
have regard to a number of factors, including the location of board meetings and operational
decision-making, and whether and to what extent directors and senior executives are located
in Bermuda.27

vii Financial statements

The Insurance Act requires every insurer to prepare annual statutory financial statements and
file these statements with the BMA together with a statutory financial return. The rules for
preparing these statements are set out in the Insurance Act and include a uniform format of
the balance sheet, income statement, statement of capital and surplus and rules for valuation
of assets and determination of liabilities. The statutory financial statements are not prepared
in accordance with generally accepted accounting principles (GAAP). The statutory financial
return includes a general or long-term (as appropriate) business solvency certificate and a
declaration of statutory ratios, which must be signed by at least two directors and the insurer’s
principal representative. These serve to confirm whether or not the business solvency margin
and (for general business insurers only) the minimum liquidity ratio have been met. The
statutory financial return is not a public document.28

22 Insurance Act 1978, Section 8.
23 Insurance Act 1978, Section 18B.
26 Guidance Note No. 20 – Special Purpose Insurers.
27 Insurance Act 1978, Section 8C.
28 Insurance Act 1978, Section 17.
In addition to preparing statutory financial statements, all Class 3A, 3B and 4 general business insurers and all Class C, D and E long-term insurers must also file with the BMA audited financial statements prepared in accordance with GAAP (or international financial reporting standards). The BMA may publish copies of these financial statements on its website.

viii Controller supervision and material changes

The BMA maintains supervision over the controllers of all registered insurers in Bermuda. A controller includes significant direct or indirect shareholders and directors and senior executives of the insurer. In addition, all insurers are required to give notice to the BMA of certain material changes to their business, including matters such as the transfer or acquisition of insurance business pursuant to court-ordered schemes, the amalgamation with or acquisition of another firm, engaging in non-insurance business and activities related thereto where the business is not ancillary to its insurance business, and engaging in unrelated business that is retail business.\(^{29}\)

ix Insurance Code of Conduct

All Bermudian insurers must comply with the Insurance Code of Conduct (the Code). The Code prescribes the duties and standards to be complied with by the insurers to ensure that they implement sound corporate governance, risk management and internal controls. Failure to comply with these requirements will be a factor to be taken into account by the BMA in determining whether an insurer is conducting its business in a sound and prudent manner under the Insurance Act. The Code will be applied in a manner proportionate to the risk profile of each insurer.\(^{30}\)

x Investigation, intervention and enforcement

The BMA may appoint an inspector with extensive powers to investigate the affairs of an insurer if the BMA believes that an investigation is required in the interest of the insurer’s policyholders, and may direct an insurer to produce documents or information relating to matters connected with the insurer’s business pursuant to the investigation.\(^{31}\) The BMA also has the power to assist other regulatory authorities, including foreign insurance regulatory authorities, with their investigations involving insurance and reinsurance companies in Bermuda if it is satisfied that the assistance being requested is in connection with the discharge of regulatory responsibilities and that such cooperation is in the public interest.\(^{32}\) The grounds for disclosure by the BMA to a foreign regulatory authority without consent of the insurer are limited and the Insurance Act provides for sanctions for breach of the statutory duty of confidentiality.\(^{33}\)

\(^{29}\) Insurance Act 1978, Sections 30D to 30JC.

\(^{30}\) Insurance Act 1978, Schedule; the Insurance Code of Conduct.

\(^{31}\) Insurance Act 1978, Sections 27A to 30C.

\(^{32}\) The Insurance Act 1978, Sections 52, 52A, 52B and 52C; Bermuda Monetary Authority Act 1969, Section 30A to 30E and Section 31.

\(^{33}\) The Insurance Act 1978, Section 52.
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xi Regulatory developments
In November 2015, the European Commission approved Bermuda for full third-country equivalence under Solvency II, making the island one of the first two jurisdictions – and the only jurisdiction outside Europe – to be granted that recognition.

In light of its high international standard of insurance regulation, Bermuda has also been designated as a Qualified Jurisdiction by the US National Association of Insurance Commissioners (NAIC), resulting in reduced reinsurance collateral requirements being imposed on the purchase by US insurers of reinsurance from Bermuda-regulated reinsurers.

It is important to note that, in the context of Solvency II equivalence, the BMA has been clear that the BSCR and enhanced capital regimes described above will be applied only to commercial insurers in Bermuda, and not to the captive insurance sector or to SPIs.

III INSURANCE AND REINSURANCE LAW
i Sources of law
Bermuda is a British overseas territory and is the oldest self-governing dependent territory of the United Kingdom. Its legislature, the House of Assembly, had its first sitting in 1620. Bermuda’s system of law is founded on English law.

The Supreme Court Act 1905 confirms that the system of law administered in Bermuda is:

- the common law of England;
- the doctrines of equity in England;
- the Acts of Parliament of general application that were in force in England at the date of Bermuda’s settlement in 1612, except where altered by English legislation after that date and made applicable to Bermuda;
- legislation enacted by the Bermuda legislature (the House of Assembly); and
- the common law and laws of equity since 1612.

Bermudian law, like English law, is based on the doctrine of precedent and judicial decisions have the following order of precedent.

- decisions of the Court of Appeal for Bermuda and the Privy Council are binding on Supreme Court judges and must be followed if they cannot be distinguished;
- the Court of Appeal is bound by decisions of the Privy Council; and
- the Privy Council is bound by its own previous decisions if relevant except in certain exceptional circumstances.

Decisions of the House of Lords (in its former role as the supreme court) and now the Supreme Court of England and Wales are highly persuasive, and are invariably followed where they involve the same points of common law or statutory interpretation. Unless

34 Supreme Court Act 1905, Section 18.
there are social and economic conditions that justify departure from English precedent, the Bermuda Court of Appeal will treat relevant decisions of the English Supreme Court as effectively binding on it.\(^{37}\)

Decisions of the High Court of England and the English Court of Appeal will also be treated as persuasive, depending on their facts and circumstances and the quality of the legal reasoning and are frequently cited and applied in matters pending before the Supreme Court.

Finally, decisions in the courts of other common law and offshore jurisdictions will also be cited and considered depending on the applicability of the decision, the quality of the reasoning and the seniority of the courts.

As described in Section II, supra, the primary source of insurance law and regulation in Bermuda is the Insurance Act 1978, together with the regulations promulgated thereunder.

\section*{Making the contract}

Bermudian law does not regulate the form of contract of insurance and the Bermudian law principles regarding the formation, interpretation and enforcement of contracts are in most areas virtually identical to English common law subject to the following points.

Definition of insurance business: the Insurance Act's definition of 'insurance business' does not include an express requirement that there be an insurable interest in the writing of insurance contracts by licensed insurers in Bermuda.\(^{38}\) The Act was deliberately drafted widely and opens up the possibility that insurance business where there is no clear insurable interest will still fall within the statutory definition provided that it can be said to be the 'payment of a sum of money on the happening of an event', satisfying part two of the definition. This provision arguably provides considerably more scope for creativity in the writing of insurance contracts than is the case where there is a clear requirement that there be an insurable interest.

Unlike England, Bermuda does not have any unfair contract terms legislation.\(^{39}\) There is no contracts (rights of third parties) legislation and the common law doctrine of privity of contract continues to apply.


\begin{footnotesize}
\begin{enumerate}
\item \footnote{Crockwell \textit{v.} Haley, Court of Appeal for Bermuda, Civil Appeal No. 23 of 1992.}
\item \footnote{The full definition of insurance business under the Insurance Act 1978 states: 'insurance business means the business of effecting and carrying out contracts: (a) protecting persons against loss or liability to loss in respect of risks to which such person may be exposed; or (b) to pay a sum of money or render moneys worth upon the happening of an event, and includes reinsurance business.'}
\item \footnote{The Privy Council in Astwood \textit{v.} Marra [1982] UKPC 24 upheld wide ranging exemption provisions in a local cycle livery contract. Exclusion clauses will not be subject to doctrines of reasonableness incorporated by statutes such as the Unfair Contract Terms Act 1977.}
\end{enumerate}
\end{footnotesize}
In the late 1980s the Bermuda Form evolved for liability policies. Its connection with Bermuda is that it was developed by Bermudian companies but it is not governed by Bermudian law or subject to dispute resolution in Bermuda. It was initially used by ACE Insurance Company Ltd but was also in a slightly different form adopted by XL Insurance. While these clauses continue to evolve, the Bermuda Form’s essential characteristics are:

a. it is a hybrid of ‘claims’ made and occurrence policies providing cover on an occurrence, first-reported basis.\(^40\) It covers occurrences that take place during the policy period but is expressed to be continuous from year to year. The occurrence must be reported during the policy period;

b. it was intended to avoid the problems of aggregation or ‘stacking’ of policy limits by requiring the policyholder to group related events together or integrate them into a single year;

c. it provides for a ‘maintenance deductible’ designed to exclude and limit expected and intended claims so that they remain the responsibility of the policyholder;

d. it is governed by the substantive law of New York; and

e. it provides for arbitration in London under English procedural law.

### iii Intermediaries and the role of the broker

The Act makes provision in relation to the role of brokers and provides that brokers who have apparent authority to act on behalf of insurers who receive payments of premium will be deemed to be the agent of the insurer and the insurer shall be deemed to have received the premium\(^41\) (reinsurers are included in the definition of ‘insurers’ under the Act).

Insurance brokers carrying on business in or from within Bermuda must be licensed as such by the BMA, with the registration being for the corporate entity, rather than individuals. The application process is very similar in terms of timing and structure to that applicable to new insurers, in that a brief business plan and related supporting documents are filed with the BMA and are normally determined within one week. The primary requirements for approval are that the applicant must evidence sufficient skill and expertise to be able to carry on business as a broker, and must provide evidence that he or she carries (or will carry, prior to conducting business) errors and omissions cover of not less than US$1 million (or such greater amount as appropriate to the level of premium expected to be placed by the broker).

All of the major international insurance brokers have substantial Bermuda operations (Marsh, Aon, Willis, JLT, etc.) and are able to provide the necessary brokerage services to the local market, either directly, or by way of referral from onshore brokers.

### IV DISPUTE RESOLUTION

#### i Jurisdiction, choice of law and arbitration clauses

To found jurisdiction under Bermudian rules:

a. the court must have jurisdiction over the defendant so that the defendant can be served with process within the jurisdiction;

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\(^41\) Insurance Act 1978, Section 29.
the criteria necessary for the court to exercise its long-arm jurisdiction must be present so that the court will give leave to serve the defendant outside its jurisdiction. Leave will be given if the claim falls within one of a number of specific headings set out in Order 11 of the Rules of the Supreme Court 1985; and companies with agents or a branch that is doing business in Bermuda may be sued in Bermuda under the External Companies (Jurisdiction in Actions) Act 1855.

Bermudian insurers are free to choose their governing law, and in practice many contracts are by their terms governed by laws other than those of Bermuda. Under the Rules of the Supreme Court Order 11, one of the bases for the court exercising its long-arm jurisdiction is where the contract by its terms or by implication is governed by the law of Bermuda. Ordinarily, the Bermudian courts will give effect to contracts containing an express choice of law. The same applies to contracts containing a submission to the jurisdiction of the Supreme Court of Bermuda. A submission to arbitration will be readily enforced by the Bermudian courts.

ii Litigation

Litigation is conducted in the Supreme Court of Bermuda. Disputes involving insurance or reinsurance will be conducted in the Commercial Court, which is made up of four commercial judges (two of whom are permanent appointments). The division is headed by the Chief Justice. The rules of civil procedure in Bermuda replicate the English Rules of the Supreme Court that were in existence prior to the Woolf reforms in 1999. However, Bermuda has adopted the overriding objective, which was introduced in the Woolf reforms in England.\(^{42}\)

The Supreme Court is frequently called upon to exercise its jurisdiction in international commercial disputes with a cross-border element. It is fair to say that claims-related litigation involving Bermuda’s exempted insurance companies is rare. Most litigation involving insurers and reinsurers arises in the context of instigation of arbitral proceedings and associated injunctive relief or enforcement of awards, and insolvency proceedings brought by insurance and reinsurance companies themselves or regulators and creditors. Recent developments are confined to those areas. There also exists a significant regulatory practice involving restructuring schemes of arrangement\(^{43}\) or transfers of long-term business.\(^{44}\)

Recent cases

Injunctions

In ACE Bermuda Insurance Limited (formerly ACE Insurance Company, Ltd) v. Continental Casualty Company and Continental Insurance Company,\(^{45}\) the Bermuda court granted an *ex parte* anti-suit injunction against the Continental companies prohibiting them from proceeding against ACE. Continental sought determination of the scope of its obligations

\(^{42}\) Rules of the Supreme Court 1985 Order 1A.

\(^{43}\) Sections 99 and 100 of the Companies Act 1981 provide for schemes of arrangement between creditors or classes of creditors or shareholders or classes of shareholders. The court will in the exercise of its discretion sanction a scheme if it is approved by a majority in number and 75 per cent in value of each class voting on the scheme and provided that the scheme is fair and reasonable.

\(^{44}\) The Act provides at Section 25 that a transfer of long-term business must be sanctioned by the court.

under excess liability insurance policies issued to Minnesota Mining and Manufacturing Company (3M) between 31 December 1969 and 1 January 1986. ACE had issued a policy to 3M that contained an arbitration clause specifying Bermuda as the seat of the arbitration. In the Minnesota proceedings there were more than 60 insurers, including ACE, joined in the proceedings as 3M had purchased insurance from each of the 60 insurers. Continental sought to bind the insurers to the proceedings in Minnesota and ACE contended that the commencement of proceedings in Minnesota Continental was infringing the provisions of the arbitration clause.

Continental challenged the order on the basis that it said ACE’s cause of action did not fall within the terms of Order 11, Rule 1(1)(d)(iii) of the Rules of the Supreme Court 1995, which was necessary to obtain leave to serve Continental out of the jurisdiction. The challenge was the lack of contractual nexus between Continental and ACE. ACE had provided insurance to 3M, not to Continental.

The Court held that the relevant rules do not require there to be a contract between the plaintiff and the defendant – they simply require that the proceedings brought in Bermuda are brought to enforce or otherwise affect a contract that by its terms is governed by the law of Bermuda. The Court therefore held that the fact that the plaintiff had brought proceedings against 3M and joined ACE to those proceedings was a sufficient basis for ACE to obtain leave to serve Continental notwithstanding that Continental was not party to the agreement between ACE and 3M and upheld the order for an anti-suit injunction.

Two other more recent cases involving injunctions and foreign proceedings are of note. In *ERG Resources v. Nabors Industries Limited*, ERG Resources LLC launched proceedings in Harris County, Texas against Nabors Global Holdings to prevent it from terminating its share purchase agreement. The effect of the termination would be that Nabors could then sell to a third party for substantially more money. Two days after the Texas court had refused to grant a temporary restraining order to ERG in Texas, ERG issued proceedings in Bermuda claiming identical relief to that claimed in Texas. It sought and obtained an *ex parte* injunction in its favour against Nabors in Bermuda in the Supreme Court. Nabors promptly applied to have the injunction discharged and sought a stay or dismissal of the proceedings in Bermuda. The Supreme Court granted Nabors’s application and discharged the injunction to stay the proceedings. It did so both on substantive grounds and on the basis that there had been material non-disclosure by ERG when it made its *ex parte* application to the Bermudian court. The Bermudian court was willing to hold that its role was ancillary to that of the foreign court in these circumstances and the Bermudian court would provide assistance to the court exercising primary jurisdiction. The Court held that it would not grant relief where application had been made to the primary court and refused or where such an application if made to the primary court would be refused.46

In *Joliet 2010 Limited et al v. Goji Limited et al.*,47 the Supreme Court considered an application to discharge an anti-suit injunction over foreign litigation. In that case the court’s jurisdiction to grant an injunction on the basis that proceeding with the foreign liquidation was unconscionable was engaged. Goji Limited had commenced proceedings in Israel against a Bermudian company seeking, *inter alia*, changes, to the company’s by-laws and its board.

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Shareholders in the Bermudian company brought parallel proceedings in Bermuda seeking declaration that the Bermudian company could continue to operate as normal and that only the Bermudian court could grant the remedy sought in Israel. They also sought an anti-suit against the Israeli litigants arguing that it was unconscionable for a litigant to seek relief from an Israeli court affecting the internal governance of a Bermudian company. In upholding the injunctions and agreeing that the case was a proper one for leave to serve out of the jurisdiction, Hellman J agreed that the conduct was unconscionable and affirmed the willingness of the Bermudian court to protect its exclusive jurisdiction over the internal governance of Bermudian companies.

**Regulatory and insolvency**

*The Bermuda Monetary Authority v. The South of England Protection and Indemnity Association (Bermuda) Limited*[^48]  

In this case, the role of the BMA in applying for the winding-up of a regulated insurer was considered. The court made a winding-up order on an application by the BMA on the recommendation of the proposed joint provisional liquidators (JPLs) of the South of England Protection and Indemnity Association. The petition was characterised as a public interest petition and the Supreme Court was asked to ‘second guess’ the professional judgement of both the BMA and the JPLs as to how the public interest would best be served. The BMA argued that the South of England Protection and Indemnity Association (P&I club) was hopelessly insolvent both under the Insurance Act 1978 and under the Companies Act 1981, it had a history of regulatory delinquency and should be wound up on the grounds of public interest. The company sought to suggest that the true picture was more complicated and that although there may have been regulatory breaches it could, if given the opportunity, establish its solvency. The suggestion was that the BMA had not grasped the commercial realities of the P&I club environment and that in particular the power under the company’s rules to cancel insurance liabilities owed to members who did not respond to supplementary calls had not been taken into account.[^49] The Court initially adjourned the petition to give the company leave to adduce further evidence. Evidence was filed by the company and the hearing resumed. The BMA also filed further evidence suggesting that the company had since inception been conducted in a manner that was inconsistent with the letter and the spirit of the by-laws and the Companies Act 1981.

The Court ultimately held that there was sufficient evidence to find insolvency notwithstanding the further evidence adduced by the company. It took the opportunity to make certain statements in connection with the public interest and the role of the regulator. The Chief Justice said:

> Insurance and reinsurance form the centrepiece of Bermuda’s offshore industry which generates over 80 per cent of the country’s foreign exchange earnings. The integrity of Bermuda’s insurance regulatory system is as important to Bermuda’s national interest as are dykes to coastal areas of the Netherlands.

[^49]: The company was a mutual company and the members were liable to contribute to its liabilities under its by-laws and rules of organisation.
It is a notorious fact that the Bermuda regulatory model is more collaborative than adversarial and that the BMA is quicker to resort to the velvet glove rather than a mailed fist in responding to regulatory challenges.

The Court stated that:

[...] when the BMA invites a court to immediately wind up a trading company in the public interest, the court must have compelling reasons to reject the natural inference that such an application is made (a) in good faith and (b) on sound objective regulatory grounds. On the other hand, the court must be careful to ensure that the legitimate expectations of persons who establish entities in Bermuda are not ignored. The reasons advanced by the JPLs for ending the uncertainty about the company's status which I found dispositive were:

a  the company's inability to find reinsurance;

b  concerns expressed by members of the club about the status of their insurance cover and the risk that significant losses may occur which the company cannot pay in circumstances where members believe they have effective cover; and

c  the absence of reliable information about the company's current financial position (and the resultant improbability of any expeditious return to a viable position).

The Court therefore ordered that the company be wound up and appointed JPLs.

**Lehman Re**

Two decisions have been rendered in proceedings relating to the insolvency of Lehman Re, an affiliate of Lehman Brothers. The main issue relates to whether or not particular assets of Lehman Re fall within the category of long-term business assets or the general assets of the company available to the company's general creditors. The matter has now been resolved; however, there have been two rulings in connection with foreign depositions and document disclosure.

In the first application\(^\text{50}\) the creditor sought leave to obtain evidence out of the jurisdiction where the Court was willing to make an order for a deposition out of the jurisdiction, despite the fact that the witness in question had not indicated his unwillingness to attend Bermuda and give oral evidence on a voluntary basis. The Court held that its jurisdiction under Order 39 of the Rules of the Supreme Court was completely unfettered by the Rules and made the order. The factors that influenced the Court were the comparatively large sums in issue, the ease of travel between Bermuda and New York, the importance of the witness' evidence and the fact that the witness was not an employee of any of the parties to the dispute or otherwise under their control and to enable the parties to preserve their existing trial fixtures.

The second ruling involves collateral undertakings as to confidentiality in relation to documents that had been disclosed in proceedings.\(^\text{51}\) Pulsar Re, general business creditor of Lehman Re, sought to be released from its implied confidentiality undertaking to use the discovery in proceedings that it had brought against Lehman Brothers Holdings Inc and Lehman Commercial Paper Inc. Lehman Brothers Holdings and Lehman Re had agreed not to disclose any information that was confidential without the other's prior consent. The

\(^\text{50}\) *In the Matter of Lehman Re, Ltd* [2011] SC (Bda) 24 Com (21 April 2011).

\(^\text{51}\) *Lehman Re, Ltd* [2011] SC (Bda) 44 Com (20 September 2011).
Court considered the competing interests of litigants in the case and whether or not the fact that the documents were disclosed in the course of a winding-up should alter the balance between a litigant’s right to confidentiality of its documents that have been disclosed in discovery versus the other litigant’s right to pursue his claim. The Court was willing to allow the creditors to deploy discovered material and distinguished cases where the collateral use of discovered material might be said to undermine the integrity of the discovery process because in the present case Pulsar Re did not obtain the discovery in adversarial litigation but by means of a court order in its capacity as a creditor of an insolvent company that Pulsar Re had a statutory right to inspect.

_American Patriot Insurance Agency Inc, Kenneth A Hendricks and Diane M Hendricks v. Mutual Holdings (Bermuda) Limited, Mutual Indemnity (Bermuda) Limited and others_ 52

This case involved a rent-a-captive structure that reinsured a series of clients. Such products are now structured using segregated cell companies created under the Segregated Accounts Companies Act 2000. Prior to 2000, such structures could be created via private Acts of Parliament but this was very expensive and time-consuming. It was therefore common for programmes to be structured using contracts, generally via preferred share series. Over time, billions of dollars of risk and reward passed through such structures.

This (now historic) form of structure was never at the time considered by the courts. However, it recently came under the microscope in the _American Patriot_ litigation, where a client sought to avoid responsibility for losses of its programme by arguing that the structure was _ultra vires_, since the reinsurer was contracting to pay out profits under individual programmes even if (because of losses under other programmes) it could not legally pay a dividend to anyone. At trial, Bell J (an experienced commercial judge now retired) dismissed the argument, pointing out that this scenario was highly unlikely to arise in reality and that many financial products were structured in a similar way (such as index-linked preferred shares). The Court of Appeal disagreed with Bell J, but without making any ruling. The Court of Appeal instead, and perhaps unhelpfully, expressed a preliminary view that the structure was _ultra vires_. Both the client and the company appealed this ‘preliminary’ view to the Privy Council, both sides requiring and asking for certainty. Before the Privy Council, the client abandoned its appeal on this point and confirmed that it did not seek to rely upon the Court of Appeal’s reasoning. Effectively abandoned, the point became academic. The Privy Council did not rule on this point but commented with disapproval on the making of _obiter_ views at an appellate level. The argument, apparently unloved by all sides and abandoned at the Privy Council, is a footnote in the history of this particular structure. 53

52 [2012] CA (Bda) 3 Civ (22 March 2012).

53 There is one other recent case involving Mutual Holdings (an affiliate of Mutual Indemnity Limited):

_Mutual Holdings Bermuda v. Matesen Insurance Brokers Supreme Court, 25 June 2014_, which cited _Mutual Holdings Bermuda v. Stateco Inc_ [2010] Bda LR 46. _American Patriot_ was also cited. Each of those cases turned on whether the company could recover losses under a commutation agreement pursuant to the indemnity provisions in the shareholders’ agreements under the rent-a-captive programme. The Supreme Court held that the company could do so.
iii Arbitration

There are two enactments governing arbitration in Bermuda: the Arbitration Act 1986 (the 1986 Act) and the Bermuda International Conciliation and Arbitration Act 1993 (the 1993 Act). The 1993 Act adopts, with certain modification, the UNCITRAL Model Law. The 1993 Act is intended to apply to ‘international’ arbitrations while the 1986 Act is intended to apply to domestic arbitrations. An arbitration is international if the parties have their places of business in different states; or the place of arbitration determined pursuant to the arbitration agreement is out of the state where of one of the parties has its place of business; or where one of the parties is situated out of the place where the substantial part of the obligations of the commercial relationship is to be performed or the place with which the subject matter is most closely connected. The parties are free to contract out of the 1993 Act and can expressly select the 1986 Act.

Both the 1986 Act and the 1993 Act confer on the Supreme Court the power to stay proceedings in favour of arbitration.

Under the 1986 Act there are default appointment provisions, which provide that the default number of arbitrators will be a single arbitrator. Under the 1993 Act the default number is three arbitrators in the absence of agreement.

Other important factors that distinguish the two Acts are the following.

Appeals

Under the 1986 Act, an appeal lies on questions of law although the parties can agree to limit the right of appeal. Under the 1993 Act the right of review is significantly limited to issues relating to the formation of the agreement to arbitrate, whether a party had been given proper notice of the arbitration, whether the panel exceeded its jurisdiction, whether the award exceeded the scope of the submission to arbitration, whether the composition of the panel was in accordance with the law of the country where the arbitration takes place, where the subject matter of the arbitration is not capable of arbitration under Bermudian law, or whether recognition of the award would be contrary to public policy.

Consolidation

Under the 1986 Act there is a statutory power to order consolidation of arbitrations where the parties are identical, and there is a common question of law or fact, the claims arise out of the same transaction or series of transactions or there is some other reason to make an

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54 This Act was largely copied from the Hong Kong Arbitration Ordinance, which in turn reflected the provisions of the arbitration legislation then in force in England.
56 See Professional Services Insurance Co Ltd v. Gerling Konzern Versicherungs Aktiengesellschaft and others [2003] Bda LR 55, where there was an issue as to whether the 1986 Act applied where the arbitration clause excluded the 1993 Act and Bermuda had not been chosen as the place of arbitration; however, the parties had submitted to the jurisdiction to the Bermuda court and there was an ‘implicit agreement that the 1986 Act applied’.
57 1986 Act, Section 15.
58 1993 Act, Schedule 2, Article 10.
59 1986 Act, Section 29.
60 1993 Act, Schedule 2, Article 34.
There is no express provision under the 1993 Act for consolidation. Consolidation can therefore only be achieved by express agreement by all proposed parties for consolidation to take place.

**Other points**

The Supreme Court has confirmed that arbitral proceedings in Bermuda are confidential. Further, unlike party-appointed arbitrators in arbitrations in the United States, party-appointed arbitrators in Bermuda are expected to be neutral and act without bias. The provisions of the New York Convention on the Enforcement of Arbitral Awards have been enacted in Bermuda under the 1993 Act.

**Recent cases**

The court’s readiness to enforce arbitration clauses and if necessary grant anti-suit relief to do so was reaffirmed in *ACE v. Continental*, (see Section IV.ii, supra). In *Princess Cruise Lines v. A Matthews*, an application was made to appoint an arbitrator in arbitral proceedings under the 1993 Act. The court considered the appointment qualifications under the 1993 Act, in particular where it is required to have regard to the nationality of the parties. The court was prepared to accept that by the selection of Bermuda as seat, the procedural law of Bermuda applied and that the arbitrator appointed should be familiar with Bermudian procedure. However, it declined to appoint a practising Bermudian lawyer as was requested by the applicant, and instead appointed a retired judge. The Bermuda court’s willingness to enforce arbitral awards was again demonstrated when the Supreme court recently refused to stay the enforcement of a Brazilian arbitral award, and made a winding-up order against a Bermuda company *In the Matter of LAEP Investments Ltd* notwithstanding that there was an application to suspend the award in Brazil.

More recently, in *Ace Bermuda Insurance Ltd v. Ford Motor Company*, the court reviewed the principles governing confidentiality in arbitration proceedings and how these principles interact with the principles of open justice in Bermuda courts, a topic that has recently been the subject of consideration in Bermuda commercial contexts (e.g., cases involving trusts and valuation cases). *Ace v. Ford* involved an *ex parte* application made without notice, which was not open to the public, seeking anti-suit relief. The purpose of bringing the application *ex parte* without notice was to avoid alerting the adverse party, which would potentially defeat the purpose of the application. The court stated it would be unconscionable to allow one side to rely upon what was *prima facie* a threatened breach of the arbitration agreement to absolve it from its contractual obligations of privacy and confidentiality, but held that the part of the hearing that dealt with the confidential material should be *in camera* while the rest of the hearing should be held in open court. Thus, the court was prepared to protect the confidentiality of arbitral proceedings.

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61 1986 Act, Section 9.
63 1993 Act, Section 2, Schedule 3.
64 [2011] SC (Bda).
65 [2014] SC (Bda) 23 Com (1 April 2014).
Alternative dispute resolution
There is no mandatory ADR mediation legislation in Bermuda, although under the overriding objective in the Rules of the Supreme Court the Court, in furthering its duty to actively manage cases, is bound to encourage the parties to use ADR procedures if it considers them appropriate and is to facilitate their use.

The 1993 Act provides a statutory framework for ‘conciliation’ prior to arbitration, which is effectively mediation. The 1993 Act incorporates the UNCITRAL Conciliation Rules, which are designed to enable parties to an international arbitration agreement to engage in conciliation. In practice, the provisions have not been widely used in Bermuda and although there is support for ADR in the local bar, it does not take place frequently.

Mediation is frequently deployed in Bermuda by the commercial bar utilising the services of both local and foreign expert mediators.

YEAR IN REVIEW
Bermuda had another active year in 2016, with a total of 42 new insurers being registered on the island for the year. Of those, 17 were SPIs, reflecting the continuing development of the ILS sector on the island. A number of the most significant global cat-bond transactions for the year were completed in Bermuda, using Bermuda-registered SPIs, and Bermuda SPIs continue to be the predominant issuer of all new cat bonds globally. In addition, there continues to be a great deal of interest in the formation of sophisticated market-facing collateralised retrocession insurers by a variety of investor groups.

In addition, new captive insurer formations continue, with a total of 13 new limited purpose insurers being formed, including eight new Class 1 and 2 insurers formed during the year, along with a further four Class 3 insurers (some of which also registered as segregated account companies). The commercial market also remains vibrant, with a total of nine new commercial general business insurers, and three new commercial long-term business insurers registered during the period. It is worth noting that many of the new commercial insurers registered during the year continue to emphasise specialised investment and asset management as a business rationale, relative to ‘traditional’ insurers, and this trend is expected to continue. Harrington Re is a notable example of this business model from 2016, having been preceded in prior years by companies such as ABR Re, Third Point Re and Validus Re’s PaCRe vehicle.

There also continues to be significant interest in mergers and amalgamations in the commercial sector over the past year, and the current market expectation is that the consolidation seen in the commercial sector in recent years is likely to continue in the near future.

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67 Rules of the Supreme Court 1985 Order 1A/4(e).
68 The BMA does not maintain information publicly as to the number of separate cells formed within segregated account companies.
VI OUTLOOK AND CONCLUSIONS

For 2017 and beyond, Bermuda is set to continue with the rigorous development of all aspects of its insurance market. Captive opportunities are increasing, particularly in the Canadian and Latin American markets, and the proportionate, risk-based approach to regulation of the captive sector will be maintained by the BMA.

From a business perspective, the commercial sector should also continue to see steady growth, particularly with respect to the development and implementation of ILS products. Regulatory development in the commercial sector is expected to continue as the BMA maintains its leadership position in developing and enhancing international prudential standards, as reflected in its full third-country equivalence under Solvency II, and NAIC Qualified Jurisdiction status. The BMA, with the support of the insurance industry itself and related service providers, remains very focused on ensuring that Bermuda retains its status as one of the most important insurance and reinsurance centres in the world. As the regulatory framework develops, the focus is on ensuring that global standards are met, on a proportionate basis and with industry needs firmly in mind. Indeed, the BMA has expressly stated that ‘the aim of this proportionate approach will be for barriers to entry to be kept to a minimum consistent with [their] objectives, so enabling the Authority to contribute to the continued growth of the insurance market in Bermuda.’

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69 Bermuda Monetary Authority Business Plan 2014.
Chapter 5

BRAZIL

Bruno Balduccini and Diógenes Gonçalves

I INTRODUCTION

Insurance and reinsurance activities are highly regulated in Brazil. This paternalistic approach seeks to foster the growth and development of the local insurance and reinsurance market. This chapter provides a general overview of the Brazilian insurance and reinsurance market, and the main rules applicable to entities aiming to conduct these activities in Brazil.

Overview

The first half of the 20th century saw important milestones that affected the growth of the Brazilian insurance market, reflecting the nationalistic tendencies of the then incumbent governments (especially during the 1930s and 1950s), of which the following can be highlighted:

a the enactment of the Civil Code of 1916, with an entire chapter dedicated to setting forth the general rules and principles that should govern insurance contracts and the relationship between insureds and insurers;

b the enactment of the Federal Constitution of 1937, which prohibited foreign insurance companies from freely operating in Brazil during the 1930s (only companies headquartered in Brazil could perform such activity within the country); and

c the creation of the Reinsurance Institute of Brazil (IRB), a state-owned reinsurance company that would hold a monopoly over all reinsurance transactions in Brazil until 2007.

The second half of the 20th century reflected a gradual but bold move towards the opening of the market to foreign competitors, especially during the 1990s. Among the most important events that took place during this period are the following:

a the enactment of Decree Law No. 73/1966, which created the regulatory bodies that are currently in charge of setting forth the rules and general guidelines to be followed by those entities deemed to be part of the National Private Insurance System (SNSP) (namely, insurers, reinsurers, open-ended private pension plan entities, public savings

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1 Bruno Balduccini and Diógenes Gonçalves are partners at Pinheiro Neto Advogados. The authors would like to thank Alessandra Carolina Rossi Martins, Mary Hamasaki, Leonardo Bedicks and Gianvito Ardito for their invaluable contributions to this chapter.

2 The Constitution was enacted during the Vargas dictatorship, which explains the nationalistic approach of the regulation of insurance and reinsurance activities provided in such legal document.
companies, and insurance and reinsurance brokers and brokerage companies). These governmental authorities are:

- the National Private Insurance Council (CNSP), which sets forth the general rules and guidelines that the entities that comprise SNSP must comply with; and
- the Private Insurance Authority (SUSEP), which further details the rules enacted by CNSP and supervises the above-mentioned entities of SNSP through routine inspections and disciplinary proceedings in the administrative sphere; and

- the revocation in 1996 of the general ban prohibiting foreign companies from controlling local SNSP entities, thereby paving the way for foreign competition to enter the Brazilian insurance market once again.

Once foreign competitors were allowed to control local insurance companies, the Brazilian insurance market experienced steady growth in terms of revenue. Allied with the stabilisation of the country’s economy, local and foreign players started to pressure the federal government to dismantle IRB’s monopoly over reinsurance activities. In response to the market’s general outcry in this regard, in 2007, Supplementary Law No. 126 was enacted by the federal government, and reinsurance activity was opened to local and foreign players, as further explained in subsection ii, infra. Less than four years after IRB’s monopoly was dismantled, more than 72 foreign companies were accredited to render reinsurance activities in Brazil, either as an admitted or occasional reinsurer, evidencing the huge success of opening the local market to foreign competitors.

ii Market overview

Stimulated by Brazil’s economic growth and stability, the country’s insurance and reinsurance markets have grown constantly since the late 1990s. According to recent surveys, the insurance market represented 2.59 per cent of Brazilian GDP in 2003, and increased to 3.71 per cent up to 2015.3

Around the same time, the local market also experienced a change regarding the types of products that had more popular appeal. While in 2003, the most popular insurance products in Brazil were auto-related (auto insurance, extended warranty), representing 29.1 per cent of the total amount of earned premiums, in 2014 and 2015 life insurance products (such as cash value life insurance plans, credit life insurance products, personal accident insurance products and group life insurance products) already represented more than 60 per cent of the total amount of earned premiums.4 This trend is largely the result of the substantial increase of the Brazilian middle class, a direct consequence of the country’s economic stability.

The growth of and changing environment in the insurance and reinsurance markets, combined with the constant overview of the regulatory agencies to improve and align their regulation with local and foreign market realities, set the grounds for a significant increase in the number of merger and acquisition (M&A) deals conducted, and provided the necessary legal and regulatory security for the entry of new players and the development of new products in Brazil.

Notwithstanding the above, market experts unanimously believe that there still is plenty of room for growth in this market in terms of its participation in Brazil’s GDP. Comparing

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4 Ibid.
the above figures with those of other countries, such as the United States (7.3 per cent), France (9.1 per cent), Japan (10.8 per cent) and the UK (10.6 per cent),\(^5\) it is evident that there is a lot of potential for growth left.

II REGULATION

i The insurance regulator

As explained in Section I.i, \textit{supra}, the entities that belong to the SNSP are currently regulated by CNSP and SUSEP, both of which are part of the Ministry of Finance.

According to Decree-Law No. 73/1966, CNSP has the authority to regulate the local insurance market with the objective of promoting and developing insurance activities in Brazil. SUSEP oversees the implementation of the rules established by CNSP and monitors the activities of participants of SNSP.

CNSP and SUSEP have recently enacted rules that seek to increase the level of transactions between insurers and reinsurers belonging to the same economic group; reduce the level of risk cession that needs to be allocated to local reinsurers; and increase the number of products under which underwritten risks may be freely ceded by local insurers to reinsurers in general (local, admitted and occasional). The expectation is that the rules will not only stimulate the growth of the local market, but also align its practices with markets of other jurisdictions.

ii The issuance of insurance products

In Brazil, there is a general rule for residents and legal entities headquartered in the country that ‘local risks should be run by local policies’. In other words, risks that may take place in Brazil should be covered by policies issued by local accredited insurance companies. This does not mean that foreign insurers cannot underwrite local risks for 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).

It is also worth stressing that 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.

iii 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.

\(^5\) Ibid., footnote 3.
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. This phase tends to last between three to four months.

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. This phase usually lasts between three and six months, and SUSEP has the prerogative to summon the controlling shareholders of the newly organised insurance company for an explanatory interview should it deem this necessary. Only after the ratification is granted will the above-mentioned organisational corporate acts be duly registered with the Board of Trade, thereby becoming valid before third parties.

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. During this third and last phase, which lasts between three and six months, the insurer submits to SUSEP the documents related to the products it intends to sell to the public at large (including the drafts of the general terms and conditions of each product, and the respective technical actuarial note or notes).

M&A involving local entities that comprise SNSP are also subject to the prior approval and ratification proceedings described above.

### iv 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).

It is worth noting that 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 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

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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 general 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.

v 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. Such 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. Currently, Brazil's biggest local reinsurer is still IRB.

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.

All types of reinsurers accredited to do business in Brazil must report to SUSEP periodically and – in the case of admitted and occasional reinsurers – renew their licences before such authority on an annual basis.

Resolution CNSP No. 168/2007 provides a limitation for risk cession between local insurers and reinsurers admitted to do business in Brazil. According to the current applicable regulatory provisions, local reinsurers have a pre-emptive right to underwrite at least 30 per cent of premiums assigned by local insurers in reinsurance transactions. This percentage will be gradually reduced as follows:

a to 25 per cent in 2018;

b to 20 per cent in 2019; and

c to 15 per cent in 2020.

The remaining portion may be reinsured by admitted and occasional reinsurers.
The regulation also determines that insurance companies may only assign 30 per cent of the premium of each considered coverage to foreign reinsurers that belong to its economic group. This limit will be gradually increased as follows:

\[ \begin{align*}
  a & \quad \text{to 45 per cent in 2018;} \\
  b & \quad \text{to 60 per cent in 2019;} \\
  c & \quad \text{to 75 per cent in 2020.}
\end{align*} \]

The objective of such regulation is to foster more competition in the Brazilian reinsurance market and align it with global practices and tendencies. Market experts predict that the increase in this limit will also lead to more investment in local reinsurance activities.

### vi Compulsory 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 Brazilian insurance market is not regulated by a single law or code, but is governed by several different types of legal documents, including the following:

\[ \begin{align*}
  a & \quad \text{the Civil Code (enacted by Law No. 10,406/2001), which dedicates an entire chapter to insurance contracts and the main principles that must govern the relationship between insured and insurer;} \\
  b & \quad \text{Decree-Law No. 73/1966, which is still in full force and effect, and which allows the regulation of this specific activity and market through regulations enacted by CNSP and SUSEP; and} \\
  c & \quad \text{Supplementary Law No. 126/2007, which sets forth the main rules for reinsurance and retrocession transactions in Brazil after dismantling IRB’s monopoly in this area.}
\end{align*} \]

Notwithstanding the above, given the adhesive nature of 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

According to the Civil Code, the main elements that have to be present in insurance contracts are the identification of the parties (insurer, insured, beneficiaries, policyholder, insurance taker), amount of the premium, details of the obligation to indemnify (claim notification and regulation rules), term of effectiveness, limit of liability and covered risks.
As a general rule, insurance coverage has to be contracted by means of the insured’s signature on a written proposal. Local regulation, however, already admits the contracting of policies through virtual channels via electronic signatures, provided that certain minimum conditions are met.

Automatic coverage renewal may also take place, but only once. Further renewal will depend upon express agreement by the parties.

At the time of placement, the applicable law and regulations demand the exchange of certain information between the insurance company and insured parties. This exchange of information must always be ruled by the principle of good faith in such a way that the necessary circumstances involving the risk and coverage are adequately explained to the respective counterparties. In this regard, should the insured party fail to provide the requested information (or omit relevant data), the insurance company may refuse to cover any claims that would otherwise be covered under the terms and conditions of the policy issued to the insured party.

The insurance company, in its turn, also 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.

As mentioned in Section II.iii, supra, the wording of any insurance product’s general and special terms and conditions (as well as its respective technical actuarial notes) must be submitted to SUSEP’s analysis prior to being distributed to the public at large. 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.

### 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 took place; and the principle of good faith of the contracting parties.

In addition to this general rule, the interpretation of insurance contracts is also 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 who adhered to such contract.

### iv Intermediaries and the role of the broker

The distribution of insurance contracts may be carried out either directly by the insurer or its agents (without using any broker or brokerage firm), or through an accredited insurance broker or brokerage firm.

According to Law No. 4,594/1964, insurance brokers are the only legally authorised intermediaries for the distribution and promotion of insurance contracts, policies and plans.
To conduct insurance brokerage activities, an individual or company needs to be previously accredited for such by SUSEP. The accreditation entails undergoing a procedure before such authority, in which the individual or firm will have to provide evidence that all the eligibility requirements for accreditation purposes have been duly met. In the case of brokerage firms, the above-mentioned requirements include the following: being headquartered in Brazil, having at least one officer who is an accredited broker and having insurance brokerage activities among the businesses listed in its corporate purpose. 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.

v Claims
Claim regulation procedures for payment of indemnifications 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 as 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).

IV DISPUTE RESOLUTION
i General remarks
Although the Brazilian insurance market has recently grown considerably, as yet 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 lengthy 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.

Owing to the current economic crisis, insurance companies are expected to be more stringent and rigorous in their claim regulation procedures. This most likely will result in an increase in the volume of litigation and arbitration procedures concerning insurance matters.

ii Litigation
Disputes involving insurance matters vary according to the underlying coverage.

Life insurance policies are considered extrajudicial enforcement instruments and, for this reason, provide grounds for the insured party to obtain the due indemnification through a simpler proceeding before the courts. This procedure does not require a court’s analysis of the rights of the parties; the objective of such procedure is simply to collect the due amounts.

When it comes to other types of insurance products, discussions will be carried out through a more time-consuming cognitive procedure. This procedure will assess the rights of the parties and, if necessary, courts will order the due payment of indemnification.
The New Civil Procedure Code (NCPC), 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 former court decisions by the superior courts binding; and making a decision in a single case the model for court decisions in cases that are similar.

The NCPC’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. This rationale is only applicable to cognitive procedures.

The defendant will only have to present its defence arguments after all conciliation alternatives have been unsuccessful. Parties shall have the opportunity to produce all necessary pieces of evidence, especially documents, expert reports and testimonies.

As mentioned above, decisions of the superior courts have also become binding on the lower courts. The objective of this innovation is to diffuse the typical aspects of common law systems that grant more legal certainty and predictability regarding court decisions, so that similar cases are decided the same way. The most significant change brought about by the NCPC is the mechanism for the resolution of similar cases. A judgment in one single case shall be taken as a model for court decisions for all other similar cases in the lower courts.

The courts are not specialised in insurance litigation to the extent that judges have very broad experience, and they are frequently geared towards civil and consumer protection law. In addition to this, there are countless procedures with similar circumstances. The standardisation of court decisions in this regard will avoid extensive discussions in every situation.

The Superior Court of Justice has recently been granting technical decisions involving insurance-related issues. Four decisions are worth mentioning:

a. the Consumer Protection Code shall only be applicable in situations where the covered assets are property of the insured. In cases where the damaged assets belong to a third party, the consumer relation is disregarded, in which case certain restrictions that would not be acceptable regarding consumers may be applied;
b. regarding civil liability insurance, the victim will be allowed to not only sue the party that caused the damage, but also to sue both the responsible party and its respective insurance company in a court proceeding seeking indemnification or reimbursement of losses incurred;
c. the total loss of the covered asset will not always result in the payment of the full limit of liability. The indemnification must be limited to the amount of the losses actually suffered by the insured party; and
d. as to life insurance products, the insured party and his or her beneficiaries will not be entitled to indemnification if a certain medical condition was deliberately not mentioned to the insurer prior to the policy being issued.

Such decisions evidence the fact that the courts are evolving in terms of insurance matters, although they have not yet reached the necessary level of sophistication of other jurisdictions such as the UK and the US.
Arbitration

Arbitration has gained a lot of attention in Brazil, as demonstrated by the development of arbitration chambers, specialised courses and lawyers focused on this practice. Recent adjustments to the applicable law have provided more solidity regarding this alternative dispute resolution mechanism.

The growth in popularity of arbitration is connected to the following:

a. it is a faster procedure;
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.

Sometimes parties resort to the courts to obtain urgency measures or to examine the regularity of the arbitration clause set forth in the underlying insurance policy.

Court decisions have recognised the validity of arbitration clauses for civil and commercial matters. Courts have challenged the mandatory inclusion of arbitration clauses when consumers are involved. In this situation, an arbitration procedure shall only be established if the consumers expressly agree to it. Otherwise, the matter will be decided by the courts.

In fact, SUSEP encourages those entities that belong to SNSP and operate big risk portfolios to include specific arbitration clauses in the general terms and conditions of this type of product.

Mediation

The use of mediation procedures has also grown in the past year. As stated above, a court procedure starts with the judge receiving a complaint and establishing a conciliation or mediation hearing. Nevertheless, Law No. 13,140/2015, applicable to mediation, also disciplines extrajudicial mediation.

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 such procedures have already begun, such procedures 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).

YEAR IN REVIEW

Important changes in Brazil's insurance and reinsurance regulation took place in 2016, and 2017 seems set to follow a similar pattern. The authorities are constantly seeking to improve
and adapt the country’s regulations to the reality of the market. In 2016, some of the main changes related to (1) the proceedings that need to be met for the organisation of local insurers, corporate restructuring transactions involving regulated entities, M&A activity, and election, appointment, dismissal and resignation of members of decision-making bodies of such regulated entities; and (2) directors and officers (D&O) insurance.

i  **Organisation, corporate reorganisations, M&A, and election and dismissal of managers and directors**

Resolution CNSP No. 330/2015, Circular SUSEP No. 529/2016 and Circular SUSEP No. 526/2016 considerably changed the rules for the organisation, corporate reorganisation and procedures related to the election, appointment, dismissal and resignation of members of decision-making bodies of SNSP-regulated entities, and became effective in March 2016.

ii  **Specific D&O insurance regulation**

Although D&O insurance has been offered to the public since the 1990s, Circular SUSEP No. 541/2016 is the first D&O insurance regulation enacted in Brazil. The main change arising from said normative act is the possibility of the insurance taker to take out specific coverage for losses arising from or incurred as a result of fines imposed to the insured individuals (which was previously not allowed). The regulation became effective in October 2016. Insurance companies have until 1 June 2017 to ensure that their D&O insurance products comply with Circular SUSEP No. 541/2016.

VI  **OUTLOOK AND CONCLUSIONS**

The current recession hit Brazil’s economy hard, and the insurance and reinsurance sector was the only segment of the economy that experienced growth between 2015 and 2016. In spite of the economic downturn that the country is still experiencing, market experts believe that there is still room for growth in this segment’s contribution to Brazil’s GDP. Growth will take place at a slower pace than that seen between 2002 and 2014, but there will nevertheless be growth. Key factors for such increase are:

a  clearer and less bureaucratic regulations for doing business in this segment;
b  a reduction in the regulatory restrictions in the reinsurance sector, enabling more participation by offshore reinsurers;
c  an increase in the demand for liability products given the country’s economic atmosphere (directors’ and officers’ liability insurance, errors and omissions insurance, civil liability insurance, engineering risks insurance, performance bonds insurance, etc.); and

d  new infrastructure construction stimulus programmes.

The above-mentioned changes are sufficient evidence that – in spite of the current pessimism surrounding Brazil’s economy – insurance and reinsurance activities still offer good business opportunities. Every year, the rules are being simplified, and are becoming more market-oriented and more open to foreign competition.

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7 Market experts are in negotiation with SUSEP to change some provisions of this regulation, but so far no amendments have been made.
Chapter 6

CAMBODIA

Antoine Fontaine

I INTRODUCTION

The insurance market in Cambodia is entering its fifth stage of development, although 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 and entered into force on 4 February 2015. Any references to the Law on Insurance in this chapter refer to the 2015 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, as the fast-growing banking industry required insurance to cover the assets provided as collateral. Until 2010, the market was limited to non-life insurance businesses (i.e., general insurance and reinsurance), but continued to maintain low retention rates.

1 Antoine Fontaine is a partner at Bun & Associates.
4 Cambodian Reinsurance Company Plc (Cambodia Re) (2002).
5 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.
6 Infinity General Insurance.
7 People & Partners Insurance Plc.
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, three others followed in quick succession, amounting to two in life and two in non-life. The two 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 their own network, selling to companies and factories, and retailing through mobile technology.

The first method consists of using the very wide network of micro-finance institutions (MFIs) to propose credit-life insurance by paving the way to the bancassurance activity. This approach was fruitful, but required some of the MFIs to obtain an insurance agent licence. The current regulation is absolutely not appropriate for this kind of distribution channel because of the low amount of commission distributed to the MFIs.

This strategy also generated something unexpected, it opened up 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 is also currently endangered by the National Social Security Fund (NSSF), which was recently put in place. 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.

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 the worldwide leader in insurance products operating here, using mobile technology for insurance distribution (i.e., Bima), micro-insurers are facing competition from other general insurance companies in this area.

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9 Figures are available at www.iac.org.kh/images/Market_statistics/General_Insurance_Market_Statistics_2010-2015.pdf. In 2015, property insurance counted for around 40 per cent of the market share (broadly driven by the banking sector), while auto, PA and health counted together for 35 per cent of the market share. Starting from scratch, despite a constant annual growth of 20 per cent, the total amount of premium remains low with almost US$89.2 million of gross premium in 2016. The main player is Forte with 47 per cent of the market share in 2016.

10 Mainly the GRET, through its SKI project (Sokopheap Krousar Insurance).


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: a new regulation (passed in 2014 but prepared in 2010), and the establishment of a state-owned life insurance company, which was recently privatised.

While non-life insurance companies, like other industries in Cambodia, remain mainly regional in their shareholding (including companies from 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, Prudential and AIA, while two Thai life insurers obtained their own licences.

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.

Insurance intermediation has grown very slowly. Until 2007, only one insurance agent and one insurance broker were duly registered. It is also the case that there were, until recently, unauthorised intermediaries (some unofficial, some official (e.g., banks)) because of the inconsistency between banking, and insurance regulations and practices. Since then, many banks, MFIs, new brokers and even telecommunication operators have been granted with insurance agent licences (although bancassurance status is still not clarified).
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 are also establishing 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 following are key assets of the Cambodian insurance market:

- Cambodia has an insurance penetration rate of only 3 to 5 per cent of the population, and its middle class is the fastest growing in the Association of Southeast Asian Nations (ASEAN);
- 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$113.6 million in 2016 compared to US$83.7 million in 2015);
- very few businesses subscribe to 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;
- 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;
- the MEF is offering this industry strong support by adopting a new set of regulations following the coming into force of the Law on Insurance, and in implementing its very ambitious Insurance Strategic Plan 2011–2020. As a matter of principle, the Law on Insurance provides that the MEF must ensure the sustainable development of the insurance industry, public interest and confidence in insurance services, consistency with the insurance core principles (ICPs), and protection of insureds’ interests. To this end, the MEF must strengthen the management and supervision of insurance businesses. It must also determine the management of operations in insurance businesses, and encourage competition, loyalty and transparency in the insurance industry; and
- more generally, the existing legal framework offers notable incentives that foreign investors might not be entitled to in neighboring countries. This includes 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.

Besides these opportunities and the government’s best efforts to promote the industry, this chapter shall examine some of the main concerns that actors are facing, mainly owing to the very recent, and sometimes not fully detailed, insurance regulation.

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

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23 0.5 per cent for life insurance as of the beginning of 2016.
24 Overall insurance coverage only amounted to 0.35 per cent of GDP 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 notably 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 has drastically increased its related sanctions. Underwriting insurance businesses without a licence will be fined 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, a period of one to five years of imprisonment, or both. Second, the Law allows for further sub-decree to provide exceptions for licensing, but for the time being there are none.

It also should be noted that the MEF requires a reinsurance company to have a Standard & Poor’s rating of at least AA+. Since this requirement is no longer really practical, the MEF is revising it. A former ministerial order required a rating of BBB+.

iii Distribution of product
According to the law, there are only two ways to distribute insurance products: through a duly licensed insurance agent or broker. The law does not mention the possibility of an insurance company’s staff distributing products, but the MEF has admitted it is permissible, 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.

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 businesses. However, this provision requires urgent clarification, as it seems to exclude micro-insurers from offering micro-health insurance, and further seems 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 currently not permitted to cover risks exceeding US$5,000 and exceeding a period of 12 months.\textsuperscript{25}

The Law on Insurance provides limited information on obtaining an insurance licence. It states that insurance companies are required to get a licence from the MEF, and imposes on the MEF a three-month time limit to decide on an application following the deposit of the required application form and supporting documents. In practice, it generally takes longer than this time limit. In addition, as indicated above, 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.\textsuperscript{26} 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.

It is worth noting that brokers, agents and loss adjusters are required to have a licence to operate.

Currently, the MEF is drafting a new ministerial order on the licensing of insurance agents and insurance brokers, which is expected to be adopted some time during 2017, 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.

The duration of the validity of a licence varies as follows:

\begin{itemize}
  \item[a] insurance company: five years for both the initial licence and renewed licences;
  \item[b] micro-insurance company: one year;
  \item[c] insurance agent: one year for both the initial licence and renewed licences;
  \item[d] insurance broker: one year for both the initial licence and renewed licences; and
  \item[e] loss adjuster: one year for both the initial licence and renewed licences.\textsuperscript{27}
\end{itemize}

\section{Compulsory insurance}

The former regulation mentioned three compulsory insurances (i.e., construction site insurance, motor vehicle third-party liability insurance for vehicles used for commercial purposes and 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.

\textsuperscript{25} Ministerial Order 009 MEF on the Issuance of a Temporary Licence for Microinsurance, dated 29 June 2011.
\textsuperscript{26} Article 113, Law on Insurance.
\textsuperscript{27} It is worth noting that a recent ministerial order dated 15 September 2015 provides a duration of five years for the 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, said licences are granted for three years, in compliance with a former ministerial order dated 23 November 2001, which should be abrogated.
In addition to these compulsory insurances, the Law on Insurance requires owners of motor vehicles (on roads or waterways) to subscribe to motor vehicle liability insurance. A sub-decree will determine the conditions. This compulsory insurance is not likely to be implemented anytime 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 all of 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 compulsory insurance: insurance brokers are required to subscribe to a professional liability insurance of US$500,000.28

### Taxation

Like many other countries, because of the economic specificity of insurance, in Cambodia, tax on profit consists of taxation at a rate of 5 per cent on the gross premium. The fact that the scope of this tax also covered the savings part of the premium clearly jeopardised the development of life insurance companies’ activities and bancassurance activities. The Law on Financial Management 2017 has brought a substantial change to the current tax regime by separating types of insurance, as opposed to types of general or life insurance company; risk and property insurance remain subject to the tax of 5 per cent on gross premium, while savings and other activities (that are not property or risk insurance, or reinsurance) shall be subject to the common tax on profit at the rate of 20 per cent. Actually, this change is far from an adequate solution. Indeed, the life insurer does not necessarily offer the option of solely saving policies; the life insurer can also offer term life, bodily injury and healthcare policies that are not substantially saving products. It is unclear whether the latest insurance policies will be deemed as risk and property insurance that will be subject to tax of 5 per cent on gross premium. Life insurers would be probably required to keep two separate accounts and file two tax returns. The MEF is expected to release a ministerial order in the near future implementing this change, but there are likely to be important challenges to its implementation and audit.

Insurance companies do not pay value added tax (VAT). However, practically it appears that part of the premium is subject to double taxation. For instance, insurance intermediaries, according to the current practice, are required to charge VAT on their commissions. Therefore, the insurance company cannot claim a VAT deduction. This non-deductible VAT will thus be included in the gross premium amount, and therefore also taxed at 5 per cent.

Further, 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 profit, VAT, tax on telecommunication). In addition to the 5 per cent tax on premium, insurance companies must pay a 0.5 per cent contribution to the MEF Insurance Industry Development Fund.

Changes in taxation on insurance intermediaries, which are expected soon, will mitigate the above-mentioned tax implications.

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28 Article 86.
It is worth noting that reinsurance premiums paid abroad were generally not subject to the 14 per cent withholding tax that is generally due for any payment abroad. 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, the new regulation seems to indicate that for the reinsurance premium not subject to the aforementioned 5 per cent tax, for example a life insurance product with saving, the insurance company must withhold 14 per cent on the reinsurance premium paid abroad, which is clearly excessive and even unfeasible.

A ministerial order on tax on profit for insurance companies is expected in 2017 to clarify the new Law on Financial Management.

vii Ownership

While there is no restriction on foreigners investing in insurance businesses, there is only one entity form available. An insurance company must be registered in the form of a public limited liability company. Surprisingly, an insurance company must have at least three shareholders, while 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.  The draft sub-decree on insurance should modify this unjustified requirement.

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.

eviii 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 comes 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. A further sub-decree will develop details of the process that are in the best interests of policyholders.

 ix Capital

The law on insurance provides a minimum capital of 5 million special drawing rights (SDRs) for general, life insurance or reinsurance companies. A further sub-decree 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:

- micro-insurance company (life or non-life): one-quarter of the amount of the underwritten premium with a minimum of 600 million riels;
- insurance brokers: 200 million riels;
- insurance agent and loss adjusters: 20 million riels.

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30 International Monetary Fund SDRs. As of 18 January 2017, 1 SDR = US$1.3557. The MEF practically considers the minimum capital required for life and general insurance companies to be equivalent to US$7 million.
x Solvency requirements

There are two kinds of solvency requirement, but these could be modified in light of the Law on Insurance since these requirements originate from a previous regulation.

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:

- insurance company: 10 per cent of the registered capital;
- insurance broker: US$50,000 (equivalent to the minimum capital); and
- insurance agent and loss adjustor: US$10,000.

Second, insurance companies must maintain a solvency margin as follows. 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.

For micro-insurance and life insurance companies, in addition to the 50 per cent solvency margin, the MEF requires such 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.

xi 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, approvals for distributions of dividends). Legal control generally consists of requiring prior MEF approval for many activities, including changes in memoranda and articles of association, products approval, and organisation of the distribution network. Economic control over the industry involves, *inter alia*, gathering data, issuing 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 decide on the complaint.

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, a provisional director may be appointed by the MEF to try to recover the company. However, if the company remains insolvent after the period of provisional governance, the insurance company may be liquidated voluntarily or through court proceedings.

The MEF may appoint a provisional director to attempt 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 make 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 certificate of authorisation from the MEF, the company must cease making new insurance contracts and must transfer existing contracts to other insurance companies before the start of the voluntary liquidation and dissolution of the company.

In the case of an insurance company’s insolvency, 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.

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 should 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.

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.

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

Regarding these standard requirements, it is worth pointing out that they 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 micro-insurance should officially authorise a paperless insurance policy. In addition, requiring the name of the beneficiary of a life insurance policy supposes that he or she is identified. Again, the future sub-decree will provide more details for life insurance products.

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.

Surprisingly, 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,32 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 non-compulsory group insurance policies. Without doubt, this issue will be clarified in a future sub-decree.

It should be noted that 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.

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32 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.
Finally, it is MEF practice to require the prior approval of insurance products, and the MEF’s Inspector may temporarily suspend the underwriting of any non-approved policies. This practice, which is absolutely understandable in a country experiencing new products, can create long delays.

A proposal for renewal or amendment of an insurance policy is deemed to be approved if the insurer has not refused such proposal within 15 days.

iii Interpreting the contract

General rules of interpretation

Currently, 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, since 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.

Type of terms in insurance contracts

The MEF is also very cautious regarding the Khmer language terminology that is used. The MEF is working on a glossary to ensure consistency among insurance policies, and should create pro forma clauses to avoid confusion.

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 the insurer to either assess the real value before covering the property, or to clearly state that it will not pay the declared value if this value is above the real value. In addition, this provision will lead to a simplification of claims when there is no independent loss adjuster.

iv Intermediaries and the role of the broker

In addition to the descriptions in Sections I, II.iii and III.ii, supra, regarding the distribution of products, there remain very few active insurance brokers and most of them received their licence very recently. However, with an insurance penetration rate of between 3 to 5 per cent among the Cambodian 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.
Apart from this, brokerage in Cambodia 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.\(^{33}\)

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 who 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.

The law provides for no payment of life insurance if the insured committed suicide.

Apart from that, all the procedures for dispute resolution will be determined by sub-decree.

The net rate ratio of claims was 21.26 per cent in 2015 for non-life activity.\(^{34}\)

### IV DISPUTE RESOLUTION

#### i Jurisdiction, choice of law and arbitration clauses

In Cambodia, 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).

Since compulsory liability insurance does not really exist, there is no set-off\(^{35}\) of mutual debts between insurance companies.

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.

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33. Article 637 et seq. Civil Code.
34. Last available data published by the MEF.
35. However set-off is legally possible by application of Article 464 et seq. Civil Code.
iii Arbitration

Even though a commercial arbitration centre has recently 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 (ADR)

The MEF does not have any ADR mechanism yet for insurance disputes. However, such mechanism may be adopted together with the arbitration mechanism. It is likely to follow the procedures for collective labour disputes in Cambodia, which provide for an internal mechanism to settle a dispute, then a conciliation procedure before the MEF, and finally a binding or non-binding award before specialised arbitrators.

V YEAR IN REVIEW

Several large life insurers have expressed interest in entering the Cambodian insurance market, including one of Japan's biggest life insurers,36 which contributed to 2016 being a fruitful year for insurance. The NSSF started to develop a health insurance and work injuries scheme for civil servants, which will cover illnesses, prenatal care and work-related injuries. This scheme is expected to become operational in 2017.

During the first half of 2016, total gross premium of general insurance rose to US$34.2 million, representing a 16.2 per cent year-on-year increase, while the life insurance sector saw an impressive 113.2 per cent year-on-year growth in premiums, according to the Insurance Association of Cambodia.

By the third quarter of 2016, the insurance industry had demonstrated steady growth with total gross premiums increasing to US$84.9 million, representing a 37 per cent increase compared with the same period in 2015. Over the same period, life insurance increased by 105 per cent, while general insurance grew by 15 per cent.

Finally, according to the Association of Southeast Asian Nations (ASEAN) Insurance Council's report presented during the 2nd ASEAN Insurance Summit held on 23 November 2016 in Yogyakarta, Cambodia had the highest growth rate of gross premiums among ASEAN countries in 2015, growing by 38.4 per cent, while total insurance premiums among ASEAN as a whole increased by 2.9 per cent during the same period.

VI OUTLOOK AND CONCLUSIONS

Cambodia is still in the early stages of developing its insurance market, but many positive changes are likely in the near future.

Many regulations will be passed during the next few years and the MEF will drastically improve the rules to promote the insurance industry, protect insurance customers and put in place reliable dispute resolution mechanisms.

These regulations will stem from the Insurance Sector Strategic Plan 2011–2020 of the MEF. In addition to regulations, this strategic plan comprises other ambitious steps:

- full compliance with the ICPs of the International Association of Insurance Supervisors by 2020;

36 Dai-ichi Life Insurance.
Cambodia

- setting up a dispute resolution office;
- establishing associations of life insurance companies, brokers and agents by 2018;
- establishing an independent insurance commission by 2020;
- putting in place a cooperation agreement with the National Bank of Cambodia to formulate the policy and guidelines on cross-sector insurance operations, which is expected to take place in 2017;
- expanding the promotion of insurance in Cambodia;
- establishing an insurance institute to offer specialised training on insurance by 2016, and to become an insurance research and development centre by 2020; and
- implementing an IT system to respond to the need to control the insurance market, which will be fully operational by 2020.

Thanks to the new Law and its upcoming implementing regulations, and the implementation of the Insurance Sector Strategic Plan 2011–2020, Cambodia will become one of the insurance markets to watch and one of the most active markets in the ASEAN in the next few years.

However many concerns remain, especially the following:

- the lack of human resources and of intermediaries, especially agents, loss adjusters and actuaries;
- the low use of insurance among the population;
- the tax system, especially that applicable to life insurance activities; and
- the methods to invest as an insurance company. An insurance company must use at least 75 per cent of its reserve funds created from insurance premiums for reinvestment in Cambodia. There are very limited options for investing in Cambodia. The stock exchange is still in its infancy; 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.
Chapter 7

CAYMAN ISLANDS

John Dykstra and Abraham Thoppil

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 of 31 December 2016, the Cayman Islands international insurance market reported total premiums of US$14.6 billion, with US$59.8 billion in total assets. The Cayman Islands is the leading jurisdiction for healthcare captives, representing almost half of all captives. Medical malpractice liability continues to be the largest primary line of business in the Cayman Islands with approximately 33 per cent of companies (re)insuring 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 21 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 the leading market for the formation and licensing of SPV insurers.

The commercial reinsurance market is an area seeing interest and growth. Together with a number of other factors, the introduction of a dedicated reinsurer’s licence (Class D) under the Insurance Law has helped facilitate this.

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 at Maples and Calder. 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;
- 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 such 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;

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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 (2016 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 Money Laundering Regulations (2015 Revision) 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 (SPCs)

Since 1998, the Companies Law has provided for the formation of 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:

- 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;
- 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 a period of not less than five years or without limit of time and either not expressed to be terminable by the insurer before the expiry of five years from the taking effect thereof or expressed to be so terminable before the expiry of that period only in special circumstances therein mentioned; and
- 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 (a) or (b).

vi Portfolio insurance companies (PICs)

The relevant provisions of the Law allowing SPCs to register subsidiary companies as 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 after 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.

It is expected that implementation of the PIC provisions will give SPCs greater appeal to smaller captive users and captive programme providers. 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.
vii 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.

viii 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.

ix 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 CIS100,000 or to imprisonment for a term of five years, or to both. In the case of domestic business, insurance brokers can be permitted by the Authority to place limited amounts of such 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.

x 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. Such 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

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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).
dispensation to an insurance broker for a fixed period (despite the duty of the insurance 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 such other figure as may be 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, supra, 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.

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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 Ltd and McLaughlin v. American Home Assurance Company.

In Zeller, the Court of Appeal upheld the judgment, applying the English authority Economides v. Commercial Union Assurance Co Plc 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 and not what he did in fact realise was so.

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. He thereby 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, 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 since it would not have induced the making of the contract on the relevant terms.

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.*, the court followed the view of Lord Goddard CJ in the English case of *Edwards v. Griffiths*, 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 currently no case law in the Cayman Islands that has confirmed the distinction between types of conditions and warranties in insurance contracts and thus the English common law remains of persuasive authority. One case considered the interpretation of a condition in a motor policy, namely *Jackson*, 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.

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

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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.
the Chief Justice. Commercial judges sit alone, without a jury. Where the assigned judge is unavailable, urgent applications may be heard or determined by another commercial judge. Visiting judges and senior lawyers from, in particular, England, Jamaica and Canada sometimes sit as acting judges.

Appeals from the Grand Court are to the Cayman Islands Court of Appeal (which usually sits three times each year). The ultimate appellate court is the Privy Council in England.

**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 but not limited to the power to trace and preserve assets; order discovery or preservation of documents; and the appointment of 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 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.

**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. It is expected that in interpreting the Arbitration Law the Cayman Islands courts will have regard to 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:

a the object of arbitration is to obtain the fair resolution of disputes by an impartial arbitral tribunal without undue delay or undue expense;

b 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

c 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.

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).
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, expert determination and early neutral evaluation are still relatively uncommon in the Cayman Islands.

YEAR IN REVIEW

The Cayman Islands continues to see an increase in the use of SPV insurers by commercial reinsurers accessing the capital markets to distribute reinsurance risk. This market first developed in the Cayman Islands in the mid-1990s and the Cayman Islands quickly became home to almost all catastrophe bond transactions. The Class C licence regime, aimed at SPV insurers such as cat bond issuers, is recognition of the fact that these transactions require a very different level of regulatory oversight, given the collateralised limited recourse nature of the payment obligations. In 2016, the Authority adopted new procedures to allow for audit waivers to be obtained in certain circumstances by Class C insurers, again in recognition of the unique nature of these products.

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. Licences are also being pursued for novel transactions that provide innovative solutions to the transfer of longevity risk.

OUTLOOK AND CONCLUSIONS

The recent overhaul of the insurance regulatory regime has had a positive impact on the insurance and reinsurance industry in the Cayman Islands. The government, working together with local service providers, is committed to facilitate industry growth. The efforts to date have yielded very positive results in the short term since the updated regime came into effect. Anecdotal evidence suggests the principal factors in play are Solvency II in other jurisdictions, the new regulatory regime in the Cayman Islands, the desire to find risk-adjusted returns and current insurance conditions (e.g., low annuity rates). Most recently, the Insurance Division of the Authority has set up specialised analyst teams to focus on complex reinsurance structures, and the application process for insurance-linked securities transactions that use a Class C insurance licence has been streamlined to ensure that licence applications can be processed within a matter of days.

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 jurisdiction.
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). 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. Life insurance companies, on the other hand, cover risks of persons or guarantee, within or upon termination of a certain term, capital, a paid-off policy or a rent for 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. 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 applied 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 Securities and Insurance Superintendency (SVS), and ranked at least within the BBB risk category or its equivalent.

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1 Ricardo Rozas is a partner at Jorquiera & Rozas Abogados.
2 Title XIII.
3 According to General Rule 197 issued by the Securities and Insurance Superintendency on 26 May 2006, 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 comply with the conditions set forth under the aforementioned rule.
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 SVS.

The foreign entities in (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 SVS who is deemed to represent the foreign reinsurance underwriters of the reinsurance contract for all legal purposes.

II REGULATION

i The insurance regulator
In Chile, the SVS 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 SVS 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 SVS. In addition, the branch offices must prove to the SVS 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

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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 SVS 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 for 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, SVS employees and stock brokers.

Notwithstanding the above, 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 SVS 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 a 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.

6 These regulations were recently amended, and DS 1055-2013 came into force on 1 June 2013.
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.);

b Title VII of Book III of the Code of Commerce, called 'About Marine Insurance' (Article 1158 et seq.);

c DFL 251, which regulates insurance companies;

d Supreme Decree 1055-2013;

e resolutions issued by the SVS; and

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

The provisions on general and non-marine insurance contained in the Code of Commerce were enacted almost 140 years ago and have not been revised since, 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) so that Chilean insurance law can finally be updated 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 in DFL 251. The New Insurance Law entered into force in December 2013.

ii 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 respond to an insurer’s request for information about a risk by honestly disclosing the information requested to allow insurers to identify the object of the insurance and assess the nature of the risk. For these purposes, it suffices that the insured reports exclusively as per the above-mentioned 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.

That said, 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, *supra*, 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 presumably 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 SVS. 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:

- a. identity of the insurer, insured and beneficiary (if applicable);
- b. insured matter;
- c. insurable interests;
- d. risks taken by the insurer;
- e. policy period;
- f. insured amount;
- g. value of the insured matter;
- h. premium;
- i. policy date and the insurer’s signature; and
- j. 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**

In Chile, 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.

**iv Intermediaries and the role of the broker**

Chilean 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.

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Insurance brokers

Insurance brokers are defined as natural persons or legal entities who have been registered as such with the SVS 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 SVS. In addition, insurance brokers are subject to a duty of providing information, and must notify the SVS of any change of their address registered with the SVS, 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 SVS. 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 SVS 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 SVS, 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 and comply with the following requirements:

a they cannot be registered as insurance brokers;
b 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
c 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.

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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.
**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 SVS. 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.

**Claims**

**Notification**

When any event that may constitute a loss occurs, the insured must notify the loss to the insurer or insurers 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**

Chilean 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. On the other hand, 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, any dispute must be settled in principle 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.
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, under Chilean law, 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 as of 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. Having said this, in Chile 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.

iii Arbitration

Format of insurance arbitrations

The Tribunal Code establishes the general rules for arbitration under Chilean law.9 These rules are complemented by the procedural rules contained under the Civil Procedure Code.10 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.

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9 Title IX, Articles 222 to 243.
10 Title VIII of Book III.
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.

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, where the parties have reached an agreement as to who the arbitrator should be, such arbitrator 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 (ADR)

Apart from arbitration, in Chile there are no other industry-specific settlement mechanisms. In addition, ADR is not much used in the context of insurance disputes.

v Mediation

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

V YEAR IN REVIEW

As of December 2013, Chile has new provisions on general and non-marine insurance contained in the Code of Commerce. These amendments were introduced with the aim of updating Chilean regulations to bring them in line with current trends and market practice. Among others, the New Insurance Law sets out some limited definitions of common insurance terms such as ‘insurance contract’, ‘deductible’, ‘endorsement’, ‘insurable interest’
and ‘warranties’. In addition, it expressly recognises different classes of insurance, and differentiates between ‘damage’ insurance (such as fire, theft or civil liability insurance) and ‘individual’ insurance (such as life insurance or income protection insurance). Furthermore, it has established that new provisions are mandatory unless they state otherwise and have changed the insured’s obligation to declare on the risk, which is now limited solely to what is required by the insurer. There are also new provisions dealing with validity, termination and aggravation of risks, insurer’s duties, subrogation, gross negligence and recklessness, multiple causes, co-insurance, reinsurance and fronting transactions. As regards litigation, insurers are now obliged to provide authorised copies of final arbitral awards to the Chilean regulator with the aim of improving the scope of jurisprudence available for parties to consider in the event of a dispute. Arbitral awards will not be binding, but this provision should improve certainty over policy interpretation.

The local adjusting regulations (Supreme Decree 863-1990) were replaced by new regulations (Supreme Decree 1055-2013) that came into force on 1 June 2013.

VI OUTLOOK AND CONCLUSIONS

The New Insurance Law appears to have two main aims: first, to bring statute law in line with modern insurance practice, and second, to provide consumers with greater protection. For the international insurance market, the amendments seeking to modernise the law may serve to provide greater certainty as to the rights and obligations of insureds, insurers and reinsurers. Modern insurance models were already part of doing insurance business in Chile. The new Law seems to be designed to reflect this reality.
I INTRODUCTION

China's 13th Five-Year Plan (the 13th Plan) was implemented in 2016. The Plan adopts national goals for the economic and social development of China from 2016 until 2020, during which the Chinese insurance industry will adapt to economic developments, carry out supply-side structural reform and establish a modern insurance service industry with competitiveness, creativity and energy. Following the introduction of the 13th Plan, the China Insurance Regulatory Commission (CIRC) published the outline of the Plan (the Outline) for the Chinese insurance industry in August 2016, setting up several goals related to reformation, innovation and regulation of the insurance industry. The Outline takes the role of setting the principles and guidelines for the development of insurance-related matters during the next five years from 2016.

On the background of the 13th Plan, the development of the insurance industry maintained its strong momentum in 2016. Following the principle that the insurance industry’s responsibility is to insure the property and life of common people, the Chinese insurance industry made a significant leap in 2016. China’s national premium income has increased from 1.4 trillion yuan in 2011 to 3.1 trillion yuan in 2016, with an annual growth rate of 16.8 per cent. The total assets of the insurance industry have increased from 6 trillion yuan in 2011 to 15.1 trillion yuan in 2016, with an annual growth rate of 20 per cent. The scale of the Chinese insurance market has already exceeded that of Germany, France and the United Kingdom, and has potentially surpassed that of Japan as the world’s second-largest insurance market in 2016. The risk guarantee provided for the whole of society has increased from 478 trillion yuan in 2011 to 2276 trillion yuan in the first three quarters of 2016, while compensation payouts have increased from 392.9 billion yuan in 2011 to 1.05 trillion yuan in 2016.

Based on the principle that the CIRC’s responsibility is to regulate, the Chinese insurance industry has endeavoured to avoid systemic risk. The number of insurance companies with substandard solvency has decreased from five in 2011 to three at the end of the third quarter in 2016. The net assets of the insurance industry have increased from 556.6 billion yuan in 2011 to 1.76 trillion yuan at the end of November 2016. From 2011 to 2016, the CIRC has investigated over 15,800 insurance institutes, imposing fines of 398 million yuan for insurance institutions and 80.15 million yuan for responsible individuals.1

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1 Zhan Hao is the managing partner of AnJie Law Firm.
There was a continued deepening of reformation and innovation in the insurance industry in 2016. The insurance regulator’s administration was further streamlined, and the powers of regulation were delegated from the central government to the lower levels. A pricing reform of insurance products was carried out, leading the market to play a decisive role in resource allocation. Insurance asset management has become market-oriented, and the scope of business has also expanded.

II REGULATION

In 2016, several new regulations were issued by the CIRC to press ahead with the reform and development of the insurance industry.

i The China Risk Oriented Solvency System (C-ROSS)

C-ROSS has completed a smooth transition and was formally implemented in January 2016. Since then, the CIRC has focused on solvency regulation with the purpose of maintaining adequate and stable solvency for the whole insurance industry. After the implementation of C-ROSS, the Integrated Risk Rating (IRR) system, which formulated a regulation mechanism with both quantitative and qualitative regulations, ran for the first time. The IRR system considers both the quantitative and non-quantitative risk of insurance companies for a comprehensive risk profile evaluation.

The CIRC also started supervision by the risk management ability assessment. Solvency Aligned Risk Management Requirements and Assessment (SARMRA) is the key method for improving company risk management ability, and promoting transformation and industrial upgrading. SARMRA has developed an incentive and constraint mechanism by combining risk management ability with capital requirements.

C-ROSS will improve solvency information transparency and market discipline by requiring insurance companies to disclose abstracts of solvency reports quarterly on their official websites and the Insurance Association of China website.

The first year of implementing C-ROSS has highlighted the risks of insurance companies, promoted industrial transformation, facilitated insurance market reformation and improved the international influence of the Chinese insurance industry. Currently, the solvency ratio of insurance companies is generally around 253 per cent, meaning that the overall risk of the insurance industry is manageable.

ii Regulation of internet insurance business

Internet finance is currently a hot topic in China, and an increasing amount of corresponding regulations have been issued to regulate this area. On 14 April 2016, the CIRC and 14 regulators published the Work Plan on Rectification of Internet Insurance Risk⁴ (the Work Plan). According to the Work Plan, rectification of risks focused on three aspects:

a Internet business with high cash value. The CIRC will investigate and rectify those insurance companies that sell insurance products online and give false descriptions, exaggerate the products’ performances in the past, unlawfully comment on profits or losses, or give other misleading descriptions.

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b Insurance institutions’ cross-border business that is conducted on the internet. The CIRC will investigate and rectify those insurance companies that carry out internet insurance business with third parties without business licences and cooperate with internet credit platforms in the business of providing credit services, establishing capital pools and raising illegal funds, etc., causing risk transfer to the insurance field, and those insurance companies with defective risk control measures or internal management during the process of operating guarantee insurance for users on internet credit platforms.

c Illegal internet insurance business. The CIRC will investigate and rectify those entities that carry out internet insurance business without relevant insurance licences, those internet enterprises that carry out insurance business on the internet without business qualifications in the name of a mutual plan, and those entities or individuals that raise illegal funds in the name of insurance companies or under the guise of insurance companies’ credit.

iii Administrative measures for indirect investment of insurance funds in infrastructure projects

In June 2016, the CIRC issued the Administrative Measures for Indirect Investment of Insurance Funds in Infrastructure Projects5 (the Administrative Measures), widening the industry scope of infrastructure projects subject to investment by insurance funds, and adding further modes of investment through cooperating with the government, and social capital (i.e., public-private partnership) and other feasible modes of investment.

In 2016, the number of insurance asset management products registered with the Insurance Asset Management Association of China was 152 – up by 25.6 per cent compared with 2015. Registered capital was 371.4 billion yuan, up by 17.3 per cent compared with 2015. The total number of insurance asset management products registered was 651, and registered capital was 1.6525 trillion yuan. The Insurance Asset Management Association of China established a national asset management information sharing platform, providing information to project-related entities and individuals. Currently, the platform has more than 360 institutional users and has launched more than 1,600 projects, with an investment scale of 3.9205 trillion yuan.6

III INSURANCE AND REINSURANCE LAW

i Sources of law

Since China is a continental law country, the sources of law are statutory codes. In China, the sources of insurance law mainly consist of:

a the PRC Insurance Law;

b 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 CIRC and other relevant government institutions.

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6 Data available at www.sinoins.com/zt/2017-01/01/content_218297.htm.
Making the contract

The PRC 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 PRC Insurance 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 PRC Insurance 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 PRC Insurance Law, an insurance contract shall contain the following particulars:

- 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.
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

In China, insurance intermediaries include insurance brokerage institutions, insurance agencies and insurance assessment institutions. China has adopted the Provisions on the Supervision and Administration of Insurance Brokerage Institutions, the Regulatory Provisions on Professional Insurance Agencies and the Provisions for the Regulation of Insurance Assessment Institutions to regulate insurance brokerage institutions, insurance agencies and insurance assessment institutions. The conduct rules for insurance brokerage institutions and insurance agencies are explained here in detail.

In China, insurance brokerage institutions 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 institutions 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, the establishment of an insurance brokerage company shall meet the following conditions:

a shareholders, promoters and sponsors shall have a good reputation, and shall have no record of major irregularities in the immediately preceding three years;
b the registered capital shall reach a minimum requirement or specified quota as mentioned in the Chinese Company Law and its provisions;
c the articles of association shall comply with the relevant provisions;
d the chair of the board of directors, the executive director and senior management shall comply with the qualifications specified herein;
e the company shall have a sound organisational structure and management system;
f the company shall have a fixed domicile commensurate with the scale of its business;
g the company shall have business, financial and other computer hardware and software facilities commensurate with its business; and
h other conditions specified in laws, administrative regulations and provisions of the CIRC.

The same conditions apply for a professional insurance agency. In addition, practitioners in these companies should gain a qualification for practising by taking qualification examinations organised by the CIRC.

An insurance brokerage institution may engage in the following insurance brokerage business:

a drafting insurance application proposals, selecting insurance companies and handling the insurance application formalities for insurance applicants;
b assisting 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 CIRC.

To engage in insurance brokerage business, an insurance brokerage institution shall 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 CIRC.

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

An insurance brokerage practitioner shall present the client notification letter to a client and, at the request of the client, explain the manner of collection and the rate of commissions. An insurance brokerage institution shall also inform a client 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, \textit{inter alia}, liability exemptions or exceptions, surrender, deduction of other expenses, cash value and cooling-off period.

A professional insurance agency may engage in the following insurance agency business:
\begin{itemize}
  \item[\textit{a}] selling insurance products as an agent;
  \item[\textit{b}] collecting insurance premiums as an agent;
  \item[\textit{c}] conducting damage surveys and claim settlements for the relevant insurance business as an agent; and
  \item[\textit{d}] other business approved by the CIRC.
\end{itemize}

To engage in insurance agency business, a professional insurance agency shall 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 CIRC.

A professional insurance agency shall prepare a standard client notification letter and present it to the client while conducting business. The client notification letter shall, 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 institution, this shall be explained in the client notification letter.

A professional insurance agency shall also clearly alert an insurance applicant of the clauses in the insurance contract regarding, \textit{inter alia}, liability exemptions or exceptions, surrender, deduction of other expenses, cash value and cooling-off period.
v Claims
Under the PRC 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 shall 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 shall assess the claim in a timely manner. If the circumstances are complex, the insurer shall complete the assessment within 30 days, unless otherwise agreed upon in the insurance contract. The insurer shall notify the insured or beneficiary of the assessment result. For a claim that falls within the insurance coverage, the insurer shall perform the obligation of paying the indemnity within 10 days 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 shall 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, make a compensation for the insured's or beneficiary's loss suffered therefore.

In cases where an insurer cannot determine the amount of indemnity to be paid within 60 days after receiving a claim for indemnity and the relevant certificates and materials, it shall first pay the amount that could 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 a dispute's amount and the influence of the case.

Generally speaking, the primary courts act as the first instance court 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 of the People's Republic of China, 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 of the PRC, Chinese law shall apply to civil activities within the PRC, except as otherwise stipulated by law. According to Article 3 of the PRC Insurance Law, this Law shall also govern insurance activities conducted within the territory of the PRC.

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, PRC 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 of the People’s Republic of China states that an arbitration agreement shall 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.

Therefore, such arbitration 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 dispute resolution clause and refuse arbitration, thus resulting in the dispute finally being resolved by litigation.

**ii Litigation**

Pursuant to Article 26 of the PRC 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 PRC Civil Procedure Law and Interpretation of the Supreme People’s
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Court on the Application of the Civil Procedure Law of the People’s Republic of China will be applied. The court shall complete trials of first instance cases within six months. The court shall complete trials of appeal cases against a judgment within three months after such appeal is docketed, but for an appeal case against a ruling, the court shall issue a final ruling within 30 days after the appeal is 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 shall be binding. The remedy for a binding judgment and verdict is legal review, but the legal review 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 of the People’s Republic of China 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 shall 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 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 will conduct this system.

Pursuant to the Notice, the courts in the pilot regions may, 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. The rules on the administration of registers shall be improved and complete, and accurate information on mediation organisations and mediators shall be provided to parties to insurance disputes for their voluntary choice. The work platform for the link-up of a court’s litigation and mediation shall be put into full play. Where conditions permit, the courts may 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 shall, under the precondition of respecting the parties’ will and in accordance with the relevant provisions of the Several Opinions of the Supreme

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7 No. 116 [2012] of the Supreme People’s Court.
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.

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 such mediation 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 shall have enforceability.

V YEAR IN REVIEW

On 30 December 2016, the CIRC promulgated a notice to solicit public opinions on the Measures for the Equity Management of Insurance Company (Draft for Comments) (the Draft Measures). To facilitate the safeguarding function of insurance, the Draft Measures contained material changes compared with the former version. It established a stricter standard for the admission of financial shareholders, strategic shareholders and controlling shareholders respectively. Additionally, it strengthened regulation on equity structure and shareholders of insurance companies by decreasing the percentage of shares held by a single shareholder to no more than one-third of the total share capital of the insurance company. Furthermore, the CIRC placed more emphasis on examination and accountability, including prior information disclosure, limitation of shareholders’ rights and restriction of shareholders’ activities, among others.

Besides this, with the promulgation of the Information Disclosure Standards for Insurance Companies on the Use of Funds No. 4: Large Investments in Unlisted Shares and Large Real Estate Investments, and the Notice of China Insurance Regulatory Commission on Further Strengthening the Information Disclosure of Affiliated-party Transactions by Insurance Companies, the CIRC increased the attention to be paid to information transparency of insurance funds investment and major investments by large insurance companies.

Notwithstanding the above, ever-increasing trend towards stricter regulations, in 2016, the Chinese insurance industry experienced a year of innovation and reform. In June 2016, the Shanghai Insurance Exchange Co, Ltd (SHIE) held an opening ceremony in Shanghai, announcing its official operation. SHIE was approved by the State Council in November 2015. After preparing for half a year, SHIE obtained the CIRC’s approval granting commencement and completed company registration in 2016. SHIE’s business scope is to provide facilities and services, and formulate related rules for insurance, reinsurance, asset management products and their derivatives.

The CIRC officially approved the establishment of Zhonghui Property mutual insurance association, Waysmos construction mutual insurance association, and Xinmei Life...
mutual insurance association in June. Mutual insurance is one of the world’s traditional insurance models, with a long history. With the recent approval of the first three mutual insurance associations in China, the Chinese insurance industry takes a further creative step towards a multi-level insurance market system.

China Life Insurance (Group) Company (China Life) established the first international representative office in London in November 2016. Having also established subsidiaries in Hong Kong, Macau and Singapore, China Life reached full achievement of its overseas layout. Considering that London is an international financial centre, future cooperation and communication between the Chinese insurance industry and European companies will be further enhanced by this development.

On 3 March 2016, the CIRC published a notice cancelling the required 15 intermediary services (e.g., capital verification service, notarisation service) that used to be preconditions for the administrative examination and approval of, including but not limited to, the establishment of insurance brokering institutions, insurance assessment institutions, insurance agencies, insurance companies and their branches, and the termination, dissolution or bankruptcy of insurance companies. Such a move by the CIRC was in accordance with the transformation of government functions and reformation of the administrative examination and approval system.

Although 2016 saw stricter regulation of the insurance industry by the regulators, a review of the major events in 2016 demonstrates that the year was also one of reform, innovation and development for the Chinese insurance industry. The insurance 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 2017 will play an important linkage role towards achieving the goals of the 13th Plan. Based on the idea proposed by the CIRC that ‘the main function of the insurance industry is to insure, the main function of CIRC is to regulate’, 2017 will see the intensifying of insurance regulation, 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 serves 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 10

COLOMBIA

Neil Beresford and Raquel Rubio

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 into the industry. Despite a challenging 2016 that included the country’s worst drought in decades, a 42-day nationwide lorry drivers strike, and a tight fiscal situation, the industry has continued to grow steadily at 11 per cent up to November 2016. A premium growth of between 9 and 10 per cent is expected in 2017.

Following this trend, since 2010 the Colombian legal system has undergone a very substantial process of improvement to satisfy the growing demand in business. A gradual review of financial regulation has been advanced since 2010, including measures to lower the barriers for foreign insurers and brokers entering the market, strong consumer protection laws and stricter regulation of distribution channels, all of which will lift the industry’s domestic reputation and stimulate local demand. Dispute resolution procedures have been fundamentally improved by the introduction of an arbitration law in October 2012 and a new Civil Procedure Code is now fully in force.

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.

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5 Article 325 Decree 663/93 EOSF.
The main regulatory framework is contained in the Organic Statute of the Financial System (EOSF),6 and other regulations including:

- Decree 2555/2010, which sets reserve and minimum asset requirements and contains the regime applicable to insurance intermediaries;
- Law 1328/2009, which regulates access to the Colombian market by foreign non-domiciled insurers and contains consumer protection rules specific to financial products;
- Law 1480/2011 on general consumer protection;
- 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
- the Commercial Code.

ii Position of non-admitted insurers

Unregulated insurance and reinsurance activity is prohibited in Colombia.7 Contracts made with unauthorised entities are void and the unauthorised insurer may be required to return all premiums received.8 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, certain policies must be purchased from a regulated entity within Colombia:9

- insurance that is compulsory under Colombian law or is contingent upon compulsory coverage;
- insurance in the nature of social security such as life insurance, annuities and employers’ liability insurance; and
- insurance issued to state entities.

iii Requirements for authorisation of insurers

Following a major reform in July 2013, Colombian law now allows 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 public limited company or a cooperative association;\textsuperscript{10}
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;\textsuperscript{11} and
c. in addition to its minimum capital, the proposed entity must maintain assets,\textsuperscript{12} a solvency margin\textsuperscript{13} and minimum reserves\textsuperscript{14} 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.

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{15}

a. minimum capital, which must be paid immediately upon the establishment of the branch office;
b. minimum assets located in Colombia; and
c. the presence of a permanent local representative with professional credentials and moral standing.

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.

Marine and aviation transport (MAT) insurance

Foreign insurers may issue transportation policies, known as 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{16}

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

\textsuperscript{10} Article 53 EOSF.
\textsuperscript{11} Articles 80 and 81 EOSF.
\textsuperscript{12} Article 2.31.1.1.1 of Decree 2555/2010.
\textsuperscript{13} Title IV of Part 2 of External Circular 029/2014.
\textsuperscript{14} Article 186 EOSF and Title 1 Chapter 2 of Book 31 of Decree 2555/2010 (as modified by Decree 2954 of 2010).
\textsuperscript{15} Articles 65 and 66 of Law 1328/2009.
\textsuperscript{16} Article 61 of Law 1328/2009.
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{17}

**Agricultural insurance**

Foreign insurers may also issue agricultural insurance policies\textsuperscript{18} by applying to the FS for a place on the Register of Foreign Insurers and Brokers of Agricultural Insurance. The principal requirements are similar to those that apply to MAT insurers, as set out above.\textsuperscript{19} Currently the government subsidises between 60 and 80 per cent of individual agricultural insurance premiums through its Finagro programme.\textsuperscript{20}

**Foreign reinsurers**

Foreign entities may transact reinsurance business in Colombia.\textsuperscript{21}

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.\textsuperscript{22}

**Representative offices 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.\textsuperscript{23} Representative offices are subject to the control and supervision of the FS.

iv **Position of brokers**

To operate in Colombia, insurance and reinsurance brokers must be authorised and regulated by the FS.\textsuperscript{24}

**Incorporated entities**

If a broker wishes to incorporate in Colombia, it must satisfy the following principal requirements:

\begin{itemize}
  \item If the proposed entity is an insurance broker, it must be incorporated as a limited company or general partnership.\textsuperscript{25} If a reinsurance broker, the proposed entity may be structured differently.\textsuperscript{26}
\end{itemize}

\begin{enumerate}
\item \textsuperscript{17} Chapter V, Title II of Part I of External Circular 029/2014.
\item \textsuperscript{18} Article 74 of Law 1450/2011.
\item \textsuperscript{19} Chapter IV, Title II of Part I of External Circular 029/2014..
\item \textsuperscript{21} Article 94 EOSF.
\item \textsuperscript{22} Chapter III, Title II of Part I of External Circular 029/2014.
\item \textsuperscript{23} The list is specified in Article 4.1.1.1.4 of Decree 2555/2010.
\item \textsuperscript{24} Article 1351 of the Commercial Code.
\item \textsuperscript{25} Article 1347 of the Commercial Code.
\item \textsuperscript{26} Article 44.1 EOSF.
\end{enumerate}
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 at least two years’ experience as managing director, consultant or other relevant functionary in the insurance sector.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 wordings, 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 in Colombia 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 Colombian legislature frequently adds new mandatory insurance requirements affecting different sectors. Recent developments include a bill requiring compulsory building guarantee insurance and liability policies for certain types of dangerous dogs.34

27 Article 2.30.1.1.3 of Decree 2555/2010.
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 of Decree 2555/2010.
34 Law 1796 of 2014 and Law 1801 of 2016, Article 127.
viii 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.\(^{35}\) 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.\(^{36}\)

Colombian 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.

ix Other notable regulated aspects of the industry

The FS must be notified of any proposed merger or acquisition involving a regulated entity;\(^{37}\) or transaction by which an investor will acquire 10 per cent or more of a regulated entity.\(^{38}\) The FS may object to such transactions for technical reasons\(^ {39}\) or for the protection of the public interest. A transaction made without the approval of the FS is void.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Colombian law is a civilian system with codified laws and a written political constitution.

Colombian 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.\(^ {40}\) 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.\(^ {41}\) Recently, 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.\(^ {42}\)

\(^ {35}\) Articles 8 and 13 of Law 1328/2009.
\(^ {36}\) See Article 57 of Law 1480/2011 and Article 24 of Law 1564/2012.
\(^ {37}\) Article 56 EOSF and Decree 2838/2013 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 1036 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 a proposal form is used, 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.

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 cancel the policy or vary its terms. If the risk has decreased, the insurer is legally obliged to reduce the premium. If no notification is made, the contract is terminated automatically upon the increase in risk.

43 Article 1083 Commercial Code (CCo). With the exception of one’s own life in cases of life insurance (Article 1137 of the CCo).
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.
49 Article 1060 CCo.
50 Article 1065 CCo.
Recording of the contract

Insurers must issue written policy documentation within 15 days of concluding the agreement. 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.

The proposal form and any attachments to it are considered part of the policy.

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.

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. 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. 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, a principle that is applied rigorously in the context of consumer insurance.

Mandatory rules

The parties to an insurance contract enjoy a relatively wide freedom to set the terms of the agreement, subject to the limits of public policy and the mandatory rules of Colombian law.
Colombia

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.\(^{60}\)

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;\(^ {61}\)

b if a policy is issued for the benefit of multiple insured parties with different interests (e.g., a directors and officers policy), non-disclosure by one insured party will not affect the validity of the coverage issued to others;\(^ {62}\) 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.\(^ {63}\)

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; \(^ {64}\)

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; \(^ {65}\)

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; \(^ {66}\) and

d either party may effect cancellation by giving notice in writing although, in the case of cancellation by the insurer, 10 days’ notice is required.\(^ {67}\) Following cancellation by either party, the insurer must return the unused part of the premium. \(^ {68}\)

The most important mandatory rules that affect the claims process are as follows:

a 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.\(^ {69}\)

\(^{60}\) Article 899 CCo.

\(^{61}\) Article 1058 CCo.

\(^{62}\) Article 1064 CCo.

\(^{63}\) Article 1091 CCo.

\(^{64}\) Article 1068 CCo. Note that different rules are applicable to life insurance policies, pursuant to Article 1151 CCo.

\(^{65}\) Article 1065 CCo.

\(^{66}\) Article 1093 CCo.

\(^{67}\) Article 1071.

\(^{68}\) Ibid.

\(^{69}\) Article 1078 CCo.
b 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;\textsuperscript{70}
c in the case of double insurance, each insurer is required to pay a rateable proportion if
the insured has acted in good faith;\textsuperscript{71} and
d the insured will forfeit its right to indemnity if it acts in bad faith during the claims
process.\textsuperscript{72}

The most important mandatory rules affecting the settlement of claims are as follows:

\begin{itemize}
  \item[a] 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;\textsuperscript{73}
  \item[b] if the insured incurs genuine mitigation costs, the insurer is required to pay the costs
  even if they exceed the sum insured;\textsuperscript{74} and
  \item[c] 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.\textsuperscript{75}
\end{itemize}

\textit{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 in three propositions:

\begin{itemize}
  \item[a] 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.\textsuperscript{76}
  \item[b] Other conditions precedent are positively reinforced by mandatory rules. For example,
  Article 1068 CCo contemplates that an insurer may make the payment of premium a
  condition precedent to its liability.
  \item[c] 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.
\end{itemize}

\textsuperscript{70} Article 1075 CCo.
\textsuperscript{71} Article 1092 CCo.
\textsuperscript{72} Article 1078 CCo.
\textsuperscript{73} 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.
\textsuperscript{74} Articles 1074, 1079 and 1089 CCo.
\textsuperscript{75} Article 1131 CCo.
\textsuperscript{76} Article 1078 CCo.
Warranties
The law defines a warranty as:

[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.\textsuperscript{77}

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{78} 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.

iv Intermediaries and the role of the broker
Agents and brokers
Colombian law recognises two types of insurance intermediary: agents and brokers. 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 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. From July 2017 all agents will be required to register with the Insurance Intermediaries Registry\textsuperscript{79} and undertake a training course before they are allow to offer their services to the public.\textsuperscript{80}

\textsuperscript{77} Article 1061 CCo.
\textsuperscript{78} Articles 1074, 1079 and 1089 CCo.
\textsuperscript{79} Circular No. 50 of 28 December 2015.
\textsuperscript{80} Section 7, Chapter II, Title IV, Part II, Circular 029 of 2014. As modified by Circular No. 50 of 2015.
A broker, on the other hand, is formally independent of either party to the transaction. Their role is defined in the following terms:

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.\(^{81}\)

As a result of this privileged legal status, claims against brokers are rare. It is also worth noting that only reinsurance brokers are required to carry professional indemnity insurance.\(^{82}\)

**Code of conduct**

All regulated intermediaries are subject to the same code of conduct that applies to regulated entities in general.\(^{83}\) 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.\(^{84}\)
\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.\(^{85}\) The commission falls due as soon as the insurance contract is signed.\(^{86}\)

**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.\(^{87}\) Second, duties of notification cannot be made conditions precedent to an insurer’s liability.\(^{88}\)

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.\(^{89}\)

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\(^{81}\) Article 1340 CCo.

\(^{82}\) Article 2.30.1.4.4 of Decree 2555/2010.

\(^{83}\) Article 72 EOSF.

\(^{84}\) Article 207.3 EOSF.

\(^{85}\) Article 2.30.1.1.4 of Decree 2555/2010.

\(^{86}\) Article 1341 CCo.

\(^{87}\) Article 1075 CCo.

\(^{88}\) Article 1078 CCo.

\(^{89}\) Article 1081 CCo.
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, which oblige the insured to mitigate loss and oblige the insurer to meet the reasonable costs of mitigation, even if they exceed the eventual limit of indemnity. Save in the case of subrogation, Colombian 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.

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, or the insured may bring the insurer into litigation by issuing a form of third-party notice known as a ‘call-in-warranty’. Both possibilities are legally viable.

In contrast, a reinsurer can be sued only by the reassured: it is not legitimate for a third party or an original insured to bring proceedings directly against a reinsurer.

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. However, for policies with a sum insured in excess of a determined threshold (currently US$4.5 million) the payment period can be extended by agreement up to 60 working days.

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. 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.

90 Article 1074 CCo.
91 Article 1079 CCo.
92 Article 1098 CCo.
93 Article 1078 CCo.
94 Article 1133 CCo.
95 Article 1135 CCo.
96 Article 1080 CCo.
97 Article 185.1 EOSF.
98 Article 1096 CCo.
99 Article 1099 CCo.
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.\(^{100}\) Policies issued outside Colombia may be subject to foreign law and jurisdiction.

ii Litigation
The Colombian judicial system is divided into four jurisdictions: ordinary, administrative, constitutional and special.\(^{101}\) 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.\(^{102}\)

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.\(^{103}\)

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 and military functions.

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 174th in a survey of 189 countries.\(^{104}\) 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.

\(^{100}\) Article 869 CCo.
\(^{101}\) Article 11 of Law 270/1996.
\(^{102}\) Law 1564/2012. Implemented through agreement PSAA1510442 of the Judicial Branch Administrative Council.
\(^{103}\) Law 1437/2011.


**Litigation stages**

Commercial cases in Colombia 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.\(^{105}\)

b. If mediation is unsuccessful, the claimant must file a formal complaint\(^ {106}\) 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.\(^ {107}\)

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 recent legislative reform,\(^ {108}\) parties may now 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, but are not limited to: statements of the parties, confession, oath, witnesses, expert opinion, judicial inspection, documents, circumstantial evidence and reports.\(^ {109}\) 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\(^ {110}\) in their local Colombian consulate by a procedure involving letters rogatory. However, this is an intricate process, which can take several months to negotiate.

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106 Articles 82 to 84 of Law 1564/2012.

107 The content of the answer is determined by Article 96 of Law 1564/2012.

108 Article 227 of Law 1564/2012.

109 Article 165 of Law 1564/2012.

110 Articles 171 and 182 of Law 1564/2012.
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.

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.\(^{111}\)

### Rights of appeal

The law guarantees that judicial decisions have two instances: a first instance decision and a right of appeal.\(^{112}\)

An appeal must be notified either orally at the judgment hearing or in writing within three days after service of the first instance decision.\(^ {113}\) In exceptional circumstances, a direct right of appeal to the Supreme Court or the Council of State may exist.\(^ {114}\)

### The duration of proceedings

As explained above, delay is a significant and continuing problem. The new procedural rules state 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.\(^ {115}\) It remains to be seen whether this objective will be achieved.

### 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 form consumer contracts are likely to be struck down as abusive.\(^ {116}\)

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112 Article 9 of Law 1564/2012.
113 Article 322 of Law 1564/2012.
114 For the ordinary jurisdiction, see Article 333–351 of Law 1564/2012. For the administrative jurisdiction, see Law 1437/2011.
115 Law 1395/2010 and Article 121 of Law 1564/2012.
116 Article 43.12 of Law 1480/2011.
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.\(^{117}\) The parties may also submit an active dispute to arbitration by way of a submission agreement.\(^{118}\)

The relevant elements to take into account when drafting an arbitration clause or a submission agreement are as follows:

- Whether the arbitration is a domestic or international arbitration and, if the latter, the applicable law and jurisdiction;
- Whether the arbitration will be *ad hoc* or institutional and, if the latter, which arbitration centre should be used;
- The number of arbitrators and the method of appointment; and
- Whether the tribunal should decide according to law or equity.

**Jurisdiction and choice of law**

As indicated, Colombian insurance policies are subject to the mandatory application of Colombian law\(^{119}\) 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.\(^{120}\)

An arbitration will be international if any of the following conditions are met:\(^{121}\)

- At the time of entering the arbitration agreement, the parties had their places of business in different states;
- The matters in dispute relate to international trade;
- A substantial part of the contract is performed outside the state in which the parties have their places of business; or
- 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.

International arbitrations tend to be referred to the International Chamber of Commerce or the International Centre for Dispute Resolution.

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117 Article 4 of Law 1563/2012.
118 Article 6 of Law 1563/2012.
119 Article 869 CCo.
120 Articles 92 and 101 of Law 1563/2012.
121 Article 62 of Law 1563/2012.
Ad hoc and institutional arbitration

Unless the arbitration agreement provides expressly to the contrary, domestic arbitrations are deemed to be institutional, 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. Moreover, the procedural rules of ad hoc arbitration are the same as those that apply to institutional arbitration.

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$85,000 it will be heard by only one.

In domestic arbitration, each of the arbitrators must be a Colombian-qualified lawyer with a valid practising certificate. 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. 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.

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.

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.130

c If the defendant to the arbitration is a state entity, the arbitration centre must notify the Agency for the Defence of the State131 of the existence of the claim.132 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.133

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:134

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.

The procedure to be followed for making an appeal is to ask the tribunal to clarify the perceived errors135 and then to ask the tribunal itself to annul the award136 before approaching the relevant court.137

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$200,000 and up to half of this for the secretary’s fees.138 In theory, the parties

130 Article 30 of Law 1563/2012.
132 Article 12 of Law 1563/2012.
133 Article 25 of Law 1563/2012.
134 Article 41 of Law 1563/2012.
135 Article 39 of Law 1563/2012.
136 Articles 40–43 of Law 1563/2012.
137 Article 45 of Law 1563/2012.
138 Article 26 of Law 1563/2012.
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 arbitral 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.  

iv Alternative dispute resolution (ADR)
Mediation and third-party adjudication are both recognised by law. As has been mentioned in subsection ii, supra, mediation is a mandatory step before accessing the courts. Agreements obtained through ADR are binding on the parties and enforceable before a judge.

V YEAR IN REVIEW
The most significant feature of 2016 was the continued growth of the industry despite the tough economic environment. The internal regulatory regime has been 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. A rule requiring that mortgage-related life insurance should be subject to bids significantly benefited consumers by increasing competition and leading to lower prices. The regulator has also tightened the standards for insurance intermediaries and actuaries to improve transparency and consumer protection.

The local 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, local currency devaluation and higher than expected inflation.

There are signs of market consolidation taking place, hence the inflow of new entrants has slowed down. For example, the merger of Ace and Chubb was authorised by a Colombian regulator, giving way to a new company Chubb Seguros Colombia SA. Equally, on 1 August 2016, Suramericana completed its acquisition of Royal & Sun Alliance, and consolidated its place as the largest company in the country, and one of the 10 largest in Latin America. New entrants include BMI life insurance, and Fairfax Financial is due to acquire all of AIG assets in the country.

139 Articles 16–22 of Law 1743/2014.
142 Financial Superintendence, Circulars 049, 050, 051 and 052 of 28 December 2015.
143 Finance Superintendence Resolution No. 1173 of 16 September 2016.
144 Caracol Radio, 2 of August 2016, ‘Suramericana de seguros consolidó el control total de RSA en Colombia’.
Throughout the year, the stability of compulsory vehicle liability insurance was compromised owing to chronic evasion and fraud. This line of business represents 9.4 per cent of total premiums in the market; however, it could be higher because of an evasion rate of 38 per cent and an exponential increase in losses in certain regions, only explained by fraud. Insurers are pushing for a change in the method used to set premiums and increased claims control by authorities to fend off fraud.\textsuperscript{146}

The rate of growth of 11 per cent in premium sales was led by social security (22 per cent), life insurance (10 per cent), and commercial and regulated lines (6 per cent). For example, health and safety risks policies and disability were boosted by low unemployment and tax breaks on employers. The sales of surety and infrastructure related insurance, which saw a 20.3 per cent drop from the previous year.\textsuperscript{147}

VI OUTLOOK AND CONCLUSIONS

On a technical level, the main areas of focus in 2017 and beyond are likely to be:

- the continued efforts of the FS to meet international standards and consolidate risk-based supervision methodologies through the gradual implementation of Solvency II regulations and International Financial Reporting Standards;\textsuperscript{148}
- consumer protection and review of abusive wording;\textsuperscript{149}
- tighter control over financial groups and their holding companies;\textsuperscript{150} and
- widening of the consumer base and financial inclusion of the lower-income population.

Commercially, the challenge is to raise the reputation of the industry. Colombians continue to regard insurance as an expensive luxury; 24 per cent consider insurance as a waste of money and therefore penetration levels continue to be low. Insurers, intermediaries and the government are working hard to raise the profile of consumer rights, and highlight the advantages of insurance cover.

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, although this is slower than in previous years. The Colombian market is still dominated by compulsory insurance, workers’ compensation and life insurance. Although commercial lines are relatively undeveloped, liability and construction are significantly outperforming other sectors of the market. The constant expansion of

\textsuperscript{146} Health Ministry, Resolution 3823 of 2016.
\textsuperscript{148} Gerardo Hernández Correa, Financial Superintendent, presentation at the XXV Fasecolda convention, September 2016, www.youtube.com/watch?v=jzbZ0EuWN2s&index=5&list=PLq1XjTam45CzgpxOtzJZY2L6jq-kCw-8r.
\textsuperscript{150} Bill No. 119 of 2016, ‘Por el cual se dictan normas para fortalecer la regulación y supervisión de los conglomerados financieros y los mecanismos de resolución de entidades financieras’. 
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 cyberthreats, fintech and the digital economy.

The insurance sector will continue to benefit from stable economic growth, and is expected to outpace the general economy. Moderate growth will entail fewer new entrants and possibly further market consolidation.
I INTRODUCTION

The Danish insurance industry originated with three different industries, namely building fire insurance, other non-life insurance and life insurance. Since Denmark’s entry into the EU in 1973, the legislation on insurance has been fundamentally changed, and the formerly sharp distinction between insurance forms has ceased. Subsequently, a number of large insurance groups providing all types of insurance have emerged in the industry.

Generally, there is a good level of competition in the Danish insurance industry even if it is dominated by four companies that collectively hold more than 50 per cent of the market share in most areas. Danish insurance companies have low but improving earnings compared to other industries, and consumer mobility is high compared to other European insurance markets. In 2015, there were 71 insurance companies in Denmark.² Tryg Forsikring is the largest insurance group in Denmark, closely followed by Codan. The ranking among the five largest companies changed in 2015 compared to the 2014 figures. The statistics include assets for foreign business.³

The majority of insurance companies in Denmark are members of the Danish Insurance Association.⁴ The Danish Insurance Association is the trade organisation for the insurance industry as well as the pensions industry in Denmark. Foreign insurance companies doing insurance business in Denmark may become members for informative purposes. Some standard terms and conditions, such as those regarding legal expenses insurance, have been drafted by the Danish Insurance Association in cooperation with the Danish Consumer Council⁵ to form agreed terms in the insurance industry.

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1 Philip Graff is a partner at Bird & Bird Advokatpartnerselskab.
5 www.taenk.dk/om-os/about-us.
II REGULATION

i The insurance regulator

Danish regulation of insurance companies

The Danish Financial Supervisory Authority (FSA) is responsible for supervising the financial sector, including insurance companies and insurance intermediaries doing business in Denmark.\(^6\) Clause 11(1) of the Financial Business Act states that undertakings that carry out insurance activities, including reinsurance activities, shall be licensed as insurance companies, or as captive reinsurance companies.

The most important supervisory activity of the FSA is monitoring whether undertakings have adequate own funds to cover their risks (supervision of solvency). In March 2015, the Solvency II Directive was implemented into Danish law with effect from 1 January 2016. As a result, insurance companies (both life and non-life insurance) are divided into Group 1 insurance companies and Group 2 insurance companies. Group 1 insurance companies must comply with the requirements resulting from the implementation of the Solvency II directive, while Group 2 insurance companies must follow simplified, national solvency regulation and changed investment rules that are based on the Solvency II Directive.

The FSA, in its capacity of supervising insurance companies and intermediaries doing business in Denmark, operates the following three different insurance registers.

The FSA insurance and reinsurance broker register

The regulation in EU Directive 2002/92/EC of 9 December 2002 on insurance mediation was implemented into Danish legislation with the Insurance Mediation Act (Act No. 362 of 19 May 2004). This Act entered into force on 1 January 2005, from which date undertakings wanting to mediate insurance products were required to register in a public register of insurance broker undertakings. In accordance with the latest amended Consolidated Insurance Mediation Act No. 1065 of 22 August 2013, only undertakings and persons who have been given authorisation by the FSA may carry out insurance broker activities.

The register includes the following information:

\( a \) Undertakings with authorisation;

\( b \) Name, address, central business register number and legal form of the undertaking;

\( c \) Date of authorisation by the FSA to mediate non-life insurance, life-insurance, or reinsurance in non-life or life insurance;

\( d \) List of the countries in which insurance or reinsurance mediation is carried out (only countries within the EU, or with which the Community has entered into an agreement for the financial area);

\( e \) Name of the person or persons who have been authorised by the FSA as employed life or non-life insurance brokers within direct insurance mediation or reinsurance mediation, including authorisation date; and

\( f \) Name of the person or persons who are responsible for the insurance mediation.

The FSA insurance agency register

With the latest amended Consolidated Insurance Mediation Act No. 1065 of 22 August 2013, any sub-agency or management company that enters into a contract on sales of insurance products with an insurance agency must register in a public register (sub-agency register).

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\(^6\) www.finanstilsynet.dk/en.
Sub-agencies are not allowed to mediate insurance unless the sub-agency or the management company has been registered in the electronic register. This register includes, in general, the same kind of basic information as the above.

**The Danish Insurance Association’s insurance agency register**

The Insurance Mediation Act entered into force on 1 January 2005, and it was amended most recently by Consolidated Act No. 1065 of 22 August 2013 on Insurance Mediation. The FSA has issued an executive order in pursuance of Section (Clause) 27(3) of the Insurance Mediation Act, which allows individual insurance companies to enter into agreements with the Danish Insurance Association on keeping the register in question.

The Consolidated Insurance Mediation Act stipulates that insurance companies and reinsurance companies that enter into an agreement with an undertaking or a management company on mediation of the insurance company’s products must keep a publicly available register of these undertakings (insurance agencies and management companies). Insurance agencies are not allowed to mediate insurance unless the insurance agency or the management company has been registered in the electronic register.

**ii Foreign insurers and reinsurers within the European Economic Area (EEA)**

As insurance business activity is a regulated activity, insurance or reinsurance companies are required to have a licence or another legal basis for carrying out insurance activities in Denmark. Insurance companies from other EEA countries may do insurance business in Denmark on either an establishment or a freedom-of-services basis. Reference should be made to Clause 30/31 of the Financial Business Act.

For foreign EEA insurance companies, the company will be considered as established in Denmark if it sets up a Danish branch or if the company appoints a Danish insurance agent with permanent authority to enter into insurance contracts on behalf of the insurance company, in which case the insurance company must appoint a general agent.

Foreign EEA insurance companies doing insurance business in Denmark are subject to the supervision of the home regulator of the insurance company. However, the insurance company is required to observe Danish good business practice rules, consumer protection regulation and certain insurance contract requirements that are contained in, for example, the Insurance Contracts Act.

**iii Foreign insurers and reinsurers from outside the EEA**

Insurance and reinsurance companies from non-EEA countries are, in general, unable to carry out insurance business in Denmark on a freedom-of-services basis, and are unable to passport any licence with the company’s home regulator. In this situation, the insurance or reinsurance company is required to set up an insurance company or a branch in Denmark and apply for a licence with the FSA to be admitted as an insurer in Denmark.

There are limited possibilities for non-admitted insurers to cover Danish risks, but it is not illegal under Danish law to procure insurance cover for Danish risks from a non-admitted insurer. Insurance intermediaries are, however, not allowed to facilitate or assist in such procurement, and non-admitted insurers are not allowed to actively market their insurance services in Denmark.
III INSURANCE AND REINSURANCE LAW

i Sources of law

The main source of law in Danish insurance is the Insurance Contracts Act,7 which regulates insurance contracts. The Act provides a number of supplementary provisions that to a certain extent are mandatory, governing the relationship between the insurance company and the insured. In addition to the general rules that apply to all insurance contracts, the Act also contains special provisions for certain types of general insurance, life insurance, and accident and health insurance.

The Insurance Contracts Act applies unless the parties to the contract agree otherwise. However, the Act is based on a fundamental idea of unequal bargaining power between the insurance company and the insured, and therefore several provisions of the Act are mandatory in order to protect the insurance seekers.

The Insurance Contracts Act does not apply to reinsurance contracts. Instead, such contracts are subject to general principles of Danish contract law where the parties enjoy the freedom of contract.8

The relationship between insurance and compensation is regulated by the Liability and Compensation Act.9

ii Making the contract

Where the Insurance Contracts Act states the rights and obligations of the parties to an insurance contract, the conclusion and completion of a contract is regulated by the principles of Danish contract law. The Insurance Contracts Act does not define the concept of an insurance contract, and thus does not contain any provisions for concluding any such contract. Instead, the Contracts Act,10 which is the general statute governing the formation of contracts, applies.

Under Danish contract law, there is a general principle of freedom of contract. There is a slight modification as regards insurance contracts, as there are some areas where it is required by law, agreement or customs to have taken out insurance (e.g., for motorised vehicles).

Forming the insurance contract

Contracts are formed on the basis of a concurrent offer and an acceptance. The most frequent way an insurance contract is formed is when an insurance seeker applies for coverage by the insurance company and the insurance company accepts this application. The application will most commonly be a printed form that the insurance seeker must fill out. If the insurance company agrees to provide coverage based on the provided information, it will send back an insurance policy together with the company’s general terms and conditions. The insurance policy constitutes the contract that confirms in writing and describes the terms and conditions that the parties have agreed upon.

7 Consolidated Act No. 1237 of 9 November 2015.
8 Insurance of maritime vessels (above a certain size) is normally covered under the Danish Maritime Hull Conditions originating from 1934.
9 Consolidated Act No. 266 of 21 March 2014.
10 Consolidated Act No. 193 of 2 March 2016.
Information disclosure and good faith
When concluding an insurance contract, the insurance company takes the financial risk of damage from the insured. According to the Insurance Contracts Act, the insured owes a duty of disclosure and answering and is hence required to answer the questions on the application form truthfully and to provide any other relevant information to the insurance company. The insured must show good faith until he or she has filled out, signed and sent the application. If the insured fraudulently provides incorrect information or fails to disclose a fact likely to be of importance to the insurance company, the contract is not binding.

iii Interpreting the contract
The interpretation of insurance contracts is subject to the general principles of Danish contract law. Different rules of interpretation apply depending on the contract type. The majority of insurance contracts consist of standard terms, which is why the standard method of interpretation is based on the wording of the insurance contract. Case law follows a rule of clarity when interpreting the terms and conditions that are usually drafted solely by the insurance company. Thereby, any doubt as to the contents will usually be interpreted against the insurance company (contra proferentem).

In addition thereto, insurance market practice and established customs are considered when interpreting insurance terms. It is not unusual for case law to refer to practice established by the Insurance Complaints Board. The Insurance Complaints Board is a private complaints board authorised by the Minister for Business and Growth.11

iv Intermediaries and the role of the broker
Insurance intermediaries must be recorded in a public register before they can arrange products for an insurance company. It is the insurance company that is under a statutory duty to register the agent and keep information up to date. Commercial insurance intermediaries are also regulated by the Insurance Mediation Act.12

The role of the insurance broker is to provide the insurance seeker with consultancy and thereby present different possible insurance solutions without there being an agreement between the broker and an insurance company. The broker works independently as opposed to another intermediary – the insurance agent – who carries out practical arrangements with insurance companies to sell their products.

v Claims
In general, the process for filing a claim with the insurance company is described in the insurance policy along with the terms and conditions.

Upon the occurrence of an insured event, the insured is required to notify the insurance company without undue delay. If the insured does not follow this provision, the insurance company will not be liable to a further extent than had timely notice been given.

The insured has to provide the insurance company with all the information necessary for the insurance company to assess the claim, including the insured event and the economic

12 Consolidated Act No. 1065 of 22 August 2013.
compensation. Interest on a claim against the insurance company will begin to accrue no later than 14 days after the insurance company has been able to retrieve the information necessary to assess the insurance event and determine the size of the damage compensation.

If a dispute occurs between the insured and the insurance company, it is possible to file a complaint with the Insurance Complaints Board instead of proceeding directly to litigation. Issues of regulatory matters or good business practice are not subject to review. It is not a requirement that the insurance company to the dispute is a member of the Insurance Complaints Board, although the majority of insurance companies doing business in Denmark are members. As the Insurance Complaints Board is a private body, insurance companies are not *per se* bound by their decisions, but the insurance company in question has to inform the Insurance Complaints Board within 30 days from the date of the decision if it does not intend to be bound by the decision.

**vi Direct action and subrogation**

Any third party suffering damage or loss can make a direct claim against the liability insurer of the insured tortfeasor if the liability of the insured has been established and the size of the economic compensation has been determined. Furthermore, the third party suffering damage or loss is able to make a direct claim against the liability insurance company of the insured in the event of the bankruptcy of the insured.

An insurance company subrogates into the legal status of the insured in the legal relationship with the tortfeasor. After having compensated the insured, the insurance company can claim recourse for the amount paid from the tortfeasor if, and only if, the tortfeasor is liable for the damage causing the compensation to be paid. Liability is determined after the general standards of Danish law, namely tort law or any contractual obligation the tortfeasor may have towards the aggrieved party.

**IV DISPUTE RESOLUTION**

**i Jurisdiction, choice of law and arbitration clauses**

Denmark has ratified the relevant parts of the Brussels I regime and the New York Convention on international arbitration, and court decisions passed by an EU country as well as arbitration awards passed by arbitration boards under the New York Convention can therefore be enforced in Denmark.

In addition, Denmark has ratified the Rome Convention on choice of law.

Under Danish law, arbitration clauses are generally considered valid and enforceable in the sense that an ordinary court will respect such clauses, if agreed, and therefore will dismiss lawsuits upon request from the defendant if the dispute is subject to arbitration. Danish courts, however, require a somewhat high degree of clarity regarding arbitration clauses, at least outside professional business relations and also tend to impose limitations on the applicability of such clauses. A textbook example is arbitration clauses referring the interpretation of an agreement (but not the legal classification on whether, for instance, an action constitutes a material breach) to arbitration. Such wording is in risk of not providing arbitrational jurisdiction over a dispute on material breach.
The leading arbitrational institute in Denmark is the Danish Institute of Arbitration,\(^\text{13}\) which is widely renowned for its high standards and competence.

ii Litigation

*Litigation stages, including appeals*

The Danish judicial system consists in broad terms of 24 district courts, two High Courts (an Eastern and a Western Division), the Maritime and Commercial Court, and the Supreme Court. Decisions passed by the district courts can be appealed to the relevant High Court (district courts in Jutland to the Western Division, and district courts on Funen, Zealand and Bornholm to the Eastern Division). Decisions passed by the High Courts can be appealed to the Supreme Court. The Maritime and Commercial Court is a specialised court mainly dealing with principal intellectual property matters, international commercial disputes, maritime disputes and principal employment law disputes, and always functions as a first instance court. Decisions passed by the Maritime and Commercial Court can be appealed to the Supreme Court if the dispute is of a principal nature, and otherwise to the High Court.

A lawsuit is initiated by the claimant filing a writ of summons with the relevant district court. The writ of summons should be accompanied by the relevant exhibits that the claimant will invoke. In addition, the writ of summons should state the witnesses that the claimant wishes to hear during the main procedure of the case.

The defendant is then requested by the court to file a defence, which should also be accompanied by any relevant exhibits that the defendant intends to invoke. In addition, the defendant should state any relevant witnesses. After the filing of the defence, the court will normally convene for a conference call to discuss and decide on the following steps, and often also schedule the date or dates for the main procedure of the dispute. If either the claimant or – more often – the defendant has formal objections to the matter, for instance that Danish courts do not have jurisdiction over the matter, the party in question can request that an interim decision on this is made. If so, the relevant part of the dispute is separated from the main dispute, and the parties are then requested to exchange written pleadings addressing these separate topics, and a separate or interim procedure is then scheduled, dealing with these separate topics.

Otherwise, the parties exchange any additional written pleadings on the main dispute accompanied by any relevant exhibits, the first one normally being the claimant’s reply, followed by the defendant’s rejoinder. As a general rule, the parties may continue filing written pleadings until four weeks prior to the main procedure.

Unlike common law systems, the Danish judicial system does not provide for a discovery phase, and depositions cannot be used.

During the main procedure, the legal representative of the claimant presents the dispute to the court by introducing the invoked exhibits, followed by the witness statements from the parties and witnesses. After this, the legal representatives provide their closing arguments, starting with the claimant, and then the dispute is referred to the court for its decision, which as a general rule must be passed within four weeks in the district courts and for appeal decisions by the High Courts, and within two months for other decisions.

Civil disputes are heard and decided upon by one judge in the district courts. If the matter is of a principal nature, three judges are appointed. In the High Court, all disputes are

Denmark

heard and decided by three judges, and in the Supreme Court by an odd number of judges (a minimum of five) depending on the importance of the dispute. In the Maritime and Commercial Court, the panel generally consists of one judge and two or four expert assessors. Expert assessors can also be appointed in the district courts. Jurors do not participate in civil disputes.

Like the vast majority of Western judicial systems, the Danish judicial system operates with a two-instance trial system as a general rule, allowing for a second appeal only in principal matters, and is subject to authorisation by the Appeals Permission Board. As a general rule, all lawsuits are initially filed with the relevant district court. If the matter is of a principal nature, each party (or the district court) can refer the matter to either the relevant High Court or to the Maritime and Commercial Court to decide on the dispute in the first instance.

Appeals exist in two different variations:

a Decisions by a court that do not conclude the dispute are court decisions or court orders, and are appealed by filing with the deciding court, which then forwards the appeal to the appeal instance. The deadline for such appeal is two weeks.

b Judgments by a court concluding the litigation process are appealed to the appeal instance. The deadline is four weeks. However, the judgment becomes enforceable if not appealed within two weeks.

The Insurance Complaints Board

The Insurance Complaints Board handles around 2,000 cases per year, and the fee for a complaint is 200 kroner. The normal time from submission of a complaint to a decision is seven to eight months.

The chair of the Board is a Supreme Court judge. Complaints may concern any legal issue arising out of the relationship between the customer and the insurance company. However, the dispute must concern an issue relating to the law of property and obligations, which means that it has to be of a financial nature. Complaints solely regarding ethical issues are outside the scope of the Board’s competence.

As a rule, the Board will only consider complaints concerning insurance taken out by private individuals (consumer insurance). However, the Board will consider all complaints concerning motor insurance.

The Insurance Complaints Board does not deal with complaints that come within the scope of the remit of a public authority, or another appeal or complaints board. It also does not handle issues that have been settled by a final judgment, validly binding arbitration or court settlement, or issues regarding criminal proceedings.

Any decision by the Board may be brought before the relevant city court.

Evidence

In broad terms, evidence can be divided into written evidence (documents, drawings, photos, etc.) and witness statements. Documents are submitted to the court in connection with the filing of the written pleadings, and witness statements are presented during the final procedure of disputes. Under certain circumstances, written witness statements can also be

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14 Court decisions cannot be appealed.
submitted as evidence. Thus, the Danish judicial system is unfamiliar with the concept of depositions. Witness statements are presented before the judge or judges and are subject to a duty of truth.

As mentioned in Section IV.ii, supra, the Danish judicial system does not operate with a discovery phase. During the past 10 years, the courts have, to an increasing extent, liberalised the admission of evidence and, generally, all types of evidence are admissible with the following exceptions. Unilateral expert survey reports prepared after the lawsuit was initiated are, as a general rule, not admissible whereas expert survey reports made prior to initiating the lawsuit will normally be admissible. Likewise, witness statements from expert witnesses are normally not allowed. Instead, a party – typically the party subject to the burden of proof – can request that an expert survey is conducted. This is done by requesting such to the court, which then appoints an independent expert surveyor to conduct the survey.

Costs

Legal costs can be divided into two categories: court admission costs in connection with filing a lawsuit or an appeal, and legal fees awarded to the prevailing party.

Court admission fees are 500 kroner plus 1.2 per cent of the value exceeding 50,000 kroner (capped at 75,000 kroner) of the value of the matter, which is payable upon filing of the writ of summons or request for appeal. An additional 1.2 per cent with the same minimum or cap is payable three months prior to the closing procedure. As previously mentioned, the court admission fee is also payable in connection with court claims lodged by the defendant and in connection with an appeal. If the defendant is ordered to pay, for example, 100,000 kroner and appeals this decision, court admission fees of 1,350 kroner are payable in connection with filing the appeal. The court admission fees are increased by 50 per cent if the case is appealed to the Supreme Court.

In addition to the court admission fees, the court will automatically, as an integrated part of a judgment, decide on the legal fees to be awarded to the prevailing party. The amount depends on the matter value, the duration and extent of the dispute, and whether an expert survey has been conducted, and, within specified limits, the courts will use their discretion.

The guideline amounts are found in a set table.\(^{15}\)

In addition to the guideline amount, the court will grant the prevailing party full coverage of any court admission fees.

The guideline amounts are independent from the actual legal fees borne by the prevailing party since Danish courts will not accept a recovery claim based on factual costs.

Arbitration

As mentioned in Section IV.i, supra, Danish courts accept the validity of arbitration clauses. In general terms, arbitration disputes are dealt with in accordance with the process described for litigation before the ordinary courts; however, there are stricter deadlines for exchange of written pleadings, a different cost structure and no possibility of appeal.

The rules governing arbitration procedures entered into force on 1 May 2013, and are available from the Danish Institute of Arbitration.\(^ {16}\)

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\(^{15}\) www.domstol.dk/selvbetjening/beregnindafgift/om%20RETSAFGIFTER/Pages/Almindeligeretssager.aspx.

**Procedure and evidence**

Arbitration disputes are dealt with in accordance with the process described for litigation before the ordinary courts. However, arbitration procedures are normally more lenient and liberal in relation to admitting evidence than ordinary courts.

**Costs**

In relation to awarding fees to the prevailing party, arbitration proceedings will also, to a large extent, follow the overall principles applicable to civil litigation before the ordinary courts. The size of court admission fees, however, depends on the arbitration tribunal in question.

The costs of arbitration include fees to the institute, arbitrator or arbitrators, administrative charges and other expenses. The cost of the proceedings is available from the Danish Institute of Arbitration.17

**iv Alternative dispute resolution (ADR)**

**Forms of ADR (including any industry-specific settlement mechanisms (e.g., maritime, construction))**

In addition to the mediation option provided by the ordinary courts, mediation is also offered by private institutions – the Danish Institute for Mediation18 being the most widely known.

**v Mediation**

**The role of the courts**

Danish courts facilitate voluntary mediation as a more or less integrated part of an ordinary court process. In connection with a request to the defendant to submit a defence, the parties are normally asked whether they would prefer to attempt to mediate the dispute. If both parties agree, the dispute is referred to mediation, and the formal dispute is put on hold. At any stage until a settlement has been reached, each party can withdraw from the process, and the civil dispute process then continues. Many court judges are also certified mediators and can chair a mediation process. If the mediation is unsuccessful, the mediating judge will not decide on the dispute.

**V YEAR IN REVIEW**

Fire is a major cost for both businesses and society in general. Every year, insurance companies pay around 3 billion kroner in damages after a fire. Additionally, it is found that at least 25 per cent of companies that experience a major fire never reopen, while others use the opportunity to move production abroad. Thus, fires cost lives, jobs and growth. Consequently, Denmark now has its first national fire prevention strategy (the result of a collaboration between a number of entities in the area), which is designed to reduce the death toll and prevent job losses.19

In the light of a report from the FSA about the insurance industry’s approaches for investigating fraud in personal injury cases, the Danish Insurance Association has introduced

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a new code of fraud investigations as a response to the contents of the report from the FSA. For example, GPS tracking can no longer be used in connection with the investigation of insurance fraud.20

On 19 November 2016 in Lichtenstein, Gable Insurance was declared bankrupt. Gable Insurance sold insurance policies in Denmark through Husejernes Forsikring Assurance Agentur, which was declared bankrupt on 8 December 2016. None of the companies was a member of the Guarantee Fund for insurance companies,21 which ensures policyholders coverage in case of insurance companies’ bankruptcies. On 8 December 2016, following discussions with the Danish Insurance Association, Parliament decided to adopt a legislative amendment resulting in customers of Gable Insurance and Husejernes Forsikring Assurance Agentur nevertheless being covered by the Guarantee Fund for insurance companies. The amendment means that the Guarantee Fund provides coverage of claims that would otherwise not be covered.

VI OUTLOOK AND CONCLUSIONS

In 2010, the Danish disaster scheme was expanded to include both flood damage, storm damage and damage caused by extreme flooding from rivers and lakes. This flood scheme is a public scheme that is regulated by the Act on Floods. The scheme covers damage to buildings and goods for both private homes and businesses. The coverage is provided for by law and is thus not part of people’s own private insurance. To be entitled to receive compensation, the damaged property or goods (or both) must be covered by taxable fire insurance, and the damage must be reported to the insurance company within two months after acknowledgment of flood. The scheme is financed by a fee of 30 kroner per fire insurance policy. The funds of the scheme are public. Hence, payment of compensation does not affect insurance companies’ finances. The insurance companies carry out case processing of flood damage to their own customers, which is done according to the rules of the Storm Council. The Storm Council declares whether there has been flood.

In recent years, a number of floods in Denmark made it clear that climate change is already affecting the cities and the areas close to the 7,000 km coastline of Denmark. In response to the floods, local authorities have developed climate adaptation plans and water companies have invested in being able to handle more, and heavier, rain. In collaboration with other relevant Danish entities, the Danish Insurance Association is implementing a campaign called ‘Regn og byer’ (rain and cities) from 2017 until 2019. In the spring of 2017, the first of several conferences will be held, which will bring professionals together to discuss the possibilities for and perspectives on innovative climate adaptation in interaction with other functions.

I INTRODUCTION

i 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 In 2015, 157 of the FTSE 250 companies and 28 of the 30 listed in the Dow Jones Industrial Average were insured at Lloyd’s.⁴

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.

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1 Simon Cooper and Mona Patel are partners at Ince & Co.
2 www.abi.org.uk.
4 Ibid.
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.5

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 London Commercial Court (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.

ii Principle of ‘regulated activities’

The UK has no express prohibition on non-admitted insurers or reinsurers. Rather, the UK regulatory regime prohibits the performance of ‘regulated activities’ within the UK

5 See www.iua.co.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. 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.

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 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. 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. 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. Certain existing ‘passporting’ provisions are expected to be moved into new legislation following the reform and replacement of particular single market directives.

The UK’s EU referendum in June 2016 saw the UK electorate vote to exit the EU (British exit – or ‘Brexit’ as it is known), 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, in a speech in January 2017, the UK prime minister, Theresa May, seemed to confirm that the UK would not seek to remain a member of the single market. Unless the passporting regime is retained in an agreement between the UK and the EU, UK insurers could lose their passporting rights. Even if certain passporting rights are retained, it seems inevitable that a major shift away from EU to UK regulation is likely.

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6 Section 19 Financial Services and Markets Act 2000 (FSMA).
8 MIFID will be replaced by the Markets in Financial Instruments Regulation (Regulation 600/2014) and the MiFID II Directive (2014/65/EU), which are currently being revised and that are expected to take effect from 3 January 2018. The Insurance Distribution Directive (EU) 2016/97) (IDD) will replace the IMD with effect from 23 February 2018. The PSD will be amended by the revised Payment Service Directive – PSD II (2015/2366/EU) (PSD II), which is due to apply from 13 January 2018.
iii  **Position of brokers**

Insurance intermediaries such as brokers are also required to be authorised when they perform regulated activities.

iv  **Requirements for authorisation**

Insurers 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 the UK’s decision to exit the EU.

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, infra).

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, 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. Such 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 to 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)\(^9\) came into effect on 22 February 2016. It has to be transposed by Member States by 23 February 2018, on which date it will repeal the Insurance Mediation Directive (IMD)\(^10\). The IDD is to be 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 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. As such, it can only be assumed, given the time frames expected for exit negotiation, that there will be sufficient time to transpose the IDD within the time frames stipulated.

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\(^9\) Directive on insurance distribution ((EU) 2016/97).

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 depends on the type of claim.

ix 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 the 1 November 2016 from 9.5 to 10 per cent and will rise to 12 per cent on 1 June 2017. The higher rate of 20 per cent (applied to travel insurance, and some vehicle and domestic or electrical appliance covers) remains the same.

Life insurance is exempt from IPT, as is reinsurance, 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. HMRC 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.

11 The new standard rate of 10 per cent has been due from 1 October 2016, with an exception for those insurers who use a special accounting scheme rather than the cash receipt method. Under this exception, the 10 per cent standard rate will be applied by such insurers only to premiums received on or after 1 February 2017, where the premium relates to risks covered by the terms of a contract entered into before 1 October 2016.

12 Westinsure Group Ltd v. HMRC [2014] UKUT 00452 (TCC) (appeal outstanding to the Court of Appeal (Civil Division); Riskstop Consulting Ltd v. Revenue and Customs Commissioners [2015] UKFTT 469 (TC).

13 VATINS5205 September 2014.
x Other notable regulated aspects of the industry

A purchaser of a regulated firm such as an insurer or intermediary requires consent from the appropriate regulator. A purchase of a book of business from an insurer will require both regulatory and court consent under the UK’s ‘Part VII’ Financial Services and Markets Act 2000 (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.

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 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) and the Life Assurance Act 1774 (LAA).

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,\(^{14}\) the cost of a hire car while the insured vehicle is repaired\(^ {15}\) 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.\(^ {16}\)

The insured-against event must be uncertain in its occurrence.\(^ {17}\) This uncertainty is tested at the time that the contract is concluded.\(^ {18}\) 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 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’.\(^ {19}\)

The Law Commissions of England and Wales and of Scotland (the Commissions) have been undertaking a review of the law of insurance contracts. In April 2016, they published a draft Insurable Interest Bill, designed to give effect to proposals put forward in a series of earlier consultations. Respondents to the consultations stated 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.

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14 *Prudential v. Commissioners of Inland Revenue* [1904] 2 KB 658.
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; it is his or her duty to disclose, before the contract is entered into, all material facts pertaining to the risk of which he or she 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 the position.20 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.21

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 Sections 22 MIA and 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.

iii 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. These principles are largely unchanged since the House of Lords decision in Investors Compensation Scheme Ltd v. West Bromwich Building Society.22 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 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. On the other hand, 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,23 the court held that a term will be incorporated only if:

\[a\] it is germane to the reinsurance, rather than being merely collateral to it;

\[b\] it makes sense, subject to permissible manipulation in the context of the reinsurance;

\[c\] it is consistent with the express terms of the reinsurance; and

\[d\] it is apposite for inclusion in the reinsurance.

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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 currently 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 never comes 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. 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. Such 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, it 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.

d ‘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

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 his or her own.

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24 In their July 2014 report entitled ‘Insurance Contract Law; Business Disclosure; Warranties; Insurers’
Remedies for Fraudulent Claims; And Late Payment’.

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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 required while acting as agent for a third party if that information is ‘confidential’ to the third party.

v 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.

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.25 ‘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’.26 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.27

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25 Layher Ltd v. Lowe.
26 HLB Kidsons v. Lloyd’s Underwriters and others [2008] EWCA Civ 1206.
Other policies will require the notification of a ‘loss’. ‘Loss’ in this context has been interpreted differently in two cases on very similar facts (RSA v. Dornoch and AIG Europe (Ireland) Ltd v. Faraday Capital Ltd). 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) the Supreme Court (by a majority of 4–1) abolished 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 new 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. Under English law at the time of writing, punitive damages against an insurer or reinsurer are not available for breaches of this duty; nor can 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. On 4 May 2017, however, the Enterprise Act 2016 (EA16) will come into force. EA16 will introduce a new Section 13A into IA15. This section will introduce an

29 [2008] Lloyd’s Rep IR 454.
30 Versloot Dredging BV v. HDI Gerling & Ors (The DC Merwestone) [2016] UKSC 45.
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 will give rise to a right to claim damages. It is important to note, however, that:
a there is a special one-year limitation period for such a claim; and
b damages will be subject to the usual criteria of 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; (3) not too remote; and (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, including appeals

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 give evidence in court, and may be cross-examined by the other party or parties.

32 In the Admiralty and Commercial Courts, where many commercial insurance disputes are brought, there is an additional Guide that supplements the CPR.
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 to 70 per cent 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 CPR Part 36. 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.

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 the 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, when the amendment to IA15 comes into force introducing Section 13A (see Section III.v, *supra*) 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
Since 1 April 2013, when the PRA and the FCA took over as the prudential and conduct regulators of the UK financial services industry, they have 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 became a ‘concurrent regulator’ alongside the Competition and Markets Authority (CMA) with ‘concurrent powers’. These powers are in addition to its regulatory powers under 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.
**Introduction of Solvency II**

Despite a number of delays, the Solvency II regime was finally implemented in the UK on 1 January 2016. The regime establishes a more harmonised approach to capital requirements, together with a modernised supervisory system.

In summary the Solvency II regime provides the framework for solvency, corporate governance, risk management, reporting and prudential standards that insurers should observe. It is hoped that it will provide for consistent levels of consumer protection and encourage competition in the insurance market.

Solvency II has introduced what is known as the Solvency and Financial Condition Report (SFCR), which will cover the solvency and financial position of insurers and will be published annually. The SFCR will be publicly available and the first reports are set to be published in May 2017.

**The Senior Insurance Managers Regime**

On 7 March 2016, the Senior Insurance Managers Regime (SIMR) was introduced for Solvency II and non-directive firms raising the benchmark of personal accountability. The SIMR introduced by the PRA replaced its approved persons regime. The FCA has also amended aspects of its own approved person’s regime. Most notably, the PRA will replace the significant influence functions under the old regime with a number of senior insurance management functions. These developments complement the implementation of the Solvency II governance provisions that demand that all those in a key function within a firm are assessed as fit and proper. The objective of each of these changes is crucial. Solvency II places the emphasis upon the firm itself to determine whether those in charge of key functions are fit and proper for their roles, while the SIMR determines that applicants for defined roles within insurance firms must be pre-approved by the regulator before taking up their posts.

Following implementation of the SIMR, the Bank of England and Financial Services Act 2016 will extend the Senior Managers and Certification Regime to all FSMA-authorised firms. This likely to take place sometime in 2018.

**ii Insurance contract law reform**

IA15 came into force in August 2016. The Act:

- replaces the current pre-placement duty to disclose all material circumstances and not to misrepresent material facts with a duty to make a ‘fair presentation’;
- introduces a new system of graduated remedies for breach of the duty to make a ‘fair presentation’;
- treats all warranties as suspensive conditions, meaning that an insurer is not liable for losses occurring or attributable to something happening while the insured is in breach of warranty, but liability is restored on remedy of the breach;
- allows insureds an opportunity to prove that their breach of a warranty or other term of the contract that is designed to limit the risk of particular kinds of loss could not have increased the risk of the loss that actually happened and, therefore, cannot relieve insurers of liability for that loss; and
- clarifies the remedies available to insurers in the event of a fraudulent claim being made.

IA15 applies to all contracts (other than consumer contracts) entered into on or after 12 August 2016, and the new rules in relation to fair presentation also apply to any variations
to existing contracts if that variation was agreed on or after 12 August 2016. It is possible for parties to contract out of most of the provisions of the Act if they observe the ‘transparency provisions’ for so doing set out in the Act.

IA15 also contains amendments to the Third Parties (Rights Against Insurers) Act 2010. The purpose of the Third Parties (Rights Against Insurers) Act 2010 is to make it easier for third parties to bring direct actions against insurers where an insured has become insolvent. It was scheduled to become law by March 2011, but the discovery of a defect in its references to insolvency procedures prevented it from coming into force. The amendments made by the IA15 remedy this defect and the Third Parties (Rights Against Insurers) Act 2010 finally came into force on 1 August 2016.

EA16 received Royal Assent in May 2016 and will come into force in May 2017. It will amend IA15 to provide that (re)insurers must pay sums due within a reasonable time. Policyholders will have the opportunity to claim damages for breach of contract if a (re)insurer’s unreasonable delay causes additional loss.

iii Dispute resolution

Insurance and reinsurance disputes have continued to keep the courts busy over the past 12 months, and the decisions discussed below represent only a snapshot of the issues with which the judiciary has been grappling.

A number of highly significant judgments in cases involving elements of fraud, including two Supreme Court decisions with contrasting outcomes for insurers, occurred in 2016. In Versloot Dredging v. HDI Gerling (The DC Merwestone) the Supreme Court held, by a majority of 4–1, that the fraudulent claim rule (whereby an insured who fraudulently exaggerates his or her claim under an insurance policy forfeits any lesser claim that he or she could otherwise properly make) does not extend to the deployment by the insured of a ‘fraudulent device’ (a lie or false evidence used by the insured in support of an otherwise valid claim). In Hayward v. Zurich, the Supreme Court, overturning the Court of Appeal, held that there was scope to set aside a settlement agreement in a matter where, post-agreement, stronger evidence of fraud on the part of the claimant came to light than had been available at the time the agreement was executed.

A number of marine insurance cases reached the courts in 2016. The Court of Appeal decision in Atlasnavios v. Navigators Insurance (The B Atlantic) stands out for its consideration of the interrelationship between insured perils and excluded perils.

There was a slew of liability insurance cases in 2016, particularly in the fields of professional indemnity and employers’ liability. AIG Europe Limited v. OC320301 saw the first consideration by the Court of Appeal of the proper construction of the aggregation clause in the Minimum Terms and Conditions of Professional Indemnity Insurance for Solicitors and Registered European Lawyers in England and Wales. The decision in Ocean Finance & Mortgages Ltd v. Oval Insurance Broking Limited is of note for its consideration of the issues involved in deciding whether and when a block notification is permissible under a professional indemnity policy. In the cases of Cox v. Ministry of Justice and Mohamud v.
WM Morrison Supermarkets, the Supreme Court ruled on various aspects of the doctrine of vicarious liability (whereby someone is held responsible for the actions or omissions of another person).

The courts saw fewer reinsurance disputes, but one is worth highlighting. In Simmonds v. Gemmell, the Court of Appeal dismissed an appeal against an arbitration award on the ground of error of law. The issue was whether the reinsured had properly aggregated claims arising from the 9/11 attacks on the World Trade Center. It was held that it was clear that the arbitrators had fully understood the test they had to apply in deciding on the question of aggregation in relation to the wording at issue.

One of the key property and business interruption decisions of 2016 was the Supreme Court’s judgment in The Mayor’s Office for Policing and Crime v. Mitsui Sumitomo Insurance Co (Europe) Ltd. This was concerned with the statutory liability of the Mayor’s Office under Section 2 of the Riot (Damages) Act 1886 to compensate various parties who suffered loss following the London riots of August 2011. The Supreme Court held that compensation payable under the Act would be limited to physical damage to property and would not include consequential losses such as loss of profit or loss of rent.

The courts continued to grapple with issues of jurisdiction and choice of law. In Axa Corporate Solutions Assurance SA v. Weir Services Australia Pty Ltd it was held in a dispute involving a global policy with no jurisdiction clause that England was the appropriate forum to hear the claim since ‘in cases concerned with insurance written in the London Market and governed by English law, there is a strong tendency for the court to consider England as the natural forum.’

iv Brexit

On 23 June 2016, the UK electorate voted to leave the European Union by 51.9 per cent to 48.1 per cent, starting a process with potentially profound consequences for the UK insurance and reinsurance markets (see Section VI.ii, infra).

VI OUTLOOK AND CONCLUSIONS

There will be some interesting developments for the UK insurance and reinsurance industry in 2017–2018, as outlined below.

i Insurance contract law reform

EA16 (see Section III.iv, supra), which received Royal Assent in May 2016 and that will come into effect in May 2017, will amend IA15 to introduce an implied term into every insurance contract agreed on or after 4 May 2017 that insurers and reinsurers must pay claims within a ‘reasonable time’.

39 Simmonds v. Gemmell.
ii Impact of Brexit on insurance regulation

Following the EU referendum in June 2016, the UK government invoked Article 50 of the Treaty on European Union (Article 50) at the end of March 2017, which has started the process and confirm the UK’s exit from the EU. Now Article 50 has been invoked, a two-year negotiation period has been triggered in which withdrawal from the EU will be discussed. Until the formal withdrawal of the UK from the EU, the legal and regulatory framework will continue as is. 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.

The UK government has indicated that most EU legislation will be transposed into UK domestic law so that EU and UK regulation is identical at the point of exit. The UK may then amend EU regulation or repeal parts of it. The two areas of regulation likely to be affected by Brexit are passporting rights and Solvency II. Depending on the outcome of the negotiations between the UK and the EU, UK-based insurers may lose their passporting rights. If passporting rights are lost, insurers may even consider establishing authorised branches or subsidiaries in another EEA country so that risks can be written on a passporting basis in the remaining EEA countries. 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.

iii 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. Whether such growth plans will be impacted by the UK’s exit from the EU remains to be seen.

The most interesting development will of course be the changes affecting insurance and reinsurance regulation following the UK’s exit from the EU. At the time of writing, the Brexit negotiations have yet to commence, rendering any future regulatory regime uncertain. For now, no laws or regulations have changed and the London Market must simply continue with business as usual.
Chapter 13

GERMANY

Markus Eichhorst

I INTRODUCTION

Approximately 866 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 1,424 German underwriters add to this number. All of these underwriters together achieved a turnover related to direct insurance of €185.4 billion, of which €10.18 billion or 5.4 per cent was generated by foreign 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 30 actively operating reinsurers who have their seat in Germany as of 31 December 2014. They have now been operating for eight years in a difficult financial environment that gives them only low interest rates on their assets so that underwriting losses cannot be compensated with capital earnings to the extent it has been in former years.

The implementation of Directive 2009/138/EC of the European Parliament and Council of 25 November 2009 on the Taking-up and Pursuit of the Business of Insurance and Reinsurance (Solvency II) into German law will also focus on the capital backing of insurers. Despite initial expectations that the Solvency II requirements might not come in force before 2017, the Bundestag (representation of the German federal states) on 6 March 2015 approved the Parliament Act on the Modernisation of the Financial Supervision of Insurance Companies, which implements the Solvency II regime in 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 have early been identified by reinsurers as drivers for

1 Markus Eichhorst is a partner at Ince & Co.
2 From 2010 to 2013, there were between 899 and 926 underwriters; source: BaFin (www.bafin.de), Statistik Statistik der Bundesanstalt für Finanzdienstleistungsaufsicht – Erstversicherungsunternehmen und Pensionsfonds (2013), p. 6 f.
3 In 2014, in total 82; BaFin, l.c.
4 In 2014, in total 866; BaFin, l.c.
5 In 2014, only three non-EEA underwriters maintained a branch in Germany, BaFin, l.c.
6 In 2013; BaFin, l.c., p. 8.
7 BaFin, l.c., p. 7.
8 BaFin, Jahresbericht der Bundesanstalt für Finanzdienstleistungsaufsicht 2013, p. 142.
9 President of BaFin Elke König’s speech of 22 January 2013 (www.bafin.de/SharedDocs/Reden/DE/re_130122_neujahrspresseempfang_p.html).
reinsurance solutions and by the growing number of run-off service providers as drivers for such 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 121 (f) of the German Insurance Supervision Act (VAG)). Germany will nevertheless be far from being a run-off paradise, since German law does not recognise the English concept of ‘schemes of arrangements’ and the German Federal Supreme Court held in 2012 that English court orders on the approval of such schemes are not enforceable in Germany. This fits with the German approach of being rather 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 Germany’s federal government. Insurers of less economic significance, and especially those that operate only within one of Germany’s federal states, may be supervised by supervisory bodies of one of Germany’s federal states. BaFin currently supervises approximately 42 per cent of German insurers. Insurers supervised by BaFin nevertheless achieve 99.6 per cent of the total earnings of both groups, which underlines BaFin’s 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 before they may operate. Under the single licence principle, insurers who have obtained a licence in another EEA state do not require a further licence to operate in Germany. Such 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 110a VAG). 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 110a (3) VAG).

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

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12 Judgment of 15 February 2012, IV ZR 194/09.
14 Thomas Schmitz-Lippert, l.c.
15 Certain EU/EEA insurers, such as mutuals with low premium income, are excluded, but nevertheless require a licence pursuant to Section 110 (d) VAG.
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 who 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 81(1) 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 as well as finance risks for their investments properly, to maintain a proper risk management system and to 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 Section 81(2) VAG, BaFin can make any orders that are appropriate and necessary to avoid deficiencies or bring such to an end and, if necessary, withdraw the insurer’s licence under Section 87 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 87(6) 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 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 German 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.16 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’ as well as risks covered under ‘open policies’. This, however, 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 German rules on unfair contract terms impose limits on any deviation from such 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 for this. This will be dealt with further 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) of the 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, *inter alia*:

- railway rolling stock: all damage to railway rolling stock;
- aircraft: all damage to aircraft;
- ships (sea, lake and river vessels): all damage to river, inland waterway and sea vessels;
- transported goods: all damage to transported goods irrespective of the means of transport;
- all liabilities arising from land transport;
- aircraft liability: all liabilities arising out of the use of aircraft (including carrier’s liability); and
- liability for vessels (river, inland waterway and sea vessels).

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.

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 Section 209 of the VVG. In this
respect, the official explanatory statement of the German legislator 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.\(^{17}\) 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 German courts’ considerations as to whether any deviations from the consumer-oriented VVG concepts are sufficiently fair (see below).

Besides marine insurance contracts, reinsurance contracts are also exempted from the scope of the VVG, so that the general rules of German civil law set out in the German Civil Code (BGB) apply.

ii Making the contract

**Contracts under the rules of the VVG (all insurance contracts except marine and reinsurance)**

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 provided the insured at that time with its general insurance 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 has 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 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).\(^{18}\)

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, and

\(^{17}\) Ibid, p. 115.

\(^{18}\) Verordnung über Informationspflichten in Versicherungsverträgen (VVG-InfoV).
in which respects, the insurance certificate deviated from the insured’s application; informs the insured of its right to object to such 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 such deviations.

If the insurer complies with these notification requirements and the insured does not object within one month after 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 (e.g., by not giving a conspicuous notice to the insured on deviations from the insured’s application), 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 such needs and on adequate insurance solutions, and to document the contents of such 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) of the VVG), who then has to comply with such 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 after 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 German law). Exceptions apply especially for insurance contracts for large risks, for some provisional cover notes and for insurance contracts with an insurance period of less than one month.

**Other 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 even sufficient to simply refer to general insurance conditions in order to incorporate them into such without actually providing the insurer’s terms and conditions.

**Information to be provided to the insurer prior to conclusion of the contract and consequences of failure to do so; disclosure and representation**

Pursuant to Section 19(1) of the VVG, the insured is under an obligation to disclose to the insurer all known circumstances prior to conclusion of the insurance contract that, first, are relevant for the insurer’s decision to enter into the insurance contract with the agreed contents, and, secondly, 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 German 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, German 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:

a) The insurer may (retroactively) withdraw from the contract (Section 19(2) of the 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.

b) 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).

c) 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.

d) All of these remedies will expire within one month after receipt of knowledge of the insured’s infringement of its disclosure or representation requirements (Section 21(1) of the VVG).

e) 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.

f) If, however, the insured maliciously infringed its disclosure or representation obligations, the insurer is not obliged to cover the loss (Section 21(2) of the 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 a 10-year period applies.

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 also 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.

| Intentional misconduct | Withdrawal from the contract (retroactively)  
No coverage obligation, Section 21(2) of the VVG |
|------------------------|--------------------------------------------------------------------------------------------------|
| Gross negligent misconduct and the contract had not been concluded at all had the insured not breached its obligations (i.e., informed the insurer as legally required) | Withdrawal from the contract (retroactively)  
No coverage obligation, Section 21(2) VVG |
| Gross negligent misconduct and the contract had 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 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)  
If the insurer is entitled to exclude certain risks retroactively, this may exclude coverage |
| Non- or simple negligent misconduct and the contract had not been concluded at all had the insured not breached its obligations (i.e., informed the insurer as legally required) | Termination, which becomes effective one month after the insured’s receipt of the insurer’s termination declaration  
No affect on coverage for any insured event that occurred or occurs before the termination becomes effective |
| Non- or simple negligent misconduct and the contract had 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 German 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 yet been published. However, it seems rather unlikely that the German courts would in this constellation 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 constellation raise doubts as to whether the German legislature fully understood its own rather complicated rules and all of their consequences |

The above rules provide for considerable judicial discretion in potential legal disputes and corresponding legal uncertainties in applying these rules on specific cases, which the German 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 who 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.

German 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.19

Insurance conditions are usually to be qualified as general terms and conditions of the contract within the meaning of the German civil law provisions on unfair contract terms as set out in Section 305 et seq. of the BGB. Pursuant to Section 305c(2) of the

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BGB, any uncertainties as to the interpretation of those general terms and conditions (including insurance conditions) are to the detriment of the party who introduced such 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.20

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 of the 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 1985,21 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 2011,22 the Federal Supreme Court gave up 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 obviously also the intention of the parties to the insurance contract) are irrelevant. The reason behind this approach is to avoid insurers circumventing the restrictive rules on avoidance of coverage for the insured’s breach of obligations, so German 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).

It has not yet been tested whether German courts would apply this differentiation method in the same way on marine insurance (the above insurance of inland waterway vessels is not marine insurance under German law), which is not subject to the VVG rules at all. Therefore, the parties should be able to freely agree whether they want an exclusion of a specific risk or an obligation that should, as usual, be determined primarily by reference to the clauses’ wording. The same should apply for large risks, although German courts tend to

20 Beschluss of 22 July 2009, IV ZR 74/08.
22 IV ZR 165/09.
apply the concept of ‘disguised obligations’ as a rule of interpretation without differentiation between large and other risks. The concept of disguised obligations is increasingly perceived as being alien to the method under which contracts are to be interpreted, so that criticism of this concept (even from a Federal Supreme Court judge) is increasing. It is likely that the Federal Supreme Court will give up this concept in the near future. Should this happen, any risk exclusion that the courts currently consider to be a (valid) disguised obligation will as of then be considered as invalid exclusion. Consequently, insurers should carefully reconsider their exclusion clauses.

Types of terms in insurance contracts; especially obligations and consequences of their breach

German 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):

a 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) of the VVG).

b The insurer is entitled to avoid coverage fully if it proves that the insured intentionally breached its contractual obligation.

c 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 must grant coverage in full or not at all. The reform requires the insurer 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.

d 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.

e If the insured breached a contractual obligation maliciously (to be proven by the insurer), causation does not matter.

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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</td>
</tr>
<tr>
<td>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 constellations, so that prejudice-driven case law is developing in this respect</td>
<td></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) of the VVG or an increase of risk not notified to the insurer (Section 23(2) of the VVG). 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 of the VVG). Section 81 of the 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. 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, 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 still exists in German marine insurance law. In respect of large risks, the parties to an insurance contract should also be able to agree that any 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. However, it has not yet been determined by German courts whether such differentiation is also required for large risks under the applicable rules of the German unfair contract terms provisions of the BGB. The ‘all or nothing’ principle is still contained in most German transport policies, which is possible as these are open policies (see above).

It is worth noting that 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 this person 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 to be qualified as the insured’s representative in a particular situation, there are various (non-binding) precedents as to who qualifies as the insured’s representative. 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 of the VVG). However, as already mentioned above, 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; 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. Two recent 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 this principle 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 such 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 after 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 current 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.

The 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. 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.

25 7 U 127/09.
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 acting as 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, the Appeal Court of Karlsruhe recently 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 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 him or her. 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, Council Regulation (EC) 44/2001 of 22 December 2000 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 EC Regulation 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 starting to develop 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 such 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 he or she considers 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 €2,568 and recoverable lawyers’ fees to approximately €3,400. 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

In 2015, 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.

The Federal Supreme Court set up a sophisticated differentiation between an intentional increase of risk that allows an insurer to avoid coverage pursuant to Sections 23 and 26 VVG, and a deliberate increase of risk. The latter does not necessarily constitute an intention.27 In 2013, but with continuing relevance, the Federal Supreme Court reconfirmed its position regarding the contractual obligation of the insured to provide information in relation to an insured event.28 This obligation ceases to exist after the insurer denies coverage as, in the

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Court’s opinion, the insurer then has no legitimate interest in any such information anymore. If the insurer decides to revoke the denial and is open to reconsider providing coverage, the obligation of the insured comes back into existence.

In a judgment of 20 January 2015, the Employment Appeal Court of Düsseldorf held in respect of D&O insurance that a cartel fine imposed on a company is not recoverable from its director (and consequently its D&O insurers) even if an event is caused by the director’s misconduct. In the opinion of the Court, the purpose of a cartel fine is to impact the company, so the fine needs to remain with the company without any recourse possibilities. This view is considered to be highly controversial, and it might not be shared by other courts.

On 15 February 2012, but with continuing relevance, the Federal Supreme Court decided that an English court order on the approval of a scheme of arrangement cannot be recognised in Germany. The Supreme Court held that a procedure under Section 425 of the Companies Act 1985, in which such schemes are approved, is not to be qualified as an insolvency proceeding, which would have to be recognised in Germany under Section 88 of the VAG or under the German rules on insolvency proceedings (InsO). It further held that an insurer may only commence actions against insureds in the state where they are domiciled in accordance with Articles 8 and 12 of Council Regulation (EC) 44/2001 of 22 December 2000 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters. According to the Supreme Court, any court proceedings that affect the rights of the insureds are legal proceedings within the meaning of that Council Regulation, and can only be pursued in the state where the insured is domiciled.

Other cases with the potential to enter into legal history are continuing. On 14 December 2012, the Munich Appeal Court handed down a judgment against Deutsche Bank and one of its previous board members, Dr Breuer. It held that both were liable for the consequences of an interview Dr Breuer gave in 2002 to Bloomberg TV. In this interview, Dr Breuer expressed doubts that the Kirch group (at that time, one of the leading media groups of companies) would be able to receive further loans from the finance market. Shortly thereafter, various Kirch companies filed for insolvency. The Munich Court found that Deutsche Bank and Dr Breuer were liable on the merits for damages to these companies with quantum to be decided later. Estimates for quantum ranged up to €1.5 billion. Before a decision on Deutsche Bank’s complaint against non-admission to the Federal Supreme Court was handed down, it settled the matter in February 2014 and undertook to pay damages of €927 million. According to press reports, in the summer of 2014, Deutsche Bank’s supervisory board decided to pursue recourse claims against former CEO Dr Breuer and its D&O insurers. In 2016, Deutsche Bank’s recourse claims against Breuer were settled for €3.2 million (i.e., a rather ‘symbolic’ 0.35 per cent of the potential claims against Breuer), while the first layer D&O insurers contributed €90 million.

On 4 February 2016, the Celle Appeal Court decided on a jewellery fraud case. The insured, a London jeweller, was defrauded of possession of jewellery worth €7.4 million.

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29 LAG Düsseldorf, VersR 2015, 782.
30 IV ZR 194/09.
31 Section 343(1) of the InsO.
32 5 U 2472/09.
33 Süddeutsche Zeitung, online, 22 February 2014.
34 Manager Magazin, online, 2 August 2014.
36 OLG Celle, 8 U 172/15 – not yet published.
The closing of the sale in question took place in a London hotel conference room where the fraudsters used a ‘Trojan Table’ to exchange real cash with facsimile bank notes. The jewellery was insured against ‘loss’ under an all risk policy on the German market. There was no explicit exclusion for ‘fraud’ in the policy, so the insured expected that he would be protected under his insurance policy. However, the Celle Appeal Court dismissed the claim, as it considered that the ‘voluntary’ (albeit as a consequence of deceit) ‘giving away’ of jewellery is not to be qualified as insured ‘loss’. The insured criticised the Appeal Court, claiming that it incorrectly interpreted an implied risk exclusion in the term ‘loss’ and overstressed the policy’s wording, and brought the matter before the Federal Supreme Court. The latter did not allow the appeal and rejected the jeweller’s application on 14 December 2016 (IV ZR 69/16) without deciding on the merits of the case as it denied, *inter alia*, the required ‘fundamental significance’ of the matter (see Section IV.ii, *supra*). This shows that even a party’s considerable economic interest (in this case, of several million euros), as such, does not allow access to the Federal Supreme Court.37

VI OUTLOOK AND CONCLUSIONS

On 1 January 2014, the preparation of Solvency II commenced. BaFin announced its intention to comply with all guidelines published in 2013 by the European Insurance and Occupational Pensions Authority in this regard. The corresponding national legislation came into force on 1 January 2016.

The Solvency II Directive aims at changing the existing supervision rules including solvency rules (i.e., capital requirements and its assessment) for insurers and reinsurers considerably. Solvency II contains three ‘pillars’: Pillar I deals with capital requirements and the evaluation of assets; Pillar II with the insurer’s governance structure and required risk and solvency management systems (own risk and solvency assessments) to be applied by insurers; and Pillar III with reporting requirements.

The substantive change in respect of capital requirements for all EU regulatory bodies will be that the capital required under Solvency II will, in future, depend on the insurer’s strategic decisions and the risks arising therefrom (risk-based solvency assessment). The new rules do not assess capital requirements by reference to premiums earned or the average insurance compensations paid in past periods,38 but provide for a framework within which supervisory bodies are to apply their (then extended) discretion to determine individually the capital requirements that are (considered) necessary by supervisory bodies to ensure that insurers will, in the long term, be able to meet their obligations under insurance contracts. BaFin has, to a certain extent, already followed a similar approach in respect of risk management and reporting requirements since 2009 with the setting up of ‘MaRisk’.39 Hence, some of the preparatory works are not new to the German industry. Further, insurers are free to decide if and which steps are taken to prepare their businesses for Solvency II. Only if BaFin is under the impression that an insurer is insufficiently prepared for Solvency II might it apply a closer control scheme to such insurers.

37 Bundesgerichtshof, IV ZR 69/16.
38 See Verordnung über die Kapitalausstattung von Versicherungsunternehmen – Kapitalausstattungsverordnung.
39 BaFin’s ‘Minimum Requirements for Risk Management in Insurance Undertakings’, Circular 3/2009, have been issued on the basis of Section 64a of the VAG.
Under material insurance, there have been no significant changes since the reform of 2008. The insurance legal practice is, however, still trying to adapt to these new rules and the most significant issues are to be expected in respect of courts’ determinations on the validity of certain insurance clauses insofar as they deviate from VVG provisions. There are significant uncertainties in this respect also regarding large risks where it is generally possible to deviate from the VVG provisions, although the limits are uncertain. The judgment of the Appeal Court of Frankfurt on cost clauses in D&O insurance contracts (see Section III.iii, supra) may serve as an example. Legal risks arising from uncertainties regarding the validity of insurance concepts and their potential clash with the general concepts contained in the VVG are primarily caused by a rather restrictive German judicature. As set out in Section III. iii, supra, the next development with significant impact on insurers will most likely be the abolishment of the concept of disguised obligations, which will automatically make exclusion clauses previously considered as disguised obligations invalid.
Chapter 14

GREECE

George Iatridis, Dimitris Kapsis, Dimitris Giomelakis and Nikolaos Mathiopoulos

I INTRODUCTION

The insurance market experiences constant change because of its interdependence with the economy as a whole. The Greek insurance market is currently under pressure (as is the rest of the Greek economy), with its main characteristic being the reduction of premiums (€3.7 billion in 2015, a reduction of 6.1 per cent compared to 2014). Greek insurance law is strongly influenced by European law, and has seen many amendments in recent years. The Greek insurance market has taken steps to ensure a smooth transition to the Solvency II regime, which was lately enacted (effective from 1 January 2016), in a highly volatile and uncertain market environment.

II REGULATION

i Regulatory agencies responsible for regulating insurance and reinsurance companies, and the relevant 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, however, 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 provide its services in all EU or European Economic Area (EEA) Member States. Insurers

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1 George Iatridis is a partner, and Dimitris Kapsis, Dimitris Giomelakis and Nikolaos Mathiopoulos are senior associates, at Ince & Co.
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.
Grant of licence regarding the conduct of insurance or reinsurance business

The licence is granted per 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.

Regulation of officers and directors

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.

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, since 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.

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. Said obligations are compliant with the provisions of the EU Solvency II legislative framework.
recently enacted in Greece. 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, said 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 Insurance insolvency winding-up proceedings

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 of insurance companies

All transactions involving a change of control of insurance and reinsurance companies have to be approved by the local regulator. In such case, the officers and directors of the acquirer will be subjected to due diligence investigations 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.

x Financing a merger

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, *inter alia*, 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.
xi  Investment in an insurance or reinsurance company
Greece
Greece

Greek law does not discriminate with regard to the origin of the investment capital that may be invested in a Greek insurance or reinsurance company. However, it should comply with anti-money laundering and counterterrorist financing legislation.

xii  Key information documents (KIDs) for packaged retail and insurance-based investment products (PRIIPs)

The application of Regulation (EU) No. 1286/2014 on KIDs for PRIIPs began on 31 December 2016. 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 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.

ii  Making the contract

Insurance contracts

According to Article 1 of the ICA, the minimum statutory or regulatory contents of an insurance contract are:

a  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);
b the period for which insurance cover is granted;
c the insured risks;
d the insured sum;
e exceptions to the cover;
f the premium;
g the applicable law; and
h the unit to which the policy is linked (with respect to unit-linked insurance policies).

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 said 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:
a to supply the policyholder with the information required under law prior the conclusion of the contract;
b 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; and
c 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 above, reinsurance contracts are not regulated by law; therefore, there are no minimum statutory or regulatory requirements.

iii 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). Terms implied in fact 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 10–16 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, including appeals

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 from 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 – following the recent amendments to the procedural law – are:

a Pleadings are submitted within 100 or 130 days (depending on the case) from the date of submission of the lawsuit; supplementary pleadings are submitted within 15 days following the expiry of the above deadline. The case file is then considered closed. Within 15 days therefrom, 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 said 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 from the service of the judgment, within 60 days from the service of the judgment in case the appellant is resident abroad or its address is unknown, or within two years from 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 from the service of the appeal court judgment, within 60 days from the service of the judgment in case the appellant is resident abroad or its address is unknown, or within two years from 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 has been abolished by the recent 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 so as to proceed with the issuance of the decision, it may issue an act ordering that witnesses be examined. Following such 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 such an appointment (Article 368 of the 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, Greek 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. Recently, 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 such 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 so as to be legally binding. Signature may be substituted by the exchange of signed letters or faxes. 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.

The reasons for annulment include:

- an invalid arbitration agreement;
- the arbitration award was issued after the arbitration agreement ceased to be in force, or was against public policy or good morals;
- the arbitrator was not validly appointed or requests to be exempted from the process for serious reasons;
- the arbitrator has abused the powers vested in him or her by law or by the parties;
- violations of principles 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 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*

In the case of 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 has been introduced as a result of the harmonisation of Greek law with EU Directive 2008/52/EC. Recourse to mediation depends either on the parties’ will (which may be encouraged by the court) or where a court of another Member State makes an order or if it is imposed by 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 the 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 six 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) has been 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. As these companies hold a considerable stake in the local market, they may become a target for multinational insurance groups already active in the Greek market. In 2015, the Eurolife ERB Insurance Group was acquired by Fairfax Financial Holding, which is also the main shareholder in Eurobank SA with a 16.88 per cent holding for €316 million. Allianz SA and Munich Re’s primary insurance unit of Ergo AG have also been in talks to acquire ATE Insurance SA. In addition, in 2016, National Insurance, the first insurance company in Greece, established in 1891 and owned by the National Bank of Greece, has agreed to acquire part of the insurance portfolio of International Life. The National Bank of Greece has announced its plans to sell National Insurance within 2017.

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, the bancassurance and the competition with the 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 venture companies 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.

Over the past decade, 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, 24 general insurers and six stand-alone health insurers, 27 third-party administrators, 376 insurance brokers, 21 web aggregators, four insurance repositories, and innumerable corporate agents and insurance agents. In December 2016, the IRDAI also granted registration to five foreign reinsurer branches in India. In addition, at present, there are two reinsurance companies in India: the government-owned General Insurance Corporation; and ITI Reinsurance Limited, which was recently granted registration by the IRDAI. Moreover, Lloyd’s of London is also currently in the process of forming a branch in India and there are various other foreign reinsurers that are also looking to establish branch offices in India.

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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’s regulations on the reinsurance of life and general insurance business. 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 IRDAI (Lloyd's India) Regulations 2016 (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 subject to satisfaction of certain conditions.

iii Position of brokers
Only insurance brokers that are registered with the IRDAI as direct brokers, reinsurance brokers or composite brokers in accordance with the IRDA (Insurance Brokers) Regulations 2013 can operate as insurance brokers in India.

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.

vi The distribution of products
Only licensed insurance agents and insurance intermediaries can solicit and procure insurance business for insurers. Insurers are also permitted to engage licensed telemarketers and licensed web aggregators for the solicitation and procurement of insurance business, and to purchase access to the database of licensed referral companies.
vii Compulsory insurance (e.g., employers’ liability)
The following are examples of insurance covers 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;
c under the Deposit Insurance and Credit Guarantee Corporation Act 1961: insurance to be taken by the banks functioning in India;
d under the IRDA (Insurance Brokers) Regulations 2013, IRDAI (Registration of Corporate Agents) Regulations 2015, IRDAI (Web Aggregators) Regulations 2013, IRDAI (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 the Carriage by Air Act 1972 requires parties to maintain adequate insurance covering any liabilities that may arise;
f under the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995: 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 the 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 (within the financial services context)
Dispute resolution in India is broadly divided into three mechanisms: (1) civil courts; (2) consumer fora; and (3) arbitration and alternate dispute resolution.

The government has recently introduced the Commercial Courts, Commercial Division and Commercial Appellate Division of High Courts Act 2015 (the Commercial Courts Act), which provides for the establishment of specialised courts to adjudicate on disputes pertaining to transactions of merchants, bankers, financiers and traders.

Amendments have also been 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, infra.

ix Taxation of premiums
Premiums received on account of insurance and reinsurance business attract service tax. Income tax laws provide deductions to the policyholder on life and health insurance premiums paid.
India

x Proposed changes to the regulatory system
The IRDAI has proposed draft regulations governing outsourcing of activities by Indian insurers to third parties. These regulations set out the category of activities that may be outsourced, and the terms, conditions and safeguards that may be incorporated in such outsourcing arrangements. The IRDAI has also released draft regulations that replace the previous framework for protection of policyholders and are more comprehensive in terms of the specific matters to be listed in insurance policies, and the duties to be placed on insurers and surveyors at the claims stage. In addition, the IRDAI has also issued a draft Stewardship Code that sets out the principles to be adopted by Indian insurers as institutional investors.

xi Other notable regulated aspects of the industry (e.g., ownership, mergers, capital requirements)
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 now been removed. In terms of M&A activity in the insurance space, press reports indicate that there is an ongoing merger between Max Life and HDFC Life, which is presently being considered by regulators. In addition, several investors in insurance joint ventures (including insurance companies and intermediaries) have entered and exited such ventures through a transfer of shares.

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 in India.

Indian 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 wordings specified by the former Tariff Advisory Committee. Very few modifications to these policy wordings have been permitted. On all other lines of insurance business (except mega risks, which are written on a special contingency basis), insurers are permitted to issue only those policy terms and conditions, endorsements and other ancillary documentation that have been approved by the IRDAI in advance. No changes are permitted to be made unless the prior consent of the IRDAI is obtained. 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. The IRDAI has also specified a number of other conditions for health insurance policies, making these policies highly regulated.

The IRDA (Protection of Policyholders’ Interests) Regulations 2002 require general insurance contracts to state several matters, including:

a full description of the property or interest insured with locations and insured values;
b period of insurance;
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 Indian courts and consumer fora 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 IRDA (Protection of Policyholders’ Interests) Regulations 2002 provide, among other obligations, that insurers 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 (warranties, conditions, insured’s obligations, cancellation provisions, conditions precedent, etc.);
• 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 (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, per the Product Filing Guidelines 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.

There is one other feature of the Indian insurance sector that is worth mentioning. It 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. However, if a corporate agent has a main business other than insurance distribution, then the corporate agent 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, corporate agents 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.

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.

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 recently issued IRDAI (Payment of Commission or
Remuneration or Reward to Insurance Agents and Insurance Intermediaries) Regulations 2016 (the Commission Regulations). 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, however, as it will depend on the facts and circumstances of each case.

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.

At present, 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.

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 defendant resides and the value of the claim.
The consumer courts follow a three-tier hierarchy, which, in ascending order, is the District Forum, followed by state consumer dispute redressal commissions (state commissions), then the National Consumer Dispute Redressal Commission (NCDRC). There are 626 district fora, which can accept claims up to a value of approximately US$29,500. There are 36 state commissions, which can accept claims of between approximately US$29,500 and US$148,000, and appeals against the decisions of the district fora. At the apex lies the NCDRC, which accepts matters with a value of over US$148,000 and appeals against the decisions of the state commissions. A decision of the NCDRC on matters with a minimum value of US$147,275.51 can be challenged before the Supreme Court of India (India’s highest court). Similarly, the broad ascending hierarchy of the civil courts comprises around 600 district courts, 24 high courts and the Supreme Court of India, 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$294,551.03 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. Recently, 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, among other disputes, are specially assigned to hear insurance and reinsurance matters. The pecuniary jurisdiction of these courts is disputes that have a value of US$148,000 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 the 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 of India.

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 recently enacted Commercial Courts Act for the first time provides for summary judgment in a suit. Under the Commercial Courts Act, plaintiffs can apply for summary judgment in a suit after summons have been served upon a defendant. If it is convinced that the defendant has no real prospect of succeeding in a claim, the court 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 such 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 such person is not a party to the proceedings, and direct it 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.

A court has the power to require witnesses who are within its 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 such person fails to attend or give evidence, the court may, in considering the absence of such 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 recently 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$44.18 for costs awards in the case of vexatious litigation, the Supreme Court suggested that the Parliament should consider raising the limit to US$1,472.76. The recently enacted 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, with the recent changes in 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. Keeping in mind the time involved in legal proceedings and the limited number of judges available, it has now 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.

### 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 of India in cases such as *Bharat Aluminium*
Co v. Kaiser (2012) and World Sport Group (Mauritius) v. MSM Satellite (2014). 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 has 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, but the consent of the parties is a condition precedent to mediation. 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.

V YEAR IN REVIEW

The Indian insurance sector has witnessed significant developments over the past year. The regulations governing reinsurance arrangements of insurers were released pursuant to which the IRDAI recently brought into effect the order of preference for cessions, which describes the hierarchy between various entities with which an insurer can place its reinsurance business.

The IRDAI also issued the Commission Regulations that place limits on the commission or remuneration payable to insurance agents and intermediaries for the solicitation and procurement of insurance business, but also introduces the payment of rewards to such agents and intermediaries. Insurers and insurance intermediaries are expected to revisit their existing arrangements given the flexibility in the amount of commission or remuneration (including rewards) now payable to such intermediaries for soliciting insurance business.
In addition, the IRDAI issued detailed corporate governance guidelines for insurers consolidating all its previous instructions. New regulations governing health insurance policies were issued that have brought about standardisation in the definitions and terms used in such policies. Moreover, the IRDAI has also recognised issuance of e-insurance policies.

Furthermore, the IRDAI released the product filing guidelines for both general insurance products and health insurance products where certain types of products are subject to the ‘use-and-file’ process (i.e., such products can be marketed subject to approval from the insurer’s internal committee; prior IRDAI approval is not a prerequisite).

**VI OUTLOOK AND CONCLUSIONS**

The Indian insurance industry has seen significant growth and development in recent years. The removal of the requirement to seek an approval from the government of India 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, where several foreign reinsurers have recently been permitted to set up branches in India. Lloyd's of London is also currently in the process of forming a branch in India and there are various other foreign reinsurers that are also looking to underwrite reinsurance business through service companies set up in India under the Lloyd’s India Regulations. It is also relevant to note that with insurers being permitted to issue products under the ‘use-and-file’ process, there is an increase in product development and innovation in India.

However, these significant yet frequent changes in the regulatory environment have led to a state of flux in the insurance industry. For instance, while 49 per cent of foreign investment is permitted in insurers and insurance intermediaries, the regulatory requirement of such entities being ‘Indian owned and controlled’ has led to implementation concerns between the Indian and foreign shareholders of such entities. Further, with the order of preference for cession of insurance risks by Indian insurers being brought into effect, insurers are expected to revise their reinsurance programmes and file such programmes with the IRDAI within the prescribed time frames. The Indian insurance sector is currently grappling with the implementation of these regulatory changes, which are expected to continue for a few more years. Consequently, players in the Indian insurance sector will be required to put in place systems and resources to keep pace with such regulatory developments.
Chapter 16

IRELAND

Sharon Daly, Darren Maher and April McClements

I INTRODUCTION

In the aftermath of the decision of the United Kingdom to leave the European Union (EU), many insurance companies are now looking to re-establish themselves in a country with guaranteed access to the single market. 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.

II REGULATION

i The insurance regulator

The Central Bank of Ireland (the Central Bank) has responsibility for the authorisation and ongoing supervision of insurance and reinsurance undertakings and intermediaries.

The supervisory role of the Central Bank involves ongoing review and assessment of an undertaking’s corporate governance, risk management and internal control systems. 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. The Central Bank has published a number of guidance notes in respect of authorisation and ongoing requirements applicable to these regulated firms. These include the Corporate Governance Code for Credit Institutions and Insurance Undertakings, the Minimum Competency Code 2011 and the Consumer Protection Code 2012.

ii Requirements for authorisation

In order to operate as an insurance undertaking in Ireland, an entity must either be authorised and regulated by the Central Bank or recognised by another EU regulator, which in turn enables the entity to avail of the ‘single passport’ regime.

As to the process applied by the Central Bank when reviewing a licence application, the applicant first has an initial meeting with the Central Bank, after which the applicant must submit a written application and any supporting materials.
Subject to the applicant satisfying the requirements of the Central Bank in respect of minimum capital requirements and any additional preconditions, the applicant will be issued with a formal authorisation.

A reinsurance provider can also establish a special purpose reinsurance vehicle (SPRV) which can streamline the authorisation process and that is subject to less rigorous supervision by the Central Bank, in comparison with fully regulated insurers.

The ongoing regulatory requirements of an authorised insurance and reinsurance undertaking include:

- 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, 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

Irish insurance and reinsurance undertakings must ensure that individuals holding certain positions comply with 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. 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.

### iv The distribution of products

Once an insurance or 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 (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 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 in Ireland 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 their 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 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 still liable to tax at 12.5 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**

EU Directive 2009/138/EC on the taking-up and pursuit of the business of insurance and reinsurance (Solvency II) aims to create a fully harmonised regime for the prudential regulation of insurance and reinsurance business in Europe. Solvency II has now been transposed into Irish law by virtue of the European Union (Insurance and Reinsurance) Regulations 2015 (the Irish Regulations), which took effect on 1 January 2016. Accordingly, the initiation of the Solvency II regime is the reform that dominates the Irish insurance industry at this time. The primary purpose of the new regime is to introduce a risk-based approach to the supervision of insurers and reinsurers, with its principal objective being the protection of policyholders. The effect of the Irish Regulations was to implement wholesale reform in respect of capital requirements, valuation techniques and governance, and reporting standards. The Irish Regulations also provide the Central Bank with increased supervisory responsibilities.

Additionally, the General Scheme of the Financial Services and Pensions Ombudsman Bill 2016 (the General Scheme) was published on 5 October 2016. Its main objective is to amalgamate the offices of the Financial Services Ombudsman (FSO) and the Pensions Ombudsman (PO). The General Scheme also proposes to amend the limitation period applicable to consumers' complaints in respect of 'long-term financial services'. These are defined for the purposes of the General Scheme as financial services ‘...the term of which exceeds six years and is not subject to annual renewal, sold to a consumer by a regulated financial service provider’. It is proposed that the limitation in respect of long-term financial
services should be six years from the date of the act or conduct giving rise to the complaint, or three years from the earlier of the following two dates:

a. the date on which the customer making the complaint first became aware of the said act or conduct; and

b. the date on which that consumer ought to have become aware of that act or conduct.

Significantly, it is also proposed that this amended limitation period would have retrospective effect, entitling a consumer to avail of this limitation period even if the impugned conduct occurred before the commencement of the General Scheme.

Finally, following on from the publication by the Law Reform Commission (LRC) of its Report on Consumer Insurance Contracts in July 2015, a draft bill – the Consumer Insurance Contracts Bill 2017 – was published in January 2017 (see Section III, infra).

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 or 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.\(^2\)

In accordance with the Solvency II regime, 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 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

\(^2\) Regulations 83–101, Irish Regulations.
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 and the Distance Marketing of Financial Services Directive.

In circumstances where the insured is a ‘consumer’, the insurer must also comply with the Consumer Protection Code and Consumer Protection Act 2007. The Sale of Goods and Supply of Services Act 1980 is also applicable to insurance contracts.

Save for 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 LRC has, however, recommended reforms to consumer insurance law and published a draft bill in July 2015. The LRC recommendations have largely been incorporated into the Consumer Insurance Contracts Bill 2017 that passed the second stage in the Dáil on 9 February. At the time of writing, this Bill is being sent to committee stage, however, there is no clear timeline for implementation.

The definition of a consumer in the 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 currently used for the purpose of complaints to the FSO and under the Central Bank’s Consumer Protection Code 2012.

Common law, if applicable
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.

ii  Making the contract

Essential ingredients of an insurance contract
Insurance contracts are governed by the general principles of contract 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 Irish 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 in Ireland (Prudential Assurance v. Inland Revenue [1904] 2 KB 658). 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 [1991] ILRM 726, and are as follows:

a  generally, the insured must have an insurable interest in the subject matter of the insurance policy;
Ireland

It should be noted in the context of consumer policies that the Consumer Insurance Contracts Bill 2017 proposes to reform the area of insurable interests. Section 5 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.

Under Irish law there is no difference between an insurance contract and a reinsurance contract.

An insurance policy will usually comprise a proposal form, policy terms and conditions, and supporting documentation provided to the insurer by the insured.

An insurance policy will typically comprise:

- **a** a proposal form completed by the insured;
- **b** policy terms and conditions drafted by the insurer; and
- **c** supporting documentation provided by the insured to the insurer at the application stage.

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 recent trend towards very short proposal forms that do not request detailed information about the risk. It is anticipated this may change in line with the changes in the UK driven by the new Insurance Act.

**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 Irish 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 Consumer Insurance Contracts Bill 2017 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 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 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 Consumer Insurance Contracts Bill 2017 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 Irish 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 man or woman. 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 man or woman 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. On the other hand, 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 reasonable persons 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 Irish law or regulation in insurance policies, although the following exist:

- *implied restrictions contained in motor insurance policies;*
- *mandatory provisions concerning professional indemnity insurance for solicitors and insurance intermediaries, the Medical Practitioners (Amendment) Bill 2014 introduces a minimum level of indemnity for medical practitioners, however, there is no time frame for implementation of this bill;*
- *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 Irish courts and there is a judicial reluctance to enforce such clauses. The Consumer Insurance Contracts Bill 2017 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 (re)insurers 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 Irish 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 Consumer Insurance Contracts Bill 2017 proposes to abolish warranties in consumer insurance contracts and replaced 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 Irish 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 Irish law reinsurance agreements.

iv Intermediaries and the role of the broker

Conduct rules

In order to undertake insurance or reinsurance mediation, a person must be registered as an insurance or reinsurance intermediary pursuant to the Investment Intermediaries Act 1995 or the European Communities (Insurance Mediation) Regulations 2005 or is operating in Ireland by virtue of the passport regime. Insurance and reinsurance mediation involves work undertaken in connection with entering into contracts of insurance, work undertaken prior to entering into such contracts, introducing persons to insurance undertakings or other insurance 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 as the Irish regulator, 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 enter an insurance or reinsurance mediator into the register, the applicant must satisfy the Central Bank that:

a. the directors satisfy the minimum competency requirements 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

Although the outsourcing of activities is permitted, Solvency II, together with the Irish Regulations, ensures that insurance undertakings, when delegating business activities to external agents, retain responsibility for all core business functions. Accordingly, an insurance undertaking is required to notify the Central Bank before outsourcing any critical and important function or activity, and is also required to inform the Central Bank of any subsequent material developments with respect to any such function or activity.3 Critical

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3 Regulation 51(3), Irish Regulations.
or important functions are defined by the European Insurance and Occupational Pensions Authority (EIOPA) as those that are ‘essential to the operation of the undertaking as it would be unable to deliver its services to policyholders without the function or activity’.

Insurance undertakings are also required to have written outsourcing policies in place, where relevant. These policies must be reviewed at least annually and amended to reflect any significant changes. All outsourcing policies (and any amendments thereto) must be subject to the prior approval of the board of directors of the insurer. In all cases where critical or important functions or activities are outsourced, there should be a written outsourcing agreement in place with the outsource service provider. This written agreement will be required by the Central Bank to demonstrate that all key factors have been taken into account. A written outsourcing agreement should include the following key factors:

- clear definitions of the duties and responsibilities of both parties;
- the duration of the agreement; the requirement that the service provider comply with all applicable laws, regulatory requirements and guidelines and cooperate with the undertaking’s supervisory authority;
- termination periods sufficient to prevent detriment to the continuity and quality of service; and
- effective access by the insurer, its external auditor and the Central Bank to all information on the outsourced functions and activities and permission to conduct on-site inspections.

How brokers operate in practice

Brokers 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. A broker must be registered with the Central Bank as an authorised 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 ongoing requirements for registered brokers include:

- ensuring the proper maintenance and reconciliation of designated client premium accounts;
- ensuring that the undertaking has sufficient professional indemnity insurance cover; and
- 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 Irish 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 in Ireland 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 Consumer Insurance Contracts Bill 2017 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 reasonably withholds or delays payment of a valid claim.

**Set-off and funding**

As per Regulation 20 of the Insurance Reorganisation Regulations, 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 in recent years 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 in Ireland 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 in Ireland.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Any dispute arising under an insurance or reinsurance contract which 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, the dispute will be brought before the Irish courts. Mediation is also a common form of dispute resolution in Ireland.

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; and
c Regulation (EC) 593/2008 on the law applicable to contractual obligations (Rome I Regulation).

ii Litigation

Litigation stages, including appeals

In Ireland, 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 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:

a the value of the claim or counterclaim exceeds €1 million; and
b the Court considers that the dispute is inherently commercial in nature.

Insurance disputes before the courts in Ireland are heard by a judge sitting alone and not a jury.
A new 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.

With the exception of the Commercial Court, where it is a requirement in contractual disputes, there is no provision for the exchange of witness statements or expert reports in proceedings before the Irish courts.

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 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 plaintiff offering a figure to settle the matter; if the defendant rejects the offer and is then awarded a lower amount at the hearing of the action, the plaintiff is penalised for costs.

iii 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 has 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(2) of the 2010 Act stipulates that such 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 in 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.

iv Alternative dispute resolution

Mediation is the most common form of alternative dispute resolution (ADR) for insurance disputes.

v Mediation

The role of the courts

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 as to costs.
V YEAR IN REVIEW

The most noteworthy event of 2016 from a financial services perspective was the decision of the United Kingdom to exit the EU (Brexit). In light of the fact that the City of London is the world’s leading insurance centre, Brexit has significant ramifications for the insurance market in both the United Kingdom and Ireland. The United Kingdom initiated the process to exit the EU, as set out in Article 50 of the Lisbon Treaty, in March 2017. As such, the ability of UK-based insurers to access the single market now looks uncertain. UK-based insurers currently access the single market by way of the financial services passport, which in effect enables an insurance company authorised by one EU Member State of the European Economic Area (EEA) to write business in and across all EEA Member States. Ireland, by virtue of being an English-speaking common law jurisdiction with geographical proximity to the UK, is an attractive alternative to UK insurers who need to ensure that they retain access to the single market and the ability to passport into other EEA Member States. The Central Bank has increased its workforce by a quarter in response to the increase in the number of authorisation queries from UK-based insurers. For any UK-based insurers considering relocating to Ireland, the Central Bank will look to see whether senior management personnel responsible for making key strategic business decisions are based in Ireland. Thus, while a UK insurer looking to relocate to Ireland can outsource certain activities, it will need to demonstrate that the ‘heart and mind’ of the operation is located in Ireland.

The Insurance Act 2015 in the United Kingdom came into force on 12 August 2016 and it is expected to have an impact on the Irish insurance industry going forward as the Irish market is closely connected to the UK (in particular the London market) and many Irish risks are written subject to UK law. Following implementation of the Act, insurance law in Ireland is significantly different from UK law for the first time since 1906.

The LRC published its Report on Consumer Insurance Contracts in July 2015, together with a draft Consumer Insurance Contracts Bill 2015. The report contains 105 recommendations, many of which are similar to those proposed by the UK Insurance Act. The Consumer Insurance Contracts Bill 2017 was published on 10 January 2017 and is substantially similar to the LRC’s draft bill. In particular the Bill proposes reform of the duty of disclosure, the introduction of proportionate remedies, the abolition of warranties, amendment of third-party rights and granting damages for late payment of claims. These reforms are to be welcomed as they seek to improve the level of certainty in insurance contract law for both insurers and the insured; however, these reforms are limited in scope to consumer contracts.

Finally, in recent times, there has been a significant increase in the number of insurance law decisions that are emanating from appeals of findings by the FSO. For example, in the recent decision of Richardson v. Financial Services Ombudsman & anor the High Court upheld a finding of the FSO that an insurer was entitled to avoid a life assurance policy on the grounds of non-disclosure. This was a significant judgment as the Irish courts have traditionally been reluctant to permit insurers to avoid policies. The decision of the High Court turned on the strength of the proposal form and serves as a useful reminder to insurers of the importance of a well-drafted proposal form.
Chapter 17

ISRAEL

Harry Orad

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 in Israel 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.

ii Licensing

Writing insurance in Israel requires a licence. Foreign insurance companies cannot write insurance business in Israel, but Israeli citizens may buy insurance abroad. Reinsurance, 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.

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;

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1 Harry Orad is a founding partner at Gross Orad Schlimoff & Co.
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 motor accident law provides compensation for all victims of motor accident 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.

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 on the Continent 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, the law 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

The Supreme Court clarified rules of interpretation of insurance policies in CA 4688/02 Cohen v. Migdal Insurance Company et al. In the Cohen decision, the Supreme Court explained that there are three stages in interpreting a policy, which are as follows:

a The first stage is based on the subjective intention of the parties to the specific policy. To ascertain 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.

c Third, 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 and in favour of the insured.

In the Cohen case, the Supreme Court held that the objective intention of the parties could be ascertained by reference to customary policies in the relevant class of business and interpreted the policy in favour of the insurer and not the insured.

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 under the ICL. 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.

The insurance agent 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 the insurance agent’s 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 CA 2626/01 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 Law, 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 who 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. The insurer must prove actual damage as a result of breach of the notification duty. Statements to this effect were made in several cases including CA 215/91 Hasneb Insurance Co v. Asulin, where the burden imposed on the insurers to prove actual damage was emphasised.

In Appeal 1438/02 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.

An extreme case was dealt with in CF 7/88 International Bank v. Prudential Insurance Co. 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 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 from 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 from the day on which a claim is submitted to the insurer, and they may be claimed separately from the remainder of the benefits.

**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 Israeli courts as legally binding in the framework of the insured–insurer relationship.

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 Israeli 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:

- 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;
- the coverage position must be provided to the insured in writing;
- where coverage is declined (whether wholly or partially), all grounds for this position must be detailed therein;
- the insurer is precluded from basing any argument on circumstances, conditions or exclusions that were not mentioned in the coverage position letter; and
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 the case of Phoenix Insurance Co Ltd et al. v. The Deborah Hotel et al.

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 CA 7298/10 Hadar Insurance Co Ltd v. Ehad Ha’am Food and Investments Ltd 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.
The recently approved Amendment No. 7 to the ICL increases the punitive interest, which a court may decide on according to Section 28a of the ICL, on insurance benefits that were not in dispute and were not paid in good faith on time according to the ICL, from up to three times to 20 times the market interest. This refers to personal insurance including life insurance, personal accidents, health insurance, and motor vehicle and apartments, and excludes liability insurance.

Recently, the Knesset (Israeli parliament) gave preliminary approval to a proposed amendment of the ICL, which states that examination of good faith of an insurer if they are avoiding paying insurance benefits will be from the point of view of a reasonable insurer. The proposed amendment also states that the burden of proof regarding the insurer’s good faith and its actions will attach to the insurer. It is also proposed that the Commissioner will be able to impose monetary sanctions on an insurer failing to pay insurance benefits within the time limit stipulated in the ICL. The amendment stipulates that if an insurance company refuses a claim filed by an insured, which is then accepted, fully or partially, by a court of law, the insurance company will have to pay punitive damages of 30 per cent to 60 per cent of the insurance benefits awarded. The higher percentage will apply if the court finds that the insurance company acted in bad faith.

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 new Israeli 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.

**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 to hold a meeting with a mediator to discuss holding mediation. 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 are 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 partial 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**

Pursuant to Section 62 of the Insurance Contract Law, an insurer has an independent right of subrogation in its own name, which is not contingent on receipt of assignment of rights of the insured.

To exercise this right and prove the third party’s liability towards the insured, the insurer had to show that it actually paid the insured insurance benefits for the loss, caused by the third party, on the basis of a valid policy.

In practically all cases, courts were prepared to assume that if actual payment to the insured had been made, the latter was entitled to the payments and that insurers do not volunteer payment of claims without being liable to do so.

This assumption was called into question by the Supreme Court in December 2014 in CA 728712 *Lloyd’s Underwriters and IEC v. Ashdod Port*. In this case the insurer failed to conduct an independent assessment of damaged goods and relied on the loss adjustment carried out by the vendor of the goods to the insured. The court criticised this reliance, in particular because the vendor was not an independent party but rather had a personal interest in selling new goods in lieu of the damaged goods.
This decision has prompted some local insurers to ascertain that adjustment of claims, which have subrogation potential, are carried out according to more stringent criteria.

VI YEAR IN REVIEW

i Cyber technologies
Cyber technologies are a rapidly growing branch of the Israeli high-tech industry, with increasing investments and number of start-ups. At the same time, cyber threats are increasing worldwide. Recently, the Commissioner issued a circular establishing the main principles of Cyber Risk Management of Financial Institutions (FI) and the duties of FIs to manage such cyber risks. The circular refers, *inter alia*, to the duties of the FI’s board of directors and chief executive officer (CEO) in respect of cyber risk management. We expect that the codification of the cyber risk duties, although not yet binding, together with the well-known global increased risk, will cause significant growth of the cyber insurance market in Israel.

ii Class actions
In the past couple of years, there has been an increasing number of class action applications against insurance companies, many of which are approved and many are often settled.

iii What is the starting date from which interest will be added to insurance benefits?
According to the provisions of Section 28 of the Insurance Contract Law, in addition to linkage differentials, interest will be added following the expiry of 30 days from the day of submission of the claim. The question of what day this is arose in a request for approval of a class action against the biggest Israeli insurance companies. The insurance companies’ position and practice is that ‘the day of submission of the claim’ is the day of submitting the final document needed to investigate the liability of the insurer. The plaintiffs’ position is that ‘the day of submission of the claim’ is the day upon which a letter of demand is submitted to the insurer for payment of insurance benefits, even without any accompanying documentation. The district court interpreted the wording of Section 28 and adopted the position of the plaintiffs. Last year we stated that a request for an appeal had been submitted to the Supreme Court; however, this year it was withdrawn as per the Supreme Court’s recommendation. The decision in the claim as to its merit is now awaited.

This decision has implications for all calculations of the extent of insurance benefits in all classes of insurance.

iv Is a D&O insurance policy valid when the insurance documents, signed by the CEO, contain misleading information?
In CA 4024/13 *Kfar Tikva v. Pinkovitz et al* (including Migdal Insurance Company Ltd), the Supreme Court remarked that there are situations where one policy insures several insureds, and some of them deliberately caused the insurance event or misled the insurer (before or after the insurance contract was signed). In such cases it is clear that those acting in malice or breaching the duty of disclosure will lose their right to insurance benefits. However, what would be the fate of the ‘innocent’ insureds who were not party to the misleading or malice? The court distinguishes between two situations: (1) if all insureds had a common interest in the insurance, the ‘innocents’ will not benefit from the policy, since it is a matter of public
policy not to encourage conspiracy between insureds, which is by nature difficult to discover or prove; and (2) if there are differences in the interests of the insureds, case law rules that the ‘innocents’ will have a right to insurance benefits.

In the current case of the D&O policy, although no common interest of the directors and the CEO can be pointed out, the court refrained from deciding on this question since the insurer did not establish the CEO’s breach of duty of disclosure. (In order to establish such fact it is not enough to deduct from the CEO’s general behaviour, but a clear factual determination is needed with evidence that the insurer was misled regarding the company’s situation prior to signing the policy.)

The court decided to leave such decision to a future discussion, realising the effect that such decision will have on D&Os insurance and the insurance of others. Only time will tell if, by this decision, the court paved the way for deciding that insurance obtained, while misleading the insurance company, is still valid.

v Subrogation: the Supreme Court rule of no right of subrogation for foreign insurers

In early 2017, the Supreme Court upheld the decision of a district court dismissing a subrogation claim by VIG Vienna Insurance Group. VIG paid 30 million new Israeli shekels to a paper plant in respect of flood damages and filed a subrogation claim against local drainage authorities, municipalities, etc., and Harel Insurance. The district court accepted the defendants’ position that according to Section 62 of the ICL, a foreign insurer has no right of subrogation if it is not registered as a foreign insurer according to the Control of Financial Services (Insurance) Law. The court also ruled that Section 62 cannot be circumvented by claiming according to the Unjust Enrichment Law. The court added that the insured’s right to claim his or her damages from the wrongdoers stays intact (if the insured is successful in his or her claim against the wrongdoer he or she may pay the foreign insurer such proceedings). This ruling is now a binding precedent.

VII OUTLOOK AND CONCLUSIONS

The Israeli insurance industry is one of the largest and most developed in the area. In 2017–2018, a steady, low premium growth can be expected.

The market will continue to be very competitive, dictating a soft market. This trend for a soft market also applies to reinsurance.

It is expected that the high level of competition and developments in technology will lead to creative new products in the market.
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 has suffered badly because of the financial crisis, the effects of which have been felt in Italy in recent years, but it now shows the first indications of improvement.

According to the European Commission’s 2016 winter forecast, all Member States have grown in 2016 (1.8 per cent for the euro area), with a further steady growth predicted for 2017 and 2018 (1.7 per cent and 1.8 per cent). Notwithstanding such a positive projection, the latest assessments released by the Italian National Statistical Institute for the fourth quarter of the past year pointed out the fact that in 2016, Italian GDP increased by a mere 0.8 per cent in real terms, and is estimated to increase by 0.9 per cent in 2017 thanks to the contribution of improved domestic demand.

This particular situation is reflected by the most recent Fitch Ratings report, according to which the ‘…outlooks for the Italian insurance market are stable, reflecting expectations that insurers’ profitability and capitalisation will be resilient despite strong pricing competition in motor insurance.’ Further, the insurance market should benefit from both the Ministry of Justice Decree No. 22 of September 2016 setting the minimum requirements for mandatory professional indemnity insurance for lawyers, as well as from the new law on provisions concerning the safety of care and professional liability of healthcare professionals, which on 28 February 2017 revolutionised the entire medical malpractice legal system.

In contrast with the non-life insurance market, Italian life insurers all reported a lower operating profitability in 2016 with deterioration of premium income drop and investment returns both in 2015 and 2016, driven by the decline of interest rates and stock-market volatility. This trend will continue throughout 2017 because interest rates are at the lowest point they have been in decades.

It is evident that, despite the difficulties in relaunching the internal economy, Italy is still a fertile ground for insurance underwriters, and provides interesting opportunities for prudent insurers and reinsurers especially in the newly reformed casualty insurance market.

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 2016. ISTAT is an active member of the European Statistical System, coordinated by Eurostat.
3 Published on 6 December 2016 by Fitch Ratings.
4 Published in the Official Gazette of the Italian Republic on 11 October 2016.
II REGULATION

i The insurance regulator

Decree-Law No. 95 of 6 July 2012\(^5\) dissolved the Italian Private Insurance Regulatory Authority (ISVAP) and replaced it with the Institute of Insurance Supervision (IVASS),\(^6\) now 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\(^7\) have been taken away from the insurance regulator’s competence and passed on to the Concessionaire for Public Insurance Services.\(^8\)

In accordance with the law, the Bank of Italy’s General Manager pro tempore is also the President of IVASS.

Other governing organs of the new 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 upon 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, IVASS 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.

Then, in October 2013 IVASS released Regulations No. 1 and 2 concerning, respectively, the imposition of 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 on 2 November with Regulation No. 3, which introduced the obligation for intermediaries

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5 Decree-Law No. 95 (the Spending Review Decree) has been 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.

6 IVASS address: 21 Via del Quirinale, Rome.

7 The Centre is responsible for providing information to parties entitled to compensation following an accident that has occurred in an EU Member State (other than the country of residence) and was caused by circulation of motor vehicles registered and insured in one of the Member States of the European Economic Area. To obtain the necessary information for users, the Italian Information Centre – in accordance with ISVAP Regulation No. 3 of 26 May 2006 – utilises data collected in the insurance coverage database maintained by the Integrated Service for Control of Automobiles run by ANIA.

8 www.consap.it.
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 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 on 17 December 2013 by Regulation No. 4 of the Council regulation on receivership of insurance companies.

In 2014, with Regulation No. 5 of 21 July, IVASS intervened to regulate the obligations of adequate due diligence and anti-money laundering registrations on the part of insurance companies and insurance intermediaries. Finally, on 2 December IVASS published Regulations Nos. 6 and 7, on 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.

During its first years of existence and until 2015, IVASS pursued the goal of bettering the transparency and clarity of information, and negotiating simplicity for the insured, while at the same time securing effective sanctions in the case of insurance companies’ non-compliance with the new market rules.

After 1 January 2016, the date on which Solvency II came into effect, IVASS concentrated its regulatory activity more on the insurers’ profitability and capitalisation. Consequently, IVASS first issued Regulations Nos. 25, 26, 27 and 28 of 26 July 2016 and Regulation No. 29 of 6 September 2016 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.

ii Position of non-admitted insurers

In Italy, only admitted insurers are entitled to provide insurance. More precisely, under the Italian 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 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 such 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. In Italy, 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; and
- **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.9

Equally, the authorisation or licence is denied if any of persons charged with the administration, management and internal control functions do not meet the prescribed requirements,10 or if the scheme of operations does not satisfy the financial needs and the technical rules for the correct management of an insurance business.11

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9 The implementation date of the EU Solvency II Directive has been delayed, pushing its introduction back probably to 2015, or even beyond, and, at the same time, there has been some expectation that Tier I capital would be set at 50 per cent of the solvency capital requirement, making it easier and less onerous for insurers to comply with the Directive.

10 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.

11 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.
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 from 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 shall be considered refused.

iv Other notable regulated aspects of the industry

In Italy, 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:

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.

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.

Should an insurance or reinsurance company enter 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 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. All the same, 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.

The distribution of insurance products in Italy 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 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).\(^{12}\)

In this respect, the former Italian regulator issued ISVAP Regulation No. 35 of 26 May 2010, providing specifically for the level of information to be provided to the prospective insured, and in information notices to facilitate the understanding of the products and their comparability. Along the same line, on 26 August 2015, IVASS and the Bank of Italy published a joint letter addressed to the insurance market (including banks and financial intermediaries) calling on them to adopt new measures so that customers purchasing insurance policies paired with mortgages and other loans (payment protection insurance) could be better informed and protected.

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 COVIP.

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:

a. section A for insurance agents;

b. section B for brokers;

c. section C for direct canvassers of insurance undertakings;

d. 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

e. 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

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\(^{12}\) ISVAP, just before its dissolution, issued a number of regulations to protect the consumer, and in particular it is worth mentioning the following:

a. ISVAP Regulation No. 40 of 3 May 2012 on mortgages, which defines the minimum requirements for life insurance contracts related to a mortgage or consumer credit as per Article 28, Paragraph 1 of Decree-Law No. 1 of 24 January 2012, amended by Law No. 27 of 24 March 2012; and

b. Regulation No. 41 of 15 May 2012, implementing provisions for the organisation and creation of procedures and internal controls aimed at preventing the use of insurance companies and insurance intermediaries for the purpose of money laundering and financing of terrorism, in accordance with Article 7, Paragraph 2 of Legislative Decree No. 231 of 21 November 2007.
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

Currently, a number of special laws impose compulsory insurance to be undertaken with private insurance companies. At other times, the private insured must instead take out an insurance contract with a public insurer such as, for example, the National Institute for the Insurance of Accidents at Work, or take out a mutual insurance contract with a private insurer through a public contracting entity.

Finally, an obligation to take out an insurance contract can be found in some National Collective Contracts of Work (CCNL) stipulated between the trade unions, representing the employees, and the Industrial Association, representing all their members who will adopt the negotiated CCNL for the specific industry.

The most recent legislation that introduced compulsory insurance is Decree-Law No. 138 of 13 August 2011, converted into Law No. 148 of 14 September 2011. This provision provided for all professionals to take out a professional indemnity insurance contract by 13 August 2012 with the exception of physicians and lawyers.

For physicians, the duty to undertake errors and omissions (E&O) insurance became effective on 15 August 2014, whereas for lawyers such obligation became effective after the

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13 Motor insurance was introduced in Italy with Law No. 990 of 29 April 1969 in OJ 3 January 1970 No. 2. It has subsequently been modified, and the most recent amendment was introduced by Decree-Law No. 179 of 18 October 2012, which provided that 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.

14 Domestic accidents compulsory insurance was introduced in Italy with Law No. 493 of 3 December 1999, which imposes from 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.

15 Typical examples of this are:
   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. Such insurance is provided through the National Federation of the Hunters; and
   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.

16 For example, the national collective labour agreement for managers and executives, according to Article 18(7)(a), (b) and (c), oblige the enterprises party to such collective contract to take out, for the benefit of their employees, executive insurance against professional and extra-professional accidents.
decree that the Department of Justice issued reforming the legal profession\textsuperscript{17} and a subsequent Department of Justice decree determined the minimum requirements for mandatory professional indemnity insurance for lawyers.\textsuperscript{18}

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.\textsuperscript{19}

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 currently due is up to 20 per cent of the capital gain, but is reduced to 12.5 per cent for the portion of income that relates to the period between the date of subscription or purchase and 31 December 2011.

The Italian State Agency, with 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

In Italy, 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 (ANIA)). 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, ANIA and the trade unions reached an agreement on the new contract terms and economic conditions for management employees.

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.\textsuperscript{20}

\textsuperscript{17} In the 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.

\textsuperscript{18} The Department of Justice Decree 22 of September 2016, published in the Official Gazette on 11 October 2016.

\textsuperscript{19} 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).

\textsuperscript{20} CCNL per i dipendenti delle agenzie di assicurazione in gestione libera (20 November 2014).
Furthermore, the national collective labour contract 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 Act\(^2\) 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:

\(\begin{align*}
  a & \text{ the Private Insurance Code;}^{22} \\
  b & \text{ the Civil Code;}^{23} \\
  c & \text{ the special legislation dealing with compulsory insurance;}^{24} \\
  d & \text{ regulations issued until 21 December 2012 by ISVAP and from that date onward by IVASS.}
\end{align*}\)

#### 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.\(^25\) Case law indicates that all information that is

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21 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’.

22 Legislative Decree No. 209 of 7 September 2005, as amended by Legislative Decree No. 130 of 30 July 2012.

23 Royal Decree No. 262 of 16 March 1942 in Official Gazette No. 79 of 4 April 1942.


25 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.26

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 onsite 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. In this respect, IVASS, as a result of numerous protests received 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 its 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.

iii 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 on 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. Should a problem of interpretation arise, the contract shall be interpreted using the general interpretation rules that are provided in the Civil Code for all contracts,27 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 pro forma contracts 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 wordings or forms designed to uniformly regulate a number of contractual relationships principally with non-professionals, the basic rule is to interpret 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.

In addition, there are terms that are considered legal but onerous for the party against which these are drafted. Such 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


27 See Articles 1362 to 1371 of the Civil Code.
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 also has to be followed in cases where the insurance has been underwritten on a claims-made basis, because although this is a legitimate contract, it deviates from the loss-occurrence basis chosen by the Italian legislature as the typical way in which insurance shall operate.\textsuperscript{28}

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\textsuperscript{29} or have an illicit scope.\textsuperscript{30}

Usually there are general conditions providing for all contracts falling within a specific class of business (i.e., professional indemnity), particular conditions for a specific group of insured (i.e., 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.

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 from 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. Should the insured not make a timely notification or not enforce its right to the indemnity within two years from the loss event, any right under the policy will be covered by the statute of limitation.

\textsuperscript{28} 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 judgement 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 on a case-by-case basis, keeping in mind the specificity of the insurance contract scope and the factual element of the case. However, the Supreme Court did not provided clear directions about the criteria that should support a validity test. Consequently, until this aspect will not become 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.

\textsuperscript{29} In the past, the nullity of kidnap and ransom insurance was grounded on ISVAP Regulation No. 246 of 22 May 2995 on the grounds that this type of insurance was inviting criminals to kidnapping insured persons with the aim of obtaining the indemnity payment. Today, the prohibition is provided by Article 12 of the Private Insurance Code.

\textsuperscript{30} 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.
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 registered letter or service of a writ of summons.

Once notified of such 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 the liability insurer 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 subrogation31 assume the rights of the insured and claim the insurance coverage. According to Italian law, 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)32 from the date of the lawsuit service to the date of final settlement.33

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 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 arbitration34 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 such clause would be in conflict with the law.

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31 In accordance with the provisions of Article 2900 of the Civil Code.
32 See Article 17, Paragraph 1 of Law No. 162, dated 2 November 2014.
33 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.
34 Inter alia, see Cass Civil No. 1081 of 18 January 2011.
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 the Italian Republic when the insured is a consumer. 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, 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.

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 such 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 conflictual issues listed are:

- insurance contracts;
- medical malpractice;

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35 In this sense, Cass Civil No. 9922 of 26 April 2010 affirmed that Article 1469 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.

36 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.

37 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.

38 See Official Gazette of the Italian Republic No. 53 of 5 March 2010.

directors and officers’ liabilities; and
d  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 such 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 who 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:

a  30 days from the date of the hearing to amend the defences;
b  30 days to present any further evidence that might be necessary to support the case – again, note that in Italy discovery is limited to what the parties consider relevant and the documents affecting the case usually are not produced in court; and
c  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, these 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. If so, the judge 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. Should one or both parties disagree with the court-appointed expert, the latter might be called to the hearing to answer questions or to draft a supplement of report; this further report usually closes the discovery phase.

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 evidentiary phase 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: the first of 60 days to lodge the last written defence, and the second of a further 20 days to rebut the final defences of the opponents.

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 such a proceeding, 10 days before the hearing for arguments the parties shall lodge a short brief with the court 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, it is impossible to anticipate the time a court requires to make its decision; usually the decision process takes from three to 14 months, and 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.\textsuperscript{40}

In Italian 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.\textsuperscript{41} 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.

A recent piece of legislation\textsuperscript{42} impacting the Italian litigation environment, and the fact that, since 1 January 2015, a series of tasks previously carried out on paper and in person must now be done electronically and remotely (the Electronic Civil Process) should, in a short period, speed up the civil proceedings and reduce the backlogs of the Italian courts.

In fact, with the Electronic Civil Process, lawyers throughout Italy can:

\begin{itemize}
\item[a] consult case court files online;
\item[b] receive telematics communications from judicial offices, and serve defences and judgments directly upon other lawyers;
\item[c] execute electronic payment of unified court duties; and
\item[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.
\end{itemize}

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 992 in 2016.

\textsuperscript{40} Usually an appeal lasts two years, and the Court of Cassation proceeding between one year and 18 months.
\textsuperscript{41} 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.
\textsuperscript{42} 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\textsuperscript{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

In Italy, 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 be only 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: whereas the formal arbitration procedure is regulated by the Civil Procedure Code\footnote{See Civil Procedure Code Title VIII: On Arbitration (Articles 806 to 840).} 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.

In Italian policy wordings, it is somewhat rare to encounter clauses providing 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,\footnote{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.} the extent of the damage suffered\footnote{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.} or the indemnification,\footnote{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 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 created 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.
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 E&O, 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 a period of three months. Should the assisted negotiation fail, the parties can then legitimately act in court to have the judge resolve the dispute.

V  OUTLOOK AND CONCLUSIONS

In 2017, it is expected that the Italian economy will benefit from the improvement of the general economic climate.

Along with the improving economic situation, in 2015 and 2016 the government enacted measures to promote the reform of the justice system considered crucial to close the efficiency gap that adversely affects not only the public at large, but also and more importantly business activities, especially the insurance market. Important steps have been taken to improve efficiency in the judicial system through the amalgamation of small courts, the introduction of the Electronic Civil Process and the encouraging of alternative dispute resolution. The next steps will focus on the final approval of pending legislation concerning, among the most important, the statute of limitation and judges’ liability.

These reforms are reflected in a Fitch Ratings report, which, with reference to non-life insurance, offers a positive analysis for 2016 despite the softening of premiums in the motor sector and fierce competition in the commercial lines, and gives a positive outlook for 2017.

Regarding the life insurance sector for 2017, Fitch Ratings predicts a decrease in premiums flow and a reduced performance because of very low interest rates. The reduction of guaranteed minimum rates to levels close to zero should reduce sensitivity to changes in interest rates on profits and capital. These positive factors continue to be offset by the higher risks inherent in the investment portfolios of life insurance companies, given the significant

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concentration of government bonds and corporate debt, a reflection of the strong relationship between the rating of the insurance sector and the sovereign one. In fact, any change to Italy’s credit rating generates a change in the rating of the Italian insurance industry.

Along with the systemic actions, the government made a number of amendments to compulsory motor insurance, according to which insurers:

- shall grant a minimum 7 per cent premium discount if a black box is installed in a vehicle. In the event of an accident, data collected from the black box will provide non-rebuttable and conclusive evidence in court. The offer of a policy connected with a black box is not mandatory for customers;
- shall grant a minimum 7 per cent premium discount if an insured undertakes the obligation to receive medical and rehabilitative treatments chosen and paid for directly by an insurer;
- shall grant a minimum 5 per cent premium discount if an insured undertakes the obligation to repair damage through a trusted repairer directly paid by an insurer;
- can now include a clause in a policy preventing the transfer of the right to claim damages to the repairer, in return for a 4 per cent discount in premium. This provision should prevent fraudulent agreements between parties that can artificially increase repair process costs; and
- shall grant an undetermined discount if an insured consents to let an insurer conduct a survey upon a vehicle prior to the issuing of an insurance certificate.

In an attempt to further limit judicial frauds, Law No. 09/2014 imposes strict rules on the admissibility of witnesses in court for cases of motor accidents with property damages only. To be called as such, a witness shall have to be identified in the accident declaration, the claim form or in a public authority report; no witness subsequently identified shall be admitted to give testimony. The same Law states that a judge presiding over any court proceedings shall inform the Public Prosecutor’s Office if an individual has been a witness in three different motor liability cases within a period of three years to investigate the respectability of the witness.

In connection with these new legal provisions, which became effective on 21 February 2014, specific obligations have been introduced in an effort to improve transparency, such as the inclusion of disclaimers on insurers’ websites, communications to IVASS and the Ministry of Economy and Finance. In addition, policyholders’ documents or information that are not timely or exhaustively executed shall be sanctioned with fines of between €1,000 and €10,000 for each breach.

The insurance market and, as a consequence, the reinsurance market, are expected to benefit from all these changes throughout 2017.

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I INTRODUCTION

The Japanese life and non-life insurance markets have been very competitive, involving a large number of companies. Although Japanese insurance companies are providing individual annuities to respond 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 in Japan 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

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1 Shinichi Takahashi is a partner, Keita Yamamoto is a counsel, and Yoshihide Matsushita and Takahiro Sato are associates, at Nishimura & Asahi.
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 of the FSA 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, such insurance providers 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:

a deposit a security deposit with the deposit office;
b 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
c conclude a broker's liability insurance contract (in this case, brokers are required to ensure the resources of at least ¥20 million by means of (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:

a the following four documents (basic documents): the applicant's:
   • articles of incorporation;
   • statement of business procedures;
   • general policy conditions; and
   • statement of calculation procedures for insurance premiums and policy reserves;
b a business plan;
c documents explaining the status of recent assets, profits and losses; and
d 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 (e.g., ownership, mergers, capital requirements)

Permitted activities and subsidiaries
Insurance companies and licensed branches can carry out only the following three 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 (a) to (d) above.

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:

- the person or entity acquires more than 50 per cent of the total voting rights of a Japanese insurance company or SASTI provider; or
- the number of voting rights held becomes either (1) equal to or less than 50 per cent, or (2) 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:

- 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

- 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 either in:

- stated capital (in the case of a stock company); or
- 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:

\[
\text{Solvency margin ratio (\%) = \frac{\text{the total amount of margin}}{\text{the total amounts of risk} \times 1/2} \times 100\%}
\]

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., 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 interests 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.2

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 speaking, 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, intentions or understandings of an individual policyholder are not considered in the interpretation of insurance contracts.3

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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:

a by giving prior notification to the FSA; or
b 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 such 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.

Generally speaking, 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:

- a policyholder is aware that any accident to be covered by the insurance has already occurred; or
- 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:

- the excess is caused by the malicious intent or gross negligence of the policyholder; or
- there is an agreement regarding the value of the object insured.

**Rights of reducing 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).

**Rights of reducing 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).

Rights to cancel by insurer

An insurer can cancel the insurance contract when (Articles 30, 57, and 86 of the Insurance Act):

a. a policyholder commits fraud or tries to commit fraud against the insurer; or
b. 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).

Rights 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.

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:

- 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);
- offer insurance policies that are suitable for such purposes;
- provide explanations of the policies to customers; and
- 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 recently 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, new IBA regulations have been 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 means of selection 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. Note that 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.

v Claims

Notification

Under the Insurance Act, notifications of loss are required where policyholders or the insured perceive such 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:¹

a be indemnified for any damage that it incurs because of the delay; or
b deduct an amount equivalent to any loss caused by failure of this notice from insurance monies.

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 such clauses in relation to disputes between ceding companies and reinsurance companies.

¹ Supreme Court decision, 20 February 1987, Minshu Vol. 41, No. 1 p. 159.
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 such clauses in relation to disputes between cedent companies and reinsurer companies. Generally speaking, 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, either party 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 (ADR) System under the IBA was introduced in Japan. Under the Financial ADR System, insurance companies and reinsurance companies are required to both:

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 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 last amendment of the IBA was passed by the Japanese Diet on 23 May 2014 (the Amendment). The Amendment mainly includes:

a establishment of new fundamental rules regarding insurance solicitation (as stated in Section III.iv, supra);
b streamlining the regulations for insurance agents;
c deregulation of overseas development of insurance companies (as stated in Section II.vi, supra); and
d relaxation of regulations for brokers.

With regard to item (a), in addition to changes noted in Section III.iv, supra, the following two matters should be noted. First, the meaning of ‘insurance solicitation’ was clarified in the Guidelines. Before, the interpretational issue as to whether an act in question falls under insurance solicitation often arose in practice because the meaning of the phrase was not clear. For greater clarity, the Guidelines provide three categories: (1) insurance solicitation, (2) insurance solicitation-related acts, and (3) acts that do not constitute insurance solicitation or insurance solicitation-related acts. Second, the Guidelines cover solicitations by telemarketing channels. These require insurance companies and intermediaries engaging in telemarketing solicitation 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 phone calls. Further, insurance intermediaries utilising
telemarketing should be focused on (1) establishing a script for the discussion, (2) ensuring
there is a ‘do not call’ registry, (3) recording telephone conversations, (4) analysing the reasons
for complaints and sharing with the persons making the phone calls measures to prevent
such complaints, and (5) monitoring conversations by personnel who are not party to the
conversations, with a view to implementing appropriate measures to address any problems
identified by the monitoring.

In relation to item (b) above, the IBA now requires that insurance agents take measures
to ensure the sound and appropriate management of their insurance solicitation business,
such as:

a. explaining important matters pertaining to their insurance solicitation business;
b. appropriately handling customer information acquired in relation to their insurance
   solicitation business;
c. properly executing any business they entrust to a third party;
d. describing the features of insurance contracts pertaining to the insurance that the
   entrusting insurance companies will underwrite in comparison with other insurance
   contracts pertaining to the same insurance; and

e. appropriately establishing guidelines and educating persons carrying out insurance
   solicitation based on those guidelines (if conducting the business of educating persons
   carrying out insurance solicitation).

Before the Amendment, only insurance companies were required to take measures to ensure
the sound and appropriate management of their business (including the supervision of
their insurance agents); in other words, the authorities aimed to supervise insurance agents
through insurance companies. The Amendment was enacted in response to the enlarged
market presence of insurance agents who are undertaking solicitation activities on behalf
of multiple insurance companies, and who are not fully managed and supervised by such
insurance companies.

VI OUTLOOK AND CONCLUSIONS

Under the Amendment, restrictions on certain aspects of the insurance business have
been relaxed, which may enable more cost-effective management of insurance providers
under the IBA and improve the accessibility of insurance products for customers. At the
same time, the Amendment introduced further solicitation restrictions to ensure customer
protection, especially in relation to persons carrying out insurance solicitation. In 2016,
customer-oriented business conduct was a hot topic in Japan because the FSA published the
‘Strategic Directions and Priorities 2016–2017’, which emphasised customer-oriented asset
management and intermediation as part of the FSA’s effort to establish ‘fiduciary duties’. 
Specifically, the FSA pointed out the current problems, which are namely that financial
institutions tend to prioritise products with high commission fees, and consumers are not
effectively made aware of the commission fees they pay and the risks associated with the
financial products they purchase. Therefore, the FSA announced its policy whereby it will
(1) establish codes and principles for customer-oriented business conduct to ensure financial
institutions fulfil their fiduciary duties in a broader sense of the term, (2) encourage enhanced
disclosure of commission fees and improved explanatory materials on the risks of financial
products, and (3) promote voluntary disclosure by financial institutions of their policy
concerning customer-oriented business conduct. This policy is, of course, addressed to the insurance sales market and will have a certain effect on it. Further, this is not new legislation or a revision of the IBA but it is highly likely that insurance companies, among others, will have to take measures to comply with this policy.
I INTRODUCTION

As of 10 June 2016, there were 25 life insurers and 31 non-life insurers (14 domestic insurance companies and 17 foreign insurance companies) in Korea. The gross profits earned by life insurers during the first half of 2016 was 2,297 billion won, which is a reduction of 18 per cent compared to the gross profits of the same period in 2015 (4.4 per cent of the average profit rate for invested insurance assets), and the gross profits earned by non-life insurers during the first half of 2016 was 2,027.5 billion won, which is an increase of 17.6 per cent compared to the gross profits of the same period in 2015 (3.8 per cent of the average profit rate for invested insurance assets).

The reinsurance market in Korea is continuously increasing and, since Pacific Life Re and Asia Capital Re started their reinsurance business in Korea in 2016, apart from Korean Re, there are 10 foreign reinsurers in Korea. This increase is can be attributed to the perception that Korea is an emerging market for reinsurance compared to Japan and that there is less political risk compared to China. Korean Re’s market share is approximately 60 per cent, a reduction of 10 per cent compared with the previous year; however, its domestic market share is considered to be high, and there is a concern that risk diversification is not being effectively conducted. In response to this, there is a movement to establish another domestic reinsurer. In 2016, the domestic life insurance market ranked seventh and the non-life insurance market ranked ninth in the world in terms of revenue.

During 2016, the growth of premium income of life insurers in Korea stalled at 2.7 per cent, and it is anticipated that growth will slow in 2017, with the growth rate likely to stay at 1.7 per cent. According to the Korea Insurance Research Institute, the growth rate of the premium income of life insurance in 2016 can be attributed to the growth of collective insurance which was the result of retirement pensions becoming compulsory for large companies. Thus, when excluding the retirement pension plan, the growth rate for 2016 would be 1.6 per cent, with a 1.1 per cent increase expected for 2017.

However, the premium income of non-life insurers, despite rapid growth of car insurance in 2016 owing to the drop in the retirement pensions and long-term saving insurance markets, increased by only 3.8 per cent compared to the previous year. Further, according to the Korea Insurance Research Institute, notwithstanding the growth in the long-term guaranteed insurance and car insurance, owing to poor growth in retirement

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pensions and long-term savings insurance as a result of the prolonged slow growth and low interest, the growth in the premium income of non-life insurers in 2017 is anticipated to remain at 2.9 per cent, which is a reduction of 0.9 per cent compared with the previous year.

II REGULATION

i The regulatory authorities
The Financial Services Commission (FSC) and the Financial Supervisory Service (FSS) regulate the Korean 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 the Korean insurance business in accordance with the Insurance Business Law (IBL) and the Insurance Supervision Regulations.

The FSS is the executive arm of the FSC and 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 that must be satisfied to perform insurance business in Korea, and if such requirements are not satisfied, the FSC will not approve a licence. Without FSC approval of a licence, insurance business should not be performed; performing insurance business in Korea without an approved licence is illegal, and is subject to imprisonment for a period of 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 perform the intermediate execution of insurance contracts, and must be duly registered at the FSC. In the sense that insurance brokers are involved in the execution of insurance contracts, they resemble insurance agents. However, insurance brokers differ from insurance agents (who act on behalf of a particular insurance company) as insurance brokers liaise with multiple insurance companies. Article 92 of the IBL prohibits insurance brokers from being affiliated with a 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
Anyone wishing to perform insurance business in Korea should obtain a licence from the FSC, and Article 6 of the IBL seeks to specify the details of the requirements to obtain a 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 such amount exceeds
5 billion won). For an insurance company that markets or solicits through 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 workforce that possesses insurance business expertise and appropriate facilities (e.g., IT facilities). In cases where an insurance company outsources some of its work (e.g., the evaluating of insurance contracts, maintaining of IT facilities and investigating of insurance accidents), it is required that the insurance company satisfy this obligation in respect of those outsourced works;

c the company’s business plan should be reasonable, and should not be contrary to public policy; and

d its principal shareholders should not be disqualified for any grounds under Article 13-1 of the IBL, they should have the necessary competent financial capacities and they should have no record of harming the economic order.

For a foreign insurance company seeking to obtain an insurance business licence:

a its business fund should be equivalent to (or exceed) the above-mentioned minimum capital requirements for domestic insurance companies;

b the kind of insurance business that the foreign insurance company seeks to operate in Korea should be the same kind of insurance business that it is operating in a foreign country in accordance with the law of that respective jurisdiction;

c the financial status, and financial and business soundness of the foreign insurance company should be internationally recognised and be adequate to operate business insurance in Korea; and

d the foreign insurance company should satisfy the conditions under (b) and (c), and the requirements for domestic insurance companies.

In order to obtain a licence, an insurance company may first apply for a provisional licence, and the FSC may place conditions on such provisional licence. An insurance company should indicate the kind of the insurance that it operates most in its company name, and companies not running an insurance business cannot include a name or mark in their name that indicates 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 money and other benefits to an insured on the occurrence of a contingency in order to guarantee any risk in exchange for such consideration.

According to Article 2-1 of the IBL, an insurance product can be subcategorised as follows:

a life insurance product: a contract prescribed by presidential decree that seeks, in exchange for consideration, to promise the payment of stipulated money and other benefits with respect to the survival or death of an individual for the purpose of guaranteeing any risk;

b non-life insurance product: a contract prescribed by presidential decree that seeks, in exchange for consideration, to promise the payment of 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 (c)) to guarantee any risk; and

c type 3 insurance product: a contract prescribed by presidential decree that seeks, in exchange for consideration, to promise the payment of 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

In Korea, while most insurance contracts can be freely executed between private parties, there are some types of insurance whose purchase is mandatory. 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 such damage to others.

The IBL does not have a separate section that compels the execution of insurance contracts. Instead, there are separate laws that require the purchasing of such insurances. Accordingly, when a party is involved in a specific act or business, it is important that it check whether purchasing insurance is mandatory by reviewing the relevant laws.

vii Taxation of premiums

Under Article 26-1-11 of the Korean Value-Added Tax Act, insurance business is exempt from 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 insurance 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.

In cases where an insurance policyholder purchases insurance under which the policyholder’s spouse or dependents are insureds, part of the paid insurance premium can be deducted from the policyholder’s income for the purpose of calculating the policyholder’s income tax.

When receiving death insurance money, if the holder of the insurance policy 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. 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 Korean 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.

viii Recent reinforcement of regulations in relation to reinsurance companies

Pursuant to its policy decision to promote the insurance industry’s competitiveness, the FSC has recently formed a task force team and is currently discussing various regulations in relation to reinsurance companies and has decided to amend the enforcement ordinance and
rules for supervision regarding reinsurance within 2017. For example, the FSC is considering to implement a rule that forbids insurance companies from passing on more than a certain percentage of their insurance revenue to reinsurance companies. According to the FSC, this is a way to restructure the current system where insurance companies are overly dependent on reinsurance companies by ceding excessive risk to reinsurance companies and not taking the actual risk. The FSC is also working on changing the standards for public disclosure from the original premium (insurance premium received from the customer) to reserved premium (insurance premium received from the customer minus the insurance premium paid to reinsurance companies).

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Korean Commercial Code (KCC) includes regulations that cover insurance in general. The general principle of the Korean Civil Code will also apply. In addition, various special Korean laws, such as the IBL, the Korean Automobile Accident Compensation Act, the Korean Act on the Indemnification for Fire-Caused Loss, and the Purchase of Insurance Policies and the Korean 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 the insureds’ 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 insurance policy is breached, the insurer cannot argue that those terms are included in the insurance contract.

Insurance policyholders and insureds are obliged to inform insurers of ‘important matters.’ Important matters are matters that, if known to the insurer at the time of execution of the insurance contract, such insurer would not have executed the insurance 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.
In cases where the obligation of notifying important matters is breached, an insurance contract may be terminated by an insurer. However, if a policyholder can prove that the breach of the obligation of notifying the important matters 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 the insurer’s 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 particular conditions 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, such 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 such 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, such information should be notified to the insurer, and if such 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 an 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, such dispute can be resolved through court proceedings, arbitration or financial dispute mediation by the FSS. However, Korea does not have any 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, such 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 Korean 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 Korean 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, such mediation order would 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 Korean judiciary system comprises three levels: 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 that has 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 based on the total legal costs (including attorneys’ fees) that will be incurred at each level of court. Since 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 each 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.

The KCAB recently 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. While the Rules are not markedly different from the previous version, the procedure for an emergency arbitrator is worth noting. 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 in Korea is conducted by the 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 would 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

In 2015, the FSC announced a roadmap to improve the competitiveness of the Korean insurance business (the roadmap). The purpose of the roadmap is to amend the insurance paradigm from the current pre-reporting system to a post-reporting regulatory system (i.e., regarding the reporting of the development of insurance products) in order to improve the competitiveness of Korea’s insurance business by enabling insurance companies to develop various kinds of insurance products, and to compete with reasonable prices. It is anticipated that the roadmap will bring significant changes to the Korean insurance regulations.

The main points of the roadmap are as follows:

a as previously mentioned, the current regulations, which require insurance companies to report on insurance products before selling them (i.e., the pre-approval system), will be amended to a post-reporting system of regulation (with some special exceptions);

b the current system, under which the Korean regulation authorities have regulated the standard terms and conditions, will be amended so that private companies can determine their standard terms and conditions at their own discretion;

c the current system, which in practice prevents insurance companies from freely adjusting their assessment of risks and limits their autonomy in adjusting premiums, will be revoked;

d the current regulations, which directly or proactively control insurance companies’ asset management, will be amended so that insurance companies’ asset management would be indirectly supervised in a post-control manner; and

e the procedure for executing insurance contracts under the current regulations (where insurance contracts need to be executed through conducting physical meetings) will be adjusted, reflecting various circumstances, such as circumstances where insurance products are purchased online.

In the first follow-up measure for the roadmap, in November 2015, the FSC amended the regulations in respect of adjusting the assessment of risks. Through this amendment, the provision that insurance companies can adjust the assessment of a risk only within the specified limit (plus-minus 25 per cent) was revoked, with the revocation becoming effective as of 1 January 2016 (as an exception, this provision will be revoked gradually for insurance for medical expenses). In addition, the standard rate of interest (which applies to the liability reserve of insurance companies), which the FSC sets to prevent excessive competition among insurance companies, was revoked on 1 January 2016. Accordingly, insurance companies can now determine their insurance premiums freely.

VI OUTLOOK AND CONCLUSIONS

On 1 January 2016, the purchase of retirement pensions became mandatory for companies with more than 300 employees, and will become mandatory for companies with more than 100 employees in 2017 and more than 30 employees in 2018. The Korea Insurance Research Institute (KIRI) is anticipating that the size of retirement pensions of life insurance will grow by 5.8 per cent in 2017. However, there is a possibility that the volume of new purchases of retirement pensions will not reach the expected level because of the continuing downturn of the Korean economy and the reconstruction of companies as a result of the downturn.

As discussed in Section V, supra, the FSC announced a roadmap to improve the competitiveness of Korean insurance businesses and induce Korean insurance companies to
develop various insurance products, which will be implemented gradually throughout 2017. In order to achieve this, in the first step, the regulation on the standard terms and conditions was abolished. However, according to KIRI’s report, it takes a considerable amount of time to develop a new kind of insurance product, and considering that the regulation on safety margin will be abolished at the end of 2017, it is expected that a full-scale development of insurance products will start in 2018. Secondly, since the announcement of the roadmap, the premium of indemnity health insurance has been increased by approximately 20 per cent. According to KIRI’s report, insurance companies have sustained losses as they have not been able to increase premiums because of the regulation on the price of premiums, which is now returning to its fair price level. Thirdly, the website ‘www.e-insmarket.or.kr’, which was created to promote the online insurance market in accordance with the roadmap, has received more than 1 million visitors during the first 11 months of being set up, and its functions will continue to be improved. On a separate note, it had been expected that the rate of premium of non-life general insurance would be adjusted in accordance with the roadmap. However, non-life insurers have maintained the premium rate agreed with reinsurers as they have traditionally done so, and are not adopting a new premium rate. However, it appears that large non-life insurers are developing their capacities to collect data and assess relevant risks to calculate premium rates.

As the roadmap has been implemented, the Korean insurance industry is entering a period of transformation to improve competitiveness, and insurers are preparing to make the necessary changes. As the authorities seek to amend Korean insurance regulations gradually in accordance with the roadmap throughout 2017, it will be necessary to monitor any amendments of the regulations.
LATIN AMERICA OVERVIEW

Duncan Strachan

I INTRODUCTION

The wave of investigations into bribery and corruption across Latin America may suggest that the bad old days have returned to the region. However, more sophisticated regulation and, specifically, more active enforcement are behind the current headlines. In spite of political and economic challenges facing the region, the demand for insurance and reinsurance products in Latin America continues to increase.

The legal regimes relating to the regulation of insurance markets and interpretation of insurance contracts are evolving. This development is linked to the political situation and economic ambition of a country. It is 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 expansion of insurance companies. It assesses the status of regulations 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

Across Latin America, there is a delicate balance to be struck between looking after national interests and being open to foreign investment. The successes and failures of government, in its management of the economy and investment in infrastructure, create risks that continue to drive a demand for insurance and reinsurance. These range from protection for companies against the development of class actions to increasing regulations on product safety.

It is a turbulent time for Brazilian companies. Many have been caught up in the Car Wash scandal concerning kickbacks and bribes paid for construction contracts and other services rendered to Brazil’s largest oil company, Petrobras. Others have been implicated in environmental disasters, such as the Samarco dam collapse. Most have been affected by the prolonged downturn in Brazil’s economy. The result has been a spate of regulatory investigations, criminal claims, and administrative and civil litigation in Brazil, not to mention the impeachment of President Dilma Rousseff.

Investigations in the US by the Department of Justice and the Securities and Exchange Commission have led to the filing of securities class action lawsuits against numerous publicly listed Brazilian companies and their directors and officers. The securities class actions

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include claims against Petrobras; Brazil’s leading mining company, Vale; its leading energy supplier, Electrobras; and one of its largest banks, Bradesco. Petrobras also faces arbitration by investors domiciled in Brazil.

The scandal surrounding Latin America’s construction giant, Brazilian company Odebrecht, is a cause for concern for the whole region, given its involvement in high-profile infrastructure projects in 10 different countries. The most high-profile example of the fallout so far is the investigation into wrongdoing by Odebrecht’s directors that led to the investigation against former Peruvian president, Alejandro Toledo. The Peruvian court issued an arrest warrant for Toledo in February 2017, based on alleged bribes worth US$20 million from Odebrecht. In turn, the Peruvian construction company Graña y Montero became the latest to face a securities class action lawsuit related to allegedly false and misleading statements about its business operations.

Despite this, with its thriving economy and the election of President Pedro Pablo Kuczynski in July 2016, Peru demonstrated its commitment to the free market and its pursuit for continued economic growth. Current indications are that Peru is the most promising market in Latin America.

The Mexican president, Enrique Peña Nieto, is no stranger to corruption scandals. The new National Anti-Corruption System, which came into force in July 2016, marked a significant step in establishing a new constitutional basis for fighting corruption, though its implementation will be challenging.

There is hope that 2017 will mark the year when the reforms introduced to allow private investment into Mexico’s energy industry start to pay off. The Energy Minister has announced that the government expects US$100 billion of investment this year. BHP Billiton was the highest bidder for the first deep-water partnership announced with Pemex in December 2016. The signs are positive for three further auctions due to be held in 2017. These projects will create a demand for sophisticated and high value insurance and reinsurance solutions.

Despite narrowly losing the October 2016 referendum on a peace deal with the FARC, President Santos signed a revised peace deal on behalf of the Colombian government in November 2016. There is belief that the deal will mark a new phase of political stability and economic growth in Colombia, where the government’s ‘4G plan’ – a US$25 billion investment programme in the country’s travel links – received an additional funding boost in 2016, headed by US investment bank Goldman Sachs.

It has been all change in Argentina, following the surprise victory of Mauricio Macri in the presidential election of 22 November 2015. The transition is only just beginning and international investment will need maintaining while the government looks to tackle high public spending. It seems unlikely that the government will meet its ambitious target of returning inflation to single digits by 2017 from the current 28 per cent. At present, predictions are that consumer prices will rise by 20 per cent in 2017. Nevertheless, the signs are positive and the Argentine insurance and reinsurance regulator (the Superintendency of Insurance (SSN)) has already taken steps to open up the reinsurance market, as described in Section IV, infra.

In contrast, there is a continuing shift to the left in Chile under President Michele Bachelet. The government has introduced major tax and labour reforms aimed at modifying the free market and increasing social welfare. Combined with a slump in commodity prices,
Chile’s economy has slowed, with 1.9 per cent growth predicted for 2017. The government’s proposals include measures that would place a higher burden on insurers in the country, such as in the private health system.

After securing a third term, Evo Morales’ Bolivian government has changed policy to try to attract investors to the country. The decision to press ahead with infrastructure and mining projects on indigenous land has created social and political tensions. The government is already being squeezed by falling commodity prices as it struggles to maintain its welfare regime.

There are similar concerns in Ecuador and Venezuela, along with the risks posed by discontent at government policy. Both countries are struggling with the fall in oil prices, compounded by a lack of investment in industry facilities. In Venezuela, there is the sense that the economic and social situation has reached a critical stage, with hyperinflation and plummeting oil prices resulting in power outages, looting, a valueless currency and anti-government demonstrations.

New challenges were brought to Latin America in 2016 in the form of natural and man-made disasters. Across the region, there continues to be huge pressure on housing and infrastructure, particularly in urban areas, and there is tension with local communities.

In January 2016, containers of acid and disinfectant came into contact with rainwater at a cargo warehouse at Guaruja, Santos, Brazil and caused an explosion accompanied by a toxic gas cloud. Sixty-six people reported respiratory problems, roads were closed, and locals were forced to evacuate their homes and businesses. The port continued to suffer interruption to usual business processes as, later, 4,000 dock workers participated in a strike for higher pay.

In February 2016, the World Health Organization classified the Zika virus as a global public health emergency. Spread across 23 territories in the Americas by the Aedes mosquito, Zika was linked to the underdevelopment of babies born to infected mothers. Health benefit-related claims, medical, travel, business interruption and workers’ compensation policies are all at risk of attachment for such epidemics.

The Ecuadorian earthquake of 16 April 2016 measured 7.8 on the Richter scale and was followed by aftershocks up to 6.0. The resulting devastation amounted to more than 600 fatalities, infrastructure collapse, damage to over 7,000 buildings and a drop in tourism revenue. At the time, damage was estimated at US$2–3 billion.

In October 2016, Hurricane Matthew reached wind speeds of 145mph as it made its presence felt from Colombia to the United States. More than 800 fatalities were reported in Haiti alone, with some cities reported to have been 98 per cent levelled. The number of cholera cases surged and plantations of staple food crops were destroyed, which will have a long-term impact on the population.

In November 2016, a Bolivian aeroplane carrying 77 people, including the Chapecoense football team from Brazil, crashed into the Colombian mountainside. Only six survived from the aeroplane, which was reported to have run out of fuel.

III INTERNATIONAL EXPANSION AND CONSOLIDATION

Many international insurers and reinsurers have set their sights on Latin America as a growth area. The more established Latin American entities, the ‘multilatinas’, also continue their expansion inside the region and internationally. However, 2016 was a relatively quiet year for expansion in most jurisdictions.
Many international insurers already have a presence in Colombia. Since October 2015, foreign reinsurers have been able to open a representative office in Colombia without meeting any requirements other than being registered in the Registry of Foreign Reinsurance Companies and Foreign Reinsurance Brokers. This led many reinsurers to open offices in 2015, including Berkley International and Zurich. The Brazilian reinsurer Austral Re gained authorisation in early 2016 to expand into Colombia as part of its growth across the region. Lloyd’s opened a Bogotá office on 21 June 2016, which enables Lloyd’s syndicates to write Colombian business directly and to provide onshore reinsurance solutions. The move by Lloyd’s into Colombia follows its decision to set up a representative office in Mexico City in 2014.

Out of all jurisdictions, Mexico is widely regarded as offering the greatest potential for growth, because of the low level of insurance penetration. The strongest growth is in the energy sector, where the end of Pemex’s monopoly is starting to stimulate further market growth and diversification.

Patria Re and Pembroke received Lloyd’s approval to establish a special purpose syndicate in 2015, which became the first Mexican reinsurer to write Latin American specialty risks through the Lloyd’s platform. In conjunction, Patria Re has established a marketing office in London, located in the Lloyd’s building.

Foreign insurers dominate the Chilean market in both the life and non-life sectors. This trend continued in 2016 with the acquisition of Magallanes SA by the German insurance group, Talanx. In another significant deal, Prudential acquired a participation in Habitat SA, a pension funds manager. There are no locally established foreign reinsurers – only one Chilean reinsurer for the whole market. This means that many insurers are involved as fronting operations for risks placed in international reinsurance markets, particularly London. Reinsurers absorbed 95 per cent of the losses from the 2015 earthquake.

Over the past decade, Brazil’s reinsurance market has transitioned from a state-run monopoly to a competitive market currently containing 16 local reinsurers accepting three times the amount of premium. The Brazilian Institute of Reinsurance still controls almost 50 per cent of the market and reported increased profitability in 2016. It will be interesting to see how the market develops, particularly in the current political context and debate over protectionist regulation of the reinsurance market.

There are signs that the relaxation of strict regulation by the SSN in Argentina is encouraging market growth. Five companies became admitted reinsurers in 2016: Austral Resseguradora SA, Starr Insurance & Reinsurance Ltd, Helvetia Compañía Suiza de Seguros SA, Navigators Insurance Company and Equator Reinsurances Ltd. The number of reinsurance brokers also increased from 110 to 113.

The Peruvian insurance market continues to expand, with almost 12 per cent growth in 2014 and estimated 8 per cent growth in 2015. The majority of Peru’s non-life market is controlled by local companies Interseguro, Rimac and Pacífico. Although there are no domestic reinsurance companies operating in Peru, this is likely to change to support the expansion of the market into new and more specialist lines of business. Peru still has one of the lowest insurance penetration rates in the region at 1.8 per cent, despite the high threat of natural catastrophe.

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3 Decree 2031 of 16 October 2015.
IV REGULATION

Over the past decade, there has been an overhaul of the regulation on insurance and reinsurance in many of the main jurisdictions. This has created a diverse group of markets, each with a distinct identity. It is difficult to overstate the importance of developing a detailed understanding of the relevant regulatory regime.

Brazil's Federal Senate is expected to make progress with its long-standing plan to produce a new Insurance Contract Law over the next few years. Following the major corruption scandals and the recent ‘Clean Company Act’, demand has soared for insurance protections for corporate entities and directors and officers (D&O). For the first time, this Law provides for strict civil and administrative liability of companies for acts of bribery committed by their directors and officers. The new law is already having an impact on the development of corporate governance of companies operating in Brazil. The Brazilian regulator, the Superintendency of Private Insurance (SUSEP), issued new regulation of D&O products at the end of 2016 that has shaken the Brazilian market. The main changes include a prohibition on insurers selling Side-C coverage for publicly traded companies. SUSEP agreed to extend the initial deadline for compliance of 23 February 2017 by 90 days to allow additional time for discussion with insurers amid concerns over remaining competitive.

The development of the Brazilian reinsurance market also continues. Currently, Brazilian insurers must first offer and place 40 per cent of any risk with local reinsurers, who have five days to decide whether to accept for facultative business, or 10 days for treaty business. Under the new regime, the 40 per cent mandatory cession has been relaxed since 1 January 2017 to 30 per cent; 25 per cent by 1 January 2018; 20 per cent by 1 January 2019; and 15 per cent by 1 January 2020. However, despite this apparent relaxation, the right of first refusal remains unchanged and means that, in practical terms, Brazilian insurers must always offer 40 per cent of any risk to local reinsurers. There are similar changes to the rule restricting ‘intra-group’ cessions, which will see the permissible limit increased from 30 per cent (as of 1 January 2017) to 75 per cent by 1 January 2020.

Many of the obstacles faced by insurers and reinsurers until recently in Argentina have been removed already by the new government. In March 2016, the government set aside the notorious ‘Inciso K’ obligation on insurers to invest a percentage of their total investment portfolio (except real estate investments) in government-approved infrastructure projects. On 11 November 2016, the SSN issued a resolution enabling the gradual opening of the reinsurance market to allow insurers to place risks directly with admitted reinsurers. Since 1 January 2017, insurers have been able to place up to 10 per cent of premiums with

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5 Circular SUSEP 541/2016.
6 Circular SUSEP 546.
7 Supplementary Law 126/2007 and subsequent resolutions issued by the National Council of Private Insurance.
8 Supplementary Law 126/07 (right of first refusal) and SUSEP regulation in 2011.
10 ‘Inciso K’ of Act 35 of Reglamento General de la Actividad Aseguradora, which had been effective from 7 February 2014.
admitted reinsurers, with this allowance due to increase by 10 per cent each year up to 80 per cent by 1 July 2024. Any risk with a limit above US$50 million may be reinsured with admitted reinsurers in its entirety.

There is genuine optimism that the ongoing project by the SSN\textsuperscript{12} to modernise the country's insurance laws\textsuperscript{13} will similarly recognise the importance of foreign investment. In a major legislative change, the old Argentine Civil and Commercial Codes were combined into a new Civil and Commercial Code.\textsuperscript{14} One potentially significant change for insurers and reinsurers in Argentina is the introduction of the concept of compound interest.

A recent Swiss Re study has identified significant improvements for insurers as a result of changes to the operating and regulatory environment in Peru and Colombia. In particular, Colombia has not looked back since opening up its local insurance market in 2013. Foreign insurers can sell direct insurance for certain lines of business: international maritime transport, international commercial aviation, space launch and transportation. The rules also permit Colombian residents and corporations to seek insurance solutions in foreign markets, eliminating the need for fronting arrangements. While this does not apply to insurance that is mandatory under Colombia law, or to the insurance of state entities, it confirms Colombia’s position as the most liberal market in the region.

The Chilean insurance regulator, the Superintendency of Securities and Insurance, has started to push for changes requiring the appointment of independent directors to the boards of insurance companies, alongside introducing other controls aimed at improved risk management.\textsuperscript{15}

Peru adopted new laws on insurance and the adjustment of losses in 2013,\textsuperscript{16} which were heavily influenced by the Chilean regime and put the loss adjuster at the centre of determining coverage. While unproblematic for routine losses, this can lead to tension in the handling of large losses involving international reinsurers, particularly where there are complicated liability and coverage issues to consider.

Insurers are permitted to contract freely with reinsurers within or outside Peru. In fact, the regulator, the Superintendency of Banks, Insurers and Private Pension Funds, specifies a minimum percentage of catastrophe risk that must be reinsured outside Peru.

Following the introduction of mandatory liability coverage for cars using the federal highways, drivers in Mexico City are now required to hold liability insurance.\textsuperscript{17} These changes, combined with increased competition among insurers, are fundamental to the evolution of the insurance market. Attempts at introducing similar measures in other cities have so far buckled under political and social pressure.

The long-standing regulatory framework in Mexico\textsuperscript{18} is seen as being outdated and an obstacle to new entrants to the insurance market, which remains dominated by the large financial groups. In contrast, Mexico has led the way in adopting new capital requirements.\textsuperscript{19}

\textsuperscript{12} Superintendencia de Seguros de la Nación.
\textsuperscript{13} Laws Nos. 17,418 (Insurance Law), 20,091 (Insurance Undertakings Law) and 22,400 (Insurance Brokers Law).
\textsuperscript{14} Civil and Commercial Code, in force from 1 January 2016.
\textsuperscript{15} Rule 309 of 2011 was amended in March 2016.
\textsuperscript{16} The Insurance Contract Law, Law No. 29,946, came into force on 27 May 2013.
\textsuperscript{17} The provision is contained within the Traffic Regulations that came into force on 15 December 2015.
\textsuperscript{18} Insurance Contract Law of 1935, regulated at a federal level under the General Law of Insurance and Mutual Companies.
\textsuperscript{19} Insurance and Surety Institutions Law, effective from April 2015.
Its regime is based on Europe’s Solvency II regime and the three pillars of corporate governance, risk management, and disclosure and transparency. Smaller participants may look to reinsurance solutions for the financial support needed to comply with the new requirements.

Brazil has implemented its own changes. Although initially it sought formal Solvency II equivalence from the European Commission, SUSEP later withdrew this request. Nevertheless, in its May 2015 decision, the Commission found that Brazil is Solvency II equivalent for group capital purposes, but not for group supervision or reinsurance purposes.

Colombia, Costa Rica and Peru are all introducing more gradual changes to their existing solvency regimes. Costa Rica has gone the furthest so far, by including separate solvency requirements for catastrophe risks and for reinsurance operations.

After holding on to power in the recent election, the Venezuelan government issued a new Law on Insurance Activity on 30 December 2015. This law repealed the 2001 Insurance Contract Law with immediate effect, while allowing the Superintendency to issue new rules within 180 days. As of 7 March 2016, the Superintendency had not made any statement.

Despite the obvious limitations of doing business in Ecuador, the mechanisms in place for the resolution of insurance disputes are well developed. Insured parties are able to refer disputes to the regulator to issue a decision, which will be influential on any subsequent litigation. In 2016, the regulatory powers for the insurance industry passed from the Superintendency of Banks and Insurance to the Superintendency of Companies, Securities and Insurance.

In some of the smaller markets, there has been little recent activity. In Uruguay, foreign reinsurers have been able to access the market openly since 2010 and there is an ongoing project to modernise insurance laws. The insurance market in Costa Rica comprises 13 insurance companies, but continues to be dominated by the state-owned National Insurance Institute. Any changes in Cuba, following the decision to re-establish diplomatic links with the United States, are unlikely to be felt for another decade.

V POLICY INTERPRETATION AND DISPUTE RESOLUTION

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 guidance. In many jurisdictions, law 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.

One of the most controversial changes introduced by the Peruvian insurance law was the prohibition of arbitration clauses in all insurance contracts. Arbitration is only permissible if agreed by the parties, once there has been a loss.

Mounting opposition to the current position in Peru has led to a proposal being presented to the Peruvian Congress for the separation of ‘large risks’. This proposal includes allowing arbitration and modifying the periods for insurers to respond to claims. The potential changes will be followed closely by reinsurers operating in the country.

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20 Official Gazette No. 6,211 on 30 December 2015 – Decree-Law, the Law on Insurance Activity.
21 Currently found in the 1865 Code of Commerce.
The overarching objective of the 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 new 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.

Chile has a close-knit insurance market and an active regulator. The protection of the insured in the insurance law fits in with a general understanding in the market that the interpretation of coverage issues will favour the insured. Unlike in Peru, the Chilean law provides for the automatic arbitration of large disputes (above UF10,000; approximately US$375,000), as well as for arbitral awards to be filed with the regulator. It will be interesting to see whether this leads to a body of case law on the interpretation of coverage issues for large risks.

In a recent decision relevant to the ongoing bribery and corruption scandal, the Brazilian Supreme Court of Justice considered the subject of insider trading in relation to D&O coverage. It upheld the insurer’s denial of cover, based on the insured’s failure to disclose relevant information prior to inception and because the insured’s conduct fell outside the scope of cover.

Brazil allows arbitration agreements in insurance contracts, albeit subject to specific requirements, including evidence of clear acceptance by the insured. Arbitration clauses are permissible in reinsurance contracts and may be subject to a foreign seat and governing law, as an exception to the general rule on mandatory Brazilian law and jurisdiction. Subject to new laws being issued in Venezuela, it is likely that a reinsurance contract would be considered an ‘international contract’, which would allow for the inclusion of an arbitration clause subject to a foreign seat and law.

There is no clear rule establishing the confidentiality of arbitration awards in Colombia. Together with court judgments, arbitral awards already form part of a significant body of case law relating to the interpretation of insurance contracts.

The Colombian Constitutional Court takes an active role in preventing insurers from relying on defences that it deems to be in breach of constitutional rights. In a recent example, the claimant had taken out a life policy as a requirement for a mortgage. During the term of the mortgage, the claimant developed a medical condition that prevented her from working, and sought an indemnity from insurers. Insurers denied the claim based on the failure to disclose pre-existing medical conditions. The court allowed the claimant to recover in the interests of protecting ‘basic rights and dignity’.

It is usual for insurers of 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 another 2015 case, the Colombian Supreme Court confirmed that

22 Ley de Seguros No. 20.667 came into force on 1 December 2013.
23 Unidades de fomento is an alternative currency that varies daily based on the previous month’s inflation rate.
24 Article 543 of the Code of Commerce.
25 Resp No. 1.602.555, Judge Ricardo Villas Boas Cueva.
26 Judgment T-370.
27 Judgment on 14 December 2015.
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.

Colombian law also recognises the right of a third-party victim to commence a ‘direct action’ against the insurer in cases of third-party liability insurance. It had seemed that a similar right would be available in Brazil, following a 2012 court decision. However, on 13 March 2015, the Superior Court of Justice issued a statement to clarify that, in respect of liability insurance, there is no scope for a third-party victim to commence a direct action against the insurer. 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.

A common theme to the handling of claims in Latin America is that there are strict periods for insurers to respond to notifications.

In Peru and Chile, the loss adjuster is usually at the centre of the process. The rules in Peru provide for a 30-day period, 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 who fail to respond to claims within one month may face expedited judicial proceedings and penalty interest in the region of 30 per cent.

Brazilian legislation requires the insurance company to respond to the request for coverage within 15 days. Insurers may be able to suspend this period by making a request for additional documents. The failure to comply with the period will result in the tacit acceptance of cover.

Unlike in most other jurisdictions, a Brazilian insurer is able to delay its response if it can show that it is dependent on there being cover under a facultative reinsurance. Reinsurers have five days to respond to a request for cover from the date they receive notification from the cedant or the brokers. Their failure to comply with this period will be considered as a denial of the risk.

VI DEVELOPMENT OF REINSURANCE LAW

Across the region, the opening up of local reinsurance markets has been successful, as shown by the steady increase of reinsurers operating in Brazil, Chile, Colombia and Peru, with Argentina now set to follow suit. Most of the laws have been aimed at developing the regulatory regime in which reinsurers are required to operate. There is not yet a clear, established body of law on the interpretation of reinsurance contracts.

Ecuador and Peru stand out as two exceptions, where the parties to a reinsurance contract remain free to choose the law and jurisdiction applicable to any dispute. At the other
end of the spectrum, Brazil and Argentina require the mandatory application of local law and jurisdiction in determining disputes involving a local insurer. Despite recent relaxation of regulations in these countries, there is no sign that this will change in the near future.

In Chile, there is a requirement for all insurance and reinsurance matters to be determined within Chilean jurisdiction. 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 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.

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.

Reinsurers may find themselves unable to rely on terms of the reinsurance contract, unless they reflect the original policy. Also, reinsurers are 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.

Chile and Peru are two of the few jurisdictions where the insurance law includes a definition of reinsurance, including recognition that is independent of the underlying policy. 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 position in the law of England and Wales, which recognises reinsurance as a separate insurance of the underlying insured risk.

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 the 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.

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. This is yet to be tested in practice and it remains to be seen how it would be applied by the Chilean courts.

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31 Article 869 of the Code of Commerce.
32 Article 138 of the Insurance Contract Law No. 29946.
33 Article 139.
34 Article 584.
The most effective way for reinsurers to protect their position is to take an active
involvement in managing claims from an early stage and, where possible, to include a clause
to resolve any dispute by arbitration. It is also helpful for all parties, whether a local insurer
or international reinsurer, to accept that there is significant uncertainty when it comes to
the interpretation of wordings 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.

As set out in Section V, supra, Brazilian insurers may refer to reinsurers’ consideration
of a claim to delay the 15-day period to respond to a claim, where there is a facultative
reinsurance in place. Brazilian legislation also recognises reinsurers’ right to participate in
the adjustment of a claim.35 This is complemented by the rule36 permitting the use of claims
control clauses in reinsurance contracts with Brazilian insurers. It is unclear whether this is
limited to local reinsurers that hold a majority share of the risk.

One area of continued debate is whether the Brazilian Civil Code, which governs the
operation of insurance contracts, applies equally to reinsurance contracts. 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.

In a somewhat surprising decision,37 the Brazilian Superior Court held that a one-year
limitation period applied to a reinsured’s recovery claim against its reinsurer. The Court based
its judgment on the one-year limitation period for claims by an insured.35 There are different
triggers for the commencement of this period depending on the type of insurance. Broadly:
for general liability, the period runs from the date a claim is served against the insured or the
date it indemnifies the claimant; in other cases, that period starts from ‘knowledge of the
fact that resulted in the right to claim against the insurer’. However, there is a considerable
body of opinion to support the view that time does not begin to run until there has been
a declinature by the (re)insurer. Another important element of the Court’s decision was
the finding that reinsurance is a type of insurance contract. Although the decision is not
binding, it seems likely that the lower courts would follow a decision of the Superior Court.
Meanwhile, academic debate over the issue continues and this is an area where clarification
of the law or comment by SUSEP would be welcome.

There is a similar debate 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.

VII OUTLOOK AND CONCLUSIONS

It seems likely that there will be a renewed focus among businesses in Latin America on
improving risk management. This is necessary to support renewed economic growth and
to protect against the type of scandal currently being witnessed. In the previous edition of

37 Special Appeal 1.170.057/MG, Judge Ricardo Villas Boas Cueva, 13 February 2014.
this chapter, we commented that, to support the demand for capacity in insurance markets, there is likely to be a need for regulation to become more accommodating to insurers and reinsurers. This is already evident in the relaxation of regulations in Argentina.

Nowhere is the debate between protectionist, pro-insured legislation and free trade more prevalent than in Brazil. Steps to relax the regulation of reinsurance are challenged by those reinsurers that committed fully to the local market, while every court decision comes under close scrutiny. However, there are signs that protectionism is slowly giving way to rules that promote growth and transparency. The same is true in Colombia and Mexico.

When it comes to interpreting insurance contracts, the approach of the courts tends towards favouring the insured. There is an important discussion under way as to whether contracts negotiated between sophisticated commercial entities (including reinsurance contracts) merit separate treatment from consumer contracts. Traditionally, Chile has led the way in the region by taking a pro-insured approach, even with respect to high-value commercial contracts. This looks set to go even further under the current government, but it seems that other jurisdictions (Brazil and Argentina included) are now on a different course.

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. Questions over the use and confidentiality of arbitration will shape the continued development of the markets in Latin America.
Chapter 22

MEXICO

Yves Hayaux-du-Tilly

I  INTRODUCTION

It has been almost two years since the new Insurance and Surety Companies Law (LISF) became effective and a year since the quantitative elements of Solvency II, on calculation of solvency capital and the implementation of the provisions related to balancing the economy, became effective. The insurance industry is now operating under the new normal conditions set forth by the LISF.

The market has now assimilated the new LISF and its regulations, and the Solvency II standards have been fully implemented in accordance with the LISF and applicable regulation.

Uncertainty over the implementation of the quantitative aspects of Solvency II continue to be a cause for concern. The foregoing has maintained an active regulatory practice in Mexico solving ongoing and new challenges created by the LISF, and the continually evolving regulatory landscape, and market practices and challenges arising therefrom. The main developments and areas of activity revolve around compliance and matters related to anti-money laundering, data protection, e-commerce and insuretech, as well as solvency, product development and efficient use of capital. There has also been growth in the activity of insurance companies as investors require complex advice on the investment regime to appease a growing appetite for securities and other assets, including real estate investments.

The National Insurance and Bonding Commission (CNSF) is overwhelmed by the multiple obligations that fall into its authority under the LISF and the lack of additional resources to cope with the added regulatory burden. This has been seriously affecting the market with multiple delays in the response from the CNSF to requests for authorisations and to resolve ongoing issues. The new legal framework requiring approval by the governing board of the CNSF on certain matters implies that such matters may only be approved in meetings of the board that convenes every quarter and, therefore, in case an item is not included in the agenda, the matter risks being delayed by a quarter with the consequences this entails for the business. It would be beneficial if an additional budget is allocated to the CNSF to build its capacity to respond in a timely fashion to the needs of the industry.

Mexico continues being the second-largest Latin American market and the lack of penetration continues being the main challenge for growth. The complexity of new risks and the increase in additional lines of business that are capital intensive or require added capacity have increased the use of reinsurance to cope with the ongoing concerns in underwriting and capacity.

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.
There is a current malaise in the Mexican insurance market with reinsurers for the manner in which claims are being handled and resolved, and a growing concern regarding the abuse by reinsurers and their advisers on the claims control clause. There are ongoing conversations to explore the manner in which the reinsurance market may change its current practices that are affecting the long-standing working relationship between cedants and reinsurers.

There has been reduced M&A activity and most of it has been the result of international transactions that have had an effect in the Mexican market. There has been a reduction in the companies currently operating in Mexico arising from the dissolution of certain companies and the revocation of licences. There has also been an important reduction in the number of reinsurance companies operating in Mexico, resulting from a stricter process and new guidelines and policies for the registration renewal of foreign reinsurance companies implemented by the CNSF under the LISF.

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 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, inspect 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. 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).

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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.
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 concerned must submit an application to 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 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 authorisation shall 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. New provisions have been incorporated to the Circular preventing foreign reinsurance companies from taking 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 of 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 three Mexican insurance companies authorised to exclusively operate reinsurance: Reaseguradora Patria, Istmo Re Mexico 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

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this registration on a discretionary basis. The registration of foreign reinsurance companies is valid until 31 December of the year on which the registration is given 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 he or she 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): (1) general conditions and model contracts, containing the general and particular conditions under which the insurance product will be commercialised; (2) a technical note, containing the technical and financial hypothesis for the calculation of the premium and the ongoing risk reserve; (3) a legal opinion, certifying that the insurance product complies with all applicable legal provisions; and (4) 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

Under Mexican law 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 in Mexico includes, among others, 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.
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

Pursuant to Mexican law, 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 minimum paid-in capital requirements applicable for 2017, expressed in Mexican pesos, for each line of business (approximate numbers):

a life: 38.64 million pesos;
b pensions: 158.73 million pesos;
c accidents and health:
  • personal accident or medical expenses: 9.66 million pesos; and
  • health, including personal accident or medical expenses: 9.66 million pesos;
d property and casualty:
  • one line: 28.98 million pesos;
  • two lines: 38.64 million pesos;
  • three or more lines: 48.31 million pesos;
  • mortgage insurance: 69.16 million pesos; and
  • financial guarantee insurance: 188.21 million pesos; and
e re-bonding:
  • one line (in one or more of the sublines): 20.72 million pesos;
  • two lines (in one or more of the sublines): 27.63 million pesos; and
  • three or more lines (in one or more of the sublines): 34.53 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 that was 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 to subject reinsurance contracts to Mexican law.

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. This 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;
a description of the insured asset or person;

a description of the risks insured;

the effective date of coverage and its duration;

the amount insured;

the insurance fees or premium; and

any other clauses required by law or agreed by the parties.

It is common to find the following clauses in insurance policies:

- coverage limits and exclusions;
- form and terms under which the premium must be paid;
- insured’s right to be informed about commissions paid to intermediaries;
- insured’s right to revise the policy if its terms differ from the agreed terms;
- competence of Condusef and choice of jurisdiction clause; and
- special clauses required for specific lines of business.

Utmost good faith, disclosure and representations

In Mexico 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.

iii Interpreting the contract

General rules of interpretation

To the extent 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:

- 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;
- if the insurance policy is generic in its terms, its interpretation must be limited to the purposes of the insurance policy;
- if the insurance policy permits various interpretations, it must be interpreted in the most convenient manner for the insurance policy to be effective;
- 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;
- 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;
- ambiguities of the insurance policy may be interpreted taking into consideration the customs of the country; and
- 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

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.
iv 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 such 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 a period of 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.

v Claims

A claim is triggered on the occurrence of a peril covered by the policy. An insurable interest is required to make a valid claim and demand payment under a policy.

The statute of limitation of claims is of two years after the date of the occurrence of the loss, except for life insurance, where the statute of limitations is five years (Article 81, LCS). The statute of limitations can be interrupted:

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
Reinstatement is the act through which an insurance contract regains its validity, once the circumstances that caused the suspension of the contract have ceased.

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 (also known as 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 policies. 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: (1) filing of the claim by the plaintiff and response from the defendant; (2) submission and presentation of evidence of any kind; (3) pleadings; and (4) award.

The parties can appeal any ruling to a higher tribunal, unless the aggregate amount is less than 574,690.47 pesos.

Each party pays its own litigation costs and the losing party might 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 34.01 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.

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.

In Mexico, 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 National Constitution refers to means of alternative dispute resolution, Mexico does not have a federal regulation regarding alternative dispute resolution processes. Nevertheless, several states of the Federation have enacted specific laws on this matter.
The most popular alternative dispute resolution procedures are arbitration and mediation, which are discussed in Sections IV.iii and IV.iv, supra.

V YEAR IN REVIEW

According to the CNSF, as of November 2016, the Mexican insurance sector is comprised of 101 insurance companies licensed to operate in Mexico and 254 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.

The CNSF has also found that, when compared with the same period in 2015, overall annual growth in the Mexican insurance industry from January to September 2016 was 9.3 per cent in real terms (reaching 323 billion pesos), which takes into account that direct premiums related to the state-owned oil company Pemex’s two-year policy renewal. Out of the 9.3 per cent growth, life insurance was the line of business with the largest annual growth, with 9.9 percentage points, followed by property, which increased by 3.3 per cent; motor insurance grew 15.9 per cent while accident and health grew by 13.1 per cent, and pensions decreased by 6.1 per cent.

VI OUTLOOK AND CONCLUSIONS

i Regulatory

Regulatory challenges are likely to arise from operating under Solvency II standards as there is ongoing concern with regard to maintaining a competitive sector while at the same time increasing penetration, maintaining operational costs in reasonable levels to permit growth and ensuring that Mexican operations are attractive to investors. Regulators will continue to be concerned and impose stricts measures in compliance with anti-money laundering and similar regulations.

Depending on the market rates, certain insurance companies may explore investment alternatives within the flexible regulatory framework under Solvency II for investments.

ii Case law

There is growth in litigation and precedents are being formed by Mexican courts. The most relevant developments are related to the awards for moral damages in similar terms to punitive damages, and the impact it will have within the insurance industry. Other recent precedents recognise the contra proferentem principle in insurance, which has already had an impact on the manner in which cases are being argued before Mexican courts. Despite there being fewer reinsurance cases brought before Mexican courts, there has been growth in reinsurance disputes.

iii Reinsurance claims

Owing to an increase in disputes arising from the inconsistency of applicable laws and regulations governing reinsurance contracts and, in particular, to abuse in the application of claim control clauses, the Mexican insurance market has expressed its concerns about certain practices of reinsurers. There is an ongoing conversation to resolve these practices that are damaging the credibility of, and confidence in, reinsurers.
One of the main problems 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 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.

While mediation and arbitration are supposed to be attractive alternatives to settle claims and disputes between Mexican cedants and the London Market, they are not effectively addressed in the reinsurance contracts, and therefore, it is difficult to include or agree on mediation or arbitration once there is a dispute.

iv Distribution

Efforts from the CNSF and the Association of Mexican Insurance Companies to expand insurance offers to small and medium-sized companies, which contribute 52 per cent of the national GDP, and enforcing automobile insurance and other mandatory insurance products have had limited success.

There is interest in developing innovative products for the Mexican market and using technology to promote, develop and expand penetration in Mexico; however, there is indecisiveness in the market combined with a conservative approach from regulators, as well as regulatory challenges.

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.

v Further consolidation

The increase in operation costs because of the new legal and regulatory framework implementing Solvency II standards, the competitive market conditions with a lack of penetration, stagnation of the Mexican economy, mediocre growth of the Mexican insurance market, and the de-risking and changes in strategy of international groups regarding Latin America and Mexico in particular, may contribute to certain groups entering the Mexican market and others exiting the market, and some consolidation of the insurance industry in Mexico. Recent growth in niche sectors, and through cross-border alliances and collaborative structures securing and bringing capacity from London and other markets to the Mexican market, may continue.
vi Lloyd’s
It is important to note the partnership announced by Grupo Nacional Provincial and Sompo Canopius, and the investment of Grupo Nacional Provincial in Syndicate 4444, the second from a Mexican investor into Lloyd’s.

vii Product development
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. Such 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).

ii Regulation and authorisation

Insurance (Prudential Supervision) Act 2010

The IPSA requires each person who carries on insurance business in New Zealand to be licensed as an insurer. 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 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).³

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.

Financial Service Providers (Registration and Dispute Resolution) Act 2008

Insurers must register on the Financial Service Providers Register (FSPR) in accordance with the FSPA. 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 of New Zealand but that carry on business in New Zealand.

iii Position of non-admitted insurers

As mentioned in subsection ii, supra, 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.⁴

iv Position of brokers

Brokers are primarily regulated under the Insurance Intermediaries Act 1994 (IIA), the FSPA 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. IIA 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.

³ IPSA, Part 2, Subpart 1.
⁴ IPSA, Section 219.
The FSPA and the FAA\(^5\) 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 qualified 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.

\textbf{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).\(^6\) 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 an employee of an insurer to be banned from participating in an insurance business in relation to certain wrongdoings.\(^7\)

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 who 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.

\textbf{vi Compulsory insurance}

Unlike some jurisdictions, there is no compulsory motor vehicle or workers compensation insurance in New Zealand. The New Zealand 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 in New Zealand.

\(^5\) As discussed in subsection ix, \textit{infra}, as of February 2017 significant proposed amendments to the FAA regime have been published for consultation.

\(^6\) IPSA, Section 37.

\(^7\) IPSA, Section 222.
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.

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 (within the financial services context)

As discussed in subsection iv, supra, insurers that provide services to retail clients are required by the FSPA to be a member of an approved dispute resolution scheme.\(^8\) There are four approved schemes, though most insurers are members of the Insurance and Financial Services Ombudsman Scheme (IFSO Scheme),\(^9\) 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.\(^10\)

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:

\(a\) 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;

\(b\) certain premiums derived by non-resident general insurers (addressed below);

\(c\) 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);
- a policyholder base (representing income derived for the benefit of policyholders);

\(^8\) FSPA, Section 11.
\(^9\) As of February 2017.
\(^10\) As of February 2017, companies are subject to an income tax rate of 28 per cent.
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.

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.

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).

Proposed changes to the regulatory system

The Ministry of Business, Innovation and Employment has recently reviewed and published draft legislation for consultation that repeals and replaces the current FAA regime. The draft legislation 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 financial advice representatives), 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.

The RBNZ is also undertaking a review of the IPSA. The RBNZ has indicated that it intends to release an Issues Paper, as part of the public consultation process, in the first quarter of 2017. The focus of the review is on the adequacy and effectiveness of the current regulatory tools over the insurance sector in New Zealand. The RBNZ has also indicated that, if legislative changes arise from the review, amendments to the legislation would not be introduced to Parliament until 2018 at the earliest.

Other notable regulated aspects of the industry (e.g., ownership, mergers, capital requirements)

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. 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.

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11 IPSA, Sections 26–27.
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 in New Zealand 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 in New Zealand 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).

Members of the Insurance Council of New Zealand (ICNZ) also agree to adhere to the Fair Insurance Code. The ICNZ currently has 28 members who collectively write more than 95 per cent of all fire and general insurance in New Zealand. 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. 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 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.

13 IPSA, Section 7.
14 Marine Insurance Act 1908, Section 24.
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).

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.15 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.16

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 New Zealand 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 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.17 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

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15 Law Reform Act 1936, Section 9.
17 Companies Act 1993, Section 162.
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. 18

**Information provided to the insurer at placement**

Under New Zealand law, the insured is subject to the general duty to disclose any material fact to the insurer. 19 The insured’s duty of disclosure extends beyond the answering of questions specifically asked by the insurer. A 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 insured may be treated as having waived disclosure if it did not make further inquiry. 20

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 inquiry: 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. 21

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. 22 While the Contractual Remedies Act 1979 imposes a general right to damages for misrepresentation (which could provide a pecuniary remedy for a breach of the duty of utmost good faith), 23 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).

### iii Interpreting the contract

**General rules of interpretation**

There are no special rules that apply to the interpretation of insurance contracts. 24 Accordingly, insurance agreements are interpreted according to the general law of contract, which aims to

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20 *Jaggar v. QBE Insurance Ltd* [2007] 2 NZLR 336.
21 Marine Insurance Act 1908, Section 18.
23 Contractual Remedies Act 1979, Section 6.
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.25

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.26

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.27 In *Vector Gas Ltd v. Bay of Plenty Energy Ltd*,28 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.29 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.

**Intermediaries and the role of the broker**

*Agency/contracting*

Brokers in New Zealand 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.30 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.31

*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.

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25 *Investors Compensation Scheme Ltd v. West Bromwich Building Society* [1998] 1 WLR 896 (HL) at 912 per Lord Hoffman.
30 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).
31 Insurance Law Reform Act 1977, Section 10(2).
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). 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.

In New Zealand 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.

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. Such 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, supra, 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, including appeals

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.

34 The district court’s jurisdiction increased from NZ$200,000 to NZ$350,000 on 1 March 2017.
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 such manner as is considered appropriate.\(^{35}\) 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.\(^{36}\)

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.

\(^{35}\) Arbitration Act 1996, Schedule 1, Clause 19.

\(^{36}\) Arbitration Act 1996, Section 7.
V  YEAR IN REVIEW

i  Kaikoura earthquake

On 14 November 2016, central New Zealand experienced a magnitude 7.8 earthquake. As of February 2017, there have been more than 2,500 commercial material damage and business interruption insurance claims as a result of the earthquake, totalling more than NZ$900 million collectively.\(^{37}\) As was experienced following the 2011 Canterbury earthquake, it is expected that insurers will increase home insurance premiums as a result of high perceived disaster risk in New Zealand and reinsurers might seek to renegotiate pricing. Managing the aftermath remains a key concern in the local insurance market and the correct application of state-funded natural disaster insurance (provided by the Earthquake Commission Act 1993) continues to be the subject of dispute in the wake of earthquakes.\(^{38}\)

ii  Revised Fair Insurance Code 2010

Revisions to the Fair Insurance Code 2010 came into effect on 1 January 2016. Key changes in the 2016 revisions are:

a  enhanced communication responsibilities when describing to the insured what their disclosure obligations are;

b  commitments by insurers to act reasonably when faced with an insured who has not met all of their disclosure obligations;

c  specific time frames set in place for acknowledging claims and determining whether to accept claims. Where these time frames are unable to be met, the insurer is required to give the insured updates every 20 business days; and

d  enhanced training requirements for the staff and agents of insurers with regards to the application of the Code.

VI  OUTLOOK AND CONCLUSIONS

Natural disaster insurance remains a key focus for the New Zealand insurance market following the Kaikoura earthquake.

A further topical issue is cyber risk. This market is still developing in New Zealand, and is expected to continue to do so as directors of New Zealand companies become more focused on the intersection between their directors’ duties and managing cyber risk.


I INTRODUCTION

In general, the Portuguese public continues to buy insurance coverage only when required by law or by contract.

The Portuguese insurance market can be characterised by the dominance of local insurers with deep ties to the banking retail business.

The 2015 overall technical result of insurance undertakings under the prudential supervision of the Portuguese Insurance and Pension Funds Supervisory Authority (ASF) totalled €580 million, an increase of 41.4 per cent compared with 2014. This variation was mainly triggered by an increase of 508 per cent in the non-life technical result, to €86.4 million, although the life technical result has also increased by 24.6 per cent, settling at €493 million. The global premiums written by the same set of undertakings recorded an 11.1 per cent decrease, while the required solvency margin reached 228 per cent.

As to the financial position of the insurance companies, in 2015, total assets decreased by 2 per cent, while total liabilities declined at a higher rate of 2.7 per cent. Consequently, total equity increased by 6 per cent in comparison with the previous year.

Notwithstanding the increased regulatory burden, the changes introduced by the implementation of Solvency II will most probably trigger positive developments in the Portuguese insurance sector in the long term (e.g., increased competitiveness and the introduction of new products in the market).

II REGULATION

The ASF is the competent authority for the regulation and the prudential and behavioural supervision of the insurance, reinsurance, pension funds (and corresponding managing entities), and insurance and reinsurance intermediation activities.

The main goal of the ASF is to ensure the sound functioning of the Portuguese insurance and pension funds markets, by contributing to the protection of the interests of the policyholders, insured persons and beneficiaries. This goal is pursued by promoting the financial stability and soundness of all institutions under its supervision, as well as ensuring the maintenance by all market operators of high standards of conduct.

The Portuguese Securities Exchange and Market Commission also has some supervisory powers in respect of conduct rules relating to unit linked life insurance products and

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1 Pedro Ferreira Malaquias is a partner and Hélder Frias is a principal associate at Uría Menéndez – Proença de Carvalho.
operations. The ASF’s supervisory powers on other matters (e.g., taking up and pursuit of the insurance business, governance, financial guarantees) over insurance undertakings offering unit-linked life insurance products and operations remain unchanged.

The taking up and pursuit of the insurance and reinsurance business is mainly governed by Law No. 147/2015, of 9 September (Law No. 147/2015), implementing into Portuguese law the Solvency II Directive, which sets out the main rules on, *inter alia*:

- authorisation of undertakings;
- solvency and other financial guarantees;
- suitability and appropriateness of directors;
- acquisition of qualifying holdings;
- systems and controls for the conduct of the insurance and reinsurance business;
- protection of policyholders, insured persons and beneficiaries (e.g., resolution of complaints); and
- the inspection and sanction of infractions.

In turn, pension funds and their managing entities are governed by Decree-Law No. 12/2006 of 20 January, as amended.

The insurance and reinsurance intermediation activities are governed by Decree-Law No. 144/2006 of 31 July, as amended (which implemented into Portuguese law the Insurance Mediation Directive) (DL 144/2006) and its implementing ASF Regulation No. 17/2006-R of 29 December, as amended.

### i Position of non-admitted insurers

The pursuit, on a professional basis, of the insurance activity in the Portuguese territory is deemed as a regulated activity, reserved exclusively to duly authorised insurance undertakings. Foreign insurers may only conclude insurance agreements covering risks or commitments situated in Portugal if the corresponding procedure for the pursuit of the insurance business under the freedom to provide services or right of establishment rules, as the case may be, is duly met (single licence principle). Insurers in the European Economic Area are subject to the financial and legal supervision of their home countries, and also to the legal supervision of the ASF in respect of their Portuguese operations.

The pursuit of the insurance activity within the Portuguese territory by a non-authorised entity shall be deemed as a serious administrative offence subject to a fine ranging from €7,500 to €1.5 million, plus ancillary sanctions.

The determination of the actual fine and ancillary sanctions is done in consideration of, *inter alia*, the material illegality of the act, the agent’s fault, the benefits obtained and his or her previous conduct. The legal person may be responsible for the administrative offence even when the facts are carried out by the members of the corporate bodies, attorneys or employees in the exercise of their functions, or in the name of or on behalf of the legal entity. However, the liability of the legal person does not exclude the corresponding individual liability.

On the other hand, if the economic gain, doubled, is more than the maximum amount of the applicable fines referred to above, then the highest value shall prevail.

Policies issued by non-authorised insurers are null and void by law. However, the non-authorised insurer shall be required to cover the claim unless the policyholder acted in bad faith (i.e., was aware of the lack of authorisation of the insurer).
ii Position of brokers

Insurance brokers carry out insurance intermediation activities in an independent form regarding insurance undertakings, basing their activities on an impartial analysis of a sufficient number of insurance contracts available in the market that allows them to advise the client, taking into consideration the client's specific needs. See Section III.iv, infra, for further information on insurance intermediation in Portugal.

iii Requirements for authorisation

Only limited liability companies by shares, mutual or public institutions may obtain an insurance authorisation from the ASF. Companies that take the form of a European company may also pursue insurance and reinsurance activity.

Documents to be submitted with the application include, among others, a programme of activities describing the risks that are intended to be covered, the reinsurance policy, and financial information (including provisional balance sheets for each of the first three years of activity).

The ASF can issue appropriate and necessary orders to avoid deficiencies or bring any such deficiencies to an end and, if necessary, withdraw the insurer's authorisation.

Insurance undertakings based in the EU, which are duly authorised for the pursuit of their insurance activity within their country of incorporation, may pursue the insurance activity in Portugal under the EU freedom of establishment regime (as a branch) or on a freedom to provide services basis (without a permanent establishment in Portugal) without the need to obtain a specific authorisation from the ASF. The only requirement would be that the ASF is duly notified of the establishment of the branch or the commencement of activity on a freedom to provide services basis by the competent supervisory authority of the relevant home Member State, in line with the EU passport regime.

In turn, if an insurance undertaking incorporated outside the EU wishes to establish a branch in Portugal, it is required to obtain prior authorisation from the ASF.

iv Regulation of individuals employed by insurers

Individuals employed by insurers are subject to the same rules as any other employee, namely the Labour Code. In addition, insurance undertakings are bound by the collective bargaining agreements entered into for the insurance business. The Portuguese employment legal framework was traditionally regarded as relatively rigid and overprotective of employees' rights. However, since 2003, significant changes have been introduced with a view to increasing flexibility in labour relationships.

v The distribution of products

The pursuit, on a professional basis, of insurance intermediation activity in the Portuguese territory is deemed as a regulated activity reserved exclusively to duly authorised insurance intermediaries. Foreign intermediaries may only carry out insurance intermediation activity within the Portuguese territory if the corresponding procedure for the pursuit of insurance intermediation business under the freedom to provide services or right of establishment rules, as the case may be, is duly met (single licence principle).
vi Compulsory insurance (e.g., employers’ liability)

Portuguese laws and regulations establish several different types of compulsory insurance including, but not limited to, third-party motor insurance, accidents at work insurance, fire damage insurance, life insurance for military or policy forces while abroad and professional liability (for auditors or lawyers) or high-income athletes. Compulsory civil liability is also required to obtain authorisation for the pursuit of certain business activities (such as industrial activity, private security firms, travel agencies, activities that are hazardous for the environment, leasing, transportation, childcare transport services or electricity generation) and for many other activities.

vii Compensation

Portuguese insolvency laws applicable to the insolvency and liquidation of Portuguese insurance undertakings establish a protection framework based on preferences between different classes of creditors instead of a regime based on the existence of a guarantee fund (e.g., Spain with the Insurance Compensation Consortium).

In the event of insolvency or liquidation of an insurance undertaking, the insurance claims (i.e., all the amounts that represent a claim over the insurance undertaking of the policyholders, the insured, beneficiaries or any injured party having a direct right of action against the insurance undertaking under an agreement of the insurance activity (the amounts due by an insurance undertaking as a result of the renouncement of the insurance agreement by the policyholder are also included in the definition of ‘insurance claims’)) take precedence over any other claims against the assets representing the technical reserves of the insurance company. As to the other assets of the insurance undertaking, insurance claims rank only below the claims of employees of the insurance undertaking arising from employment relationships and, regarding the non-life insurance business, claims on assets secured by rights in rem. As an exception to the foregoing, expenses arising from the winding-up procedures of the insurance undertaking take precedence over any claims against the insurance undertaking (including insurance claims).

This precedence implies that, in the event of insolvency of a Portuguese insurance undertaking, the policyholders shall, with the exceptions described above, have priority over the other creditors of the insurance undertaking.

viii Dispute resolution regimes (within the financial services context)

Portuguese insurance undertakings must receive and resolve any claims or complaints that are filed against them within the deadlines imposed by law. To this effect, insurance undertakings are required to put in place a written internal regulation on the management and settlement of complaints.

If the insurance undertaking fails to reply within these deadlines, or denies the claim or complaint, the interested party may file an appeal with the customer ombudsman (who must be appointed by the insurance undertaking or a group of insurance undertakings), who must handle and resolve the claims and complaints submitted to him or her within the deadlines imposed by law. Insurance undertakings must appoint a preferred interlocutor between the ASF and the customer ombudsman, and the identity of the customer ombudsman must be disclosed to the policyholders, insured persons, beneficiaries or any other interested party. After this period has elapsed, if the insured’s claim or complaint is not answered or is dismissed, the claimant can submit a grievance to the complaints service of the ASF. The policy must indicate the insured’s right to proceed in this way.
Also, any insurance undertaking with a customer service desk in Portugal must have a complaints book available for any customer.

ix Taxation of premiums
All applicable charges over insurance premiums under Portuguese law have been compiled by the ASF and are regularly updated.²

x Other notable regulated aspects of the industry (e.g., ownership, mergers, capital requirements)
Portuguese law does not establish any legal or regulatory limitation regarding the types of entities and individuals that may own a controlling interest in an insurance undertaking, other than the typical assessment by the ASF of the identity and suitability of its directly and indirectly qualified shareholders to ensure sound and prudent management of insurance undertakings.

The intention or project to acquire, directly or indirectly, a qualifying shareholding (i.e., a shareholding that is equal to or exceeds any of the thresholds of 10, 20, 33 or 50 per cent of the share capital or voting rights or that, by any means, allows for the exercise of a dominant influence in the management of the target insurance undertaking or in such a way that the target insurance undertaking becomes an affiliate of the other) in an insurance undertaking shall be notified in advance to the ASF.

The ASF may oppose such an acquisition if it considers:

a that the acquirer does not meet the necessary conditions to guarantee sound and prudent management; or

b if the information provided is not sufficient.

Furthermore, if the insurance undertaking is listed, the acquirer is subject to several disclosure information duties and, as the case may be (if the threshold of one-third of the voting rights corresponding to the share capital is exceeded), it can be required to launch a tender offer over all the shares issued by the insurance undertaking.

Mergers and insurance portfolio transfers that involve insurance undertakings operating in Portugal are subject to the prior authorisation of the ASF.

If any competition issue derives from the aforementioned acquisition of a qualifying shareholding or merger, a report from the Portuguese Competition Authority is also required. The Portuguese Competition Authority may oppose the transaction, or accept it but only with the fulfilment of certain conditions and remedies.

Portuguese law establishes that the following should be the minimum, fully paid-up, share capital for insurance undertakings:

a insurance undertakings intending to pursue life assurance: €7.5 million;

b insurance undertakings intending to pursue non-life insurance:

• €2.5 million for insurance classes of ‘sickness’, ‘legal assistance’ and ‘assistance’;

• €7.5 million if the insurance undertaking intends to pursue more than one of the insurance classes referred to at (b) or any other non-life insurance class;

c insurance undertakings intending to pursue life assurance together with one or more class of non-life insurance: €15 million;

d assistance undertakings: €2.5 million; and

e mutual insurance undertakings: €3.75 million.

In addition to the minimum share capital referred to above, insurance undertakings are required under Portuguese law to possess minimum amounts (as determined by law) of technical reserves and solvency capital. In addition, insurance undertakings must comply with the applicable framework, for prudential purposes, for the evaluation of their assets and liabilities, and their own funds and investments, as required by law.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Statutory law is the main source of law in the Portuguese legal system. Custom is also deemed as a source of law in the Portuguese legal system to the extent that the custom is not contrary to the general good faith principle. However, there are very few situations in which it is accepted that an implemented solution had custom as its source. There is, therefore, a stark contrast between the importance given to custom and the practical relevance it actually assumes.

Case law and doctrine play a secondary role (although an important one), even where principles are concerned, as sources of law in the Portuguese legal system. They are used exclusively as a means of disclosing (or identifying or clarifying) pre-existing legal standards or solutions, generally from a legal source. Case law precedents are not binding and the very same issue could receive different treatment from one court to the next.

The main Portuguese insurance and reinsurance statutes and regulations are:

a the Insurance Contract Law, enacted by Decree-Law No. 72/2008, of 16 April (ICL);
b Law No. 147/2015;
c the Commercial Code (in respect of marine insurance);
d the Civil Code;
e the regulations issued by the ASF;
f the regulations issued by the Portuguese Securities Market Commission in respect of unit linked life insurance contracts and operations;
g the special legislation dealing with compulsory insurance; and
h the special legislation dealing with consumer protection (including the Portuguese Unfair Contract Terms Act).

ii Making the contract

Without prejudice to the main principles on contract law that may be found in the Civil Code, the ICL establishes the specific process and requirements for the making of an insurance contract.

As a general rule, this process starts with the delivery by the prospective policyholder of a duly completed application form prepared by the insurer, which will evaluate the risk and quote the premium. Prior to the conclusion of the insurance contract, the policyholder and the insured person, when different persons, must declare exactly all circumstances within their knowledge that they reasonably consider material to the risk assessment conducted by
the insurer, even if reference to all these circumstances is not expressly requested by the insurer in whatever questionnaire or form the insurer may provide for those purposes, subject to the legally prescribed sanctions for a wilful or negligent non-disclosure or wrongful disclosure.

Insurers are also required to enquire about the insured party's insurance needs, and to advise on those needs and on adequate insurance solutions, and they must document the contents of this advice and its reasons.

Within 14 days following receipt of the application form, duly filed and signed, where the policyholder is a natural person, the insurer must notify the policyholder of the execution and entry into force of the insurance contract (usually by issuing a policy schedule); or of the documentation required and information deemed necessary to conclude the insurance contract; or of the refusal to conclude the insurance contract. If the insurer does not respond within the aforementioned 14-day period, the insurance contract should then be deemed to have been tacitly entered into, as is.

The rules established in the previous paragraphs are not applicable if the insurer is able to prove that it does not enter into, under any circumstances, insurance agreements with features similar to those that may be found in the application form.

In any case, risk coverage under any insurance contract depends upon the previous payment of the premium.

The policyholder may be entitled to a certain cooling-off period in some types of insurance contracts (e.g., 30 days counting from the date of receipt of the insurance policy in the case of a life insurance contract with a term greater than six months).

The validity of an insurance contract is not dependent on any specific form. However, the insurer must put the insurance contract into written form (the insurance policy) and deliver the written document, duly dated and signed by the insurer, to the policyholder. The same applies to any amendments or endorsements to the insurance contract.

iii Interpreting the contract

The contents of a contract should be construed objectively; that is to say, a statement shall be construed to have the meaning that would be attributed to it by a reasonable person in the position of the addressee, except if the person making that statement could not have reasonably anticipated such a meaning. In the latter case, it can be concluded that in fact no agreement has been reached. Or if it can be established that the addressee was aware that the person making that statement intended it to have a particular meaning, that meaning shall prevail.

Where the meaning of a statement gives rise to doubt, the meaning that should prevail is that which entails the greatest balance between the parties' undertakings, in the case of onerous contracts (as an insurance contract).

Contract terms shall be interpreted within the context of the whole contract. Where doubt arises as to the precise meaning of a specific contractual term not individually negotiated, the meaning that should take preference is that which is more favourable to the party who has not supplied it. In any case, terms that are the result of individual negotiation prevail over those that are not.

Silence may only be interpreted to amount to an indirect demonstration of intention, and hence as a contractual statement, in those cases where that value is attributed thereto by a statutory or contractual provision or by any applicable usages.

As a general rule, the terms and conditions of an insurance contract are subject to and must comply with the Portuguese law requirements on unfair contract terms.
As such, a contract term that has not been subject to individual negotiation is deemed to be excluded from a contract whenever:

- it is not adequately communicated to the adhering party before the contract is concluded;
- it is not sufficiently explained to the adhering party;
- because of its graphic layout, its heading or the context in which it appears, it would not have been apparent to the average contracting party; or
- it is inserted in a form after the signature of any of the contracting parties.

A number of provisions of the ICL are compulsory, unless large risks are concerned in certain specific situations. Other provisions are usually compulsory, in the sense that they cannot be derogated to the detriment of the policyholder, insured or beneficiary unless large risks are concerned.

The terms and 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 establish the invalidity, extension, suspension or termination of the insurance contract; establish the scope of the covers (notably exclusions or limitations); or impose on the policyholder or beneficiary any duties subject to a deadline, must be highlighted and written in bold letters.

Otherwise, the policyholder shall be entitled to request the correction of the insurance policy or terminate the agreement within 30 days counting from the receipt of the insurance policy (unless this breach by the insurer has not reasonably affected the policyholder’s decision to enter into the insurance contract or any third party has filed a claim).

Risk coverage under any insurance contract depends upon the previous payment of the premium.

### Intermediaries and the role of the broker

‘Insurance intermediary’ is defined under Portuguese law as any natural or legal person who, for remuneration, takes up or pursues an insurance intermediation activity.

Insurance intermediation is a regulated activity that comprises any activity of introducing, proposing or carrying out other work considered preparatory to the conclusion of insurance contracts, or of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim.

In addition to insurance brokers (see Section II.ii, supra), the other insurance intermediary categories established by DL 144/2006 are as follows:

- **tied insurance intermediary** – where the person carries out the activity of insurance mediation:
  - for and on behalf of one insurance undertaking or, with authorisation from that insurance undertaking, for and on behalf of various insurance undertakings, as long as the person is tied only to one insurance undertaking in the class or classes that it is authorised to act in, but does not collect premiums or amounts intended for the customer and who acts under the full responsibility of those insurance undertakings for the products that concern them respectively;
• in addition to his or her principal professional activity, if the insurance is complementary to the goods or services supplied in the framework of this principal professional activity and the person does not collect premiums or amounts intended for the customer, acting under the responsibility of one or several insurance undertakings for the products that concern them respectively; and

b insurance agent – where the person carries out the insurance mediation activity for and on behalf of one or more insurance undertakings, according to the terms of the contracts entered into with said undertakings.

Tied insurance intermediaries and insurance agents must enter into a written insurance intermediation agreement (which must comply with certain legal requirements) with each insurance undertaking with which they operate.

Contrary to tied insurance intermediaries and insurance agents, insurance brokers act for the policyholder and must provide the latter with an objective and independent analysis. In practice, brokers operate in Portugal as dealmakers and typically coordinate the parties involved in an insurance contract.

v Claims
Any claim must be notified to the insurer as soon as possible. As a general rule, insurance claims must be reported within eight days (or a greater period agreed in the insurance contract) counting from the date the policyholder, the insured or the beneficiary became aware of the claim, unless the insurer became aware of the claim by other means.

The policyholder, insured or beneficiary is required by law to provide all information available on the circumstances and consequences of the claim.

An insurance contract may establish that in the event of failure to make a timely report of a claim a lower amount shall be paid by the insurer. In cases of wilful behaviour that causes significant damage to the insurer, the insurance contract may establish that the insurer shall be under no obligation to settle the claim. This rule is not applicable in cases of compulsory civil liability insurance, although in such cases the insurer is entitled to a right of recourse against the defaulting party.

The insurer must pay the claim, if accepted by the insurer, within 30 days. An unjustified rejection of claims or a delayed decision on coverage has no particular consequences. The insured may then simply sue the insurer.

The insurer may set off any open premium claims under an insurance contract from any claims payable under the contract.

IV DISPUTE RESOLUTION
i Jurisdiction, choice of law and arbitration clauses
The competent court for any dispute arising out of or in connection with an insurance contract shall be the court of the defendant’s domicile. Alternatively, for any dispute filed by the policyholder, the insurer or the beneficiary against the insurer, the competent court shall be that of the plaintiff’s address.

The choice of law rules applicable to insurance contracts are laid down in Article 7 of Regulation (EC) No. 593/2008 of the European Parliament and of the Council of 17 June 2008 on the law applicable to contractual obligations (Rome I Regulation).
The parties to an insurance contract may take advantage of a greater freedom afforded to them by the ICL, for the purposes of Article 7(3) of the Rome I Regulation and choose any governing law provided that they have a serious interest in that law or that law has a connection with any relevant element of the insurance contract, as defined in private international law.

The ICL expressly acknowledges the freedom of the parties to an insurance contract to submit to arbitration any disputes arising from the contract. However, contrary to reinsurance contracts, arbitration clauses are not commonly used in insurance contracts.

Although alternative dispute resolution (ADR), especially mediation, is starting to develop in Portugal (in particular, tax arbitration), it is rarely used in insurance matters.

ii Litigation

Insurance-related disputes are subject to general civil procedure, which, in Portugal, may be characterised as an adversarial procedure with a preference for oral expression, and with certain fundamental principles, such as the right of access to justice, the right to reasonable duration of proceedings and the right to a fair trial (principle of equity).

Both civil and criminal proceedings include different stages. Generally, proceedings are initiated by the parties submitting pleadings, followed by a stage in which evidence is provided. Subsequently, the trial takes place and the court issues its decision. Finally, the parties can appeal the judgment, provided that certain conditions are met.

Despite the above, the new Civil Procedure Code establishes that all witnesses must be offered with the submission of the pleadings.

There are two kinds of civil proceedings: declarative and enforcement. Through the former, the court’s decision has *res judicata* effect and the court decides on the merit of the litigation between the parties. Enforcement proceedings may serve three purposes: the payment of an amount; the delivery of a certain object; or forcing the counterparty to carry out a certain action.

Ordinary declaratory proceedings in Portugal may take from one to three years until a final court decision is issued, while enforcement proceedings may take from one to two years.

Subject to the exceptions provided for in the law, each party bears the burden of proving those facts supporting his or her claim in the proceedings.

The courts have wide discretion when assessing evidence, subject to reasoning founded on the applicable law and the relevant facts.

Court costs are to be advanced by both parties. The winning party may claim from the losing party the judicial fees that were paid during the proceedings. The winning party may have to pay additional amounts at the end of the proceedings and claim the corresponding reimbursement from the losing party.

iii Arbitration

Arbitration continues to flourish in Portugal. Parties have progressively added arbitral agreements to contracts and there is a general sense that Portugal may become a privileged forum for arbitrations between companies based in Portuguese-speaking countries such as Brazil, Angola and Mozambique. On 15 March 2012, a new Law on Arbitration entered into force, replacing the former Arbitration Act.
The new Law is rather innovative, drawing inspiration from the 2006 version of the UNCITRAL Model Law, introducing provisions intended to grant more flexibility with regard to the formal validity of an arbitration agreement, making it simpler to comply with the written form requirement.

Five years after its entry into force, it is reasonable to state that the Law has increased flexibility in Portuguese arbitration and facilitated the increasing number of arbitral agreements included in contracts.

The leading arbitral centre is the Arbitration Centre of the Portuguese Commercial Association. As regards foreign arbitration, Portugal is party to the 1958 New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards.

iv Alternative dispute resolution

The greatest criticism of the Portuguese legal system is the length of time proceedings take. Furthermore, during the past decade, the annual number of actions filed before court has increased dramatically. In light of the above, both the civil society and the government have been encouraging the promotion of ADR; namely arbitration, mediation, conciliation and resolution by justices of the peace. In 2001, the government created the Cabinet for Alternative Dispute Resolution, a department of the Ministry of Justice exclusively dedicated to ADR.

Besides arbitration, mediation and conciliation, the most popular form of ADR is conducted by a justice of the peace, who is governed by Law No. 78/2001 of 13 July 2001 (as recently amended by Law No. 54/2013 of 31 July, which widened the scope and jurisdiction of justices of the peace), and numerous centres have been created under the supervision of a special commission. Justices of the peace are only available to settle disputes among individuals and have jurisdiction on civil matters purporting to small claims (up to €15,000). Under the legal framework on justices of the peace, legal persons may now resort to mediation (excluding for class actions) and preliminary injunctions are now available.

In Portugal, the Information, Mediation, Ombudsman and Arbitration Insurance Centre functions as a private non-profit association with the purpose of making available ADR mechanisms. To this effect, this Centre created two independent and autonomous procedures: an insurance mediation and arbitration service; and an insurance customer’s ombudsman service.

At present, the Centre promotes the settlement of disputes arising from insurance agreements of the following classes:

- motor;
- civil liability (family, exploration, hunting, use and possession of firearms) relating to complaints of up to €50,000; and
- multi-risk home insurance (commercial and housing) relating to complaints of up to €50,000.

Additional insurance classes are expected to be included in this ADR in the future.

v Mediation

Law No. 29/2013, of 19 April, establishes the general principles on mediation in Portugal. The law filled a legal gap by introducing important provisions pursuant to which any dispute regarding property issues or any rights that may be the object of transactions by the parties may be submitted to mediation.
Another important provision establishes that private mediation settlement agreements are, under the following specific circumstances, enforceable directly, without the need to obtain homologation from a court or the obligation to execute extrajudicial settlements in mediation centres supervised by the Ministry of Justice:

a the settlement’s object must be capable of being mediated and not subject to a mandatory court decision;
b parties must have capacity to execute the settlement;
c the settlement must have been reached through mediation and according to law;
d the content of the settlement must not violate the public policy of the Portuguese state; and
e the settlement must be reached with the intervention of a mediator included on the Ministry of Justice’s public list of mediators.

This statute also includes provisions on the training, duties, rights and legal impediments of mediators, as well as the rules applicable to public mediation frameworks.

However, mediation and conciliation settlement agreements in Portugal are traditionally negotiated between the parties’ attorneys, in the majority of the cases, during pending lawsuits. Parties are usually very reluctant to use mediation and conciliation.

V YEAR IN REVIEW

The legal framework implementing Solvency II was enacted in 2015, with effect from 1 January 2016, introducing significant changes to the rules governing the taking up and pursuit of insurance and reinsurance activities in Portugal. The new framework has also had an impact on the day-to-day business of Portuguese insurance undertakings.

In terms of transactions and changes of ownership of insurers, the market continued to evolve in 2016, as the change of ownership over Açoreana, to the same foreign private equity firm that previously acquired Companhia de Seguros Tranquilidade, SA, at the beginning of 2015, was completed in 2016. Real Vida Seguros became the sole insurer with a presence on the Portuguese stock market when its parent company, Patris Investimentos, debuted at Alternext marketplace. Real Vida Seguros ended 2016 with the acquisition of Finibanco Vida, a specialised life insurer formerly owned by the Mutualist Group Montepio.

Regarding legislative and regulatory initiatives, the following topics affecting the insurance and reinsurance market have been addressed in the past year:

a ASF Regulation No. 8/2016-R of 16 August, establishing the new framework for the reporting duties of insurance to the ASF;
b ASF Regulation No. 10/2016-R of 15 September, providing the new chart of accounts for insurance companies; and
c Ordinance No. 74-B/2016 of 24 March 2016, setting forth the contributions to the ASF owed by insurance companies.

Regulatory initiatives regarding other matters have also been carried out, notably in relation to the reporting duties concerning changes in the insurance companies’ shareholding structure and the role of the external auditor and of the responsible actuary in the reporting to the ASF.
VI OUTLOOK AND CONCLUSIONS

Despite unfavourable conditions resulting from financial distress and the challenges to economic recovery that have followed years of crisis, the insurance and reinsurance markets in Portugal have achieved satisfactory results; in particular, the sustained levels of foreign investment interest demonstrate a generally positive outlook for the Portuguese insurance market from the standpoint of private investors.

Direct insurance contracts decreased in 2015 by 6.6 per cent compared with 2014, while claims costs increased by 9.3 per cent (strongly influenced by life insurance) and insurers, investment portfolios decreased by 2.6 per cent. By contrast, at the end of 2015, the coverage rate of the solvency margin was at 238 per cent, which represents an increase of 32 per cent. From 2014 to 2015, the Portuguese insurance sector became more capitalised, with a global net result of €378 million.

From a legislative perspective, the Solvency II Directive has been in force since 1 January 2016. Its implementation has mostly been achieved, but it has not been without its challenges.

In addition to Solvency II, other relevant EU legal provisions will either be transposed or their implementation prepared in the coming months, notably Directive (EU) 2016/97 on insurance distribution, which, among other things, aims to ensure consumers benefit from the same level of protection regardless of differences between distribution channels. At a local level, 2017 will also see a new regulation being enacted on the ASF registration procedures of the persons who effectively manage or supervise: insurance undertakings; people who hold key functions; and responsible actuaries.

In conclusion, the insurance and reinsurance sectors face challenging times in light of the new regulatory requirements imposed. The ASF will have to closely monitor the relevant aspects of this new regime, as well as its implementation.

In view of the above, the coming year will most certainly be a proving ground for Portuguese insurance and reinsurance undertakings as they continue to adapt to the requirements and impact of Solvency II on their day-to-day business.

This notwithstanding, the Portuguese insurance sector will continue to benefit from new market entrants and the forecast economic growth.
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 has changed slowly following a severe 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 state wholly 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 Competitiveness.

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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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 of insurance and reinsurance intermediaries, reinsurance brokers and senior management carried by the DGIPF. It is not an authorisation proper, but just a formal requirement to be able to carry out their activity. See Section III.v, infra, for further information.

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 Competitiveness if they wish to set up a branch in Spain.

v Regulation of individuals employed by insurers

Generally speaking, 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

In Spain, there are several forms of compulsory insurance including but not limited to 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). It should also be noted that 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 (such as 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, 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 to the 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, infra, for further information.

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 1.5 per mille 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

Of particular interest to the insurance industry in 2017 is the new Law on Distribution of Private Insurance and Reinsurance. The DGIPF has drafted the preliminary bill. The new Law will transpose the Insurance Distribution Directive (Directive 2016/97/EU) to Spanish legislation.
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 acceptor, 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.
Regard must also be had to the Law on Standard Contract Terms, which 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. It should also be noted that case law (e.g., Decision of the Supreme Court of 30 November 2011, RJ\2012\3519) has drawn a subtle (and not always too 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. Such principles might 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.

Intermediaries and the role of the broker

Conduct rules

The operations of insurance and reinsurance intermediaries are subject to the Private Insurance and Reinsurance Mediation Act 2006 (PIRMA), as amended.

The PIRMA applies to intermediation activities between insurance policyholders or the insured on the one hand, and insurance entities on the other. 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.

As mentioned in Section II.xi, supra, the DGIPF has drafted the preliminary draft bill on the Distribution of Private Insurance and Reinsurance, which intends to transpose the Insurance Distribution Directive (Directive 2016/97/EU) to Spanish legislation.

**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.

On the one hand, 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 this 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.

On the other hand, 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.

Claims

Notification

As a general rule, insurance claims must be reported within seven days from 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 notify the insurer in writing of the list of the existing objects at the time of loss, of those saved and the estimate of loss. 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.

Currently, 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 common opinion in Spain that such a 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.

Regard must be had, however, to 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 (also known as ‘Brussels I Regulation recast’).

Concerning 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, regard must be had to 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), which applies to insurance contracts concluded as from 17 December 2009. The Rome Convention 1980 would apply to insurance contracts
concluded before that date and to those countries that opted out of the Regulation (Denmark),
but it should be noted that the Rome Convention 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.

In the case of insurance, this general principle has been 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 ADR method.

**ii Litigation**

**Litigation stages, including appeals**

Generally speaking, 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). It is important to note that 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 after
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 (1) interrogation of the parties, (2) public documents, (3) private
documents, (4) experts’ reports, (5) judicial examination, and (6) 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 from 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.

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 main event in 2016 was the entry into force of Solvency II. Insurance and reinsurance companies have had to face significant changes in management, corporate governance and organisation. According to the information provided by the DGIPF resulting from the tests carried out by the European Insurance and Occupational Pensions Authority, the initial results are satisfactory: the industry is exceeding more than double the compulsory capital required by Solvency II. The DGIPF has continued to expand on the regulatory framework under Solvency II. It has published a number of ministerial orders, decisions, guidelines and consultations.

Also of note is the announced reform of the ICA. The Council of Ministers’ meeting, held on 30 May 2014, approved the draft bill of the Commerce Code to replace the current Commerce Code, the ICA and the PIRMA, among other acts. In May 2016, the call for elections and the dissolution of the legislative chambers caused all draft bills being processed to be withdrawn. To date, the government has not yet published the draft bill of the Commerce Code to be presented to Parliament for consideration.

VI OUTLOOK AND CONCLUSIONS

The insurance industry in Spain is focused on implementing Solvency II and will continue to be so in the coming years.

In addition, 2017 will see the insurance industry facing the approval of the new Law on Distribution of Private Insurance and Reinsurance. This new Law will transpose the Insurance Distribution Directive into Spanish legislation.
Chapter 26

SWITZERLAND

Lars Gerspacher and Roger Thalmann

I 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 not only consists 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.2

In 2014–2015, the total number of insurance and reinsurance companies under supervision was 214 (of which 49 were branches of foreign insurance companies). The total number of reinsurers was 59 (of which 29 were reinsurance captives).3

II REGULATION

The regulatory body in Switzerland is the Swiss Financial Market Authority (FINMA),4 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 EU or the EEA, the freedom of services regime and the possibility to apply for local passporting rights do not come into play. Although there are bilateral treaties between the European Community and Switzerland in place, there is no single passport of licences between EEA Member States and Switzerland. There is, however, one bilateral treaty between Switzerland and Liechtenstein that gives freedom of services in insurance matters between these two countries.

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

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1 Lars Gerspacher is a partner and Roger Thalmann is an associate at gbf Attorneys-at-law Ltd.
3 FINMA insurance market report 2015, dated 7 September 2016, at p. 4.
4 www.finma.ch.
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. 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 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.

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. 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. 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.

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. The application and the business plan are based on a number of standardised forms. In short, the applicant needs to show:

- what type of business it intends to carry out;
- which classes it would like to insure in;
- how it will meet the financial requirements; and
- who will be the persons responsible for the management and supervision, who must have a good reputation and sufficient professional qualifications.

FINMA usually needs one month to review a first draft of the business plan, and one further month to review the final business plan and draft its order. The process of obtaining all documents and drafting of all forms of the business plan normally takes three to four months.

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5 Article 1(1) ISO.
6 Article 2(a) ISA.
7 Article 1(2) ISO.
8 Article 3(1) ISO.
9 Articles 42 and 43 ISA.
10 Article 182 ISO.
11 Article 4(1) ISA.
As far as taxation is concerned, 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.

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 the Federal Constitution of the Swiss Confederation provides. The legislation for private insurance is in the competence of the federal state.12

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.13 If the insurance requires a medical examination, the application period is stretched to four weeks.14

The conclusion of an insurance contract necessitates mutual consent with respect to the essential terms and the expression thereof by the parties.15 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.16 With respect to such relevant risk factors, a customer only has to disclose information that the insurer explicitly requests in writing.

12 Article 98(3) Federal Constitution of the Swiss Confederation.
13 Article 1(1) ICA.
14 Article 1(2) ICA.
15 Article 1(1), Article 2(1) and Article 18(1) CO.
16 Article 4(1) ICA.
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). 17

Further, it is worth mentioning that 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 such duty only has an effect if it has an impact in a concrete insured event. 18

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). 19

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. 20

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.

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. 21

18 Article 29 ICA.
19 Article 3 ICA.
20 Stephan Fuhrer, op cit. 17, No. 3.96.
In interpreting the contract, a judge avails him 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 purpose of the contract and the parties' interests in the performance thereof; the history of the contractual negotiations and the conduct of the parties before entering into the contract ('historical interpretation'); and usages in the specific field.

Findings based on such means of interpretation are subject to further rules of interpretation. The most important are as follows:

a) of outstanding importance is the 'principle of trust'. Based on this principle, a statement made by one party is to be interpreted from the addressee's objective point of view;

b) contract 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);

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. 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; and

d) the interpretation in *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. 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 on the one hand and the insurers' general standard terms and conditions (GTCs) on the other. 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.

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.

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22 Swiss Supreme Court judgments, reported at BGE 129 III 702, at p. 707; and at BGE 119 II 368, at p. 373.
23 See, for instance, the Swiss Supreme Court judgment, reported at BGE 114 II 265, at p. 267.
24 Gauch et al, op cit. 21, No. 1230.
25 Swiss Supreme Court judgments, reported at BGE 119 II 368, at p. 372, and Swiss Supreme Court judgment No. 4C.215/2002 of 11 November 2002, consid. 2.4.
26 Gauch et al, op cit. 21, Nos. 1128 et seq. and 1138 et seq.
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.

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.27 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).28 Many Swiss brokers are members of the Swiss Insurance Brokers Association,29 which has its own conduct rules.30 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 such liability arises in connection with commercial activities conducted under official licence, any exclusion thereof may apply at most to slight negligence.31 To cover such claims, brokers are, under regulatory law, obliged to have professional indemnity insurance or similar financial security.32

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, who can be held liable for it.33

v  **Claims**  

The insured has to inform the insurer about an event covered by the policy as soon as he or she becomes aware of such incident and the resulting claims.34 Unless otherwise agreed, there

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27 Article 43(1) ISA.  
28 Article 45 ISA.  
29 See www.siba.ch.  
31 Article 101(3) CO.  
32 Article 44 ISA.  
33 Article 34 ICA.  
34 Article 38(1) ICA.
is no form 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.

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 after four weeks from 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 said 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.\(^{44}\) It must be borne in mind that the Convention includes a special chapter concerning insurance disputes. The consumer-related norms in Article 15 et seq. do not apply.

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.\(^{45}\) In all other cases, parties may diverge from the general rules.\(^{46}\) 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.\(^{47}\) 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.\(^{48}\) If only the defendant is registered and the said value in dispute is reached, the claimant may choose between the commercial court and the ordinary court.\(^{49}\) 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 as well. 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.\(^{50}\) Such appeal may be filed on grounds of incorrect application of law or incorrect establishment of the facts.\(^{51}\)

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.

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\(^{44}\) Convention of 30 October 2007 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

\(^{45}\) Article 120(2) PILA.

\(^{46}\) Article 116 PILA.

\(^{47}\) Article 18 PILA.

\(^{48}\) Article 6(1) CPC.

\(^{49}\) Article 6(2) CPC.

\(^{50}\) Article 308 CPC.

\(^{51}\) Article 310 CPC.
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. 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.

**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 such 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.

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. Rendered legal aid must be reimbursed as soon as the beneficiary is in a position to do so.

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, but it is not specifically regulated.

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52 Article 74 Federal Supreme Court Act.
53 Article 105(2) Federal Supreme Court Act.
54 Article 117 CPC.
55 Article 122 CPC.
56 Article 123 CPC.
iii  Arbitration

Although it would be permissable 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.57

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 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 proceed58 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 orders59 or where evidence can only be taken with the assistance of the courts).60 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:61

- the sole arbitrator was designated or the arbitral tribunal was constituted in an irregular way;
- the arbitral tribunal wrongfully accepted or declined jurisdiction;
- the arbitral tribunal decided on points of dispute that were not submitted, or it left undecided prayers for relief that were submitted;
- the principle of equal treatment of the parties or the right to be heard was violated; or
- the award is incompatible with public policy.

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.62

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57 Article 169(1) ISO.
58 Article 182(2) PILA.
59 Article 183(2) PILA.
60 Article 184(2) PILA.
61 Article 190(2) PILA.
62 Article 192(1) PILA.
iv Alternative dispute resolution

Methods for alternative dispute resolution (including mediation) are hardly 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 such obligation are not very clear, apart from the fact that such obligation could not prevent one party from initiating arbitration without having followed the required methods laid down in the reinsurance contract.

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 the mediation style when they summon parties to a hearing and try to convince them to settle the claim.

V YEAR IN REVIEW

The ICA is more than 100 years old. As a result, it was partially amended, effective as of 1 January 2006, to address urgent consumer protection issues. Hereafter, the Swiss Federal Council set out to prepare a total revision of the ICA in a first step. As such endeavour turned out to involve too many controversial issues, the Swiss Federal Council was requested to prepare a partial revision. On 6 July 2016, the draft for this revision was submitted for public consultation. It ended on 27 October 2016. In a further step, the Swiss Federal Council will prepare its formal dispatch on the subject matter for the attention of Parliament. An important new element of the revision regards the insured’s right to assert a claim directly against the liability insurer. Currently this is only possible for very few claims. Another amendment of considerable significance relates to the recourse possibilities of property insurers. At present, their right of recourse is restricted. For instance, under current law the insurer covering a damage may not take recourse against the responsible person if it is only liable based on strict liability or if it is contractually liable but did not act through gross negligence.\textsuperscript{63} The revised ICA will provide for a norm that leads to full subrogation rights by putting insurers into the shoes of the insured and, thus, also enabling property insurers to take recourse actions in matters such as those mentioned above (also, see the new 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 US (such as ACE). The process is known in

\textsuperscript{63} Cf. Swiss Supreme Court judgments, reported at BGE 137 III 353 and 80 II 247 and explanatory report of the Federal Department of Finance on the 'Revision of the Insurance Contract Act (ICA)' dated 6 July 2016, p. 51.
Switzerland as ‘redomestication’, since under Swiss corporate law it is possible to move a foreign domiciled company into Switzerland without dissolving it. Recent entrants include Amlin Re Europe, Catlin Re, Novae Re and Q-Re. Both the movement of existing businesses from offshore centres to Switzerland and the establishment of new businesses in the country continue to be hot topics in the reinsurance world.
I  INTRODUCTION

i  Nature of the insurance and reinsurance market

Since May 2014, the number of active insurance companies incorporated in Turkey has remained at 61. Among those, 38 are non-life insurance companies, five are life insurance companies and there are 19 pension companies currently active. Turkey has two reinsurance companies; however, as one of those companies does not generate premiums, it only has one active reinsurance company. Reinsurance cover is mostly provided to Turkish insurance companies by foreign reinsurers.

The total of premiums collected in 2016 amounted to approximately 40 billion liras indicating an increase by 30 per cent compared with the previous year.\(^2\) Of this aggregate value, approximately 35 billion liras were derived from non-life insurers,\(^3\) whereas approximately 6.1 billion liras were derived from life insurers. These values include the premiums collected from both inside and outside Turkey.

As of November 2016, the share of the relatively small insurance segment\(^4\) in the financial services sector has increased from 3 per cent of GDP to 3.1 per cent.\(^5\) The premium to GDP ratio in Turkey is low, demonstrating potential for growth in the future years.\(^6\) It is also worth noting that the goal of the insurance sector is to generate up to 63 million liras in premiums by 2023.\(^7\)

Insurance sales in Turkey are conducted via direct sales, agencies, bancassurance and brokers. Agencies had the biggest share in 2015, with their total sales constituting 60 per cent of the overall total, and worth more than 18 billion Turkish liras. This significant amount of sales is the result of the agencies’ strong presence in Turkey. There were more than

\(^1\) Pelin Baysal is a partner and Ilgaz Önder is an associate at Gün + Partners. Previous versions of this chapter have been prepared by Pelin Baysal and Bensu Aydin.
\(^3\) www.odd.org.tr/folders/2837/categorial1docs/1740/T%C3%BCrkiye%20Sigorta%20Sekt%C3%B6r%20Raporu%20Aral%C4%B1k%202016.pdf.
\(^4\) Including private pensions.
\(^5\) European Commission Turkey 2016 Progress Report, p. 36.
16,000 actively operating agencies as of 2015. Agency sales are followed by bancassurance sales. Bancassurance grew from 17 per cent to 22 per cent from 2008 to 2015, exceeding 6.9 billion Turkish liras in total sales.8

In recent years, foreign investors’ interest has grown significantly with the stabilisation of the economy, the efforts to comply with EU laws and regulations, and the considerable insurance potential in Turkey. The foreign share in the insurance sector at the end of 2013 totalled 61.29 per cent of active insurance companies.9 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.

Despite growing awareness of insurance, the Turkish insurance market is still underpenetrated and there is still a significant lack of legal and practical experience, particularly with respect to various types of policies including but not limited to directors’ and officers’ liability insurance, infidelity, commercial crime and various aspects of complex policies such as all-risks construction and engineering policies.

ii The legal landscape for insurance and reinsurance disputes

Enforcement through the Turkish court system is a rather 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) and 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 ADR but are required to remind them of their options at the end of the preliminary examination.

In 2007, a voluntary insurance arbitration system was introduced. The total number of disputes settled by the Insurance Arbitration Commission has reached 64,281 as of 31 December 2016.10 The fact that the Commission had settled 37,607 disputes (more than half of the total amount) as of 31 December 201511 clearly reveals that arbitration has become more popular in recent years. Traffic insurance and car insurance disputes accounted for approximately 95 per cent of the applications.12

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,

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insurance companies must obtain approval from the Ministry of Customs and Trade. Insurance companies must apply to the Undersecretariat for licensing in each insurance licence class. Companies failing 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 liras, 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. 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 with local insurance companies are frequently made.

Insurance products are aimed to be distributed in accordance with business and ethical rules and commercial customs, with a focus on the needs and demands of the customer.

As in other markets, in 2015 bancassurance became the main life insurance distribution channel in Turkey.13 Banks function as agents bringing together insurers and clients, demanding simple and low-cost products from trusted financial institutions.

There are a considerable number of areas of compulsory insurance in Turkey, particularly in relation to dangerous categories such as gas boilers, transportation, medical injuries, clinical trials and hazardous materials. The most frequent type of compulsory insurance in Turkey is cover for motor vehicles. Following the unfortunate mining accident in Turkey on 13 May 2014, in 2015, to enhance working conditions and ensure workers’ safety, the Ministry introduced compulsory personal accident insurance for those working in mines. 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.

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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 moveable and immoveable properties within municipal boundaries and adjacent areas.

III  INSURANCE AND REINSURANCE LAW

i  Sources of law
Turkey operates a continental law system and legislation is the principle and primary source of law. The provisions of the Turkish Code of Obligations (TCO) shall be applicable to the insurance contracts where the Insurance Chapter of the TCC is silent. The principles of freedom of contract apply subject to the mandatory and protective measures of these Codes. Accordingly, the Insurance Act provides that 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.

Turkish law does not explicitly contemplate reinsurance contracts. 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 following can be identified as the main elements of indemnity insurance.

Insurable interest
The Code refers to an ‘interest measurable in monetary terms’.

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 such 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.¹⁴

**Insurance sum**

The insurance sum is subject to the limit of the insured value and the actual loss in indemnity insurance.

**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’.

A new amendment has been introduced by the TCC regarding the insurer being silent at the conclusion of the indemnity contract.

Since 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.

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 orally or in writing by the insurer are presumed 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.

¹⁴ 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.’
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.

The insurer must issue an ‘insurance policy’ recording the mutual rights, obligations, including default provisions and special provisions, accompanied by general conditions predetermined by the Undersecretariat and signed by the insurer. Written form is not a condition for validity but a regulatory requirement for the protection of the insured.

iii 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 there is ambiguity or contradictions in the wording; interpretation in favour of the insured prevails since the primary duty of providing a 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

There is no legal discussion with respect to the conditions of incorporation of insurance terms to the reinsurance contracts; however, the terms subject to incorporation must be in compliance with statutory provisions. For instance, provisions concerning public order have to be taken into consideration.

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 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 liras and 50,000 liras for any additional type of insurance. Brokers that are currently active are required to comply with this capital threshold within one year of publication of the Regulation (i.e., by 27 May 2016).

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 Section III.ii, ‘Insurance premium’, supra), 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 increasing 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. 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 Code on International Civil Procedure with respect to insurance contracts provides 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 their domicile in Turkey.

The above provisions are unlikely to apply to reinsurance agreements with a foreign element.

The Turkish Civil Procedure Code applicable to the local disputes restricts the freedom of choice of local jurisdiction to agreements between merchants and between public legal entities. Insurance agreements with no foreign element concluded with real persons and legal entities 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.

Regarding choice of arbitration in insurance and reinsurance contracts, see Section IV.iv, infra.

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 Turkish laws of public order. The requirement of the existence of a foreign element is controversial and in a relatively recent decision of the Court of Appeal in an insurance case filed by an insured company, it was concluded that the choice of a foreign law would suffice for the fulfilment of the ‘foreign element requirement’ even if there is no foreign element with respect to the dispute. The general approach under Turkish law is that mandatory rules are not necessarily matters of public order. Where, however, the insured is not a merchant but a real person, consideration of public order and the law on ‘standard contract terms’ protecting the weaker party of the contract may prevail for the sake of protection of the insured.

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**

Maturity of the indemnity payment arises upon conclusion of the insurer’s investigations into the scope of the indemnity and in any case upon 45 days after notification of the occurrence of the risk. The investigation of the insurer shall in any case be concluded within three months from 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** Written submission by the parties of their claim, defence, rebuttal and rejoinder and evidence.

- **b** 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’ evidences. At the preliminary hearing, the judge will also encourage the parties to settle or resort to the mediation. In this stage, the parties can amend their evidence and assertions only if the counterparty gives his or her consent.

- **c** Turkish courts almost always revert to court-appointed expert examinations even in legal matters. Hearings are being held on the disputed elements of the case, where the court could hear witnesses and obtain expert reports.

- **d** Upon assessment of all evidence and facts, the court delivers a short judgment followed by a reasoned judgment. According to the new Turkish judicial system, which became operational for the judgments that are rendered after 20 June 2016, the appeal procedure is to be conducted by a two-tier system composed of regional appellate courts and the Supreme Court. Accordingly, the decisions of first instance courts concerning a dispute amounting no less than 3,110 liras 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 liras. This new system is expected to decrease the workload of the appellate courts and accelerate the appeal stage.

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 the case law where the law or practice is ambiguous. This is particularly important for insurance law because the Supreme Court has not been satisfactory until now in providing 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 (i.e., deductibles, exclusions and subrogation).

**Evidence**

Under Turkish civil law, the adversarial system prevails.

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15 Article 341 of the CCP.
16 Article 361 of the CCP.
The burden of proof of the existence of the contractual relationship, the occurrence and amount of the loss lies with the insured. The insurer must prove the lack of cover and application of exemptions. Every transaction exceeding 2,500 liras 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 views subject to the questions of the judge and the parties (without any common law-style cross-examination procedure) as supportive evidence without any need to obtain a judge order in this regard. Neither expert reports ordered by the court nor expert views submitted by the parties are binding for the judgment.

**Costs**

6.831 per cent of the claimed amount needs to be paid as court fees. One-quarter of this amount has to be paid to the court in advance by the claimant. Court fees and court expenses (the most significant of which are expert fees at around €500–€750 per expert) 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 authorising its establishment, the Istanbul Arbitration Centre was established and parties currently have the opportunity to refer disputes either to the Centre or to the Insurance Arbitration Commission, whose function is explained in detail below. At present, the Istanbul Arbitration Centre seems to present an efficient alternative to court litigation, as the costs are low and the pace of proceedings is high.

**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 each other. Provisions of Civil Procedure Law will be leading the parties to arbitrate in Turkey in a local dispute, whereas the International Arbitration Act will be applicable 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.

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17 Umar, Bilge; HMK Şerhi sayfa 801 vd.
20 Drafted in consideration of the UNCITRAL Model Law on International Commercial Arbitration, the Arbitration Law is applicable to those disputes involving a foreign element.
Arbitration Commission
The Insurance Act provides that an institutional arbitration proceeding must be settled before the Insurance Arbitration Commission 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.

Format of insurance arbitrations
The Arbitration 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 liras, it is compulsory to form a tribunal. The tribunal decides by majority.

Procedure and evidence
The requirement for application to the Arbitration 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 Procedural 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 referred to in the Minimum Attorney Fees Tariff.

The application fee is determined by the Undersecretariat and varies from 100 liras to 350 liras, depending on the amount of the dispute.\textsuperscript{21}

The fees of arbitrators are paid by the Commission. Arbitrators shall decide on the additional costs as regulated under the Civil Procedural Code.

Awards of the Arbitration Commission in 2016
Most of the awards rendered by the Arbitration 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.

Alternative dispute resolution

Complaints of the insured

The insured can apply to the Insurance General Directorate, incorporated under the Undersecretariat, regarding their complaints arising from interpretation of the regulations or conduct of an insurance company.

Mediation

Mediation has not been a frequently used method of dispute resolution. Mediation was recognised in Turkish law for the first time by the Mediation Act, which entered into force in June 2013. The courts are also obliged to invite but not force parties to settle disputes by means of mediation or settlement.

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. Such an annotation gives the agreement reached as a result of mediation the power of a court judgment.

YEAR IN REVIEW

The main hot topic in Turkish insurance law concerns the private pension scheme, which recently became compulsory for Turkish citizen employees and public servants. According to very recent regulations, employers are obliged to contribute to the private pension scheme for each of their employees who are not older than 45 years. The contribution made through the employers is 3 per cent of the employee’s salary and this amount is to be deducted from the salary. The state also contributes to the employees’ scheme along with each premium. Currently, there are 18 life insurance companies that provide private pension schemes.

Apart from the above, there was no progress on insurance and occupational pensions.22

OUTLOOK AND CONCLUSIONS

The Turkish 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 has the insurance sector, among others, in its sights. Because of the increase in foreign investment and developments in the Turkish economy, it is expected that the insurance sector will gain momentum over the coming years.

The Undersecretariat is also planning on enhancing insurance regulations to incentivise participants in the insurance market and to develop new products that will create opportunities for insurance companies. Efforts are still required to be made regarding alignment with the EU on insurance regulation and these are expected to continue.

Chapter 28

UNITED ARAB EMIRATES

Sam Wakerley, John Barlow and Josianne El Antoury

I INTRODUCTION

i The nature of the UAE insurance and reinsurance market

The United Arab Emirates (UAE) insurance market is the largest in the Gulf Cooperation Council (GCC) and one of the best performing insurance markets in the region. While the UAE Insurance Authority was established in 2007 and is still relatively new, the insurance market is becoming increasingly regulated. There is generally low insurance penetration, although motor insurance and health insurance in certain emirates are compulsory.

Only licensed insurers can write business ‘onshore’ in the UAE and there is currently a moratorium on the issuing of new onshore licences. Therefore, significant additional capacity is provided by way of reinsurance. There are effectively two separate insurance jurisdictions: the onshore UAE market; and the Dubai International Financial Centre (DIFC). There is also, separately, the Abu Dhabi Global Market (ADGM), which is largely made up of wholesale ‘offshore’ reinsurance centres. The onshore insurance market is largely dependent on reinsurers and significant capacity is now available in the DIFC, since Lloyd’s opened there in 2015. The DIFC has its own legal framework and court system based on common law.

There are no express legal provisions restricting insurance fronting transactions in the UAE. 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. In the recent renewal period, global reinsurers in the property insurance market are now requiring that local property insurers retain at least 30 per cent of the risk of the gross written premium following a high number of fires in the region.

1 Sam Wakerley and John Barlow are partners, and Josianne El Antoury is an associate, at Holman Fenwick Willan Middle East LLP.
3 An analysis of DIFC law as well as other offshore jurisdictions (such as the ADGM) are beyond the scope of this chapter.
ii The legal landscape for insurance and reinsurance disputes

The Insurance Authority will generally require insurance policies issued in the UAE to be governed by UAE law. In the case of reinsurance policies, the parties are free to choose the law applicable to the contract. The parties can also choose arbitration as the method of dispute resolution.4

The UAE legal system is a civil law system, and the primary source of law is a statutory code. This means 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 insurance disputes, the court will typically appoint an expert to investigate the facts and the technicalities of the case, meet with the parties, gather evidence and prepare a report, and the findings and recommendations in the report are usually followed by the court.

There is no pre-action protocol or procedure. Although, for civil, commercial and labour claims in Abu Dhabi, it is mandatory that the claim is first filed with the Abu Dhabi Settlement and Reconciliation Committee. Similarly, in Dubai, all claims must first be filed with the Centre for Amicable Settlement of Disputes (save for a few categories of claims that are exempt).5 The purpose of the Committee and the Centre is to allow the parties an opportunity to reach an amicable settlement.

The doctrines of reservation of rights or without prejudice correspondence are not expressly recognised under UAE 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 clients without the client’s consent or other limited circumstances.

II REGULATION

i The insurance regulator

The onshore UAE insurance market is regulated by the Insurance Authority, which oversees all insurance business in the country (i.e., insurers, brokers and other insurance service providers). In addition to the Insurance Authority, there are separate regulators for the health insurance sector in some of the individual emirates; at present, these are the Dubai Health Authority and the Health Authority Abu Dhabi (HAAD).

ii Position of non-admitted insurers

UAE law prohibits non-admitted insurance and any insurer conducting insurance business in the UAE must be licensed by the Insurance Authority. This prohibition applies to all types of insurance business and is contained in the UAE Insurance Law (Federal Law No. 6 of 2007).6

4 However, in relation to insurance contracts, strictly speaking, the arbitration clause must be set out in a separate agreement agreed to by both parties as per Article 1028(1)(d) of the Civil Code.

5 For example: labour disputes; temporary and summary actions or orders; proceedings where the government is named as a party; and proceedings that are outside the Civil Court’s jurisdiction.

6 Article 26 of the Insurance Law 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
iii Position of brokers

Brokers operating in the UAE are also required to be licensed by the Insurance Authority.

iv Requirements for authorisation

In order to undertake insurance activities from or within the UAE, an insurer must be licensed by the Insurance Authority and must be established as either: (1) a locally incorporated public joint-stock company, listed on a UAE stock exchange and with UAE nationals owning at least a 75 per cent stake in the company; or (2) a branch of a foreign insurance company. Insurers are required to hold regulatory capital pursuant to the Insurance Authority’s regulations.

v Regulation of individuals employed by insurers

Certain activities are controlled functions in that the Insurance Authority must approve any individual working in that role. Broadly, these roles include directors, chief executive officers, compliance officers, finance officers and money laundering reporting officers of an insurer or broker.

In addition, an insurance company regulated by the Insurance Authority must circulate the Instructions Concerning the Code of Conduct and Ethics to be Observed by Insurance Companies Operating in the UAE to its employees, as well as develop internal professional codes of conduct for the company and its employees.8

vi Distribution of products

Insurance products should only be distributed in the UAE by insurers licensed by the Insurance Authority (i.e., direct sales), insurance brokers and consultants licensed by the Insurance Authority, or banks licensed in the UAE via bancassurance arrangements between a locally licensed insurer and the bank.9

vii Compulsory insurance

In the UAE, third-party liability insurance in respect of motor vehicles is compulsory. Health insurance is also compulsory in the emirates of Dubai and Abu Dhabi.

viii Compensation and dispute resolution regimes

The Insurance Authority 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 stated in the Complaint Register.10 The Insurance

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7 The Insurance Authority’s Board Resolution No. 3 of 2010.
8 Article 3(12) of the Insurance Authority’s Board Resolution No. 3 of 2010.
9 While bancassurance arrangements are practised in the UAE, the Insurance Authority’s board of directors’ decision of 2016 concerning the instructions on marketing insurance policies through banks is still in draft form and is yet to be enacted.
10 Article 10 of the Insurance Authority’s Board Resolution No. 3 of 2010.
Authority inspectors have access to the Complaint Register to verify the information recorded therein. Each complainant (whether it is the insured or the beneficiary) may appeal decisions to the Insurance Authority if their complaint is rejected by the insurance company.

**ix Taxation of premiums**

Although no federal taxation currently exists in the UAE, each of the individual emirates has issued corporate tax decrees that theoretically apply to all businesses established in the UAE. However, in practice, these laws have not been applied to date. The UAE will implement value added tax (VAT) at the rate of 5 per cent on 1 January 2018. Strictly speaking, insurers and reinsurers based in the UAE are not liable to pay tax on premiums at present. At the time of writing, it is not clear whether VAT will apply to insurance premiums.

However, an annual fee is payable to the Insurance Authority\(^\text{11}\) that is calculated as a percentage of the total subscribed annual premiums underwritten minus locally applicable reinsurance premiums underwritten by an insurance company as follows:

- life and capital insurance: 0.2 per cent of annual premium;
- health insurance: 0.4 per cent of annual premium; and
- property and liability insurance: 0.5 per cent of annual premium.

**x Proposed changes to the regulatory system**

The UAE has one of the most developed life insurance markets in the region and it is continuing to grow. The Insurance Authority has proposed Draft Regulations for the life insurance market. These Draft Regulations are intended to secure market conduct with the various entities that provide and facilitate the provision of life insurance products in the UAE. In the Draft Regulations, the Insurance Authority places significant focus on regulating the commission structure, disclosure obligations owed to the client and protecting policyholder values. The Draft Regulations are currently at the consultation stage.

**xi Other notable regulated aspects of the industry**

The Financial Regulations for Insurance Companies determine the limits of distribution and allocation of invested assets permitted for insurance companies by setting a ceiling limit for overall exposure in certain asset classes.\(^\text{12}\) For example, for real estate assets and UAE equity instruments, the ceiling is 30 per cent; for non-UAE equity instruments, the ceiling is 20 per cent. The ceilings for government debt securities are significantly higher, at 100 per cent for UAE emirate debt securities and 80 per cent for debt securities for A-credit rated foreign countries.

It is notable that the Insurance Authority’s solvency margin is based on the assumption that the company will continue to operate as a going concern.\(^\text{13}\) The Insurance Authority, when considering the licensing of an entity, places great emphasis on this aspect. Solvency capital requirements are applied to each company to ensure that potential risks are provided

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\(^{11}\) According to Article 2 Cabinet Decision No. 23 of 2009 concerning Charges, Supervision, Control and Transactions of Insurance.

\(^{12}\) Section 1, Article 3 of Decision No. 25 of 2014 Pertinent to Financial Regulations for Insurance Companies (Financial Regulations).

\(^{13}\) Section 2, Article 4(1)(a) of Decision No. 25 of 2014 Pertinent to Financial Regulations for Insurance Companies.
for and must cover underwriting, market, liquidity, credit and operational risks. The purpose behind these requirements is to ensure that companies maintain funds higher than their minimum capital requirement, solvency capital requirement and minimum guarantee fund. Companies are required to inform the Insurance Authority should capital fall below these set minimum amounts.

III INSURANCE AND REINSURANCE LAW

i Sources of law

In the UAE, insurance is regarded as a commercial activity and, in theory, is governed by the UAE Commercial Code. Under the UAE Commercial Code, the hierarchy of laws is as follows: (1) the Commercial Code; (2) the agreement of the parties (i.e., the policy); (3) rules of commercial customs and practices (with specific or local customs and practices superseding general); and (4) the Civil Code, insofar as it does not contradict the general principles of the commercial activity.

However, the substantive provisions of insurance law are contained in the Civil Code and therefore, in practice, the insurance provisions of the Civil Code are applied by the UAE courts, despite the hierarchy of laws in the Commercial Code.

Marine insurance law in the UAE is set out within the Maritime Code. 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 are still written on or using 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 Islamic shariah 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 Islamic shariah, courts may nevertheless look to shariah principles for guidance in interpreting and applying the law.

Takaful insurance is an alternative system of cooperative Islamic insurance that is also 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, as set out in the Insurance Authority Board Resolution No. 4 of 2010.

15 Section 2, Article 8(1) of Decision No. 25 of 2014 Pertinent to Financial Regulations for Insurance Companies.
18 Articles 1026–1055 of the Civil Code.
19 Along with the Insurance Law and the Insurance Authority Board Resolution No. 3 of 2010.
21 An analysis of takaful insurance is beyond the scope of this chapter.
Making the contract

Essential ingredients of an insurance contract

Under UAE law, insurance is a contract whereby the insured and insurer cooperate in facing 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. The general provisions in relation to formation of contracts under the Civil Code will apply to insurance contracts, insofar as they do not contradict those specific provisions in the insurance sections of the Civil Code.

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’.

In the case of liability insurance, the obligations of the insurer only arise when the injured third party makes a claim against the insured. This can include a legal judgment awarded against the insured but it has been held in certain cases that this is not strictly required.

Although not explicitly stated, there must be a fortuity (i.e., there must be an element of risk or uncertainty).

Requirement of insurable interest

There is no express concept of insurable interest within UAE law. 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. It is likely that this provision would apply equally to non-marine insurance.

It is also worth noting that 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. There is also an express obligation on an insurance company to carry out its business on the basis of absolute good faith.

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.

22 Article 1026(1) of the Civil Code.
23 Articles 125–148 of the Civil Code.
24 Article 1026(1) of the Civil Code.
25 Article 1035 of the Civil Code.
26 Court of Cassation judgment No. 281 of 1993.
27 Article 368 of the Maritime Code.
28 Article 246(1) of the Civil Code.
29 Article 3 of the Insurance Authority’s Board Resolution No. 3 of 2010.
30 Article 1033 of the Civil Code.
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 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.31

To give a degree of protection to insureds, there is an obligation on the insurer to include all of the necessary queries 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.32

**Recording the contract**

A contract of insurance is recorded by way of a written policy. As a result of the enactment of the Electronic Transactions and E-Commerce Law,33 contracts between parties can be executed electronically; for example, contracting by ‘click-to-accept’ means 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.

The content of insurance policies is governed by the Insurance Authority 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.34 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.35

Insurance policies in the UAE 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.36 Failure to issue a policy in Arabic can result in a fine37 as well as uncertainty as to how the terms will be interpreted.

**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.38 If the words are clear, they cannot be departed from.39

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31 Article 388 of the Maritime Code.
32 Article 6 of the Insurance Authority's Board Resolution No. 3 of 2010.
33 Federal Law No. 1 of 2006.
34 Article 7 of the Insurance Authority's Board Resolution No. 3 of 2010.
35 Article 373 of the Maritime Code.
36 Article 28 of the Insurance Law.
37 Article 104 of the Insurance Law.
38 Articles 258(2) and 259 of the Civil Code. There is often confusion in this area as the Civil Code also provides that the criterion in construing contracts is intentions and meanings and not words and form (as per Article 258(1) of the Civil Code).
39 Article 265(1) of the Civil Code.
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 in UAE law 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, exclusion clauses (or any clause that relates to a circumstance leading to the avoidance of the contract or the lapse of the rights of the insured) must be shown ‘conspicuously.’ This has been further defined as printing the clause in another font or in another colour. Arguably, any such clause should also be countersigned by the insured.

An arbitration agreement is void unless it is contained within a special agreement, separate from the general printed conditions of the policy.

The following provisions in an insurance policy are void: (1) any provision excluding cover for a breach of the law, other than a felony or deliberate misdemeanour; (2) a late notification provision in the event that there is a reasonable excuse for the delay; and (3) any arbitrary provision, breach of which was not causative of the occurrence of the incident insured against.

Finally, 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.

**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, although as a matter of practice, both UAE practitioners and courts are familiar with these terms.

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40 Article 265(2) of the Civil Code.
41 Article 266(1) of the Civil Code.
42 Article 266(2) of the Civil Code. See, for example: Dubai Court of Cassation Case No. 125/2009 which held that a Construction All Risk insurance policy was a contract of adhesion under Article 266 of the Civil Code and therefore any ambiguity should be resolved against the insurer; Dubai Court of Cassation Case No. 247/2003 also held, in a life insurance case, that any ambiguity should always be resolved in favour of the insured.
43 Article 7 of the Insurance Authority’s Board Resolution No. 3 of 2010.
44 Article 1028(c) of the Civil Code.
45 Article 7(2)(a) of the Insurance Authority’s Board Resolution No. 3 of 2010; Article 28 of the UAE Insurance Law.
46 Article 28 of the Insurance Law.
47 Article 1028(d) of the Civil Code; Article 7(2) of the Insurance Authority’s Board Resolution No. 3 of 2010.
48 Article 1028 of the Civil Code.
49 Article 246(2) of the Civil Code.
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.

Likewise 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.

iv Intermediaries and the role of the broker

Conduct rules

There is no legal requirement under UAE law 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 Insurance Authority, which prohibits insurance companies from dealing with brokers in respect of UAE insurance business not licensed by them.50

Agency/contracting

Under UAE law, a broker is an independent intermediary who 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.51

How brokers operate in practice

Brokers that are established and authorised in the UAE must comply with the UAE Insurance Authority’s Brokers Regulations. A broker in the UAE is not permitted to act as both insurance broker and reinsurance broker for the same customer and the same transaction.52 Reinsurance brokers are not directly regulated under UAE law, provided they do not carry on business activities in the UAE (i.e., their business activities are conducted outside the UAE). 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.

v Claims

Notification

The procedure for providing notice of a claim will usually be set out in the insurance policy itself. The Insurance Authority Directive provides that the procedures the insured has to follow upon the occurrence of the risk have to be clearly indicated on the policy.53

50 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’s Brokers Regulations).
51 Article 3(3) of the Insurance Authority’s Brokers Regulations.
52 Article 3(4) of the Insurance Authority’s Brokers Regulations.
53 Article 7(5) of the Insurance Authority’s Board Resolution No. 3 of 2010.
Under UAE law, there are no specific consequences for late notification in insurance contracts; rather, the general position as regards breach of contract will apply (see below). In the event of a breach of contract, 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 under UAE law. Further, ‘arbitrary’ clauses are void (i.e., where a breach not connected to the occurrence of the insured risk is potentially invalid); this could include breach of a notification provision.

If an insured fails to provide all information requested by insurers following notification, this can amount to a reason to deny the claim in circumstances where such information is required to ascertain the incident or the extent of the loss and where the insured has no reasonable excuse for the delay.57

The limitation period for claims under insurance contracts is three years from the occurrence of the incident, or from the date of the insured having knowledge of that occurrence.58 The limitation period in respect of marine insurance is generally two years from the date of the incident or where a third party makes a claim against the insured.59 Further, limitation is suspended under marine insurance by ‘registered letter or delivery of other documents relating to the claim’,60 or a ‘legal excuse’.61

**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.62 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 the 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**

The courts have jurisdiction over any dispute arising out of an insurance policy where the domicile of the insured is within the jurisdiction.63 The courts also have jurisdiction over

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54 Article 1028(b) of the Civil Code.
55 Article 1028(e) of the Civil Code.
56 Article 9(6) of the Insurance Authority’s Board Resolution No. 3 of 2010.
57 Article 1028(b) of the Civil Code.
58 Article 1036 of the Civil Code.
59 Article 399(1) of the Commercial Maritime Code.
60 Article 399(3) of the Commercial Maritime Code.
61 Article 399(1) and (2) of the Commercial Maritime Code.
62 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)).
63 Article 37 of the Civil Procedure Code (Federal Law 11 of 1992), which requires that insurance policy claims should be filed with the Court having jurisdiction over the place in which the beneficiaries are domiciled.
claims brought against UAE nationals (i.e., a UAE legal entity) or a foreign legal entity with a domicile or place of residence in the UAE. Any agreement to the contrary is void under UAE law.65

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,66 contracts entered into or performed in the UAE67 and employment matters. In practice, however, foreign choice of law provisions will likely be ignored by a UAE court.

Arbitration clauses are recognised and enforced in the UAE. However, there are certain formalities that need to be observed for an arbitration clause to be valid under UAE law. An arbitration agreement must be evidenced in writing and must be signed by someone who has the specific authority to settle disputes.68

ii Litigation

Litigation stages, including appeals

Litigation in the UAE is divided into three stages: (1) court of first instance; (2) court of appeal; and (3) the Federal Supreme Court (colloquially referred to as the Court of Cassation in the emirates, which have their own judicial system).

In the event a claimant seeks to file a claim in the courts of Abu Dhabi or Dubai, it must first file the claim with the Abu Dhabi Settlement and Reconciliation Committee (in respect of civil, commercial and labour claims) or the Centre for Amicable Settlement of Disputes (for the majority of claims in Dubai save for a few exempt categories)69 respectively.

Substantive proceedings are then 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.

Either party has an automatic right to appeal judgments of the court of first instance to the court of appeal.70 Appeals to the Court of Cassation 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).71

64 Article 20 of the Civil Procedure Code.
65 Article 24 of the Civil Procedure Code.
66 Article 21(2) of the Civil Procedure Code.
67 Article 21(3) of the Civil Procedure Code.
68 Article 203 of the Civil Procedure Code. In respect of insurance contracts for example and as identified above, an arbitration clause must be in a special agreement and separate from the general printed conditions of the policy (Article 1028(1)(d) of the Civil Code).
69 For example: labour disputes; temporary and summary actions or orders; proceedings where the government is named as a party and proceedings which are outside the Civil Court’s jurisdiction.
70 Article 158 of the Civil Procedure Code.
71 Article 173 of the Civil Procedure Code.
The judgment creditor should apply to the Execution Court in order to enforce the judgment against the defendant.

**Evidence**

A party is required to present evidence that it relies on in support of its claims 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, the original documents must be produced. All submissions to the court, including documentary evidence, must be filed in Arabic. Any 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.

Experts are appointed by the court from a panel of experts according to their particular specialisation. 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) is binding upon a UAE court.

**Costs**

In the UAE, 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.

**iii Arbitration**

*Format of insurance arbitrations*

The applicable UAE insurance law recognises arbitration agreements. As above, 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 in the UAE.

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73 Article 45 of the Civil Procedure Code.
74 Article 90(1) of the Law of Evidence.
75 Articles 7 and 8 of the Law of Evidence.
76 As per Article 1028(1)(d) of the Civil Code.
Arbitration proceedings in the UAE (i.e., onshore) are governed at the federal level by Articles 203 to 218 of the Civil Procedure Code, whereas different arbitration laws will govern offshore arbitrations.

The arbitration provisions of the Civil Procedure Code are not based on the UNCITRAL Model Law and these federal law provisions are largely underdeveloped, as compared to the DIFC and the ADGM arbitration laws, which are modelled on the UNCITRAL Model Law and in accordance with international standards of best practice.

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, such as in Sharjah and Ras Al Khaimah. Examples of offshore institutions include the DIFC-LCIA Arbitration Centre and the ADGM. 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 is a party to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards (1958) since 2006. While there has been uncertainty around the enforcement of arbitral awards in the UAE under the Convention, recently, UAE courts have more readily recognised enforcement of foreign arbitral awards. 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 winner’s costs.

Alternative dispute resolution
In relation to insurance claims, UAE onshore legal proceedings will be subject to the Abu Dhabi Commercial Conciliation and Arbitration Centre, and the Centre for Amicable Settlement of Disputes in Dubai, as explained in subsection iii, supra. In respect of other emirates, there are no other insurance-specific alternative dispute resolution centres.

Mediation
Parties can mediate disputes at the Abu Dhabi Commercial Conciliation and Arbitration Centre, and the Centre for Amicable Settlement of Disputes in Dubai.

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77 As above, Article 203 states that an arbitration agreement must be evidenced in writing and signed by someone who has the specific authority to settle disputes.

78 For example, the DIFC Arbitration Law 2008 apply in the DIFC and the ADGM Arbitration Regulations 2015 apply in Abu Dhabi.

79 For example, see Case No. 693 of 2015 where the Court of Cassation recognised for enforcement a London-based arbitration award.
V YEAR IN REVIEW

i Regulation

Financial regulations came into force in 2016 requiring insurers that are operating in the UAE to maintain significant internal systems and risk management policies to comply with their obligations, including risk-based solvency capital requirements, establishment of a risk management system and rules requiring investment of company assets in a prudent manner.

In mid-2016, HAAD announced a number of amendments to the Abu Dhabi health insurance programme. A significant change to one of the plans stipulates that beneficiaries under the plan will receive 80 per cent of the coverage of the fees for treatment at private healthcare facilities, but will continue to benefit from 100 per cent coverage for treatment at governmental healthcare facilities in Abu Dhabi. The UAE now requires that health insurance is in place as a prerequisite to the issuance or renewal of an Emirati resident visa.

At the end of September 2016, the Insurance Authority issued the unification (i.e., standardisation) of motor vehicle insurance policies. In addition, on 18 December 2016, the Insurance Authority issued the vehicle Insurance Rates Regulation, which adopted minimum and maximum limits of premium rates. Insurance companies, agents and brokers are precluded from imposing or collecting any additional premiums over and above the specified rates.

ii Insurance Law reform

No recent insurance law reforms have taken place. A new Commercial Companies Law has recently come into force in the UAE that is likely to have implications for directors and officers (D&O) insurance. D&O insurance has not been widely purchased in the UAE to date. This may change as a result of the new Commercial Companies Law widening the duties and liabilities of directors and officers (including managers) and broadening sanctions for breaches of those duties.

As a result of the widening duties and liabilities of directors and officers under the Commercial Companies Law, it is unclear whether a company can legally indemnify a director or officer (such that it could claim under a side B (corporate reimbursement) cover). In the light of this uncertainty, any director or officer should look carefully at their side A cover, which is likely to be the responsive cover.

iii Dispute resolution

In October 2016, the DIFC’s Dispute Resolution Authority (DRA) and the Jebel Ali Free Zone Authority (JAFZA) entered into a memorandum of understanding in which the authorities agreed to allow access to the DIFC courts for JAFZA companies, and to allow these companies to freely choose to use DIFC laws and the DIFC courts as a jurisdiction for dispute resolution.

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80 The 'Thiqa' plan, which is a minimum standard health insurance plan for UAE nationals.
81 Changes to the Basic Plan (which is a minimum standard for expatriates with a visa issued in Abu Dhabi only) include allowing workers above the age of 40 to co-pay their insurance premium, up to 50 per cent, as agreed between the employee and employer. In addition, all employees (domestic workers working at Emirati households are currently exempt) under this Basic Plan will be required to pay 50 per cent of the insurance policy’s premium for their dependants (wife and up to three children).
82 Federal Law No. 2 of 2015.
Moreover, Decree No. 19 of 2016 has created a new judicial authority to exclusively deal with conflicts of disputes between the DIFC courts and the Dubai courts. Prior to this, all matters regarding conflicts of disputes were generally referred to the Union Supreme Court and it is envisaged that this Decree will obviate such referrals and the attendant delays. However, it remains to be seen how the Decree will be applied in practice with its first decision setting back the status of the DIFC courts as a ‘conduit jurisdiction’.83

VI OUTLOOK AND CONCLUSIONS

i Regulation
The Insurance Authority is taking a more proactive approach to the regulation of the insurance and reinsurance market. With respect to vehicle insurance, the Insurance Authority is considering proposals to compel insurance companies to insure electrical vehicles. Significant focus has been on managing market conduct to ensure client protection and promoting transparency and fairness for all parties. Future regulation of the insurance market is expected to be drafted with the same principles in mind.

ii Insurance law reform and procedural developments
Early in 2016, a committee was established to review the Maritime Code and determine whether it could benefit from revision and updating. At the time of writing, no such revisions or updates have been published but this is an area to watch to see whether there is an overhaul of marine insurance law in the UAE.

iii Dispute resolution
The proposed, and highly anticipated Federal Law on Arbitration is likely to be a unifying (i.e., standardising) law and it is anticipated that it will increase the UAE’s profile as a destination for alternative dispute resolution as it is based on the UNCITRAL Model Law, and is expected to replace the existing federal regime under Articles 203–218 of the Civil Procedure Code.

Since the DIFC courts have taken a proactive approach to enforcement of foreign arbitral awards, it has become a popular conduit through which parties can enforce foreign arbitral awards onshore.

Initiatives, such as the memorandum of understanding between the DRA and JAFZA, and Decree 19, are becoming more common as the various jurisdictions work towards the Dubai Plan 2021 and the UAE Vision 2021.

83 The Judicial Tribunal’s first decision has ordered the DIFC Courts to (1) ‘cease to entertain’ a claimant’s application for the recognition and enforcement of a 965 million dirhams arbitration award of the Dubai International Arbitration Centre against a DIFC-based company (Daman Real Estate); and (2) refer the matter to the onshore Dubai courts for trial.
I INTRODUCTION

The United States insurance market is one of the largest financial markets in the world. In 2015, US insurers underwrote approximately $1.31 trillion in life and non-life direct premiums, accounting for just under 29 per cent of the global insurance industry. To put that number in perspective, the $1.31 trillion in underwriting amounted to roughly 7.26 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 2015, the total cash and invested assets of US insurers reached $5.2 trillion. As such, the US insurance market plays a significant role in the global economy.

In 2015, the US insurance market included $635.6 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 2015 US insurance market also wrote $519.8 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 $41.5 billion in 2015. Reflecting the

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1 Michael T Carolan, Paul W Kalish and William C O’Neill are partners, and Thomas J Kinney is an associate, at Crowell & Moring LLP.
5 Id.
6 Id.
7 Id.
8 Id.
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.

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.\textsuperscript{13} While the federal government has recently taken steps to increase its regulatory role, those steps have largely been at the edges of the insurance and reinsurance markets.

i State-by-state regulation

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.\textsuperscript{14} 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

\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 current Presidential Administration and Congress have made moves towards repealing the Affordable Care Act, but at this time the legislation remains in effect.

\textsuperscript{14} Certain large states, such as California and New York, regulate the solvency of any insurance company selling policies in their state, regardless of its domicile.
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.

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 general public by regulating insurer business practices while monitoring their insolvency. 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 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  

15 The most important exception is for surplus lines.
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.

Generally speaking, 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 in an effort 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 before the sale policies in the state.

**Market conduct regulation**

States also regulate the business of insurance by prohibiting insurance companies from engaging in unfair, deceptive, or anticompetitive conduct. In order 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/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.16

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

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16 State control of the regulation of insurance companies was confirmed by the Insurance Capital and Standards Clarification Act of 2014, which was signed into law on 18 December 2014. The Act makes clear that if an insurer’s activities are regulated by state insurance regulators, it is not subject to the minimum capital requirements for depository institution holding companies and non-bank financial companies laid out in the Dodd-Frank Act (discussed below).
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 of December 2014, 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 financial statements discussed in Section I, *supra*.

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/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 of its jurisdiction. In recent years, such indirect regulation has come under criticism.

In response to this criticism, a number of states have reduced collateral requirements for certain approved non-admitted reinsurers. As of April 2016, 32 states have passed legislation to implement revised reinsurance collateral provisions focused on the solvency risk of reinsurers as opposed to their admitted status. The terms of the agreement are discussed in more detail in Section V, *infra*, but it is expected to greatly ease the regulatory burden on reinsurers doing business in both the US and the EU.

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17 Covered Agreement on Reinsurance Consumer Protection Collateral, NAIC Government Relations Issue Brief (April 2016). As of April 2016, 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.

United States

**Insurance insolvency**
In the US, 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.

**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.19 Examples of direct federal insurance involvement include terrorism risk insurance,20 flood insurance,21 and crop insurance.22

**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 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.

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19 The examples cited herein of direct US federal government participation in insurance markets are illustrative and not exhaustive.
20 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 will, among other things, extend the federal terrorism reinsurance program established by the TRIA until 31 December 2020 and incrementally raise the trigger for reinsurance coverage each year from $100 million to $200 million beginning in 2016.
22 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. Of note, the Federal Agriculture Reform and Risk Management Act of 2013, signed into law on 7 February 2014, includes, among other things, expanded crop insurance subsidies paid by the US government over the next 10 years.
**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. However, the FIO does not currently have any express regulatory authority over the insurance industry.

The FIO monitors all lines of insurance, except for health insurance, long-term care insurance and crop insurance. The FIO also has certain responsibilities relevant to the insurance industry and the US financial system, including, among others: acting to pre-empt state regulations that conflict with international insurance agreements, monitoring whether traditionally underserved communities have access to affordable insurance products, and reporting to the US Congress, including annual reports on acts to pre-empt state law because of international insurance agreements, a report on modernisation of insurance regulation, and reports on the US and global reinsurance markets.

**Financial Stability Oversight Council**

In 2010, the Financial Stability Oversight Counsel (FSOC) was created with the purpose of identifying and responding to risks to the financial stability of the US. The FSOC has the authority to subject a ‘non-bank financial company’ (NBFC), 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. In making its determination, the FSOC considers factors such as size, leverage, interconnectedness and current regulatory scrutiny. By statute, the FSOC may only designate an NBFC as a SIFI if the company’s material financial distress, or its size, scope, nature, scale, interconnectedness, concentration or mix of activities, pose a threat to the financial stability of the US. Once a company is identified as a SIFI, it is subject to direct supervision by the US Federal Reserve Board and enhanced prudential standards, including specific reporting requirements, risk-based capital requirements, liquidity requirements, risk management requirements, leverage limits and credit exposure limits. Once a company has been designated, the FSOC is required by statute to re-evaluate each year, and considers whether material changes at the company warrant a rescission of the SIFI designation. Aside from the annual re-evaluations, a designated company can request a re-evaluation if it has undergone a change that materially reduces the threat that it might pose to US financial stability.

On 4 February 2015, the FSOC voted to adopt changes to its NBFC designation process. In general, these changes aim to improve transparency by (1) informing NBFCs that they are under evaluation earlier in the review process, (2) providing for increased

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24 Id.
engagement with NFBCs and financial regulators during both the initial review and annual re-evaluation, and (3) making more information available to the public about the FSOC process.26

**Nonadmitted and Reinsurance Reform Act (NRRA) – surplus lines**

In the US, 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 surplus lines broker is sometimes faced with conflicting state requirements for surplus lines placement, including allocation of the tax payments. Effective 2011, the NRRA addressed these conflicts by investing exclusive taxing authority with respect to surplus lines and non-admitted insurance policies in a policyholder’s ‘home state’. The NRRA also encourages (but does not mandate) the formation of interstate compacts to manage the reporting, payment, collection and allocation of premium taxes remitted on surplus lines policies covering multistate risks. In addition, the NRRA provides that surplus lines insurance is subject only to the regulatory requirements of the policyholder’s home state (except for workers’ compensation business). Finally, the NRRA permits large commercial insurance purchasers that meet certain conditions to directly access the surplus lines market.

**NRRA – reinsurance**

The NRRA also addresses certain issues of regulatory redundancy with respect to reinsurance. Under the NRRA, if an insurer’s domicile recognises credit for reinsurance for the insurer’s ceded risk, then no other state may deny such credit for reinsurance, so long as the domiciliary state is NAIC-accredited, or has solvency requirements substantially similar to those required for NAIC accreditation. The NRRA also pre-empts the laws and regulations of non-domiciliary states, to the extent that such laws or regulations: restrict or eliminate the right to resolve reinsurance disputes pursuant to reinsurance contractual arbitration provisions; require that a certain state’s law shall govern the reinsurance contract; or attempt to enforce a reinsurance contract on terms different than those set forth in the reinsurance contract itself. Finally, the NRRA invests exclusive authority to regulate the financial solvency of a reinsurer in the reinsurer’s domiciliary state.

**III INSURANCE AND REINSURANCE LAW**

i **Sources of law**

As discussed in Section II, supra, pursuant to the McCarran-Ferguson Act, the US Congress has declared that states will be the primary regulators of the insurance and reinsurance markets.

In the US, 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

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26 Id.
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.

Notwithstanding the McCarran-Ferguson Act, federal law also addresses insurance issues. Under the US Constitution, federal statutes may pre-empt state statutes and laws where they overlap. Thus, a federal statute such as the NRRA (discussed above) 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 insureds 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 insured 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 typically 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.27

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.28

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 insured 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. If the insurance company fails to do so, it opens itself up to a potential breach claim by the policyholder. 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.

In the US, many casualty insurance policies contain arbitration clauses. In some states, however, such clauses are not permitted and disputes are required to be resolved through litigation in state or federal courts. On the other hand, most reinsurance contracts contain dispute resolution clauses mandating confidential arbitration.

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

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28 Depending upon the facts, a broker may also act for the insurance company or reinsurer.
dispute resolution process. In that regard, some insurance policies and most reinsurance 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 in the US 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.

No two state court systems are exactly alike. 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. On the other hand, the federal district courts 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 in the US 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 truly 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 International Insurance Law Association 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 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 in the US is that each party pays its own costs for insurance and reinsurance arbitrations. However, insurance and reinsurance contracts may specify otherwise. Additionally, unless forbidden by the applicable contract, arbitration panels are generally empowered to order one party to pay the other party’s costs.

iv Mediation

Beyond settlement conferences, 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 in the US. 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 such procedures to handle intra-industry claims. Of course, the level of interest in these procedures can vary greatly by company or industry.

V YEAR IN REVIEW

There were significant industry, judicial and regulatory developments for the US insurance industry in 2016. While a comprehensive review of developments in the industry far 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 2017.
i US and EU negotiate a new bilateral covered agreement addressing prudential measures regarding insurance and reinsurance

In January 2017, the US and the EU announced that they had agreed to the terms of a bilateral covered agreement on prudential measures regarding the regulation of insurance. The agreement 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 calls for an end to collateral and local presence requirements for EU and US reinsurers. The agreement sets forth a five-year implementation plan, pursuant to which both the US and the EU will identify and roll back inconsistent or pre-empted legislation, and establishes conditionality between provisions as an enforcement mechanism, to ensure equal compliance and equal benefits. While a large number of insurers and reinsurers seem to be welcoming the news of the new agreement, others are more sceptical. In particular, the NAIC expressed scepticism of the agreement, noting that state regulators were not permitted to participate in the negotiation process, and voicing concerns that the agreement may function as a ‘back door to impose foreign regulations on US companies’.

ii New York Court of Appeals approves ‘all sums’ allocation of loss in a long-tail claim

In May 2016, the New York Court of Appeals held that non-cumulation, and non-cumulation and prior insurance provisions in triggered excess liability policies, required an ‘all sums’ approach to allocation of loss. That case, In re Viking Pump, came to the Court on two certified questions from the Delaware Supreme Court: (1) whether all sums or pro rata allocation applies where the excess insurance policies at issue contain a non-cumulation or prior insurance provision, and (2) whether, in light of the answer to the allocation question, horizontal or vertical exhaustion is required before upper level excess policies attach. In what some characterised as a departure from the historical rule that New York courts apply pro rata allocation to long-tail claims, the New York Court of Appeals found an all sums approach was required. Additionally, the Court found vertical exhaustion should apply, as it is more consistent with the all sums approach.

In the underlying case, the policyholders sought coverage under a number of primary and excess insurance policies for asbestos-related liabilities arising from their pump manufacturing businesses. After it was established that the policyholders were entitled to recover under the terms of the policies, a dispute arose among the insurers and the policyholders regarding prorata and all sums allocation of loss.

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30 Id. at 2.
32 Fact Sheet at 4.
34 In re Viking Pump, et al., 27 N.Y.3d 244 (NY 2016).
35 Id. at 265.
36 Id. at 251.
the method by which losses would be allocated over the policy periods. The insurers argued for pro rata allocation, noting that the policies were governed by New York law, and citing Consolidated Edison v. Allstate Ins. Co, 774 N.E.2d 208 (NY 2002), as evidence that the New York Court of Appeals had endorsed the pro rata approach. The policyholders argued that the policy language at issue in Consolidated Edison was distinguishable, and instead urged the Delaware court to permit them to recover fully from any triggered policy under an all sums approach. The Delaware Superior Court disagreed, however, and the matter was ultimately appealed to the Delaware Supreme Court, which in turn certified the matter to the New York Court of Appeals.

The New York Court of Appeals agreed with the policyholders, finding that under the terms of the relevant policies, all sums allocation was appropriate. Importantly, the Court did not decide that all sums allocation was required by New York law. Rather, the Court stressed that the all sums approach was dictated by the relevant policy language. Under New York law, courts view insurance policies like any other contract, and look to the relevant policy language to settle disputes. Because of this, the Court noted, the common perception that it had adopted a blanket ruling in favour of pro rata allocation in Consolidated Edison was flawed. Rather, that case (like all other contractual disputes) had turned on the particular policy language at issue.

Turning to the Court’s analysis of the relevant policy language, the Court’s decision turned largely on its interpretation of the non-cumulation clauses and prior insurance provisions included in the policies. In this case, the non-cumulation clause provided that only a single policy limit was available for a loss covered under multiple policy periods, while the prior insurance provision reduced policy limits by the amount of coverage available to the policyholder under earlier insurance policies. The Court found that these clauses could not be reconciled with pro rata allocation. As such, it found the all sums approach was required.

Notably, the Court of Appeals is set to address this issue again in early 2017. In Keyspan Gas East Corporation v. Munich Reinsurance America, Inc, an intermediate New York appellate court held that the relevant policy language required a pro rata approach to allocation, such that losses attributable to periods where the policyholder was uninsured because insurance was unavailable in the marketplace should be borne solely by the policyholder. In reaching this conclusion the court stressed that under Consolidated Edison and Viking Pump, the

37 Id. at 253-4.
38 Id.
39 Id.
40 Id. at 257.
41 Id.
42 Id.
43 Id. at 258.
44 Id. at 264.
46 Id. at *2.
predominant consideration driving its analysis was the policy language itself, and not economic, social or public policy considerations. The case is currently pending before the Court of Appeals, and a decision is expected sometime in 2017.

iii Third Circuit orders arbitration of fraud in the inducement claim arising out of reinsurance agreement

In October 2016, the US Court of Appeals for the Third Circuit in *South Jersey Sanitation Co, Inc v. Applied Underwriters Captive Risk Assurance Co, Inc* found that an arbitration provision in a reinsurance agreement compelled arbitration of the policyholder’s fraud in the inducement claim. The dispute arose when the policyholder refused to pay premiums allegedly owed under a reinsurance placement agreement (RPA) between the parties. The policyholder argued that the reinsurer had fraudulently misrepresented the RPA as a policy that would enable it to recoup substantial rebates at the end of the policy term in the event that premiums outweighed benefit payouts. When the policyholder was billed for additional premiums in lieu of the anticipated refund, it filed suit alleging fraudulent inducement. The reinsurer moved to dismiss the case, arguing that the parties’ dispute was subject to an arbitration provision in the RPA. The US District Court for the District of New Jersey denied that motion, citing a Nebraska state statute that declared certain arbitration provisions in insurance policies unenforceable. The reinsurer subsequently appealed that decision, arguing that the District Court erred by ruling on the pre-emption issue without first considering whether arbitrability is a question for the courts or the arbitrator.

On appeal, the Third Circuit agreed with the reinsurer, and reversed the District Court. In doing so the Court noted that the policyholder’s suit challenges the legitimacy of the whole agreement between the parties, not merely the legitimacy of the arbitration provision. Pursuant to US Supreme Court precedent, courts can only adjudicate claims for fraud in the inducement of an arbitration provision itself, and cannot consider challenges to the formation of the contract generally. As such, the Court found that the policyholder’s claims should be left for an arbitrator’s consideration. Additionally, the Court found that the impact of the Nebraska statute on the parties’ arbitration agreement was a question for the arbitrator, not the district court.

iv MetLife’s SIFI designation overturned by federal court, but it may be a short-lived victory

In December 2014, the FSOC formally designated MetLife, Inc as a non-bank SIFI. MetLife was the third insurance company labelled as a non-bank SIFI, following American International Group, Inc and Prudential Financial, Inc in 2013. MetLife subsequently filed suit in the US

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47 Id. at *5.
48 840 F.3d 138 (3d Cir. 2016).
49 Id. at 140.
50 Id.
51 Id. at 142.
52 Id. The parties had previously stipulated that Nebraska state law governed their dispute.
53 Id.
54 Id. at 144-45.
55 Id.at 145.
56 Id. at 146.
District Court for the District of Columbia seeking to overturn the designation, and in March 2017, a federal judge ordered the FSOC to remove the tag. In the court’s decision, the judge identified three separate bases for overturning the designation under principles of administrative law, but all involved flaws the judge identified in the FSOC’s decision-making process. Because of these flaws, the Court found the FSOC’s decision to designate MetLife to be ‘arbitrary and capricious’, and as such ordered the designation rescinded.

Notably, although MetLife was successful in challenging its designation as a non-bank SIFI, there are a number of reasons to question the ultimate impact of the Court’s decision. First and foremost, the FSOC has already appealed the decision to the US Court of Appeals for the District of Columbia Circuit, and a decision is expected sometime in 2017. Secondly, although MetLife was victorious on its procedural arguments, it was unsuccessful in its argument that it did not qualify as a non-bank SIFI owing to the nature of its business. To the contrary, the court explicitly ruled that MetLife met the criteria of a non-bank SIFI. Lastly, there is nothing in the court’s decision that prevents the FSOC from re-examining MetLife for potential non-bank SIFI status under the procedures deemed appropriate by the District Court. Indeed, in the event the FSOC is unsuccessful in its appeal of the District Court’s decision, it is reasonable to assume the FSOC will take a second look at MetLife’s operations. Accordingly, this issue merits close scrutiny in the coming years, as insurers struggle to stay abreast of the current regulatory environment while exploring options to minimise their regulatory costs.

v Anticipating insurance coverage issues related to commercial drone use

As technology advances, the global insurance market must adapt quickly. New technologies beget new potential liabilities, which in turn create new demands for coverage. Nowhere is this more evident than in the burgeoning field of commercial and private drone use. Drones – unmanned aircraft flown remotely by a grounded pilot – have already become a popular recreational pursuit. However, in the coming years they are expected to be employed across an ever-widening range of businesses. While Amazon made headlines in 2014 when it announced its plan to use drones as package delivery agents, a number of other commercial carries have announced similar plans, including delivery giant UPS.

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58 Id. at 13-4.
59 Id. at 33.
60 The case is MetLife v. FSOC, No. 16-5086 (D.C. Cir.).
61 Id. at 18.
64 Id.
Commercial applications for drones extend far beyond parcel delivery, however, as potential applications have been identified in agriculture, construction, environmental monitoring and media, among others.\textsuperscript{66} Indeed, even the insurance industry has begun to incorporate drones in the underwriting and claims assessment processes.\textsuperscript{67} Because of the many potential commercial applications for drones, the US Federal Aviation Administration (FAA) estimates that by 2020, approximately 30,000 drones will be in use by all types of businesses across the US.\textsuperscript{68}

As drone use increases, insurers will be asked to respond to a wide range of new coverage issues. Potential liabilities include claims for bodily injury or property damage caused by the drone itself, claims for invasion of privacy arising from misuse of the drone, and even claims for cyber-liability arising from third-party hacking of stored data. While as of yet no drone-related coverage disputes have been filed, courts are already being asked to settle civil disputes arising from drone use.\textsuperscript{69} Thus it seems clear that at some point in the near future courts will be asked to address coverage issues relating to drone use. What remains to be seen, however, is how the global insurance industry will respond. While some insurers have started to offer specialised unmanned aircraft policies,\textsuperscript{70} the real question facing the industry is how drone-related liabilities fit within the standard commercial general liability (CGL) policy.

The standard CGL policy typically provides two separate forms of coverage: Coverage ‘A’ and Coverage ‘B’. Coverage A insures against liability for bodily injury and property damage, while Coverage B insures against personal liability for other torts not related to bodily injury or property damage, like slander or invasion of privacy. As noted above, drone use could theoretically give rise to liabilities triggering coverage under either Coverage A or Coverage B. However, Coverage A frequently contains an ‘aircraft’ exclusion, barring coverage for bodily injury or property damage ‘arising out of the ownership, maintenance, use or entrustment to others of any aircraft, auto or watercraft owned or operated by…’ any insured. Notably, the term ‘aircraft’ is left undefined in the standard CGL. Thus, a key issue regarding the availability of coverage for bodily injury or property damage arising from drone use under standard CGLs may be the extent to which courts conclude that drones constitute ‘aircraft’ within the meaning of the exclusion.

There is the potential for some uncertainty on this point. The US defines drones as ‘aircraft’ for purposes of federal regulation,\textsuperscript{71} and the FAA requires both commercial and

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\textsuperscript{69} See, e.g., John David Boggs v. William H. Merideth, No. 3:16-CV-6-DJH (W.D. Ky. Filed 4 January 2016) (involving claims that the defendant shot down the plaintiff’s drone while it was hovering over the defendant’s property).


private drone users to register their craft with the federal government. Under this definition, drones seemingly would trigger the aircraft exclusion to Coverage A. However, policyholders will likely argue that ‘aircraft’ as used in the exclusion was intended to refer to a manned aircraft in the traditional sense, as evidenced by the fact that the exclusion also bars coverage for damages arising from the use of other traditionally manned vehicles, like auto- or watercraft. Inevitably, policyholders will argue that the policy language is at best ambiguous, and thus should be construed against the insurer and in favour of coverage.

This is but one of the many questions facing the global liability insurance market in light of the anticipated explosion of commercial drone use. However, as technology continues to improve, and as drone use becomes more commonplace across industries, it is expected that courts will be called upon to address this and other drone-related coverage issues in the coming years.

VI OUTLOOK AND CONCLUSIONS

The growth of the size, scope and complexity of the US insurance and reinsurance markets continued in 2016. Likewise, the numerous and varied laws and regulations applicable to insurance and reinsurance companies are evolving to keep pace with the industry. As this growth and evolution will no doubt continue in 2017 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.

Appendix 1

ABOUT THE AUTHORS

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Jorge Angell is the senior partner of LC Rodrigo Abogados, specialised in corporate and commercial law, insurance and reinsurance law, private international law, litigation, arbitration and mediation.

He frequently acts as an expert in Spanish law before foreign courts, especially English and US courts, and as an 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 Spain, the London Court of International Arbitration and the European-Latin American Arbitration Association.

He is currently the chairman of the Reinsurance Working Party of AIDA. He is a member of the following LPD committees of the IBA: Business Organisations, Insurance, Litigation 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 also a member of the Credit Insurance Working Party of AIDA, as well as an adjunct member of the International Association of Claim Professionals; the Defence Research Institute and the Spanish Arbitration Club.


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Bruno Balduccini has been a partner in the corporate group of Pinheiro Neto Advogados’ São Paulo office since 2000, practising in banking and finance, structured finance, insurance and reinsurance.

He graduated from the Pontifical Catholic University of São Paulo, Brazil in 1992 and holds a master’s in international banking law from Boston University, US (1998).
As part of his international professional experience, he was a foreign associate at Sullivan & Cromwell LLP, US (1998/1999).

He is a former chair of the Banking Law Committee of the São Paulo Lawyers Institute. Mr Balduccini has been consistently named a leading lawyer by Chambers Latin America, Chambers Global, Latin Lawyer, The Legal 500 and Who’s Who Legal. He is fluent in Portuguese, English and Italian.

JOHN BARLOW

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John Barlow is a partner in the Dubai office of HFW. He advises insurers and reinsurers of financial institutions in connection with their fidelity, computer crime, D&O, PI/civil liability and cyber liability programmes, and on claims that arise under these products. 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 that assists insurers, brokers and MGAs wishing to establish a presence in the DIFC. John and his team’s work includes advising on setups 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 which 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.

John is qualified in England and Wales.

PELİN BAYSAL

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Pelin Baysal is the partner responsible for the firm’s insurance and reinsurance practice group. She advises and represents national and multinational insurers and reinsurers on the regulatory and contractual aspects of insurance and reinsurance law. Her practice includes general commercial law and liability disputes, with a particular focus on insurance and reinsurance.

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Neil is a partner at Clyde & Co. He specialises in policy coverage, liability defence and subrogated recoveries in all areas of property and liability insurance, including product and environmental liability. He is recognised by the legal directories as a leading lawyer in insurance, reinsurance and dispute resolution in the United Kingdom and Colombia.

Neil leads the firm’s international product liability practice. His practice includes work in the United Kingdom and internationally, but he has a special interest in Colombia, where for over 10 years he has represented insurers before the local courts and in domestic arbitration.
Before joining Clyde & Co, Neil was a barrister and a fellow of Robinson College, University of Cambridge, and a speechwriter to the Lord Chancellor, Lord Irvine of Lairg. He maintains active ties with the University of Cambridge and teaches there regularly during term time.

MICHAEL T CAROLAN
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Michael T Carolan is a partner in Crowell & Moring’s insurance/reinsurance group, where he focuses on litigating and arbitrating disputes concerning a variety of issues, including reinsurance, complex insurance coverage and brokers’ liability. Michael has represented both company and intermediary clients in life, health and property/casualty disputes regarding issues such as policy and contract interpretation, notice, underwriting practices and claims management, allocation, follow the fortunes, rescission, fraud, misrepresentation, and sunset and commutation clauses. He has also written on reinsurance issues related to credit default swaps and financial products. Michael received his JD from George Washington University in 2006. Prior to joining Crowell & Moring, Michael represented a variety of domestic and offshore captive insurance companies owned US corporations, providing counselling on tax and healthcare issues, reinsurance and fronting arrangements, policy drafting, claims management, and commutation agreements.

SIMON COOPER
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Simon Cooper has over 30 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 The Legal 500, is a member of the IUA clauses subcommittee and edited the second edition of Reinsurance Practice & the Law. He writes and lectures frequently on insurance and reinsurance law.

SHARON DALY
Matheson

Sharon Daly 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 policy holdings, 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.

JOHN DYKSTRA
*Maples and Calder*

John Dykstra is a partner in the Cayman Islands office of Maples and Calder. His practice includes a focus on structured finance, including catastrophe bond transactions and other similar insurance-linked securities transactions. 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 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, construction, leasing and insurance.

MARKUS EICHHORST
*Ince & Co*

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.

JOSIANNE EL ANTOURY
*Holman Fenwick Willan Middle East LLP*

Josianne El Antoury is an associate in the Dubai office of HFW. She has commercial litigation and dispute resolution experience across the professional indemnity, financial institutions and construction practice areas and advises on a varied caseload of insurance/reinsurance claims as well as advising on coverage disputes. Josianne’s work involves UAE court, English High Court and DIFC court litigation as well as arbitration and mediation dispute resolution. Josianne is also experienced in acting for construction professionals and their insurers in

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disputes that are resolved by court proceedings, adjudication or mediation. As a fluent Arabic speaker, Josianne has advised on some of the MENA region’s highest-value insurance claims.

**PEDRO FERREIRA MALAQUIAS**  
_Uría Menéndez – Proença de Carvalho_

Pedro Ferreira Malaquias is a partner based in the Lisbon office of Uría Menéndez – Proença de Carvalho.

He joined Vasconcelos, F Sá Carneiro, Fontes & Associados (which later integrated with Uría Menéndez – Proença de Carvalho) as a partner in 2001. He heads the firm’s finance department and is responsible for the areas of banking and insurance.

Before joining this firm, Pedro worked in the legal department of the Banco Português do Atlântico, SA, in the Competition Directorate General of the European Commission, and headed up the legal department of BCP Investimento – Banco Comercial Português de Investimento, SA between 1995 and 2001. Since 1998 Pedro has worked as a legal consultant for the Portuguese Banking Association and acts as their representative on the legal committee and on the consumers’ committee of the European Banking Federation.

He specialises in banking and insurance law and is involved in banking, including advice on all legal aspects related to retail and investment banking, and securitisation of credits; and insurance, including negotiation of insurance contracts on project finance and structured finance transactions, advice on financial products and regulatory and supervision issues.

**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 in 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. He is fluent in French and English, and conversant in Khmer.
HÉLDER FRIAS
_Uría Menéndez – Proença de Carvalho_

Hélder joined the Lisbon office of Uría Menéndez – Proença de Carvalho in 2006 and became a principal associate in 2015. Hélder worked in the London office of the firm from September 2010 to August 2011.

He advises on banking, finance, insurance, securities, including financial intermediation, and corporate law.

Hélder also advises clients regularly on all legal, regulatory and supervisory aspects related to retail and investment banking, cross-border services and financial products within the insurance field.

MICHAEL FRITH
_Conyers Dill & Pearman Limited_

Michael Frith is director in the corporate department in the Bermuda office of Conyers Dill & Pearman. Michael joined Conyers in 2003. Michael’s practice includes all aspects of corporate law, with a particular focus on insurance and reinsurance regulatory and transactional matters, including new insurance incorporations, financing and transactional work for insurance companies, insurance-linked securities transactions (cat bonds, collateralised reinsurance, etc.) and related corporate and regulatory matters.

DAVID GERBER
_Clayton Utz_

David Gerber is a partner in the Sydney office of Clayton Utz and is the head of the firm’s insurance national practice group. 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 the _Expert Guides Guide to the World’s Leading Insurance and Reinsurance Lawyers_. According to _Best Lawyers_, for the past four years he has been selected by his peers for inclusion in _The Best Lawyers in Australia_ in the area of insurance law. In 2016 and 2017, he was ranked by _The Legal 500 Asia Pacific_ as one of Australia’s ‘Leading Individuals’ in insurance.

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, 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 in the areas of insurance and reinsurance law, aviation and maritime law as well as 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. He particularly advises reinsurers in re-domesticating their business to Switzerland.

Mr Gerspacher is recognised in, inter alia, Who’s Who Legal: Insurance & Reinsurance as one of the leading practitioners in these fields.

DIMITRIS GIOMELAKIS

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 degree 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 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, of which he chairs the Italian chapter; 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, practising 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 USP, Brazil (2002).

As part of his international professional experience, he was a foreign associate at Villa Manca Graziaedi in Italy in 1997.

He is currently the coordinator of the litigation group in Pinheiro Neto Advogados, and a member of the São Paulo Lawyers Institute, the International Association of Defense Counsel, Insuralex and the Brazilian 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*. He is fluent in Portuguese, English and Italian.

PHILIP GRAFF
*Bird & Bird Advokatpartnerselskab*

Philip Graff is recognised as a leading practitioner in the Danish market. In addition to corporate and M&A matters, his areas of specialty include banking and finance, and dispute resolution. He has a broad client international base, mainly within energy, transportation, maritime, retail, clean tech and financial services, ICT and life sciences. He previously worked as the general global counsel of the energy services division of AP Moller-Maersk, undertaking M&A work in more than 30 countries. In addition, he has in-depth experience of the Asian market, having lived there for a number of years, and has also been the chair of several significant industrial companies with operations in China. He has been admitted to the Supreme Court of Denmark, and is a member of the International Bar Association, the Danish Bar Association, the Danish Society for Insurance law, the Danish Society for Energy Law, CMI and AIDA. Mr Graff undertook a senior management development course at Penn State University in the US. He also holds a bachelor’s degree in finance and an LLM from Copenhagen University, together with a graduate diploma in finance from Copenhagen Business School.

ZHAN HAO
*AnJie Law Firm*

Dr Zhan Hao is the managing partner of AnJie Law Firm. He has significant experience in litigation and arbitration concerning insurance claims and subrogation, acquisition of insurance companies’ equities, establishment of domestic and foreign insurance organisations in the PRC, utilisation of insurance funds, compliance with insurance regulations, insurance products review, extended warranties, corporate governance, subordinated debts issuance and IPOs for insurance companies.

From 2009 to present, Dr Zhan Hao has been honoured and recognised by a number of ranking institutions, including Insurance Lawyer of China – *Chambers and Partners* (2009–2017); World’s Leading Insurance & Reinsurance Lawyers – *Who’s Who Legal* (2010–2016); Insurance Lawyer of China – *Expert Guide* (2010–2014); Leading Insurance Individual
About the Authors


Currently, AnJie Law Firm’s insurance department, which is led by Dr Zhan Hao, is the biggest and most influential insurance team among those of Chinese law firms.


YVES HAYAUX-DU-TILLY

Nader, Hayaux & Goebel

Yves 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, Skandia, 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 AIDA, former vice chairman of CILA, and was responsible for establishing ARIAS Mexico. He is also a member of the presidential council of AIDA, vice president of the transnational legal practice committee of the American Bar Association and honorary 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 wordings 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 as the 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 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.

GEORGE IATRIDIS
Ince & Co
George Iatridis acts for a wide range of Greek and international clients on the full range of shipping, corporate and insurance matters. He has a strong reputation for contentious and non-contentious shipping and insurance work. This includes mergers and acquisitions, investments, corporate acquisitions and the incorporation of companies in both Greece and abroad. George also advises on employment law.

George joined Ince & Co as a partner in 2009 after previously being a partner in another law firm for 12 years. George heads the firm’s Greek law team.

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.

PAUL W KALISH
Crowell & Moring LLP

Paul W Kalish is co-chair of Crowell & Moring’s insurance/reinsurance group. He received his BA from Duke University in 1983, where he graduated magna cum laude, and his JD from Northwestern University School of Law in 1986 where he was an editor of the Northwestern University Law Review and member of the Order of the Coif. Paul represents domestic and Bermuda-based clients in a variety of litigation and counselling matters, including: (1) serving as national coverage counsel for insurers with regard to various tort (implants, asbestos, pharmaceuticals) and environmental matters; (2) representing insurers and reinsurers in liquidation matters, such as the Midland Insurance Company and Home Insurance Company liquidation proceedings; (3) representing insurers in international arbitrations including a London-based arbitration arising out of Hurricane Katrina; (4) representing insurers sued for unfair claims handling practices and negligent undertaking in connection with the handling of thousands of underlying claims; and (5) counselling insurers with regard to new insurance products and policy wording. In addition, since 2000 Paul has served as counsel for the Coalition of Litigation Justice, a group formed by insurers to address abuses and inequities in the US mass tort litigation environment.

DIMITRIS KAPSIS
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 degree 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
Crowell & Moring LLP

Thomas J Kinney is an associate at Crowell & Moring in the insurance/reinsurance group. His practice involves litigation, arbitration, and counselling on a wide variety of insurance/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.

CHRISTIAN LUTHI
Conyers Dill & Pearman Limited

Christian Luthi is a director in the litigation and restructuring department in the Bermuda office of Conyers Dill & Pearman. Christian joined Conyers in 1994. Christian’s practice encompasses all aspects of civil and commercial litigation, including company law, insolvency, schemes of arrangement, insurance, telecommunications and general common law. The major part of Christian’s practice involves the conduct of litigation in the Supreme Court of Bermuda, or arbitrations conducted in Bermuda.

DARREN MAHER
Matheson

Darren Maher is a partner in 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 has published 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
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.

YOSHIHIDE MATSUSHITA
Nishimura & Asahi

Yoshihide Matsushita is an associate at Nishimura & Asahi and was admitted to practise in 2007. Yoshihide's areas of practice include insurance, M&A and international transactions. His recent transactions include 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 concerning various coverage issues, including those related to the Great East Japan Earthquake in 2011 and the flood in Thailand in 2012.

APRIL McCLEMENTS
Matheson

April McClements is a partner in the insurance and dispute resolution team. April 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
Crowell & Moring LLP

William C O’Neill is co-chair of Crowell & Moring’s insurance/reinsurance group and heads the firm’s reinsurance practice. Bill is recognised as a top insurance and reinsurance attorney in Chambers USA, Euromoney’s Guide to the World’s Leading Insurance & 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 is an associate working both in the corporate and commercial law, and dispute resolution departments at Gün + Partners. He concentrates on commercial litigation in various fields including employment law, insurance and reinsurance law and commercial law.

**HARRY ORAD**

*Gross Orad Schlimoff & Co*

Harry began his legal career in 1976 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 frauds and white-collar crimes. Since 1986 Harry has specialised in insurance and reinsurance law. Harry 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 directors’ and officers’ liability, banking insurance (bankers blanket bonds), financial institutions, crime insurance, credit insurance, product liability, pollution and contamination.

Harry has acted for underwriters and insurers worldwide on complex financial insurance matters.

**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 & Co*

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
About the Authors

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.

PETER ROGAN
Ince & Co

With over 30 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 has developed a strong reputation for sensible strategic advice in relation to large disputes.

His international practice has a particular emphasis on litigation affecting the London market and its counterparts abroad. As well as advising his clients, Mr Rogan has a wider role within the market on behalf of Ince & Co, and regularly chairs and speaks at conferences in London and abroad. Over the years, he has held senior positions in both ARIAS UK and the insurance committee of the International Bar Association. He has handled countless arbitrations and mediations, and this experience has enabled him to develop an arbitration and mediation practice, in respect of which he has taken a number of appointments.

He is a mediator and arbitrator on the London and New York panels of JAMS International, and is also on the panel of arbitrators for the Singapore International Arbitration Centre.

Mr Rogan was Ince & Co’s senior partner between 2000 and March 2008. In addition, as a result of the experience he gained during his period as senior partner, he is well placed to handle all types of disputes that may arise in professional practices.

He 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 was named ‘Global Insurance & Reinsurance Lawyer of the Year’ in the 2012 Who’s Who Legal Awards.

Who’s Who Legal describes him as ‘a truly outstanding individual’. Another interviewee also mentioned that ‘he is unrivalled for this line of work anywhere else in the world’. He is nominated for his arbitration and mediation practice. Chambers and Partners notes that he is ‘a deeply experienced insurance practitioner.’

RICARDO ROZAS
Jorquiera & Rozas Abogados

Awarded with the ILO Client Choice Awards 2011, selected for inclusion in Who’s Who Legal: Insurance & Reinsurance (2011–2016) and recommended among ‘Leaders in their Field’ for Chambers Latin America 2014, Ricardo Rozas 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 others, 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.
He is the immediate 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, UK. 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 is a senior associate at Clyde & Co, and is qualified in England and in Spain. Raquel specialises in international disputes with emphasis on insurance and reinsurance litigation, and the defence of liability claims. She has extensive experience in litigation and arbitration in Colombia, where she has spent the past 10 years acting for insurers and reinsurers in the defence of financial institutions claims before the local courts, the financial authorities and in arbitration.

Before joining Clyde & Co, Raquel practised as an in-house lawyer in an international credit insurance company in Madrid. She then moved to London, where she gained an LLM in commercial and corporate law from Queen Mary University of London and qualified as a solicitor.

TAKAHIRO SATO
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Takahiro Sato is an associate at Nishimura & Asahi and was admitted to practise in 2011. Takahiro’s areas of practice include insurance, structured finance and securitisation, real estate transactions and asset finance.

His recent transactions include the acquisition by a Japanese insurance company of a Japanese insurance company, and advising a Japanese insurance company on applying for authorisation for a merger.

J H SHIN
*Law Offices Choi & Kim*

J H Shin joined Choi & Kim in 2013. He mainly handles marine casualties, and 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.

He was admitted to the Korean Bar in 2005. He gained a BA from Seoul National University (1998) and attended the Judicial Research and Training Institute, Korean Supreme Court, from 2005 to 2008.

He is a member of the Korean and Seoul Bar Associations.
DUNCAN STRACHAN
Sedgwick, Detert, Moran & Arnold LLP

Duncan Strachan is fluent in Spanish and deals regularly with large and complex cases across Latin America. He is experienced in advising on litigation defence and coverage issues in the key jurisdictions, including Brazil, Colombia, Chile, Ecuador, Argentina and Venezuela.

His Latin American expertise covers the energy industry, the utilities sector and financial services. Commentators say that he ‘stands out for his proactive approach and willingness to include all parties where he can’. They continue: ‘He is very approachable and brings a calmness to the process.’

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 and product liability claims.

SHINICHI TAKAHASHI
Nishimura & Asahi

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 recent 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
gbf Attorneys-at-law Ltd

Roger Thalmann practises in particular in the field of insurance and reinsurance law, 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.

ABRAHAM THOPPIL
Maples and Calder

Abraham Thoppil is a partner in the Cayman Islands office of Maples and Calder. 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 US, Chile, the UK, 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.

**SAM WAKERLEY**
*Holman Fenwick Willan Middle East LLP*

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’.

**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.
Appendix 2

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