

THE INSURANCE AND
REINSURANCE
LAW REVIEW

EIGHTH EDITION

Editor
Peter Rogan

THE LAWREVIEWS

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For further information please contact Nick.Barette@thelawreviews.co.uk

Editor

Peter Rogan

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PUBLISHER

Tom Barnes

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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 emerging markets in Asia and Latin America developing apace.

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

Although 2019 looks likely to be benign in terms of insured losses from natural catastrophes, there is continuing concern that climate change will see a long-term increase in the number and severity of such losses; the scope of the Australian wildfires at the end of the year may be a portent of things to come. From a legal perspective, the changing nature of natural catastrophes will raise issues of policy construction in relation, for example, to aggregation clauses and the obligation on reinsurers to follow their insured's underlying settlements.

Aggregation may also be an area of uncertainty in relation to the treatment of catastrophic losses such as the coronavirus outbreak originating in China but with worldwide consequences.

The year 2019 saw no respite in the number or scale of cyber events, including the huge data breaches at Facebook and at other global organisations such as Microsoft, Capital One, First American Corporation and government organisations in countries ranging from Bulgaria to Singapore. 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. Most recently the courts in England and Wales have held that cryptocurrencies such as bitcoin are 'property' for legal purposes.

Looking ahead, 2020 is likely to see new developments and new legal issues. In particular, the impact of insurtech on the way in which insurance is underwritten, serviced and distributed will continue to present challenges around the world. This is reflected in our chapter on artificial intelligence.

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

Peter Rogan

Ince

London

April 2020

INSURTECH AND ARTIFICIAL INTELLIGENCE

*Simon Cooper*¹

I INTRODUCTION

The rapid development of converging technologies is bringing about fundamental changes to the insurance industry. In the long term, organisations that are slow to embrace these new technologies will struggle to compete and to retain their place in the market.

In the insurance sector, the use of technology to innovate or disrupt is known as ‘insurtech’. This is an elastic term that takes in the use of new technologies by both start-ups and incumbent insurance companies to transform access to and analysis of data, build new products, drive customer engagement and squeeze inefficiencies from the current insurance model. Technologies such as telematics, the internet of things including smart home technologies, aerial imagery and drone technologies are giving insurers new ways to access data while developments in artificial intelligence (AI), machine learning and natural language processing are enabling insurers to process, analyse and gain insights from these large data sources. Associated technologies such as chatbots, robotic process automation and gamification are being deployed to reach new customers and enhance consumer experience. Many insurtech projects are exploring the use of blockchain and distributed ledger technology to disrupt the value chain, enable new applications and improve efficiency in the insurance sector.

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

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

II INSURANCE UNDERWRITING

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

¹ Simon Cooper is a consultant at Ince.

III USAGE-BASED INSURANCE

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

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

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

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

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

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

While initiatives of this nature will benefit the healthy insured, there is a danger that the use of this personal source data may result in less affordable insurance for less healthy insureds. This in turn may lead to regulatory challenges in relation to potential discrimination. Particular regulatory issues may also arise in connection with the use of sensitive personal

information (called 'special data' in the General Data Protection Regulation (GDPR), which has been supplemented and tailored for the United Kingdom by the Data Protection Act 2018).

IV ROBOTIC PROCESS AUTOMATION

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

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

V BLOCKCHAIN AND THE VERIFICATION OF DATA

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

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

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

VI CLAIMS HANDLING

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

Detecting fraudulent claims is a major issue for insurers. Recent figures from the Association of British Insurers show that approximately 98,000 fraudulent claims with a value of approximately £1.2 billion were detected in the United Kingdom alone in 2018. It is no surprise, therefore, that insurers are developing algorithms that use big data and machine learning to identify the markers of a fraudulent claim. Claims are then tested against these markers by the AI so that suspicious activity can be subjected to closer examination.

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

VII POTENTIAL PROBLEMS

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

i The insurer

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

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

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

ii The insured

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

iii The intermediaries

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

iv Legal challenges

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

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

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

VIII SUMMARY

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

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

CYBER INSURANCE

*Simon Cooper*¹

I INTRODUCTION

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

With widespread cyberattacks becoming more common, cyber risk has become a subject of much greater concern for businesses of all sizes.² Since the high-profile WannaCry and NotPetya viruses of 2017, we have seen attacks on a number of leading companies such as Facebook, Uber, British Airways and Marriott International.

The cybersecurity insurance market is expected to grow from US\$4.52 billion in 2017 to US\$17.55 billion in 2023.³ Given that the average cost of a cybersecurity breach is in the region of £0.6 million to £1.15 million (£65,000 to £115,000 for SMEs),⁴ it is of little surprise that businesses are increasingly looking to cyber insurance to provide additional levels of protection.

II WHAT IS CYBER RISK?

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

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

¹ Simon Cooper is a consultant at Ince.

² In a Cyber Governance Health Check report published by the Department for Digital, Culture, Media and Sport, it was found that 54 per cent of boards surveyed viewed cyber as a top-level risk. Source: HM Government: FTSE 350 Cyber Governance Health Check Report 2017 (July 2017), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/635605/tracker-report-2017_v6.pdf.

³ 'Global Cyber Security Insurance Market 2018 Size, Overview, Trends, Various Insurance Types, Applications, Key Player's Competitive Analysis & Growth by 2023', Reuters. <https://www.reuters.com/brandfeatures/venture-capital/article?id=36676>.

⁴ <https://www.lloyds.com/news-and-risk-insight/news/emerging-risk/emerging-risk-2015/a-quick-guide-to-cyber-risk>.

- b malicious insiders (this could include deliberate acts by disgruntled employees who compromise their employer's systems or intentionally leak confidential or sensitive information);⁵ and
- c accidental losses (such as human error and lost or stolen devices).

The above is by no means an exhaustive list.

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

III CYBER COVERAGE

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

- a Business interruption (e.g., in respect of losses resulting from a business being unable to trade owing to its website being compromised, thus preventing it from accepting orders). The indemnity will be subject to a time deductible or 'waiting period' as well as a financial deductible. The precise scope of cover, however, varies so that some policies will only respond where the insured alone was the target of the cyberattack that gave rise to the loss. Other policies will respond where the insured is the victim of an untargeted attack or incident.
- b Loss of data. Cyber insurance typically provides third-party cover in respect of data breach. This will include cover for any liability payments that have to be made to individuals or corporations whose data has been lost or damaged by the insured as a result of a data breach. Usually, however, these costs are only payable where the quantum of the payment has been the subject of judicial ruling or is the result of a settlement that the insurer has endorsed. Typically, this cover also includes defence costs.
- c Recovering and repairing data.
- d Payment of compensation to customers for their loss of data.⁶
- e Ransom demands. Extortion is one of the most common forms of cyberattack. It occurs when an attacker disables the insured's computer systems by contaminating

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

6 See *Vidal-Hall v. Google Inc* [2015] EWCA Civ 311 where the Court of Appeal held that victims of a data breach could recover compensation for distress associated with a contravention of the Data Protection Act 1998, even in circumstances where no direct financial loss had been suffered by the claimant. This principle was subsequently applied in a case against the Home Office (*TLT and others v. The Secretary of State for the Home Department and the Home Office* [2016] EWHC 2217 (QB)), where a number of asylum seekers' personal data was wrongfully published on the Home Office website. The claimants in this instance were each awarded between £2,500 and £12,500. While the amount of damages a court may award will be determined on a case-by-case basis, these cases demonstrate that a cyberattack resulting in a large volume of data being compromised could result in significant third-party liability.

it with 'ransomware'. The system can only be unlocked by payment of a ransom, which is often relatively low and to be paid in bitcoin or other cryptocurrency. The relatively modest level of the ransom payment is intended to encourage early payment and to prevent the response to the attack being 'escalated' outside the insured's own organisation. First-party cyber insurance will usually provide cover for such payments. Many, but not all, policies will also indemnify the insured when a ransom is paid in response to a threat to disable its computer system but before any attack has actually been carried out.

- f* Expenses associated with an attack. Some, but not all, policies will provide insurance for associated costs such as call centre costs to deal with enquires from individuals whose data has been lost or destroyed, credit monitoring and Payment Card Industry Data Security Standard expenses.
- g* To the extent insurable at law, losses associated with complying with regulatory investigations and the related defence and enforcement costs.
- h* Incident response. More complex policies provide an incident response package that will include public relations and legal advice as well as technical assistance to address the IT vulnerability that gave rise to the breach.

Significantly, the High Court has held recently that bitcoin and other cryptocurrencies are 'property'.⁷ This may well have consequences for the scope of cover granted (deliberately or otherwise) by insurers. As in this case, however, this ruling may also assist insurers in their attempts to subrogate against hackers by, for example, obtaining a proprietary injunction over cryptocurrencies believed to have been paid in settlement of ransoms.

IV POLICY TERMS AND FEATURES

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

i Claims-made cover

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

⁷ *AA v. Persons Unknown* [2019] EWHC 3556.

ii Notification

It is a requirement of all cyber policies that any claims against the insured that are covered under the policy are notified to the insurer within a specified period of time. The precise time will vary depending on the policy and may be anything from ‘immediately’ to ‘as soon as possible’, ‘promptly’ or ‘as soon as practical’, or within a fixed number of days of the insured becoming aware of the claim. These requirements are almost always conditions precedent to the insurer’s liability; cover can be refused if the claim is not notified as required. Most policies also require the insured to notify circumstances that may give rise to a claim.

iii Claims control

Under cyber policies, the insurer usually has the right (but not the obligation) to take over the management of the insured’s response to any third-party claim. Where this right is not exercised directly, it is likely to be a condition precedent to coverage under the policy that the insured does not admit liability or enter into negotiation or settlement with a third-party claimant without the insurer’s written consent.

iv Claims cooperation

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

v Other common terms

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

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

vi Important policy exclusions

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

- a* physical damage and personal injury, whether directly or indirectly caused by a cyber event;
- b* contractual liability – this provision excludes cover for losses incurred by the insured following a cyber event as a result of its contractual liabilities, except to the extent that such liability would have attached in any event;
- c* losses occurring prior to the retroactive date – all cyber policies include a retroactive date. Cover is excluded for losses occurring prior to that date even if the loss is only detected and notified during the policy period;
- d* losses resulting from the fraud, dishonesty or reckless conduct of a director or senior officer of the insured;

- e* claims resulting from the insured's use of unproven or illegal software;
- f* claims resulting from the failure of the cloud or other utilities or external services;
- g* betterment;
- h* employer's liability claims; and
- i* losses recoverable under another insurance policy.

V INTERACTION WITH OTHER INSURANCES AND 'SILENT CYBER'

Cyber insurance policies will generally purport to exclude physical losses and, increasingly, property policies will also seek to exclude cyber-related incidents. However, there are instances where policies will not explicitly include or exclude cyber-related losses (known as 'silent' or 'non-affirmative' cyber cover). The High Court's decision that cryptocurrencies are 'property' for legal purposes⁸ has added a further level of complexity to this issue. The question of whether a non-cyber policy would respond to cyber losses is untested and will turn on the construction of the specific policy wording.

Silent cyber is best illustrated with examples:

- a* A computer is hacked and compromised in such a way that leads to it overheating, causing fire damage to the insured's and a third party's property. In this situation, which of the insured's policies should respond (property, liability or cyber)?
- b* A law firm's computer systems are hacked resulting in client data (or money) being lost. This may give rise to a claim under the firm's professional indemnity policy as well as its cyber policy.

The UK regulators are aware of issues relating to silent cyber and the Prudential Regulatory Authority has issued regulatory guidance,⁹ which sets out how it expects insurers to 'introduce measures that reduce the unintended exposure' to cyber risk from physical and non-physical damage. In July 2019, Lloyd's mandated that all policies provide clarity regarding cyber coverage by either excluding or providing affirmative coverage.¹⁰

The importance of precise exclusions can be highlighted by reference to a common 'cyber exclusion' known as the CL380 clause. In summary, this clause is designed to exclude losses which are caused by malicious cyberattacks. However, the onus will be on insurers to prove that the cyber incident was malicious, and any inability to do so will mean that the exclusion does not bite. This is because CL380 does not deal with non-malicious cyber issues, which are in many cases, just as common. In these instances, the CL380 exclusion clause would not be apply, and the insurer may still face liability.

VI CYBER REGULATION

As well as being a pressing issue for businesses, UK and EU legislators have introduced new regulatory regimes that go some way towards mapping out baseline cybersecurity standards. One of the key pieces of legislation is the General Data Protection Regulation EU2016/679 (GDPR), which overhauled previous data protection rules, and which requires data controllers

⁸ *AA v. Persons Unknown* [2019] EWH 3556.

⁹ See PRA Supervisory Statement SS4/17.

¹⁰ See Lloyd's Bulletin Y5258.

and processors to ensure that appropriate measures are in place to protect against unlawful processing of personal data. The GDPR is reflected in the United Kingdom in the Data Protection Act 2018.

The Security of Network and Information Systems Directive EU 2016/1148 (the NIS Directive) was also implemented by EU Member States in 2018.¹¹ Broadly speaking, the NIS Directive purports to ensure the reliability and security of network and information systems across the European Union by requiring certain ‘operators of essential services’ (such as energy, transportation and banking sectors (as well as others)) and ‘digital service providers’ (online marketplaces, search engines and cloud computing services) to adopt appropriate measures to manage cybersecurity risks. Non-compliance with the GDPR and the NIS Directive will expose firms to significant fines.

Both pieces of legislation are likely to continue to apply and remain in force in the United Kingdom notwithstanding Brexit, and demonstrate the additional regulatory burden that businesses are having to comply with and insure against.

¹¹ In the United Kingdom, the NIS Directive has been introduced by the Networks and Information Security Systems Regulations (2018 No. 506).

FRAUD INSURANCE CLAIMS: WHERE ARE WE NOW?

*Simon Cooper*¹

I INTRODUCTION

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

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

II DISHONESTY DURING THE CLAIMS PROCESS

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

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

Until 2016, the insurer’s remedy in respect of each of the above-mentioned categories was forfeiture of the entire claim – the fraudulent claims rule. The essence of the rule is that, if an insured presents a claim that is in whole, or in part, fraudulent, the insured will forfeit the entirety of the claim. Since the Supreme Court’s decision in *Versloot Dredging v. HDI-Gerling (The DC Merwestone)*,² however, genuine claims that are advanced by fraudulent devices or collateral lies are no longer classified as fraudulent claims and so do not attract this remedy.

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

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

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

¹ Simon Cooper is a consultant at Ince.

² *Versloot Dredging v. HDI-Gerling (The DC Merwestone)* [2016] Lloyd’s Rep IR 468.

i Wholly invented claims

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

ii Exaggerated claims

Claims may arise where the loss itself is genuine but the value of the claim has been deliberately exaggerated. The fact that a claim has been exaggerated does not of itself mean that it is fraudulent. Judges are prepared to accept that a certain amount of 'horse trading' goes on between an insured and its insurer. The difficulty is in deciding where the line is to be drawn between 'acceptable' exaggeration and fraud. Generally, the courts look at the degree to which the claim has been inflated; the greater the exaggeration the easier it is to impute a fraudulent intent.³

In *Orakpo v. Barclays Insurance Services*,⁴ 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*,⁵ an insured claimed for loss of rent in relation to a property divided up into 13 flats, each of which had been sublet. The insured claimed that all flats had been vacated following a fire at the property and his loss of rent claim was based on all of the flats being unoccupied. This was untrue; a lot of the flats remained occupied. In deciding whether the claim should be forfeit for fraud, the court found that an exaggerated claim would be categorised as fraudulent where:

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

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

If a claim for, say, loss of items by theft is partly genuine and partly fraudulent, the law says the claim is not severable. Thus, if the degree of fraud in relation to one part of the claim is material, the entire claim will be forfeited. For example, in *Galloway v. Guardian Royal Exchange (UK) Ltd*,⁶ 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.

3 Another important factor when considering this issue is the extent to which the parties both have access to the same level of information.

4 *Orakpo v. Barclays Insurance Services* [1995] LRLR 443.

5 *Danepoint Ltd v. Underwriting Insurance Ltd* [2006] Lloyd's Rep IR 429.

6 *Galloway v. Guardian Royal Exchange (UK) Ltd* [1999] Lloyd's Rep IR 209.

The position in relation to personal injury claims is governed by Section 57 of the Criminal Justice and Courts Act 2015. This provides that if a claimant is fundamentally dishonest in relation to a claim, the claim must be dismissed in its entirety (including any valid element), unless doing so would cause a substantial injustice. The definitions of fundamental dishonesty and substantial injustice have been examined recently in *London Organising Committee of the Olympic and Paralympic Games v. Sinfield*⁷ and *Razamus v. Ministry of Justice*.⁸ In judging dishonesty in this context, the courts applied the test set out by the Supreme Court in *Ivey v. Genting Casinos (UK) Ltd*.⁹ This requires the Court to ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts and then determine whether his or her conduct was honest or dishonest by the (objective) standards of ordinary decent people. There is no requirement that the individual concerned must appreciate that what he or she has done is, by those standards, dishonest. Fundamental dishonesty is dishonesty of the type described above, which goes to the 'root' of the claim. That means that the dishonesty substantially affects the presentation of the claimant's case in respect of either liability or quantum in a way that potentially adversely affected the defendant in a significant way.

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

iii Fraudulent devices

In *Agapitos v. Agnew (The Aegeon)*,¹⁰ the Court of Appeal held that if an insured used a fraudulent device to support his or her claim or to better his or her chances of a favourable settlement before litigation, then the insurer could rely on the common law defence of forfeiture. A fraudulent device in this context meant a lie or other false evidence that was deployed in support of a genuine claim.

This principle was approved and applied in subsequent cases by courts up to and including the Privy Council.¹¹

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

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

7 *London Organising Committee of the Olympic and Paralympic Games v. Sinfield* [2018] EWHC 51 (QB).

8 *Razumas v. Ministry of Justice* [2018] EWHC 215 (QB).

9 *Ivey v. Genting Casinos (UK) Ltd* [2017] UKSC 67.

10 *Agapitos v. Agnew (The Aegeon)* [2003] 3 WLR 616.

11 Equivalent to the Supreme Court, the Judicial Committee of the Privy Council is the court of final appeal for the UK overseas territories and Crown dependencies, and for those Commonwealth countries that have retained the appeal to Her Majesty in Council or, in the case of Republics, to the Judicial Council.

While upholding the fraudulent claim rule in respect of fraudulently exaggerated claims, the majority considered it to be ‘a step too far’ and ‘disproportionately harsh’ to deprive a claimant of his or her claim by reason of his or her fraudulent conduct if it turns out that the fraud had been unnecessary because the claim was in fact always recoverable.

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

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

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

III DISHONESTY DURING THE LITIGATION PROCESS

Different rules governing the consequences of fraudulent claims come into effect once legal proceedings are commenced in respect of that claim.¹² That does not mean that the insured will receive no sanction for dishonesty during the legal process; simply that the court rules of procedure apply instead.

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

i Contempt of court

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

12 *Manifest Shipping Co Ltd v. Uni-Polaris Shipping Co Ltd (The Star Sea)* [2001] 2 WLR 170.

In the 2004 case of *Sony Computer Entertainment v. Ball*,¹³ 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*,¹⁴ for example, following the trial of a road traffic accident claim that was held to be fundamentally dishonest, the court granted the defendant insurer permission to bring contempt proceedings against the claimant for making false statements verified by a statement of truth. The court noted that bringing a false claim in the courts was extremely serious, leading to a waste of court time and resources. Although the claim in this case was small in financial terms and contempt proceedings would be costly, in the interests of justice and the overriding objective of the CPR (namely, to deal with cases justly and at proportionate cost), the court found that it was appropriate to pursue them. Similarly, in the 2017 case of *Liverpool Victoria Insurance Company v. Yavuz*,¹⁵ nine individuals were given prison sentences after being found guilty of contempt of court for making false and dishonest statements in support of their motor insurance claims.

ii Striking out

The question for the Supreme Court in *Fairclough Homes Ltd v. Summers*¹⁶ was whether the defendants were entitled to have an entire claim struck out in circumstances where the claimant had put forward a grossly exaggerated and fraudulently maintained claim for personal injuries. It held that while the court had jurisdiction to strike out such a claim, it should only do so in very exceptional circumstances. The test in each case, it held, must be what was 'just and proportionate'.

iii Adverse costs consequences

The default position under English law is that a losing party pays the winning party's legal costs – the 'costs follow the event' rule. However, in deciding whether to make a different order the court is entitled to take into account the conduct of the parties. The courts have shown that they will express their disapproval of dishonest claims in adverse costs orders. For example, in *Sulaman v. Axa Insurance Plc*,¹⁷ 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.

13 *Sony Computer Entertainment v. Ball* [2005] FSR 9.

14 *Aviva Insurance Ltd v. Randive* [2016] EWHC 3152 (QB).

15 *Liverpool Victoria Insurance Company Ltd v. Yavuz & Ors* [2017] EWHC 3088 (QB).

16 *Fairclough Homes Ltd v. Summers* [2013] Lloyd's Rep IR 159.

17 *Sulaman v. Axa Insurance Plc* [2009] All ER (D) 116.

iv Reopening a fraudulent settlement

In 2016, the Supreme Court gave a landmark judgment in *Hayward v. Zurich Insurance Company plc*,¹⁸ holding that where an insurer suspected fraud but nonetheless chose to settle a claim, it was entitled to set aside the settlement when new evidence of the fraud came to light.

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

In *UK Insurance v. Gentry*,¹⁹ an insurer who had paid out sums in relation to a road traffic accident successfully claimed repayment after suing the claimant for fraudulent misrepresentation after evidence subsequently came to light that the accident giving rise to the claim had been staged.

IV CONCLUSION

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

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

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

Once legal proceedings are brought in respect of a claim, the sanctions for fraud are governed by the courts' procedural rules. These rules apply not only to fraudulent insureds but also to dishonest third parties bringing claims against innocent insureds. A range of penalties is available and the courts are increasingly willing to use them. Finally, the Supreme

18 *Hayward v. Zurich Insurance Company plc* [2016] UKSC 48.

19 *UK Insurance Ltd v. Gentry* [2018] EWHC 37 (QB).

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.

LATIN AMERICA OVERVIEW

*Duncan Strachan and Kayleigh Stout*¹

I INTRODUCTION

Latin America faces a critical 12 months as new regimes across the region aim to accelerate reform and avoid an escalation in the social unrest seen towards the end of 2019. Our statement in the previous edition of this text, that the region is entering a new period of political and economic transition, takes on added significance. Targeted focus on reducing corruption and driving growth with increased transparency for a frustrated and determined population remains set to influence the region's course over the next few years.

There is a sense that there needs to be a clear shift in policy to address income inequality, and pressure on governments to act is likely to be heightened further, due to the economic and social impact of the covid-19 pandemic. The outbreak in Latin America came later than in other regions. At the time of writing, it is too early to tell whether the health response will be sufficient to contain the spread, with concerns that many countries lack the healthcare systems to cope. Already, the economic forecast is gloomy, with the IMF predicting negative growth for 2020.²

A downturn in the economy would likely compound the issues already facing many countries, including the two largest economies – Brazil and Mexico, and stifle signs of a recovery. In such circumstances, the insurance market may also struggle to show a return to growth, after premiums for 2018 shrunk by 5.5 per cent.³

The insurance penetration rate remained largely unchanged in 2018, at 2.9 per cent, with the highest rate of 4.6 per cent seen in Chile. While there has been steady growth in Peru, as well as Central American countries, the direction over the coming year will be linked to whether governments can effectively implement economic and judicial reforms, and increase stability in the region. At an industry level, the rise of insurtechs and increased digitalisation may provide new solutions able to promote growth in traditional areas such as home, life and motor insurance.

Each country has its own, distinct commercial and legal requirements, and it remains crucial for insurers and reinsurers to understand these factors when carrying out all functions of business, from underwriting to claims handling. This chapter considers some of the challenges and opportunities facing the insurance and reinsurance markets across the region, as well as the international players involved in writing Latin American business. It assesses

1 Duncan Strachan is a partner and Kayleigh Stout is an associate at DAC Beachcroft LLP.

2 IMF Blog 'COVID-19 Pandemic and Latin America and the Caribbean: Time for Strong Policy Actions', 19 March 2020.

3 MAPFRE Economic Research, 2018 Report on the Latin American Insurance market.

the status of regulatory developments in each of the main jurisdictions, as well as providing a snapshot of how experience of applying these regulations in practice is leading to an increasingly sophisticated legal landscape.

II OVERVIEW OF THE REGION

In this overview, we describe some of the major economic and political developments over the past year. We also provide an update on three key themes to understanding risk in the region: corruption, civil unrest, and major disasters (man-made and natural).

Following his successful election in October 2018, with 55 per cent of the votes, Jair Bolsonaro assumed the Brazilian presidency in January 2019, marking a significant shift in the country's political and economic landscape. The far-right president has already been dubbed by the media as 'Trump of the Tropics' owing to his stance on women's rights, homosexuality, race, gun laws, control of the media and foreign relations. Popularity ratings have tumbled since taking office, and Bolsonaro's leadership is set to be tested in the wake of the country's response to the covid-19 pandemic. What seems clear is that Bolsonaro may no longer be able to rely on signs of an economic upturn to support his agenda in 2020. Support for the government in Congress, where the ruling PSL party has less than 10 per cent of the seats in the lower house, is set to face its first significant test.

BHP Billiton was served with a US\$5 billion claim for group litigation in the UK courts in 2019 for allegations over its role in the Samarco incident. This type of action is part of a growing trend for international corporations to be targeted in their 'home territories' in respect of acts or omissions worldwide operations, whether through joint ventures or subsidiaries. Similarly, victims of the January 2019 Brumadinho tragedy filed a criminal complaint with German authorities against Tüv Süd (the German engineering company that had certified the stability of the tailings dam) in October 2019.

The year 2019 saw continued developments in the scandal on the widespread construction perpetrated by Brazilian construction company, Odebrecht, throughout the region. Operation Car Wash, which first hit Brazil in 2014 before expanding across the region, has led to continued political and judicial change, as well as promises of a tough stance on corruption, as expanding middle classes become frustrated with what they see as corrupt regimes. What started as a small investigation into money laundering of goods and services supplied to Petrobras has unveiled probably the largest corruption scandal ever known.⁴

Reforms in Brazil aimed at ending the culture of corruption have followed in Peru, Colombia and other countries. At the same time, the past five years has seen a spike in the investigation of public contracts and corruption-related litigation, as well as under D&O policies and surety bonds. The need for protection offered by these products has also risen as companies come under increasing scrutiny and face up to more stringent regulation.

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

⁴ 'Shaking the Latin American Equilibrium: The Petrobras & Odebrecht Corruption Scandals', *Fordham Journal of Corporate & Financial Law*, 4 November 2019.

In Peru, the government continues to suffer from the fallout of the corruption scandal that saw the impeachment and resignation of former president Pedro Pablo Kuczynski in 2018.

One of the major tasks facing the Peruvian government is to address the US\$159 billion infrastructure gap across all sectors of the economy. In particular, there is a need for investment and modernisation of the oil and gas industry to allow safe and effective operation. As things stand, key provisions in laws relating to maintenance of pipelines have been suspended since 2016, in order to allow operators time to present plans for their safe operation. The Peruvian Amazon has been affected by multiple oil spillages over the past decade. In another example of how legal action is increasingly crossing national borders, Peru's indigenous communities lodged a complaint with the Organisation for Economic Co-operation and Development (OECD) against the Dutch parent company of Pluspetrol in March 2020.

In April 2019, another former president, Alan García, took his own life as police officers were preparing to arrest him on corruption charges relating to the Odebrecht scandal. In September 2019, President Martín Vizcarra unexpectedly dissolved Congress and called for parliamentary elections. His new cabinet, hastily appointed on 3 October 2019, faces the difficult task of building trust between the executive and legislative branches of government, and most importantly with the Peruvian people.

To a large extent, the underlying mistrust of government was the 'loaded gun', triggered by austerity measures and price hikes, which set off civil protests in Chile, Ecuador, Bolivia, Colombia and elsewhere in the last few months of 2019.

Some of the worst protests were seen in Chile as peaceful demonstrations turned violent and the government declared a constitutional state of emergency that lasted between 19 and 27 October 2019. Despite being one of the most stable economies in the region, Chile also has one of the highest levels of income inequality among developed nations.⁵ The violence forced President Piñera to reshuffle the cabinet and promise a series of referenda on constitutional change. Although the social unrest had subsided by the end of 2019, January 2020 marked a return to violence that was only interrupted by the covid-19 outbreak, with the first referendum postponed until October 2020.

In Bolivia, the return to power of Evo Morales was short-lived as his success in the October 2019 election became the subject of accusations of fraud. Morales was forced to resign amid violent protests that resulted in over 30 fatalities. There is uncertainty over how long the interim government, led by Jeanine Áñez, will be able to survive.

Although not on the same scale, mass strikes and demonstrations also hit Colombia during November and December 2019. The National Strike Committee has drawn up a list of 104 points, from dissolving the riot police to completely nationalising state-run oil company, Ecopetrol. The government led by conservative president, Iván Duque Márquez, faces a challenge to reach an agreement that will prevent further demonstrations during the coming year.

Economic problems were at the heart of the 11 days of violent protests in Ecuador in October 2019. The government was forced to backtrack on its plan to scrap fuel subsidies that have been in place for 40 years. However, the country continues to struggle to balance the demands of the IMF bailout package and protection of indigenous groups.

The fallout from the Odebrecht scandal continued through 2019, with the discovery of leaked documents by a news agency in Ecuador. The documents show that the massive

5 OECD. <https://data.oecd.org/inequality/income-inequality.htm>.

corruption scheme led by the Brazilian construction company across the region extended even further than had been publicly reported, including major infrastructure projects in the Dominican Republic, Panama, Venezuela and Ecuador. Meanwhile, in January 2020, Odebrecht submitted a claim for US\$184 million in alleged unpaid costs against state-owned Petroecuador in relation to the construction of the Pascuales-Cuenca pipeline.

In July 2018, Andrés Manuel López Obrador (AMLO) was triumphant in his presidential campaign in Mexico, although political violence targeted many of his supporting politicians in the process (a total of 175 politicians were assassinated between 1 September 2017 and 31 August 2018, according to consulting firm Etelekt Consultores). As anticipated, AMLO has already faced obstacles to his ambitious plans for reform and to 'purify public life', mandating relief for the poor, eradicating corruption and continuing to strengthen currency.⁶ The opposition say that, far from making progress, the country has been paralysed by the cancellation of public infrastructure projects, such as the US\$13.3 billion planned mega-airport for Mexico City.

AMLO highlighted the increasing importance of Mexico's oil and gas industry by unveiling his National Hydrocarbons Production Plan at the end of 2018. The plan seeks to boost production to 2,624,000 barrels a day by 2024, by repairing and modernising Mexico's current refineries, expanding targeted exploitation of new reserves and reducing theft from pipelines. Parties bidding for Mexican gas resources recognise the potential for Mexico to soon generate the most demand in the world's energy landscape. The question remains as to whether economic growth can be sustained in the midst of sweeping changes in public policy.

There was a surprise in Argentina, when incumbent president, Mauricio Macri lost power to Alberto Fernández in elections at the end of 2019, with Cristina Fernández returning to power as vice president. The new leftist government has promised higher taxes and looser monetary policy, but will also need to address inflation that hit almost 54 per cent for the year in 2019. Macri's downfall was sealed when he failed to secure the support of the International Monetary Fund (IMF) for a rescue package. With international support unlikely, the government's strategy of widespread tax hikes has already seen protests from the agriculture industry.⁷

The economic crisis in Venezuela continues following a reduction in oil exportations, failing state-owned PdVSA and ineffective currency controls over recent years. The introduction of the sale of oil for Petro tokens has had limited success, with international buyers concerned that they may fall foul of ever-tightening US sanctions. The IMF predicts that the downward spiral will continue, with an anticipated 35 per cent decrease in GDP in 2020. EU sanctions against Venezuela continue and the US strengthened its sanctions regime in 2019 by freezing the assets held by PdVSA in the United States. Neighbouring Colombia, Ecuador, Peru and Chile have seen an estimated 5 million nationals cross the borders. While many seek to reach the United States or Spain, over 1.6 million people are reported to have settled in Colombia, many of whom live without any support or access to medical care. With the spread of covid-19, there are fears that this group will be particularly at risk. The migration issue reached the Supreme Court of Brazil in 2018, which refused to close Brazilian borders to Venezuelan nationals. However, the global pandemic is now forcing many countries to close their borders and it is unclear how migrants will be protected from the outbreak.

6 Associated Press in Mexico City, as reported by *The Guardian* on 2 December 2018.

7 *Financial Times*, 'Farmer's protests pose challenge to Argentina's new president', 18 March 2020.

In addition to political and economic challenges, Latin America also faced multiple man-made and natural disasters during 2019, including hurricanes, flooding and droughts.

The Bahamas and other Caribbean islands suffered the full impact of Hurricane Dorian, with losses estimated at up to US\$8 billion. These losses would likely have been much worse had it not been for the Bahamas having some of the strictest legal requirements for construction in the Caribbean.

Mexico was also hit by US\$25 million in insured losses, compared to the estimated economic impact of US\$383 million caused by Tropical Storm Fernand.

World headlines were dominated by the Amazon wildfires, with a reported 85 per cent increase in the number of fires during 2019.⁸ The wildfires affected the rainforest and biome within Brazil and extended to Paraguay, Peru and Bolivia. The fires were linked to deforestation and illegal slash-and-burn-methods, with 970,000 hectares lost.

Argentina's economic fortunes were worsened by heavy rains in the northeast of the country at the start of 2019, causing mass evacuations and power cuts. Heavy rain and flooding were repeated in the middle of the year, with neighbouring Uruguay also affected. The rain was attributed to the effects of the El Niño weather pattern, due to the warming of the surface waters in the Pacific. Although a natural weather event, the impacts of El Niño and La Niña (the upwelling of cold water to the surface of the Pacific, usually following El Niño) are likely to increase in frequency and demonstrate more polarised effects as global warming worsens.

Colombia continues to see regular flooding incidents year on year. Torrential rain in June and July 2019 resulted in humanitarian assistance being provided to 2,173 families in the Orinoquía region in the east of the country, on the border with Venezuela. The flooding also severely affected agricultural land and over 5,000 homes.

Flash floods and landslides are a common feature of many regions in Colombia and across the region, with the location of houses and construction methods putting many people in danger. In March 2019, heavy rain caused major flooding across Paraguay, Ecuador, Peru and Bolivia, which affected tens of thousands of people.

By contrast, between November 2017 and April 2018, Argentina and Uruguay suffered from the worst droughts since those of 2008 and 2009, and central Chile has been through a decade-long 'mega-drought'. Thousands of people have been left without direct access to drinking water and the impact on flora and fauna has been critical. From an economic standpoint, drought is one of the key challenges facing the agriculture industry and is one area where parametric crop insurance may be part of the solution. In Colombia, subsidies for parametric insurance have helped facilitate access to weather index insurance for smallholder farmers, such as through the *CaféSeguro* programme backed by the Blue Marble Consortium.

There are clear opportunities for insurers and reinsurers to address the huge protection gap in the region, which is reflective of stubbornly low insurance penetration. Recent research by AON suggesting that US\$8 of every US\$10 of losses due to natural disasters are uninsured.⁹ The research showed that the largest loss events in 2019 were all weather related, with total economic losses for Latin America, the Caribbean and Canada of US\$19 billion.

8 The National Institute for Space Research (Inpe) satellite data.

9 AON, 'Weather, Climate & Catastrophe Insight 2019 Annual Report'.

The growth in insurtech is allowing access to online platforms offering home and life policies to a market that had previously been difficult to reach. Examples of local innovation are found in Chile, with comparison website *ComparaOnline*, and in the Dominican Republic with *Contigo* (a product that facilitates access to health insurance).

At the other end of the market, there are similar opportunities for innovation. Cyber insurance is one product with room for growth in a region where 92 per cent of banks were subject to a cyberattack in 2018. Likewise, in support of much-needed investment in construction and infrastructure projects, surety and trade credit insurance, often placed via reinsurance arrangements in international markets, provide specialist support for investors and banks.

In August 2019, there was an oil spill along 2,250 km of coastline in northeastern Brazil, the source of which remains unverified. As countries bring in increasingly strict environmental regulation, there is also scope for more specialist environmental insurance products to gain support. Environmental groups and local communities in Central America have placed open pit mining under increasing scrutiny, with the activity now banned in Costa Rica and El Salvador.¹⁰ There is also a push for a move away from the oil and gas industry. At the UN Climate Conference in December 2019, a regional initiative coordinated by the Latin American Energy Organization (OLADE) set an ambitious regional target of reaching at least 70 per cent of renewable energy in electricity by 2030.

III INTERNATIONAL EXPANSION AND CONSOLIDATION

Growth in the Latin American insurance market stalled in 2019, and 2020 looks set to be a challenging year if, as expected, the economic recovery is disrupted by the covid-19 pandemic. In fact, premium growth reached a peak in 2013 and growth has been concentrated in smaller economies such as Peru and Central America, whereas four of the five largest markets – Brazil, Mexico, Venezuela and Colombia – have been stagnant.

Insurance companies will face difficult economic conditions, and some insurers may struggle, so we would expect to see continued consolidation, as well as opportunities for those insurers able to push continued innovation. Diversifying the means of promotion and access to insurance products, including through the embracement of digitalisation, will be important in increasing penetration rates in 2020 and beyond.

It remains common practice across the Latin American region for many local insurers to act as fronting operations for risks placed in international reinsurance markets, particularly in London. In recent years, there has been a significant increase in regional capacity provided by local insurers and reinsurers in their native countries but also throughout the region, commonly known as ‘multi-Latinas’. Colombian insurer, *Suramericana (Grupo Sura)*, is cited as a success story, including the acquisition of Argentinian, Brazilian and Uruguayan operations through the purchase of *RSA’s* Latin American arm in 2015.

Some significant international market moves into the region took place during 2018. In particular, in February, *Zurich* entered into an agreement to acquire the operations of *QBE* in Latin America, immediately becoming the leading insurer in Argentina. In 2019, *Axon Re* was established by *Axon Underwriting Services* to provide both facultative and

10 <https://country.eiu.com/article.aspx?articleid=108016794>.

treaty reinsurance protection in property, cargo and stock risks, as well as environmental protection, in Chile, Panama and Ecuador. However, there has been notably less activity over the past 12 months.

In Brazil, despite welcoming many new entrants to the reinsurance market over the past decade, the former state-owned reinsurer IRB Brasil Resseguros SA continues to dominate with a one-third share of the market. During 2019, in line with President Bolsonaro's plan to reduce the role of the state, the Brazilian government sold its last stakes in IRB Brasil Re. Despite expectations that Brazilian banks Itaú Unibanco and Bradesco would follow the government's lead, this is yet to happen.

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

Liberty is the dominant player in Chile, following its merger with local company Penta Seguros in 2017. Liberty Mutual sold its Venezuelan carrier to Chilean businessman Isidora Quiroga in 2019. Venezuela poses almost insurmountable difficulties for the international market, owing to uncertainty surrounding the political and economic landscape. In April 2017, President Trump imposed new sanctions against Venezuela and, in December 2017, the European Union imposed the Venezuela (European Financial Sanctions) Regulations¹¹ against specific Venezuelan individuals and entities. The lists of individuals continue to be extended and, in January 2019, the US applied additional sanctions in the petroleum, gold, mining, food and banking industries. Insurers and reinsurers must now be even more careful during the process of scrutinising the ultimate beneficiaries of any reimbursements made to Venezuelan bodies, under their policies.

Like most of Latin America, Peru is underinsured owing to a traditional lack of insurance culture with respect to both business and property. However, technology is changing the way business is placed and the dominant market position held by the two largest insurers, Rimac Seguros and Pacifico Seguros, is being challenged by Mapfre Perú, La Positiva and others. In 2019, the Peruvian market began to purchase insurance for catastrophic risk. For the first time in history, the government obtained cover for up to US\$200 million of catastrophe risks for 2019 as part of a catastrophe bond backed by the World Bank that also covered Chile (US\$500 million), Colombia (US\$400 million) and Mexico (US\$260 million).

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

Premium collections on surety bonds in Brazil increased by 8.9 per cent during 2018 (amounting to 2.44 billion reais), but continued growth will be largely linked to the country's economic fortunes and projects in the infrastructure and energy markets. Discussions over a new Bidding Law¹² and an amendment¹³ that provides for mandatory surety bond

11 These sanctions can be viewed in Council Regulation (EU) 2017/2063.

12 Bill No. 1,292/1995.

13 Bill No. 6,814/2017.

insurance of at least 30 per cent over the project's amount for large construction works over 100 million reais gained the preliminary approval of the House of Representatives in June 2019, suggesting simpler and more transparent mechanisms could govern the contractual and bidding processes of the future if agreed by the National Congress.

Mexico's large population and low insurance penetration rates make it a target for many insurers and reinsurers, and they saw steady growth in surety and insurance during 2018 and 2019. However, there were already signs at the end of 2019 that the market was starting to contract. While Lloyd's has been a licensed foreign reinsurer in Mexico since 1985, it was not until 2015 that Patria Re (and Pembroke) obtained Lloyd's approval to establish a special purpose syndicate, becoming the first Mexican reinsurer to write Latin American specialty risks through the Lloyd's platform. In 2018, Swiss Re began operations from Mexico City after receiving formal authorisation from local regulators, and Pioneer Underwriting launched a new regional hub with a focus on property and casualty business.

The insurance market in Guatemala grew by 6 per cent during the first half of 2019. It remains in the early stages of development in a country where motor insurance is not obligatory and only 10.7 per cent of vehicles are insured. There have been discussions around increased regulation in this area.

In most Latin American countries, there are strict requirements applicable to insurance and reinsurance companies. For example, in Peru, solvency restrictions are dependent on whether a company operates in life or general risks, or insurance or reinsurance. Minimum capital limits reach almost US\$3.1 million for reinsurance companies, roughly US\$6.8 million for insurance companies and approximately US\$5.1 million for those operating in both markets. Mexico introduced Solvency II type regulations in 2016, with Chile, Brazil and Colombia all implementing a risk-based capital scheme to some extent. In all cases, it is vital that an insurer or reinsurer seeking to make an international move considers the requirements of the specific market. This is not an environment where one size fits all.

IV REGULATION

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

There is recognition across the region of the need to target corruption and money laundering, as set out in the Lima Commitment for Democratic Governance Against Corruption agreed at the Eighth Summit of the Americas in April 2018. The government of Nicaragua expressly denied its approval of the Lima Commitment owing to its non-participation in negotiations. Nicaragua appears to have the third-lowest Corruption Index rating in South America (ranked 161st out of 180 global nations), after Haiti (168th out of 180) and Venezuela (173rd out of 180), despite comprehensive legislation.¹⁴ Enforcement of the region's developing regulations is therefore key in combating such issues – and to understanding the commercial environment.

Following years of financial scandal in Brazil, development of the country's Anti-Money Laundering Regulations continues to progress in Brazil. The Brazilian Superintendence of Private Insurance (SUSEP), the National Superintendence for Pension Funds and

14 Transparency International: Corruption Perceptions Index 2019.

the National Agency of Supplementary Health have safeguarded their decision-making independence and will operate as separate entities in 2020, despite government downsizing rumours last year. New legislation has established various working groups and committees to identify the national risks associated with money laundering, terrorist financing and the proliferation of weapons of mass destruction financing, and also to combat corruption within federal administration (Decree No. 10,270 of 6 March 2020 and Decree No. 9,755 of 11 April 2019). Despite such progress, those at the top of political power continue to require investigation by the Brazilian Supreme Court with the activities of former president Michel Temer and others subject to an investigation at the end of 2019.

The regulation of the Chilean insurance market is among the most open and sophisticated in the region, and there are strict regulations on the adjustment of losses, which were introduced after the 2010 earthquake. It would not be surprising therefore to see the Financial Market Commission (CMF) step in to regulate the response of insurers to the adjustment of losses caused by civil unrest. The immediate impact of the protests has led commercial premiums to double and insurers to introduce exclusions for 'strikes, riots and civil commotion'. In many property policies, cover for political violence had become automatic, due to soft market conditions and the view that Chile was low risk. The events of 2019 are likely to have a knock-on effect for the terms on which insurers and reinsurers offer property cover across the globe.

There are similarly strict adjustment rules in Peru. As with Chile, the loss adjuster is regulated and must carry out the role of an impartial adjudicator of the loss, in compliance with strict time periods. Over the past few years, Peru has sought to establish provisions on the personal liabilities of specific officers in public and private entities. For example, a 2018 tax ruling provides for the personal liability of private sector officials designing, approving or executing tax planning intended for avoidance. This new liability scenario is considered an attractive opportunity for the placing of D&O policies, given the risk to which officials are exposed and the demand for cover of administrative fines and defence costs.

The Peruvian regulator, Superintendencia de Banca, Seguros y AFP (SBS), came under pressure from local and international insurers and reinsurers for its statement in October 2018 that 'claims-made' policies were not permitted under Peruvian law and would be declared null.¹⁵ The opinion was based on a strict interpretation of the Peruvian Insurance Contract Law;¹⁶ specifically, the description of the trigger for civil liability policies as being the occurrence of the harmful act – within the policy period.

The SBS reconsidered its position on the validity of claims-made policies and issued a draft bill on 17 May 2019. This passed into law on 19 August 2019 by way of Statutory Law SS No. 3695-2019, which recognises that civil liability policies may respond to third-party claims made within the policy period or extended reporting period. In March 2018, Peru approved Law No. 2408, ensuring that civil damages to the state are immediately payable in corruption circumstances and preventing paralysis of public and public-private partnership works. The new law obliges offenders to establish a compliance programme and to meet international standards. The passing of this law provided that bond letters and surety bonds guaranteeing the obligations of those associated with the Odebrecht scandal to the Peruvian state would be honoured. It remains unclear whether insurers will be able to safeguard themselves from associated claims.

15 Memorandum No. 36805-2018.

16 No. 29946, principally Articles 105 and 109.

On 28 June 2019, Argentina issued a decree allowing businesses or individuals carrying out activities that pose a risk to the environment to take out surety insurance for environmental damage.¹⁷ The requirement for mandatory environmental insurance has been in force since May 2017,¹⁸ in order to guarantee the availability of funds to restore the environment, regardless of whether damage has occurred as a result of a sudden or accidental event.

The state would assume the role of the beneficiary of the surety insurance, whereas typical liability products see the state acting as the third-party claimant. Insurers and reinsurers offering public liability insurance should therefore check that cover for pollution liability aligns with these mandatory requirements and any other insurance held by the insured. There are also strict restrictions on policy limits and excesses for environmental insurance and, more generally, for the insurance of public risks.

In 2017, by way of Resolution 40,422, the Argentine insurance regulator (SSN) signalled the relaxation of regulations on foreign reinsurers admitted to provide reinsurance for risks placed in the Argentine market. As of 1 June 2019, admitted reinsurers can compete with local reinsurers for 75 per cent of all risks. However, there remains caution over entering a market that has been problematic for international reinsurers, underpinned by the current economic uncertainty and recent experiences of the unpredictable interpretation of Argentine insurance and reinsurance law.

The Brazilian regulator (SUSEP) marked the 10-year anniversary of the end of the state monopoly by removing any mandatory rule for placing reinsurance in the local market. Brazilian insurers must now only show that they offered ‘first choice’ to local reinsurers of 40 per cent of each treaty or facultative risk. In practice, the need to record and document that this has been done has also been relaxed.

The relaxation of the rules regulating the Brazilian market continued in 2019 with Decree No. 10,167/2019. The new rules allow insureds to cede 95 per cent (a significant increase on the previous maximum of 10 per cent), based on gross written reinsurance premiums in a calendar year, to ‘occasional reinsurers’. Similarly, ‘local reinsurers’ are now permitted to transfer up to 95 per cent of risk (based on the same measure), which is an increase on the previous 50 per cent restriction. Occasional reinsurers need only be registered with SUSEP, without requiring a representative office in Brazil. With rates hardening in Brazil after recent losses, and the regulatory environment developing, there are opportunities for reinsurers at the top end of the market.

Brazil approved a data protection bill in July 2018, which is strongly inspired by the General Data Protection Regulation formulated by the European Union.¹⁹ The Brazilian General Data Protection Law (LGPD) is due to come into force on 18 August 2020,²⁰ although there is now a proposal to postpone this date until 15 August 2022. When applicable, the LGPD must be observed in all data processing operations carried out in Brazil, as well as foreign processing of personal data collected in Brazil or relating to individuals in Brazil. Breaches of the LGPD may lead to fines of 2 per cent of annual revenue, subject to a maximum of 50 million reais, and administrative sanctions, such as suspension of data processing activities.

17 National Decree No. 447/2019 of 28 June 2019.

18 Article 22 of the General Law of the Environment.

19 Brazilian Personal Data Protection Law No. 13,709 of 2018 from Bill 53/2018.

20 Law No. 13,709.

The new regulation is expected to have a double impact on the Brazilian insurance and reinsurance market, not only creating the need for data processing companies to adjust their internal controls, but also increasing demand in the cyber insurance market. In 2017, Brazil was the country with the second-highest number of cyberattacks, with more than 62 million people being victims of attacks and approximately US\$22 billion of losses. According to studies by Willis Towers Watson, Jardine Lloyd Thompson and Aon, the interest in cyber insurance has more than doubled since the new law was published. This is not surprising when data breach claims concerning redress to data subjects involve defence costs and administrative fines that can reach up to 2 per cent of the company's net annual turnover, limited to 50 million reais.²¹

In December 2019, the Ministry of Justice and Public Security hit Facebook with a US\$1.6 million fine for the misuse of personal data of almost half a million users. This is already a significant increase on the £500,000 fine in the UK and the introduction of the LGPD will put data controllers under more scrutiny. The LGPD includes a broad definition of 'personal data', with organisations required to notify breach incidents within a 'reasonable time'. The uncertainty around how the LGPD will be interpreted and enforced poses a challenge for businesses inside and outside Brazil, particularly in the financial services sector.

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

Chile saw the creation of specialist environmental courts in 2012,²² together with increased regulation for operations affecting the environment. This additional scrutiny comes following the severity of the 2017 wildfires and ongoing 'mega-drought' in central Chile. The CMF is now consulting on the introduction of laws that will require companies to report on their carbon footprint and environmental impact. In turn, there is a growing demand for environmental insurance products that will respond to the broad range of exposure faced by insureds in all sectors.

The local and international insurance and reinsurance markets were following developments in Colombia closely, particularly with regard to the Comptroller General of the Republic (CGR) or Contraloría. By way of Constitutional Amendment No. 355 of 2019, which was approved in September 2019, the CGR gained new powers to take proactive and preventative measures to guard against the misuse of public funds. We discuss the latest position with regard to the CGR's views on claims-made policies below.

21 As at January 2019.

22 Created by Act No. 20,600 of 2012.

V POLICY INTERPRETATION AND DISPUTE RESOLUTION

In Latin America, laws affecting policy interpretation may be found in a variety of types of legislation, from civil codes and codes of commerce, to financial regulation and regulatory guidance. In many jurisdictions, laws on consumer protection will also be relevant. In Brazil, for example, all individuals, as well as corporate entities in some circumstances, will benefit from consumer protection, which imposes strict rules (in favour of the insured) when it comes to interpreting insurance contracts.

The overarching objective of Chilean insurance contract law²³ is to protect the insured, regardless of its status or size. There is a general prohibition on insurers altering the wording of registered policies in any way that does not favour the insured. Although the 2013 law is not mandatory for policies with a premium above 200 *unidades de fomento* (UF),²⁴ it is influential on the way risks (irrespective of their size) are written. There may also be times where a fronting operation for the facultative reinsurance of a large risk does not meet this requirement.

The Mexican and Brazilian markets have also traditionally been consumer-focused. The most effective way for insurers and reinsurers to protect their position is to provide very clear policy wordings and to take active involvement in managing claims from an early stage. In recent years, due to the increased use of arbitration and signs of a more sensible approach by the courts in some countries, there is a noticeable trend towards more commercially and technically sound decisions, as well as sensible discussion with the insurance regulators.

At the beginning of 2017, legislation was issued in Peru that stated that institutional arbitration must be used to resolve all disputes that arise from state contracts for the purchase of services and goods.²⁵ Chile went one step further by providing for the automatic arbitration of large disputes (above UF 10,000), as well as for arbitral awards to be filed with the regulator.²⁶

Substantial progress has been made in Brazil in recent years, with arbitration agreements now permitted in adhesion contracts (such as insurance policies) providing that the specific clause is expressly executed by the insured to demonstrate agreement. This has resulted in a rise in the number of both domestic and international arbitration cases. However, the draft Insurance Law Bill²⁷ threatens to impede foreign arbitrations by establishing that all forms of conflict resolution involving contracts entered into in Brazil, Brazilian domiciled insureds, assets located in Brazil or interests over assets relevant to Brazilian infrastructure, must be performed in Brazil with the exclusive application of Brazilian law. If the law is passed, this would represent a step backward in the reduction of protectionism demonstrated by the Brazilian state in recent years as it has sought to establish the country as a reputable and competitive arbitration centre for external, and higher-value, disputes.

Following enactment of the new Brazilian Code of Civil Procedure in 2015 (Law No. 13,105), the reasoning in decisions of the Brazilian Superior Court of Justice²⁸ (STJ) may be binding on lower courts. In 2019, the STJ provided some clarification on the interpretation of the three-year limitation period for claims for ‘compensation’ under Article 206 of the Civil

23 Insurance Law No. 20,667 came into force on 1 December 2013.

24 *Unidades de fomento* is an alternative currency that varies daily based on the previous month's inflation rate.

25 Legislative Decree 1341.

26 Article 543 of the Code of Commerce.

27 Bill No. 5,555 of 2004 and amendments.

28 Special Appeal No. 1,281,594 – SP.

Code. The STJ stated that this provision applies only to claims alleging liability in tort and therefore claims in contract are subject to a limitation period of 10 years. This clarification is helpful for insurers and reinsurers writing civil liability insurance products for Brazilian insureds. The decision is part of a trend of the Brazilian courts towards a more technical interpretation of insurance policies, based on the wording as opposed to an overwhelming need to find in favour of the insured.

In Colombia, arbitral awards already form part of a significant body of case law relating to the interpretation of insurance contracts. However, there is no clear rule establishing the confidentiality of arbitration awards. The Colombian courts, particularly the Supreme Court of Justice, provide a reliable source of clear guidance on the interpretation of insurance policies. As with many jurisdictions, there is less understanding of insurance in the lower courts and within government institutions, as borne out by the uncertainty that has been created over claims-made policies by some decisions adopted by the CGR – the government authority in charge of fiscal control in Colombia. The CGR deemed claims-made clauses to be disproportionate, or abusive, and stated the view that the Colombian Commercial Code and Law 389/1997, which regulates insurance contracts in Colombia, was not applicable in fiscal liability proceedings.

After a period of consultation, the CGR revoked one of its more criticised decisions in November 2019 and recognised the operation of claims-made clauses. It is hoped that this will clear a path towards consistent and clear recognition of this concept.

Colombian law recognises the right of a third-party victim to commence a direct action against the insurer in cases of third-party liability insurance. It is usual for insurers of third-party liability policies in Colombia to be the subject of a ‘call into guarantee’, by which they become a defendant to the proceedings brought against an insured. In a 2015 case,²⁹ the Colombian Supreme Court confirmed that the limitation period against the third-party claimant starts to run from the date of the loss, while the limitation period for the insured to issue proceedings against the liability insurer runs from the date of the ‘judicial or extrajudicial claim’ made by the third-party victim.

A similar right is available in Brazil, following a 2012 court decision.³⁰ However, a statement issued by the Superior Court of Justice on 13 March 2015, clarified that a direct action cannot be filed exclusively against an insurer by a third-party claimant; all claims against an insurer must also include the insured as a defendant.³¹

Meanwhile, the Mexican Federal Civil Code was amended in January 2018 to alter the measure and restatement units³² applicable for calculating compensation to victims of personal injury, with the effect of reducing the basis for such calculation to 25 per cent of that previously anticipated. These changes may mark the end of a trend in increasing moral damages awarded by the Mexican courts, shifting from a compensatory approach to one that aims to punish the perpetrator for undesirable actions. From an insurer perspective, this is a welcome change. Punitive damages are often excluded under an insurers’ general terms and conditions, while moral damages are more likely to be governed by the expressed general liability policy provisions.

29 Judgment on 14 December 2015.

30 Superior Court of Justice, Special Appeal 962230/RS, Judge Luis Felipe Salomão, 8 February 2012.

31 Súmula 529, which is a non-binding but persuasive statement to clarify the law.

32 *Unidad de Medida y Actualización*.

These are just some examples of how, even though case law is non-binding across Latin America, the courts are becoming increasingly important in the development of insurance and reinsurance law.

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

In Peru and Chile, the rules around the adjustment of losses provide for a strict timeline that directly affects insurers. The rules in Peru³³ provide for 30 days, from the delivery of complete documentation, for insurers to respond to a claim. Any request for additional information must be made within the first 20 days, even where a loss adjuster has been appointed. In Chile, insurers must make any challenge to a loss adjuster's final report within 10 days. In both countries, failure to comply with these periods will be taken as an acceptance of cover.

A similar 30-day rule in Mexico puts an insurer at risk of paying interest, or being subject to fines or sanctions. In Colombia, insurers that fail to respond to claims (in which the insured has duly accredited the occurrence and amount of the claim) within one month may face expedited judicial proceedings and interests on arrears (of approximately 30 per cent). Brazilian legislation also allows 30 days for the conclusion of a loss adjustment, counted from the date on which all of the relevant documents have been provided by the insured to the insurer. There is no specific law applying this deadline to reinsurance, which must self-determine an applicable time frame. Failure to comply with the period will result in the tacit acceptance of cover.

If passed by the legislature, the Brazilian draft Insurance Law Bill would interfere with the claims adjustment procedures currently regulated by SUSEP. For example, a claim would be considered covered if partial or total consideration passes between insurer and insured, or if a denial of cover fails to contain reasoning. Additionally, the deadline for a reinsurer's response to a request for cover would be stipulated as 10 days. The Brazilian Superior Court of Justice has also consolidated rules that an insurer may only deny insurance indemnity based on premium default if the insured has been previously notified of its default.³⁴

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

Peru has confirmed the importance of an insurer knowing the extent of the risk it is writing at time of placement by codifying the duty to enquire into circumstances that may influence the terms of it entering into the policy.³⁵ A policy will only be found null when there is fraud or inexcusable fault on the part of the insured. The insurer will also only have 30 days from obtaining knowledge of the inaccurate statement to dispute cover, otherwise the right to such a defence will be lost. Insurers and reinsurers must, therefore, make sure that they know the true state of the risk at the time of contracting; if necessary, tailor their questionnaires appropriately to the potential insured; and act quickly if fraud or fault is confirmed.

33 Article 74 of the Insurance Contract Law.

34 Precedent No. 616 of the Superior Court of Justice.

35 Insurance Contract Law No. 29,946.

VI DEVELOPMENT OF REINSURANCE LAW

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

The demand for reinsurance cover for infrastructure and energy projects; life and health products; cyber and insurtech; as well as D&O, and property and casualty, continued to grow during 2019. Although the immediate impact of annual hurricane season is likely to spark an upturn in premium rates in South American markets, the development of new products to combat the risks posed by natural hazards is encouraging. The year 2018 saw a record-breaking catastrophe bond of US\$1.36 billion, being issued by the World Bank and structured by Aon, to provide earthquake reinsurance protection to multiple Latin American countries including Mexico, Chile, Colombia and Peru. This diversification of risks and international support for local economic development is likely to boost the confidence of foreign investors to take on more business in the involved nations.

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

Whether the provisions of the Brazilian Civil Code apply equally to reinsurance contracts as to insurance contracts remains an area of continued debate. Many Brazilian lawyers consider that the provisions in the Civil Code are limited to insurance contracts. Others consider that the Code applies to reinsurance by analogy. The latter view reflects the approach in Colombia and Argentina, and now appears to be supported by the Brazilian draft Insurance Law Bill, which continues to make slow progress through Congress. This remains an area where clarification of the law or comment by SUSEP would be welcome.

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

The new Ecuadorean Commercial Code entered into force on 29 May 2019; it includes rules on the regulation of insurance contracts in the 'Sixth Book' (Article 690 onwards). In Article 794, there is express recognition that rules relating to insurance will also apply to reinsurance contracts by default, but with the possibility for the parties to expressly contract otherwise.

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

Chilean law³⁶ 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, although this provision remains largely untested.

Peruvian contract law defines reinsurance³⁷ as obliging the reinsurer 'within the agreed limits' to meet 'the debt that arises in the patrimony of the reinsured as a consequence of the obligation assumed by it as the insurer under the contract of insurance'. It is difficult to reconcile this statement with the separate recognition of autonomy between insurance and reinsurance, which states the general prohibition on the payment of an indemnity under the original policy being conditional on the relationship between the insurer and reinsurer.³⁸ The simple explanation is that the aim of this provision is to prevent insurers from deferring to reinsurers as an excuse for late payment, although there is now an exception to this rule.

In most countries, local insurers are not permitted to delay payment under a policy while they wait for reinsurance funds to become available. In Peru, however, new rules for taking out reinsurance and coinsurance via fronting arrangements entered into force during 2018. These rules allow insurance companies to incorporate a clause into insurance and reinsurance contracts that allows the insurer to pay a loss when the reinsurer pays (i.e., 'pay when paid' provisions). This clause may only be agreed in fronting operations when the insurer transfers 100 per cent of the risk and highlights the importance of ensuring that the underlying policy is aligned with the reinsurance in back-to-back reinsurance.

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

Colombia has one of the most sophisticated bodies of law on insurance and reinsurance, including helpful guidance from the Supreme Court of Justice. The Colombian Commercial Code and supplementary laws contain detailed provisions, which include the express recognition of the 'follow the fortunes' principle in reinsurance contracts, as set out in Article 1134 of the Code of Commerce, and subject to the contractual terms agreed between the parties (Article 1136).

As a general rule, it is therefore helpful for all parties, whether a local insurer or an international reinsurer, to accept that there is significant uncertainty when it comes to the interpretation of wording drafted in line with common law principles, such as those emanating from the London market. For example, the use of terms such as 'condition precedent' will usually mean nothing to a local court.

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

36 Article 584.

37 Article 138 of the Insurance Contract Law No. 29,946.

38 Article 139.

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

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

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

The governing principle under Colombian law is related to the place of performance of the contract.³⁹ There is little doubt that this means any contract with a Colombian insured or insurer must be subject to Colombian law. The position in Mexico is less clear, despite the regulator's insistence that local law and jurisdiction must be used.

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

VII OUTLOOK AND CONCLUSIONS

This chapter has highlighted the renewed focus in Latin America on improving risk management and challenging corruption. This is necessary to support renewed economic growth and to protect against a repeat of widespread scandals, such as those uncovered by Operation Car Wash. In a previous edition of this chapter, we commented that protectionist regulation was continuing to wane in favour of growth and transparency, but that political and economic volatility could undermine the progress being made. This remains the case at the beginning of 2020, with many Latin American countries having recently elected presidents promising change, who now face huge challenges to bring about economic stability – and political transparency.

When it comes to interpreting insurance contracts, the approach of the courts tends towards favouring the insured, but a clear trend is developing towards a more technical interpretation reflecting the wording of the contract. There is a continuing debate over whether contracts negotiated between sophisticated commercial entities (including reinsurance contracts) merit separate treatment from consumer contracts. There is a sense that renewed growth in the region will be accompanied by the need for risk transfer, and an opportunity for insurers and reinsurers to offer new products and improved accessibility across all lines of business.

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 conjunction with an understanding of the political, economic and social context. 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.

³⁹ Article 869 of the Code of Commerce.

The Latin American market faces new challenges in 2020, as the covid-19 pandemic threatens to eradicate the green shoots of economic growth that had appeared in 2019. The use of technology and digitalisation provides a way to increase accessibility of insurance products for consumers in areas such as life and healthcare. On the commercial side, there is also a need for innovation to provide solutions in areas such as cybersecurity and environmental liability, as well as in traditional lines such as D&O and property and casualty, to ensure that they are understood by companies across the full range of industries.

AUSTRALIA

*David Gerber and Craig Hine*¹

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 2019, there were 28 registered life companies (including both direct insurers and reinsurers) in Australia with combined assets of A\$202.9 billion,² and 97 authorised general insurers (including both direct insurers and reinsurers, but not including Lloyd's Australian operations) with combined assets of A\$128.3 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 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. It monitors and promotes market integrity in the financial system. The ASIC also has functions and powers related to consumer protection that are conferred on it by or under the Corporations Act 2001 (the Corporations Act), the Australian Securities and Investments Commission Act 2001, the Insurance Contracts Act 1984 (the Insurance Contracts Act) and the Life Insurance Act 1995 (the Life Insurance Act).⁶

1 David Gerber is a partner and Craig Hine is a special counsel at Clayton Utz.

2 See <https://www.apra.gov.au/sites/default/files/Quarterly%20Life%20Insurance%20Performance%20Statistics%20September%202019.xlsx>.

3 See <https://www.apra.gov.au/sites/default/files/Quarterly%20General%20Insurance%20Performance%20Statistics%20September%202019.xlsx>.

4 See <https://www.privatehealth.gov.au/dynamic/insurer>.

5 Australian Prudential Regulation Authority Act 1998 (Cth), Section 8.

6 Australian Securities and Investments Commission Act 2001 (Cth), Section 12A.

ii Regulation and authorisation of general insurers and life insurers

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

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

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

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.⁹

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

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

iii Regulation and authorisation of health insurers

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

The Private Health Insurance Act 2007 and Private Health Insurance (Prudential Supervision) Act 2015 regulate private health insurance business. A body corporate may apply to the APRA for registration as a private health insurer.¹⁰ The private health insurance regime

7 Insurance Act, Sections 9 and 10.

8 See Section 32 of the Insurance Act and Section 230A of the Life Insurance Act.

9 See Section 9 of the Insurance Contracts Act, which excludes several types of contracts of insurance, including contracts of reinsurance.

10 Private Health Insurance (Prudential Supervision) Act 2015 (Cth), Section 12.

sits alongside and is closely linked to the government-funded Medicare scheme. Medicare is a Commonwealth scheme administered by the Department of Health in accordance with the National Health Act 1953.

iv Position of non-admitted insurers

General insurance

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

Generally speaking, an entity is prohibited from conducting insurance business in Australia unless it is authorised. Under the Insurance Act, 'carrying on insurance business in Australia' includes the insurance business of an insurer carrying on business outside Australia through an agent or broker in Australia, except where the insurance business of the insurer is solely a business of reinsurance.¹¹

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.

¹¹ Insurance Act, Sections 3(6) and 3(6A).

vi Regulation of individuals employed by insurers

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

vii Compulsory insurance

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

viii Compensation and dispute resolution regimes

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

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

ix Other notable regulated aspects of the industry

The general and life insurance legislation deals with portfolio transfers between Australian insurers. Under the Insurance Act, a general insurer may not transfer its rights and liabilities under policies to another Australian regulated insurer, except under a scheme confirmed by the Federal Court of Australia.¹² 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.¹³

For both general insurers and life insurers, acquisitions of 15 per cent or more of an insurer's book of the assets of the company are regulated by the Insurance Acquisitions and Takeovers Act 1991 and require approval by the APRA.

12 Insurance Act, Division 3A.

13 Life Insurance Act, Section 190.

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

III INSURANCE AND REINSURANCE LAW

i Sources of law

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

ii Making the contract

Essential ingredients of an insurance contract

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

- a the insured must have a contractual right to be indemnified;¹⁴
- b the insurer must be legally obliged to pay money (or its equivalent) to the insured in the event of a specified event occurring;¹⁵
- c it must be uncertain whether the specified event will occur, or the time at which it will occur;¹⁶ and
- d the contract must be for some consideration: usually, but not necessarily, periodical payments called premiums.¹⁷

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.¹⁸

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 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.

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

15 *Medical Defence Union Ltd v. Department of Trade* [1979] 2 All ER 421, 429.

16 *Prudential Insurance Co v. Inland Revenue Commissioners* (1904) 2 KB 658, 663.

17 *ibid.*

18 Insurance Contracts Act, Sections 16 to 18.

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

Utmost good faith, disclosure and representations

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

There is also a duty of disclosure. At common law, this duty requires the insured to reveal all material facts of which it is aware in the negotiations leading up to the formation or renewal of the contract.¹⁹ 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.²⁰

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.²¹ The Insurance Contracts Act also modifies the common law rights of life insurers in relation to misrepresentations, non-disclosures²² and misstatements of age.²³ A court may disregard avoidance in certain circumstances.²⁴

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.²⁵ Prudential standards issued by the APRA regulate the documenting of contracts of reinsurance.

iii Interpreting the contract

General rules of interpretation

The ordinary rules applying to the interpretation of commercial contracts in general apply equally to insurance contracts.²⁶ The ordinary rules include that:

19 *Carter v. Boehm* (1766) 97 ER 1162.

20 Insurance Contracts Act, Section 21.

21 Insurance Contracts Act, Section 28(3).

22 Insurance Contracts Act, Section 29.

23 Insurance Contracts Act, Section 30.

24 Insurance Contracts Act, Section 31.

25 Insurance Contracts Act, Section 74.

26 *Australian Casualty Co Ltd v. Federico* (1986) 160 CLR 513, [6] (Chief Justice Gibbs).

- a as a commercial contract, an insurance policy will be given a ‘business-like’ interpretation²⁷ – words and phrases are to be given their ordinary and natural meaning²⁸ unless they have a technical meaning or the sense in which they are used suggests that such a meaning is inappropriate;
- b the contract is read as a whole, taking into account the text, context in which words appear and the purpose of the policy’s provisions, which, if appropriate to consider, may include relevant surrounding circumstances;²⁹
- c the main object or commercial purpose of the contract is to be taken into account;³⁰ and
- d any ambiguity is to be resolved against the party who drafted the contract (the *contra proferentem* rule).³¹

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.³² The rule is subject to a number of exceptions. For example, extrinsic evidence may be considered to resolve inherent ambiguity.³³ Extrinsic evidence may also be adduced to prove that a policy does not express what was clearly agreed by the parties to it³⁴ or that there is a collateral contract that contains a separate undertaking.³⁵

Types of terms in insurance contracts

The terms ‘condition’ and ‘warranty’ can have different meanings in insurance law than in general contract law. They can both refer to clauses for which the insurer may repudiate the contract for breach. Whether a term is in fact a condition or warranty is a question of construction. The use of the word ‘condition’ or ‘warranty’ will not be conclusive.³⁶ 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

27 *McCann v. Switzerland Insurance Australia Ltd & Ors* [2000] 203 CLR 579, [22] (Justice Gleeson); See also *Todd v. Alterra* [2016] FCAFC 15, [42] (Chief Justice Allsop and Justice Gleeson).

28 *Australian Casualty Co Ltd v. Federico* (1986) 160 CLR 513, [6] (Chief Justice Gibbs). See also *Todd v. Alterra* [2016] FCAFC 15, [42] (Chief Justice Allsop and Justice Gleeson).

29 *Electricity Generation Corporation v. Woodside Energy Ltd* (2014) 251 CLR 640, [35] (Chief Justice French and Justices Hayne, Crennan and Kiefel). See also *Todd v. Alterra* [2016] FCAFC 15, [42] (Chief Justice Allsop and Justice Gleeson).

30 *Electricity Generation Corporation v. Woodside Energy Ltd* (2014) 251 CLR 640, [35] (Chief Justice French and Justices Hayne, Crennan and Kiefel).

31 *McCann v. Switzerland Insurance Australia Ltd & Ors* [2000] 203 CLR 579, [74] (Justice Kirby).

32 *Codelfa Construction Pty Ltd v. State Rail Authority (NSW)* (1982) 149 CLR 337, 340.

33 *L & M Electrics Pty Ltd v. SGIC (Qld)* (1985) 3 ANZ Ins Cas 60-641, 78, 946.

34 *Griffiths v. Fleming* [1909] 1 KB 805, 817.

35 *Gates v. City Mutual Life Assurance Society Ltd* [1982] 2 ANZ Ins Cas 60-485.

36 *ANZ Banking Group Ltd v. Beneficial Finance Corp Ltd* (1982) 44 ALR 241, 246.

or contributing to a loss covered by the contract of insurance before the insurer may refuse to pay the claim.³⁷ 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.³⁸

iv Intermediaries and the role of the broker

Conduct rules

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

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

Agency and contracting

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

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

v Claims

Notification

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

Section 40(3) of the Insurance Contracts Act, which applies in respect of certain contracts of liability insurance (essentially, claims made and notified insurance policies),³⁹ has the effect of attaching coverage where an insured notifies circumstances within the policy period.

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

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

37 Insurance Contracts Act, Section 54(2).

38 Insurance Contracts Act, Section 54(1).

39 Insurance Contracts Act, Section 40(1).

exercise its powers of enforcement against the insurer. In sufficiently serious cases, the ASIC has the power to vary, suspend or cancel an Australian financial services licence, and to ban persons from providing financial services.

Dispute resolution clauses

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

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

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

It is common for parties to a contract of insurance or reinsurance to submit to the courts of a selected jurisdiction and agree to be governed by its laws.

Jurisdiction clauses typically identify whether the nominated jurisdiction is an exclusive or non-exclusive jurisdiction. If a jurisdiction clause identifies courts that are the natural forum for a dispute, this is a factor that would support the clause being read as an exclusive jurisdiction clause. In a contract of insurance, ambiguity as to the jurisdiction tends to be interpreted in favour of the insured.⁴⁰ 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.⁴¹

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

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

ii Litigation

Litigation stages

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

Typically, proceedings are conducted by an exchange of pleadings. Court rules may allow, or one or more parties may seek orders for, discovery of documents. Discovery requires the party that is subject to the order to undertake a search for particular documents that are relevant to the issues in dispute, including those that may be adverse to their case. Following

40 See, for example, *ACE Insurance Ltd v. Moose Enterprise Pty Ltd* [2009] NSWSC 724 (Justice Brereton, 31 July 2009).

41 See, for example, *Akai Pty Ltd v. The People's Insurance Co Ltd* (1996) 188 CLR 418.

discovery, or in some courts before discovery, parties will usually be required to exchange evidence in preparation for trial. The final stage is a trial that usually involves evidence (including cross-examination) and legal argument.

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

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

Evidence

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

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

Costs

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

iii Arbitration

Format of insurance arbitrations

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

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

Procedure and evidence

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

The role of witnesses may be limited by agreement of the parties. The process may be similar to a court procedure, and allow for oral testimony of witnesses with the ability of the

other party to cross-examine each witness. Conversely, the parties may agree that only written evidence is allowed. Similarly, sometimes oral submissions may be made or, as is the case under the ACICA Expedited Rules, oral submissions may be prohibited.

Costs

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

iv Mediation

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

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

V YEAR IN REVIEW

i Regulatory changes

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

- a* the prohibition of the hawking of insurance products, including by way of unsolicited offers and sales;
- b* the implementation of a deferred sales model for the sale of any 'add-on' insurance and a cap on commissions paid to vehicle dealers;
- c* the replacement of the existing statutory duty of disclosure (under the Insurance Contracts Act) with a duty to take reasonable care not to make a misrepresentation to the insurer (essentially, adopting the duty enacted under the UK Consumer Insurance (Disclosure and Representations) Act 2012, which introduced a duty in the terms recommended by the UK Law Commission and the Scottish Law Commission in their 2009 report entitled 'Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation');

- d* a change to the circumstances in which a life insurer may avoid a contract on the basis of non-disclosure or misrepresentation;
- e* the application of 'unfair contract terms' legislation to certain insurance contracts; and
- f* legislative changes to make insurance claims handling subject to the Corporations Act licensing regime and regulation by the ASIC under the Corporations Act.

ii Key case

In *Australian Securities and Investments Commission v. Westpac Securities Administration Limited*,⁴² the Full Court of the Federal Court delivered a judgment that addressed the characterisation of 'general advice' and 'personal advice' under the Corporations Act. The characterisation of these two distinct legislative concepts is significant because additional legal obligations arise where 'personal advice' is provided, including additional disclosure obligations and the need to comply with a best interests duty.

The case concerned a marketing campaign which the Court found was designed to convince customers to consolidate multiple superannuation accounts into a single account by giving no more than general advice. The marketing campaign involved telephone calls during which no express recommendation was given to the customer to consolidate their accounts.

The Court found that the telephone exchanges had to be considered as a whole and that, by doing so and taking into account that the customers were making a decision on consolidation during the call, there was an implied recommendation in each call that the customer should consolidate.

The judgment potentially impacts upon the approaches taken across the financial services industry to drawing a distinction between general advice and personal advice in marketing campaigns. We understand that it has prompted industry participants to review practices for marketing and distributing products as well as the scope of their licensed activities.

VI OUTLOOK AND CONCLUSIONS

The insurance industry in Australia is constantly adapting to regulatory and other changes. Consumer protection through the regulation of both sales and claims conduct has been a focus of insurance regulators in recent times and the Royal Commission. Substantial regulatory change has followed the Royal Commission and has affected the industry. Regulators have taken action against a number of insurers for the sale of 'junk' insurance products and, combined with legislative and other changes, many insurers are changing their business models and product offerings. These changes, which are likely to continue in the foreseeable future, have also contributed to some banks selling their life insurance arms and have given rise to questions as to the future of the bancassurance model in Australia. There will be more regulatory change for the insurance industry over the next year.

42 [2019] FCAFC 187.

AUSTRIA

Peter Konwitschka, Manuela Zimmermann, Marguerita Sedrati-Müller, Natascha Garo, Daniel Höhn, Sebastian Jackwerth-Feige, Daniel Lackner, Caroline Lichtenberg and Julia Peric¹

I INTRODUCTION

The framework conditions for insurance and reinsurance companies in the European Economic Area (EEA) and therefore also in Austria have changed fundamentally in recent years.

Many parallel developments are affecting insurers: increased insurance regulation, the effects of the persistent low interest rate environment, climate change, demographic change, the increasing availability of data and information (big data), the legitimate need of insurance customers for more transparency and comparability between the products and, finally, as this chapter is being finalised (March 2020), the developing covid-19 pandemic. All of this will probably boost digitalisation efforts of all market participants.

Nevertheless, 2019 was a good year for Austrian insurance undertakings.

The premium volume in 2019 was €17.56 billion (16 per cent of premiums go to reinsurance), consisting of €9.83 billion in property and casualty insurance, €5.40 billion in life and €2.33 billion in health insurance. Austria's insurers booked €15.02 billion in expenses for insurance claims (payments and provisions for outstanding claims), which was an increase of 6.59 per cent.

While the number of court cases in various non-litigious matters outside the insurance industry has increased dramatically in recent years, overall civil litigation declined. The reduced number of insurance disputes was one of the main drivers of this multicausal phenomenon.

In 2018 and 2019, the Supreme Court passed about 20 headline decisions on insurance law. Lower courts saw a significant number of litigation about 'eternal' cancellation rights due to ECJ C-209/12 *Endress*.

II REGULATION

The Austrian Financial Market Authority (FMA) is the national competent authority for insurance and reinsurance undertakings. Before pursuing contractual insurance activities within the territory of Austria, local and third-country insurers and reinsurers are required to obtain a licence from the FMA. Insurance undertakings holding a licence from another Member State of the EEA can operate in Austria under the single licence principle. Such insurers do not require an additional Austrian licence and may conduct insurance business

¹ Peter Konwitschka and Manuela Zimmermann are partners, Marguerita Sedrati-Müller is counsel, and Natascha Garo, Daniel Höhn, Sebastian Jackwerth-Feige, Daniel Lackner, Caroline Lichtenberg and Julia Peric are senior associates at Schönherr Rechtsanwälte GmbH.

on a freedom of services basis or by establishing a branch in Austria. Nevertheless, EEA insurance companies must notify the competent supervisory authority in their home country before initiating insurance business in Austria.

The FMA may request information from insurance and reinsurance undertakings about any business activity issues as well as the presentation of relevant documents at any time and determine the manner in which these documents must be presented (Section 272 of the Austrian Insurance Supervision Act 2016 (VAG 2016)).

The FMA may, in order to ensure insurance marketing activities are conducted in a lawful manner, at any time request information from insurance undertakings and other intermediaries, in particular any information regarding contracts that are held by intermediaries or regarding contracts that are entered into with third parties and may inspect such information on site.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Austrian Insurance Contract Act (VersVG) is the primary legal source for private insurance. It has been in force since 5 April 1959² and originally mirrored the German Insurance Contract Act (VVG). That changed in 2008 when Germany passed its VVG reform. Nevertheless, many German court decisions, commentaries and scholarly writings, in particular those dating before 2008, are still considered as also being relevant in Austria.

After its enactment, the VersVG remained in force in its original form for over 30 years and was first amended in 1994 in preparation for Austria's accession to the EU.³ It contains provisions on both property and life insurance but excludes maritime insurance and reinsurance. Maritime insurance is set out in the Austrian Commercial Code but hardly ever concluded under Austrian law. Reinsurance contracts are governed by civil law provisions only. Other primary legal sources of Austrian insurance contract law are the general policy conditions as well as any agreements made between the parties, including special legal regulations such as the Motor Vehicle Liability Insurance Act 1994 and the Compensation for Traffic Victims Act.

An Austrian peculiarity is that information obligations are not part of insurance contract law but of the supervisory laws (VAG 2016). This system allows the FMA to pass regulations that set out information obligation in more detail. So far, the FMA has issued regulations with respect to life and health insurance.

Other sources of law relevant for structuring insurance products are the Consumer Protection Act (KSchG), the Remote Financial Services Act and provisions of the Austrian General Civil Code (ABGB) of 1811. Last but not least, all relevant EU regulations (mainly the PRIIPs Regulation) are of course also directly applicable in Austria.

Neither the VersVG nor the VAG 2016 define the term 'insurance'. Following the example of Germany, the Austrian legislature has deliberately omitted to include such a legal definition and still leaves the definition of the term to the jurisdiction.⁴

For large risks within the meaning of Article 7 Paragraph 2 Rome I, the VAG 2016 regulations on product governance do not apply (Section 129 Paragraph 7 VAG

2 Bundesgesetz über den Versicherungsvertrag (Versicherungsvertragsgesetz 1958), BGBl 1959/2.

3 BGBl 90/1993.

4 Fletzberger in Korinek/G. Saria/ S. Saria, VAG § 1 rec. 5.

2016). Further, there are exceptions to the general information obligations (Section 130 Paragraph 4 VAG 2016) and the consultation prior to the submission of the contractual declaration in the case of the sale of large risks (Section 132 Paragraph 1 VAG 2016). Additionally, the obligations regarding product information are limited for the insurance of major risks (Section 133 Paragraph 2 VAG 2016).

ii Making the contract

The insurance contract is concluded by the submission of concordant declarations of the insurer and policyholder. Consent to the contract must be free, serious, definite and understandable. The 'overall scheme' of the regulations of an insurance contract determines whether it is an insurance contract within the meaning of the VersVG.⁵ According to the prevailing view, the essential ingredients of an insurance contract are (1) bearing of risk by the insurer, which may not be a mere ancillary benefit of another contract; (2) covering a respective 'need' of the policyholder; (3) providing a legal claim of the policyholder to the insurance benefit; (4) the existence of a risk collective and calculation according to the law of large numbers in the sense of assuming the risk of the occurrence of an uncertain event; and (5) the premium.⁶

The information obligations and rules of conduct of insurers are set out in Sections 128–136 VAG 2016, which are intended to ensure that policyholders receive all product-specific contractual documents (e.g., insurance terms and conditions, product information). With respect to life and health insurance, special regulations by the FMA set out more detailed information obligations.⁷ The form in which insurance undertakings must convey pre-contractual information is primarily paper, unless agreed otherwise. Provisions for electronic information or information via a website are slightly different than those set out for PRIIPs KIDs in Article 14 of the PRIIPs Regulation 1286/2014. In addition, insurers and policyholders may agree on electronic communication (in practice, via email), which, if sent, is deemed to have been received by the policyholder (Section 5a VersVG). This provision is a unique tool for insurers to make sure they can prove that policyholders received communication sent to them.

Under the widely used 'application model' customers apply for the conclusion of the insurance contract and insurers accept these offers by sending the policy within six weeks. The contracting parties are in principle free to choose the content of the insurance contract. However, this freedom is limited by the general civil law regulations, especially in terms of possibility and permissiveness according to Section 879 ABGB. For example, insurance against fines is deemed void pursuant to Section 879 Paragraph 1 ABGB, but precedents on this are old. It therefore remains to be seen whether Austrian courts will accept insurance against fines under the EU General Data Protection Regulation.

5 Fenyves in Fenyves/Schauer VersVG § 1 rec. 7.

6 Fenyves in Fenyves/Schauer VersVG § 1 rec. 8-16.

7 Verordnung der Finanzmarktaufsichtsbehörde (FMA) über die Informationspflichten für die Lebensversicherung (Lebensversicherung Informationspflichtenverordnung 2018 – LV-InfoV 2018), Austrian Federal Law Gazette II no. 247/2018; Verordnung der Finanzmarktaufsichtsbehörde (FMA) über die Informationspflichten für die Krankenversicherung nach Art der Lebensversicherung (Krankenversicherung Informationspflichtenverordnung – KV-InfoV), Austrian Federal Law Gazette II No. 374/2015.

Since 2019, a new Section 5c VersVG has established a uniform cancellation right for policyholders within 14 days (in the case of life insurance within 30 days) without giving reasons (Section 5c Paragraph 1 VersVG). Annex 1 to the VersVG provides for model cancellation information which, if used, is deemed to be sufficient information about the cancellation right.

The insured must notify the insurer of all circumstances known to him or her that are substantial to the assumption of the risk when concluding the contract (Section 16 VersVG). Substantial are those circumstances that are likely to influence the insurer's decision to conclude the contract at all or to conclude it under the agreed terms. In case of doubt, a circumstance that the insurer has asked for explicitly and in written form is considered to be substantial. In assessing whether there has been a breach of an obligation to notify, an overall view must be taken. The objective suitability of a risk circumstance to influence the insurer's decision to conclude a contract is important.⁸ If, contrary to this provision, a significant circumstance is not notified, the insurer may revoke the contract within one month (Section 16 Paragraph 2 VersVG). The insurer may also revoke from the contract if an incorrect notice has been given about a substantial circumstance (Section 17 Paragraph 1 VersVG). The cancellation period starts as the insurer becomes aware of the breach of the duty of disclosure (Section 20 Paragraph 1 VersVG).

Obligations as prerequisites to be fulfilled for a policyholder's claim to insurance cover must be expressly agreed. The agreement in the general terms and conditions is sufficient but the insurer can only derive rights from the negligent breach of an agreed obligation if the policyholder has previously received the insurance conditions or another document in which the obligation is communicated (Section 6 Paragraph 5 VersVG).

A distinction is made between obligations to be fulfilled before and after the insured event. However, only the culpable breach, whereby slight negligence is sufficient, of an obligation to be fulfilled before the insured event leads to the insurer's exemption from liability and entitles the insurer to terminate the contract within one month of becoming aware of the breach without complying with a period of termination (Section 6 Paragraph 1 VersVG). In the case of obligations that must only be fulfilled after the occurrence of an insured event, the insurer shall only be released from its duty to provide insurance coverage in the event of an intentional or grossly negligent breach of the obligation. If the obligation is not breached with the intention of influencing the insurer's duty to provide insurance cover or of impairing the determination of such circumstances which are recognisably significant for the insurer's duty to provide cover, the insurer remains obliged to provide cover insofar as the breach has had no influence on the determination of the insured event or on the determination or the scope of the cover incumbent on the insurer (Section 6 Paragraph 3 VersVG).

Furthermore, in the event of a breach of an obligation intended to maintain the equivalence between risk and premium on which the insurance contract is based, the agreed freedom from insurance coverage only applies to the extent that the agreed premium is lower than the premium provided for in the tariff for the higher risk. In the event of a breach of obligations relating to other mere reports and notifications that have no influence on the insurer's assessment of the risk, indemnification shall only be granted if the obligation has been breached intentionally (Section 6 Paragraph 1a VersVG).

An agreement according to which the insurer shall be entitled to revoke the contract in the event of a breach of an obligation is invalid (Section 6 Paragraph 4 VersVG).

8 Heiss/Lorenz in Fenyves/Schauer VersVG §§ 16-17 rec. 5.

Insurers must send a signed document of the policy to the policyholder on paper or, as a result of an agreement on electronic communication according to Section 5a VersVG, by email. If the insurance contract relates to a life, occupational disability or pension insurance, the insurance certificate must also be sent on paper. The current Austrian government's plan is to further facilitate electronic communication between insurers and policyholders – it remains to be seen whether this will happen soon.

Policyholders can at any time request copies of the declarations made with regard to the policy and they can also ask for a copy of the policy against payment of a fee (Section 3 VersVG).

Claims for insurance benefits become statute-barred within three years of their due date (Section 12 Paragraph 1 VersVG). In connection with life insurance contracts, the Austrian Supreme Court ruled that the ancillary service claim according to Section 3 VersVG exists at any time during the contract and after its termination until complete settlement (i.e., until there is legal certainty that no more claims can be asserted from the insurance contract).

iii Interpreting the contract

The ABGB contains the essential provisions on contract law, whereas the KSchG provides for special rules for consumer contracts. These provisions are of central importance when interpreting insurance contracts as well as the general terms and conditions.

Further to the Austrian Supreme Court, the following rules apply:

- a* the interpretation must take into account a 'reasonably circumspect policyholder';
- b* clauses of general terms and conditions of insurance contracts must be interpreted objectively (i.e., without taking into consideration the subjective intentions of the insurer or the policyholder) and the interpretation of such clauses must be limited to their wording, unless they were the subject and result of contract negotiations;
- c* the purpose of a clause that is discernable for an objective observer must always be taken into consideration;
- d* clauses limiting the insured risk therefore are invalid insofar as one cannot expect a policyholder without legal education to understand them; and
- e* clauses that are unclear from an objective perspective have to be interpreted as a reasonably circumspect policyholder must have understood them. In case of uncertainties they have to be interpreted to the detriment of the insurer.

The result of such interpretation is subject to additional legal scrutiny as several provisions in the ABGB limit the validity of clauses: ancillary clauses (i.e., all the 'small print'), which are disadvantageous for the insured and which a reasonable reader would not have to expect at the place where they are written do not become part of the contract (Section 864a ABGB). In addition, all provisions except the main subject matter of the insurance contract are null and void if they are grossly detrimental to the policyholder (Section 879 Abs 3 ABGB). The Austrian Supreme Court has a quite narrow view on what forms the main subject matter of the contract, thus enabling it to basically verify almost all clauses and whether they are grossly detrimental, including all provisions modifying the premium. For example, in several decisions, the last one in 2019,⁹ the Supreme Court held that a clause linking the premium and the amount insured in legal cost insurance to the consumer price index is null and

⁹ OGH 27.02.2019, 7 Ob 242/185.

void because it leads to a constant increase of the premium for the benefit of the insurer. Although this has been widely criticised among legal scholars, it remains to be seen whether the Supreme Court will change its view. In another 2019 decision,¹⁰ however, the Court upheld the indexation of premiums in endowment life contracts.

In consumer contracts, provisions must also meet the transparency requirement (Section 6 Paragraph 3 KSchG). The average consumer must be able to understand the content and the consequences of all clauses, including their economic consequences – a task not easy to fulfil. And, further to ECJ C-260/18 *Dziubak*, it has become even more questionable whether invalid clauses can be replaced by anything else (e.g., supplementary rules of Austrian law, supplementary interpretation of the contract, etc.). Utmost scrutiny of the wording and knowledge of the vast amount of Austrian Supreme Court cases on transparency is therefore necessary when designing new products for the Austrian market.

iv Types of terms in insurance contracts

If the risk situation at the time of the conclusion of the contract increases to the disadvantage of the insurer, the insured must notify the insurer (Sections 6 and 23 VersVG). If the increase in risk lies within the responsibility of the insured, the insurer is entitled to avoid coverage and may cancel the contract. An increase in risk due to negligent omission of the insured may also allow the insurer to take these actions. Changes that are not relevant for the risk assessment also have to be notified to the insurer (e.g., change of address for contents insurance).¹¹ Another typical obligation of the insured in damage insurance is the obligation to keep the damage as low as possible (Section 62 VersVG).

General terms and conditions sometimes contain clauses that refer to exclusions of risk which are to be considered as ‘hidden’ obligations. However, the decisive factor is not the name but whether the clause contains an individualised description of a particular risk or whether it requires a certain preventive behaviour from the insured to keep insurance cover.¹² For example, the Austrian Supreme Court qualified in legal expenses insurance policy a clause according to which the insurance company in principle pays the costs in a covered claim only from the time when the insured requests cover, as a hidden obligation.¹³

v Intermediaries and the role of the broker

Insurance distribution is defined in Article 137 Paragraph 1 of the Austrian Trade Act (GewO) as:

- a* advising, proposing or carrying out other preparatory work for the conclusion of insurance contracts;
- b* concluding insurance contracts or assisting in their administration and performance, in particular in the event of a claim;
- c* the provision of information on one or more insurance contracts based on criteria chosen by a customer via a website or other media, and the establishment of a ranking

10 OGH 23.10.2019, 7 Ob 133/19p.

11 Grubmann, *Versicherungsvertragsgesetz* § 6, Rz 2 ff.

12 OGH 28.04.2003, 7 Ob 70/03z; RIS-Justiz RS0103965, RS0080168.

13 OGH 06.07.2004, 7 Ob 41/04m; OGH 23.01.2013, 7 Ob 201/12b; RIS-Justiz RS0080166.

of insurance products, including a comparison of prices and products, or a discount on the price of an insurance contract, where the customer can directly or indirectly conclude an insurance contract via a website or other media; or

d the activities referred to in (a) to (c) in respect of reinsurance contracts.

Insurance distribution in Austria is a regulated profession for which a certificate of competence is required (Article 94, 137 GewO). Insurance intermediaries must be registered with the trade register by the administrative district authority (Article 365a Paragraph 1 and Article 365b Paragraph 1 GewO). Except for bancinsurance, supervision of intermediaries is therefore not a competence of the FMA but of 106 local authorities.

Insurance distribution may be carried out by ‘insurance agents’ (Article 43 VersVG) or ‘brokers’ (Article 26 of the Austrian Brokers Act (MaklerG)).

Insurance agents are constantly entrusted by the insurer to mediate or conclude insurance contracts (Article 43 VersVG). An agent and all declarations made by an agent are therefore attributed to the insurer.

The broker, on the other hand, is not constantly entrusted by one or more insurers to mediate or conclude insurance contracts and is not in any economically ‘close relationship’ to the insurer. Despite working for both parties, the broker must predominantly protect the interests of the insurance client and is also considered to be within the sphere of his or her responsibility (Article 27 Paragraph 1 MaklerG).

Insurance intermediaries must declare if they act as an insurance agent or broker (status transparency). They are also obliged to ensure that the insurance customer is given the required information upon conclusion of an insurance contract and, if necessary, upon changes or renewals of the contract (Article 137f Paragraph 8 GewO). The insurance intermediary must fulfil his or her duties to provide information before any contract declaration by the insurance customer is given.

vi Claims

The insured must notify the insurer immediately on the occurrence of an insured event (Article 33 VersVG).

An immediate notification in accordance with Austrian insurance law is given if sent ‘without undue delay’. It is also regularly contractually agreed that a breach of the notification duty releases the insurer from its coverage obligation. However, the insurer remains obliged to grant coverage if the policyholder proves that he or she was not at fault or in proving that he or she only breached the obligation through slight negligence (Article 6 Paragraph 3 sentence 1 VersVG).

If the insured breached his or her duty through gross negligence or with ‘plain’ intent, the insurer remains obliged to grant coverage insofar as the breach has had no influence on the determination of the insured event or on the determination or the scope of coverage. Only if the policyholder breaches an obligation with the intent to manipulate the evidence after the insured event occurred (*dolus coloratus*) is the insurer entirely released from its coverage obligation.

The insurer may demand that the policyholder provides all information necessary to determine the insured event or the extent of the insurer’s obligation to grant cover (Article 34 VersVG). The obligation to provide information and evidence is an obligation of the policyholder, who must inform his or her contractual partner about all circumstances necessary for the determination of the insured event and the scope of the insurance benefit

in good faith in order to enable the contractual partner to examine the claim – also in good faith – and to make the decisions necessary for the fulfilment of the contract. The principle of good faith, therefore, is an important cornerstone in Austrian insurance law.

Unjustified rejections of claims may lead to coverage claims against the insurer which have to be filed within one year after denial of coverage.

The insurer may set off any premium claims due or any other claim to which he or she is entitled under the policy from any coverage claims payable under the insurance policy, even if the insurer owes coverage not to the policyholder but to a third party (Article 35 lit b VersVG). The insurer may therefore set off claims against every third claimant to the same extent as the insurer would be able to offset against the policyholder if the latter claimed coverage.

For indemnity insurances, the insured's claim against a third party is by law transferred to the insurer to the extent the insurer compensates the insured's loss (Article 67 VersVG). If the insured abandons the claim for compensation against the third party or a right serving to secure it, the insurer is not obliged to indemnify insofar as he or she could have obtained compensation from the claim or the right. Against members of the policyholder's family living in the same household as the policyholder, the insurer may only take recourse if the claim for compensation is caused intentionally.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Article 11 clause 1 Regulation (EU) No. 1215/2012 sets out that an insurer domiciled in a Member State may be sued: (1) in the courts of the Member State in which he or she is domiciled; (2) in another Member State, in the case of actions brought by the policyholder, the insured or a beneficiary, in the courts for the place where the claimant is domiciled; or (3) if he or she is a co-insurer, in the courts of a Member State in which proceedings are brought against the leading insurer.

Disputes arising out of insurance matters are subject to ordinary jurisdiction (Section 1 Austrian Jurisdiction Standard (JN)). In the case of a dispute between a consumer and an insurer as entrepreneur, the Austrian district courts have jurisdiction as to the substance of the matter up to an amount in dispute of €15,000; above that amount, the Austrian regional courts have jurisdiction (Sections 49 and 50 JN). The local jurisdiction is based on the defendant's domicile or seat (Sections 65 and 66 JN). Disputes arising from business-related transactions belong to the independent commercial courts, if the subject of the dispute exceeds the amount of €15,000 in money or monetary value, if the claim is directed against an entrepreneur registered in the Commercial Register and the transaction on the side of the defendant is a business-related transaction (Section 51 JN).

If an insurance agent mediated or concluded the contract, Section 48 VersVG sets out that the court in whose district the insurance agent had his or her place of business or residence at the time of mediation or conclusion of the contract is competent for actions against the insurer arising from the insurance relationship.

An agreement of domestic jurisdiction according to Section 104 Paragraph 1 JN is only effective for disputes that have already arisen; the absence of domestic jurisdiction, however, heals according to Section 104 Paragraph 3 JN.

Arbitration clauses are only used in marine insurance and reinsurance contracts.

Alternative dispute resolution, especially mediation, is just starting to develop in Austria and usually on an ad hoc basis.

ii Litigation

In the event that an insurance intermediary was involved in the conclusion of an insurance contract, the court in the district in which the intermediary had his or her commercial branch office or (in the absence thereof) his or her residence at the time of the conclusion of the contract is competent for disputes arising from the insurance relationship (Section 48 VersVG). In all other cases, the general rule of Austrian law applies, according to which the court in district in which the defendant has his or her residence or seat is competent.

District courts have jurisdiction for claims of up to €15,000. Regional courts are competent for higher amounts in dispute.

In general, the Austrian civil procedure system provides a three-tier litigation structure with two levels of appeal. After the court of first instance (i.e., either a district or regional court) has decided, an appeal against the judgment may be lodged either to the regional court (against the district court decision) or the higher regional court (against regional court decisions). The court of last resort is the Austrian Supreme Court. According to Section 502 of the Austrian Code of Civil Procedure, an appeal against the judgment of the court of appeal is only admissible if the judgment depends on the resolution of a question that is of considerable importance for maintaining legal unity, legal certainty or legal development, for example because the court of appeal departs from the case law of the Supreme Court or because such case law is absent or inconsistent. The admissibility of an appeal to the Supreme Court also depends on the amount in dispute; claims below €5,000 are generally (apart from some exceptions) not admissible.

Evidence is taken by the court of first instance. The main rule in Austrian civil procedure law is that each party bears the burden of proof regarding the applicability of the legal provisions most favourable for them. While the Austrian Code of Civil Procedure does not limit the means of evidence, the most common ones are: documents, witness statement, party examination and expert opinions.

The decision on costs is rendered together with the decision on the merits. In general, the Austrian Code of Civil Procedure provides that the losing party has to reimburse the winning party for all costs. The costs are calculated according to the tariffs set out in the Attorney Tariffs Act and can be lower than the fees agreed upon between the attorney and the client. Austrian law prohibits contingent fees in form of *quota litis* agreements.

iii Arbitration

The Austrian Arbitration Law Reform Act 2006, which came into force on 1 July 2006, supported Austria in becoming an even more arbitration-friendly jurisdiction. However, regarding insurance-related matters, arbitration is still no real alternative to civil litigation as it is not applicable for consumer business. Arbitration clauses are only used in commercial and industrial insurances policies and in reinsurance policies between insurance carriers. The same applies to mediation.

iv Alternative dispute resolution

With the Alternative Dispute Resolution Act (AStG), the Austrian legislature has transposed the Alternative Dispute Resolution Directive (ADR Directive, RL 2013/11/EU) as well as certain aspects of the Regulation on Online Settlement of Consumer disputes (ODR Regulation, VO (EU) 524/2013) into national law.

Pursuant to Article 1 Paragraph 1, the AStG is applicable to ‘proceedings for the alternative settlement of disputes concerning contractual obligations arising from sales or service contracts between a company established in Austria and a consumer resident in Austria or elsewhere in the European Union . . . before the bodies for alternative dispute resolution’.

Article 4(1) lists the competent ADR centres. These are all external bodies that do not deal with complaints (expressions of dissatisfaction) from policyholders but are intended to arbitrate disputes that have already arisen.

Insurers are subject to extensive information obligations regarding alternative dispute resolution. These information obligations are regulated in Article 19 AStG. Pursuant to Article 19 AStG, insurers are subject to general information duties and, in certain cases, special information duties.

Pursuant to the general information duties, insurers must inform the policyholders in a clear, comprehensible and easily accessible manner, on the company’s website (if available) and, where appropriate, in the general conditions or (if there are neither websites nor terms and conditions) in brochures, leaflets or contractual documents on the relevant ADR units and their websites, if the company is obliged (or has undertaken) to use the relevant ADR methods to resolve disputes with consumers.

Additionally, in the case of online contracts, the information must be published pursuant to the ODR Regulation.

Pursuant to the special information duties, and in addition to the general information duties, the insurer must inform the policyholders (or beneficiaries) each time a dispute arises resulting from a policyholder’s complaint that has not been acted upon by the entity, in written form, in German (or in another language at request of the policyholder), on paper or another durable medium, about the relevant ADR methods and their websites, provided that the company is obliged (or has undertaken) to use the relevant ADR methods to resolve disputes with consumers, and whether the company will participate in the proceedings. (In the case of life insurance, this also applies to complaints by beneficiaries.)

V YEAR IN REVIEW

The Austrian legislature was quite active in 2019 regarding the insurance industry. One of the most important legal innovations was Regulation BGBl II No. 162/2019, which introduced rules of professional conduct for insurance mediation, which are intended to implement the EU Insurance Distribution Directive.

The following two decisions were particularly notable:

- a ECJ C-355/18 *Rust Hackner*, originating from Austrian cases, will be relevant for all insurance policies in the EEA. The ECJ answered five questions regarding cancellation of life insurance contracts as follows:
 - The period for exercising a cancellation right cannot begin to run if the policyholder has not received any information about its existence.

- Only incorrect information that deprives the policyholder of the possibility of exercising the cancellation right under substantially the same conditions as if the information was correct leads to an indefinite period to exercise the cancellation. That is for the national court to determine.
 - Cancellation is also permissible after surrendering the contract.
 - The claim from a cancellation may not generally be limited to what the beneficiary would receive in the case of an ordinary termination of the policy (i.e., the surrender value).
 - National legislatures may provide for limitation of the claim for interest from the cancellation if this does not affect the validity of the policyholder's cancellation right.
- b* In connection with the obligation for insurers to retain and hand over documents of insurance contracts, Austrian Supreme Court Case No. 7 Ob 221/17a ruled that the ancillary service claim according to Section 3 VersVG exists at any time until no more claims can be asserted from the insurance contract. Therefore, the insurer must fulfil its obligation to provide ancillary benefits in good faith in accordance with Section 3 VersVG in the event of a known unclear legal situation at least until clarity is created by law or case law, or both. The insurer must enable the policyholder to maintain their own legal position, for which knowledge of the documents mentioned in Section 3 VersVG may be a prerequisite. This is the case, for example, with late cancellation in the life insurance sector.

VI OUTLOOK AND CONCLUSIONS

The developing covid-19 pandemic will certainly be the main issue for insurers in 2020: maintaining services in times of restricted access to public areas, working from home and still selling products are key challenges. This and other pandemic-related questions (e.g., lack of cover in business interruption policies and legal cost insurance) will unfortunately, but still most likely, overshadow all other ongoing developments.

BRAZIL

*Bruno Balduccini, Diógenes Gonçalves, Carlos Eduardo Azevedo and Mariana Magalhães Lobato*¹

I INTRODUCTION

The Brazilian insurance market is the largest insurance market in Latin America, and one of the largest insurance markets in the world. It has 124 general insurance companies (life and non-life), 134 reinsurance companies, 1,210 healthcare operators, 13 entities operating open-ended private pension funds, and over 93,000 insurance and reinsurance brokers.² These companies include globally operating all liners to locally based providers of tailor-made solutions.

In 2019, Brazilian insurers had a turnover of approximately 76 billion reais in non-life insurance, 172.3 billion reais in life insurance and 23.9 billion reais in capitalisation bonds, totalling 272.2 billion reais. In relation to the healthcare sector, in 2018, the turnover was approximately 181.7 billion reais. The healthcare and insurance sectors correspond to approximately 6.5 per cent of the total Brazilian gross domestic product.² Although insurance penetration is still very low, it is expected to increase with the expansion of economic activity.

II REGULATION

i Financial regulation

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

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

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

1 Bruno Balduccini and Diógenes Gonçalves are partners, Carlos Eduardo Azevedo is a senior associate and Mariana Magalhães Lobato is an associate at Pinheiro Neto Advogados.

2 Estatísticas do Mercado Segurador (2019), available at <http://cnseg.org.br/cnseg/estatisticas/mercado/>.

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

ii Insurance regulators

Authority for the oversight and regulation of the Brazilian insurance market is even more fragmented:

- a CNSP and SUSEP regulate the National Private Insurance System (SNSP), which comprises insurance and reinsurance companies, entities operating open-ended private pension funds, capitalisation companies, and insurance and reinsurance brokers;³
- b CNPC, together with PREVIC, regulates and oversees entities operating private closed pension funds; and
- c the National Regulatory Agency for Private Health Insurance and Plans (ANS) regulates the health insurance and healthcare industries.

CNSP and SUSEP

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

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

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

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

- a executing CNSP policies by inspecting the incorporation, organisation, functioning and operation of insurance and reinsurance companies, capitalisation companies and entities operating open-end private pension funds;
- b ensuring that the entities within those markets are liquid and solvent; and
- c protecting the rights of the insured persons.

3 Please refer to our comments regarding intermediaries and the role of the broker in Section II.ix.

Although this chapter focuses on insurance companies, which carry out life and non-life insurance activities, regulated by CNSP and SUSEP, below is a summary of the roles of the other governmental authorities that regulate other products of the Brazilian insurance industry (e.g., closed-end pension funds and health insurance).

CNPC and PREVIC

CNPC regulates complementary pension funds operated by entities managing closed-end pension funds. CNPC is composed of (1) the Social Security Minister (who acts as CNPC's chairperson) and representatives of (2) PREVIC, the Special Secretariat for Pension Policies under the Chief of Staff at Ministerial Level, (3) the Ministry of Economy, as well as (4) delegates from pension funds, pension fund sponsors and pension fund beneficiaries. PREVIC is a governmental agency under the Ministry of Social Security, responsible for supervising and inspecting closed-end complementary pension entities (pension funds) and for executing the policies set for complementary pensions. The Brazilian government has made public its intention to merge PREVIC and SUSEP, which would create a single supervisory entity for insurance and pension funds. Although such merger is still under discussion, no concrete actions towards such unification have been taken so far.

ANS

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

iii Offer of insurance by foreign entities

Brazilian laws and regulations provide the following insurance should be exclusively contracted in Brazil: (1) mandatory insurance; and (2) non-mandatory insurance related to risks in Brazil taken out by individuals resident in Brazil or by legal entities (of any kind) domiciled in the Brazilian territory. In other words, as a rule, only local accredited insurance companies can underwrite this type of risk in Brazil. This does not mean that foreign insurers cannot underwrite local risks for Brazilian residents and legal entities headquartered in Brazil through policies issued abroad, but this practice is restricted to a narrow list of circumstances (e.g., whenever there is no local insurer interested in underwriting the local risks, or whenever foreign corporations may take out worldwide coverage abroad, including Brazil, but this coverage is not provoked, requested, funded or caused by the Brazilian insured).

Companies underwriting insurance in Brazil without authorisation or in cases not under the exceptions above, or both, are subject to fines of up to 3 million reais and their shareholders, directors and officers could be held jointly liable for such fine and may be indicted to criminal prosecution in some cases.

iv Authorisation to operate as an insurance company

Authorisation to operate as a Brazilian insurance company is granted according to the business segment and the regions of the country where the entity seeking to do business will distribute its products. The authorisation procedure is divided into three major steps: prior approval, ratification and product approval.

A prior approval request must first be submitted to SUSEP by the entities that intend to control the insurance company. This request must be made prior to any organisational corporate act. The prior approval phase focuses on the financial and operational capacity of the shareholders in relation to the types of insurance segments that they intend to operate (life, non-life, private pension funds etc.). Together with the prior approval request, an applicant also needs to submit a business plan to SUSEP detailing the estimated projections of the insurance company's business for a time span of at least three years.

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

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

v Transactions and corporate reorganisations

Transactions (including M&As and portfolio acquisitions) and corporate reorganisations involving local entities that comprise the SNSP are, in most cases, subject to prior approval and ratification proceedings before SUSEP, depending on the characteristics of the parties involved and the project. Transactions subject to prior approval require a pre-closing procedure before SUSEP, while simplified ratification proceedings require post-closing or implementation.

vi Product regulation

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

vii Other regulatory requirements of insurance companies

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

Brazilian insurance companies are not subject to the insolvency and bankruptcy laws applicable to non-regulated entities. If an insurance company is in a dire financial situation, it will be subject to the following specific procedures originally created to target financial institutions: intervention, extrajudicial liquidation and the temporary special management regime. SUSEP is entitled to check the solvency situation of all entities accredited to do business within the SNSP and, if necessary, implement the above proceedings. This authority may also place insurance companies under a fiscal management regime,⁴ which is essentially a measure under which SUSEP allocates one of its agents to supervise all activities of the regulated entity that are not meeting the applicable solvency requirements. The supervisor agent has broad powers to conduct – jointly with the entity's management – the latter's business, and must keep SUSEP informed about all activities of said company.

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

viii 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. Brazilian insurance companies must give preference (right of first refusal) to local reinsurers to underwrite at least 40 per cent of the reinsured risks in each treaty or facultative agreement.
- b* Admitted reinsurers may be headquartered abroad, but need to have a representative office in Brazil. The representative office must be organised either as a joint-stock or limited liability company, but must have as its exclusive corporate purpose the representation of the offshore admitted reinsurer in reinsurance and retrocession transactions. There are some eligibility requirements that must be met by this type of reinsurer for purposes of accreditation, in particular the requirements to opening a local bank account and to keep, at all times, a balance of US\$5 million in such account. The representative office's management must follow the same ratification rules applicable to local insurers upon the election, appointment or replacement of its officer or director, or both.
- c* Occasional reinsurers are in many ways very similar to admitted reinsurers, the only difference being that they do not need to have a representative office in Brazil. For this reason, eligibility requirements for purposes of accreditation by SUSEP are more restrictive than those applicable to admitted reinsurers.

⁴ As provided in Decree-Law No. 73/1966 and in Decree No. 60,459/1967.

ix Intermediaries and the role of the broker

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

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

Insurance brokers are the legally authorised intermediaries for the distribution and promotion of insurance contracts, policies and plans. Insurance brokers may be individuals or companies. Traditionally, to conduct insurance brokerage activities, insurance brokers were required to be previously accredited for such by SUSEP. Recently, through Provisional Measure No. 905, issued by the Brazilian Presidency on 11 November 2019, the insurance brokers were deregulated. SUSEP, in commenting on the legislation, indicated that the industry was mature enough for autoregulation through market agents, such as IBRACOR. However, it is possible that the provisional measure will not be converted into a law before its statutory 120-day effectiveness. In such case, the Provisional Measure will no longer be in effect and brokers will again be regulated by SUSEP.

Considering that the deregulation is not definitive, it is worth mentioning that the previous accreditation entailed 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. For example, among other requirements:

- a* they must be organised in accordance with Brazilian law;
- b* they must be headquartered in Brazil;
- c* they must include the expression ‘insurance brokerage’ as part of their own corporate name;
- d* they must include insurance brokerage services as part of the activities that comprise their corporate purpose; and
- e* they must have an officer responsible for insurance brokerage who is duly registered before SUSEP as an insurance broker.

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

x Mandatory insurance

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

III INSURANCE AND REINSURANCE LAW

i Sources of law

Brazil's legal system is based on civil law; therefore, its framework is composed of numerous laws and legal codes. For this reason, the 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:

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

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

ii Making the contract

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

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

At the time of placement, the applicable law and regulations demand the exchange of certain information between the insured parties and the insurance company. The insured parties must comply with the duty of utmost good faith, disclosing all material facts and acting honestly towards the insurance companies, in such a way that the insurance company has sufficient information about the circumstances involving the risk and coverage. Should the insured party fail to provide the requested information (or omit relevant data), the insurance company may (1) increase the premium, if the omission was not in bad faith; or (2) refuse to cover any claims that would otherwise be covered under the terms and conditions of the policy issued to the insured party, if the omission was in bad faith. Brazilian courts require more than a showing of mere negligence to support a bad faith claim – as a general rule the insured party must have engaged in intentional wrongdoing.

iii Interpreting the contract

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

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

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

iv 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 from the date on which all documents requested from the insured or beneficiary for claim regulation purposes are forwarded by the latter to the insurer (SUSEP allows an insurance company to make one request for additional documents and information during the above-mentioned term, the counting of which is suspended until such additional request is met by the insured or beneficiary). Some complex claims adjustments tend to last longer – reaching six to 12 months.

IV DISPUTE RESOLUTION

i General remarks

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

ii Governing law

The basic principles of private international law were incorporated into Brazilian law by Decree-law No. 4,657 of 4 September 1942 (usually known as the Law of Introduction to the Rules of Brazilian Law). Such rule provides guidance on the effectiveness, applicability and interpretation of Brazilian law and sets forth conflict of law rules. It also provides that agreements should be governed by the law of the country they were entered, but such legal

provision does not exclude the contractual freedom of the parties to elect the law that will govern the rights and obligations under international agreements. Such contractual freedom is more limited if the dispute is subject to Brazilian courts, and the right of the parties to choose the governing law of agreements would depend on the existence of a link between chosen governing law and the underlying transaction. It is broader if the dispute is subject to arbitration, because arbitration law expressly allows parties to freely choose the governing law and rules.

iii Litigation

The Brazilian litigation system has three instances:

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

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

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

iv Arbitration

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

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

- a* it is, usually, faster than procedures in Brazilian courts;
- b* arbitrators are chosen by the parties and may be more experienced on specific technical questions (as is the case regarding insurance and reinsurance matters);
- c* parties may choose the applicable law;
- d* parties may establish that the existence of the dispute and the decision will be confidential;
- e* the procedure is more flexible; and
- f* arbitration decisions may be enforced by courts.

These characteristics make arbitration procedures more attractive than regular court procedures, especially considering that insurance matters are highly specific and complex. In

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

v Mediation

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

V YEAR IN REVIEW

In 2019, the federal government, which was elected in 2018, took office and made several changes to the administration of SUSEP and to the CNSP's members. The new administration took office with a modernising and disruptive approach. Several proposals were subject to public consultation and are currently being internally evaluated by SUSEP.

The new government has a liberal economic agenda. One of the important changes made on a federal level was the enactment of the Declaration of Economic Freedom Rights (Law No. 13,874/2019). Announced as an effort to reduce bureaucracy and regulatory interference in the development of the Brazilian economy, such law has put in place a set of principles aimed at reassuring the free market status of the country's economy.

Aligned with the new agenda and in a joint effort with the Brazilian Central Bank and the Brazilian Securities Exchange Commission, SUSEP issued, on March 2020, new regulations for a regulatory sandbox. Innovative and disruptive companies wishing to underwrite risks could obtain, through the sandbox programme, a temporary limited licence from SUSEP to issue insurance products under reduced entry barriers. The intention of the programme is to foster innovation and competition, with the ultimate goal of enhancing customer experience, increasing market penetration and reducing insurance prices. Such resolution was welcomed by the burgeoning insurtech start-ups that face high costs and strict regulation challenges associated with risk underwriting activities in Brazil. The regulations subject to public consultation were inspired by the sandbox initiatives of other countries, such as the United Kingdom's FCA initiative.

SUSEP is also pursuing a risk-based approach to its regulation. In order to reduce overwarming bureaucracy and related costs, SUSEP proposed, through the publication of a draft resolution, the segmentation of the insurance companies into four different categories: S1, S2, S3 and S4. Companies characterised as S4 are deemed to offer less risk to the market, and, therefore, are subject to reduced capital and prudential requirements. Such requirements gradually become stricter as the company grows and moves to the higher segments. Consistent with other initiatives, SUSEP is seeking to promote the competition through the admission of new players.

Furthermore, aiming to enhance its supervision abilities and integrate the insurance market in an electronic platform, SUSEP published draft rules for public consultation regarding the mandatory registration of reinsurance, insurance, capitalisation and open-ended pension funds transactions. Such a rule is commonly referred to as the ‘electronic policy’ within the market and, if in place, will require supervised companies to register relevant information regarding its transactions for easy access by SUSEP. The initial draft rules submitted for public consultation provided for a variety of features and uses, making the system available to other governmental authorities, market players and the consumers. However, six months after the first public consultation in May 2019, SUSEP published new draft rules that were much more focused on the use of the registration system as a supervising tool rather than a market integrator. Finally, in March 2020, CNSP published the first definitive resolution for determining the registration of the transactions, which mostly follows the second draft published.

Supervised companies will need to comply with a schedule for registering new and existing policies into the system. Considering the drafts published for public consultation, the first products to be mandatorily registered are insurance bonds. However, additional rules by SUSEP detailing the resolution published in March will establish the deadlines and other criteria for making the registry mandatory.

In addition, SUSEP enacted a new regulation allowing insurance companies to issue intermittent risk insurance policies and insurance policies with a small term of effectiveness, calculated by trips, months, days, hours or even minutes. This regulation was well received by the market, and creates new opportunities for several products, including micro-insurance, travel, residential and auto.

VI OUTLOOK AND CONCLUSIONS

The current government seems to be delivering on its promise of a more liberal economy, which will foster efficiency and competition. Considering the large number of important regulations published for public consultation in 2019, 2020 will be an exciting year for the Brazilian insurance market, with the enactment of new regulations designed to foster competition and reduce entry barriers, enabling new opportunities to arise.

In 2019, the government managed to approve the reform of the public pension system, an important step towards promoting financial stability. This reform, combined with other ongoing measures, is expected to increase foreign investors’ confidence and help in the recovery and development of the Brazilian economy, and the insurance market, in the next few years.

BULGARIA

*Irina Stoeva*¹

I INTRODUCTION

The Bulgarian insurance market is underpenetrated, as compared to the European market. Low household incomes result in the dominance of compulsory insurance. In 2018 gross written premiums amounted to €1.3 billion and non-life insurance accounted for 84 per cent of this amount. The motor insurance share in total non-life insurance premiums was 75 per cent (45 per cent of that share was attributed to compulsory motor third-party liability insurance (MTPL) and 30 per cent to vehicles insurance). Insurance premiums per capita spent in 2018 in Bulgaria (as compared to the respective European average (EA)) in the following sectors were approximately: MTPL €110 (EA: €240); property insurance €20 (EA: €180); and life insurance €25 (EA: €1,260). These figures are not expected to have materially changed in 2019.²

The major act regulating insurance and reinsurance activity in Bulgaria is the Insurance Code 2015 (IC). The IC implements the new Solvency II prudential framework and risk-based supervisory approach.³ Insurers with a smaller volume of activities may opt for less stringent regulation on financial condition; however, such insurers will be restricted in their provision of services on the common market on the grounds of the right of establishment and freedom to provide services.

II REGULATION

i The insurance regulator

The Financial Supervision Commission (FSC) is the Bulgarian authority that is responsible for the regulation and supervision of insurance and reinsurance activity, as well as for capital markets and pension funds.

ii Requirements for authorisation

To operate as an insurer or reinsurer, a Bulgarian entity must be granted a licence by the FSC. An insurance licence is issued either for life insurance or for general insurance only (principle of business separation), and it lists the specific classes of business that the entity is

1 Irina Stoeva is a managing partner at Stoeva Tchompalov & Znepolski.

2 2018 Annual report of the FSC; Insurance Europe: European Insurance – key facts (September 2019).

3 Directive 2009/138/EC on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II).

authorised to underwrite. Additional licences can be granted for extension of the initial scope of activity over new classes of business. A reinsurance licence may be issued for reinsurance of life insurance or general business insurance, or both.

An insurance or reinsurance licence may be granted by the FSC, if the authority is satisfied about the sufficiency and suitability of the technical and financial resources of the applicant, the integrity, expertise and experience of the applicant's directors and senior management, and of the transparency and reliability of its shareholders.

An insurer or reinsurer based in another EEA Member State may, under the single licence principle, carry out business in Bulgaria either under the right of establishment or under the freedom to provide services without having to obtain a licence from the FSC. Such an operation is limited to the scope of services defined by the licence held by the insurer or reinsurer.

An insurer or reinsurer based in a non-EEA Member State may carry out business in Bulgaria subject to setting up a branch and obtaining a licence from the FSC. Such a licence can be issued only for the class of business for which the insurer or reinsurer is authorised by its existing licence.

A person who has not obtained a licence for insurance operations shall not have the right to pursue any activity as insurer or reinsurer in Bulgaria.

iii The distribution of products

The Insurance Distribution Directive (IDD) was transposed in Bulgarian law through amendments to the IC, which became effective on 7 December 2018. In principle, Bulgarian lawmakers have kept as close to the IDD original language as possible. Bulgaria has decided not to apply the discretion to make the provision of advice mandatory for the sales of insurance-based investment products (IBIPs), but the lawmakers have implemented the derogation that permits Bulgaria to allow execution-only sales (i.e., no advice and without an appropriateness assessment) in relation to IBIPs in limited circumstances. Bulgaria has refrained from the possibility of also limiting or prohibiting the acceptance or receipt of third-party inducements in relation to the provision of advice for IBIPs. Further, Bulgaria has not implemented the IDD discretion to provide for criminal sanctions for breach of the IDD, in addition to administrative sanctions.

While Member States are required to adopt at least one measure for protection of the client's monies, Bulgaria has implemented three of all four measures provided by the IDD: monies paid by the customer to the intermediary are treated by law as having been paid to the insurer, whereas monies paid by the insurer to the intermediary are not treated as having been paid to the customer until the customer actually receives them; intermediaries may decide to transfer the customer's monies via strictly segregated customer accounts (the funds therein not used to satisfy other creditors in the event of bankruptcy) or, alternatively, to maintain a permanent financial capacity amounting to 4 per cent of the sum of annual premiums received, but not less than approximately €20,400; the IC has introduced payment deadlines for intermediaries and, in certain cases, requirement for notary authorisation of intermediaries by their clients.

iv Compulsory insurance

Compulsory insurance, in particular MTPL, is the main driver behind the Bulgarian market. According to data announced by the FSC, as of the end of March 2019, the gross written premium income for MTPL insurance accounted for 45 per cent of the insurance premium of non-life insurance; furthermore, the value of the paid MTPL claims amounts to 51 per cent of the whole non-life insurance paid claims.

The category of compulsory insurance products is large and it comprises, among others, various types of professional liability insurance (for physicians, dentists, solicitors, public notaries, auditors, constructors, insurance brokers and other occupations) and accident insurance (for public transport vehicle passengers, employees, magistrates and civil servants).

An insurer who carries out compulsory insurance on Bulgarian territory must sign a contract with each client who requests to purchase compulsory insurance. An insurer offering compulsory insurance against occupational accident under the conditions of the right of establishment, or of the freedom to provide services, shall be obligated to designate the Bulgarian legislation as the applicable law to the insurance contract.

v Compensation

The National Bureau of Bulgarian Motor Vehicle Insurers (an NGO of the insurers offering MTPL in Bulgaria), is required, under the conditions laid down in the IC, to pay indemnity to a damaged party in Bulgaria when:

- a* the insurer of the guilty driver (or its claims settlement representative in Bulgaria) has not given a reasoned reply to the damaged party's claim within a three-month period;
- b* the insurer of the guilty driver has not appointed a representative for settlement of claims in Bulgaria;
- c* the guilty driver's motor vehicle is typically in a Member State other than Bulgaria; or
- d* the insurer of the guilty driver cannot be identified within two months of the insured event in a Member States other than Bulgaria.

A Guarantee Fund is established pursuant to the IC as a special purpose legal entity to implement the following main functions, among others:

- a* to pay the damages inflicted by an unidentified motor vehicle or the guilty driver does not have valid MTPL, or when there is no compulsory accident insurance of the passengers;
- b* to guarantee the receivables of the damaged persons for the liability associated with motor vehicles located in Bulgaria, in case of bankruptcy of Bulgarian insurers (and third country insurers with a registered branch in Bulgaria) offering compulsory MTPL and compulsory accident insurance of passengers;
- c* to guarantee the receivables under life insurances in case of bankruptcy of Bulgarian life insurers (and third country insurers with a registered branch in Bulgaria); and
- d* to carry out insolvency administrator's functions in connection with the bankruptcy of an insurer.

vi Taxation of premiums

Insurers, including from EU and third countries, are subject to 2 per cent premium tax for policies covering risks in Bulgaria. Policies exempt from taxation include (without limitation) life insurance, permanent health, aircraft and vessels insurance, and reinsurance.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Bulgarian insurance law, which is generally harmonised with the EU legislation, is primarily set out in the IC; however, other statutes also regulate specific insurance matters (e.g., marine insurance is regulated by the Merchants Shipping Code). Detailed regulatory requirements are established by ordinances issued primarily by the FSC.

The IC also contains provisions addressed to the activity and supervision of reinsurers and reinsurance intermediaries (including, without limitation, licensing and ongoing financial, organisational and qualification requirements, insolvency and liquidation rules). However, the IC does not apply expressly to reinsurance contracts, which are concluded under the freedom of contract principle and typically in accordance with international practice.

Though Bulgaria has a continental statutory based legal system, case law – more specifically, the Supreme Court of Cassation judgments – is important because normally it is strictly adhered to by the lower courts and regulators.

ii Making the contract

Similar to other contracts, an insurance contract becomes legally binding once the contract offer has been accepted. Normally the insured makes the offer to the insurer requesting an insurance cover for certain risks, usually by completing the insurer's form (such as a questionnaire or proposal). In addition, the IC lays down obligations for insurers to make certain disclosures to the insured prior to the conclusion of the insurance contract, such as complaint procedure and supervisory authority, as well as other IDD related disclosures and documents (see subsection iv below).

According to the IC, an insurance contract must be concluded in writing as a hard copy or as an electronic document, signed by qualified electronic signatures within the meaning of Electronic Signatures Regulation (EU) 910/2014 and the Bulgarian Electronic Document and Electronic Trust Services Act. In addition, MTPL may be concluded on the internet page of an insurer or insurance intermediary even without the signature of the insured, if he or she has paid the insurance premium or part of it on that same internet page using a credit or debit card issued in the name of the insured.

The IC requires the insurance contract to stipulate clearly, unambiguously and exhaustively:

- a* the risks covered and the exclusions to coverage;
- b* the conditions for payment of premiums by the insured and the consequences of non-payment or inaccurate payment;
- c* the insurer's liabilities, payment term, and the manner of specifying the amounts of payments;
- d* the obligations upon occurrence of an insured event and its establishment;
- e* the circumstances relating to amendments to the insurance legal relationship; and

- f the terms and the amount of any preliminary payments or borrowings against life insurance policies and their redemption.

The general terms of the insurer, as accepted by the insured, shall form an integral part of the insurance contract. Any amendments to or substitution of the general terms shall be in effect only in cases where these have been approved by the insured in writing.

Prior to the conclusion of a contract, the insured (in person or acting by proxy and also through an insurance broker) is obliged to disclose fully and exhaustively to the insurer, pursuant to a questionnaire or a proposal form provided by the latter, all the information the insured is aware of that may be relevant for the evaluation of the risk. The IC provides that only the information the insurer has asked about in writing shall be deemed to be substantial. The insured is also under an obligation to declare immediately to the insurer any new and relevant information that has become known after the conclusion of the contract.

The written proposal or request addressed to the insurer, concerning the conclusion of an insurance contract, and the written replies of the insured to insurer's questions, with regard to the nature and amount of risk assessment, are deemed to be an integral part of the insurance contract.

The whole premium or the first instalment thereof shall be paid upon conclusion of the insurance contract, unless provided otherwise in the law or in the contract. Significant increase or decrease of the insurance risk during the term of the contract would entitle each party to request the increase or decrease of the premium, or termination of the contract.

Misrepresentation and concealment

If the insured, or his or her representative, has consciously given an incorrect statement ('misrepresentation') or withheld information about their circumstances ('concealment') (or is aware of such misrepresentation or concealment), which, if known by the insurer, would have led to a refusal to enter into the contract, the insurer may demand amendment or termination of the contract within one month of learning about the misrepresentation or concealment. If the insured does not accept the proposed amendments within two weeks of receipt thereof, the contract shall be terminated. The insurer is entitled to retain the paid share of premium or to demand payment of premium for the period until the contract termination, or both. If an insurance claim is made in a case of misrepresentation or concealment, the insurer can only fully or partially refuse to pay the insurance indemnity if the inaccurately stated or withheld information has affected the claim. Where such details have only resulted in an increase in the amount of damages, the insurer cannot refuse payment, but may be able to reduce the payment to the proportion of the amount of the premium paid for the initial premium, which is to be paid according to the actual insurance risk.

In the event of unconscious misrepresentation or concealment, both the insurer and the insured are entitled to propose an amendment of the insurance contract within two weeks of learning about the misrepresentation or concealment. If the other party does not accept the proposal within two weeks of its receipt, the proposing party is entitled to terminate the contract, and return the proportion of the premium collected for the remaining term of the agreement. If, prior to the termination of the contract, an insurance claim is made, the insurer cannot refuse payment; however, the payment can be reduced in proportion to the amount of the premium paid for the initial premium, which is to be paid according to the actual insurance risk.

A non-reply or unclear reply to an insurer's question, where no concealment of substantial information has occurred, cannot constitute a ground for unilateral termination or amendment of the insurance contract, or for refusing payment on a claim.

iii Interpreting the contract

Bulgarian legal agreements (including insurance policies) should be interpreted according to their wording, and the actual mutual will of the parties shall be sought. Each individual clause shall be interpreted in conjunction with the others and shall be construed in the exact sense that is manifested in the entire agreement, in terms of the aim of the agreement, the established customs and according to the principle of good faith.

Bulgarian law does not contain a rule that the ambiguous word or phrase will be resolved against the party that has drafted or proposed the contract; however, there is a principle that rights under the agreement may not be exercised with the aim of damaging the counterparty.

Where the insured is a consumer under the Consumer Protection Act (i.e., a natural person who enters into an agreement outside the scope of his or her professional activities), consumer protection regulations would also apply regarding unfair trade practices and contractual provisions establishing disparity between the parties.

iv Intermediaries and the role of the broker

The main categories of insurance intermediaries in Bulgaria are brokers and agents, both registered with the FSC.⁴ These intermediaries play key roles in generating business for insurers. Insurance and reinsurance brokers are wholly independent intermediaries between purchasers of insurance and reinsurance, on the one side, and insurers and reinsurers, on the other. Though brokers' remuneration is included in the insurance premium and is, therefore, paid by the insurer, brokers act for the insured and their typical role is to provide clients with objective insurance information (and sometimes with advice), to obtain quotes from various insurers and guide their clients in determining the adequate policy from the range of products. In practice, with respect to certain technical functions, brokers may also act on behalf of the insurer (e.g., collection of insurance premiums).

In contrast, an insurance agent acts on behalf of one or several insurers according to a written contract for the insurance agency. Insurance agents shall be obligated to notify the consumer about the insurers and the insurance products they are authorised to provide.

The IC presents the general principle that insurance distributors (insurers and insurance intermediaries) must always act honestly, fairly and professionally in accordance with the best interests of their clients and contains a number of specific conduct rules, which generally mirror those in the IDD framework (including demand and needs test, advice, appropriateness and suitability) and specific obligations regarding the provision to the client of a standardised product information document and other pre-contractual disclosure (nature and basis of remuneration, whether the distributor provides advice or not, conflict of interest related information).

⁴ The IC also regulates (1) ancillary insurance intermediaries (as defined in the IDD), which are subject to registration with the FSC; and (2) unregistered ancillary insurance intermediaries, whose distribution activity meets the conditions under Article 1(3) of the IDD; the latter are subject to some of the conduct rules applicable to the registered intermediaries.

In Bulgaria reinsurance brokers are typically local subsidiaries of large international brokers that usually act on behalf of the cedent.

v Claims

The IC mandates that insurance claims shall be filed first with the insurer (and not with the court). In general, the insurer is obligated to respond to an insurance claim (other than to a claim under big risk insurance policies), within 15 business days of the submission of all evidence by the insured, as instructed by the insurer, either by assessing and paying the claim, or by issuing a reasoned refusal to make payment. In any case, the insurer is required to respond to the claimant not later than six months, and in relation to MTPL claims – not later than three months, from the date of filing the respective claim.

When the insurer has asked questions in the process of finalising the insurance contract, the insurer cannot refuse to make payment on a claim on the basis of circumstances existing prior to the date of the insurance contract, which has not been asked by the insurer in writing. In addition, if the insurer has concluded a contract, regardless of the fact that the insurer's questions have been answered unclearly or have not been answered at all, the insurer is not allowed for either of these reasons to terminate unilaterally the insurance contract, to refuse or to reduce the amount of the payment on a claim (see also 'Misrepresentation and concealment' in subsection ii above).

Upon occurrence of an insured event, the IC obligates the insured to pay maximum efforts for mitigation of the damages and to comply with the insurer's instructions; otherwise the insurer may reduce the indemnity. In case of reinsurance, the claims procedure will depend on what the parties have agreed upon.

Notification

Notices on occurrence of an insured event or of circumstances that may give rise to a claim (under liability policy) would typically be provided in writing to the insurer within a term set forth in the policy. The documents evidencing the occurrence of the event and the amount of the damage might be provided at a later stage. It is common practice under motor vehicle insurance policies for the insurers to require a telephone call first, in addition to a written notice. Under travel assistance policies, the insurers typically require telephone notice.

The insured under property insurance must notify the insurer of damage to the property within seven days as of the date of becoming aware thereof, or within another, contractually set, time limit. However, this limit may not be shorter than three days. For 'theft' and 'burglary' offences the limit is 24 hours as of the date the insured becomes aware of the crime. Under general liability policies, notice shall be provided within seven days as of the date on which either the insured performed payment to the third party or the insured became aware of the circumstances, which may result in its liability, or claims are initiated against the insured.

In case of late notice, the insurer may deny coverage on the grounds of late notification of the damage to the property under property and general liability insurances only if:

- a* the insured intended thereby to prevent the insurer from revealing the circumstances related to the damaged property; or
- b* the late notification made the identification of the circumstances impossible; this exception may not be made by a general liability insurer who is defending a direct claim by the damaged third party.

Under the MTPL insurance, the insurer may not reduce the compensation due to a damaged third party on the grounds of non-disclosed information existing upon execution of the contract, or recent changes in the insured's circumstances.

The insured's failure to notify the insurer of any recent changes in his or her circumstances, for which the insurer posed a question in the proposal form, shall have the consequences as per misrepresentation or concealment of information. A notice to the insurer must be given immediately once the insured becomes aware of a change in circumstances.

Where the insured has failed to notify a change in address stated in the insurance contract, all notices sent to the initially declared address by the insurer shall be deemed validly received by the insured and shall have the prescribed statutory or contractual effect.

If the insurer fails to pay the due compensation or sum within the terms set forth in the insurance policy or by IC, the general legal interest rate for default payment of monetary debts will apply. However, Bulgarian law does not recognise punitive damages as under the Bulgarian legal doctrine the function of civil liability is limited to repairing or compensating damages.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Bulgaria is an EU Member State and, therefore, EU law takes precedence over domestic rules.

International insurance disputes, which are out of the scope of Regulation (EU) 1215/2012 on jurisdiction and enforcement of judgments (Brussels Ia), are governed by the Bulgarian Private International Code (BPIC). The latter requires the Bulgarian court to examine *ex officio* whether it has jurisdiction over the claim brought before it; however, the Bulgarian court will most likely have jurisdiction for all insurance disputes with an international link (regardless of the nature of that link), unless the dispute has no connection with Bulgaria at all or if there is a choice-of-court clause in favour of a foreign court.

Similarly, the BPIC applies to international insurance disputes falling out of the scope of Regulation (EC) 593/2008 on the law applicable to contractual obligations (Rome I), or Regulation (EC) 864/2007 on the governing law of non-contractual obligations (Rome II). The BPIC provides that contracts shall be governed by the law chosen by the parties; nevertheless, where all the elements of a contract at the time of choice are connected with one state only, the choice of a foreign law must not prejudice the application of the mandatory rules of the said state, from which it cannot contractually be derogated. In the absence of a choice-of-law clause, the law of the state most closely connected with the contract will apply, that is, the law of the state where the insurer, as the party with the characteristic performance, has its seat.

According to the BPIC, the obligations arising out of a tort (delict) shall be governed by the law of the state within whose territory the direct damage arises or is likely to arise. The same applicable law shall govern the right of direct action by the injured person against the insurer of the person claimed to be liable, unless the injured person prefers to base his or her claim on the law applicable to the insurance contract.

ii Litigation

Regional courts are competent to hear all insurance disputes at first instance, where the claim does not exceed approximately €12,500; if the claim exceeds this sum, district courts are competent to hear the dispute in first-instance courts.

Decisions of the first-instance courts may be appealed before the district courts or the appellate courts, respectively. The appellate court *ex officio* reviews the validity of the first-instance decision in its entirety and its admissibility with regard to the part appealed.

To take into account the correctness of the decision (that is, correct establishment of relevant facts, correct application of substantive and procedural law), the court of appeal is limited to the complaints raised in the appeal. Within these limits, the court of appeal considers the facts and the law. As an exception, the court of appeal may *ex officio* apply mandatory substantive legal rules.⁵

Parties dissatisfied with the outcome of the first level appeal may further appeal the appellate decision before the Supreme Court of Cassation (SCC).

Cassation appeal is subject to two limitations. First, the case meets the formal criteria for minimum monetary evaluation of the claim. Second, cassation appeal, even if admissible, is discretionary. The SCC is entitled to select the cassation appeals that it will hear and resolve, applying criteria provided under the Civil Procedure Code (CPC), including, *inter alia*, where the second-instance decision deviates from compulsory precedents or interpretative decisions of the SCC, or contradicts to acts of the Bulgarian Constitutional Court or of the Court of Justice of the EU. Regarding cassation appeals submitted after 31 October 2017, the SCC shall admit cassation appeals if it finds that the second instance decision is likely invalid or inadmissible, or is clearly incorrect.

The SCC is typically a court on correct application of law. It is also competent to establish, on the basis of the evidence already gathered, a factual background different from the one described in the appellate decision.

Revocation of a final and binding decision of either a state court (or an arbitration tribunal) may be sought only on limited grounds and within compulsory statutorily determined time frames.

Evidence

Parties may present or request from the first-instance court collection of written documents, material objects or expert witness statements, interrogation of witnesses (written evidence from witnesses is not permitted), etc.

In general, the evidentiary record is limited to the one before the trial court. As an exception, parties may indicate newly discovered facts and new evidence before the court of appeal subject to conditions set out in the CPC. Parties may also require the gathering of new evidence by the court of appeal that was not admitted by the trial court because of incorrect interpretation of procedural law.

Costs

The losing party in the court decision reimburses the winning party's costs (for example, state and legal fees, costs incurred for translation and the gathering of evidence). If the claim is only partially awarded, then the reimbursement of the legal costs will also be partially

⁵ Interpretative Decision No. 1/2013 dated 9 December 2013, issued by the Supreme Court of Cassation on Interpretative Case No. 1/2013.

recognised. The courts normally reimburse legal fees in the minimum amount set forth by an ordinance adopted by the national bar association, regardless of the actual fees stipulated with the client. No legal aid exists in Bulgaria.

iii Arbitration

Insurance disputes may also be litigated in arbitration proceedings (either arbitration institutions or ad hoc arbitration, on the grounds of an arbitration agreement), but the prevailing practice in the last 10 years indicates that the insurers abstain from arbitration proceedings.

iv Alternative dispute resolution

In accordance with the Bulgarian Consumer Protection Act and to promote the development of alternative dispute resolution (ADR), in 2015 the Minister of Economy established Sectoral Insurance Conciliation Commission to hear insurance disputes. However, conciliation is not compulsory and is rarely used in practice.

v Mediation

Bulgarian law covers mediation in a separate statute, which transposes Directive 2008/52/EC on certain aspects of mediation in civil and commercial disputes into Bulgarian law. However, parties do not generally resort to mediation despite the courts typically requesting that parties do so.

V YEAR IN REVIEW

In contrast to 2018, where the focus was on the GDPR, 2019 was a particularly challenging year for the insurance industry with respect to the implementation of the Bulgarian law and regulations transposing the IDD and the Fourth Anti-Money Laundering Directive.

The compulsory liquidation of the Cypriot Olympic Insurance Company (Olympic), whose main business was actually in Bulgaria and whose bankruptcy in 2018 left nearly 197,000 Bulgarians with terminated MTPL policies, was opened in August 2019.

After the withdrawal of the much-criticised draft legislative amendments related to the introduction of a *bonus-malus* system in Bulgaria in 2018, an updated draft was published in November 2019 for public consultation. The new *bonus-malus* proposal faced significant obstructions from the industry and was also withdrawn by the inter-ministerial working group for further revisions.

VI OUTLOOK AND CONCLUSIONS

The insurance industry is anticipating important regulatory amendments: first, the next *bonus-malus* draft (see Section V) and, second, the draft methodology for determining the amount of indemnities for material and non-material damages resulting from physical injury and death of an injured person (to be adopted by the FSC jointly with the health and labour ministers).

The adjustment process for the new IDD/AML regulatory framework will continue throughout 2020. It is expected that the FSC will start checking insurers' and intermediaries' compliance with these rules and, most likely, regulatory acts and case law will follow in connection with the new requirements' implementation.

Tens of thousands of Bulgarians, formerly insured by Olympic, are hoping to receive at least partial compensation for their claims in the insurer's liquidation procedure. Taking into consideration that a main reason for the significant MTPL market share of Olympic was its substantially low MTPL prices, the FSC warning that the low insurance premiums cannot cover costs and, deducting from data announced in 2019 by the FSC, that nearly two-thirds of the MTPL gross premium income is concentrated in four Bulgarian insurers and for three of them the MTPL accounts for more than 80 per cent of their total premium income, stringent supervisory measures from the FSC are expected, which will be aimed at ensuring the financial stability of the insurance sector.

CAMBODIA

*Antoine Fontaine*¹

I INTRODUCTION

The insurance market in Cambodia is entering its sixth 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,² 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.³ 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 2014.⁴ Any references to the Law on Insurance in this chapter refer to the 2014 version.

The second stage required the government to strengthen the industry by the design of two main tools: a new law in 2000 to increase the solvency and capital requirements, and the establishment of a state-owned reinsurance company.⁵ The latter also had the purpose of retaining part of the reinsurance premium in Cambodia⁶ and to offer a local reinsurance option to the Cambodian insurers. Following this new law, two general insurance companies obtained their licences in 2007⁷ and in 2015.⁸

1 Antoine Fontaine is a founding partner at Bun & Associates.

2 First Law on Insurance dated 9 January 1964 (abrogated in 1975 by the Khmer Rouge regime).

3 Cambodian National Insurance Company, Plc (1993); Forte Insurance (Cambodia) Plc (1996); and Asia Insurance (Cambodia) Plc (1996).

4 Law on Insurance, NS/RKM/0814/021, dated 4 August 2014, which entered into force on 4 February 2015.

5 Cambodian Reinsurance Company Plc (Cambodia Re) (2002).

6 The law provided a pre-emption right on 20 per cent of the reinsurance premium for the benefit of the Cambodia Re. This privilege was aborted through the accession of Cambodia to the WTO with effect from 1 January 2009. WTO WT/ACC/KHM/21, 19 August 2003 (03-4316) especially its Addendum Part II-Schedule of Specific Commitments in Services List of Article II MFN Exemptions.

7 Infinity General Insurance.

8 People & Partners Insurance Plc.

In the third stage, banks' affiliated insurance companies entered the market from 2007 to 2009,⁹ as the fast-growing banking industry required insurance to cover the assets provided as collateral. This stage is currently reinvigorated thanks to three financial groups proposing bank, general insurance and life insurance services.¹⁰

Until 2010, the market was limited to non-life insurance businesses (i.e., general insurance and reinsurance), but continued to maintain low retention rates.

The fourth stage occurred in 2011. General insurance companies could have satisfied themselves in playing a limited role, providing standardised and limited insurance policies to the urban middle class while still getting a profit at the level of their investments.¹¹ 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' experiences¹² 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,¹³ seven others followed in quick succession from 2014 to 2017,¹⁴ which were mainly in health and life, often in partnership with microfinance institutions. The first micro-life insurers played a very strong role in promoting insurance. A micro-insurance business is sustainable only by selling products to the mass market; micro-insurers have opted to use the three best methods available to promote their insurance policies to those in Cambodia who can afford to pay a small amount of premium: by using micro-finance institutions' (MFIs') networks, selling to companies and factories, and retailing through mobile technology.

The first method consists of using the very wide MFIs' networks to propose credit-life insurance by paving the way to the bancassurance activity. This approach was fruitful, but has been recently jeopardised by a series of new regulations mainly originated from the National Bank of Cambodia.¹⁵

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

9 Campubank Lonpac Insurance Plc (2007) affiliated to Cambodia Public Bank Plc; and Cambodia – Vietnam Insurance Company Plc (2009) affiliated to the Bank for Investment and Development of Vietnam.

10 PhillipCapital Group which operates PhillipBank, Phillip General Insurance (Cambodia) Plc (2017) and just established Phillip Life Insurance Plc (2018); Canadia Investment Holding Plc operating the newly set up Dara Insurance Plc (2018), Sovannaphum Life Assurance Plc (2015) and Cambodia Post Bank, an affiliated to Canadia Bank Plc; and Maybank's affiliate, Etiqa, has obtained both life and general licences.

11 Figures are available at http://www.iac.org.kh/images/Media%20Release/Statistics/General/2017/4Q/Statistic%20for%20General%20Industry%20in%204Q17_Press.pdf.

12 Mainly the GRET, through its SKY project (Sokopheap Krousar Yeung).

13 Prévoir (Kampuchea) Micro Life Insurance Plc (PKMI) (2011). In 2019, PKMI was acquired by Japanese car leasing company Renet Japan Group Co, Ltd.

14 Milvik (Cambodia) Micro Insurance Plc (Bima) (2014); Cambodian People Micro-Insurance Plc (2014); Mekong Micro Insurance Plc (2015); Meada Rabong Plc (2015) – former Cambodian Health Community (1994); Prosur Micro-insurance Plc. (2016) Forte Micro-Insurance Plc, HI Micro Insurance (2017) Plc.

15 See Section II.iii below.

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). 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. Since the end of 2017, it has been compulsory for every employer to contribute to the NSSF for both accident and health schemes.

The third method used by micro-insurers to target the poor is to work with telecommunication operators to sell insurance products using mobile technology. Even with 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 and, recently, life insurance companies in this area.

The fifth stage began in 2012 and led to the introduction of the life insurance industry, which was a significant move in the market and recognised by the government as necessary. In order to introduce life insurance, the government relied on two main pillars: the new regulation (passed in 2014), and the establishment of a state-owned life insurance company.¹⁶

While non-life insurance companies, like other industries in Cambodia, remain mainly regional in their shareholding (including companies from Singapore, Indonesia, Thailand, Malaysia, Hong Kong and Vietnam), leading worldwide life insurance companies entered into the Cambodian market soon after life insurance was introduced in 2012 and the flow of companies has been steady since then. The MEF granted licences to Manulife,¹⁷ Prudential,¹⁸ AIA¹⁹ and Dai-ichi Life,²⁰ while four Asean life insurers obtained their own licences.²¹ A Malaysian insurance player, Etiqa Group, entered the Cambodian life and general insurance market earlier in 2019.

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, with endowment accounting for 86.8 per cent of the market share in 2019, while term life remains unchanged at 4.1 per cent.²²

16 Cambodian Life Insurance Company Plc (2012), which were eventually privatised and purchased by the Royal Group of companies.

17 Manulife (Cambodia) Plc (2012).

18 Prudential (Cambodia) Life Assurance Plc (2013).

19 AIA (Cambodia) Life Insurance Plc (2017).

20 Dai-ichi Life Insurance (Cambodia) Plc (2018).

21 Sovannaphum Life Assurance Plc (2015) affiliated to Canadia group (in Cambodia) and Muong Thai Life insurance (in Thailand); Bangkok Life Assurance (Cambodia) Plc (2016), former partner of the state-owned Cambodian Life Insurance Company Plc.; Forte Life Insurance (2016); and Phillip Life Assurance (Cambodia) Plc (2018).

22 <http://www.iac.org.kh/images/Media%20Release/Statistics/Life/2019/Market%20Statistic%20for%20Life%20Industry%202019.pdf>.

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

Insurance intermediation has grown very slowly. Until 2007,²⁵ only one insurance agent and one insurance broker were duly registered. But recently, Cambodia has been facing an unstoppable flow of new brokers.²⁶ Although bancassurance suffers from an inconsistency between banking, and insurance regulations and practices, many banks, MFIs, financial leasing companies, as well as telecommunication operators have been granted with insurance agent licences.²⁷ However, the number of insurance agents operating as a main activity remains very low, and even decreased due to aversive legal requirements.

With the exception of the General Insurance Association of Cambodia, which was established in 2005 and became the Insurance Association of Cambodia in 2013 (to include life and micro 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:

- a* Cambodia has an insurance penetration rate of only 10 per cent of the population,²⁸ and its middle class is the fastest growing in the Association of Southeast Asian Nations (ASEAN);
- b* a very fast premium growth rate of 20 per cent per year during the past 15 years, which nevertheless should be minimised because of the very low amount of premium (US\$143 million in 2017 compared to US\$113.6 million in 2016) largely boosted by the very recent life insurance segment; as of 2019, there was 25 per cent growth of

23 EverCare Insurance Plc (2017) member of Chinese AIBO group; East Insurance Plc (2017) member of Guangzhou Yuetai Group and Ly Hour Insurance Plc (2017).

24 Grand China Life Insurance Plc (2017) member of China's largest financial insurance corporation: China Life Insurance Company.

25 AG Insurance Agent (2006), which became AG Insurance Broker (Cambodia) (2016), and Poema (Cambodia) Co Ltd (2007).

26 MGA Insurance Brokers Co Ltd (2014); Gras Savoye (Cambodia) Insurance Brokers Plc (Willis) (2015); Bassac Insurance Broker Co Ltd (2015); Hong Kong TeamYoun (Cambodia) Insurance Brokers Co Ltd; Branch of Toyota Tsucho Insurance Management Corporation; Insurance Broker Solutions (Cambodia), Ltd (2016); Icon Insurance Brokers Co Ltd (2016); Taiping Insurance (Cambodia) Brokers Co, Ltd (2016); Provita Insurance Broker Co Ltd (2017); LC Insurance Brokers Co, Ltd (2017); Alpha Insurance Broker Co Ltd (2018), Elite Insurance Broker (Cambodia) Plc (2018); Worldbridge Insurance Broker Plc, (2018); Tigermar (Cambodia) Insurance Broker Co, Ltd (2018); Global General Insurance Broker Plc, (2018); Start Insurance Broker Co, Ltd (21 September 2018), etc.

27 Banks: Cambodian Public Bank Plc (Lonpac-2006 and AIA's agents-2017); ACLEDA Bank Plc (Prudential's-2013 and Forte's-2016 agent); Maybank (Cambodia) Plc (Manulife's agent-2016); ANZ Royal Bank (Cambodia) Ltd (Manulife's agent-2016), CIMB Bank Plc (Manulife's agent-2016), Foreign Trade Bank of Cambodia Plc, (Manulife's agent-2016); Advanced Bank of Asia Limited (Manulife's agent-2016); ABA Agent; Canadia Bank Agent; MFIs: Angkor Mikroheranhvatho (Kampuchea) Co Ltd (Forte's agent-2014); Telecom: SMART Axiata Co Ltd (Forte's and Bima's agents-2014); Amret (2018); AMK Plc. Other: Cambodia Investment Management Insurance Agent Co Ltd (2014); Infinity Financial Solutions (Cambodia) Ltd, Samic Plc, Asiaone Insurance Agency (Cambodia) Co Ltd, Cover Link Insurance Agent Co, Ltd (Forte Agent 2018); (Safetynet Insurance Services (Cambodia) Co, Ltd (Forte Agent 2018); iCare Benefits (Cambodia) Co, Ltd (2016); Vattanak Bank (Dai-ichi Life Agent 2019).

28 4.4 per cent for life insurance in 2019.

insurance premium (US\$245.8 million in 2019 compared to that of US\$196.4 million in 2018 yet life insurance segment slowed down within the first three quarters in 2019, which increased only 7 per cent compared to the 35 per cent increase in 2018;²⁹

- c 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;³⁰
- d while some foreign businesses are covered in Cambodia through their worldwide policies, any risk in Cambodia must be underwritten by a duly authorised insurance company. Sanctions have been drastically increased with the Law on Insurance; and
- e more generally, the existing legal framework offers notable incentives that foreign investors might not be entitled to in neighbouring countries. 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 will 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 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

29 MEF, IAC, Overview of Cambodian Insurance Market 2019, booklet.

30 Overall insurance coverage only amounted to 0.93 per cent of GDP in 2019, an increase from 0.48 per cent in 2015.

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' 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 an equivalent 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 through a 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. The MEF also understands that a pure referrer does not require a licence since they do not act on behalf of the insurance contract parties.

However, distribution of insurance through a third party is particularly difficult due to the requested minimum capital deposit of US\$10,000 for agents and US\$50,000 for brokers. Therefore, life insurers who used to distribute through a wide network of individual agents have had no choice other than to recruit employees, so-called 'consultants'. The employment relationship must be real, otherwise the insurer may be heavily sanctioned under the insurance, the tax and the labour regulations.

Furthermore, bancassurance, which is essential for micro-insurers, life insurers and to some extent to general insurers, is generally not permitted, due to the National Bank of Cambodia's position stating that those can only refer insurers and cannot act on their behalf. According to the above, acting as referrer only, these establishments should not be required to obtain a licence from the MEF. But surprisingly, the MEF requires them to obtain an agent licence. Therefore, insurance companies have no other choice than having their own staff (not agent for the reason outlined above) in the banks and MFIs' premises, which drastically increases the acquisition cost.

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

iv Authorisations

According to the Law on Insurance, there are four kinds of insurance companies: life insurance, general insurance, micro-insurance and reinsurance. Both general and life insurance companies may conduct health and micro-insurance 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.³¹

31 Ministerial Order 009 MEF on the Issuance of a Temporary Licence for Microinsurance, dated 29 June 2011.

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. A sub-decree will provide further details for obtaining a licence. The former sub-decree and related ministerial order remain valid in the meantime.³² 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 soon, 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:

- a* insurance company: five years for both the initial licence and renewed licences;
- b* micro-insurance company: one year;
- c* insurance agent: one year for both the initial licence and renewed licences;
- d* insurance broker: one year for both the initial licence and renewed licences; and
- e* loss adjuster: one year for both the initial licence and renewed licences.³³

v Compulsory insurance

The former regulation mentioned three compulsory insurances (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.

In addition to these compulsory insurances, the Law on Insurance requires owners of motor vehicles (on roads or waterways) to obtain 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

³² Article 113, Law on Insurance.

³³ It is worth noting that a 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.

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 obtain professional liability insurance of US\$500,000.³⁴

vi 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 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, life insurers do not necessarily offer endowment policies only; they can also offer term life, bodily injury and healthcare policies that are not substantially savings 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 released a ministerial order on 31 March 2018 implementing this change, but this regulation is far from being detailed enough, which leads to uncertainty. For instance, the said ministerial order has not provided an understandable rule on deductibility of technical provisions for life insurers.

Furthermore, practically it appears that part of the premium is subject to double taxation. Indeed, insurance companies are value added tax (VAT) exempted, but, according to the current practice, which may be jeopardised soon, insurance intermediaries are not, although the regulation is silent on it. Therefore, the insurance company cannot claim a VAT deduction on the insurance intermediaries' commissions. This non-deductible VAT will thus be included in the gross premium amount, and therefore also taxed at 5 per cent.

Moreover, the tax administration has not put in place any set-off system when the payment to an insurance intermediary originates from a prepayment subject to other tax (1 per cent minimum tax on 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.

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

34 Article 86.

cent tax (e.g., an endowment product), the insurance company must withhold 14 per cent on the reinsurance premium paid abroad, which is clearly excessive and even unfeasible. It is also worth noting that Cambodia has several double tax treaties in force with a number of countries (i.e., Brunei, China, Hong Kong, Indonesia, Singapore, Thailand and Vietnam), which might solve some of the cross-border tax issues of the insurance industry.

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.³⁵ The Law on Commercial Enterprise only requires a minimum of three directors.³⁶

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

viii Transfer of portfolio

A Cambodian insurance company may apply to the insurance regulator for approval to transfer all or part of its insurance business to another Cambodian insurance company. The transfer 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)³⁷ 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:

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

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.

35 However, the Ministry of Commerce, legally unfunded, recently requested a minimum of two shareholders for every public limited company.

36 Article 118 Law on Commercial Enterprise dated 19 June 2005.

37 International Monetary Fund SDRs. As of 9 April 2020, 1 SDR = US\$1.362600. The MEF practically considers the minimum capital required for life and general insurance companies to be equivalent to US\$7 million.

First, insurance companies and intermediaries must maintain a deposit with the National Treasury (i.e., the MEF's account at the National Bank of Cambodia (this account does not generate interest)) as follows:

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

Second, insurance companies must maintain a solvency margin 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. This rule has recently been extended to general insurers, insurance intermediaries and loss adjusters.

It is worth noting that a new sub-decree on insurance and additional ministerial orders should be passed soon, which could change both capital and solvency requirements. The MEF started to implement part of the drafted regulation from the second half of 2017.

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 (actually almost all) activities, including changes in memoranda and articles of association (e.g., change of address, change of shareholders' representatives, change of directors, increase of capital, etc.) products approval (understanding that each rider is considered as one product), advertisement campaigns, and organisation of the distribution network. From past experience, everything went generally well, but with the huge increase of insurer players – more than 70 in 2019 – it has been very difficult for the Insurance and Pension Division of the MEF to cope with the huge amount of requests. It is not rare to wait six months for a simple approvals of change of directors; the MEF has even recently limited insurance companies to submit a maximum of two policies at a time. In addition, some of the above actions require authorisations from other ministries, especially the Ministry of Commerce, which extends the length of the process.

Economic control over the industry involves, *inter alia*, gathering data, issuing and renewing licences, maintaining fair competition and approving any transfer of shares exceeding 10 per cent of the capital. The MEF may organise inspections, and has wide powers

to do so. Measures undertaken during an insurance inspection may be challenged by bringing a complaint within 45 days to the MEF. The MEF then has two months to decide on the complaint. However, this delay may vary depending on MEF's internal rules.

It worth noting that this situation has led insurance institutions to run behind in requiring prior approval, which is sometimes not even practicable when unexpected (e.g., resignation of a director, transfer of a portfolio, which requires the parties to act quickly to maintain the economic interest of the transactions, etc.). The amount of fines drastically increased in the past year.

The Law on Insurance considerably reinforced both the MEF's control and procedures in cases where an insurance company is facing a serious financial crisis. In such a case, the MEF may appoint a provisional director to 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 2001,³⁸ 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.

ii Making the contract

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

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

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 insurance maintains a writing agreement and signatures; however, during the discussion with private sector, the MEF has accepted paperless insurance policy.

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.

38 Law on Insurance No. NS/RKM/0700/02, dated 25 July 2000 and Sub-Decree on Insurance No. 106 ANK.BK, dated 22 October 2001.

Furthermore, 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;³⁹ however, it is not the usual definition of a policyholder as it is commonly understood. In addition, the Law does not mention the possibility of underwriting a group insurance policy even if, in practice, group insurance policies are widely spread out and accepted by the MEF, which even distinguishes between compulsory and facultative group insurance policies.

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.

Finally, the insurance regulation may contradict other ones leading to a Kafkaesque situation. For instance, a regulation proper to general insurance companies (but interpreted as applicable to any institutions) prohibits chairmen of the board from holding an executive role. However, the Ministry of Labour and Vocational Training together with the Ministry of Interior requires them to hold a working permit in order to get a visa business allowing them to lawfully remain on the Cambodian territory. Such working permit requires an employment contract, which could not be with a fake salary, since the General Department of Taxation could reassess it.

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.

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

³⁹ 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.

understandable. The Cambodian population is not familiar with insurance policies, and may not understand that insurers provide an amount lower than the declared or insured value of the property. This rule obliges insurers to either assess the real value before covering the property, or to clearly state that it will not pay the declared value if it exceeds the actual one.

iv Intermediaries and the role of the broker

In addition to the descriptions in Sections I, II.iii and III.ii, above, regarding the distribution of products, there remain very few active insurance brokers and most of them received their licence very recently, with an impressive pick in July 2018 with four new licensed brokers. However, with an insurance penetration rate of 10 per cent among the Cambodian population, the lack of knowledge of many business people (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 and more specifically under the regulation applicable to agency agreement.⁴⁰

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 no payment of life insurance if the insured died by suicide.

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

The net rate ratio of claims was 25 per cent in 2019 for non-life activity, 34 per cent for life insurance and 17 per cent for micro insurance. As of 2019, claims for general insurance and life insurance totalled US\$29.13 million and US\$2.3 million respectively.⁴¹

40 Article 637 et seq. Civil Code.

41 <http://www.iac.org.kh/images/Media%20Release/Statistics/General/2019/Market%20Statistic%20for%20General-Insurance-2019.pdf>; <http://www.iac.org.kh/images/Media%20Release/Statistics/Life/2019/Market%20Statistic%20for%20Life%20Industry%202019.pdf>.

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-off⁴² 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. It was conceived when Cambodia's Commercial Arbitration Law entered into force, which then was amended to accommodate the establishment of the National Commercial Arbitration Centre of the Kingdom of Cambodia until its final approval in July 2014.

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 Law on Insurance and sub-decree address mediation. The first mediation case was brought before the MEF at the very beginning of 2019 and involved a micro-insurer.

V YEAR IN REVIEW

Because the MEF decided to freeze life insurance licences, there were very few licences granted in 2019, and the same goes for microinsurance licences. However, from the third quarter of 2018, the MEF decided to reopen the licence; therefore, we may expect a lot of licences granted in 2020.

In 2019, the total gross premium of insurance sector in Cambodia rose from US\$196.4 million (2018) to US\$245.8 million (2019), a 25 per cent increase with the help of the general insurance sector of 14.2 per cent and life insurance sector of 42.4 per cent, according to the Insurance Association of Cambodia.

42 However set-off is legally possible by application of Article 464 et seq. Civil Code.

VI OUTLOOK AND CONCLUSIONS

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

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

With regard to claims, fraud has become a major issue, especially with a small number of loss adjusters.⁴³ In addition, the tax regime applicable to life insurance activities and the double taxation of brokers and agents may cause frustration.

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

Finally, in terms of distribution, we do not see improvement regarding the conditions to become an independent insurance agent, and although we expect improvements soon, insurers are still waiting for a more clement bancassurance framework.

⁴³ There are only three insurance loss adjusters: Mclarens Cambodia Ltd, MSM International Adjuster (Cambodia) Limited (2011) and Branch of AJAX Adjusters & Surveyors Pte (2017).

CAYMAN ISLANDS

*John Dykstra and Abraham Thoppil*¹

I INTRODUCTION

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

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

Captive insurance business may be taken to be all insurance (and reinsurance) business where the premiums originate from the insurer's related business. The captive market began to develop in the late 1970s and there has been a steady natural growth since then. As at 31 December 2019, the Cayman Islands international insurance market reported total premiums of US\$17.96 billion, with US\$68.90 billion in total assets.² The Cayman Islands is the leading jurisdiction for healthcare captives, representing almost one-third of all captives. Medical malpractice liability continues to be the largest primary line of business in the Cayman Islands with approximately 32 per cent of companies insuring and reinsuring medical malpractice liability.³ 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.⁴

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

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

1 John Dykstra and Abraham Thoppil are partners at Maples and Calder, the Maples Group's law firm. The authors would like to thank John Ebanks for his 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.*

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

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

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

i Insurance licensing

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

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

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.

- 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;
- b* ‘insurance broker’ licence, for arranging or procuring, directly or through representatives, insurance or reinsurance contracts 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 (2020 Revision) of the Cayman Islands (the Companies Law) or registered by way of continuation and that has a minimum of two directors (who have been approved by the Authority to be fit and proper persons) may be granted a licence by the Authority.

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

iii Licensing requirements

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

- a* the persons carrying on the business to which the application relates are fit and proper to be directors, managers or officers in their respective positions;
- b* it is able to comply with the Law and the Anti-Money Laundering Regulations 2020 of the Cayman Islands;
- c* the grant of a licence will not be against the public interest of the Cayman Islands;
- d* it has personnel with the necessary skills, knowledge and experience, and such facilities and such books and records as the Authority considers appropriate, having regard to the nature and scale of the business;
- e* the structure of its insurance group, if any, will not hinder effective supervision; and
- f* its capital complies with the prescribed level.

iv Capital and solvency requirements

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

v Segregated portfolio companies

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

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

- a* on human life or contracts to pay annuities on human life, including linked policies, but excluding contracts for credit life insurance and term life insurance other than convertible and renewable term life contracts;
- b* against risks of the persons insured:
 - sustaining injury as the result of an accident or of an accident of a specified class;
 - dying as the result of an accident or of an accident of a specified class;
 - becoming incapacitated in consequence of disease or diseases of a specified class;or
 - being contracts that are expressed to be in effect for not less than five years or without limit of time and either are not expressed to be terminable by the insurer before the expiry of five years from the taking effect thereof or are expressed to be so terminable before the expiry of that period only in special circumstances therein mentioned; and
- c* whether by bonds, endowment certificates or otherwise whereby in return for one or more premiums paid to the insurer a sum or series of sums is to become payable to the person insured in the future, not being contracts falling within points (a) or (b).

vi Portfolio insurance companies

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

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

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

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

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 CI\$100,000 or to imprisonment for five years, or to both.⁶ In the case of domestic business, insurance brokers can be permitted by the Authority to place limited amounts of this business with unlicensed foreign insurers. Accordingly, an unlicensed insurer with whom a broker can place insurance business pursuant to any such dispensation would not be considered as carrying on insurance business.⁷

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

6 Insurance Law 2010, Section 3(2).

7 Insurance Law 2010, Section 19(5).

In addition, an insurance broker is prohibited from entering into a binding authority with an insurer other than a Class D insurer.⁸ However, the Authority may grant a 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 another figure prescribed by the Authority. The professional indemnity insurance shall extend to include the activities conducted on behalf of the insurance broker and be subject to review by the Authority. In the event that the professional indemnity insurance is invalidated, becomes voidable or is withdrawn, cancelled or not renewed, the broker shall immediately notify the Authority and shall forthwith cease to solicit further insurance business until the professional indemnity insurance has been reinstated or replaced.⁹

III INSURANCE AND REINSURANCE LAW

i Sources of law

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

ii Making the contract

Parties

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

Insurable interest

There is no statutory requirement for insurable interest in Cayman Islands law, although English common law may be taken to imply a requirement for insurance interest in all types of indemnity insurance. In *Rowe v. Proprietors, Strata No. 83*¹⁰ the court ruled that a party has an insurable interest if it had a legal relationship with property that renders it liable to pay

8 Insurance Law 2010, Section 19(1).

9 Insurance Law 2010, Section 13(1)–(3).

10 (Grand Court), 2009 CILR N [31].

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.

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*¹¹ and *McLaughlin v. American Home Assurance Company*.¹²

In *Zeller*, the Court of Appeal upheld the judgment, applying the English authority *Economides v. Commercial Union Assurance Co Plc*¹³ 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 material.

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

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

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

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

12 [1994–1995] CILR N-18 and [1996] CILR N-6.

13 [1998] QB 587.

14 [1989] 1 Lloyd's Rep 568.

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*,¹⁵ the court followed the view of Lord Goddard CJ in the English case of *Edwards v. Griffiths*,¹⁶ where he ruled that a contract should be construed against the insurer where there is an ambiguity or a doubt as to its extent; if a question should arise as to liability of the insurer, the court should apply a construction most favourable to the insured.

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

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

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

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

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

ii Litigation

Litigation stages

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

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

15 [1994–1995] CILR 313 and N-19.

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.

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 the power to trace and preserve assets, order discovery or preservation of documents and appoint interim receivers.

Costs

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

iii Arbitration

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

The Arbitration Law is founded on the following principles:

- 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;¹⁸ 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.¹⁹

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.²⁰

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).

iv Alternative dispute resolution

There is no formal requirement in the Cayman Islands to pursue alternative dispute resolution (ADR). The Grand Court Rules require parties to deal with each case in a just, expeditious and economical manner, and judges encourage the parties to pursue ADR where appropriate. Although the court cannot compel the parties to use ADR, there will usually be costs consequences where the parties do not follow such a suggestion. ADR methods such as mediation, early neutral evaluation and expert determination are still relatively uncommon in the Cayman Islands.

V YEAR IN REVIEW

In 2019, the Cayman Islands licensed 33 new captive insurers, which included a PIC and Class B insurers, and at year end had a total of 646 licensed captives. Medical malpractice liability continues to remain the primary line, followed by workers' compensation. SPV insurers are increasingly used by commercial reinsurers to access the capital markets to distribute reinsurance risk.

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

VI OUTLOOK AND CONCLUSIONS

An overhaul of the insurance regulatory regime has had a positive impact on the insurance and reinsurance industry. The government, working together with local service providers, is committed to facilitating industry growth. The efforts to date have yielded very positive results. In 2019, the Cayman Islands licensed 33 new captive insurers and at year end had a total of 646 Class B, C and D licensees. Medical malpractice liability continues to remain the primary line, followed by workers' compensation. The two main types of captives were pure captives and group captives. North America continues to be the main geographical source of business.

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

CHILE

*Ricardo Rozas*¹

I INTRODUCTION

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

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

Anyone is free to take out insurance in Chile. Taking out insurance abroad is not forbidden, but insured parties are subject to the legislation governing international charges and taxation. 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 Commission for the Financial Market (CMF), and ranked at least within the BBB risk category or its equivalent.³

Reinsurance can be provided to the above-mentioned entities either directly or through reinsurance brokers registered in the Registry of Reinsurance Foreign Brokers Registry, which is managed by the CMF.

The foreign entities 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

1 Ricardo Rozas is a partner at Jorquiera & Rozas Abogados.

2 Title XIII.

3 According to Article 16 of the Insurance Companies Act (DFL 251), the Lloyd's of London insurance market is expressly recognised as a reinsurance entity.

necessary to designate an attorney if the reinsurance is made through a reinsurance broker registered with the CMF 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 CMF supervises the solvency and operations of insurance and reinsurance companies, brokers and loss adjusters, and has the power to request balance sheets, financial statements and portfolio information. In addition, the CMF issues general rules relating to intermediation, underwriting, adjustment and policy contracts, which are compulsory for all the companies under its supervision.

The CMF was created in March 2017 to replace the former Securities and Insurance Superintendency (SVS).⁴ Generally speaking, the CMF is vested with broader faculties to supervise the financial market and enforce its regulations.⁵ The CMF works through a Council comprised of five members known as ‘commissioners’. The Council has one president vested with several faculties, including executing and enforcing the regulations and agreements of the Council. In addition, the President represents the CMF. The law that creates the CMF also separates the functions of investigating potential breaches to the law and regulations and imposing sanctions. In this sense, all investigations are now led by a ‘prosecutor’, while the potential sanctions are determined and decided by the Council.

While the law that creates the CMF implied certain organic changes, there are no substantive changes with regard to the regulation that deals with insurance and reinsurance (including regulations for brokers and loss adjusters). However, the CMF has more faculties than the former SVS in connection with different operational aspects of the companies under its supervision, including requesting financial information in connection with the process of mergers, acquisitions, divisions, transformation or liquidation of companies; coordinating and cooperating with other government entities such as the Chilean Internal Revenue Service and the Public Prosecutor’s Office; examining specific operations of companies and requesting the corresponding information.

The CMF’s main objectives are to continue contributing, including adequate control measures, to maintaining and increasing markets’ confidence and providing more efficient tools for their development. The CMF is contemplating important changes with respect to its predecessor. First, it is ruled by a five-member Council, whereas before there was a single supervision system. The CMF has more research tools to prevent and detect specific regulatory breaches. In addition, the investigative and sanctioning processes are separated, which is an important step towards guaranteeing due process in connection with individuals and companies subject to the supervision of the CMF.

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

5 Transitory Article 4 of Law No. 21,000 established that the CMF would commence to function on 14 December 2017 and that the SVS would cease to exist effectively by 15 January 2018.

ii Position of non-admitted insurers

Foreign insurers that are incorporated abroad may offer and sell direct insurance cover in Chile relating to international marine transportation, international commercial aviation and cargo in international transit.

In addition, in June 2007, Decree No. 251 (DFL 251) was amended to allow companies incorporated abroad to establish branch offices in Chile. These branch offices are subject to the general procedure provided by the Corporations Act for the incorporation of agencies of foreign companies, and must obtain authorisation from the CMF.⁶ In addition, the branch offices must prove to the CMF that they comply with all requirements established for the authorisation of insurance companies, and need to follow further publication and registration formalities.

iii Requirements for authorisation

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

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

To meet the obligations of underwriting insurance and reinsurance business, Chilean-regulated insurers and reinsurers must establish technical reserves in accordance with the current principles, procedures, mortality charts, interest rates and other technical parameters within the time limit and in the format established by the CMF through general rules.

iv Position of brokers

Brokers are regulated under the Regulations Applicable to Insurance Industry Officers (Supreme Decree 1055-2013),⁷ 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

6 Matter regulated under Title XIII of the Chilean Corporations Act.

7 DS 1055-2013 came into force on 1 June 2013.

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

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 CMF regulations and the Consumer Protection Act.

vii Compulsory insurance

Some areas of compulsory insurance cover in Chile are motor liability, employers' liability for occupational accidents and diseases, and brokers' errors and omissions. In addition, Decree-Law 3500 of 1980, which regulates the Chilean pension system, also establishes 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.

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 CMF (and previous resolutions issued by the Securities and Insurance Superintendency (SVS)); and
- f* the general provisions relating to the interpretation of contracts that are found in the Civil Code (Article 1560 et seq.).

The provisions on general and non-marine insurance contained in the Code of Commerce were enacted almost 140 years ago and for a long time were not revised, despite numerous industry developments. However, on 9 May 2013, a new law was enacted (Law 20,667 (the New Insurance Law)), which replaced all the former non-marine provisions (contained in Title VIII of Book II of the Code of Commerce) and finally updated Chilean insurance law to be in line with current trends and market practice. The New Insurance Law also changed certain provisions on marine insurance (contained in Title VII of Book III of the Code of Commerce) and introduced a couple of amendments 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 honestly disclose the information requested by the insurer to allow the latter to identify the object of the insurance and assess the nature of the risk.⁸ For these purposes, it suffices that the insured reports exclusively as per the aforementioned insurer's request.⁹ However, if the insurer fails to request information at the placement stage, the insurer is then not allowed to 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.¹⁰

If the loss has not occurred and the insured culpably has incurred in errors, reticence or inaccuracies that are decisive in the risk assessment as per the above rules, the insurer can rescind the insurance contract. However, if such errors, reticence or inaccuracies are not decisive, the insurer can request an amendment of its terms to adjust the premium or coverage to the unreported circumstances. If the insured rejects the insurer's amendment proposal or fails to answer within 10 days from the date on which it is sent, the insurer can rescind (avoid) the contract.¹¹

If the loss has occurred, the insured may be exonerated from its liability to pay indemnity if the risk is one that could have allowed the rescission of the insurance contract as per the rules of the preceding paragraph. If not, the insurer can request that the indemnity is proportionally reduced to the difference between the agreed premium and the one that would have been applied if the true extent of the risk had been known.¹²

The above sanctions are not applicable if the insurer, before concluding the insurance contract, has known or should have known the errors, reticence or inaccuracies contained in the insured's statement of risk, or, after its conclusion, agrees to remedy them or accepts them either expressly or tacitly.¹³

8 Article 524 No. 1 of the Chilean Code of Commerce.

9 Article 525, Paragraph 1, of the Chilean Code of Commerce.

10 Article 525, Paragraph 2, of the Chilean Code of Commerce.

11 Article 525, Paragraph 3, of the Chilean Code of Commerce.

12 Article 525, Paragraph 4, of the Chilean Code of Commerce.

13 Article 525, final paragraph, of the Chilean Code of Commerce.

The insurance contract is null and void if the insured knowingly provides substantial false information when giving the risk statement to the insurer and the contract is resolved if the insured engages in such conduct when claiming compensation. In such cases, once the annulment or resolution of the contract is declared, the insurer may retain the premium or claim for payment along with the expenses needed as proof, even though the risk has not run. The foregoing is without prejudice to the criminal action that may apply.¹⁴

In addition, under Chilean insurance law, the insured is subject to the obligation of not aggravating the risk.¹⁵ The main principles related to aggravation of risk are contained in Article 526 of the Chilean Code of Commerce, which can be summarised as follows:

- a The rules on aggravation of risk are only applicable to circumstances that substantially aggravate the risk.
- b The insured must inform the insurer of circumstances that substantially aggravate the risk within five days from the time he or she becomes aware of them.
- c It is assumed that the insured knows the aggravation of risk that comes from events that occurred with his or her direct involvement.
- d If the loss has not occurred, the insurer has 30 days to inform the insured about either the rescission of the insurance contract or an amendment of its terms to adjust the premium or coverage to the true state of the risk.¹⁶ If the insured rejects the insurer's amendment proposal or fails to answer within 10 days from the date on which it is sent, the insurer can rescind the contract.
- e If the loss has occurred and the insured has not informed the insurer about the circumstances that substantially aggravate the risk, as per (b) above, the insurer is exonerated from its obligation to pay indemnity.
- f If the aggravation would have led the insurer to celebrate the insurance contract in more onerous conditions for the insured, the insurer cannot rescind the insurance contract. However, in such a case the insurer can request that the indemnity is proportionally reduced to the difference between the agreed premium and the one that would have been applied if the true extent of the risk had been known.
- g The above sanctions do not apply if the insurer, due to the risk's nature, could have known and agreed on it either expressly or tacitly.
- h Except in the event of wilful aggravation of risk, if the insurance contract is terminated, the insurer must return the insured the proportion of the premium related to period in which, consequently, it is discharged from liability.

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.

14 Article 539 of the Chilean Code of Commerce.

15 Article 524 No. 5 the Chilean Code of Commerce.

16 The 30-day term is counted from the time the insurer has knowledge of the aggravation of risk.

iii Interpreting the contract

General rules of interpretation

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

The Chilean position can be broadly summarised as follows:

- a* The provisions of the New Insurance Law are in general mandatory, unless stated to the contrary. However, if a clause is deemed to provide an insured with a greater benefit than is provided under the law generally, the specific terms of a policy will prevail over the Code of Commerce.
- b* Chilean law considers it of paramount importance to determine the intentions of the parties at the time of contracting and to give effect to those intentions even if they are not reflected in the literal words of the contract.
- c* A Chilean tribunal will strive to facilitate clauses in contracts with the goal of ensuring that the parties' intentions are fulfilled. Actions can include amending the contract if no provision is made for a given state of affairs.
- d* Under Chilean law, it is permissible for a tribunal to ascertain the parties' intention by looking outside the contract at, for example, the negotiations between the parties and market practice at the date of contracting.
- e* In the event of ambiguity in a policy, the interpretation that is more favourable to the insured prevails.¹⁷

Incorporation of terms

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

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

Types of terms in insurance contracts

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

- 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;

¹⁷ DFL 251 Article 3 (E) Paragraph 3 specifically imposes a duty on the insurer to make sure that the wording is clear and understandable.

- 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'.¹⁸

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.

Insurance brokers

Insurance brokers are defined as natural persons or legal entities who have been registered as such with the CMF and who act as independent intermediaries in the contracting of insurance policies with any insurer.¹⁹

According to Chilean regulations, insurance brokers must provide information to all their clients on the diversification of their businesses and on the companies with which they work, in the manner determined by the CMF. In addition, insurance brokers are subject to a duty of providing information, and must notify the CMF of any change of their address registered with the CMF, any amendment to the partnership agreement, and any changes in managers, general representatives, directors or other administrators. They must also provide a summary of their operations in the manner and on the dates determined in a general rule issued by the CMF. Insurance brokers who become disqualified or have incompatibilities with their position, or who do not provide proof that they have contracted an insurance policy in the time and form required for their job, will be eliminated from the registry and may not work again as brokers. This notwithstanding, they will continue to be obligated

18 Article 513, Letter 'L' of the Code of Commerce.

19 According to Article 58 *bis* of the Insurance Companies Act (DFL 251), foreign brokers may trade insurance cover in Chile in connection with international marine carriage, international commercial aviation and goods under international transit.

and liable to the insured for the brokerage they have already made. Insurance brokers must be registered in the Insurance Trade Auxiliaries Registry kept by the CMF and comply with different requirements to conduct their activity, including establishing a guarantee, either through a bank bond or insurance policy, as determined by the CMF, which cannot be less than 500 UF or 30 per cent of the net premium of the insurance contracts brokered in the immediately preceding year (whichever is the higher), limited to 60,000 UF to cover liability for correct and complete compliance with all obligations arising from their activity, and particularly for damages that they might cause to the insureds who contract through them.²⁰ In addition, legal entities must be legally incorporated in Chile. Managers, legal representatives or employees of the legal entity may not engage independently in insurance brokering, or work for an insurance company or for another person engaged in insurance brokering.

Reinsurance brokers

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

- 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.

Loss adjusters

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

Agencies and contracting

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

20 Article 58, letter d) of the Insurance Companies Act (DFL 251).

v 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, in principle 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.

ii Litigation

Stages of litigation

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

Unless remedies are waived, 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 from the service of the decision. Depending on the subject of the trial and the type of decision appealed, the processing of an appeal can take up to two years.

Regarding appeal stages, in Chile there is only one appeal stage, and the second instance tribunal is allowed to review both factual and legal issues. 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:

- a* at the request of a party, to accept additional means of proof to those pointed out above;
- b* to decree evidentiary measures *ex officio* at any stage of the trial;
- c* to request recognition of documents and deal with objections; and
- d* 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.²¹ These rules are complemented by the procedural rules contained under the Civil Procedure Code.²² Furthermore, Article 222 of the Tribunal Code establishes that 'arbitrators are the judges appointed by the parties or by a judicial authority for the resolution of a litigious matter.' Article 223 of the Tribunal Code provides that there are three types of arbitrator, as follows: arbitrators at law; arbitrators *ex aequo et bono* (friendly mediators); and mixed arbitrators.

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

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).

21 Title IX, Articles 222 to 243.

22 Title VIII of Book III.

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 used often 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

Owing to the October 2019 civil unrest in Chile, it is likely that policies providing or excluding related risks, such as civil disturbance, civil commotion, looting or terrorism among others will be tested by local adjusters and courts. The aforementioned may also include the testing of aggravation clauses, limits and sub-limits wording and deductibles. In addition, it remains to be seen how the local policies will respond in connection with the covid-19 pandemic, particularly in connection to business interruption.

VI OUTLOOK AND CONCLUSIONS

Since October 2019 Chile has been subject to difficult times, first due to the October 2019 civil unrest and currently due to the covid-19 crisis, which raises several unique challenges, including the response of the insurance industry to different issues such as communications, cybersecurity, office environment, human resources function, third-party service providers and assessing financial condition (investments and liabilities).

CHINA

Zhan Hao, Wang Xuelei, Yu Dan, Chen Jun, Wan Jia and Zhang Xianzhong¹

I INTRODUCTION

In 2019, the Chinese insurance industry embraced several changes. First, China further opened up the financial sector of the Chinese market by amending the administrative regulations on foreign-funded insurance companies. These new policies loosen certain restrictions on foreign insurance investors and encourage more insurance institutions to enter the Chinese insurance market. Allianz established the first wholly foreign-owned insurance holding company in China. Secondly, health insurance has seen new developments in China. The China Banking and Insurance Regulatory Commission (CBIRC) released certain new administrative measures on health insurance. Compared with the original regulatory measures, the latest health insurance measures have made innovations in many aspects, including the adjustable rate of long-term medical insurance products. Thirdly, the CBIRC has further strengthened and improved its supervision of property insurance products, further adjusted the scope of examination and approval towards insurance products, and changed the approval mechanism of automobile insurance, credit insurance and guarantee insurance products with a term of more than one year to a filing-for-record mechanism, to avoid the repeated examination and approval of standardised products and vague supervision focus. Lastly, Chinese authorities continue to strengthen the supervision of internet insurance. Under the premise of controllable risk and safe isolation, insurance institutions can actively use the internet, big data, artificial intelligence, blockchain and other new technologies to explore internet insurance business innovation and service innovation, enhance insurance operation efficiency, improve the insurance experience for consumers, and develop a digital ecosystem for the application of insurance technology.

Based on data released by the CBIRC on its official website² on 22 January 2020, overall original insurance premium income reached 4.2645 trillion yuan, rising by 12.17 per cent year on year; insurance indemnities and other expenditures reached 1.2894 trillion yuan, rising by 4.85 per cent; the total assets of the insurance industry reached 20.5645 trillion yuan, rising by 12.18 per cent; the net assets of the insurance industry reached 2.4808 trillion yuan, rising by 24.66 per cent; and the overall amount of insurance funds reached 18.5271 trillion yuan, rising by 12.91 per cent.

1 Zhan Hao is the managing partner and Wang Xuelei, Yu Dan, Chen Jun, Wan Jia and Zhang Xianzhong are partners at AnJie Law Firm.

2 <http://www.cbirc.gov.cn/cn/view/pages/ItemDetail.html?docId=887993&itemId=954>.

II REGULATION

In 2019, several new regulations were issued by the CBIRC and other government authorities to press ahead with the reform and development of the insurance industry.

i Measures for Further Opening up the Financial Sector

On 20 July 2019, the Financial Stability and Development Committee under the State Council (FSDC) released the Measures for Further Opening up the Financial Sector. As prescribed in the Measures, China has further expanded the degree of opening up the financial industry and launched 11 measures to open up the financial industry to foreign investors. In terms of the insurance industry, these measures include:

- a* advancing the transitional period from the originally scheduled 2021 to 2020. From 1 January 2020, the original 51 per cent restriction on the proportion of foreign investment in joint venture life insurance companies will be officially removed, and 100 per cent investment will be allowed;
- b* abolishing the limit that domestic insurance companies shall hold no less than 75 per cent of the shares in an insurance asset management company in total, and permitting overseas investors to hold over 25 per cent of the shares in such companies; and
- c* easing the access conditions for foreign insurers by removing the requirement of over-30-year operation experiences.

ii Measures on Health Insurance

On 31 October 2019, the CBIRC released the Measures on Health Insurance. The Measures put forward the basic requirements for insurance companies to operate and develop health insurance. According to the Measures, health insurance mainly includes medical insurance, disease insurance, loss of income insurance, nursing insurance and medical accident insurance. Health insurance companies, life insurance companies and endowment insurance companies may operate health insurance business with the approval of the CBIRC. Insurance companies are encouraged to provide innovative health insurance products to meet the multi-level and diversified health insurance needs of insurance consumers. Insurance companies may adjust the premium rate of the long-term medical insurance products, but must clearly indicate the trigger conditions of the rate adjustment.

iii Administrative Measures on Connected Transactions of Insurance Companies

On 25 August 2019, the CBIRC released the Administrative Measures on Connected Transactions of Insurance Companies (the Connected Transaction Measures). In recent years, the CBIRC has paid great attention to regulating the transfer of interests through illegal connected transactions. Prior to the promulgation of the Connected Transaction Measures, the CBIRC formulated a number of regulatory measures on the identification and management of connected transactions. Compared with the previous regulatory measures, the Connected Transaction Measures optimise the original system from the aspects of improving the management of related parties, strengthening the internal control mechanism of connected transactions, strengthening the external supervision of connected transactions, strengthening the penetration supervision of connected transactions, and strengthening the

supervision responsibility. This will help to prevent related parties from using their special status to infringe the interests of insurance companies, insurance investors or insurance consumers through connected transactions.

iv CBIRC Notice on Further Strengthening the Supervision of Automobile Insurance

On 14 January 2019, the CBIRC released the Notice on Further Strengthening the Supervision of Automobile Insurance. Although the proportion of automobile insurance business is gradually decreasing, the automobile insurance business is still the development focus and main pillar of the Chinese insurance industry, and the competition in this field is also very fierce. The Notice mainly aims at the two outstanding problems of not using approved vehicle insurance terms and rates as required and unfair disclosure of business and financial data. The Notice further promotes the orderly development of automobile insurance.

III INSURANCE AND REINSURANCE LAW

i Sources of law

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

- a* the 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 CBIRC and other relevant government institutions.

ii Making the contract

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

Pursuant to the Law, an insurance contract is defined as an agreement in which an applicant and an insurer set out their respective rights and obligations under the insurance policy. The term 'applicant' refers to the party that concludes the insurance contract with the insurer, and who must pay the premium in accordance with the contract. The term 'insurer' refers to the insurance company that concludes the insurance contract with the applicant, and that is liable for paying insurance indemnities in accordance with the contract.

The Law classifies insurance contracts into personal insurance contracts and property insurance contracts classes. A personal insurance applicant shall have an insurable interest in the insured at the time when the insurance contract is formed, while an insured in property insurance shall have an insurable interest in the subject insured at the time when an incident covered by the insurance occurs.

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

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

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

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

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

For those clauses in the insurance contract that exempt the insurer from liability, the insurer shall give sufficient warning to the applicant of those clauses in the insurance application form, the insurance policy or any other insurance certificate, and expressly explain the contents of those clauses to the applicant in writing or orally; if the insurer fails to give a warning or explicit explanation thereof, those exemption clauses shall not be effective.

iii Interpreting the contract

The provisions of the insurance contract become ambiguous when the insurer and the insurance applicant, the insured or the beneficiary, have different interpretations of the policy. If a provision is found to be ambiguous, it should be interpreted in accordance with the following interpretation methods.

Semantic interpretation

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

Systemic interpretation

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

Contract aim-based interpretation

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

Good faith interpretation

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

Special interpretation

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

Unfavourable interpretation

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

iv Insurance intermediaries

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

Insurance brokerage companies and insurance agencies have to be in the form of either a limited liability company or a joint-stock limited company. Brokers provide intermediary services to insurance applicants and insurance companies to execute insurance contracts based on the interests of insurance applicants, while insurance agencies are, based on authorisations by insurance companies, authorised to handle insurance business on their behalf. The two

regulations on insurance brokerage companies and insurance agencies respectively provide the requirements on market access, operation rules, market exit, supervision and inspection, and legal liabilities. Further details are also provided regarding the business establishment, qualifications of personnel, scope of business and prohibited acts.

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

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

The same conditions apply for a professional insurance agency.

An insurance brokerage company may engage in the following business:

- a* drafting insurance application proposals, selecting insurance companies and handling the insurance application formalities for insurance applicants;
- b* assisting the insured or beneficiaries in claiming compensation;
- c* reinsurance brokerage business;
- d* providing clients with disaster, loss prevention, risk assessment or management consulting services; and
- e* other business approved by the CBIRC.

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

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

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

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

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

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

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

v Claims

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

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

indemnity as agreed upon therein. If the insurer fails to perform the obligation as prescribed, it shall, in addition to paying the insurance indemnity, pay compensation for the insured's or beneficiary's loss suffered.

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

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Jurisdiction

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

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

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

For litigation involving marine insurance, the court of first instance is the professional marine court, and the Marine Special Procedure Law is applied in such procedure.

Choice of law

As a common rule, the parties to a contract can choose the governing law in a contract. However, pursuant to Article 8 of General Principles of the Civil Law, Chinese law shall apply to civil activities within China, except as otherwise stipulated by law. According to Article 3 of the Insurance Law, this Law shall also govern insurance activities conducted within the territory of China.

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

Arbitration clauses

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

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

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

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

ii Litigation

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

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

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

If any party is unsatisfied with the judgment or verdict of the first instance court, the party can appeal to the appellate court at the higher level. The judgment or verdict of the appellate court is binding. The remedy for a binding judgment and verdict is legal review, but this procedure is rarely initiated.

The judge plays an active role in court hearings. He or she will direct the trial process and is responsible for finding the facts. It is very much an inquisitorial approach. During the civil procedure, the party shall submit evidence to prove the facts upon which its own litigation requests are based or upon which its refutation of the counterparty's litigation requests is based. However, in insurance disputes, the insurer shall bear the burden of proof under several conditions based on the Interpretations of the Supreme People's Court on

Several Issues Concerning the Application of the Insurance Law (II). For instance, if the parties concerned have any dispute over the scope and content of the inquiry at the time of concluding the insurance contracts, the insurer will bear the burden of proof.

iii Arbitration

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

iv Mediation

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

Pursuant to the Notice, the courts in the pilot regions can, in accordance with the spirit of the Overall Plan of the Supreme People's Court on Expanding the Pilot Reform of the Mechanism for Settling Disputes by the Linkup of Litigation and Non-Litigation,³ establish registers of mediation organisations and mediators that are specially invited. Where conditions permit, the courts can also provide mediation organisations and invited mediators with mediation rooms that are specifically provided to carry out the work required for settling insurance disputes.

The courts in pilot regions must, under the precondition of respecting the parties' will and in accordance with the relevant provisions of the Several Opinions of the Supreme People's Court on Establishing a Sound Mechanism for Settling Disputes by the Linkup of Litigation and Non-Litigation,⁴ guide parties in effectively settling disputes with low costs through the mechanism for linking insurance dispute litigation with mediation by means of appointed mediation before a case is docketed, and by means of authorised mediation after a case is docketed.

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

After receiving the bill of complaint and before registering a case, a people's court shall guide the parties to resolve insurance disputes via mediation. If the parties agree to this, they must complete relevant mediation forms or sign a letter of consent; if the parties do not agree, the people's court will register the case. After the case is registered, the people's court can still appoint mediation organisations to mediate the dispute with the consent of

3 No. 116 [2012] of the Supreme People's Court.

4 No. 45 [2009] of the Supreme People's Court.

the parties based on the development of the case. The mediation organisations must finish mediating the dispute within 20 working days of being assigned the case. The mediation period can be extended by seven working days in special circumstances, with the consent of the parties. The mediation organisations can consult with the people's court when dealing with complicated cases.

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

V YEAR IN REVIEW

On 13 December 2019, the CBIRC issued the latest version of the Administrative Measures on Internet Insurance (draft for comments). Compared with the Interim Measures for the Regulation of Internet Insurance Businesses issued in 2015, this draft more comprehensively reflects the latest supervision trend and thinking of the CBIRC on internet insurance. The draft focuses on the following issues:

- a* Clarifying the essence of internet insurance. Internet insurance changes the mode of human-human interaction into the mode of human-computer interaction in the insurance industry. Therefore, internet insurance should focus on the authenticity of participants' identities, the full and accurate transmission of information, high-quality consumer services and network security.
- b* Strengthening the qualification management of internet insurance business, and strengthening the main responsibilities of self-capacity evaluation, marketing publicity, information disclosure, foreign cooperation management, after-sales service, etc.
- c* Reconstructing the third-party network platform. In developing internet insurance, it shall give full play to the advantages of customer resources of the third-party network platform, but at the same time it shall pay attention to the problems of illegally operating insurance business and sales misleading existed in the third-party network platform.
- d* Regulating the behaviours of insurance practitioners and making fair disclosure via the internet.

The draft is an effective and prompt response to the existing problems in developing internet insurance.

On 4 December 2019, the CBIRC issued a Notice on Issues related to Regulating Endowment Insurance Products. The Notice is conducive to further enriching the supply of endowment insurance products, regulating the development and design of endowment insurance products and protecting the legitimate rights and interests of insurance consumers. According to the Notice, an insurance company developing and designing an endowment insurance product shall ensure that the insurance period of the product is consistent with the actual duration. An insurance company shall not carry out any of the following acts during the product design:

- a* changing the actual duration of a product in a disguised manner through designing clauses such as insurance policy-pledged loans, partial receipt, receipt upon survival, and reduction of sum insured;

- b* changing the actual duration of a product in a disguised manner through designing the pricing parameters of the product such as fees for surrender of an insurance policy and continuous reward; or
- c* increasing or reducing the cash value of a product in a disguised manner through adjusting the interest rate of cash value and other methods.

An insurance company selling endowment insurance products shall concentrate on business with an insurance period of five years or more. For liquidity management or asset-liability matching management needs, an insurance company may develop and design endowment insurance products with an insurance period of not shorter than three years but no more than five years.

An insurance company selling endowment insurance products with an insurance period of not more than five years shall maintain a comprehensive solvency adequacy ratio of not lower than 120 per cent. An insurance company with a comprehensive solvency adequacy ratio lower than 120 per cent shall immediately cease the sale of endowment insurance products with an insurance period of not more than five years.

VI OUTLOOK AND CONCLUSIONS

The year 2020 will play an important role in achieving the goals of the people-centred development philosophy and serving the real economy, which is the main industry policy of the CBIRC. Based on the idea proposed by the former CIRC that ‘the main function of the insurance industry is to insure, the main function of CIRC is to regulate’, 2020 will see the intensifying of insurance regulations, the active and prudent disposal of potential risks, and the promotion of supply-side structural reform, which will in turn give full play to safeguarding the real function of insurance, and further ensure that the insurance industry contributes to the development of the economy and society in China. Meanwhile, further reforms and innovations concerning the insurance market system, auto-insurance premiums and insurance asset utilisation will take place.

Thus, by 2021, a modern and mature insurance industry will be established step by step according to the blueprint of CBIRC, and China hopes to have a stronger insurance industry overall.

COLOMBIA

Neil Beresford, Raquel Rubio and Andrés García¹

I INTRODUCTION

Colombia is among the world's most dynamic and competitive insurance markets. Over the last decade, the industry has grown at a strong pace supported by the country's general economic expansion, a growing middle class, product development and competition from the entry of new participants. Despite the economic downturn faced by other economies in the region, Colombia continues to enjoy growth at an annual rate of 3.1 per cent and it is estimated to grow in 2020 at a rate of between 3 per cent and 3.6 per cent.² The insurance sector is growing at a rate above the national average: it increased by 11 per cent during 2019.³

The Colombian legal system remains challenging but it is constantly improving. Conservative regulatory standards, together with gradual reforms of financial regulation, have allowed the insurance market to maintain its stability and growth perspective. The regulator is planning to lower barriers for insurers to sell new products by waiving, in many cases, the requirement to obtain authorisation for new policy wordings.⁴ Those reforms will lift the industry's domestic reputation and stimulate local demand.⁵ After the wave of mergers and acquisitions that have affected the Colombian market since 2014, recent entrants have entered a phase of growth and market acquisition.

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.⁶

1 Neil Beresford is a partner, Raquel Rubio is a legal director and Andrés García is an associate at Clyde & Co LLP.

2 World Bank, Global Economic Prospects, <https://www.bancomundial.org/es/publication/global-economic-prospects>.

3 Fitch Ratings, 'Perspectiva de Fitch Ratings 2020: Seguros en Colombia', 19 December 2020.

4 Financial Superintendent, 'Supervision Agenda for the Market', Revista Fasecolda, No. 176, Convención Internacional de Seguros 2019.

5 For example, the adoption of International Financial Reporting Standards and Law 1870 of 21 September 2017, which regulates the regulation and supervision of financial conglomerates.

6 Article 325, Decree 663/93 EOSF and subsequent additions to the EOSF.

The main regulatory framework is contained in the Organic Statute of the Financial System (EOSF),⁷ and other regulations including:

- a* Decree 2555/2010, which sets reserve and minimum asset requirements and contains the regime applicable to insurance intermediaries;
- b* Law 1328/2009, which regulates access to the Colombian market by foreign non-domiciled insurers and contains consumer protection rules specific to financial products;
- c* Law 1480/2011 on general consumer protection;
- d* Law 1870/2017 on the regulation of financial conglomerates;
- e* Part I of External Circular 029/2014 of the FS, modified by External Circular 027/2019, 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
- f* the Commercial Code.

ii Position of non-admitted insurers

Unregulated insurance and reinsurance activity is prohibited.⁸ Contracts made with unauthorised entities are void and the unauthorised insurer may be required to return all premiums received.⁹ It may also be subject to further sanctions in the form of fines, compulsory dissolution and disqualification.

Colombian residents are generally free to purchase insurance outside Colombia, in which case the contract will fall outside the scope of Colombian regulation. Colombian insurers may cede 100 per cent of their written risks abroad by way of reinsurance. However, the following policies must be purchased from a regulated entity within Colombia:¹⁰

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

iii Requirements for authorisation of insurers

Colombian law provides four options for insurance entities wishing to do business in Colombia: incorporated insurance or reinsurance companies; branch offices of foreign insurers; registered foreign insurers or reinsurers; and representative offices of foreign reinsurers.

7 Decree 663/1993, EOSF.

8 Articles 39 and 108, EOSF.

9 Article 108.3, EOSF.

10 Article 39, EOSF.

Incorporated insurance and reinsurance companies

Insurers or reinsurers wishing to incorporate in Colombia require prior authorisation from the FS. The principal requirements for authorisation are as follows:

- a* the proposed entity must be structured as a limited company or a cooperative association;¹¹
- 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;¹² and
- c* in addition to its minimum capital, the proposed entity must maintain assets,¹³ a solvency margin and minimum reserves¹⁴ according to law.¹⁵

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:¹⁶

- 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 insurance

Foreign insurers may issue transportation policies (marine and aviation transport (MAT) insurance), in respect of goods, vessels and associated liabilities arising in the course of international transportation by air and sea, including space launch.¹⁷

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

11 Article 53, EOSF.

12 Articles 80 and 81, EOSF.

13 Article 2.31.1.1.1, Decree 2555/2010.

14 Articles 82 and 186, EOSF and Title 1, Chapter 2, Book 31 of Decree 2555/2010 (as modified by Decree 2954 of 2010).

15 Decree 1349 of 2019, which establishes the amount of funds required by insurers to respond to unexpected losses.

16 Articles 65 and 66, Law 1328/2009.

17 Article 61, Law 1328/2009 and Article 39 EOSF.

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.¹⁸

Agricultural insurance

Foreign insurers may also issue agricultural insurance policies¹⁹ 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.²⁰ The government subsidises between 70 per cent and 90 per cent of individual agricultural insurance premiums for small landholders and between 50 per cent and 70 per cent for larger landholders through Finagro, Colombia's rural development bank.²¹ The government is currently exploring the reforms that would be required to promote the use of parametric insurance.

Foreign reinsurers

Foreign entities may transact reinsurance business in Colombia.²² 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.²³

Representative offices and subscription agencies of foreign reinsurers

A reinsurer that is included on the REACOEX register may also open a representative office in Colombia. Applications are made to the FS and require extensive documentation to be served in support.²⁴ Representative offices are subject to the control and supervision of the FS. Since November 2018, foreign reinsurers may also carry out business through subscription agencies that are in charge of placing reinsurance on behalf of foreign reinsurers. Subscription agencies must be registered in REACOEX and set out the business lines available through the agent.²⁵

iv Position of brokers

To operate in Colombia, insurance and reinsurance brokers must be authorised and regulated by the FS.²⁶

18 Chapter V, Title II of Part I of External Circular 029/2014.

19 Article 74, Law 1450/2011.

20 Chapter IV, Title II of Part I of External Circular 029/2014.

21 Agricultural Insurance Incentive, <https://www.finagro.com.co/productos-y-servicios/incentivo-seguro-agropecuario>.

22 Article 94, EOSF.

23 Chapter III, Title II of Part I of External Circular 029/2014.

24 The list is specified in Article 4.1.1.1.4, Decree 2555/2010.

25 External Circular No. 20 of 3 October 2018, which creates Articles 2.2.1.8, 3.2.1.9 and modified Article 3.1 of the Basic Legal Circular. Lloyd's of London, Colombia: Offshore coverholder notification requirement. See also <https://www.lloyds.com/lloyds-around-the-world/americas/colombia/coverholder-registration-process>.

26 Article 1351, Commercial Code.

Incorporated entities

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

- a* If the proposed entity is an insurance broker, it must be incorporated as a limited company.²⁷ If a reinsurance broker, the proposed entity may be structured differently.²⁸
- b* The managing directors and administrators of the proposed entity must be approved by the FS and possess a minimum level of qualifications and personal standing. A candidate is presumed to be suitable if he or she can show they have sufficient experience in the brokerage industry and good business management records;²⁹ and
- c* The proposed entity must satisfy a minimum capital requirement.³⁰

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.³¹ 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.³²

vi The distribution of products

Regulated entities must submit their policy wording, including any schedules, amendments and premium models to the FS whenever they begin writing a new line of business.³³

The FS may disallow the use of wording that does not comply with Colombian insurance law and regulation or is insufficiently clear.³⁴ The FS may also prohibit the sale of a product if it determines that the proposed premium is unfair or unjustified by statistical evidence.

The FS has recently announced that it is planning to allow certain well qualified insurers to offer new products and business lines without previous authorisation.

27 Article 1347, Commercial Code and article 101 Law 510 of 1999.

28 Article 44.1, EOSF.

29 Article 2.30.1.1.3, Decree 2555/2010, modified by Decree 2123 of 2018.

30 Chapter III, Title IV of Part II of External Circular 029/2014.

31 Article 53, EOSF.

32 Article 72, EOSF.

33 Article 184.1, EOSF.

34 Article 184.4, EOSF.

vii Compulsory insurance

There are more than 50 types of compulsory insurance, including various forms of motor liability, employers' liability, transportation liability, environmental liability and credit insurance in transactions involving international trade and state entities. Unfortunately, there is no single point of reference and it is beyond the scope of this chapter to list them all. However, reinsurance brokers are among a very small number of professions that are required to carry professional indemnity and fidelity insurance.³⁵ The legislature frequently adds new mandatory insurance requirements affecting different sectors. Developments in recent years include a bill requiring compulsory building guarantee insurance and liability policies for certain types of dangerous dogs.³⁶

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.³⁷ 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.³⁸

The law does not provide for a statutory fund of last resort for customers of insurance or reinsurance firms. The solvency and reserving practices of these institutions are kept under continuous review by the FS.

ix Other notable regulated aspects of the industry

The FS must be notified of any proposed merger or acquisition involving a regulated entity;³⁹ or transaction by which an investor will acquire 10 per cent or more of a regulated entity.⁴⁰ The FS may object to such transactions for technical reasons⁴¹ 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.

35 Article 2.30.1.4.4, Decree 2555/2010.

36 Law 1796 of 2014 and Article 127, Law 1801 of 2016, Decree 282 of 21 February 2019.

37 Articles 8 and 13, Law 1328/2009.

38 See Article 57, Law 1480/2011 and Article 24, Law 1564/2012.

39 Article 56, EOSF and Article 2.36.12.2.4, Decree 2555/2010, Ministry of Finance and Public Credit.

40 Article 88, EOSF.

41 See Articles 58 and 88.1, EOSF.

The courts are subject to codified law but are allowed to use, at their discretion, ancillary tools such as jurisprudence, custom, doctrine, general principles of law and equity.⁴² 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.⁴³ 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.⁴⁴

ii 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.⁴⁵ 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;⁴⁶
- b an insurable risk – non-fortuitous or impossible events do not constitute risks and are therefore uninsurable.⁴⁷ Wilful misconduct, gross negligence⁴⁸ and deliberate acts of the beneficiary are also uninsurable;⁴⁹
- 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.⁵⁰ Material facts are those that, if known to the insurer, would have prevented it from entering the contract or caused it to apply more onerous terms.

The duty of disclosure applies in all cases. However, the insurer's remedy depends upon whether a proposal form is used – if it is, any incomplete or inaccurate answers result in the policy becoming voidable. If no proposal form is used, the policy is voidable if the insured gives incomplete or inaccurate information by reason of negligence or fraud. If the insured

42 Article 230, Colombian Constitution.

43 Article 1036 et seq. for non-marine, Article 1703 et seq. for marine and Article 1900 et seq. for aviation insurance.

44 Laws 1328/2009 and 1480/2011.

45 Article 1083, Commercial Code (CCo). With the exception of one's own life in cases of life insurance (Article 1137).

46 Supreme Court, decision of 21 March 2003, exp. 6642, magistrate César Julio Valencia Copete.

47 Article 1054, CCo.

48 With the exception of liability insurance (Article 1127, CCo).

49 Article 1055, CCo.

50 Article 1058, CCo.

acts innocently, the policy is not voidable but a proportional remedy applies. In other words, if the misrepresentation or non-disclosure leads to the insured paying only 50 per cent of the correct premium, the insurer is required to pay only 50 per cent of the claim.

The law is silent on the question of severability. Directors' and officers' (D&O) insurers are therefore free to include severability provisions to address non-disclosure or misrepresentation on the part of individual directors. Provided the declarations are made on their own behalf and not on behalf of the company, there is no reason to prevent insurers from pursuing the partial avoidance of the policy.

No remedy will be granted if the undisclosed or misrepresented facts were known to the insurer, or ought to have been known to the insurer, at the date of inception.

The duty of good faith continues throughout the duration of the contract. The insured must notify the insurer in writing of any material increase in risk, whereupon the insurer may cancel the policy or vary its terms.⁵¹ If the risk has decreased, the insurer is legally obliged to reduce the premium.⁵² If no notification is made, the contract is terminated automatically upon the increase in risk.

Recording of the contract

Insurers must issue written policy documentation within 15 days of concluding the agreement.⁵³ 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.⁵⁴

The proposal form and any attachments to it are considered part of the policy.⁵⁵

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.⁵⁶

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.⁵⁷ 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.⁵⁸ Therefore, a high degree of emphasis is placed upon the evidence of those involved in the contracting process and the

51 Article 1060, CCo.

52 Article 1065, CCo.

53 Article 1046, CCo as amended by Article 3, Law 389/1997.

54 Article 1047, CCo as amended by Article 2, Law 389/1997.

55 Article 1048, CCo.

56 Articles 7 and 9 to 12, Law 1328/2009 and Articles 9 and 10, Chapter 6, Title 1 of External Circular 007/1996.

57 Article 822, CCo.

58 Article 1618, Civil Code.

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*,⁵⁹ a principle that is applied rigorously in the context of consumer insurance.⁶⁰

The interpretation of the above principles might differ depending on the forum in which the claim is being heard. For instance, an insurance dispute might be heard before the administrative courts where principles of public law will be read into the contract. Equally, regulators such as the Office of the Controller General (the Controller's Office),⁶¹ a public body with discretion to commence quasi-judicial proceedings against private and public officials or entities involved in the management of public funds, might join their liability and bond insurers on the basis of inapplicable wording or multiple policy periods.

Mandatory rules

The parties to an insurance contract enjoy relatively wide freedom to set the terms of the agreement, subject to the limits of public policy and the mandatory rules of Colombian law.⁶² 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.⁶³

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;⁶⁴
- b* if a policy is issued for the benefit of multiple insured parties with different interests (e.g., a D&O policy), non-disclosure by one insured party will not affect the validity of the coverage issued to others;⁶⁵ 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.⁶⁶

59 Article 1624, Civil Code.

60 Supreme Court, decision of 27 August 2008, exp. 1997-14171. Magistrate William Namén Vargas. See also Article 34, Law 1480/2011.

61 Law 610 of 2000 and Law 1474 of 2011.

62 The rules made mandatory by the Commercial Code are listed in Article 1162.

63 Article 899, CCo.

64 Article 1058, CCo.

65 Article 1064, CCo.

66 Article 1091, CCo.

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;⁶⁷
- 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;⁶⁸
- 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;⁶⁹ 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.⁷⁰ Following cancellation by either party, the insurer must return the unused part of the premium.⁷¹

The most important mandatory rules affecting 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;⁷²
- 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;⁷³
- c* in the case of double insurance, each insurer is required to pay a rateable proportion if the insured has acted in good faith;⁷⁴ and
- d* the insured will forfeit its right to indemnity if it acts in bad faith during the claims process.⁷⁵

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

- 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;⁷⁶
- b* if the insured incurs genuine mitigation costs, the insurer is required to pay the costs even if they exceed the sum insured;⁷⁷ and

67 Article 1068, CCo. Note that different rules are applicable to life insurance policies, pursuant to Article 1151, CCo.

68 Article 1065, CCo.

69 Article 1093, CCo.

70 Article 1071.

71 *ibid.*

72 Article 1078, CCo.

73 Article 1075, CCo.

74 Article 1092, CCo.

75 Article 1078, CCo.

76 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.

77 Articles 1074, 1079 and 1089, CCo.

- 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.⁷⁸

Conditions precedent

Colombian law does not use the language of conditions precedent. It neither prohibits nor endorses them. The effect of clauses that are expressed as conditions precedent must therefore be approached on an individual basis, in the context of the mandatory rules explained above.

The law may be summarised as follows:

- 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.⁷⁹
- b Some conditions precedent are positively reinforced by mandatory rules. For example, Article 1068 of the CCo contemplates that an insurer may make the payment of premium a condition precedent to its liability; and
- 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.

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.*⁸⁰

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

78 Article 1131, CCo.

79 Article 1078, CCo.

80 Article 1061, CCo.

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,⁸¹ 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

Intermediaries

There are four types of insurance intermediary: agents, brokers, bancassurance and correspondents. Agents are contractors or employees of the insurer and act on the insurer's behalf. Unless they are especially large, agents are regulated by the FS as part of the insurer for whom they act. Their precise rights and obligations depend upon the extent of their delegated authority, although all agents have power to collect money, inspect the physical risk and assist in arranging the policy. Some agents have delegated underwriting and claims authority. Increased scrutiny has led the regulator to tighten regulation for agents. As of July 2017, all agents are required to register with the Insurance Intermediaries Registry⁸² and undertake a training course before they are allowed to offer their services to the public.⁸³

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.*⁸⁴

As a result of this privileged legal status, claims against brokers are rare. Only reinsurance brokers are required to carry professional indemnity insurance.⁸⁵

Most recently, the FS promoted alternative intermediation methods, including bancassurance, to increase the availability of insurance in the mass market. It also extends to other retailers acting as correspondents with allowances to offer consumer products, such as mandatory vehicle insurance or basic life insurance.⁸⁶

Code of conduct

All brokers and agents are subject to the same code of conduct that applies to regulated entities in general.⁸⁷ The specific duties of intermediaries include prohibitions on:

- a* misrepresenting the scope of cover or the terms of the contract;
- b* paying commission to the insured;

81 Articles 1074, 1079 and 1089, CCo.

82 Circular No. 50 of 28 December 2015.

83 Section 7, Chapter II, Title IV, Part II of Circular 029 of 2014. As modified by Circular No. 006 of 2018.

84 Article 1340 CCo.

85 Article 2.30.1.4.4 of Decree 2555/2010.

86 Articles 2.36.9.1.17 of Decree 2555 of 2010 as modified by Decree 2123 of 2018.

87 Article 72, EOSE.

- c interfering with the business of other brokers;
- d competing unfairly; and
- e acting without instructions.⁸⁸

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.⁸⁹ The commission falls due as soon as the insurance contract is signed.⁹⁰

v 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.⁹¹ Second, duties of notification cannot be made conditions precedent to an insurer's liability.⁹²

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.⁹³ The Controller's Office applies a five-year limitation period based on its own procedural rules.

Good faith and the claims process

The duty of good faith subsists throughout the contract. In the claims context, the duty of good faith is reflected in Articles 1074 and 1079 of the CCo, which oblige the insured to mitigate loss⁹⁴ and oblige the insurer to meet the reasonable costs of mitigation, even if they exceed the eventual limit of indemnity.⁹⁵ Save in the case of subrogation,⁹⁶ the law does not impose on the insured any specific duties to cooperate with their insurers in the defence or adjustment of claims.

In practice, these rules can leave insurers with only limited control of claims. However, if an insured commits bad faith in the claims process, it will forfeit the right to indemnity.⁹⁷

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,⁹⁸ or the insured or a regulator may bring the insurer into litigation by issuing a form of third

88 Article 207.3, EOSF.

89 Article 2.30.1.1.4, Decree 2555/2010.

90 Article 1341, CCo.

91 Article 1075, CCo.

92 Article 1078, CCo.

93 Article 1081, CCo.

94 Article 1074, CCo.

95 Article 1079, CCo.

96 Article 1098, CCo.

97 Article 1078, CCo.

98 Article 1133, CCo.

party notice known as a 'call-in-warranty'. The Controller's Office has the discretion to draw liability and bond insurers into a form of recovery proceedings as guarantors of their insured's potential liabilities.

In contrast, a reinsurer can be sued only by the reinsured: it is not legitimate for a third party or an original insured or a regulator to bring proceedings directly against a reinsurer.⁹⁹

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.¹⁰⁰

However, for policies with a sum insured in excess of a determined threshold (currently US\$3.9 million) the payment period can be extended by agreement up to 60 working days.¹⁰¹ 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.¹⁰² 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.¹⁰³

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.¹⁰⁴ Policies issued outside Colombia may be subject to foreign law and jurisdiction.

ii Litigation

The judicial system is divided into four jurisdictions: ordinary, administrative, constitutional and special.¹⁰⁵ 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 2016.¹⁰⁶

99 Article 1135, CCo.

100 Article 1080, CCo.

101 Article 185.1, EOSE.

102 Article 1096, CCo.

103 Article 1099, CCo.

104 Article 869, CCo.

105 Article 11, Law 270/1996.

106 Law 1564/2012.

- 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.¹⁰⁷
- c* The constitutional jurisdiction is overseen by the Constitutional Court, which decides upon the constitutionality of laws and has the last word in constitutional protection claims (Tutelas).
- d* Special jurisdictions include tribunals set up for the determination of indigenous rights, the supervision of the judiciary, military functions, and for the enforcement of the peace agreement with the Revolutionary Armed Forces of Colombia.

Insurance disputes may be heard in either the ordinary or administrative jurisdiction, according to the identity of the insured. Cases are heard by professional judges appointed by an independent government agency. Juries are not used in Colombia.

Traditionally, the court system has suffered badly from delays; the World Bank ranks the speed of Colombian justice at 177th in a survey of 190 countries.¹⁰⁸ 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.

Litigation stages

Commercial cases follow a particular sequence. The typical components of an action before the courts of the ordinary jurisdiction are explained below. This is a detailed explanation because in many respects it is also representative of the procedure followed in domestic arbitration and in the administrative jurisdiction:

- a* Before a claim is submitted, Colombian law requires the parties to participate in a mediation hearing, which suspends the statute of limitations.¹⁰⁹
- b* If mediation is unsuccessful, the claimant must file a formal complaint¹¹⁰ 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.¹¹¹
- 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.

107 Law 1437/2011.

108 World Bank Group, *Doing Business 2020, Colombia*, <https://www.doingbusiness.org/content/dam/doingBusiness/country/c/colombia/COL.pdf>.

109 Article 35, Law 640/2001. A similar requirement now applies in many administrative cases by virtue of Law 1285/2009 and Law 1437/2011.

110 Articles 82 to 84, Law 1564/2012.

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

- d* Once pleadings have closed, the claimant may amend the pleadings on one occasion only. The defendant has no right to amend other than in response to a complaint by the claimant.
- e* The pleadings must include reference to any evidence that the party wishes to volunteer as part of its case. By virtue of a legislative reform in 2012,¹¹² parties can adduce their own expert evidence.
- f* During the initial hearing, the judge makes concrete proposals that are intended to encourage a settlement between the parties. If no agreement is possible, the judge will seek to establish the disputed facts and order the evidence in the case. The types of admissible evidence include statements of the parties, confessions, oaths, witnesses, experts' opinions, judicial inspections, documents, circumstantial evidence and reports.¹¹³ 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 conference¹¹⁴ in their local Colombian consulate by a procedure involving letters rogatory. However, this is an intricate process, which can take several months to negotiate.
- i* If expert evidence is required, the judge will normally appoint a single expert from an official court list. The expert's evidence is received in writing and the cost is met either by the party that requested the evidence or by the parties jointly, as appropriate. Since the General Procedure Code became fully enforceable in 2016, expert evidence may also be received verbally.
- j* Once the evidence is complete, the case moves to the conclusion hearing, at which the attorneys for each party have 20 minutes to make oral closing statements. The judge will take a decision in the case either immediately or at a separate judgment hearing.

Funding and costs

The costs of proceedings consist of an official tariff, lawyers' fees, and miscellaneous costs such as expert evidence, administrative expenses and witnesses' expenses.

Contingency fees, conditional fees and third-party funding are all permitted by law. The law makes no obvious provision for security for costs.

The judge may order the losing party to pay the winner's fees and legal costs, although the amount is subject to a cap. In the case of commercial disputes, the losing party should not be required to pay more than 20 per cent of the judgment sum in costs.¹¹⁵

112 Article 227, Law 1564/2012.

113 Article 165, Law 1564/2012.

114 Articles 171 and 182, Law 1564/2012.

115 Agreement 10554/2016.

Rights of appeal

The law guarantees that judicial decisions have two instances: a first instance decision and a right of appeal.¹¹⁶

An appeal must be notified either orally at the judgment hearing or in writing within three days after service of the first instance decision.¹¹⁷ In exceptional circumstances, a direct right of appeal to the Supreme Court or the Council of State may exist.¹¹⁸

Duration of proceedings

As mentioned above, delays in the court system are a significant and continuing problem. The General Procedure Code states that cases before the courts of the ordinary jurisdiction should take no more than a year to be resolved at first instance and no more than a further six months on appeal.¹¹⁹ It remains to be seen whether this objective will be achieved.

iii Arbitration

Arbitration is a well-established and relatively sophisticated mechanism of dispute resolution in Colombia. Arbitration clauses can be agreed in consumer contracts if the consumer expressly agrees to submit a dispute to arbitration, although arbitration clauses in standard consumer contracts are likely to be struck down as abusive.

Separate rules apply to domestic and international arbitrations. Both sets of rules are found in Law 1563/2012, which came into force in October 2012. A reform to Law 1563 is expected in the course of 2020, which will address the delays faced by arbitrations in their initial stages and other recurring issues. 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.¹²⁰ The parties may also submit an active dispute to arbitration by way of a submission agreement.¹²¹

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

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

116 Article 9, Law 1564/2012.

117 Article 322, Law 1564/2012.

118 For the ordinary jurisdiction, see Article 333–351, Law 1564/2012. For the administrative jurisdiction, see Law 1437/2011.

119 Law 1395/2010 and Article 121, Law 1564/2012.

120 Article 4, Law 1563/2012.

121 Article 6, Law 1563/2012.

Jurisdiction and choice of law

As indicated, Colombian insurance policies are subject to the mandatory application of Colombian law¹²² 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.¹²³

An arbitration will be international if any of the following conditions are met:¹²⁴

- a* at the time of entering the arbitration agreement, the parties had their places of business in different states;
- b* the matters in dispute relate to international trade;
- c* a substantial part of the contract is performed outside the state in which the parties have their places of business; or
- d* the subject matter of the dispute is most closely connected with a place that is outside the state in which the parties have their places of business.

Ad hoc and institutional arbitration

Unless the arbitration agreement provides expressly to the contrary, domestic arbitrations are deemed to be institutional,¹²⁵ 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.¹²⁶ Moreover, the procedural rules of ad hoc arbitration are the same as those that apply to institutional arbitration.¹²⁷

For those reasons, the vast majority of arbitrations are carried out on an institutional basis.

Appointment of arbitrators

Unless provided for in the arbitration agreement, the law presumes that three arbitrators will hear a dispute. If the value of the claim is less than US\$100,000, it will be heard by one arbitrator.¹²⁸

In domestic arbitration, each of the arbitrators must be a Colombian-qualified lawyer with a valid practising certificate.¹²⁹ Party-appointed arbitrators are not permitted, and the parties must agree upon the choice of arbitrators. If no agreement is reached, the parties may

122 Article 869, CCo.

123 Articles 92 and 101, Law 1563/2012.

124 Article 62, Law 1563/2012.

125 Article 2, Law 1563/2012.

126 Article 2, Law 1563/2012.

127 Article 57, Law 1563/2012.

128 Articles 2 and 7, Law 1563/2012.

129 *ibid.*

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.¹³⁰ 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.¹³¹

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.¹³² 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.¹³³
- c* If the defendant to the arbitration is a state entity, the arbitration centre must notify the Agency for the Defence of the State¹³⁴ of the existence of the claim.¹³⁵ 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.¹³⁶

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:¹³⁷

- 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;

130 Article 8, Law 1563/2012.

131 Article 73, Law 1563/2012.

132 Article 12, Law 1563/2012.

133 Article 30, Law 1563/2012.

134 Law 1444/2011; www.defensajuridica.gov.co/Paginas/Default.aspx.

135 Article 12, Law 1563/2012.

136 Article 25, Law 1563/2012.

137 Article 41, Law 1563/2012.

- b* 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 errors¹³⁸ and then to ask the tribunal itself to annul the award¹³⁹ before approaching the relevant court.¹⁴⁰

A party may also petition the Constitutional Court for an order quashing an arbitration award if it feels that the tribunal infringed its rights to a fair hearing.

Costs

The arbitrators will determine the fees and expenses of the tribunal in accordance with the amount claimed. The maximum amount allowed by law to be charged by an arbitrator is currently US\$260,000 and up to half of this for the secretary's fees.¹⁴¹ In theory, the parties can agree the fees between themselves and inform the arbitrators of what has been decided when they are designated. However, that option is not always open if the list of available candidates is short.

There are additional costs relating to the functioning of the tribunal in an arbitration centre. These are usually a fixed percentage of the sum in dispute. The arbitrators' fees and the sum paid to the centre are subject to a new 2 per cent arbitral tax for the financing of the ordinary courts.¹⁴²

iv Alternative dispute resolution

Mediation and third-party adjudication are both recognised by law.¹⁴³ As mentioned in subsection ii, 'Litigation stages', mediation is a mandatory step before accessing the courts. Agreements obtained through alternative dispute resolution (ADR) are binding on the parties and enforceable before a judge.

v Other forums

Insurance disputes may also be heard before the Controller's Office, which has discretion to adjudicate on matters involving negligent or fraudulent misconduct on the part of public and private entities or individuals trusted with the management of public funds.

If it has grounds to suspect that public funds have been misused, the Controller's Office may pursue a recovery action, known as a fiscal liability proceeding (FLP), against any relevant entity or individual. It does not impose fines or penalties but seeks restitution, hence its relevance to insurers: not only does an investigation trigger defence costs but awards against individual or corporate entities may attract indemnity under D&O insurance, professional indemnity insurance, crime or bond policies. Insurers are frequently called to

138 Article 39, Law 1563/2012.

139 Articles 40 to 43, Law 1563/2012.

140 Article 45, Law 1563/2012.

141 Article 26, Law 1563/2012.

142 Articles 16 to 22, Law 1743/2014.

143 Decree 1818/1998.

FLP proceedings to guarantee the obligations of their insureds.¹⁴⁴ The Controller's Office has no jurisdiction over insurers based abroad or reinsurers.¹⁴⁵ Insurers have the same rights of defence as their principals.

The Controller's Office has its own procedural rules, set out in Law 610/2000. They involve a two-stage process whereby the Controller's Office first carries out an audit and later presents charges via FLP proceedings. A final decision must be reached within five years of commencement of the FLP¹⁴⁶ (overriding the usual Colombian rules of limitation) and payment becomes enforceable within five days of a final decision. Liability is commonly imposed on a joint and several basis among the principals, and severally across their insurers. Policy limits tend to be observed but little regard is given to the policy wording or the nature of the cover. For example, it is not uncommon to see various claims-made policy periods involved on the basis that the irregularities occurred for a prolonged period of time. In 2019 the Controller took two decisions that purported to respect the terms of insurance policies but it is not yet certain whether those decisions will translate into an established pattern of behaviour.¹⁴⁷ The arbitrary nature of the decisions emanating from the Controller's Office have made the local and international markets wary of insuring Colombian public entities and their directors.

The decisions of the Controller's Office may be challenged through judicial review before the administrative jurisdiction. In the event of a successful judicial review, any amounts paid to the Controller's Office will be returned.

V YEAR IN REVIEW

The most significant feature of 2019 was the inability of the new government to implement its main policies due to its lack of a majority in Congress and the outbreak, during the final months of the year, of social discontent in Colombia's main cities. Social discontent has led to a higher than normal increase in the minimum wage, which may affect corporate profits. As previously stated, the FS is planning to lift the previous authorisation regime for non-social security new business lines and replace it with a general authorisation, which will lead to increased product offering and greater market dynamism.¹⁴⁸ As announced, this general authorisation will only be available to highly qualified insurers and will also entail an increased level of enforcement by regulators.

The insurance market has continued to grow at a double-digit rate. However, overall technical results (premiums minus losses and operating costs) are negative, which has put pressure on companies to increase profitability. The internal regulatory regime continues gearing up to face international shocks through strict capital and reserving rules, and the gradual implementation of risk-based regulation as set out by international organisations.¹⁴⁹ Decree 1349 of 2019 introduced new variables to update the solvency index for a five-year

144 Article 44, Law 610 of 2000.

145 Article 1135, CCo.

146 Article 9, Law 610 of 2000.

147 Decision No. 0450 of 2 May 2019, D No. 2. PRF-2014-05213_UCC-PRF-033-2014 (Saludcoop) and Decision No. 737 of 18 November 2019 (Instituto de Desarrollo Urbano-IDU-).

148 Financial Superintendent, 'Supervision Agenda for the Market', Revista Fasecolda, No. 176, 'Convención Internacional de Seguros 2019'.

149 Unidad de Proyección Normativa y Estudios de Regulación Financiera, 'Updating Insurance Regulation: a URF promise' Revista Fasecolda, No. 176, 'Convención Internacional de Seguros 2019'.

transition period.¹⁵⁰ The Ministry of Housing issued the long awaited delegated legislation on mandatory building insurance (Decree 282 of 2019), but the market is not expected to offer any coverage until 2021 when the guidelines for issuing building certifications have been finalised.¹⁵¹

The local insurance market has benefited from increased competition from local and foreign companies, and abundant reinsurance options. However, industry profitability has been under constant pressure because of competition and local currency devaluation. Market consolidation continued to take place during 2019 but at a slower pace. Seguros Bolívar purchased the life insurance division of Liberty Colombia; in November 2019 Spanish insurer Mutua Madrileña bought a 45 per cent stake in the second largest non-life insurer Seguros del Estado, with the possibility of taking a majority percentage within four years.¹⁵²

According to Fitch compulsory vehicle liability insurance is starting to stabilise after many years of severe losses as a result of chronic evasion and fraud. The recovery is attributed to a lower level of accidents and improved pricing strategies.¹⁵³

The rate of growth of 11 per cent in premium sales was led by life insurance (16 per cent) Social Security (9 per cent) commercial lines (10 per cent) and social security (9.9 per cent).¹⁵⁴

VI OUTLOOK AND CONCLUSIONS

On a technical level, the main areas of focus in 2020 and beyond are likely to be:¹⁵⁵

- a* the continued efforts of the FS to meet international standards and consolidate risk-based supervision methodologies through the gradual implementation of EU Solvency II regulations and International Financial Reporting Standards;¹⁵⁶
- b* implementation of the general authorisation for issuing new business lines;
- c* pension and social security reform will continue to be high on the agenda of the government to reduce the impact of social spending on the public budget and increase individual savings;
- d* increased availability of mandatory vehicle insurance (SOAT) to increase distribution of risk and establish a cross-subsidy compensation scheme;^{157, 158}

150 Fitch Ratings, 'Perspectiva de Fitch Ratings 2020: Seguros en Colombia', 19 December 2020.

151 La República 'El Registro de Supervisores para el Seguro Decenal Estará Listo en 2020 según MinVivienda'.

152 Portafolio, 'Llega una nueva aseguradora al país' 7 November 2019 <https://www.portafolio.co/internacional/aseguradora-mutua-entra-a-colombia-535361>.

153 Fitch Ratings, 'Perspectiva de Fitch Ratings 2020: Seguros en Colombia', 19 December 2020.

154 Fasecolda, Presentation of Industry Figures, 2019. <https://fasecolda.com/cms/wp-content/uploads/2020/02/Cifras-diciembre-2019-1.pdf>.

155 'Actualizar la regulación en Seguros: un compromiso de la URF' 019' Financiera Superintendent 'Agenda de la Industria Aseguradora para el Gobierno Entrante' and Unidad de Proyección Normativa y Estudios de Regulación Financiera, 'Updating Insurance Regulation: a URF promise' Fasecolda Magazine No. 176, <https://revista.fasecolda.com/index.php/revfasecolda>.

156 Jorge Castaño Gutiérrez, Financial Superintendent, presentation at the Fasecolda convention, 2 October 2019, <https://youtu.be/YgYJvgGM7g0>.

157 Revista Fasecolda, No. 176, 'Convención Internacional de Seguros 2019' <https://revista.fasecolda.com/index.php/revfasecolda>.

158 Unidad de Proyección Normativa y Estudios de Regulación Financiera, 'Updating Insurance Regulation: a URF promise' Fasecolda Magazine No. 176, <https://revista.fasecolda.com/index.php/revfasecolda>.

- e* widening of the consumer base and financial inclusion of the lower-income population and remote areas of the country previously inaccessible owing to the internal conflict;
- f* implementation by financial institutions and online businesses of the new cybersecurity requirements (see Section V) will prompt businesses to request cyber insurance;
- g* the Controller's Office will continue to be a source of uncertainty in the insurance and reinsurance markets for public entities and public officers due to unresolved and ongoing fiscal liability proceedings; and
- h* the regulator has announced its plans to regulate the decision making processes of actuaries within insurance companies and to improve corporate governance.

Commercially, the challenge remains to persuade Colombian consumers that insurance is more than a luxury.¹⁵⁹ Insurers, intermediaries and the government are working hard to raise the profile of consumer rights, highlight the advantages of insurance cover, and implement technological solutions to facilitate claims and the purchase of insurance. It is estimated that, currently, only 30 per cent of Colombian households have non-mandatory products.¹⁶⁰

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 projects that began or were contracted in the final year of local and departmental governments.

The Colombian market is still dominated by compulsory insurance, workers' compensation and life insurance, which will continue to grow with the increase of formal employment and the availability of credit. Although commercial lines are relatively undeveloped, liability and construction are significantly outperforming other sectors of the market. The constant expansion of compulsory insurance requirements is a major source of business for the sector, including commercial lines such as building guarantees and other sorts of construction insurance. New trends include lines such as fintech and the digital economy. There are important opportunities in agricultural insurance where only 3 per cent of the total 40 million hectares of cultivated land is insured.

The insurance sector will continue to benefit from stable economic growth and is expected to grow at rates similar to those in 2019.

159 FS and Fasescolda 'Estudio Demanda de Seguros' December 2018, <https://www.superfinanciera.gov.co/jsp/Publicaciones/publicaciones/loadContenidoPublicacion/id/10099214/dPrint/1/c/0>.

160 FS, Fasescolda and Banca de Oportunidades, Estudio de Demanda de Seguros, 2018, <https://www.superfinanciera.gov.co/.../20181211estudiodemandaseguros>.

DENMARK

Henrik Nedergaard Thomsen and Sigrid Majlund Kjærulff¹

I INTRODUCTION

The majority of Danish insurance companies are members of Insurance and Pension Denmark (IPD), an association that promotes the interests of the entire insurance (and pensions) industry. Foreign insurance companies engaged in the provision of services in Denmark may become ‘info’ members.

The Danish insurance market is characterised by strong competition for customers. According to the statistics published by the association, the number of Danish insurance companies has more than halved over the past 20 years, from 138 companies subject to Danish supervision in 1999 to 61 in 2018.² In the same period, the number of employees fluctuated, from 13,751 in 1999 to 10,305 in 2005 to 13,533 in 2014 to 10,343 in 2017 and to 8,211 in 2018.³ Customers are also switching between companies more frequently to get better cover and prices.⁴ In 2013, the number of new customers (less than four years as a customer) increased by 22 per cent, which grew to 35 per cent in 2017.⁵ Customer satisfaction is also very high, with a score of 77 (out of 100) in 2019.⁶ Denmark also has the highest industry score in Scandinavia.⁷

The annual profit of the insurance industry decreased by 35.6 per cent from 2017 to 2018, to 8.4 billion kroner before tax. Underwriting profits decreased by 1.4 per cent in the same period to 7.6 billion kroner.⁸ This was primarily a result of the two big companies, Alpha Insurance and Qudos Insurance, which went bankrupt in 2018, and, thus, do not appear in the annual report for 2018. It is assumed that the annual report for 2019 will give a more fair presentation of the insurance industry, as it will be possible to compare two years without taking the bankrupt companies into account.⁹

1 Henrik Nedergaard Thomsen and Sigrid Majlund Kjærulff are partners at Poul Schmith.

2 www.forsikringopension.dk/statistik/selskaber-i-forsikrings-og-pensionsbranchen.

3 www.forsikringopension.dk/statistik/beskaeftigede-i-forsikrings-og-pensionsbranchen.

4 www.finans.dk/erhverv/ECE10020825/danskerne-skifter-forsikringselskab-som-aldrig-foer/?ctxref=ext.

5 www.epsi-denmark.org/report/forsikring-2017.

6 www.epsi-denmark.org/wp-content/uploads/2019/12/Pressemeddelelse-EPSI-Forsikringsstudie-2019.pdf.

7 www.epsi-denmark.org/branchestudier/forsakring.

8 www.forsikringopension.dk/statistik/resultatopgoerelsen-for-forsikringsbranchen.

9 www.finanstilsynet.dk/Tal-og-Fakta/Markedsudvikling/Markedsudvikling/MU-skade-19.

In terms of the balance sheet total in 2018, Tryg Forsikring was the biggest insurance company in Denmark, followed by Codan and Topdanmark. The statistics only cover companies in the Danish market under Danish supervision.

II REGULATION

i The insurance regulator

The insurance market is regulated, and the requirements for establishing and carrying on insurance business are laid out in the Danish Financial Business Act.¹⁰

However, a large number of other statutory provisions also apply, including those contained in:

- a* the Danish Anti-Money Laundering Act;
- b* the Danish Companies Act;
- c* the Danish Capital Markets Act; and
- d* the Danish Act on Processing of Personal Data.

The Financial Business Act also applies to reinsurers. However, special rules for these companies may also apply.

The Danish Financial Services Authority (FSA)¹¹ monitors and regulates the financial sector in Denmark, including insurance and reinsurance companies. The purpose of the FSA is to supervise, legislate and provide information. In 2018, the FSA was authorised to obtain information from enterprises subject to the new Danish Insurance Mediation Act¹² (see subsection ii, 'Insurance distribution'). The FSA is also authorised to obtain information from persons and enterprises not subject to the Act in order to assess whether they should be subject to the rules.

The FSA may prosecute, issue orders and report issues to the police if insurers or reinsurers fail to comply with the rules applying to financial services firms, and, as another consequence of the new Act, violation of the rules of the Act could be punishable by a fine or imprisonment for up to four months.

ii Registration with the FSA

Insurance and reinsurance companies

Insurance and reinsurance business in Denmark require a licence from the FSA.¹³ The licence is issued based on a plan of operations prepared by the insurer or reinsurer. The FSA establishes the rules for the information that must be included in the plan of operations.

10 Consolidated Act No. 937 of 6 September 2019.

11 www.dfsa.dk.

12 Act No. 41 on Insurance Distribution of 22 January 2018.

13 Section 11(1) of the Financial Business Act (Consolidated Act No. 937 of 6 September 2019).

Foreign insurance and reinsurance companies in the European Economic Area and European Union

Insurance and reinsurance companies from other Member States of the European Economic Area (EEA) or the European Union (EU) may carry on insurance business in Denmark on either an establishment or a freedom-of-services basis (without the need for a licence from the FSA) if they have already been licensed in another EEA or EU Member State.

These companies may operate in Denmark on a cross-border basis immediately after the FSA has received notification from the supervisory authorities of the company's home country, or the home country can notify the FSA and the company may operate through a branch in Denmark two months after the notification has been given.¹⁴

The company must observe Danish good business practice rules, consumer protection regulation and certain insurance contract requirements that are contained in, for example, the Insurance Contracts Act (ICA).¹⁵

Foreign insurance and reinsurance companies from outside the EEA or the EU

Insurance and reinsurance companies from outside the EEA or the EU may not carry on insurance business in Denmark using a licence from their home country.

If the company wants to carry on business in Denmark, it is required to set up an insurance company or a branch in Denmark and apply for a licence from the FSA.

Other requirements

As a result of the implementation of the EU Solvency II Directive into Danish law (with effect from 1 January 2016), the law distinguishes between Group 1 and Group 2 insurers. Group 1 insurers are big companies calculated (among other factors) according to their gross annual premium. Group 2 companies include all other companies.

Depending on which group the insurer belongs to, there will be different additional capital and solvency requirements, as well as organisational requirements.

Insurance distribution

On 1 October 2018, the new Insurance Mediation Act came into force, implementing the EU Insurance Distribution Directive into Danish law. The Act increases the protection of consumers by, among other things, introducing stricter licence and registration requirements. It is no longer enough for agents and subagents to be registered; they must also have a licence from the FSA (provided that they fall under the definition of insurance intermediaries).

Enterprises selling goods or services and selling insurance in connection with the sale of these other goods or services are not required to have a licence but must be registered. This applies to travel agents and car dealers, for example.

One requirement for receiving a licence from the FSA to distribute insurance is that the registered office of the enterprise is in Denmark. It is also a requirement that the enterprise has liability insurance or another corresponding guarantee against claims for damages and has measures in place ensuring that customers are protected against the distributor's inability

14 Sections 30 and 31 of the Financial Business Act (Consolidated Act No. 937 of 6 September 2019).

15 Consolidating Act No. 1237 of 9 November 2015.

to pay. The enterprise must also have a management fulfilling the suitability and integrity requirements of the Act, ensuring a responsible and efficient operation of the insurance intermediaries.

It follows from the transitional provisions of the Act that enterprises already licensed as insurance brokers before the Act entered into force have to submit a new application, but that the enterprise may continue its activities until the FSA has made a decision on the matter.

The same applies to enterprises registered as insurance agents or as subagents and to enterprises selling insurance that did not require a licence under the preceding Act (Consolidated Act No. 937 of 6 September 2019). These enterprises must submit an application for a licence but may continue their activities until the FSA has made a decision.

Non-compliance

If insurance is effected before a licence to carry on insurance business has been issued and registration has been made, the individuals who have effected the insurance or who are responsible are jointly and severally liable for the performance of the contract. However, if the insurer accepts the liability no later than four weeks after registration, the liability is repealed (provided that the policyholder's security is not significantly weakened as a result).¹⁶

If the rules for are not complied with, the FSA can exercise certain powers. For instance, an order may be issued stipulating that the insurer or reinsurer will be subject to strict supervision. Ultimately, the company could risk losing its licence to carry on business in Denmark.

The members of the executive board and the board of directors of an insurance or reinsurance company may incur liability if the management does not fulfil the necessary requirements.

iii Compulsory insurance

A number of specific laws, contracts and other regulation stipulate that compulsory insurance cover must be taken out in certain areas, including the following: motor vehicle; professional liability (for some advisers, such as lawyers and accountants); industrial injury; dog and horse liability; railway liability; aviation liability; occupational disease; oil pollution; maritime claims (for all Danish ships with a gross tonnage of 300 or more); drones (that are not micro-drones); and, as of 15 May 2018, injuries caused by jet skis, etc., in connection with maritime accidents.

Insurance brokers must also take out liability insurance and provide security for the claims that may be raised against them as a result of their business.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The ICA regulates insurance contracts and provisions, which are mandatory to a certain extent, governing the relationship between an insurer and a policyholder.

¹⁶ Sections 22 of the Financial Business Act.

Different rules on consumer protection and good practice also apply (e.g., the insurer must give correct advice on insurance products). These rules must be complied with or the advisers may incur professional liability. The rules on good practice are laid down in Part 6 of the Financial Business Act, and they apply to insurers in contractual relationships.

The ICA does not apply directly to reinsurance, but it is applied by analogy together with the general law of contract, including the freedom of contract.

Insurance brokers and others selling insurance commercially are subject to the Danish Insurance Mediation Act (see subsection iv).

ii Making the contract

Any issues relating to the rights and obligations between an insurer and a policyholder are regulated by the ICA. However, the characteristics of an insurance contract are not defined in the ICA but are governed by the Contract Act¹⁷ and the general principles of Danish contract law, including freedom of contract (for some areas insurance is compulsory, see Section II.iv).

An insurance contract is generally defined as ‘an agreement to take over a financial risk for the occurrence of an unexpected event, against a consideration calculated statistically based on the distribution of that risk on a plurality of policyholders’.¹⁸

When entering into an insurance contract, an insurance seeker will usually apply for cover from the insurance company, after which it will fill out a form with a number of questions provided by the insurance company. The underwriters will draft the policy terms based on the information provided and enter into an insurance contract with the insurance seeker on behalf of the insurer.

A general duty of good faith and fair dealing in respect of other contracting parties applies to all contractual relationships. Furthermore, when it comes to insurance and reinsurance contracts, the ICA stipulates that the insurance seeker has a duty of disclosure and to provide answers. If it fails to answer the questions in the application form truthfully or fails to disclose an important fact, the rules of the ICA will determine whether an insured event is to be compensated and whether the company is bound by the contract at all.¹⁹

The insurance premium must be paid 21 days after a claim for payment has been made. Only then may the insurer terminate the insurance contract.

iii Interpreting the contract

Denmark has a civil law system that is based on general rules and principles to some extent, and the interpretation of insurance and reinsurance contracts is, in line with the interpretation of other contracts, subject to these rules and principles.

The interpretation of an insurance contract involves both the disputed provision and the agreement as a whole, including the other provisions of the contract, and the background and purpose of the contract.

As a general rule, the provisions of an insurance policy should be interpreted strictly, and in relation to the other provisions of the policy (both general and specific).

17 Consolidated Act No. 193 of 2 March 2016.

18 Ivan Sørensen, *Forsikringsret*, sixth edition, p. 57, with additional references.

19 Sections 4 to 10 of the ICA (Consolidating Act No. 1237 of 9 November 2015).

If the policy wording generates doubt as to the contents, the circumstances of the conclusion of the contract and the purpose of the insurance may be included in the interpretation. Occasionally, ambiguities regarding the contents of the specific policy provision will be detrimental to the insurers that wrote the policy (the ambiguity rule).

When interpreting the contract, the ICA and the general rules of contract law must always be read with a consideration of trade usage, case law and other legal standards and rules of interpretation that apply (which can vary depending on the contract type).

iv Intermediaries and the role of the broker

Insurance mediation is regulated by the Insurance Mediation Act. The Act does not apply to insurers, but rather to brokers and other parties that have a licence to sell insurance commercially. This licence is issued by the FSA. According to the Act, insurance agents will also require a licence from the FSA to carry out activities (see Section II.ii, 'Insurance distribution').

The parties responsible for insurance mediation must have general knowledge of insurance mediation. The responsible persons must have theoretical training in, and practical knowledge of, insurance mediation activities. Insurance brokers must comply with the duty of disclosure and other obligations about regular reporting.

The FSA monitors insurance brokers. If the insurance broker does not comply with the guidelines laid down in the Insurance Mediation Act, the FSA may cancel the insurance broker's licence to sell insurance commercially.

v Claims

The party with an insurance claim must file the claim with the insurer before the statute of limitations expires. There are no formal requirements on how an insurance claim must be filed, and thus it can be made both orally and in writing. In recent years it has become commonplace to file the claim through a form on the insurer's website.

It is sufficient in respect of certain types of business insurance that a party entitled to damages has filed its claim for damages with the policyholder in time (the business covered by insurance).

A policyholder must provide the insurer with all available information on matters of significance to the assessment of the claim. If the holder fails to do so, the insurer may refuse to take a position on the insurance claim.²⁰

An insurer may also refuse to provide cover to a policyholder, or a third party entitled to damages if the claim for damages or the insurance event has not been proved, or if it is clear that the claim is not covered by or is exempt from the insurance cover.

An insurer may also refuse cover if the insurance contract was based on incorrect information given by the policyholder. The insurance contract is either void (based on fraudulent misrepresentation or non-disclosure) or the insurer is exempt from liability or entitled to reduce compensation (based on a negligently false statement).

20 Sections 21 and 22 of the ICA (Consolidating Act No. 1237 of 9 November 2015).

vi Third-party action

An injured third party is free to file a claim directly with the insurer if the claim is filed under liability insurance. The insurer is directly liable to an injured third party in certain situations (e.g., bodily injury caused by a motor vehicle).

When the insured's liability for damages to the injured party has been established and the amount of damages assessed, the injured party must be subrogated to the insured's rights against the insurer, but only to the extent that the party entitled to damages has not already received the amount claimed in whole or in part.²¹

A policyholder cannot be a party to a reinsurance contract and cannot file a claim directly with the reinsurer. As a contractual party, the insurer may file a claim with the reinsurer.

vii Subrogation

As a general rule, if an insurer has paid damages to an injured party, it is subrogated to the injured party's claim. However, the Danish Act on the Liability to Pay Compensation contains important exemptions in this regard, as it limits an insurer's right to recourse in many situations where insurance cover has been taken out.²²

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Insurance litigation and arbitration are governed by the Danish Administration of Justice Act²³ and the Danish Arbitration Act.²⁴ Regarding the issues of jurisdiction and the choice of laws, Denmark has ratified the relevant parts of the Brussels I Regulation, the Lugano Convention, the Hague Convention and the Rome Convention.²⁵

As a general rule, parties may agree both before and after a dispute has occurred that proceedings are to be heard in Denmark by a specific court. However, in certain instances the courts in a specific country have exclusive jurisdiction and the consequence is that the agreement cannot be relied upon. The parties are not allowed to agree that a case is to be heard by a court that has no jurisdiction in respect of the substance of the matter. For example, the parties are not allowed to agree that the case is to be brought before the Danish Supreme Court as the court of first instance.

In addition, the parties may agree to resolve disputes by arbitration. They may also enter into an arbitration agreement either before or after a dispute has arisen, which Danish courts, if the arbitration clause has the necessary clarity, will recognise and enforce. Both

21 Section 95 of the ICA (Consolidating Act No. 1237 of 9 November 2015).

22 Part 2 of the Consolidated Act No. 1070 of 24 August 2018. Corresponding limitations can be found in other acts.

23 Consolidating Act No. 938 of 10 September 2019.

24 Consolidating Act No. 553 of 24 June 2005.

25 Consolidating Act No. 1282 of 14 November 2018 on Recognition and Enforcement of Certain Judicial Decisions in the area of Civil and Commercial Law, and Consolidating Act No. 139 of 17 February 2014 implementing the Rome Convention on the Law Applicable to Contractual Obligations.

written and oral arbitration agreements are valid under Danish law. However, to enforce the agreement, the Danish Institute of Arbitration recommends the following standard clause to be included in the contract:²⁶

Any dispute arising out of or in connection with this contract, including any disputes regarding the existence, validity or termination thereof, shall be settled by arbitration administrated by The Danish Institute of Arbitration in accordance with the rules of arbitration procedure adopted by The Danish Institute of Arbitration and in force at the time when such proceedings are commenced.

With regard to a consumer contract, the costumer is not bound by an arbitration agreement concluded before the conflict arose.

ii Litigation

Any disagreement between the insurer and a consumer regarding an insurance policy may be brought before the Insurance Complaints Board, directly before the courts or settled by arbitration (see subsection iii).

The Insurance Complaints Board

In case of any disagreement between the insurer and a consumer regarding an insurance policy, the matter may be brought before the Insurance Complaints Board,²⁷ which is a private complaints board authorised by the Minister for Business and Growth.

The advantage of bringing the matter before the board is that it is possible to get a decision in a few months if the policyholder pays a nominal amount. Any decision by the board may be brought before the relevant district court. As a main rule, the board only hears complaints concerning insurance taken out by private individuals.

The judicial system

In broad terms, the judicial system is composed of the Supreme Court, the High Courts of Western and Eastern Denmark, the Maritime and Commercial Court, the Land Registration Court and 24 district courts.²⁸ No courts in Denmark are specialised in insurance disputes, so as a general rule insurance cases (like all other court cases) commence in the district courts.

The legal system is based on a two-tier principle, according to which it is usually possible to appeal against a decision made by a court once. However, there are many exceptions to this rule. If a case is of general public importance (implications for rulings in other cases),²⁹ the Danish Appeals Permission Board³⁰ may grant leave to appeal to a court of third instance (the Supreme Court).

26 www.voldgiftsinstitutet.dk/en/recommended-clauses/rc-arbitration.

27 www.ankeforsikring.dk/Sider/english.aspx.

28 www.domstol.dk/om/otherlanguages/english/thedanishjudicialsystem/Pages/TheDanishjudicialsystem.aspx and Section 1 of the Administration of Justice Act.

29 Section 371 of the Administration of Justice Act (Consolidating Act No. 938 of 10 September 2019).

30 www.domstol.dk/om/otherlanguages/english/thedanishjudicialsystem/appealspermissionboard/Pages/default.aspx.

In addition, if the case involves a matter of general public importance, the district court may commit the case to one of the High Courts upon request.³¹ In this case, the first instance High Court judgment may be appealed directly to the Supreme Court.

Judgments delivered by a district court concerning an amount of less than 20,000 kroner cannot be appealed without leave from the Appeals Permission Board. The High Court may also dismiss an appeal if there are no prospects of a different result than that of the district court.

The Maritime and Commercial High Court is a specialised first instance court.³² The Court hears cases concerning the Danish Trademarks Act, the Danish Designs Act, the Danish Marketing Practices Act and the Danish Competition Act, and cases concerning international trade conditions as well as other commercial matters. The Court is not specialised in insurance law. Decisions passed by the Maritime and Commercial High Court may be appealed to the Supreme Court if the case is of general public importance; otherwise, they will be appealed to one of the High Courts.

*The main stages in civil proceedings*³³

A court case is initiated by the plaintiff filing a writ with the court. The defendant will then file a statement of defence if the defendant disputes the plaintiff's claim. The exchange of pleadings may take several months.

Further pleadings will often be exchanged and a pretrial hearing (by telephone) will be held during which the court discusses the matter with the parties. An expert opinion may also be requested at that stage. The duration of the procedure depends on the nature of the case and can vary from a few months to more than a year.

When the case has been set down for the final hearing, the court will inform the parties of when the pretrial stage ends. After this date, new claims, allegations or evidence will not, as a general rule, be permitted. After the final hearing, the court will make its decision on the claims submitted. Normally, one to two months will pass from the time of the conclusion of the pretrial stage until a final appealable judgment is delivered.

Sometimes the court will decide on procedural issues during the case, including on whether to admit certain evidence, whether to commit the matter to another court, etc. These procedural issues may, as a general rule, be appealed during the case; however, this is often subject to prior leave by the Appeals Permission Board.

For cases involving claims of up to 50,000 kroner, the case may be brought before the courts according to the cheapest and fastest small-claims procedure.

Time frame for insurance litigation

Insurance litigation includes everything from small cases to large and complicated claims for damages covered by business insurance. A hearing by a court of first instance could take anything from a few months to several years. According to the most recent statistics published by the courts in 2018, the average case processing time in civil cases decided by settlement or judgment before the district courts was 10 months.³⁴

31 Section 226 of the Administration of Justice Act (Consolidating Act No. 938 of 10 September 2019).

32 Section 14-17 of the Administration of Justice Act (Consolidating Act No. 938 of 10 September 2019).

33 Part 33 of the Administration of Justice Act (Consolidating Act No. 938 of 10 September 2019).

34 www.domstol.dk/om/talogfakta/statistik/Pages/civilesager.aspx.

Evidence

As a general rule, the parties are free to determine which evidence and legal issues should be considered in cases and all types of evidence, in board terms, are admissible.

The most important types of evidence are documents, witness statements and expert surveys by specialists who may be examined in court. Expert opinions or expert witnesses are not widely used because expert surveys (reports based on an appraisal by experts appointed by the court) are preferred; however, new rules encourage their use to a wider extent. Courts may bar unnecessary evidence, but they are generally reluctant to do so. Evidence produced by an illegal or criminal act is also admissible in most cases, but the court will decide the level of importance to attach to the evidence.

The court may also, either at the request of one of the parties or on its motion, request the opponent to produce relevant evidence and may also bar unnecessary evidence.³⁵ The evidence is for the court to assess and is not subject to particular rules. Even in the absence of a pending case, evidence may be taken before a court without a trial, including for use in a later case. In personal injury matters, special bodies have been established by law that provide medical assessments of the nature of the personal injury or assessments of the extent and impact of the personal injury.

Persons called as witnesses of fact are not allowed to make observations as experts when giving evidence. They are therefore only allowed to give evidence of their knowledge of the incident in the specific case. Written statements on factual information may be used as documentary evidence and are sometimes used as an alternative to witness statements, provided that the court has no objections.

Witness statements are generally presented during the final hearing. However, in special cases, the court may decide that the statement is to be given before the final hearing. The witness statement may be given by using telecommunication (with or without an image) if found appropriate and if special considerations for the witness favour the procedure (e.g., if a witness resides abroad).³⁶

The disclosure of documents and witness statements is subject to some limitations (see Sections 169 to 172 the Administration of Justice Act). As a result, persons bound by professional secrecy cannot give evidence about matters that have come to their knowledge in the course of their function.

Costs

The institution of proceedings is subject to a court fee of 500 kroner.³⁷ If the value of the case exceeds 50,000 kroner, another 250 kroner is added, plus 1.2 per cent of the part of the value of the case exceeding 50,000 kroner. However, the court fee cannot exceed 75,000 kroner. If the matter concerns a review of a decision by an authority, the maximum fee is 2,000 kroner. The same applies to certain other types of cases. If appealing to the Supreme Court, the court fee is increased by 50 per cent.

In addition to the fee payable if the value of the matter exceeds 50,000 kroner, a fee is to be paid for the final hearing (the trial hearing) or the written proceedings that may replace the trial hearing. The fee will generally be the same as the fee for instituting proceedings.

35 Sections 298 and 299 of the Administration of Justice Act (Consolidating Act No. 938 of 10 September 2019).

36 Section 174(2) of the Administration of Justice Act (Consolidating Act No. 938 of 10 September 2019).

37 Consolidated Act No. 1252 of 27 November 2014 on Court Fees.

As a general rule, it is the party making or requesting a procedural step that, provisionally, has to pay the costs in this respect. The unsuccessful party to a case will usually have to compensate the costs of the successful party. Legal fees, however, are not covered according to realised costs, but will be fixed according to certain rates as a rule, depending on the financial value of the claim and whether an expert opinion has been obtained.

iii Arbitration

The parties are entitled to agree that an insurance dispute is to be settled by arbitration, and both ad hoc and institutional arbitration are widely used. The framework applying to arbitration follows from the parties' contract and the Arbitration Act, which follows the UNCITRAL Model Law of 1985 to a wide extent.

Denmark does not have a specific board of arbitration that deals with insurance disputes, but several institutes handle arbitration cases. The Danish Institute of Arbitration³⁸ processes all types of cases, and the rules governing the arbitration procedures of the institute entered into force on 1 May 2013. The Arbitration Board³⁹ is reserved for construction matters.

In the Danish Institute of Arbitration, the judges are usually appointed by the parties, whereas the chairman is appointed by the Institute. Expert judges usually participate in Arbitration Board cases. Both institutions offer mediation, conciliation and expert opinions. These methods are used to a minor extent, but in particular there is a trend towards mediation being an attractive alternative to the parties. Mediation is also offered by the special institution, the Mediation Institute, and by individual mediators.

iv Mediation

At the request of the parties, the court may appoint a mediator to assist the parties in reaching a settlement during the proceedings,⁴⁰ but it has no powers to force the parties to participate in mediation.

Mediation is also offered by the Danish Mediation Institute⁴¹ and other private, independent institutions.

V YEAR IN REVIEW

There has been an increased focus on cyber risk in 2019. Both the sales of cyber insurance and the number of incidents and consequential claims has increased in 2019. Tryg reports selling 10,000 cyber insurance policies (22 per day) to mid-cap companies⁴² and Codan, a part of RSA Group, reports that the number of reported hacker attacks has increased more than 300 per cent since 2010.⁴³ In September 2019, the Danish hearing healthcare company Demant announced in a message to its investors⁴⁴ that a ransomware infection had resulted in a significant loss of up to US\$95 million, including an anticipated payout from Demant's insurance company of 100 million kroner.

38 www.voldgiftsinstituttet.dk/en/about/.

39 www.voldgift.dk/?lang=en.

40 Part 27 of the Administration of Justice Act (Consolidating Act No. 938 of 10 September 2019).

41 www.mediationsinstituttet.com.

42 <https://ib.dk/er-forebyggelse-et-guldaeg-spoergsmaalet-splitter-forsikringsbranchen/>.

43 <https://www.codan.dk/erhverv/forsikringer/cyberforsikring>.

44 <https://newsclient.omxgroup.com/cdsPublic/viewDisclosure.action?disclosureId=904650&lang=da>.

Also in 2019, the FSA has been focusing on cybercrime and the risks associated with Brexit, IT security and money laundering.⁴⁵

The Danish Insurance Mediation Act entered into force in October 2019. There has been an intense focus of attention on the Act but so far, no published complaints or cases showing how the Act will be administered or sanctioned and, thus, it must be assumed that there will be a continued focus of attention on the Act in 2020.

VI OUTLOOK AND CONCLUSIONS

i Climate change risk and litigation

There has been a significant focus on climate change risk and litigation in 2019 and this focus is expected to increase in 2020. While our Scandinavian neighbours in Sweden and Norway as well as a wide range of other European countries have been hit by climate-related legal actions against the oil, gas and energy sector as well as public authorities, Denmark has not (yet) faced any climate related litigations. Thus, the various actions and decisions within this field highlights the need also for the Danish insurance industry to address the issue of climate change at both an underwriting and structural level.

An aspect to consider is the fact that some companies, such as those in the oil, gas and energy industry, could be more vulnerable to climate change risks. It will become even more important in 2020 for directors and officers (D&O) to demonstrate they have considered the climate change risks and taken actions to mitigate these risks where necessary. This means that D&O insurers may be affected by climate change disclosure claims in the year ahead.

ii Cyber risk

The above-mentioned increased focus on the cyber risk in 2019 is likely to continue in 2020 where the constant devolvement of loss scenarios from cyberthreats gives rise to ongoing considerations on how customers' risk shall be assessed and how premiums and damage coverage shall be priced. Claims from shareholders against the board and senior executives related to cyberattacks and whether such claims may trigger the D&O insurance is expected to be a continued hot topic in 2020.

As a result of more and more sophisticated information technology and owing to the extent of cyber-related damages, we expect an increased focus of interest on asset tracing investigations, especially in relation to CFO fraud.

iii Digitisation and new technologies

Digitisation and new technologies provide insurers new opportunities for customer retention, customer satisfaction and access to new segments that have been out of reach, so far.

Several new InsureTech startups are challenging the traditional Danish industry with user-friendly solutions. A common feature is that they have a clear focus on the customer's needs while offering flexible solutions and good user experiences. An example of this is Undo,⁴⁶ a Danish startup that reaches its customers through an app and has a focus on and mainly appeals to a young target group.

45 <https://www.finanstilsynet.dk/Nyheder-og-Prese/Pressemeddelelser/Risikobillede2019>.

46 https://www.undo.app/?gclid=EAIaIQobChMImpPXrJS_5wIVy8reCh0nDAz-EAAYASAAEgKN5vD_BwE.

Apart from having invested in Undo and possessing half of the company, Tryg has also developed a wide range of various pay-per-use insurance solutions to sharing services, etc. According to Tryg, customer satisfaction as well as customer retention is improving as a result of new innovative products and solutions as well as digitalisation, which makes it easier for the customer.⁴⁷

⁴⁷ https://finanswatch.dk/secure/Finansnyt/Forsikring___Pension/Tryg/article11311475.ece.

ENGLAND AND WALES

*Simon Cooper and Mona Patel*¹

I INTRODUCTION²

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.³

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. Traditionally it has been 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.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

1 Simon Cooper is a consultant and Mona Patel is a partner at Ince.

2 This chapter is affected by Brexit and cannot reflect the continuing discussions between the UK and EU during the Brexit transition period.

3 www.abi.org.uk.

4 www.lloyds.com.

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 Commercial Court (a specialist court, part of the Business and Property Court of the High Court of Justice, handling complex national and international business disputes), and indeed the appellate courts, understand, for example, what a 'slip' is and what roles are played by all involved in the placement of business in the London Market.

Secondly, England and Wales have 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 REGULATION⁶

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

⁵ See www.iaa.co.uk.

⁶ The regulatory sections of this chapter describe the current regulatory position in the UK as it continues to apply during the Brexit transition period; however, this is subject to change following ongoing discussions and developments during the Brexit transition period which could impact the regulatory framework.

regulated by the FCA and Lloyd's. However, Lloyd's members (who provide capital and participate in Lloyd's syndicates) are only subject to Lloyd's regulation. The Society of Lloyd's is regulated by the PRA and the FCA.

When the PRA and the FCA took over as the prudential and conduct regulators of the UK financial services industry, they each adopted distinct supervisory approaches. For dual-regulated firms such as insurers, the practicalities of working with two regulators have become clearer, although concerns continue to exist about the possible duplication of regulatory efforts.

On 1 April 2015, the FCA also became a 'concurrent regulator' alongside the Competition and Markets Authority (CMA) with 'concurrent powers'. These powers are in addition to its regulatory powers under Financial Services and Markets Act 2000 (FSMA) as amended by the Financial Services Act 2012. The FCA now has the ability to enforce the prohibitions in the Competition Act 1998 on anticompetitive behaviour in relation to the provision of financial services, together with investigatory powers under the Enterprise Act 2002, to carry out market studies and to make market investigation references to the CMA relating to financial services. The FCA issued its first ever competition law enforcement decision on 21 February 2019 following a three-year investigation by the FCA into conduct by two asset managers regarding the sharing of strategic and price-sensitive information relating to an initial public offering UK.⁷

ii Regulatory framework

In the UK, insurers and reinsurers have, since 1 January 2016, functioned under Directive 2009/138/EC (the Solvency II Directive, Solvency II) in respect of their insurance and reinsurance activities. This is applied in the UK by the FSMA (as amended), and the Financial Services and Markets Act 2000 (Regulated Activities) Order 2001 (SI 2001/544) (RAO), which deliver the structure for the regulation of insurance and reinsurance activities. The directly applicable Solvency II delegated acts also apply in the UK, which provide comprehensive guidelines on solvency and capital calculations, governance and reporting (including the use of these requirements at group level). The FCA handbook and the PRA rulebook provide rules and guidance on governance, capital and conduct of business obligations.

The Insurance Distribution Directive ((EU) 2016/97) (IDD) revises and updates the EU's framework for regulating insurance brokers, agents and other intermediaries previously contained in the 2002 Insurance Mediation Directive (2002/92/EC) (IMD). The IDD came into effect on 22 February 2016. EU Member States adopted and began to apply the measures contained in the IDD by 1 October 2018 while the IMD was repealed. The IDD deals with the authorisation, passporting and general regulatory requirements for insurance and reinsurance intermediaries and distributors. It also covers organisational and business obligations for insurance and reinsurance undertakings.

⁷ See <https://www.fca.org.uk/news/press-releases/fca-issues-its-first-decision-under-competition-law>.

iii Principle of 'regulated activities'

There is no express prohibition on insurers or reinsurers. Rather, the UK regulatory regime prohibits the performance of regulated activities within the UK by unauthorised firms. These include insurer activities such as effecting and carrying out contracts of insurance, and distribution activities such as arranging, advising upon, selling and administering contracts of insurance.

It is a criminal offence to perform a regulated activity without being an authorised (or exempt) firm.⁸ 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.

iv Position of brokers

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

v Requirements for authorisation

A firm intending to carry on insurance or reinsurance business must obtain Part 4A FSMA permission from the PRA unless it is exempt or able to rely on the EU's passporting regime. Such firms are required to meet a number of threshold criteria, primarily relating to geographic location, regulatory capital, and systems and controls. A condition of obtaining permission is that the threshold criteria must be satisfied on authorisation and must continue to be maintained.

Authorisation for insurance intermediaries is similar to that of insurers save that application for authorisation is made to the FCA alone and the FCA has a shorter window of time (three months) than the PRA (who has six months) in which to process the application and make its decision.

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 vii).

Application for authorisation is made to the PRA for insurers, and the FCA for intermediaries (such as brokers).

EEA insurers and brokers authorised under one of the EU single market directives⁹ are able to 'passport' into the UK, on a freedom of establishment (branch) or freedom of services (no branch) basis, on the basis of their home state authorisation. The notification procedure that firms should follow when exercising their 'passporting' rights is set out in each single market directive. Subject to notification, such passports are, in effect, automatic, with the FCA having only a subsidiary regulatory role (conduct of business and marketing)

⁸ Section 19 FSMA.

⁹ The single market directives are currently the Alternative Investment Fund Managers Directive (2011/61/EU); the CRD IV Directive (2013/36/EU); the Insurance Distribution Directive ((EU) 2016/97) (IDD); the MiFID II Directive (2014/65/EU); the Solvency II Directive (2009/138/EC); the UCITS IV Directive (2009/65/EC); the Mortgage Credit Directive (2014/17/EU); the Payment Service Directive (2015/2366/EU) (PSD II); and the Second E-Money Directive (2009/110/EC).

with limited powers to block, or impose conditions on, an incoming EEA firm. Similarly, UK-authorized insurers and insurance intermediaries are able to passport into other EEA Member States. One of the key advantages of passporting is that a regulated firm will have only one principal (home state) regulator, and for insurers this means only one regulatory capital regime. The role of the host state generally relates to the conduct of a regulated firm's business in the host territory. For pure reinsurers (whose insurance business is restricted to reinsurance) there is no requirement for notification, as the Solvency II Directive grants automatic passporting rights.

The UK's EU referendum in June 2016 saw the UK electorate vote to exit the EU (Brexit).¹⁰ The UK left the European Union at 11pm on Friday, 31 January 2020 (Exit Day). At the time of writing, the UK has entered into what is known as the Brexit 'transition period' (also referred to as the Brexit 'implementation period'), which shall continue (assuming there is no Brexit transition period extension) until 31 December 2020.¹¹ During the Brexit transition period the UK and the EU will seek to negotiate the future relationship between the UK and the EU. Throughout the Brexit transition period EU rules and regulations will continue to apply to the UK as though it remains an EU member (although the UK shall no longer have the right to contribute to EU governance and the determination of decisions undertaken). For insurers, reinsurers and intermediaries that means passporting rights will continue up until the end of the Brexit transition period without the need to become authorised in the relevant Member State. Equally, EEA Member State insurers, reinsurers and insurance intermediaries can continue to passport without UK authorisation until the end of the Brexit transition period. Following the end of the Brexit transition period, unless a deal can be agreed on financial market access, passporting rights will no longer be available to insurance firms seeking to carry on business in EEA Member States or to insurance firms based in EEA Member States seeking to carry on business in the UK.

vi Regulation of individuals employed by insurers

Certain activities, such as being a director (including a non-executive director), or a chief executive (or a manager who can exert significant influence over the business) of an insurer or insurance intermediary such as a broker, are controlled functions, meaning that the appropriate regulator must approve an individual in that role before they can perform those functions. That 'approved person' is then subject to the senior managers and certification regime (SM&CR). The SM&CR was extended to insurers and reinsurers on 10 December 2018. The SM&CR replaced the PRA's Senior Insurance Managers Regime and the FCA's revised approved persons regime, extending to employees who are not necessarily senior managers but whose roles could potentially cause significant harm to the firm.¹² The SM&CR sets out the responsibilities of the individual including those around personal conduct.

10 Triggered formally by the UK invoking Article 50 of the Treaty of the European Union on 29 March 2017.

11 Under the Withdrawal Agreement the Brexit transition period can be extended by a further two years provided the UK and the EU agree such extension before 1 July 2020; however, the UK government has indicated that it does not expect to extend the Brexit transition period any further.

12 The final rules and guidance of the SM&CR are set out in FCA 2018/45 (Individual Accountability (Duel-Regulated firms) Instrument 2018).

vii The distribution of products

While the changes imposed by the IDD are less fundamental than those presented by Solvency II, the effects are more far-reaching as they capture both insurers and reinsurers and intermediaries distributing insurance products. Like Solvency II, there are a raft of rules and guidance under this regime.

The IDD was implemented with a view to harmonising insurance sales practices across Europe and ensuring consumer protection across all distribution channels from brokers to direct sales by insurers. The IDD imposes a range of obligations, for example product oversight, remuneration and information disclosure.

The IDD will not be retained EU law as it is a directive that has already been implemented in the UK through domestic legislation and FCA rules.¹³ Unless the UK repeals these rules, intermediaries will need to continue complying. The Insurance Distribution (Amendment) (EU Exit) Regulations 2019 (SI 2019/663) (the Regulations) came into force on Exit Day. The purpose of the Regulations, which were made on 25 March 2019, is to correct deficiencies in retained EU law relating to the IDD that arise from the UK leaving the EU. The Regulations fix deficiencies in the directly applicable EU delegated regulations that have been made under the IDD.¹⁴

viii 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.

ix Compensation and dispute resolution regimes

If a regulated firm cannot resolve a customer complaint, then certain complainants – generally consumers, small businesses and some other small organisations – have the right to use the services of the Financial Ombudsman Service.

If a regulated firm is unable to meet its financial obligations, for example because of insolvency, then the Financial Services Compensation Scheme is available to compensate policyholders. However, the regime is generally restricted to consumers and small organisations – although there are important exceptions for compulsory insurance (notably employers' liability) where large organisations are also able to bring a claim. Compensation available under the scheme will also depend on the type of claim.

x 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.

13 The IDD has been transposed into UK law by the Insurance Distribution (Regulated Activities and Miscellaneous Amendments) Order 2018 (SI 2018/546) and the Insurance Distribution Directive Instrument 2018 (FCA 2018/25).

14 i.e., the Commission Delegated Regulations (EU) 2017/2358 and (EU) 2017/2359).

The standard rate of IPT increased on 1 October 2016 from 9.5 per cent to 10 per cent and rose again to 12 per cent on 1 June 2017. Premiums that relate to risks for which the period of cover began before 1 June 2017 will be subject to IPT at the old rate of 10 per cent, provided that they were received before 1 June 2018. The higher rate of 20 per cent (applied to travel insurance, and some vehicle and domestic or electrical appliance covers) remains the same.

Reinsurance is exempt from IPT, as is insurance for commercial ships and aircraft, and insurance for commercial goods in international transit. Premiums for risks located outside the UK are not subject to IPT, but may be liable to similar taxes imposed by other countries.

Insurance premiums are exempt from UK value added tax (VAT), as are commission payments to brokers and insurance agents. However, the analysis is more difficult in relation to payments between entities in the insurance 'supply chain', such as introducers, and case law is still developing as to which of those payments are VAT-exempt and which are not.¹⁵ Her Majesty's Revenue and Customs has updated its internal guidance on tax, confirming that an introducer-appointed representative selling leads is not perceived to act as an intermediary and therefore is unlikely to be exempt from VAT unless it meets certain requirements.¹⁶

xi Other notable regulated aspects of the industry

A purchaser of a regulated firm such as an insurer or intermediary requires prior consent from the appropriate regulator. It is a criminal offence¹⁷ to acquire or increase control in an insurer, reinsurer or intermediary without notifying and obtaining prior approval from the relevant regulator, which can lead to a fine and the transaction being held void. A purchase of a book of business from an insurer will require both regulatory and court consent under the UK's Part VII FSMA process. 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 in relation to commercial insurance was the Marine Insurance Act 1906 (MIA), which codified the case law as it existed at the time. In August 2016, however, the Insurance Act 2015 (IA15) came into force. This introduced the most significant

15 *Westinsure Group Ltd v HMRC* [2014] UKUT 00452 (TCC); *Riskstop Consulting Ltd v Revenue and Customs Commissioners* [2015] UKFTT 469 (TC).

16 VATINS5205 updated 9 January 2020.

17 Section 191F FSMA.

changes to English commercial insurance law in over 100 years and swept away central provisions of the MIA (though parts of the MIA remain in force). IA15 applies to contracts and variations of contracts entered into on or after 12 August 2016. Most provisions of the MIA and IA15 apply equally to marine and non-marine insurance, and to reinsurance. Other relevant legislation includes the FSMA, which regulates financial services (including insurance), the Life Assurance Act 1774 (LAA) and, in relation to consumer insurance, the Consumer Insurance (Disclosure and Representations) Act 2012.

ii Making the contract

Essential ingredients of an insurance contract

Under English law, an insurance contract is an agreement by the insurer to provide, in exchange for a premium, agreed-upon benefits to a beneficiary of the contract upon the occurrence of a specified uncertain or contingent future event, affecting the life or property of the insured.

The distinguishing features of a contract of insurance are the transfer of risk and the requirement for an insurable interest. These are considered in more detail below.

The transfer of risk when the uncertain event occurs

The contract must be such that, when the insured-against event occurs, the insurer responds by bearing all or part of the risk. Often, this response will mean that the insurer pays money to the insured. However, the contract may require the insurer to provide benefits in kind, rather than a monetary payment, such as the reinstatement of property damage,¹⁸ the cost of a hire car while the insured vehicle is repaired¹⁹ 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.²⁰

The insured-against event must be uncertain in its occurrence.²¹ This uncertainty is tested at the time that the contract is concluded.²² 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

18 *Prudential v. Commissioners of Inland Revenue* [1904] 2 KB 658.

19 *Digital Satellite Warranty Cover Limited and another v. Financial Services Authority* [2013] UKSC 7.

20 *Scottish Amicable Heritable Securities Assn Ltd v. Northern Assurance Co* (1883) 11 R (Ct Sess) 287, 303.

21 *Scottish Amicable Heritable Securities Assn Ltd v. Northern Assurance Co* (1883) 11 R (Ct Sess) 287, 303.

22 *Department of Trade & Industry v. St Christopher Motorists' Assn* [1974] 1 Lloyd's Rep 17, 19.20.

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'.²³

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, the Commissions published a draft Insurable Interest Bill, which was designed to address concerns that the current law is unclear in some respects and antiquated in others. Following consultation on the draft Bill, however, the Commissions concluded that there was little demand for amendment of the law outside the area of life insurance and related products. Accordingly, an amended draft Bill limited to these classes was published in June 2018 and the Commissions are currently considering responses to this latest draft.²⁴

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 obligation is set out in Section 17 MIA, which provides that '[A] contract of marine insurance is a contract based on the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.' This imposes an onerous duty on the party seeking insurance cover to disclose, before the contract is entered into, all material facts pertaining to the risk of which it is, or ought to be, aware, and to avoid misrepresenting any of the material facts.

Under the MIA a similar duty is imposed on the insured's placing broker.

Material facts are judged objectively, and are defined as those that would be likely to influence the judgement of a hypothetical prudent insurer in determining whether and on what terms to accept the risk, and in fixing the level of premium. In this regard, it is not necessary that a prudent insurer would have refused the risk, or even charged a higher premium, but enough to show that it would have liked the opportunity to consider the position.²⁵ In the event of a material misrepresentation or non-disclosure, the insurer

23 Reforming Insurance Contract Law: Issues Paper 10: Insurable Interest: Updated Proposals.

24 <https://www.lawcom.gov.uk/project/insurance-contract-law-insurable-interest/>.

25 *Container Transport International Limited v. Oceanus Mutual Underwriting Association* [1982] 2 Lloyd's Rep 178 CA.

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.²⁶

Following a lengthy review of British commercial insurance law by the Commissions, IA15 was passed in 2015 and came into effect on 12 August 2016. IA15 retains the name and concept of the duty of utmost good faith and amends Section 17 MIA to provide that 'a contract of marine insurance is a contract based upon the utmost good faith.' It introduces, however, a number of changes to the insured's pre-contractual duty. IA15:

- a replaces the pre-contractual duty of disclosure and non-misrepresentation with a 'duty of fair presentation', whereby the insured is required to disclose all material circumstances about the risk or give the insurer sufficient information to put it on notice that it needs to make further enquiries for the purpose of revealing all the material circumstances about the risk. This puts a greater emphasis on the insurer to ask questions about the risk and to make clear what information it requires;
- b replaces the single remedy of avoidance for breach of the duty with a system of graduated remedies based on what the insurer would have done had it received a fair presentation; and
- c requires the insured to carry out a 'reasonable search' prior to the placement for material information available to it within its own organisation and 'held by any other person'.

Consumer insurance has already been the subject of similar reforms, as enacted by the Consumer Insurance (Disclosure and Representations) Act 2012.

Recording the contract

Insurance contracts are usually evidenced by a written policy, and Section 22 MIA and Section 2 LAA require a written policy. The London Market has also introduced the Market Reform Contract, a standard form that aims to increase contractual certainty and that is widely used in practice.

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. 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.

26 *Pan Atlantic Insurance Limited v. Pinetop Limited* [1994] 3 WLR 677.

The meaning that a document would convey to a reasonable person is not the same thing as the meaning of its words. The meaning of words is a matter of dictionaries and grammar; the meaning of the document is what the parties using those words against the relevant background would reasonably have been understood to mean.

The rule that words should be given their natural and ordinary meaning reflects the common-sense proposition that it is not easy to accept that people have made linguistic mistakes, particularly in formal documents. However, if it could nevertheless be concluded from the background that something must have gone wrong with the language, the law does not require judges to attribute to the parties an intention that they plainly could not have had.

Incorporation of terms

Reinsurance contracts often contain general words such as 'all terms, clauses and conditions as original' or 'as underlying'. Such general words are not necessarily sufficient to incorporate a term from the insurance contract into the reinsurance contract. In *HIH Casualty & General Insurance Ltd v. New Hampshire Insurance Co*,²⁷ the court held that a term will be incorporated only if it:

- a* is germane to the reinsurance, rather than being merely collateral to it;
- b* makes sense, subject to permissible manipulation, in the context of the reinsurance;
- c* is consistent with the express terms of the reinsurance; and
- d* is apposite for inclusion in the reinsurance.

By way of example, arbitration clauses, jurisdiction clauses and choice of law clauses are unlikely to be incorporated from an insurance contract into a reinsurance contract because they are not considered germane to the reinsurance. These provisions should, therefore, be dealt with specifically in the reinsurance contract. Similar principles apply to attempts to incorporate wording into excess layer contracts from the primary layer insurance.

Types of term in insurance and reinsurance contracts

Terms in insurance and reinsurance contracts may be divided into three broad categories: conditions, conditions precedent and warranties. Of these, the latter two require some comment.

Conditions precedent

There is more than one possible type of condition precedent in an insurance or reinsurance contract. A term can be a condition precedent to the existence of a binding contract, the inception of the risk, or the insurer's or reinsurer's liability. This is a matter of the wording of the particular clause. Whatever the type of condition precedent, there is no need for an insurer or reinsurer to prove it has suffered any prejudice before it can rely on a breach of the term.

A condition precedent to the contract must be satisfied, otherwise the contract will not come into being. A condition precedent to the inception of the risk presupposes a valid contract but one where the risk does not attach until the condition precedent has been met. A condition precedent to the contract or to the risk may, for example, relate to the provision

²⁷ *HIH Casualty & General Insurance Ltd v. New Hampshire Insurance Co* [2001] Lloyd's Rep IR 224.

of further information by the insured or reinsured or payment of the premium. Both types (in the absence of any specific wording) mean that the insurer or reinsurer cannot be liable for any loss that predates the fulfilment of the condition precedent.

A condition precedent to the insurer's or reinsurer's liability usually means that the insurer or reinsurer will not be liable for a claim unless the condition precedent is satisfied but the contract will generally continue in force. These conditions precedent are often concerned with the claims process. For example, the time period within which notification of a claim must be given is often expressed as a condition precedent to the insurer's or reinsurer's liability (as to which, see below).

The effect of a condition precedent to liability has been altered by Section 11 IA15. Under Section 11, if the condition precedent is, on its proper construction, one that would tend to reduce the risk of loss of a particular kind, at a particular location or at a particular time, insurers cannot rely on the insured's breach of the condition precedent to deny a claim if the insured can show that its breach could not have increased the risk of the loss that actually happened in the circumstances in which it occurred. The only exception to this is in relation to terms that 'define the risk as a whole' (e.g., a term that defines the age, identity and qualifications of the owner or operator of a vehicle, aircraft, vessel or item of personal property).

Warranties

An insurance warranty is not the same as a warranty in an ordinary commercial contract. For contracts entered into before 12 August 2016, the former is defined by Section 33(1) MIA as 'a promissory warranty, that is to say, a warranty by which the assured undertakes that some particular thing shall or shall not be done, or that some condition shall be fulfilled, or whereby he affirms or negatives the existence of a particular state of facts'. A warranty is a way in which the insurer or reinsurer can procure from the insured or reinsured a guarantee of the accuracy or continued accuracy of a given fact or a promise that certain obligations will be fulfilled.

Under the MIA, the effect of a breach of warranty is to discharge the insurer or reinsurer automatically from liability as from the date of breach. The insurer or reinsurer is not required to show that the warranty was in any way material to the risk or that the breach has contributed to the loss.

The severity of the remedy for a breach of warranty under the MIA 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 liable for losses attributable to something happening after the remedy (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 Commissions²⁸ is that of a lock warranty in an insurance policy, requiring the hatch on a private yacht to be secured by a special type of padlock. Compliance with the lock warranty would tend to reduce the risk of a specific type of loss: loss caused by intruders. Under Section 11, breach of such a warranty would not suspend the insurer's liability for other types of loss, such as loss in a storm. However, if there was a break-in, liability would be suspended even if the special padlock would not have prevented it.

- 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 of the Consumer Insurance (Disclosure and Representations) Act 2012.

iv Intermediaries and the role of the broker

English law usually views an insurance broker as the agent of the insured for the purposes of placing an insurance contract. The essence of the relationship between the broker and the insured is one that gives rise to a number of fiduciary duties, including an expectation that the broker will put the insured's interests before its own.

Commission

Notwithstanding that the broker is the agent of the insured at placement, the commission or brokerage that it earns when an insurance contract is placed is usually agreed and paid by the insurer – often as a percentage of the premium.

Consistent with ensuring that brokers act in the best interests of their clients, English regulation places a strict prohibition upon additional payments that are contingent upon the amount of business placed by the broker with a particular underwriter or the profitability of the business being entered into by an underwriter.

The agent's duty of disclosure

For contracts entered into before 12 August 2016, the law on the duty of disclosure affecting brokers is contained within Section 19 MIA. This provides that a placing broker is required to disclose to the insurer every material circumstance about the risk to be placed that is known to it or that in the ordinary course of business ought to be known by, or to have been communicated to, it. When IA15 came into force in August 2016, this provision was repealed; now, the broker's knowledge is attributable to the proposer, insofar as it is reasonably available to it. The broker owes a professional duty of care to the proposer to ensure that it does not cause the proposer to be in breach of its duty to make a fair presentation. The only exception to this is that a broker will not be required to disclose material information that it acquired while acting as agent for a third party if that information is confidential to the third party.

28 In their July 2014 report entitled 'Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; And Late Payment'.

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 2016.²⁹

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.³⁰ ‘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’.³¹ 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.³² Finally, the term ‘give rise to a claim’ requires a causal as opposed to a mere coincidental link between the circumstances notified and the ultimate claim.³³

Other policies will require the notification of a loss. In this context, loss has been interpreted differently in two cases on very similar facts (*RSA v. Dornoch*³⁴ and *AIG Europe (Ireland) Ltd v. Faraday Capital Ltd*³⁵). 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)*³⁶ the Supreme Court (by a majority of 4–1) abolished

29 *Versloot Dredging BV & Anor v. HDI Gerling Industrie Versicherung AG & Ors* Lloyd’s Rep IR 468.

30 *Layher Ltd v. Lowe*.

31 *HLB Kidsons v. Lloyd’s Underwriters and others* [2008] EWCA Civ 1206.

32 *Zurich Insurance Plc v. Maccaferri Ltd* [2016] EWCA Civ 1302.

33 *The Cultural Foundation and Abu Dhabi National Exhibition Co v. Beazley Furlong Ltd & Others* [2018] EWHC 1083 (Comm).

34 [2004] Lloyd’s Rep IR 826.

35 [2008] Lloyd’s Rep IR 454.

36 *ibid.*, footnote 27.

the insurer's remedy of forfeiture for the assured's use of a fraudulent device to further an otherwise valid claim. In doing so, it overturned the Court of Appeal's judgment in the same case and decided that Lord Justice Mance (as he then was) had been wrong in *The Aegeon*³⁷ in expressing the opinion that the public policy objective of deterring fraud in the insurance claims context warranted the forfeiture of a claim that had been promoted by fraudulent means, even though the claim was in all other respects valid.

While upholding the fraudulent claim rule in respect of fraudulently exaggerated claims, the majority considered it to be 'a step too far' and 'disproportionately harsh' to deprive a claimant of his or her claim by reason of his or her fraudulent conduct if the fraud had been unnecessary because the claim was in fact always recoverable. In a strong dissenting judgment, Lord Mance expressed the opinion that there was no distinction to be drawn between the deployment of a fraudulent device and the pursuit of a fraudulently exaggerated claim. In his view, forfeiture was proportionate in both cases, and justified by the public policy objective of deterring fraud in the insurance claims context.

IA15 seeks to clarify insurers' remedies for fraudulent claims. The statutory regime, which came into effect in August 2016, stipulates that, in the event of a fraudulent claim, the insurer will have no liability to pay the claim, and will have the option, by notice to the insured, to treat the contract as having been terminated from the time of the fraudulent act (and to retain all of the premium); however, the insurer will remain liable for legitimate losses before the fraud.

Owing to the mutual nature of the duty of good faith, an issue also arises (at least in theory) as to whether poor claims handling practices can place an insurer in breach of duty. Prior to the coming into force of the Enterprise Act 2016 (EA16) on 4 May 2017 under English law punitive damages against an insurer or reinsurer were not available for breaches of this duty; nor could an insurer or reinsurer be made to pay compensatory damages for any losses caused by an unreasonable declinature of a claim or delay in processing it. From 4 May 2017, however, EA16 introduced a new Section 13A into IA15. This Section introduces an implied term into every insurance contract subject to English law entered into on or after that date to the effect that insurers and reinsurers must pay claims within a reasonable time. A breach of that term gives rise to a right to claim damages. However, there is a special one-year limitation period for such a claim; and damages will be subject to the usual criteria for assessing contractual damages, which are that the loss must have been (1) foreseeable when the contract was entered into; (2) caused by the breach of contract; and (3) not too remote; and also that (4) the insured must have taken all reasonable steps to mitigate its loss.

37 *Agapitos v. Agnew* [2003] QB 556.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

It is usual for the parties in their contract to submit to the courts in a selected jurisdiction to hear disputes arising between them. The parties may also agree that any dispute is to be determined by arbitration rather than in the courts by insertion of an arbitration clause. Arbitration may be favoured for a variety of reasons, but in particular, for confidentiality. English courts generally will uphold and enforce these choices.

ii Litigation

Litigation stages

Civil proceedings in the High Court are governed by the Civil Procedure Rules (CPR).³⁸ 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 required to be disclosed. The duty of disclosure continues until proceedings have been concluded;
- c witness statements (see below);
- d expert reports (see below);
- e trial; and
- f appeal – an unsuccessful party may, with the permission of the court, appeal an order or judgment to a higher court.

Evidence

Witness evidence is provided by signed statements setting out the evidence a witness would be allowed to give orally at trial. If a party has served a witness statement and wishes to rely on the evidence of the witness at trial, the witness must be called to confirm their written evidence in court, and may be cross-examined by the other party or parties.

The court's permission is required if the parties wish to adduce expert evidence at trial. The expert's duty is to set out an independent, objective, unbiased opinion on matters within his or her expertise, arrived at without regard to the exigencies of the dispute or of either party's position in it, based on and taking account of all the factual evidence provided for their review. The expert's overriding duty is to assist the court (not the party who has undertaken to pay their fees). If a party puts an expert's report in evidence at trial, that expert may be cross-examined by the other party or parties to the case.

38 In the Admiralty and Commercial Courts, where many commercial insurance disputes are brought, there is an additional Guide that supplements the CPR.

Costs

The default position in English proceedings is that the losing party pays the reasonably incurred, reasonable costs of the successful party. These costs are 'assessed' by the court and, in practice, only 60 per cent to 70 per cent of the costs actually incurred by the successful party is usually recoverable from the unsuccessful party.

The parties have the ability to alter a costs outcome early in the proceedings by utilising the mechanism afforded by Part 36 CPR. If a party makes an offer to settle (in the prescribed form) that is rejected by the other party but the other party fails to 'beat' the offer at trial then the declining party, even though ultimately successful at trial, will be liable for the offering side's costs (including interest) from the date of expiry of the offer.

The 'Jackson reforms', implemented on 1 April 2013, affect the conduct of litigation in general but focus mainly on costs management (and disclosure that drastically affects costs). In particular, the reforms introduced a further 10 per cent sanction payable by defendants who decline a reasonable offer.

Under the CPR, each party is required to submit a budget for the case to the judge at the case management conference for approval by the court, and the court may order the budget to be reduced or disallowed in certain respects. The parties are entitled to apply to the court for variations in the budget during the case if new developments justify additional expenditure.

In recent years there has been an increase in the provision of third-party funding, also known as litigation funding. This is where a third party, with no previous connection to the litigation, agrees to finance all or part of a party's legal costs of the litigation in return for a fee payable from the proceeds recovered by the funded litigant.

iii Arbitration

Format of insurance arbitrations

The Arbitration Act 1996 codified English arbitration law and will govern the terms of an arbitration unless the parties have determined different rules (by reference to the rules of a particular institution) are to apply. The International Chamber of Commerce and the London Court of Arbitration are examples of commonly used international arbitral institutions with their own independent rules to govern the proceedings. However, most insurance and reinsurance arbitrations are ad hoc.

Procedure and evidence

Many London arbitrators will follow Commercial Court procedure, particularly in relation to evidence. It is open to the tribunal, however, to adopt different rules, for example, the International Bar Association Rules on the Taking of Evidence in International Arbitration, which allow for each party to request specific documents or a category of specific documents that are reasonably believed to exist, and to be in the possession of another party with reference to how the particular documents are relevant and material to the outcome of the case.

Costs

In the absence of a particular provision or agreement between the parties, costs in a London insurance arbitration will usually be payable by the unsuccessful party on the same basis as in the courts. While arbitration can be quicker than litigation, there are also added costs to consider. A panel of three arbitrators (the tribunal) each charging hourly rates, compared

with a judge who is effectively free (save for the initial court fee), will quickly add up. Further, on top of, inter alia, legal fees, experts' fees, administrative fees and arbitrators' expenses, the parties must supply and fund the venue.

iv Alternative dispute resolution

While the courts actively encourage mediation and routinely ask the parties whether they have considered it, they cannot 'order' mediation. Rather, they have the power to penalise the parties from a costs perspective if they believe settlement options have not been adequately investigated. Given the soaring cost of litigation, an adverse costs order can be grave, so a threat of this kind is substantial. Our experience is that parties to insurance and reinsurance disputes will usually attempt to mediate prior to trial. In addition, now that the amendment to IA15 has come into force introducing Section 13A (see Section III.v, above) so that insurers can be liable for damages for the late payment of claims, an insurer's failure to consider alternative dispute resolution is likely to be one of the factors taken into account in deciding whether a claim has been settled within reasonable time.

Various alternatives to litigation, arbitration and mediation have been devised over the years to fast-track a resolution and keep costs down. These include expert appraisal (early neutral evaluation), expert determination, final offer arbitration, mediation-arbitration and the structured settlement procedure.

V YEAR IN REVIEW

The past 12 months have seen some interesting developments in the regulatory and legislative landscape, as well as a number of significant judgments.

i Regulation

Solvency II

While the Solvency II Directive has been integrated well since being implemented in the UK on 1 January 2016, it continues to be the subject of adjustment at EU and domestic level. The European Insurance and Occupational Pensions Authority (EIOPA) conducted a planned review of the regime and consulted on advice to the European Commission about changes to the Solvency II standard formula. On 9 November 2018, the Commission published for consultation a draft version of a Commission Delegated Regulation intended to amend the Solvency II Directive. This has since been published in the Official Journal of the EU and came into force on 8 July 2019. Among other things, it amends provisions relating to the capital requirement standard formula, and the alignment of the Solvency II standard formula with those rules that are applicable in the banking sector. The Solvency II Directive (as amended by Directive 2014/51/EU, known as the Omnibus II Directive) requires that the European Commission undertake a full of Solvency II before the end of 2020. The European Commission together with EIOPA will therefore continue to consider a number of areas to amend the Solvency II regime as part of its '2020 review'. While the future course of the UK regulatory regime after the Brexit transition period is not clear, the Solvency II 2020 review remains a fundamental development for UK firms and represents an important milestone in the future of the regulatory framework for insurers.

The senior managers and certification regime

The SM&CR was extended to insurance intermediaries on 9 December 2019.

Outsourcing by regulated firms

Outsourcing of functions by regulated firms continues to be on the UK regulators' radar. In December 2019, the PRA published a Consultation Paper (CP30/19) on outsourcing and third-party risk management, which sets out the PRA's expectation of PRA-regulated firms with respect to outsourcing arrangements with third parties (in particular cloud/technology providers). For example, it is noted that subject to the outcome of the consultation, insurers may be expected to maintain a register of all of their cloud outsourcing arrangements. The consultation closes on 3 April 2020.

ii Dispute resolution

The year 2019 provided little guidance from the courts on the construction and operation of the Insurance Act 2015. In *Ageas v. Stoodley*³⁹ (a case under the Consumer Insurance (Disclosure & Representations) Act 2012), however, the Court was prepared to accept evidence from the insurer's underwriting manager as proof of what the insurer would have done if a fair presentation of the risk had been made at placement – even in the absence of the underwriter who had accepted the risk and any supporting materials. This may provide some guidance as to how the courts will approach the same issue under IA15. In *Young v. Royal & Sun Alliance Plc*,⁴⁰ the Court confirmed that the law of waiver is unchanged by IA15.

There have been a number of other significant court decisions across all sectors of insurance. Some examples are outlined below.

One decision that has the potential to make a profound impact on a number of classes of business, including cyber, property and all risks cover, was the High Court's ruling in *AA v. Persons Unknown and others*.⁴¹ The facts of the case are complex and concerned a subrogated claim by an insurance company to recover a US\$950,000 ransom which it had paid in bitcoin to hackers who had locked the insured out of its own IT network. The case turned on the issue of whether or not bitcoin or other cryptocurrencies are 'property' such that they can be subject to proprietary remedies such as injunctions. In ruling that cryptocurrencies are indeed property, the Court sought to reflect modern life rather than adhere to concepts of property which are now many years old. The case should, however, prompt both insurers and insureds to review the definitions, insuring clauses and exclusions in policy wordings.

In the liability sector, the Court of Appeal addressed the often complex issue of notification in *Euro Pools v. Royal & Sun Alliance Plc*.⁴² The case concerned the nature of the link required between a notified 'circumstance' and a subsequent claim such that the claim is taken to have been made when the circumstance was notified for the purpose of coverage under a 'claims made' policy. The case turned on its particular facts but the Court set out some general principles of interest. In particular, it confirmed that it is permissible to notify a

39 [2019] Lloyd's Rep. IR 1.

40 [2019] CSOH32.

41 [2019] EWHC 3556.

42 [2019] EWCA Civ 808.

problem in general terms (or a ‘hornets’ nest’) as a circumstance without fully appreciating its cause or potential consequences. What is required is some causal connection which is more than merely coincidental between the notified circumstance and subsequent claim.

The property market saw a number of important judgments in 2019. Perhaps one of the most interesting was *Sartex v. Endurance Corporate Capital*.⁴³ This case concerned the issue of whether insurers were required to pay the reinstatement value or market value of industrial premises destroyed in a fire. The insured claimed the cost of reinstating the site, which was considerably more than its market value. Insurers argued that if an insured is to recover on a reinstatement basis it must have had the intention to reinstate the property at the time that the loss occurred and continued to have that intention until the commencement of proceedings. In this case, however, the insured had taken no steps towards reinstating the site eight years after the loss and, indeed had been considering alternative sites. In rejecting this argument, the Court held that when deciding the appropriate basis of indemnity, it is necessary to consider the nature of the loss suffered by the insured, the measure of indemnity which fairly and fully indemnifies the insured for that loss, and whether subsequent events show that such measures may over indemnify the insured.

VI OUTLOOK AND CONCLUSIONS

i Insurance contract law reform

The first substantive court decisions on the interpretation of IA15 have yet to be published and it is to be hoped that in 2020 the courts will give guidance on, for example, the application of the new proportionate remedies for breach of the duty of fair presentation and the operation of Sections 10 and 11 IA15, which deal with the operation of warranties.

ii Impact of Brexit on insurance regulation

Until the end of the Brexit transition period, the legal and regulatory framework will continue as normal. As such, the UK will remain subject to existing EU legislation and any new EU laws coming into force prior to the effective date of Brexit.

The UK government and the insurance and reinsurance regulators have, since the Brexit vote in June 2016, been establishing rules and regulations to safeguard the regulatory framework so that it continues to effectively operate after the Brexit transition period.

The European Union (Withdrawal) Act 2018 (EUWA), as amended, will bring applicable direct EU legislation (that is, primarily EU regulations) into domestic UK law at the end of the transition period. EUWA also gives the government the power to make secondary legislation to amend UK and domesticated EU legislation to ensure that it is legally operative following the end of the Brexit transition period. The UK government is currently undertaking the mammoth task of onshoring (also known as domestication), which involves replicating EU law in UK legislation and regulation and revising it so that it is effective following the end of the Brexit transition period. This is challenging in the area of insurance and reinsurance, given that so much of the UK’s regulatory regime executes or uses EU law. This process of onshoring is expected to continue until the end of the Brexit transition period. The government has also provided the FCA and the PRA (and the Bank of England and the Payment Systems Regulator) with the authority (through the Financial

43 [2019] EWHC 1103.

Regulators' Powers (Technical Standards etc.) (Amendment etc.) (EU Exit) Regulations 2018 (SI 2018/1115)) to make amendments to domesticated EU technical standards and their own rules to reflect the UK's position after leaving the EU.

At the time of writing, the approach to be adopted for 'passporting' remains uncertain. However, it is clear that unless the passporting regime is retained in an agreement between the UK and the EU, UK insurers will lose their passporting rights either if the UK exits the EU with no deal or at the end of the Brexit transition period if a deal is agreed. The passporting rights of EU insurers into the UK will be similarly impacted. If passporting rights fall away, the UK, as a third country (being a country that has left the EU) would not be able to continue its activities in the EEA on the basis of its UK authorisation. The appropriate licences and authorisations would have to be sought in the relevant Member States unless the UK and the EU are able to agree market access during the Brexit transition period. Certain EU financial services legislation permits specific financial institutions based in third countries to access the EEA markets. This is known as the third country equivalence regime, which allows non-EEA firms to provide services into the EEA if their home country regulatory regime is 'equivalent' to EU standards. The UK and the EU have agreed that they will assess the equivalence of each other's regulatory and supervisory regimes as soon as possible after Exit Day, with aim of concluding these equivalence assessments before the end of June 2020. The UK and the EU have also agreed to keep their respective equivalence frameworks under review. However, even if the equivalence assessments are concluded within the proposed timescales, they are no replacement for passporting. The Solvency II Directive and the IDD do not include equivalence regimes relating to market access. As such, any equivalence assessments will need to address these gaps.

Given the uncertainty around the outcome for passporting, and the recognition that 'equivalence' is unlikely to fully plug the gap, many insurers and reinsurers have taken the time since the Brexit vote to restructure their business and prepare contingency plans by relocating or opening new branches of the business in EU member locations to ensure that they can continue to operate within the EU following the end of the Brexit transition period. Many have seen this as the only sure-fire way to avoid lost revenue and huge business disruption. Insurers are also introducing 'contract continuity clauses' into their policy wording, which allows risks currently underwritten by a UK entity to be transferred to an EEA licensed insurer at the end of the Brexit transition period.

Lloyd's of London has established a subsidiary, Lloyd's Insurance Company S.A (Lloyd's Europe), in Brussels with a policy that 'all new non-life EEA direct insurance policies are written by Lloyd's Europe and all renewing EEA non-life direct insurance policies are transferred to Lloyd's Europe on their renewal'.⁴⁴ To ensure contract continuity of policies that could be affected by the loss of passporting rights, Lloyd's of London has also initiated a Part VII transfer (see Section II.xi, above) of affected policies to Lloyd's Europe; this is expected to be finalised before the end of 2020.

With the continued uncertainty around market access the UK has put in place a temporary permissions regime (TPR). The TPR will give EEA insurers and reinsurers currently operating in the UK on a passporting basis (and hoping to continue to maintain their UK business) a limited transitional period following the end of the Brexit transition period for their branches to carry on operating in the UK while they establish separately authorised UK

⁴⁴ See further <https://www.lloyds.com/news-and-risk-insight/news/lloyds-news/2020/01/brexit-what-happens-next>.

branches. Insurers and reinsurers can take advantage of the TPR through a simple notification process. While the window for TPR notification closed on 30 January 2020 the FCA have indicated that they are considering reopening this later in the year to allow for additional notifications to be made before the end of the Brexit transitional period.

Alongside the TPR, the UK has also set up the financial services contracts regime (FSCR), to ensure that those insurers and reinsurers that do not enter into the TPR, or those that do enter the TPR but fail to obtain authorisation, have a period of time during which they can wind down their UK business appropriately after the Brexit transition period.

While the insurance regulatory regime in the UK is expected to remain exactly the same during the Brexit transition period only time will tell how it may evolve over the transition period.

iii Insurtech

Insurtech refers to the use of technology innovations designed to increase efficiency in the insurance market. Over the past couple of years, innovations such as automation have brought improvements around risk and quality. There is likely to be real momentum in 2019 in terms of the development and implementation of blockchain technology, virtual reality, robotics, artificial intelligence and the internet of things.

iv Summary

The insurance industry in England has undergone some of the most significant regulatory and legal reforms to affect it for many years. These changes have provided both challenges and opportunities for the London Market, whose strength historically has been built, inter alia, on its ability to adapt to change. The London Market appears to have embraced the rapidly changing landscape and many within it have begun setting their sights on growth.

The most interesting development will of course be the changes affecting insurance and reinsurance regulation following the end of the Brexit transition period. At the time of writing, the future regulatory regime remains uncertain and the London Market is still having to consider its contingency arrangements.

FRANCE

*Alexis Valençon and Nicolas Bouckaert*¹

I INTRODUCTION

The French insurance and reinsurance industry is doing well. In 2018, the insurance sector's turnover grew by 3.7 per cent, mainly led by life and health insurance (+4 per cent), with property and liability insurance growing at a slightly more modest pace (+2.8 per cent). Profitability, for its part, increased more significantly, having reached €12.8 billion in 2018, compared to €10.6 billion in 2017.²

II REGULATION

i The insurance regulator

An independent administrative authority, the French Prudential Supervision and Resolution Authority (ACPR), was created by Ordinance No. 2010-76 of 21 January 2010 and modified by Law No. 2013-672 of 26 July 2013. It licenses and supervises banking, insurance and reinsurance activities, with the aim of providing more effective regulation of these sectors. The ACPR combines two roles, namely:

- a* overseeing insurance policies written by insurers; and
- b* issuing general rules and guidelines (by way of circulars, decrees, etc.) regarding banking, insurance and reinsurance activities.

ii Position of non-admitted insurers

According to Articles L310-2 and L310-10 of the Insurance Code (IC), non-admitted insurers cannot do business in France. Any breach results in sanctions set out in Article L310-6 et seq. of the IC, which include fines (from €4,500 to €375,000) and may go as far as having the offending company wound up. Exceptions exist for maritime and aviation risk coverage.³

1 Alexis Valençon and Nicolas Bouckaert are partners at Kennedys.

2 Information provided in the *Tableau de bord de l'assurance* report (year in review), produced by the French Federation of Insurance for the 2018 calendar year.

3 Article L310-27, IC.

iii Requirements for authorisation

In order for a new insurance or reinsurance company to be authorised to write insurance or reinsurance, it must comply with the licensing procedure prescribed in Articles L321-1 to L321-3 and R321-1 to R321-5 of the IC. A licence may be granted conditionally or unconditionally, or be refused, by the ACPR, which bases its decision on the following criteria:

- a* the extent and suitability of the technical and financial means that the applicant plans to implement;
- b* the integrity, expertise and experience of the applicant's managers; and
- c* the applicant's shareholding structure and shareholder status.⁴

In addition, the vast majority of insurance companies operating in France are subject to the EU Solvency II Directive (Solvency II)⁵ and must therefore comply with minimum capital requirements,⁶ have a governance system that ensures sound and prudent management, organise regular internal reviews and have an adequate risk management system.⁷

In the event that the ACPR refuses to grant the licence sought by an applicant, the latter can challenge the decision before the highest administrative court, the Council of State. Licences are granted to insurance companies for specific categories of business. Applicants must choose among the 26 categories listed in Article R321-1 of the IC. Insurance companies, unlike reinsurance companies, may not be licensed for both life and non-life insurance business.⁸

iv Regulation of individuals employed by insurers, position of brokers and the distribution of products

Articles A512-6 and A512-7 of the IC lay down the requirement that insurance company employees and general agents and brokers must hold a master's or bachelor's degree or professional certificate in finance, banking or insurance.

The European Union's legal framework for insurance distribution was thoroughly reformed by Directive (EU) No. 2016/97 of 20 January 2016 on insurance distribution (the Insurance Distribution Directive). Article L511-1 et seq. and Article R511-1 et seq. of the IC, which regulate the activity of distributing insurance products, were amended accordingly. In this context, the definition of the distribution of insurance products was broadened to include distribution over the internet and over the telephone. Also, whereas formerly only intermediaries who undertook distribution as a principal activity fell under the scope of former Article L511-1 of the IC, its recast version now also applies to insurance companies and includes the majority of distributors who undertake the activity on a secondary basis.⁹

4 Article L321-10-1, IC.

5 Article L310-3-1, IC.

6 Article L352-5 et seq., IC.

7 Article L354-1 et seq., IC.

8 Article L321-1 Section 3, IC.

9 Article R511-1, IC.

v Compulsory insurance

There are more than 200 instances of compulsory insurance (e.g., employers' liability), which concern a vast array of sectors and activities: automobile; transport; health; housing; real estate; construction; environment; sports; recreational activities; culture; education; training; employment; industrial, agricultural, economic and financial activities; certain regulated professions; property insurance; and life insurance.

vi Compensation and dispute resolution systems

In principle, any natural or legal person may bring a claim before the ordinary courts or, in certain cases, an arbitral tribunal.

By way of exception, since 2014, some authorised consumer associations are allowed to file specific group or class actions against insurers. These types of group or class actions were initially limited to non-bodily injuries; however, since 2016, they include claims for bodily injuries and their scope has been extended to other fields, such as health products, personal data and discrimination.

The ACPR regulates banks and insurers and, more generally, the distribution of financial products. Although it does not have jurisdiction to hear individual claims, it does have the power to impose fines on insurers that breach statutory provisions or engage in conduct likely to jeopardise the interests of policyholders or the market.

In addition, the Financial Markets Authority (AMF) was established by the Financial Security Act of 1 August 2003 to prevent any malfunction in the financial markets. For this purpose, it is empowered to conduct investigations into professionals operating in these markets and may impose fines or sanctions for breaches of the AMF General Regulations or professional obligations. It may also organise mediations between individuals and entities through its ombudsman, whose role is to facilitate compensation for losses but does not include the power to impose penalties or award damages.

On 16 December 2005, the French Federation of Insurance Companies (FFSA), a professional insurance federation of which the majority of French insurers are members, adopted an arbitration convention that is binding on all its members and provides that any disputes between insurers (that are members of the FFSA) regarding the indemnification of a given loss must be brought before an FFSA arbitral tribunal, rather than state courts. The FFSA became the FFA by merging with another professional body, the Group of Mutual Insurance Companies (see Section IV.iv).

vii Taxation of premiums

French insurance premium tax (IPT) is regulated under Article 991 et seq. of the General Tax Code and applies to all insurance policies covering risks situated in France.

Insurance companies that are not established in France must be registered with the French tax authorities and appoint a representative responsible for paying IPT.

The rate of IPT varies from 7 per cent to 33 per cent, depending on the insured risk.

viii Proposed changes to the regulatory system and other notable regulated aspects of the industry

EU Directive 2019/2177 amending the Solvency II Directive 2009/138/EC, MiFID II Directive 2014/65/EU and EU Directive 2015/849 on the prevention of the use of the financial system for the purpose of money laundering or terrorist financing was published in the Official Journal of the European Union (27 December).

The Directive aims to improve the supervision of financial markets by strengthening the coordinating role of the European Supervisory Authorities (ESAs) and to promote the exchange of information and cooperation between national supervisory authorities and the European Insurance and Occupational Pensions Authority (EIOPA), in particular by setting up a notification system.

In this respect, Article 2 of the amending directive provides for notification obligations in the case of significant cross-border insurance activities or in crisis situations. It also sets out the conditions for setting up cooperation platforms, at the initiative of the EIOPA or at the request of one or more of the supervisory authorities concerned, where an insurance or reinsurance undertaking carries on or intends to carry on business that is based on the freedom to provide services or the freedom of establishment and there are justified concerns about adverse effects on policyholders.

The deadline for transposition of that Directive shall be 30 June 2020 for the amendments to be made to Directive 2009/138/EC and 30 June 2021 for other amendments.

In addition, the new Delegated Regulation 2019/981 was published on 18 June 2019 in the Official Journal of the European Union. It amends Delegated Regulation 2015/35 and entered into force on 8 July 2019. It simplifies the calculation of Solvency Capital Requirements (SCRs), corrects technical inconsistencies and removes possible constraints on the financing of the economy.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The statutory framework for insurance mainly consists of the IC, the Mutual Code, the Social Security Code, and the Financial and Monetary Code. Provisions of other codes, such as the Civil Code (CC), may also apply. French insurance regulation is widely influenced by EU legislation. In addition, French case law clarifying insurers' and policyholders' duties can also be considered a source of law.

ii Making the contract

The IC lays down specific obligations for insurers to provide information and documents both during the pre-contractual phase and during the life of the insurance contract itself. Pursuant to Article L112-2 of the IC, prior to the conclusion of the contract, the insurer must provide the policyholder with an information sheet that sets out the particulars regarding the premiums owed and the policy limits, the functioning over time of occurrence-based or claims-based coverage and the consequences of a succession of contracts with different bases for triggering coverage.

The insurer must also provide the insured with a copy of the draft contract and the attachments thereto, or a brochure on the contract precisely describing the coverage and exclusions and the insured's obligations. The draft will not be binding on the insured or the insurer, as only the policy or the cover note will prove their agreement.

The Insurance Distribution Directive modified Article L112-2 of the IC imposing a new obligation on insurance distributors to provide their clients with a standardised document detailing essential information regarding the contract (e.g., coverage type and summary, main exclusions, duration). The requirements of this document are provided by Article A112 of the IC.

These obligations do not apply to insurance contracts covering large risks as defined by Articles L111-6 and R112-2 of the IC. As regards the information to be supplied by the policyholder to the insurer, Law No. 89-1014 introduced a system based on the completion of a questionnaire drawn up by the insurer. The duty to disclose is not, however, confined to the questionnaire and can include any question submitted by the insurer by fax, letter, etc., provided that the insurer can prove that it clearly phrased the question. As a consequence, the policyholder only has a duty to answer the insurer's questions and is under no obligation to spontaneously disclose information that might be relevant to the insured risk. The policyholder can, however, make spontaneous statements upon taking out the policy, regardless of the absence of any legal duty forcing him or her to do so. In such a case, the policyholder's spontaneous statements must be truthful and accurate, as otherwise the contract could be avoided for fraudulent misrepresentation.¹⁰ The information given in relation to a risk at the time of the insurance contract's inception will also determine the scope of the policyholder's continuous duty to disclose all new relevant information to the insurer, pursuant to Article L113-2 Section 3 of the IC.

Regarding the truthfulness of the information provided by the policyholder (whether upon inception of the insurance contract or during its lifespan), the law makes a distinction between erroneous answers (or absence of disclosure) that are made in good faith or bad faith (i.e., deliberately).¹¹

If the misleading information was provided in good faith, the possible indemnity owed will be reduced according to a pro rata calculation based on the premium the insurer would have requested, had it been informed of the true nature of the risk. If, on the other hand, the misleading information was provided deliberately and had an impact on the insurer's choice to cover the risk or the price of the premium requested for said cover, then the insurance contract can be deemed to be null and void.

None of these provisions apply to reinsurance contracts.¹²

iii Interpreting the contract

General rules of interpretation

The CC provides general rules of interpretation in Article 1188 et seq., but these are only guidelines and the courts may interpret contracts as they deem fit.

10 Article L113-8 of the IC.

11 Articles L113-8 and L113-9, IC.

12 Article L111-1, IC.

However, judges should only interpret contracts when their terms are unclear or ambiguous,¹³ otherwise they risk being overturned upon appeal;¹⁴ this principle also applies to the pre-contractual questionnaire submitted by the insurer to the policyholder (and the policyholder's answers thereto).¹⁵

When interpreting contractual provisions, the overarching principle is that it should be interpreted according to the parties' common intention.¹⁶ In case of doubt, a private agreement shall be interpreted against the creditor and in favour of the debtor, and standardised pre-drafted contracts (such as those habitually offered to consumers) shall be interpreted against the party who offered the agreement.¹⁷

In the event of a contradiction between a clause contained in the general terms and conditions of a contract and a clause contained in the special terms and conditions of the contract, the latter will prevail.¹⁸

Furthermore, contracts are to be interpreted in their entirety, and clauses are not to be read independently from one another; similarly, contracts that concern the same operation should not be interpreted independently from one another, but together.¹⁹

Regarding the case of exclusion clauses, Article L113-1 of the IC provides that these must be 'express and limited', failing which the insurer would be unable to enforce the clause and would have to cover the loss.²⁰ They must also appear very clearly in the policy, as per Article L112-4 of the IC.²¹ Any exclusion clause that requires interpretation is necessarily found not to comply with Article L113-1 of the IC²² and will, therefore, be deemed unenforceable.

Finally, with respect to the specific case of insurance offered to consumers or non-professionals, Article L211-1 of the Consumer Code provides that the terms of the contract 'must be set out and written in a clear and comprehensible manner'. Moreover, 'in case of doubt, they are to be interpreted in the sense which is most favourable to the consumer or non-professional'.²³

Incorporation of terms and types of terms in insurance contracts

Insurance contracts must be written in French and in clear print. They must also comply with the requirements of Articles L112-4, L113-15 et seq. and R112-1 of the IC, which respectively provide that the policy must indicate:

- a* the nature of the insured risks, the starting point and period of coverage and the policy limit;
- b* the duration of the contract and the terms applicable to termination; and

13 Article 1192, CC.

14 Court of Cassation, 2nd civil division, 28 October 2017, appeal No 16-22.564; 13 September 2018, appeal No 17-24871.

15 Court of Cassation, 2nd civil division, 3 March 2016, appeal No. 15-12464.

16 Article 1188, CC.

17 Article 1190, CC.

18 Court of Cassation, 1st civil division, 9 February 1999, appeal No 96-19538; 4 October 2018, appeal No. 17-20624.

19 Article 1189, CC.

20 Court of Cassation, 2nd civil division, 26 October 2017, appeal No. 16-23696.

21 Court of Cassation, 2nd civil division, 24 May 2018, appeal No. 17-16431.

22 Court of Cassation, 2nd civil division, 12 April 2012, appeal No. 10-20831.

23 Court of Cassation, 2nd civil division, 20 December 2012, appeal No. 11-27225; 26 October 2017, appeal No. 16-22.564.

- c the duration of the mutual undertakings made by the parties, the terms of tacit renewal of the policy, the policyholder's duty to disclose, and the two-year limitation period for insurance claims and the causes of interruption of that period.²⁴

Warranties, conditions precedent and conditions

The policy may stipulate that the contract will only enter into force once certain conditions precedent are satisfied by the insured, such as, for instance, the payment of the first premium.²⁵

The policy may also contain coverage conditions, which should be distinguished from conditions precedent. If these conditions are not satisfied during a certain period of the insurance contract's life, coverage will not be owed for that particular period. Conversely, as soon as the condition in question is satisfied again, coverage would be available from that date onwards. These types of conditions are common, for instance, in relation to coverage for breaking and entering or theft,²⁶ where policies will often provide that coverage may only be owed under the contract if certain security measures are maintained at all times (such as the presence of a working alarm system). Though they may sometimes lead to the same results, coverage conditions are distinct from exclusion clauses and are not, therefore, subject to the obligations of being written in bold characters or drafted in an 'express and limited fashion'.²⁷

iv Intermediaries and the role of the broker

Conduct rules

Insurance intermediaries that distribute insurance or reinsurance coverage on a principal or secondary basis must meet the integrity and professional qualification requirements set out in Articles L512-4 and L512-5 of the IC. For instance, insurance intermediaries must not have been convicted of certain offences. As far as professional qualifications are concerned, brokers need to meet certain requirements pursuant to Article R512-9 of the IC (i.e., two to four years of professional experience devoted to the production or management of insurance contracts, or a specified minimum level of higher education) or receive 150 hours of training.²⁸ In any event, brokers must have at least 15 hours of training per year.²⁹ They must also carry professional-liability and financial-bond insurance.³⁰ They can incur various sanctions, ranging from fines to imprisonment, for breach of statutory requirements, such as not being registered.³¹

Brokers and insurance companies are also bound by brokerage customs and industry practice. Legal commentators are, however, divided and cautious about their qualification as a rule of law and their possible enforcement by or against a third party.

24 Court of Cassation, 3rd civil division, 16 November 2011, appeal No. 10-25246.

25 Court of Cassation, criminal division, 17 January 1996, appeal No. 95-80847.

26 Court of Cassation, 2nd civil division, 30 June 2011, appeal No. 10-23309.

27 Court of Cassation, 1st civil division, 18 December 2002, appeal No. 00-21991.

28 Article R512-9, IC.

29 Article R512-13-1, IC.

30 Articles L512-6 and L512-7, IC.

31 Articles L514-1 to L. 514-4, IC.

Agency and contracting

Insurance intermediaries must be registered with the organisation in charge of the French Register of Insurance Intermediaries. Registration must be renewed annually and is subject to the payment of a fixed fee.³²

The Insurance Distribution Directive reinforced the freedom to provide services and the freedom of establishment of insurance intermediaries within the European Union by providing that the registration with their home Member State should allow them to operate in other Member States.³³

How brokers operate in practice

Traditionally, brokers provide clients with pre-contractual advice on coverage and premiums, and consequently fall under the category of insurance distributors. As such, they have certain obligations regarding pre-contractual information and advice.³⁴ These obligations have been reinforced by a decision of the Court of Justice of the European Union in May 2018, which found that even if the pre-contractual advice is given without a real intention to enter into a contract from the intermediary's part, its actions nonetheless fall under the scope of intermediation, as does the financial advice given by an intermediary.³⁵

Brokers are, however, increasingly involved in claims handling. They may, for instance, strive to defend their clients' interests by guiding policyholders from the time of occurrence of a loss, and assisting them during the investigation and adjustment of the loss. Brokers may also guide insurers on the choice of party-appointed adjusters

The extent of a broker's involvement in the handling of a claim mainly depends on the size of the loss. For instance, a claim liable to have a major financial impact will be handled directly by the insurer, but the broker may keep it under close review.

Brokers may also act on behalf of the insurer, for example by collecting insurance premiums.

v Claims

The insured must give the insurance company notice of any claim that falls within the policy limits and scope of coverage, and provide the company with all the documents enabling it to appreciate the circumstances of the loss.

Insurance policies cannot impose a specific method of notifying claims; any clause imposing a special method is therefore invalid. The insured should notify the claim as soon as he or she is aware of it and within the time limit, if any, specified in the policy.

Pursuant to Article L113-2 of the IC, where a policy clause stipulates a specific time limit for the notifications of claims, the insurer may deny coverage of any claim reported outside the time limit in question, provided that:

- a* the delay in reporting has caused the insurer prejudice, inter alia, by increasing the cost of the claim;
- b* the specified time limit for reporting claims is not less than five days; and

32 Article L512-1, IC.

33 Directive (EU) No. 2016/97, Recital 20.

34 Articles L112-2 et seq. and L521-1 et seq., IC.

35 Court of Justice of the European Union, 31 May 2018, C-542/16 QPC.

- c the policy's relevant sections appear in bold print and clearly state that late reporting results in forfeiture of coverage.

Generally speaking, there is no duty on the insured to mitigate damage (except in marine insurance); nevertheless, the courts have occasionally found this duty on the basis of a breach of contract.³⁶ Legal commentators have, however, remained rather cautious on this point, as the duty has neither been clearly defined nor confirmed by further court decisions. However, the project for the reform of tort law (which has not yet been adopted), *inter alia*, envisages, in its Article 1263, imposing this obligation in matters other than bodily injury.³⁷

Finally, where the policy so provides in very clear print, fraudulent overstatement of losses can result in forfeiture of coverage, even if the overstatement caused no prejudice to the insurer.

Set-off

The liability insurer cannot set-off the unpaid premiums upon the indemnity it may be obligated to pay to the third-party victim.³⁸

However, the insurer has a right to assert set-off, including in an insolvency context, but only if the right is asserted before the judgment opening insolvency proceedings, and under certain conditions. Accordingly, an insurer can set-off premiums owed to it by a policyholder against insurance proceeds owed by it to the policyholder.

Reinstatement

For annual policies, the policy limit is automatically reinstated in full on the first day of the next year of insurance. Moreover, the insured or policyholder can request reinstatement of mandatory coverage. If the policy limit has not been exhausted, the remaining portion is not carried over to the next year.

In addition, insurance contracts can provide for reinstatement of the policy limit depending on changes in the risks. Such a provision is subject to a higher premium and is drafted on a case-by-case basis.

Dispute resolution clauses

Generally speaking, insurers can stipulate mediation and conciliation clauses in their policies. Article L112-2 of the IC provides that the insurance contract must indicate how the insured can initiate a mediation. Insurance contracts relating to large risks³⁹ can also contain mediation and conciliation clauses, but they do not, however, need to indicate the exact means of initiating mediation, as would have been the case with a consumer.

According to case law, if an insurance contract contains a conciliation clause or a mediation clause, the parties have to go through these processes before taking legal action.⁴⁰

36 Court of Cassation, 2nd civil division, 24 November 2011, appeal No. 10-25635.

37 http://www.justice.gouv.fr/publication/Projet_de_reforme_de_la_responsabilite_civile_13032017.pdf.

38 Court of Cassation, 1st civil division, 31 March 1993, appeal No. 91-13637.

39 Article R112-2, IC.

40 Court of Cassation, mixed divisions, 12 December 2014, appeal No. 13-19684; Court of Appeal of Dijon, 19 September 2017, appeal No. 15/00277; Court of Appeal of Versailles, 7 February 2017, appeal No. 15/00896.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

There are two types of first instance courts in France: civil courts and commercial courts. Commercial courts differ from civil courts in that they are staffed by non-professional judges, who are usually experienced business people. There are no trials by jury in either the civil or the commercial courts.

If neither one of the parties is a commercial entity, the district court or high court has jurisdiction (depending on the amount of the claim) to rule on any disputes in first instance. Alternatively, the regional commercial court has exclusive jurisdiction if all the parties to the dispute are commercial entities (unless the contract at issue contains a jurisdiction clause that explicitly stipulates that civil courts have jurisdiction). Finally, if a claimant is a non-commercial entity but the defendant is, for its part, a commercial entity, the former can choose before which court, commercial or civil, he or she brings his or her action.

It follows from the above that insurers are accustomed to appearing before both civil and commercial courts (though mutual insurance companies must necessarily initiate proceedings or be sued before civil courts, as they are non-commercial entities).

Taking property and casualty insurance as a representative example,⁴¹ the principles that govern applicable law or choice of law may be summarised as follows:

- a* compulsory insurance contracts that correspond to a legal obligation (such as motoring insurance) are necessarily governed by French law;⁴²
- b* insurance contracts entered into with a French resident in relation to a risk that is deemed to be located in France (according to the criteria set out in Article L310-4 of the IC) will necessarily be governed by French law;⁴³ and
- c* insurance contracts entered into with a consumer will also necessarily be governed by French law, provided the consumer has his or her habitual residence in France and the insurer carries out his or her usual business in France.⁴⁴

There are, however, certain conditions where the parties can elect for the insurance contract to be governed by a foreign law, namely:

- a* if the risk is located in France, but the insured resides or has its registered office abroad, the insurance contract can either be governed by French law or the law of the country the insured resides in;⁴⁵
- b* if the risk is not located in France, but the insured resides or has its registered office in France, the insurance contract can be governed by French law or by the law of the state where the risk is located;⁴⁶ and

41 Other rules may apply to more specialised areas of French insurance law, such as in marine insurance or life insurance.

42 Article L182-1, IC.

43 Article L181-1-1, IC.

44 Rome I Regulation, Article 6.

45 Article L181-1 Section 2, IC.

46 *ibid.*

- c if the risk qualifies as a large risk, as defined by Article L111-6 of the IC, the contract can be governed by any law the parties elect (rather than merely the law of the state associated with the residence of the insured and the location of the risk)⁴⁷ – however, in this instance, if the main elements of the insurance contract are located in France, then the overriding mandatory provisions of French insurance law will apply, regardless of the governing law elected by the parties.

In the three instances listed above where the insured and the insurer elect a governing law other than French law, the governing law retained by the parties must either be identified explicitly or be self-evident in light of the other clauses of the contract or the facts of the case. If this is not the case, the governing law will be that of the state that has the closest ties with the insurance contract, which is presumed to be the law of the state where the risk is located.⁴⁸

Insurance contracts can contain arbitration clauses, which will, therefore, be binding on the parties in the event of a dispute regarding the application of the policy (provided, of course, the legal conditions applicable to the validity of any arbitration clause are satisfied). The identity of the insured will, however, have a significant impact on whether the arbitration clause at issue is enforceable; specifically, whether the insured is a professional or a consumer. If the insured is a professional, and the insurance contract was taken out in connection with its professional activity, the arbitration clause will be binding on both the insurer and the insured alike. If, however, the insured is a consumer, then the insurer will not be able to invoke the clause against it, as Article R212-2-1 of the Consumer Code provides that arbitration clauses are presumed unfair and should be set aside when they are entered into with a consumer and Article 2061 of the CC additionally provides that arbitration clauses entered into with non-professionals cannot be invoked against them (but the said non-professionals remain free to invoke their application, should they so wish).

ii Litigation

Litigation stages

Generally speaking, first instance proceedings in a commercial case usually take about a year and a possible appeal will usually add another year. A possible, ultimate appeal before the French Supreme Court, the Court of Cassation (which can only be made on a point of law, rather than an issue of fact), would add another 18 months. These periods can vary depending, inter alia, on the complexity of the case, the number of parties or whether investigative measures are ordered by the court.

Urgent proceedings, such as summary proceedings for interim relief and fixed-date proceedings, also exist. These proceedings can take several weeks to several months depending on the complexity of the case and the parties' diligence.

Evidence

Proceedings before French courts do not include discovery, in a marked difference to the way evidence is produced before common law jurisdictions.

According to Article 132 of the Code of Civil Procedure (CCP), each party must produce the documents relied upon in its submissions and communicate copies thereof to the

47 Article L181-1-5, IC.

48 Article L181-2, IC.

other parties. In the event that a party does not comply with this obligation, its opponents could apply to the court for a disclosure order.⁴⁹ The court would then indicate the time limit for disclosure, if necessary on penalty of a daily fine, and, where appropriate, the method of disclosure.⁵⁰ The judge on the merits could also choose to exclude whatever documents have not been served in due time.⁵¹ If a party wishes to rely on a document evidencing a transaction to which it was not itself a party, or any other document held by a third party, the court may order the production of the original or a certified copy of the said document.⁵²

Pursuant to Article 199 of the CCP, if testimonial evidence is admissible, the court shall admit statements from third parties whose first-hand knowledge can help clarify the facts at issue. Such statements can be made in writing or brought by means of an inquiry or investigation, depending on whether they are written or oral.

Costs

According to Article 695 of the CCP, costs include:

- a* the fees, taxes, fees or emoluments charged by the court registry offices or by the tax administration, except any fees, taxes and penalties payable in respect of documents or title deeds produced in support of the parties' claims;
- b* the cost of translating documents, where translation is required by law or by an international commitment;
- c* allowances paid to witnesses;
- d* experts' fees;
- e* fixed disbursements;
- f* emoluments of public officers;
- g* counsel's fees insofar as they are regulated, including fees for counsel's addresses; and
- h* expenses incurred for service of process in a foreign country.

These costs, which do not, however, include the other parties' legal costs, are born by the losing party, once the judgment on the merits is handed down – though the court can, in its judgment (provided its decision is motivated), order that part of these costs also be borne by another party.⁵³

While the losing party will habitually be ordered to pay part of the successful party's legal expenses,⁵⁴ the amount usually corresponds to only a fraction of the successful party's entire legal costs.

iii Arbitration

Format of insurance arbitrations

The parties to arbitration have wide autonomy, especially as regards the procedural rules to be followed by the arbitration proceedings, which can be agreed upon in the arbitration agreement. Arbitral proceedings must, however, comply with the mandatory guiding principles set out in the first section of the CCP. Additionally, arbitration agreements are not

49 Article 133, CCP.

50 Article 134, CCP.

51 Article 135, CCP.

52 Article 138, CCP.

53 Article 696, CCP.

54 Article 700, CCP.

enforceable against all individuals, in particular non-professionals having entered into the agreement on a private basis.⁵⁵ However, non-professionals may choose between arbitration and state courts to have their case heard.

There is a legal distinction between domestic and international arbitration; though some provisions apply to both,⁵⁶ there are also specific provisions for each.⁵⁷ The distinctive criterion is that of the domestic or international nature of the trade interests at stake in the dispute.⁵⁸ In matters of reinsurance, some authors argue that the inherently complex and transborder nature of reinsurance schemes implies that arbitration on reinsurance matters is necessarily international.⁵⁹

Arbitration clauses can be included in contracts, before any disputes have arisen. To be valid in domestic arbitration, they must be in writing, designate the arbitrator or arbitrators, or indicate the manner in which they are to be appointed, and determine the subject matter of the dispute.⁶⁰ In international arbitration, there are no formal requirements regarding the arbitration agreement.⁶¹ It is, however, recommended to specify the place and language of arbitration, the rules of arbitration to be applied and, where necessary, the governing law.

The forms of procedure (e.g., the content of the request for arbitration or the valid means of communication) should be detailed. Moreover, it is important to state: whether the arbitral tribunal may disregard strict rules of law and decide on an equitable basis; and which remedies, if any, are available against the award.

If a dispute has arisen and no arbitration clause can be identified, the parties can decide to enter into an arbitration agreement whereby they agree to submit the dispute to arbitration. In domestic arbitration, an arbitration agreement, like an arbitration clause, should designate the arbitrators or specify the manner in which they are to be appointed.⁶² In addition, arbitration agreements must, in order to be valid, indicate the subject matter of the dispute.⁶³

During the pre-arbitration phase, French courts can intervene, at the request of one of the parties, if and when a difficulty arises regarding the appointment of the arbitrators.⁶⁴ Moreover, if the arbitral tribunal has not yet been constituted, parties to the arbitration may file a claim for urgent proceedings before a state court for temporary or protective measures.⁶⁵ If, however, the arbitral tribunal has been constituted, only the arbitral tribunal has jurisdiction to order such measures.

French courts may have jurisdiction to hand down a judgment on the validity of arbitration clauses, provided the arbitral tribunal has not yet been constituted and the clause at issue is obviously void or unenforceable.⁶⁶

55 Article 2061, CC.

56 Article 1506, CCP.

57 Articles 1442 to 1503 for domestic arbitration and Articles 1504 to 1527 for international arbitration, CCP.

58 Article 1504, CCP.

59 M Hagopian and M Laparra, *Theoretical and Practical Aspects of Reinsurance*, *L'Argus*, 1991, p. 74.

60 Articles 1443 to 1445, CCP.

61 Article 1507, CCP.

62 Article 1444, CCP.

63 Article 1445, CCP.

64 Article 1454, CCP.

65 Court of Cassation, 2nd civil division, 7 March 2002, appeal No. 00-11526.

66 Article 1448, CCP.

As a general rule, awards cannot be appealed or opposed.⁶⁷ However, in domestic arbitration, parties have the possibility to provide in their arbitration agreement that an appeal will be possible.⁶⁸ In that event, the appeal will aim either to obtain the reversal or the setting aside of the award,⁶⁹ however the court of appeal can only rule in accordance with and within the limits of the arbitral tribunal's mandate.⁷⁰

In the absence of any agreement on a possible appeal of the award, and in any event in international arbitration, the only possible recourse against an arbitral award is an action to have the award set aside.⁷¹ Contrary to an appeal, the action to set aside an arbitral award can only be brought on a limited number of grounds, some of which are shared between domestic and international arbitrations, while others are specific:⁷²

- a* the arbitral tribunal wrongly upheld or declined jurisdiction;
- b* the arbitral tribunal was not properly constituted;
- c* the arbitral tribunal ruled without complying with its mandate;
- d* due process was violated;
- e* the award is contrary to public policy (applies only to domestic arbitration);
- f* the award failed to state the reasons upon which it is based, the date on which it was made, the names or signatures of the arbitrators having made the award, or where the award was not made by majority decision (applies only to domestic arbitration); or
- g* recognition or enforcement of the award is contrary to international public policy (applies only to international arbitration).

These actions are, however, rarely successful as French procedural law and French courts are particularly respectful of the autonomy of arbitration.

Finally, in domestic arbitration, arbitral awards may be challenged by a third party whose interests are adversely affected by the award⁷³ and may also be subject to a special remedy before the arbitral tribunal itself, called revision, but only on certain limited grounds, including fraud. In such a case, the award is re-examined by the arbitral tribunal.⁷⁴

Evidence

Arbitral tribunals are granted wide-ranging powers and discretion when it comes to evidence. They may hear all relevant persons or order any party to communicate all relevant documents.⁷⁵

Arbitral tribunals may order parties to perform any temporary or protective measures they deem appropriate.⁷⁶

67 Articles 1489, 1503 and 1518, CCP. 'Opposition' is a form of recourse under French law, available when a judgment is rendered by default because a defendant was not properly notified of a hearing. The defendant can, in such circumstances, 'oppose' the judgment in question.

68 Article 1489, CCP.

69 Article 1490, CCP.

70 Article 1490, CCP.

71 Articles 1491 and 1518, CCP.

72 Articles 1492 and 1520, CCP.

73 Article 1501, CCP.

74 Article 1502, CCP.

75 Article 1467, CCP.

76 Article 1468, CCP.

Costs

There is no French statutory provision regulating arbitrators' fees. Consequently, the arbitrators' fees are set by the arbitrators themselves or by the arbitration institution to which the dispute is referred. Fees are mainly based on the number of hours worked and/or the amount involved in the dispute, and factors such as the complexity of the case, the reputation of the arbitrators, etc. are also taken into account.

The allocation of arbitration costs between the parties is usually decided by the arbitrators and clearly indicated in the award. Arbitration costs include the arbitrators' fees, as well as the parties' legal costs.

iv Alternative dispute resolution

French jurisdictions and French procedural law are generally in favour of alternative dispute resolution (ADR), which they have increasingly tended to promote.

Up until quite recently, parties to a dispute could only initiate judicial proceedings provided they had previously attempted to solve the dispute amicably. In practice, however, this obligation had little impact, because the relevant sections of the CCP did not provide sanctions in case of non-compliance and compliance could, in any case, be achieved by including a simple declaration, in the writ, that efforts to resolve the dispute amicably had been undertaken and failed. This changed with Law No. 2019-222 of 23 March 2019 (and the ensuing decree regarding its application), which has both limited the scope of the disputes concerned (i.e., essentially disputes relating to less than €5,000) but strengthened the parties' obligation to attempt to find an amicable solution. Parties will now need to take certain active steps (such as go before a mediator), and be in a position to prove that they have done so, before they can initiate proceedings, and non-compliance will render writs before the courts inadmissible.⁷⁷ However, as the financial threshold that determines the application of this new regime is quite low, the said regime should, in practice, only apply to a small fraction of insurance disputes.

Moreover, parties are always free to resort to ADR methods, such as conciliation and mediation.

Conciliation aims to bring the parties closer in order to lead them to reach an agreement. Although the ombudsman issues an opinion on the dispute, he or she is not an arbitrator and the opinion is therefore not binding in any way. Mediation, on the other hand, requires the third party to be neutral and to refrain from opining.

Conciliation and mediation may be either judicial⁷⁸ or contractual.⁷⁹ When the proceedings are contract-based, parties choose the third party that conducts them. In both instances, parties have to agree to the proceedings: there cannot be an injunction to participate.

Judicial conciliation may be conducted by the judge or by a judicial conciliator appointed by the judge.⁸⁰ Like conciliation, mediation may be either contractual or judicial. Within the framework of a judicial mediation, subject to the agreement of the parties, the mediation procedure is conducted by a judicial ombudsman. The judicial ombudsman is

77 Article 750-1, CCP.

78 Article 127 et seq., CCP.

79 Article 1528 et seq., CCP.

80 Article 128, CCP.

independent, must possess certain skills and meet specific professional requirements.⁸¹ The judge sets the duration of the mediation, the remuneration of the ombudsman and may end the mediation at the request of the parties, or the ombudsman, or if the normal conduct of the mediation is compromised.⁸² When parties have reached an agreement, the judge ratifies it.⁸³

Regarding contractual mediation in insurance matters, since 2016, proceedings are handled by the insurance ombudsman. This mediation system is compulsory for insurance companies that are members of the FFA (i.e., the overwhelming majority of the French market). Insurance companies that are not members of the FFA but operate in France can participate in FFA mediation proceedings on a voluntary basis. The insurance ombudsman is independent and may intervene in relation to disputes that arise between insurers, insurance intermediaries and even consumers. Subject to the agreement of the insurer member of the FFA, the insurance ombudsman may also intervene in relation to disputes regarding professional insurance (but excluding large risks). This form of mediation is free and confidential. Parties are not bound by the decision of the ombudsman; however, if the insurer does not intend to comply with the decision, the ombudsman must be informed by letter from the general director of the insurer. Limitation periods are suspended during the mediation proceedings.

V YEAR IN REVIEW

French insurance law has not been affected by any significant changes in 2019. However, several decisions related to time limitation are worth noting.

According to French insurance law, insurers must indicate the provisions of the French Insurance Code that specify the two-year time limitation and the means to suspend or interrupt such limitation. Moreover, insurers can successfully claim the limitation period only if the policy at issue duplicates the sections of the French Insurance Code regulating the time limitation period and explains the means to interrupt it.

A Court of Cassation decision handed down on 18 April 2019 added that the insured does not have to prove the policy did not quote all the relevant provisions in full; on the contrary, it is the insurer who must prove the compliance of the above obligations in the policy.⁸⁴

On 21 March 2018, the Court of Cassation had already stressed insurers' obligations to refer to all the necessary provisions regarding time limitation in their policies. It specified that, if the insurer had failed to do so, it could not claim the standard five-year time limitation period provided by the CC as some form of fallback regime.⁸⁵

These decisions are relevant, because they could mean that when the insurer does not reproduce the relevant provisions in its policies, it finds itself in a situation where no limitation period of any kind could successfully be invoked against the insured. The insurer in question could therefore be exposed to possible claims from the insured indefinitely or until the end of the absolute cut-off period (*'délai butoir'*, i.e., 20 years) – that is, in any case, a position

81 Articles 131-4 and 131-5, CCP.

82 Articles 131-10 and 131-13, CCP.

83 Article 131-12, CCP.

84 Court of Cassation, 2nd Civil division, 18 April 2019, Appeal No. 18-13.938.

85 Court of Cassation, 3rd Civil division, 21 March 2019, Appeal No. 17-28.021.

the Paris Court of Appeal seems to have adopted in a recent decision⁸⁶ (it should, however, be borne in mind that this is an isolated decision, which has, moreover, been criticised by a significant number of legal commentators).

VI OUTLOOK AND CONCLUSIONS

The main issue, in terms of horizon-scanning, is the effective impact of Brexit, now that the United Kingdom ceased to be a member of the political institutions of the European Union (the European Parliament, the Council of the European Union and the European Commission) on 31 January 2020.

During the transitional period, which is currently scheduled to end on 31 December 2020, the United Kingdom will:

- a* remain a member of the economic institutions and security cooperation agreements;
- b* continue to be treated as a member of the single market and the customs union; and
- c* continue to apply European Union law and the decisions of the Court of Justice of the European Union.

Therefore, insurance undertakings that have their head office in the United Kingdom should be able to carry on insurance operations on the French territory during this transitional period, pursuant to Article L310-2, I, 2° of the French Insurance Code.

However, we do not know yet what solution will be adopted at the end of this transition period regarding insurance operations. Indeed, it will depend on the terms of the commercial agreement that will be adopted between the United Kingdom and the European Union (or, indeed, individual Member States).

In view of the uncertainties surrounding the possibility of a ‘hard Brexit’, ongoing negotiations have, *inter alia*, envisaged the possibility of the loss of the ‘European passport’ regime. In practice, for the time being, the following measures have been adopted:

- a* for European insurers operating in the United Kingdom, the British regulator has set up a system of temporary permissions that should enable them to continue to operate in the UK for a period of three years after Brexit; and
- b* as regards British insurers operating in France, measures were adopted in February 2019 to ensure the continuity of current insurance contracts concluded before Brexit. These measures provided that such contracts could nevertheless not be renewed or give rise to the issue of new premiums.

However, the implementation of these arrangements seems compromised by the final adoption of the agreement of 17 October 2019 since, on the one hand, the UK permission regime is subject to the absence of a transition period and to the loss of the European passport upon withdrawal from the United Kingdom and, on the other hand, the French arrangements would apply only in the event of and as from the date of withdrawal ‘without agreement’.

Insurers have nevertheless largely anticipated these uncertainties as well as the loss of the European passport by establishing themselves on the European continent. Thus, a British insurer establishing a subsidiary in the territory of a continental European country or a

86 CA Paris, 16 May 2017, No. 16/09576.

European company will be able to benefit from the European passport via its subsidiary once it has received approval from the host country. This process is accompanied by a portfolio transfer of insurance contracts, thus ensuring the continuity of current contracts.

Similarly, 'Brexit clauses' have been included in insurance contracts stipulating that Brexit cannot terminate the contract, setting out the terms and conditions for the transfer of the contract or, failing this, organising the terms and conditions for terminating the contract. The interest of these clauses remains intact although the principle is that of the continuity of contracts in force during the transitional period (the United Kingdom being considered as a Member State).

Beyond Brexit, and turning specifically to foreseeable trends within the insurance and reinsurance industry, we expect the trend towards more corporate concentration, which we have witnessed over the past several years, to remain vigorous (by way of illustration, Covea, who has recently tried and failed to acquire SCOR, is now in talks to possibly acquire PartnerRe). Although it is partly encouraged by other factors, it should be noted that this trend is also the result of the current international legal and regulatory frameworks (i.e., compliance with Solvency II requirements, for instance, or with international regulations and the associated risks of significant sanctions and fines), which are becoming increasingly complex, require more staff and heightened internal due diligence obligations and are, therefore, more difficult to navigate for smaller, independent players.

GERMANY

*Markus Eichhorst*¹

I INTRODUCTION

Approximately 914 foreign insurers are underwriting direct risks on the German market,² either through a branch³ or, for the majority, by offering services from their foreign places of business.⁴ Most of these insurers are based in countries of the European Economic Area (EEA).⁵ Approximately 1,265 German underwriters⁶ add to this number. All of these underwriters together achieved a turnover related to direct insurance of €117 billion in non-life insurance and €92.4 billion in life insurance, of which €6.3 billion and €5 billion respectively was generated by EEA insurers.⁷ 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 that have their seat in Germany and five that are seated in the EEA as at 30 September 2019.⁸

The implementation of Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the Taking-up and Pursuit of the Business of Insurance and Reinsurance (Solvency II) into German law focused on the capital backing of insurers. Despite initial expectations that the Solvency II requirements might not come into force before 2017,⁹ on 6 March 2015 the Bundesrat (representation of the German federal states) approved the Parliament Act on the Modernisation of the Financial Supervision of Insurance Companies, which implemented the Solvency II regime into national law. The German Solvency II legislation came into force on 1 January 2016. Under the Solvency II regime, both low interest rates and capital requirements were identified by reinsurers as drivers for reinsurance solutions¹⁰ and by the growing number of run-off service providers as drivers for run-off solutions. As required by European law, insurers may transfer portfolios

1 Markus Eichhorst is a partner at Ince & Co Germany LLP.

2 BaFin (www.bafin.de), 2018 Statistic – Insurance undertakings and pension funds, p. 10 f.

3 In 2018, in total 91; BaFin, p. 10.

4 In 2018, in total 823; BaFin, p. 10.

5 In 2018, only three non-EEA underwriters maintained a branch in Germany, BaFin, p. 10.

6 In 2018; BaFin, p. 11.

7 In 2018; BaFin, p. 10.

8 BaFin (www.bafin.de), 2018/2019 Statistic – Reinsurance undertakings, p. 8.

9 President of BaFin Elke König's speech of 22 January 2013 (www.bafin.de/SharedDocs/Reden/DE/re_130122_neujahrspresseempfang_p.html).

10 Munich Re press release of 12 March 2012 (www.munichre.com/de/media_relations/press_releases/2012/2012_03_13_press_release.aspx): 'Zudem geht MunichRe davon aus, dass im weiteren Verlauf der Finanzkrise und mit der Einführung von Solvency II der Bedarf für Rückversicherungslösungen steigt'.

to other insurers in a Member State of the European Union, which, since 2008, also applies to reinsurers (Section 166 of the German Insurance Supervision Act (VAG)). Germany is far from being a haven for run-off services, however, as German law does not recognise the English concept of 'schemes of arrangements' and the Federal Supreme Court held in 2012 that English court orders on the approval of these schemes¹¹ are not enforceable in Germany.¹² This fits with the German approach of being somewhat protective with regards to the position of the insured, often without any strict differentiation as to whether an insured is a consumer or a business entity.

II REGULATION

BaFin supervises insurers on behalf of the federal government. Insurers of less economic significance, and especially those that operate within only one of the federal states, may be supervised by supervisory bodies of one of Germany's federal states. BaFin currently supervises approximately 43 per cent of German insurers.¹³ Insurers supervised by BaFin nevertheless achieve 99.9 per cent¹⁴ of the total earnings of both groups, which underlines its economic significance. Pension funds and domestic reinsurers are also subject to BaFin's supervision, whereas statutory insurance institutions (statutory accident, unemployment, pension, health institutions) are not.

Insurance companies require a licence to operate. Under the single licence principle, insurers who have obtained a licence in another EEA Member State do not require a further licence to operate in Germany.¹⁵ These insurers may conduct business in Germany in accordance with their right to provide services under Article 56 of the Treaty on the Functioning of the European Union (TFEU) or through a branch in Germany in accordance with their right under Articles 49 to 52 TFEU. However, before commencing business from a branch in Germany, certain notification requirements must be met (Section 61 VAG and Section 169 VAG for reinsurance companies).

EEA insurers are subject to the financial and legal supervision of their home countries and, in respect of their German operations, additionally to the legal supervision of BaFin (Section 62 VAG).

In light of the Brexit negotiations it remains to be seen if and how insurance companies that have their home Member State in the United Kingdom and a licence from the Prudential Regulatory Authority (PRA) are allowed to conduct their business in Germany. BaFin stated that a 'hard Brexit' would cost UK insurance companies their Member State status in accordance with Section 7 No. 22 VAG. Instead the United Kingdom would be considered a third country pursuant to Section 7 No. 6 VAG.¹⁶ As a result, the company could no longer legally operate in Germany with a licence from the PRA pursuant to Section 61 VAG. In order to soften the effect of a possible hard Brexit, on 23 March 2019, Germany

11 Section 425 of the Companies Act 1985.

12 Judgment of 15 February 2012 – IV ZR 194/09.

13 In 2018, 550 under federal supervision and 715 under supervision of the federal states; BaFin, 2018 Statistic – Insurance undertakings and pension funds, p. 11 f.

14 In 2017, €222,353,560,000 under federal supervision and €42,352,800 under supervision of the federal states; BaFin, p. 12 f.

15 Certain EU and EEA insurers, such as mutuals with low premium income, are excluded, but nevertheless require a licence pursuant to Section 110(d) VAG.

16 BaFin (https://www.bafin.de/DE/Aufsicht/Uebergreifend/Brexit/Versicherer/brexit_node.html).

adopted a bill on Tax-Related Provisions accompanying the Withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union.¹⁷ Article 10 of this bill amends the new Section 66(a) into the VAG. As of Section 66(a) VAG, BaFin can declare Sections 61 to 66 and 169 VAG applicable by analogy for UK-based insurance companies that were operating in Germany prior to the withdrawal of the UK from the EU for the purposes of settling the insurance contracts concluded up to the time of withdrawal during a transitional period not longer than 21 months.¹⁸ BaFin already used this newly created discretionary power on 15 April 2019 entering into an agreement with the Prudential Regulation Authority (PRA) in the UK. They agreed that they will continue to cooperate on financial supervision and market conduct supervision regarding those companies that no longer write new business in the host country.¹⁹ Furthermore, BaFin will keep handling complaints against insurers based in UK regarding contracts concluded in Germany.²⁰

Only public limited companies, mutuals or public law institutions can obtain a licence from BaFin. Documents to be submitted with the application include, inter alia, a business plan describing the risks that are intended to be covered, the reinsurance policy, proof of sufficient funds to cover the risks (minimum guarantee fund – the required quantum depends on the class of insurance) as well as sufficient funds to develop a business and sales organisation (organisation fund). At least two senior managers or executive directors need to demonstrate that they are sufficiently qualified and experienced to run the business.

The principle of business separation applies, which means that an insurer cannot obtain a licence for all classes of business (e.g., an insurer that has been granted a licence to cover life risks cannot obtain an additional authorisation for property risks).

Insurance supervision comprises legal and financial supervision. In respect of legal supervision, BaFin supervises whether insurers comply with all statutory requirements (Section 294 VAG). In respect of financial supervision, BaFin controls whether insurers comply with the principle of good business practice, which requires them to maintain proper accounts, consider risks under the insurance contracts and finance risks for their investments properly, maintain a proper risk management system, and keep sufficient funds (solvency). Generally, an insurer must refrain from conducting non-insurance business in order to avoid non-insurance related business risks.

Pursuant to Sections 294 and 298 VAG, BaFin can make any orders that are appropriate and necessary to avoid deficiencies or bring these to an end and, if necessary, withdraw the insurer's licence under Section 304 VAG. The VAG sets out additional competences for BaFin, such as being able to prohibit a manager who has recklessly breached obligations from continuing to work in his or her function pursuant to Section 303 VAG.

17 'Gesetz über steuerliche und weitere Begleitregelungen zum Austritt des Vereinigten Königreichs Großbritannien und Nordirland aus der Europäischen Union (Brexit-Steuerbegleitgesetz)' of 23 March 2019.

18 This transitional period will most probably only last until 31 December 2020 as it shall not be longer than the transition period to negotiate the future relationship between the UK and the EU (cf. Draft bill on Tax Related Provisions accompanying the Withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union, Bundestagsdrucksache 19/7377, p. 29).

19 BaFin (https://www.bafin.de/SharedDocs/Veroeffentlichungen/EN/Meldung/2019/meldung_190418_MoU_Versicherer_Brexit_en.html).

20 BaFin (https://www.bafin.de/SharedDocs/Veroeffentlichungen/EN/Meldung/2019/meldung_190418_MoU_Versicherer_Brexit_en.html).

In accordance with EU Directive 2002/92/EC of 9 December 2002, all persons who intend to distribute insurance products require a licence. This Directive has been implemented into German law in Sections 11a, 34d and 34e of the German Trade, Commerce and Industry Regulation Code, and in the Insurance Broking and Advice Regulation.

III INSURANCE AND REINSURANCE LAW

i Sources of law

German material insurance law is primarily set out in the Code on Insurance Contracts (VVG). The rules of the VVG initially came into force in 1908 but were considerably changed in a reform that came into effect in 2008. As a consequence of this reform, judgments on the interpretation of the VVG rules of courts and other publications need to be considered carefully to establish whether they refer to the old or the current rules.

The reform's purpose was to modernise German insurance law, and especially to improve the position of the insured.²¹ Although the VVG is always focused on consumer protection, its rules also apply to non-consumer insurance contracts. The VVG's only differentiation between consumer and some non-consumer insurance contracts is that the insurer of consumer risks cannot deviate from most of the rules of the VVG to the detriment of the insured so that the VVG provides a minimum standard of consumer protection, whereas the parties to insurance contracts on specific non-consumer risks can, to a certain extent, deviate from all VVG provisions as dealt with further below. These specific non-consumer risks that allow deviations from the provisions of the VVG pursuant to Section 210 VVG are large risks and risks covered under open policies. However, this does not mean that there are no limits for deviations even where they are generally allowed. Insofar as the VVG generally applies, it sets out the overall concepts as to what rights and obligations German law considers a fair balance between the potentially colliding interests between insurer and insured. The rules on unfair contract terms impose limits on any deviation from the overall legislative concepts even in purely business relationships without any consumer involvement. The evaluation of whether a deviation from general statutory concepts is sufficiently balanced (and, therefore, valid) often gives German courts considerable discretion. This leads to considerations in German judgments that might appear odd, especially to foreign practitioners. Judgments on the claims-made principle or costs clauses in directors' and officers liability' (D&O) insurance contracts are good examples (discussed below).

Large risks (as opposed to mass risks), which determine whether an insurer is generally able to deviate from provisions of the VVG that otherwise were compulsory, are – partly by reference to VAG provisions – set out in Section 210(2) VVG. The term large risks and the risks so classified have their origin in European law, and have been introduced by Article 5 of the Second Council Directive 88/357/EEC of 22 June 1988 'on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 73/239/EEC'. Large risks are, *inter alia*:

- a* railway rolling stock: all damage to railway rolling stock;
- b* aircraft: all damage to aircraft;

21 Entwurf eines Gesetzes zur Reform des Versicherungsvertragsrechts of 20 December 2006, Bundestagsdrucksache 16/3945, p. 1.

- c* ships (sea, lake and river vessels): all damage to river, inland waterway and sea vessels;
- d* transported goods: all damage to transported goods irrespective of the means of transport;
- e* all liabilities arising from land transport;
- f* aircraft liability: all liabilities arising out of the use of aircraft (including carrier's liability); and
- g* 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 its Section 209. In this respect, the official explanatory statement of the legislature for the 2008 VVG reform is noteworthy as it admits the existence of a considerable legal uncertainty if the consumer-related general concepts of the VVG applied generally on marine insurance.²² It was felt that this might disadvantage German marine insurers, so marine insurance was totally excluded from the scope of the consumer-oriented VVG. Other purely business-related insurance contracts, such as industry property or D&O, are not excluded and are therefore exposed to courts' considerations as to whether any deviations from the consumer-oriented VVG concepts are sufficiently fair (see subsection ii).

Reinsurance contracts are also exempted from the scope of the VVG as of its Section 209, so that the general rules of civil law set out in the German Civil Code (BGB) apply.

ii Making the contract

Contracts under the rules of the VVG

An insurance contract, as any contract, requires a contract offer of one party and its acceptance by the other party. Usually, the insured makes the contract offer (application) by requesting from an insurer cover for certain risks, usually by filling in the insurer's forms

22 id, p. 115.

(which refer to the insurer's general insurance terms and conditions) and by answering the insurer's questions. This, of course, requires the insured to obtain some information from the insurer on its insurance products including application forms before making the application.

Prior to the 2008 VVG reform the insurer, when willing to insure the risk, accepted the insured's application by way of providing the insured with the policy, which sets out the risks covered, the premium, other specific conditions, and the general terms and conditions. The insurance contract was concluded on the basis of the provisions in the policy and all conditions to which it referred. Unless large risks are concerned, the 2008 VVG reform modified this procedure as follows: prior to the reform it was sufficient that the insured received information on the scope of cover, premium and especially the insurer's general terms and conditions only with the insurer's acceptance of the insured's contract application. This was called the policy model, as in insurance law it was deemed sufficient that the insured received the insurer's insurance conditions only with the insurer's acceptance of the insured's insurance application, that is, together with the insurance policy – hence, policy model. In 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).²³

The insurer's acceptance of the insured's application can still deviate from the insured's contract application, provided the insurer gives to the insured a conspicuous notice that the insurance certificate deviated from the insured's application and the ways in which it did so; informs the insured of its right to object to these deviations within one month; and informs the insured that its failure to object in a timely manner is statutorily deemed as the insured's acceptance of the deviations.

If the insurer complies with these notification requirements and the insured does not object within one month of receipt of the insurance certificate, the insurer's deviations are deemed accepted by the insured. If, however, the insurer does not comply with its notification requirements, the insurance contract is concluded on the basis of the insured's application.

Insurers (insofar as large risks are not affected) are exposed to further obligations prior to the conclusion of an insurance contract: they are obliged to enquire about the insured's insurance needs, to advise on these needs and on adequate insurance solutions, and to document the contents of the advice and its reasons. Apart from the exclusion of large risks from this obligation, this does not apply if the contract is concluded through an insurance broker (Section 6(6) VVG), which then has to comply with the advice and information obligations instead. The insured may, however, waive in writing its right to be advised and informed.

If the insurer fails to comply with these obligations, it may be liable to indemnify the insured for any losses caused. Moreover, the insurer's general insurance terms and conditions may not be validly incorporated into the contract.

Generally, the insured is entitled to withdraw from its contract application (so that the insurance contract ends retroactively) within two weeks of receipt of the insurance

23 Regulation on Information Obligations for Insurance Contracts.

policy or certificate if properly advised on this right in text form (text form includes emails, which would not be qualified as written form under the law). Exceptions apply especially for insurance contracts for large risks, for some provisional cover notes and for insurance contracts of less than one month.

Insurance contracts not subject to the VVG

The conclusion of insurance contracts that are not subject to the VVG (marine insurance and reinsurance) is governed by the general rules of the BGB and, therefore, only require offer and acceptance without any further compliance requirements. It is sufficient to simply refer to general insurance conditions in order to incorporate them into the contract without actually providing the insurer's terms and conditions.

Disclosure and representation

Pursuant to Section 19(1) VVG, the insured is under an obligation to disclose to the insurer all known circumstances prior to conclusion of the insurance contract that (1) are relevant for the insurer's decision to enter into the insurance contract with the agreed contents and (2) that the insurer requests the insured to answer specifically in text form (text form includes emails, which would not be qualified as written form under the law). This includes a prohibition to make false representations. Usually, all circumstances that the insurer requests specifically are relevant for its decision, although there may be exceptions. As a consequence of the 2008 VVG reform, the insurer can no longer expect the insured to disclose any circumstances not specifically asked for, so there is no longer any doctrine comparable to the English concept of utmost good faith (requiring the insured to disclose anything material for the risk even without any specific questions) under the rules of the VVG.

As they are not subject to the rules of the VVG, marine insurance and reinsurance contracts may still require the insured to disclose even material circumstances without any specific questions of the insurer. For example, Section 19 of the General German Marine Insurance Conditions still requires the insured to disclose all material circumstances that are relevant for the insurer's acceptance of the risk without the requirement to submit specific questions. It should also be possible to agree on similar terms for large risks falling under the provisions of the VVG, although this has not yet been tested in court to this extent. The Hamm Appeal Court only stated in its judgment of 3 November 2010 with regard to large risks insurance contracts that pursuant to Section 210 insurers may deviate from Section 19 if this deviation is explicitly agreed between the parties.²⁴

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) 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).

²⁴ Judgment of 3 November 2010 – I-20 U 38/10.

- 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 of receipt of knowledge of the insured's infringement of its disclosure or representation requirements (Section 21(1) 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) VVG).
- g* The insurer's right to withdraw or to terminate the contract expires five years after the conclusion of the contract, unless the insured breached its obligations intentionally and maliciously, in which case it is 10 years.
- h* In any case, the insurer may challenge the contract in accordance with the general civil rules applicable to a malicious deception (Section 22 of the VVG).

In summary, the consequences of the insured's breach of its disclosure or representation obligation depend on the insured's degree of fault and, partly, on whether the insurer would have entered into an insurance contract (even with additional risk exclusions or with an increased premium, or both) had it known the actual facts or circumstances. The following table gives an overview on the most relevant situations. It is based on the assumption that the insured's breach of disclosure or misrepresentation obligations refers to circumstances that were relevant for the occurrence of the insured event, or for the insurer's determination of the insured event or the scope of its obligations under the insurance contract.

Intentional misconduct	Withdrawal from the contract (retroactively). No coverage obligation (Section 21(2) VVG).
Gross negligent misconduct and the contract would not have been concluded had the insured not breached its obligations (i.e., informed the insurer as legally required)	Withdrawal from the contract (retroactively). No coverage obligation (Section 21(2) VVG).
Gross negligent misconduct and the contract would have been concluded (with different terms) had the insured not breached its obligations (i.e., informed the insurer as legally required)	Adoption of the contract as of 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.
No misconduct or simple negligent misconduct and the contract would not have been concluded had the insured not breached its obligations (i.e., informed the insurer as legally required)	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.

<p>No misconduct or simple negligent misconduct and the contract would have been concluded (with different terms) had the insured not breached its obligations (i.e., informed the insurer as legally required)</p>	<p>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).</p> <p>The potential affect on coverage has not yet been clarified by the courts. The retroactive adoption, if relevant risks were excluded, might have the odd result that coverage of a certain insured event might be excluded retroactively, although a simply negligent misconduct should not affect coverage at all (see box above). Judgments on this issue have not been published. However, it seems unlikely that the courts would, in this situation, allow an insurer to avoid coverage for occurrences that occurred prior to the insurer's demand to adopt the contract. The legal uncertainties of this situation raise doubts as to whether the legislature fully understood its somewhat complicated rules and their consequences.</p>
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The above rules provide for considerable judicial discretion in potential legal disputes and corresponding legal uncertainties in applying these rules in specific cases, which the legislature nevertheless accepted for assumed fairness considerations.

iii Interpreting the contract

Insurance terms and conditions are to be construed objectively (i.e., by reference to the hypothetical understanding of an average insured that has no specific insurance or legal expertise). The starting point of any interpretation is the wording, its objective sense and the systematic context in which a particular clause is contained. All relevant contractual information, including the insurance certificate, product information sheets or other product information, may serve as an interpretation aid.

The courts tend to interpret exclusion clauses (i.e., clauses that limit the coverage for certain risks or impose certain additional limitations for coverage) narrowly as the insured does not have to expect potential gaps in the coverage that the clause does not sufficiently clarify.²⁵

Insurance conditions are usually qualified as general terms and conditions of the contract within the meaning of the civil law provisions on unfair contract terms as set out in Section 305 et seq. BGB. Pursuant to Section 305c(2) BGB, any uncertainties as to the interpretation of those general terms and conditions (including insurance conditions) are to the detriment of the party that introduced the conditions into the contract (*contra proferentem*). This is usually the insurer. It follows that this interpretation method is not applicable (at least not against the insurer) if it was not the insurer who introduced certain insurance conditions into the contract. This may be the case for some broker insurance conditions if the broker developed the conditions and then obtained insurance coverage under these conditions. The Federal Supreme Court confirmed this in respect of particular D&O insurance conditions of one of Germany's leading D&O insurance brokers.²⁶

There is a further interpretation rule that applies to the differentiation of the definition between risks and their exclusion or limitation and the insured's obligations. Pursuant to Section 28 VVG, the parties may agree on certain obligations in the insurance contract with which the insured has to comply. The consequences of the insured's breach of such obligations depend on the degree of its negligence, so that the insurer is not necessarily entitled to avoid coverage. Contrary to this, losses are not covered that are caused by an

25 Prölss/Martin, *Versicherungsvertragsgesetz*, 28. Auflage 2010, Vorbem. III Rn. 16; Court Order of 22 February 2018 – IV ZR 318/16, RdTW 2018, 373 para. 3.

26 Court Order of 22 July 2009 – IV ZR 74/08.

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 1985,²⁷ 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 2011,²⁸ the Federal Supreme Court changed its previous view and found that the clause is to be considered as setting out a ‘disguised obligation’. It held that the wording and systematic position of a clause are irrelevant for its qualification as either a (disguised) obligation or as an exclusion of risk. According to the Court, it matters whether the clause either describes a specific risk or whether it primarily requires a specific behaviour of the insured. Consequently, German law and practice requires a careful analysis of whether a particular clause is to be qualified as description of a risk (including limitations and exclusions) or as setting up an obligation of the insured. This analysis must not focus on the clause’s wording, as the wording and systematic position of a clause (and the intention of the parties to the insurance contract) are irrelevant. The reason behind this approach is to avoid insurers circumventing the restrictive rules on avoidance of coverage for the insured’s breach of obligations, so the courts are rather sceptical about potential risk exclusion clauses that could alternatively have been phrased as a clause requiring a certain behaviour of the insured (in the above case, the behaviour to commence the voyage only with a vessel that was fit for the journey).

The concept of disguised obligations is increasingly perceived as alien to the method under which contracts are to be interpreted, and is being criticised (even by Federal Supreme Court judges).²⁹ Nonetheless, the Federal Supreme Court handed down a judgment on 14 May 2014 in which it reiterated the concept of the disguised obligation. The insured sued under aircraft liability insurance. He sought cover for an accident that occurred during the start of an air show. The co-insured pilot crashed into spectators, killing two of them and leaving several injured. The insurer rejected coverage because the pilot flew without a valid licence. Under Section 4 of the Liability Insurance Conditions, ‘exclusion’ cover was excluded ‘if the pilot lacked the necessary permit, licence or certificate of competence’. The Court held that the clause was a disguised obligation and not an exclusion of risk because the cover depends on the conduct of the insured. Since aircraft liability insurance is a large risk pursuant to Section 210(2)(1) VVG it seems that the Federal Supreme Court applies the differentiation to all large risks and open policies.

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

27 Judgment of 11 February 1985 – II ZR 290/83, VersR 1985, 629.

28 Judgment of 18 May 2011 – IV ZR 165/09.

29 Joachim Felsch, *Verhüllte Obliegenheiten – ein Nachruf*, r+s 2015, 53 ff.

Types of terms in insurance contracts

The law differentiates between terms that describe the risk including risk-related objective limitations, or exclusions or other objective requirements for compensation and the insured's obligations. Clauses that do not constitute contractual obligations of the insured can simply be construed under application of the rules explained above. If the requirements set up by such clauses are fulfilled, they trigger the consequences set out in the contract. The position is more complicated in respect of the insured's contractually agreed obligations, as the consequences depend on the degree of the insured's negligence and also partly on causation issues.

The breach of a contractual obligation is not comparable with a breach of a warranty under English law. The VVG sets out a differentiated system of remedies, depending on the specific circumstances of any case, as follows (ignoring some constellations and minor formal requirements):

- 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) 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 granted coverage in full or not at all. Now, the insurer is required in cases of gross negligence to compensate the losses partly to an extent that depends on the gravity of the insured's fault. In respect of coverage (as opposed to termination) the insured is to disprove the assumption of gross negligence if it intends to avoid these consequences.
- 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.

The following overview clarifies the various positions.

Malicious intent – to be proven by the insurer	No coverage; no causation considerations.
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	The insurer may reduce the contractual compensation in proportion to the insured's fault (which may be up to 100 per cent), unless the insured proves lack of causation. Since the 2008 VVG reform came into force, a considerable number of judgments have been published as to what percentage compensation may be reduced to in various situations, which has resulted in prejudiced case law developing.
Intentional breach – assumption of gross negligence to be disproved by the insurer	No coverage, unless the insured proves lack of causation.
Negligent breach – assumption of gross negligence to be disproved by insured	Full coverage.

Similar provisions apply in respect of an increase of risk caused by the insured that is prohibited under Section 23(1) VVG or an increase of risk not notified to the insurer (Section 23(2)).

Depending on the gravity of the insured's breach, the insurer may avoid coverage, reduce the compensation or terminate the insurance contract, or both (Sections 24 and 26 VVG). Section 81 VVG expressly sets out that the insurer is not obliged to make any compensation if the insured intentionally causes the insured event. If the insured causes the insured event with gross negligence, the insurer is entitled to restrict its compensation in proportion to the gravity of the insured's negligence.

Again, these rules do not apply to marine insurance and reinsurance (Section 209 VVG). German marine insurance conditions do not have such a sophisticated system of consequences of the insured's breach of obligations. Paragraph 23 of the DTV Hull Clauses (DTV-Kasko 1978/2004), for example, discharges the insurer from liabilities caused by a vessel that was unseaworthy when the journey commenced, unless the insured could not have avoided this with reasonable care. Therefore, any fault of the insured enables the insurer to avoid coverage fully without any need to differentiate between various degrees of negligence, so that the all or nothing principle even exists for 'ordinary' negligence. This exceeded and still exceeds the provisions of the VVG before the reform in 2008.

In respect of large risks in accordance with Section 210 VVG, the parties to an insurance contract can agree that gross negligence of the insured enables the insurer to avoid coverage fully as under the insurance of large risks deviations from the VVG provisions are possible. This view was also held by the Hamburg Appeal Court in a 2018 judgment.³⁰ It stated that the all or nothing principle for gross negligence can be agreed upon in an insurance of a large risk. It therefore remains to be seen whether this principle can be agreed upon for any negligence in a large risk or an open policy in accordance with Section 210 VVG. The Cargo Insurance Conditions (DTV-Güter 2000/2008) already restrict the all or nothing principle to cases of gross negligence and intent.

Any fault of a person who is deemed to be the representative of the insured is attributable to the insured. This includes any person to whom the insured entrusted the administration of the insured risk, so this person should comply with the insured's obligations irrespective of whether he or she is the insured's director or may otherwise legally represent the insured. As there is no easily applicable test as to whether a person qualifies as the insured's representative in a particular situation, there are various (non-binding) precedents to determine this. The captain of a vessel, for example, qualifies as the shipowner's or insured's representative in respect of a marine hull policy, but is not the representative of cargo owners under the transport policy.

Validity of clauses

Various provisions of the VVG are compulsory in a way that they cannot be derogated from to the detriment of the insured, unless large risks are concerned.

In respect of large risks and open policies, the parties are generally free to deviate from the provisions of the VVG (Section 210 VVG). However, as already mentioned in subsection i, the VVG provides for an overall legislative concept of a fair balance between the rights of the insurer and the insured. Insofar as the VVG generally applies (including large risks and open policies, and excluding marine insurance and reinsurance), an insurer is not

30 Judgment of 8 March 2018 – 6 U 39/17.

entitled to deviate from the provisions of the VVG without any limitation in its general terms and conditions of contract. The following two judgments on D&O insurance clauses clarify the position.

In an often-quoted judgment of the Appeal Court of Munich,³¹ the Court considered whether the claims-made principle contained in D&O insurance conditions was valid as it is alien to the occurrence principle of German liability insurance practice. Claims-made liability policies define the insured event in general as the actual pursuance of a claim (with modifications) irrespective of when the event that caused such claims occurred. The occurrence principle defines as the insured event the actual occurrence that led to claims, irrespective of when these claims are pursued. As opposed to the occurrence principle, the claims-made principle might disadvantage an insured insofar as it might not be entitled to coverage if claims are only pursued against it after the expiry of the liability policy even if this policy was in place when the event occurred that caused the claims. The Appeal Court of Munich considered carefully whether this disadvantage is sufficiently balanced with the advantages the claims-made policy provided to the insured and found that this was the case. Consequently, the Court confirmed the validity of the claims-made principle. However, the reason for this was only that the policy also contained the usual clause according to which claims are even covered after the expiry of the policy if they are notified to the insurer within one year of the expiry of the liability policy, and that even claims that were caused prior to the inception of the policy are covered. Today, there is no doubt that the claims-made principle, as defined in D&O insurance conditions, is valid. Nevertheless, the Munich judgment serves as a good example that German courts will always carefully consider whether any deviations from VVG provisions and its legislative concepts are sufficiently balanced.

D&O insurers were less fortunate in a dispute on which the Appeal Court of Frankfurt handed down a judgment on 9 June 2011.³² The Court considered the usual clause that the costs of legal proceedings ‘including lawyers’, experts’, witness’ and court costs are contained in the maximum amount insured’ to be invalid as it found this to deviate in an unbalanced way from the overall legislative concept of the VVG according to which an insurer is to indemnify such costs in addition to the maximum liability agreed in the insurance contract. It is doubtful whether other courts will follow this approach, although the Federal Supreme Court has not overruled this position to date. However, this judgment again underlines that German law provides for considerable uncertainties in its effort to protect consumers and business entities alike. This also confirms that marine insurance practitioners were right in their successful effort to exclude marine insurance from the scope of the VVG provisions totally, which has never been an issue in respect of reinsurance.

iv Intermediaries and the role of the broker

The VVG differentiates between the insurer’s agents and brokers. Agents are persons or entities that the insurer entrusted with the task of concluding or arranging insurance contracts (Section 59(2) VVG). Agents act on behalf of the insurer. Persons or entities that arrange insurance contracts between an insurer and an insured ‘without doing so on behalf of an insurer’ (Section 59(3) VVG) are brokers. This usually means that the insured instructs the broker to arrange coverage. Any misconduct or knowledge of the agent is attributable to the insurer, while this, in principle, is not the case for brokers. However, in 2011 the Appeal

31 Judgment of 8 May 2009 – 25 U 5136/08.

32 Judgment of 9 June 2011 – 7 U 127/09.

Court of Karlsruhe found that a broker's misconduct in giving improper advice to the insured was attributable to the insurer, as the latter did not have an independent distribution system but exclusively relied on the services of brokers.³³ 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 (Section 86(1) VVG). 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.

33 Judgment of 2 August 2011 – 12 U 173/10.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Pursuant to Section 215 VVG, the insured is entitled to sue the insurer at the place where the insured is based. The court at the insured's place of business is exclusively competent for claims against it. The parties are free to deviate from this in respect of large risks, although this has not yet been confirmed in judgments. In any event, Regulation (EU) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, which is applicable if a person domiciled in a Member State is sued in another Member State, prevails.

Any agreements on the applicable law are subject to Regulation (EC) No. 593/2008 of 17 June 2008 on the law applicable to contractual obligations (Rome I), which will not be dealt with as Germany directly applies this Regulation as part of European law.

Arbitration clauses are commonly (albeit not only) used in marine insurance and reinsurance contracts. They are rarely used in other insurance contracts, even if large risks are concerned. Arbitration clauses usually agreed to in marine insurance contracts may refer any disputes to an arbitration tribunal under the rules of the German Maritime Arbitration Association. Alternatives are the German Institution of Arbitration or ad hoc tribunals without any specific procedural rules. German arbitration proceedings are conducted in a similar way to usual litigation, although they should be quicker, and the arbitrator should be more familiar with insurance concepts and, although this has rarely been discussed, would probably not have such strong reservations as regards deviations from the VVG provisions in respect of large risks as state courts sometimes have.

Alternative dispute resolution, especially mediation, is still developing in Germany, although normally on an ad hoc basis rather than as a contractually agreed requirement.

ii Litigation and arbitration

German litigation and arbitration proceedings do not have any pretrial procedures, as there are no procedural disclosure requirements. In principle, each party is required to substantiate the facts and submit evidence without being able to obtain these facts and evidence from opponents through disclosure, although there is a duty within legal proceedings not only to object to the opponents' statements of facts flatly but to make substantiated counter submissions, and to make substantiated submissions on facts that the other party cannot know. Moreover, the judge may order the parties to submit certain documents that they consider relevant (Section 142 of the Code on Civil Procedure). Material law might also require a party to disclose information and documentation to the other party on its request irrespective of whether legal proceedings have already commenced. This is the case under insurance contracts, for example, according to Section 31 VVG, the insured is under an obligation to give any information to the insurer that it requires to determine the scope of its obligations, as well as documentation that the insured can reasonably obtain. This obligation ceases with the rejection of coverage.

Oral hearings are usually prepared by the exchange of written submissions (points of claims, points of defence, further reply submissions). The judges or arbitrators will, at the beginning of the proceedings (usually at the beginning of the oral hearing), try to induce a settlement between the parties. In this respect, they might even be quite open with their preliminary view on the facts and the merits of the case, and might hear the parties or their representatives personally. If the matter cannot be settled, the judge usually discusses

the merits with the parties' counsel and explains how he or she intends to proceed further (e.g., to hand down a judgment usually a few weeks after the closure of the hearing or to hear evidence). The judge might also order the parties to make further submissions of fact that he or she considers necessary. If the matter is not ready for a decision, the hearing will be postponed. Judgments can be appealed before the appeal courts, which, however, will only reconsider the facts determined in first instance if relevant procedural mistakes have been made that might have resulted in wrong factual determinations or if there are other indications that the court's determinations were incorrect. German appeal courts are rather reluctant to set aside a judgment for potential mistakes as to the evaluation of evidence in first instance. A further appeal to the Federal Supreme Court is only permissible if such is necessary to clarify legal questions of fundamental significance, if similar legal questions are evaluated differently by different lower courts or if lower courts deviated from the Federal Supreme Court's findings on law as set out in its previous judgments.

The losing party is to indemnify the winning party for costs incurred for proceedings in accordance with statutory fee tariffs. The recoverable costs depend on the sum in dispute. Court costs are to be advanced by the plaintiff. By way of example, court costs for an action for payment of €100,000 in first instance amount to €3,078 and recoverable lawyers' fees to approximately €3,750. Disbursements such as travel costs, expert fees, etc., have to be added. The statutory fee tariffs and their effect on recoverable costs make the cost risks involved in litigation easily assessable for parties to a dispute. Similar cost principles and tariffs apply in arbitration proceedings, unless the parties agree otherwise.

V YEAR IN REVIEW

At the end of 2018 and in 2019, German courts handed down various judgments on the construction of provisions of the VVG and on consequences of the 2008 VVG reform as well as the construction of clauses in insurance contracts.

On 7 November 2018, the Saarbrücken Appeal Court held that an insured is still obligated to protect any recourse claims as of Section 86(2) VVG even if the insurer definitely and finally rejects coverage.³⁴ In this case the insured, a lessee of a restaurant, claimed coverage under a loss of income insurance for its loss of income during damage repair works of defects of the kitchen floor. It was proven that the kitchen never met the contractual requirements under the lease agreement. Therefore, the lessee was entitled to claim for damages against the lessor. The insurer rejected coverage under the loss of income insurance. Later during negotiations, the insured waived all claims against the lessor of which the insurer became aware during the proceedings on the claim for coverage pursued by the insured. In the opinion of the Court it would be inappropriate and incompatible with the parties' interests if the insured that seeks to enforce its claim for coverage could waive any claim against third parties and not suffer from the sophisticated consequences of Section 86(2) VVG. In contrast, the obligation to provide the insurer with all necessary information on the claim shall be suspended after the insurer's rejection of coverage. With its rejection the insurer declares that further information is no longer needed, therefore the insured shall not be obliged to provide it.

In September 2019, the Federal Supreme Court issued a court order³⁵ concerning the insured's obligation to disclose all known circumstances to the insurer and the consequences

34 Judgment of 7 November 2018 – 5 U 22/18.

35 Court Order of 25 September 2019 – IV ZR 247/18.

of simple negligent lack of knowledge of such circumstances. The insurer claimed for retroactive adoption of an endowment life insurance with supplementary occupational disability insurance. Prior to conclusion of the contract the insurer asked for any known accidents excluding simple fractures without joint involvement. The insured therefore did not declare a fibula fracture, as he was not aware of any joint involvement. During a detailed assessment a few years after conclusion of the contract the insurer became aware of this fracture with actual injury of the ankle. The courts of first and second instance already held that in consideration of the content of the medical's letter with regard to the fracture, the insured might be slightly negligent. The Federal Supreme Court nevertheless stated that the negligent lack of knowledge cannot constitute knowledge of circumstances. The insurer is under the onus to prove positive knowledge of the insured of all circumstances the insured has to disclose. As the insurer could not prove such knowledge, it could not claim for retroactive adoption of the insurance contract.

VI OUTLOOK AND CONCLUSIONS

According to BaFin, the main focus of supervision in 2020 will be (1) the challenges of digitisation, IT and cyber risks; (2) the integrity of the financial system and combating financial crime; (3) sustainable business models; and (4) sustainable finance.³⁶ Key issues of the German insurance market related to digitisation are the implementation of the insurance supervisory requirements for IT and the analysis of cyber risk insurance. In relation to sustainable business models, BaFin will focus on the following areas: analysis on how life insurers and pension funds deal with the challenges of low interest rates; analysis on real estate exposure and real estate loans of the supervisory properties; and material exposures on 'BBB', high yield or equivalent investments without rating. Furthermore, BaFin will develop a recommendation on an imposition of a capital add-on pursuant to Section 301(1) Nos. 1 and 3 VAG.

BaFin named the following further areas to be focused on by the German insurance market in the coming year:³⁷ the transferability of own funds to insurance groups, revision of how companies deal with the requirements of Section 48a VAG for sales remuneration which deals with the avoidance of conflicts of interest of sales remuneration and entered into force on 23 February 2018, analysis of the premium situation of non-life reinsurers, review of the market-oriented valuation of the claims reserves in property and casualty insurance (best-estimate pursuant to Solvency II), and audit of technical provisions in the life sector, revision of the implementation of the insurers' statutory information obligations in the event of a deterioration of the economic situation and of the auditors in the event of risks threatening the existence of the company.

36 BaFin (https://www.bafin.de/SharedDocs/Downloads/DE/Broschuere/dl_Aufsichtsschwerpunkte2020.html?nn=13483392).

37 BaFin (https://www.bafin.de/SharedDocs/Downloads/DE/Broschuere/dl_Aufsichtsschwerpunkte2020.html?nn=13483392).

GREECE

*Dimitris Giomelakis, Nikolaos Mathiopoulos, George Asproukos and
Marilena Papagrigoraki¹*

I INTRODUCTION

The insurance market experiences constant change because of its interdependence with the economy as a whole. The Greek insurance market is showing slow but definite signs of recovery broadly along the lines of GDP growth, reflected in the quarterly statistics on insurance corporation assets published by the Bank of Greece. Local insurers are looking to switch to technology platforms that enable development and cost reduction. The EU Solvency II framework, which directly links taking new risks with efficiency and maintaining high capital adequacy, is leading companies to stable and safe paths on policies for new production, avoidance of guarantees, and complex products that usually bring higher capital requirements.

II REGULATION

i Regulatory agencies and legislation

In 2008, the supervision of insurance companies was passed from the Ministry of Trade to a legal entity called the Private Insurance Supervisory Committee (PISC). Soon after, pursuant to Law 3867/2010, the PISC was abolished and the Bank of Greece was appointed to regulate the private insurance sector.

State supervision of the Greek private insurance and reinsurance industry is mainly governed by Law 4364/2016, which introduced in Greece the Solvency II Directive (2009/138/EC), Articles 2 and 8 of Directive 2014/51/EU and Article 4 of Directive 2011/89/EU. Hence, the provisions of the previous law (Decree 400/1970) were abolished. Law 4364/2016 governs all primary aspects of insurance and reinsurance undertakings' licensing, conduct of business, state supervision, solvency requirements and winding-up proceedings. Insurance intermediaries' conduct of business is governed by Law 4583/2018 (implementing the Insurance Distribution Directive (IDD)).

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, acting as the Greek supervising authority. The licensee is granted the right to passport its services in all European Union (EU) or European Economic Area (EEA) Member States. Insurers domiciled or established

¹ Dimitris Giomelakis is a partner, Nikolaos Mathiopoulos and George Asproukos are senior associates, and Marilena Papagrigoraki is an associate at Herring Parry Khan Law Office, trading as Ince.

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 subject 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.

With Law 4583/2018 Greece transposed into its national legal corpus the Insurance Distribution Directive (Directive (EU) 2016/97), ensuring a higher level of consumer protection in their dealings with insurance corporations as well as a level playing field for distributors of insurance and reinsurance products.

iv Requirements for authorisation

Requirements for the insurer

An insurer domiciled in Greece must be incorporated as a *société anonyme* (as revised by Law 4548/2018) or a *società europea* 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.

Licence to conduct insurance or reinsurance business

A licence is granted according to the type of insurance for all or some of the risks, and grants the insurer the right to provide its services under the freedom of establishment (FOE) or freedom of services (FOS) regime within EU and EEA Member States, and Switzerland (with respect to non-life risks, pursuant to the bilateral agreement between the EU and the Swiss Confederation 91/370/EEC). An insurer can also undertake reinsurance risks within the scope of its primary insurance licence.

With respect to reinsurance, the licence can be granted for both life and non-life reinsurance risks, or for either of the two alone. The licensee can operate in all EU and EEA Member States under the FOS or FOE regime.

v Regulation of directors and officers

According to Law 4364/2016, the board of directors of every Greek insurance or reinsurance company should consist of a majority of Greek citizens or citizens of other EU or EEA Member States. Any person who has been convicted of theft, embezzlement, usury, swindling, fraud, extortion, forgery, corruption, bankruptcy or smuggling, who has been declared bankrupt, or who has been a director of an insurance company that has been declared bankrupt or whose licence has been revoked because of infringement of the law, cannot be elected or appointed as chief executive officer, managing director, executive director, deputy chief executive officer, officer or board member of a Greek insurance company.

Furthermore, 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.

vi Compulsory insurance

Compulsory insurance is imposed in cases where it is essential to protect innocent third parties from damages caused by high-value risks.

A third party (i.e., a person other than the policyholder) can file a direct action if it is the person insured in a policy concluded on the account of that third party (Article 9 of Law 2496/1997); or if it is the person injured, and the insurer has undertaken to provide compulsory third-party liability cover to the person liable to compensate the third party (Article 26 of Law 2496/1997). However, with the exception of motor third-party liability claims (regulated by Law 489/1976) and claims arising from wreck removal, this right of direct action is still not in effect, as practical issues must still be resolved by means of a ministerial decision regulating which authorities shall be authorised to certify compliance with the requirements of compulsory insurance.

vii Requirements with respect to reserves maintained by insurance and reinsurance companies

Insurers and reinsurers must conduct their business in a fit and proper manner, and comply with the regulatory obligations that have been set to safeguard their soundness. These obligations are compliant with the provisions of the EU Solvency II legislative framework

enacted in Greece in 2016. In particular, insurance and reinsurance companies must form and maintain adequate technical reserves or provisions, which must be prudently covered by investments. With respect to insurers, these investments must meet the statutory eligibility requirements, especially in terms of safety and profitability. Reinsurers, on the other hand, must abide by the prudent management requirement for investing in assets and securities. Insurers and reinsurers must also maintain a solvency margin and a guarantee fund to meet their obligations. If they fail to meet the above solvency requirements, the regulator may impose administrative sanctions, such as the submission of a plan for their short-term funding and the reorganisation of their business or a financial recovery plan, or may freeze their assets or revoke their licence and place them under compulsory winding-up proceedings.

Regarding capital requirements, each insurance and reinsurance company is obliged to comply with the Solvency II regulatory requirements. Regarding reinsurance companies, the minimum solvency margin should amount to at least €3 million pursuant to Article 267 of Law 4364/2016.

viii Insolvency

Insurance and reinsurance companies are placed under compulsory winding-up proceedings if their licence has been revoked on the grounds of failing to abide by solvency requirements or if the regulator has frozen their assets pursuant to Law 4364/2016. The proceedings have immediate effect in all EU and EEA Member States where the insurer is established. The liquidator is appointed by the local regulator, and has the duty to notify all persons who are entitled to insurance compensation and domiciled in other EU and EEA Member States about the proceedings and the procedure to notify their claims. Persons domiciled in Greece are invited to notify their claims and all evidence by an invitation published in national newspapers. Claims arising from compulsory third-party liability insurance are covered by the Auxiliary Fund. Claims arising from life assurance are handled by the Private Insurance Guarantee Fund (established by Law 3867/2010).

ix Mergers

All transactions involving a change of control of insurance and reinsurance companies have to be approved by the local regulator. In this case, the directors and officers of the acquirer will be subjected to due diligence by the Bank of Greece. An approval decision of the Bank of Greece is also necessary in the case of an insurance or reinsurance portfolio transfer, and cooperation with another designated national regulating authority may be required for proposed transfers involving an insurance or reinsurance entity domiciled in another EU Member State.

Financing

There are no specific provisions in the law introducing regulations regarding the financing of an acquisition of an insurance or reinsurance company by either a person or a legal entity. Subject to the specifications of each financing scheme, corporate law restrictions, including the prohibition of loan or guarantee granting by an insurance or reinsurance company for the acquisition of its own shares by third parties, the rules on qualified holdings requirements and anti-money laundering regulations, including the transposition of the Fourth Anti-Money Laundering Directive into Greek law and the establishment of national Ultimate Beneficial Owner (UBO) register, both pursuant to Law 4557/2018, should also be taken into account.

x Investment

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

xi Key information documents for packaged retail and insurance-based investment products

Regulation (EU) No. 1286/2014 on key information documents for packaged retail and insurance-based investment products (PRIIPs) entered into force on 1 January 2018. This Regulation obliges the producers or sellers (such as fund managers, insurance undertakings, credit institutions or investment firms) of investment products intended to be sold to small and non-professional investors or retail investors to supply key information documents (KIDs) providing accurate, fair, clear and not misleading information about these investment products. This Regulation also provides for the civil liability of the producers or sellers of such investment products for any infringement of the Regulation where damage was suffered by retail investors as a result of compliance with a KID that is inconsistent with pre-contractual or contractual documents under the producers' or sellers' control or that is misleading or inaccurate.

The aim of the Regulation is to help investors to understand and compare the key features and risk-and-reward profile of such products, to establish uniform rules on transparency at EU level that apply to all participants in the PRIIPs market and thereby to enhance investors' protection, and to rebuild their confidence in the financial market, in particular in the aftermath of the financial crisis.

III INSURANCE AND REINSURANCE LAW**i Sources of law*****Insurance contracts***

Greece has a statutory legal system. Law 2496/1997, the Insurance Contract Act (ICA), sets out the regulatory contents of an insurance contract, and the obligations and rights of the insurer and the insured. Law 4364/2016 (Solvency II) 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 (as amended), 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 these terms and conditions apply to the contract, and a copy of the terms must be provided to the policyholder.

Article 3 of the ICA sets out the statutory or regulatory requirements aimed at the protection of the policyholder during the conclusion process of an insurance contract. The insurer bears the following notification duties:

- 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 in subsection i, 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). Implied terms are based upon the principle of good faith (Article 288 of the Civil Code).

Greek law requires that for the insurer to be exempted from payment, a breach must be causally connected to the loss. Article 4 of the ICA entitles the insurer to terminate the cover if the nature of the risk changes during the policy period.

The effects of a contract can be made dependent on the occurrence of future and uncertain events, which are called conditions. Conditions fall into two main categories: those that suspend the effects of the contract until the condition is met, and those that allow for the effects of the contract to occur immediately. However, upon their fulfilment, the effects of the contract will cease automatically.

iv Claims

Insurance contracts

An insurer cannot deny coverage based on late notice of claim unless there is an express provision to that effect in the agreed terms. The insurer can only claim damages. The wrongful denial of a claim could lead to a claim for bad-faith damages, owing to the moral pain and suffering caused to the insured.

Usually, the liability insurer has a right, but not an obligation, to defend a claim. Subject to the specific contractual arrangements, the notification, by either the policyholder or the insured, of the occurrence of an insured peril triggers payment under the policy provided the quantum of damages is known.

In indemnity policies, the insurer's indemnity obligation is triggered by the notification of the occurrence of the event by the policyholder to the insurer. If a longer period is required for the assessment of the full extent of the loss, the insurer shall pay the undisputed amount without undue delay.

Reinsurance contracts

No specific law exists. Reinsurance contracts are subject to specific contractual arrangements.

The duty of utmost good faith implied in reinsurance contracts differs from that applicable to other commercial agreements, in that the reinsurer relies on the diligence of the

insurer. If, for example, a claim in excess was notified to the reinsurer, it could result in the total release of the reinsurer, while in other commercial agreements this could only result in the recovery of a reduced amount.

A policyholder or non-signatory to a reinsurance agreement cannot bring an action against a reinsurer unless this is specifically provided in a clause in the reinsurance contract.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

The method of dispute resolution, jurisdiction and choice of law should be agreed upon by the parties in advance and in writing, but, in any case, the defendant may make an appearance without challenging the jurisdiction of the court. If an agreement provides that a court other than the competent Greek court has exclusive jurisdiction, this agreement must be in writing. In relation to future disputes, jurisdiction clauses must be in writing and define the legal relationships to which they refer.

Most insurance policies specify the law that applies and the courts before which any dispute should be referred. Where there is some link to an EU Member State, it is important for insurers to be mindful of the impact of the Regulation (EU) No. 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (especially Articles 10 to 16 regarding jurisdiction in matters relating to insurance) (choice of court and jurisdiction) and the Rome I Regulation (especially Article 7 regarding insurance contracts) (choice of law) on the application of such provisions in policies.

ii Litigation

Most insurance disputes are referred to the courts. However, arbitration has been enjoying increasing popularity, unlike other dispute resolution mechanisms such as mediation, which is still of limited application.

Litigation stages

Proceedings start by way of filing a lawsuit that, apart from the names and addresses of the parties (actions *in rem* are not allowed under Greek law), also include full particulars of the claim. The claimant must, at the outset, specify the exact amount sought rather than a range or a statement that the amount sought will be notified during the proceedings.

There are three types of civil courts of first instance: courts of peace, which hear claims of up to €20,000; single-member courts of first instance, which hear claims between €20,000.01 and €250,000; and multi-member courts of first instance, which hear claims in excess of €250,000.

There is no prescribed claim form. The issue of proceedings does not interrupt the time bar; this requires that the lawsuit has also been served on the defendant.

The only available method of service is via a court bailiff instructed by the claimant to serve the lawsuit on the defendant. In cases where the defendant is domiciled in Greece, the lawsuit should be served within 30 days of its filing; where the defendant is not domiciled in Greece, it should be served within 60 days. If the defendant is domiciled in an EU Member State, the service is effected pursuant to the provisions of Regulation (EC) No. 1393/2007; for non-EU residents, the Hague Service Convention of 1965 applies.

After the lawsuit is served, the main stages of the proceedings are as follows:

- a* Pleadings are submitted within 100 or 130 days (depending on the case) of the date of submission of the lawsuit; supplementary pleadings are submitted within 15 days of the expiry of the above deadline. The case file is then considered closed. Within 15 days, the case is assigned to a court judge, and at the same time the hearing is scheduled within a period of no longer than 30 days. No witnesses are examined at the hearing, and the case may be heard without the parties or their lawyers being present. Following the study of the file, witnesses can be examined later if this is considered necessary by the court.
- b* The judgment usually takes three to 10 months to be issued. In complex cases, the court may reserve its final judgment and issue a preliminary judgment requesting additional evidence by way of, for example, expert witness or opinion.
- c* The final judgment is subject to appeal. There is no need for leave to appeal – all judgments are subject to appeal, either on questions of fact or on questions of law. The appeal must be filed within 30 days of the service of the judgment, within 60 days of the service of the judgment in case the appellant is resident abroad or its address is unknown, or within two years of the date the judgment was drawn up and sealed by the court but not served on the other party (service is done by the parties).
- d* A further appeal may be filed before the Supreme Court, but only on questions of law. This must be filed within 30 days of the service of the appeal court judgment, within 60 days of the service of the judgment in case the appellant is resident abroad or its address is unknown, or within two years of the day the judgment was drawn up and sealed by the appeal court but not served on the other party (service is, again, pursued by the parties).

Evidence

Generally, all documents to which reference is made in the action, or that support the claim or the defence, must be submitted together with the parties' pleadings as outlined above.

The disclosure is not a pretrial stage. An application seeking a disclosure order can be filed, but, since the particular documents for which disclosure is sought must be prescribed in great detail, this remedy is rarely sought.

The oral debate that took place during hearings was abolished by the amendments to the civil procedural law, and has been replaced by a written procedure. The main rule, as mentioned above, is that witnesses shall no longer be examined at the hearing. If the court considers that the case has not been sufficiently clear to proceed with the issuance of the decision, it may issue an act ordering that witnesses be examined. Following the repetition of the hearing, the parties have the right to submit within eight working days their memoranda commenting on or evaluating the testimonies, or both.

An expert witness may be appointed by the court to give an opinion only if the court finds that the matter calls for expert knowledge or a party requests the appointment (Article 368 of the Code of Civil Procedure (CCP)). The number of experts appointed is at the discretion of the judge. In this case, the parties are entitled to appoint their own experts, known as technical advisers.

Costs

The rule is that the unsuccessful party pays the costs of the other party. However, the courts usually order the defeated party to pay a nominal amount, which is only a fraction of the actual costs incurred by the successful party. A trend has developed in commercial disputes to award costs on the basis of 2 per cent of the court's adjudged amount or, if a claim is rejected, of the amount of the original claim. A defendant can, in theory, apply to the court for security for legal costs if there is an obvious risk of non-payment by the claimant if the latter is ordered to pay the costs, but this is rarely granted in practice.

iii Arbitration

Format of insurance arbitrations

Provided there is an arbitration agreement, all disputes concerning insurance and reinsurance matters can be resolved by arbitration. The arbitration agreement must be in writing and signed by the parties to be legally binding. A signature may be substituted by the exchange of a signed letter or fax. If the agreement is not in writing, it is only enforceable if the parties appear before the arbitrators and participate voluntarily in the proceedings without contesting the tribunal.

Domestic arbitration is governed by the rules set out in the CCP. Unless otherwise provided, domestic arbitral awards cannot be appealed, but can be annulled if certain strict requirements are met. An award can be annulled for the following reasons, among others:

- a* the arbitration agreement was invalid;
- b* the arbitration award was issued after the arbitration agreement ceased to be in force, or was against public policy or good morals;
- c* the arbitrators were not validly appointed or requested to be exempted from the process for serious reasons;
- d* the arbitrators abused the powers vested in them by law or by the parties;
- e* principles were violated concerning the equality of the parties, the delivery of the award and the existence of grounds for the reopening of the decision; and
- f* the award itself is incomprehensible or contains inconsistent provisions.

International arbitration is governed by Law 2735/1999, which introduced the UNCITRAL Arbitration Rules into national law, and is applicable in cases where Greece is the chosen venue for the arbitration.

Procedure and evidence

As with court litigation, the principle of civil procedure, which requires that evidence should be provided at the initiative of the parties to an action, also applies in arbitration.

Costs

With regard to domestic arbitration, the arbitrators' remuneration is calculated as a percentage of the value of the claim. The award determines which party is responsible for paying the arbitrators' fees and the costs of the arbitration. In international commercial arbitration, the allocation of costs and expenses is subject to the parties' agreement; in the absence of an agreement, the tribunal allocates costs and fees between the parties. This allocation may be the subject of a separate decision by the tribunal.

iv Mediation

Mediation in civil and commercial matters was introduced as a result of the harmonisation of Greek law with Directive 2008/52/EC. After a previous unsuccessful attempt to introduce compulsory mediation for a range of civil and commercial matters in 2018, Law 4640/2019 makes it compulsory to hold a first mediation session for disputes that fall within the jurisdiction of single-member courts of first instance, if the claim exceeds €30,000, and for all cases heard by the multi-member courts of first instance in their regular proceedings, as well as several types of family disputes. To that effect, on condition of inadmissibility, all new actions must include a signed document from the lawyer and the client that the lawyer has informed them of the mediation option, where mediation is non-compulsory, or a copy of the minutes of the first mediation session, signed by the mediator, where it is compulsory under Articles 6 and 7 of Law 4690/2019, effective as of 15 March 2020.

It remains to be seen how the new mediation legislation will be received by the Greek litigation community, and whether it will introduce an additional costly obstacle to civil and commercial right of recourse or succeed in lightening the workload of Greek courts.

V OUTLOOK AND CONCLUSIONS

The debt crisis in the eurozone is still felt on the local insurance industry even after 10 years, although there have been signs of slow but steady upturn, with key legislative change and further integration with EU framework policies offering a backbone of regulatory stability in the midst of a precarious economic situation. With the complete lifting of capital controls in the latter half of 2019, the Greek market is looking outward, while at the same time insurance premiums have seen significant increase across both non-life and life insurance sectors.

INDIA

Neeraj Tuli and Celia Jenkins¹

I INTRODUCTION

The Indian insurance market was nationalised shortly after India's independence in 1947, and remained so until the government's industrial policy of 1991 announced the advent of a liberalised Indian economy, which included private participation in the insurance sector. In 1993, the government set up the Malhotra Committee to review the then-existing structure of the regulation and supervision of the insurance industry and to suggest reforms. The Committee recommended, inter alia, that the private sector be permitted to enter the insurance industry and that foreign insurers be allowed to enter the Indian market by forming joint ventures with Indian partners.

There was considerable delay in implementing these recommendations, and in particular a rather lengthy debate over the right level of the cap on foreign ownership, but in 1999 the Insurance Regulatory and Development Authority of India (IRDAI) (formerly, the Insurance Regulatory and Development Authority (IRDA)) was set up as an autonomous body to regulate the insurance industry and develop the insurance market, and in August 2000 private competition was permitted with a foreign ownership cap of 26 per cent.

There were growing complaints about the relatively low 26 per cent cap on foreign investment. The cap on foreign investment was intended to be raised to 49 per cent, and ultimately, after a long legislative history, on 20 March 2015, the Insurance Laws (Amendment) Act 2015 (the Amendment Act) was notified, which, inter alia, increased the foreign investment cap on insurers and insurance intermediaries to 49 per cent. The Amendment Act also permitted the establishment of branch offices in India by foreign reinsurers. Recently, the Indian Insurance Companies (Foreign Investment) Amendment Rules 2019 (the Foreign Investment Amendment Rules) were notified, which increased the limit on foreign investment in insurance intermediaries from 49 per cent to 100 per cent.

At present India has 24 life insurers, 27 general insurers and six stand-alone health insurers, 25 third-party administrators, 457 insurance brokers, 25 web aggregators, four insurance repositories, 597 corporate agents and numerous insurance agents. There are 10 foreign reinsurer branches in India, including the branch office of Lloyd's of London set up under the IRDAI (Lloyd's India) Regulations 2016 (the Lloyd's India Regulations). In addition, at present, there is one reinsurance company in India: the government-owned General Insurance Corporation, which has been granted registration by the IRDAI.

¹ Neeraj Tuli is the senior partner and Celia Jenkins is a partner at Tuli & Co.

II REGULATION

i The insurance regulator

Insurance and reinsurance companies, foreign reinsurer branches and intermediaries in India are governed by the IRDAI.

ii Position of non-admitted insurers

Overseas non-admitted insurers cannot write direct insurance business in India. Non-admitted insurers who have registered with IRDAI as cross-border reinsurers can reinsure risks written by Indian insurers in accordance with the IRDAI (Re-insurance) Regulations 2018 (the Reinsurance Regulations) (see Section V). Pursuant to the Amendment Act, overseas non-admitted reinsurers are now also permitted to access the Indian market by way of branch offices set up in India and service companies set up under the Lloyd's India Regulations.

Indian residents may purchase life insurance policies issued by an insurer outside India provided the policy is held under specific or general permission of the Reserve Bank of India. Indian residents are prohibited from purchasing insurance in respect of any property in India or any ship, vessel or aircraft registered in India with an insurer outside India without the permission of the IRDAI. Indian residents can, however, purchase health insurance policies from an insurer outside India provided aggregate remittance including amount of premium does not exceed the limits prescribed by the Reserve Bank of India under the Liberalised Remittance Scheme from time to time.

iii Position of brokers

The framework governing the operation and functioning of insurance is provided under the IRDAI (Insurance Brokers) Regulations 2018 (the Brokers Regulations). Only insurance brokers that are registered with the IRDAI as direct brokers, reinsurance brokers or composite brokers in accordance with the Brokers Regulations can operate as insurance brokers in India. The Brokers Regulations have set out provisions for sale of insurance online and sale of insurance using distance marketing modes. Further, the Brokers Regulations also set out norms with regard to the minimum capital requirements for insurance brokers, agreements with third-party service providers, remuneration or fee receivable by the insurance brokers and the services that a registered insurance broker is permitted to perform.

iv Requirements for authorisation

The general rule is that only licensed insurance agents and insurance intermediaries can distribute insurance products for Indian insurers. Unlicensed persons are prohibited from soliciting and procuring insurance business or providing introductions or leads.

v Regulation of individuals employed by insurers

Individuals employed by Indian insurers must be internally trained by the insurer to carry out the distribution of insurance products. Indian insurers are also permitted to use individual insurance agents that are licensed in accordance with the IRDAI (Appointment of Insurance Agents) Regulations 2016 for the distribution of insurance products.

vi The distribution of products

Only licensed or registered insurance agents and insurance intermediaries can solicit and procure insurance business for insurers. Insurers are also permitted to engage licensed telemarketers and registered web aggregators for the solicitation and procurement of insurance business, and to purchase access to the database of licensed referral companies.

The IRDAI notified the Guidelines on Motor Insurance Service Provider (the MISP Guidelines) to identify and regulate the role of automobile dealers in distributing and servicing motor insurance products. Pursuant to the notification of the MISP Guidelines, a duly registered motor insurance service provider (MISP) is permitted to solicit, procure and service motor insurance policies for insurers and insurance intermediaries. In addition, the IRDAI has also issued guidance for the appointment of a point of sales person (POSP) for solicitation and servicing of point of sale products on behalf of life, general and health insurers.

vii Compulsory insurance (e.g., employers' liability)

The following are examples of insurance cover that are compulsory by central law:

- a* under the Public Liability Insurance Act 1991: accidental cover for persons handling hazardous substances and environmental issues;
- b* under the Motor Vehicles Act 1988: compulsory third-party liability insurance and compulsory personal accident cover;
- c* under the Deposit Insurance and Credit Guarantee Corporation Act 1961: insurance to be taken by the banks functioning in India;
- d* under the Brokers Regulations, IRDAI (Insurance Web Aggregators) Regulations 2017, IRDAI (Registration of Corporate Agents) Regulations 2015, Guidelines on Repositories and Electronic Issue of Insurance Policies of 29 May 2015, and IRDAI (Registration of Insurance Marketing Firm) Regulations 2015: professional indemnity insurance covering errors and omission, dishonesty and fraudulent acts by employees, and liability arising from loss of documents or property;
- e* under the Carriage by Air Act 1972: parties are required to maintain adequate insurance covering any liabilities that may arise;
- f* under the Rights of Persons with Disabilities Act 2016: an insurance scheme for employees with disabilities;
- g* under the Personal Injuries (Compensation Insurance) Act 1963: employers' liability for workers sustaining injuries;
- h* under the Employees State Insurance Act 1948: insurance for employees in case of sickness, maternity and employment injury;
- i* under the Payment of Gratuity Act 1972: insurance for gratuity payments to employees;
- j* under the War Injuries (Compensation Insurance) Act 1943: for workers sustaining injury in war;
- k* under the Marine Insurance Act 1963: insurance for marine adventures;
- l* under the Merchant Shipping Act 1958: insurance on the lives of crew members;
- m* under the Inland Vessels Act 1917: insurance of mechanically propelled vessels; and
- n* under the Companies Act 2013: insurance of deposits accepted by companies.

viii Compensation and dispute resolution regimes (within the financial services context)

Dispute resolution in India is broadly divided into three mechanisms: civil courts; consumer forums; and arbitration and alternate dispute resolution.

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

Amendments were also made to the Arbitration and Conciliation Act 1996 (ACA) to ensure that commercial arbitrations are completed within a specified timeline and an attempt has been made to do away with the archaic system of awarding costs followed in India, and to make the costs more realistic.

Further detail on these regimes is provided in Section IV.

ix Taxation of premiums

Premiums received on account of insurance and reinsurance business attract applicable taxes, including goods and services tax. Income tax laws provide deductions to the policyholder on life and health insurance premiums paid.

x Proposed changes to the regulatory system

The IRDAI has issued an 'Exposure Draft on Insurance Regulatory and Development Authority of India (Conflict of Interest) Guidelines' of 8 March 2019 to provide guidance on the procedure and conditions for obtaining approval of the IRDAI for the appointment of common directors between insurers and insurance intermediaries.

The IRDAI has issued the 'Draft Insurance Regulatory and Development Authority of India (Public Disclosures for insurers transacting other than Life Insurance Business) Guidelines' of 25 March 2019 proposing revised guidelines applicable to public disclosures required for non-life insurers and reinsurers.

The IRDAI has released 'Exposure Draft on IRDAI (Minimum Information for Inspection or Investigation) Regulations' of 17 May 2019, pursuant to which insurers and insurance intermediaries are required to maintain minimum information at their principal place of business.

The IRDAI has issued 'Exposure Draft on Revisiting the product structure for Dwellings, Offices, Hotels, Shops etc and Micro, Small and Medium Enterprises against Fire and allied perils' of 20 May 2019 proposing the introduction of new insurance product structures for fire and allied perils focused on dwellings, offices, hotels, shops and micro, small and medium-sized enterprises.

The IRDAI has also issued 'Draft Guidelines on Wellness and Preventive Features/Benefits' of 7 November 2019, which propose to supersede the earlier norms on wellness features and benefits prescribed under the 'Guidelines on Product Filing in Health Insurance' of 29 July 2016.

In 2019, the IRDAI has issued the 'Exposure Draft – Revisiting the product structure for Motor Own Damage' of 25 November 2019, which recommends the revised tariff wordings for motor insurance.

In order to bring into uniformity the wordings of health insurance policies, the IRDAI has issued an Exposure Draft re the 'Guidelines on Standardisation of General Clauses in

Health Insurance Policy Contracts' of 10 January 2020, which proposes to standardise certain general clauses that are commonly incorporated in indemnity-based health insurance policies.

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 been removed.

The IRDAI has also mandated that insurance companies must be 'Indian owned and controlled'. The Foreign Investment Rules read with the Guidelines on 'Indian owned and controlled' of 19 October 2015 provide that Indian ownership means that more than 50 per cent of the equity capital is beneficially owned by resident Indian citizens or Indian companies, which are owned and controlled by resident Indian citizens.

The IRDAI has released the IRDAI (Investment by Private Equity Funds in Indian Insurance Companies) Guidelines 2017 of 5 December 2017, to facilitate and regulate investment by private equity funds in insurance companies, as investors and promoters. These guidelines have been made applicable to unlisted Indian insurance companies and to the private equity funds who have invested in such unlisted insurance companies. These guidelines further allow private equity funds to invest either directly in Indian insurance companies in the capacity of an investor or to invest through a special purpose vehicle in the capacity of a promoter in the insurance company.

The IRDAI has notified the Foreign Investment Amendment Rules, which increase the limit on foreign direct investment (FDI) in insurance intermediaries from 49 per cent to 100 per cent. The IRDAI also notified the circular on 'Withdrawal of Indian owned and controlled condition for insurance intermediaries' of 19 November 2019, pursuant to which the requirement of complying with 'Indian owned and controlled' was removed for insurance intermediaries.

There has been a significant increase in the volume of mergers and acquisition activity in the insurance sector in India. Additionally, various insurance companies have issued their initial public offerings in the past few years, and other insurance companies are looking to follow suit in the coming year. Press reports indicate that the Indian government is finalising the merger of three of the four state-owned general insurance firms (i.e., National Insurance, United Insurance and Oriental Insurance).

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Insurance Act 1938, the Insurance Regulatory and Development Authority Act 1999, the Marine Insurance Act 1963 and the regulations, guidelines, circulars and notifications issued by the IRDAI, govern insurance and reinsurance business.

The courts may refer to common law if there are no judicial precedents available under Indian law. Common law is, however, not binding on Indian courts.

ii Making the contract

The terms and conditions of property and engineering insurance covers are currently governed by the policy wording specified by the former Tariff Advisory Committee. Very few modifications to this policy wording have been permitted. In all other lines of insurance business, insurers are permitted to issue only those policy terms and conditions, endorsements and other ancillary documentation that have either been approved by the IRDAI in advance or filed with the IRDAI, in accordance with the prescribed product filing procedures. The IRDAI has issued standardised wordings for exclusions under health insurance contracts. 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, exclusions not allowed in health insurance policies, existing diseases that may be permanently excluded, modern treatment methods that should be covered and standards and benchmarks for hospitals in the insurance network. It has also specified a number of other conditions for health insurance policies, making these policies highly regulated.

The IRDAI (Protection of Policyholders' Interests) Regulations 2017 require general insurance contracts to state several matters, including:

- a* the names and addresses of the insured and of any banks or any other person having financial interest in the subject matter of insurance, unique identification number of the product, name, code number, contact details of the person involved in the sales process;
- b* a full description of the property or interest insured;
- c* the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;
- d* the period of insurance;
- e* the sums insured;
- f* perils covered and not covered;
- g* any franchise or deductible applicable;
- h* premium payable and where the premium is provisional, subject to adjustment, the basis of adjustment of premium be stated;
- i* policy terms, conditions, warranties and exclusions, if any;
- j* action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;
- k* the obligations of the insured in relation to the subject matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances;
- l* any special conditions attached to the policy;
- m* the grounds for cancellation of the policy, in the case of a retail policy;
- n* the address of the insurer to which all communications in respect of the insurance contract should be sent;
- o* the details of the endorsements and add-on covers attaching to the main policy;
- p* that, on renewal, the benefits provided under the policy or terms and conditions of the policy, including the premium rate, may be subject to change; and
- q* details of the grievance redressal mechanism along with the address and other contact details of insurance ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

Similarly, the IRDAI (Protection of Policyholders' Interests) Regulations 2017 specifies the matters to be stated in a health and life insurance policy as well. Further, all condition precedents and warranties are required to be stated in express terms in the policy documentation.

In addition, all product literature is required to be in 'simple language' and 'easily understandable to the public at large', and all technical terms used in the policy wording are to be clarified to the insured. To the extent possible, insurers are also required to use similar wording for describing the same insurance cover or the same requirements across all their products, particularly in relation to clauses on renewal, basis of insurance, due diligence, cancellation and arbitration.

An insurance contract is one of utmost good faith, and insurers are entitled to a fair presentation of the risk prior to inception. The Indian Marine Insurance Act 1963 obliges an insured to make a full and frank disclosure prior to inception, and the Supreme Court has stated that this includes by way of the proposal. There is an argument that an insurer may limit the insured's duty by limiting the questions asked in the proposal form unless the proposal form contains a statement that has the effect of negating any restriction of the disclosure obligation by reference to the questions asked. The IRDAI (Protection of Policyholders' Interests) Regulations 2017 also impose an obligation on the insured to disclose all material information.

If there has been a misrepresentation or non-disclosure of a material fact, then an insurer may avoid the policy *ab initio*. Unless the misrepresentation or non-disclosure was fraudulent, the premium must be returned to the policyholder.

iii Interpreting the contract

In general terms, the statutory framework may be said to favour insurers more than insureds, but the regulatory framework and the interpretation of applicable law is perhaps more favourable to insureds. For example:

- a* the courts and consumer forums have held that if there is any ambiguity in the terms and conditions, then these shall be construed in favour of the insured;
- b* the Insurance Act 1938 restricts the ability of insurers to call a life insurance policy into question after three years from inception on any grounds, including fraud;
- c* the IRDAI (Protection of Policyholders' Interests) Regulations 2017 provide, among other obligations, that insurers must follow certain practices at the point of sale of the policy as well as at the processing or claims stage so that:
 - the insured can understand its terms properly;
 - insurers have proper procedures and mechanisms to hear any grievances of the insured;
 - the policy terms are clearly stated (e.g., warranties, conditions, insured's obligations, cancellation provisions, conditions precedent);
 - certain claims procedures are followed to expeditiously process claims; and
 - insurers pay interest at a rate of 2 per cent above the prevalent bank rate in cases of delayed payment, etc.;
- d* following the IRDAI (Health Insurance) Regulations 2016 (the Health Regulations), general insurers and health insurers are ordinarily required to renew a health insurance policy except on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the insured. Renewal cannot be denied on grounds such as an adverse claims history. Moreover, according to the Guidelines on Product Filing Procedures for General

Insurance Products issued by the IRDAI in February 2016, in a general insurance policy, the insurer can cancel the policy mid-term only on grounds of fraud, misrepresentation and moral hazard;

- e the IRDAI has also directed that all health insurance policies offer portability benefits whereby policyholders are given credit for the waiting periods already served under previous health insurance policies with that insurer or any other Indian insurer; and
- f pursuant to the Health Regulations, the IRDAI is also monitoring wellness benefits provided to policyholders under health insurance policies by mandating that such policies clearly stipulate the manner of calculation, accrual, redemption and carrying forward of such benefits.

Another feature of the insurance sector concerns government-owned insurers, which are considered instruments of the state and are thus expected to act justly and reasonably.

iv Intermediaries and the role of the broker

Insurance brokers, corporate agents, web aggregators, referral companies, insurance marketing firms and insurance agents are granted a licence for a fixed period of three years, following which the licence may be renewed for a further three years at the discretion of the IRDAI.

Insurance brokers and web aggregators are required to exclusively carry on the distribution of insurance products, while corporate agents may have a main business other than the distribution of insurance products, and newly introduced insurance marketing firms are allowed to sell or service other financial products.

If a corporate agent has a main business other than insurance distribution, then it is not permitted to make the sale of its products contingent on the sale of an insurance product or vice versa. Corporate agents were previously restricted to acting for a maximum of one life insurer and one general insurer, however, following the notification of the IRDAI (Registration of Corporate Agents) Regulations 2015, they are permitted to adopt an open architecture under which they can act for up to three life insurers, three general insurers and three health insurers.

The IRDAI's regulations specify separate codes of conduct for each insurance intermediary that governs the conduct expected of each intermediary while performing their functions. Breach of the respective code of conduct could lead to suspension or cancellation of their licence or certificate of registration.

The regulatory limits on the commission or remuneration payable to insurance agents and insurance intermediaries for the solicitation and procurement of insurance business continue to remain under the IRDAI (Payment of Commission or Remuneration or Reward to Insurance Agents and Insurance Intermediaries) Regulations 2016 (Commission Regulations), as amended from time to time. However, insurers are now permitted to make other payments in the form of rewards to insurance agents or insurance intermediaries.

Insurance agents and insurance intermediaries are also prohibited from offering rebates to customers on the premium or commission receivable.

All insurance brokers are required to be part of the Insurance Brokers Association of India.

v Claims

Insurance policy terms and conditions are meant to specify the requirements for notification of claims or circumstances that may give rise to a claim. In our experience, usually the notification of a claim is required ‘immediately’, ‘as soon as practicable’, ‘as soon as reasonably practicable’, etc. 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 through its Circulars dated 20 September 2011, 28 October 2016 and 28 June 2017, has mandated that insurers should not deny claims, which have been otherwise verified as genuine, in a mechanical manner on the ground of delay in notification where such delay was due to unavoidable circumstances.

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. Following the IRDAI Circulars, the Supreme Court two-judge bench in *Om Prakash v. Reliance General Insurance and Anr*² held that delayed notification cannot be a basis for rejecting claims where such delay has been satisfactorily explained and otherwise proved to be genuine. However, this view appeared to deviate from the previous judgment of 2010 delivered by another two-judge bench of the Supreme Court in *Oriental Insurance Co Ltd v. Parvesh Chander Chadha*,³ where the court took the view that the claim deserved to be repudiated because of the delay in informing the insurance company.

In an August 2018 judgment, A three-judge bench of the Supreme Court in *Sonell Clocks v. NIA*,⁴ observed that the rejection of the claim on the ground of delayed notification is ‘not a technical matter but *sine qua non* [an indispensable condition] for a valid claim to be pursued by the insured, as agreed upon between the parties’.

In recent cases, the National Commission has considered the delay in notification but not for repudiation, and only to reduce the quantum. In *Shriram General Insurance v. Kamlesh*, decided on 21 June 2019, the National Commission held that timely intimation to the police and the insurer is necessary because it affords them the opportunity to conduct proper investigations. In this case, there was a delay of four days in intimating the police and two days in notifying the insurer. The Commission held that while the insured had ‘violated the condition of the policy by not immediately giving information to the Insurance Company’, it was still entitled to receive 60 per cent of the claim amount on a ‘non-standard basis’. In *Royal Sundaram Alliance Insurance Co Ltd v. Manish Shivlabhai Kalavadiya*,⁵ the National Commission held that ‘the claim can be accepted on the non-standard basis’ as there was a delay of five days in informing the insurer.

Recently on 24 January 2020, a three-judge bench of the Supreme Court, in *Gurshinder Singh v. Sriram General Insurance Co Ltd*,⁶ took a view favourable to the insured in case of vehicle theft. The Court held that ‘when an insured has lodged the FIR immediately after the theft of a vehicle occurred and when the police after investigation have lodged a final report after the vehicle was not traced and when the surveyors / investigators appointed by

2 Civil Appeal No. 15611 of 2017, decided on 4 October 2017.

3 Civil Appeal No 6739 of 2010, decided on 17 August 2010.

4 (2018) 9 SCC 784.

5 RP No. 2659/13, decided on 27 August 2019.

6 SLP No. 24370/2015.

the insurance company have found the claim of the theft to be genuine, then mere delay in intimating the insurance company about the occurrence of the theft cannot be a ground to deny the claim of the insured⁷.

Insurance policy terms and conditions are also meant to expressly state the insurer's grievance redressal procedure and the applicable dispute resolution provisions for differences or disputes arising under the policy. While there are no specific regulatory requirements in this regard, it is common for retail policies to give exclusive jurisdiction to the Indian courts and commercial lines policies to contain express arbitration provisions.

General insurance policies are usually annually renewable policies with the entire premium being paid in advance, and it is not common to offer these policies on a long-term basis or to provide for premium payments in instalments. Life insurance policies usually have policy terms of at least 10 years and, unless a single premium is payable in advance, it would usually be payable at regular intervals during the policy terms. All life insurance policies are required to contain express provisions and conditions for reinstatement of the policy in the event of discontinuance of premium payments.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Policyholders have a statutory right to sue for relief under an insurance policy in Indian courts, and Indian law shall be applicable. This right cannot be abridged by the terms of the insurance policy or otherwise.

It is common for retail policies to be subject to the exclusive jurisdiction of Indian courts and for commercial lines policies to contain arbitration clauses.

ii Litigation

An insured can approach a civil court or (if the dispute qualifies) a consumer court. An insurer can only approach a civil court. Both civil and consumer courts have territorial and pecuniary jurisdiction, so actions before them need to be brought keeping in mind the geographical location pertaining to the cause of action or the place where the defendant resides and the value of the claim.

The consumer courts follow a three-tier hierarchy that comprises, in ascending order, the district forums, followed by the state consumer dispute redressal commissions (the state commissions), followed by the National Consumer Dispute Redressal Commission (NCDRC). There are 626 district forums, which can accept claims up to a value of approximately US\$28,570; and there are 36 state commissions, which can accept claims of between approximately US\$28,570 and US\$143,000, and appeals against the decisions of the district forums. At the apex lies the NCDRC, which accepts matters with a value of over US\$143,000 and appeals against the decisions of the state commissions. A decision of the NCDRC on matters with a minimum value of US\$143,000 can be challenged before the Supreme Court (the country's highest court). The Consumer Protection Act 2019 was passed by Parliament on 9 August 2019, which enhances the pecuniary limits to US\$139,898 for the district forums, US\$1,399,110 for the state commissions and above US\$1,399,110 for the NCDRC. However, the Consumer Protection Act 2019 will come into force only once it is notified by the government.

Similarly, the broad ascending hierarchy of the civil courts comprises around 600 district courts, 25 high courts and the Supreme Court, which only hears appeals and cases from the

lower courts that involve breaches of fundamental rights. Four of the 25 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\$279,851 and above. The district courts under them do not hear matters involving values higher than that limit. The remaining district courts have an unlimited pecuniary jurisdiction, and are the competent courts of first instance to hear any insurance dispute falling within their territorial jurisdiction. The Commercial Courts Act has led to the establishment of commercial courts at the district level and commercial division, and commercial appellate division benches within the high courts. These commercial courts are specially assigned to hear insurance and reinsurance matters, among other disputes. The pecuniary jurisdiction of these courts is disputes that have a value of US\$4,211.35 and above. There is no right to a hearing before a jury, and cases are decided by judges.

Unless otherwise expressly provided in law, an appeal lies from every decree passed by a court exercising original jurisdiction to the court authorised to hear appeals from the decisions of such court, unless such decree has been passed with the consent of the parties.

As a general rule, an appeal will lie if there is a substantial question of law involved. Facts established at the lower court are not normally disturbed.

In civil disputes, the usual sequence is that the decision of a district court is appealable before a single judge of a high court. The single judge's decision can be appealed before a division bench of the high court. The final stage of appeal is before the Supreme Court.

The limitation period for filing an appeal ranges from 30 to 90 days depending on the stage of appeal, and delays can be condoned at the court's discretion for sufficient cause shown and reasonable reasons resulting in such delay.

The Code of Civil Procedure 1908 (CPC) governs the method of instituting and trying civil suits. The Commercial Courts Act provides, for the first time, for summary judgment in a suit. Under this Act, plaintiffs can apply for summary judgment in a suit after summons have been served upon a defendant. If the court is convinced that the defendant has no real prospect of succeeding in a claim, it may grant a summary judgment. In other circumstances, the court may pass conditional orders allowing a defendant to defend the suit after payment of a deposit or on such other terms as the court may deem fit.

The CPC allows either party to the action to apply to the court for an order directing the other to make discovery. The court will consider the relevance of the documents requested for the dispute to be determined, and direct the discovery of a particular document or type of document accordingly. The CPC also allows a party to give notice to the other party in whose pleadings or affidavits a reference is made to any document to produce the document for inspection. Non-compliance with a discovery order can lead to the dismissal of the action or defence, as the case may be. The CPC also allows a court to summon any person, even if that person is not a party to the proceedings, and direct him or her to produce any document, material or testimony regarding the dispute, and to do so in person at the court.

Indian courts have held that the position under Indian law relating to privilege is similar to that under English law. In this regard, the Bombay High Court has effectively recognised privilege over documents created in contemplation of litigation. As regards documents prepared in the course of settlement negotiations or attempts, it is common for parties to mark them 'without prejudice', but they are not expressly protected as privileged documents under the Evidence Act, and as a matter of practice are commonly produced before courts.

Courts have the power to require witnesses who are within their jurisdiction to give evidence and to issue an arrest warrant if a witness refuses to comply. A court cannot compel

the attendance of a witness outside its jurisdiction, and thus cannot impose any penal consequences for non-attendance. The CPC allows a court to issue a commission for the examination of a witness outside its jurisdiction and allows it to issue a commission for the examination of a person resident outside India. If the person whose attendance as a witness is deemed necessary by the court is a party to the action and this person fails to attend or give evidence, the court may, in considering the absence of this person, dismiss the plaint or the defence, as the case may be.

Courts may award the successful party its costs, but the award is at the court's discretion. It is common for costs awards to be made in favour of a successful party, but the level of costs awarded is rarely sufficient to cover the actual costs incurred. The Supreme Court has commented that costs awards are too low, and therefore do not serve as a deterrent to discourage vexatious litigation. Referring to a statutory upper limit of US\$41.91 for costs awards in the case of vexatious litigation, the Supreme Court suggested that Parliament should consider raising the limit to US\$1,398. The Commercial Courts Act attempts to rectify the situation, as it amends the CPC to permit courts to grant actual costs to a successful party. In view of the low level of costs awarded, there are, as yet, no material advantages in making a pretrial offer in civil litigation.

In addition, Section 89 of the CPC embraces a provision for the settlement of disputes outside court. All cases that are filed in court need not necessarily be decided by the court itself. Considering the time taken for legal proceedings and the limited number of judges available, it has become imperative to resort to an alternative dispute resolution (ADR) mechanism with a view to end litigation between parties at an early date. The ADR mechanism as contemplated by Section 89 is arbitration, conciliation or judicial settlement, including settlement through a Lok Adalat (a mode of ADR) or mediation. There is usually a mediation cell associated with each court.

iii Arbitration

The ACA is based on the UNCITRAL Model Law. The ACA preserves party autonomy in relation to most aspects of arbitration, such as the freedom to agree upon the qualification, nationality and number of arbitrators (provided this is not an even number), the place of arbitration and the procedure to be followed by the tribunal. The principle of party autonomy has recently been confirmed by the Supreme Court in a number of cases. The decisions restrict the scope of the Indian courts to intervene in respect of those arbitrations where the seat is non-Indian.

The Arbitration and Conciliation (Amendment) Act 2015 (the 2015 Amendment Act) amended the ACA. This 2015 Amendment Act made 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.

On 9 August 2019, the Arbitration and Conciliation (Amendment) Act 2019 (the Amendment Act) came into force, which introduced further changes to the ACA. The Tribunal now has a time frame of six months for the completion of pleadings and 12 months thereafter to conclude the arbitration. This period can be extended by another six months upon the consent of the parties, but any further extensions can only be granted by a court.

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 Alternative dispute resolution

The ACA recognises arbitration and conciliation as valid forms of ADR.

v Mediation

The courts may direct the parties to refer their disputes to ADR with the parties' consent. There are a number of mediation cells associated with the courts. The mediator is either selected by the parties or by the court. The mediator acts as a facilitator to encourage parties to settle their disputes. However, unlike arbitration, the mediation process is not binding on either party. The Commercial Courts Act contemplates compulsory mediation between the parties prior to filing of a suit unless urgent interim relief is sought.

V YEAR IN REVIEW

The Indian insurance sector has witnessed significant changes over the past year. The following regulations have been introduced:

- a* The Foreign Investment Amendment Rules were notified, which increased the limit on FDI in insurance intermediaries from 49 per cent to 100 per cent. The IRDAI also notified the circular on 'Withdrawal of Indian owned and controlled condition for insurance intermediaries' of 19 November 2019, pursuant to which the requirement of complying with 'Indian owned and controlled' was removed for insurance intermediaries.
- b* Pursuant to the Foreign Investment Amendment Rules, the IRDAI (Insurance Intermediaries) (Amendment) Regulations 2019 (the Intermediaries Amendment Regulations) were notified, which amended the existing regulations governing insurance intermediaries in line with the Foreign Investment Amendment Rules. Insurance intermediaries having a majority shareholding of foreign investors are required to submit an undertaking to the IRDAI, stipulating compliance with certain additional conditions, in the prescribed format.
- c* The IRDAI (Non-Linked Insurance Products) Regulations 2019 and the IRDAI (Unit Linked Insurance Products) Regulations 2019 were issued, which superseded the erstwhile regulations governing issuance of linked and non-linked life insurance products in India.
- d* The IRDAI (Regulatory Sandbox) Regulations 2019 and the 'Guidelines on operational issues pertaining to the Regulatory Sandbox' of 22 August 2019 were issued to

facilitate the creation of a regulatory sandbox environment for testing new business models, processes and proposals and applications, to strike a balance between orderly development of the insurance sector by facilitating innovation on the one hand and the protection of policyholders' interests on the other. The IRDAI has recently notified the proposals, which have been accepted under the sandbox.

e The first amendment to the IRDAI (Insurance Brokers) Regulations 2018 was notified, pursuant to which the restriction on a subsidiary company being a promoter in an insurance broker was relaxed.

f The IRDAI (Health Insurance) (Amendment) Regulations 2019 and the IRDAI (Third Party Administrator – Health Services) Regulations 2019 were notified.

g In addition to the above, numerous circulars were issued stipulating the following:

- revised guidelines with respect to group life insurance products;⁷
- norms governing communications made by insurers to policyholders and claimants with respect to servicing of policies and claims;⁸
- norms required to be complied with by all general and stand-alone health insurers, with respect to insurance policies issued towards domestic and overseas travel coverage;⁹
- filing of minor modifications to the approved general and health insurance products¹⁰ and life insurance products;¹¹ and
- standardisation of exclusions in health insurance policies, pursuant to which, inter alia, certain exclusions are prohibited from being incorporated in health insurance policies and insurers are required to use the standardised wordings for the exclusions as stipulated therein.¹²

VI OUTLOOK AND CONCLUSIONS

The Indian insurance industry has seen significant growth and development in recent years. The removal of the requirement to seek approval from the Indian government to increase the foreign investment cap from 26 per cent to 49 per cent in insurers and insurance intermediaries is one of the factors that has led to an increase in the quantum of economic investments in existing Indian players, along with various foreign players exploring options of setting up insurance joint ventures in India. The recent removal of the foreign investment cap for insurance intermediaries is expected to attract more international players into the Indian market. Moreover, there has been a noteworthy increase in the number of players in the reinsurance space, whereby several foreign reinsurers have recently been permitted to set up branches in India. Lloyd's of London has set up a branch office in India under the

7 Circular on 'Group Life Insurance Products and other operational matters' of 26 September 2019.

8 Circular on 'Information to the insurance policyholders/claimants about various insurance policy services' of 10 April 2019.

9 Circular on 'Travel Insurance Products and operational matters' of 27 September 2019.

10 Guidelines on Filing of Minor Modifications in the approved Individual Insurance Products offered by General and Stand Alone Health Insurers on Certification Basis of 20 September 2019.

11 IRDAI's Circular re 'Use and File Procedure for certain modifications under existing products and riders offered by Life Insurers' of 26 July 2019.

12 Guidelines on Standardisation of Exclusions in Health Insurance Contracts of 27 September 2019.

Lloyd's India Regulations. Further, with insurers being permitted to issue products under the 'use-and-file' process, there has been an increase in product development and innovation in India.

However, these significant, and frequent, changes to the regulatory environment have led to a state of flux in the insurance industry. For instance, with the notification of the Foreign Investment Amendment Rules and the Intermediaries Amendment Regulations, 100 per cent FDI has been permitted in the insurance intermediary space. However, the reaction and feedback of the insurance industry remains to be seen with respect to the additional conditions stipulated under the Foreign Investment Amendment Rules and Intermediaries Amendment Regulations, particularly with respect to the conditions stipulating that the majority of key managerial persons and directors of an insurance intermediary having a majority shareholding of foreign investors be Indian residents.

Various regulatory amendments have been made in the past year and further amendments are expected. For instance, a committee set up by the IRDAI, in its final recommendations, suggested revising the existing motor tariff structure in India. In addition, in order to make available a standard health product across the industry, the IRDAI has issued guidelines for standard individual health insurance products. In order to bring into uniformity the wordings of health insurance policies, the IRDAI has issued an Exposure Draft of the 'Guidelines on Standardisation of General Clauses in Health Insurance Policy Contracts' of 10 January 2020, to propose standard general clauses that are commonly incorporated in indemnity-based health insurance policies.

Over the past few years, the Indian jurisdiction has seen a consistent growth in the volume and quantum of financial line claims, particularly in the professional indemnity and directors and officers sector given the dynamic economic and regulatory environment. We are also seeing increasing interest and development in the cyber sector in terms of the wording and the post-claim support being offered by the insurers, given the increasing claim notifications and the attached quantum. We believe the upwards trend is likely to continue in the coming year.

IRELAND

*Sharon Daly, Darren Maher, April McClements and Gráinne Callanan*¹

I INTRODUCTION

The UK's decision to leave the European Union has resulted in a number of financial services firms engaging with the Central Bank of Ireland (the Central Bank) to discuss potential moves and authorisation, ranging from UK firms looking to re-establish themselves in advance of Brexit in a country with guaranteed access to the single market to a number of branches of UK entities in Ireland considering their future corporate structures post-Brexit. The efficiency of Irish domestic regulators, well-established prudential regulation and a young, well-educated English-speaking workforce has cemented Ireland's status as a thriving hub for the insurance industry in the EU.

The moves come as the possibility of a no-deal Brexit arises, despite a 'standstill' transition agreement being struck between the EU and the UK government in March 2018, which was arguably designed to avoid such relocations.

II REGULATION

i The insurance regulator

The Central Bank has responsibility for the authorisation and ongoing supervision of insurance and reinsurance undertakings, insurance intermediaries and captives.

The supervisory role of the Central Bank involves ongoing review and assessment of an undertaking's corporate governance, risk management and internal control systems. The Central Bank's administrative sanctions regime provides it with a credible tool of enforcement and acts as an effective deterrent against breaches of financial services law.

In order to facilitate this supervisory process, insurance and reinsurance undertakings are obliged to submit annual and quarterly returns to the Central Bank in respect of their solvency margins and technical provisions. The Central Bank is also empowered to conduct regular themed inspections across the industry. There are certain requirements that regulated firms under the Central Bank's supervision must comply with on an ongoing basis, including the Corporate Governance Requirements for Insurance Undertakings 2015, the Corporate Governance Requirements for Captive Insurance and Reinsurance Undertakings 2015, the Consumer Protection Code 2012, the Fitness and Probity Standards, the Minimum Competency Regulations 2017 and the Minimum Competency Code 2017.

¹ Sharon Daly, Darren Maher, April McClements and Gráinne Callanan are partners at Matheson. The information in this chapter was accurate as at April 2019.

ii Requirements for authorisation

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

As to the process applied by the Central Bank when reviewing a licence application made pursuant to European Union (Insurance and Reinsurance) Regulations 2015 (the Irish Regulations), which transposed the EU Directive 2009/138/EC (Solvency II) into Irish law, the applicant first has a preliminary meeting with the Authorisations Team of the Central Bank. Thereafter, the application proceeds through the submission of a detailed application and business plan to the Central Bank.

Broadly, subject to the applicant satisfying the requirements of the Central Bank in respect of minimum capital requirements and any additional preconditions or undertakings specified in the letter of authorisation in principle issued by the Central Bank, the applicant will be issued with a formal final certificate of authorisation.

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

The ongoing regulatory requirements of regulated firms under the Central Bank's supervision include, where applicable:

- a* ensuring it retains authorisation from the Central Bank;
- b* maintaining technical reserves and required solvency margin;
- c* submitting quarterly and annual returns in respect of minimum capital requirements;
- d* ensuring compliance with the relevant corporate governance codes and guidance, as published by the Central Bank;
- e* ensuring compliance with the general good requirements contained in the Consumer Protection Code (in the case of Irish resident undertakings); and
- f* ensuring compliance by all directors, executives and staff with the fitness and probity regime.

iii Regulation of individuals employed by insurers

As part of an application for authorisation, the Central Bank reviews both the proposed corporate governance structures and the individuals who are to be appointed to key roles within the insurance and reinsurance undertaking. This is to ensure that the undertaking has the necessary people, skills, processes and structures to successfully manage its insurance and reinsurance business.

All proposed directors and senior management will have to apply to the Central Bank for prior approval to act as part of the Central Bank's Fitness and Probity regime. Forty-six senior positions are prescribed as pre-approval controlled functions (PCFs), including the positions of director, head of finance and head of compliance. PCFs are a subset of Controlled Functions (CFs) – in other words PCFs are by definition also CFs.

Unlike CFs, the prior approval of the Central Bank is required before an individual can be appointed to a PCF, to ensure that a person performing a PCF has a level of fitness and probity appropriate to the performance of that particular function. The individual must complete an online individual questionnaire that is endorsed by the proposing entity and then submitted electronically to the Central Bank for assessment.

The main implication of being appointed to a PCF role is that a person must comply on an ongoing basis with the Fitness and Probity Standards introduced by the Central Bank Reform Act 2010 and confirm this in writing to the Central Bank.

Where a person comes within the Minimum Competency Framework (as defined in subsection vi), qualifications may be necessary but generally no set exams are mandatory. The Central Bank is required to set out a specification for each PCF role that might include a qualification (see Appendix 4 of the Minimum Competency Code 2017), and the PCF holder must meet that specification.

iv The distribution of products

Once an insurance and reinsurance undertaking holds the relevant authorisation, it is entitled to market and sell both its services and contracts in Ireland. However, the manner in which insurance and reinsurance contracts can be marketed and sold to the consumer is subject to a number of general good requirements contained in the Consumer Protection Code 2012 (published by the Central Bank); Consumer Protection Act 2007; Sale of Goods and Supply of Services Act 1980; European Communities (Unfair Terms in Consumer Contracts) Regulations 1995; and the European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004.

v Taxation of premiums

Non-life insurance companies

Non-life insurance business carried on by a company is taxed at the standard rate of 12.5 per cent corporation tax. While profits liable to taxation are generally recognised in accordance with relevant accounting treatment, particular accounting treatment applies to certain aspects of the insurance business such as: the realisation of non-financial investment assets; treatment of equalisation or catastrophe reserves; and taxation of captive insurers (which is similar to the treatment of non-captives).

Life assurance companies

There is a divergence in the tax treatment of life assurance companies, depending on whether its life assurance business was contracted before or after 1 January 2001. Business contracted prior to 1 January 2001 is taxed on investment return as apportioned between policyholders and shareholders, with the policyholder's share taxed at 20 per cent on an annual basis and the shareholder's share taxed at 12.5 per cent corporation tax rate. Conversely, for business contracted after 1 January 2001, income and gains within the fund are not liable to tax for the term of the policy. Exit taxes arise on payments made to certain classes of Irish policyholders. The exit tax rates applicable are 25 per cent where the policyholder is a company and opts to make an election or 41 per cent in all other cases. Policyholders that are not resident in Ireland and can provide a declaration to that effect are exempt from paying tax in Ireland. The insurer's income from business contracted after 1 January 2001 is liable to tax at the standard corporation tax rate of 12.5 per cent.

Reinsurance companies

Reinsurance business is taxed in the same manner as non-life insurance businesses at the standard 12.5 per cent corporation tax rate. The distinction between business contracted before or after 1 January 2001 in respect of life assurance businesses does not apply to

reinsurance companies. However, it is possible to establish SPRVs on a tax-neutral basis, provided they qualify under Section 110 of the Taxes Consolidation Act 1997. SPRVs are liable to tax at 25 per cent; however, this is charged on the company's net taxable profit, which, by virtue of specific tax-deductible expenditure, can be maintained at a very low level.

vi Changes to the regulatory system

The Financial Services and Pensions Ombudsman Act 2017 (the 2018 Act) came into force on 1 January 2018. The 2018 Act amalgamates the Financial Services Ombudsman and the Pensions Authority into the Office of the Financial Services and Pensions Ombudsman (FSPO). The 2018 Act strengthens the functions of the FSPO and extends the limitation period for bringing complaints to the FSPO.

The limitation period for consumer complaints in respect of long-term financial services has been extended from six years to: (1) six years from the date of the conduct giving rise to the complaint; (2) three years from the date on which the person making the complaint first became aware or ought to have become aware of that act or conduct; or (3) a longer period, as may be permitted by the FSPO.

Significantly, the 2018 Act applies retrospectively although it is limited to conduct complained of after 2002. Therefore, the FSPO can investigate conduct complained of before the enactment of the 2018 Act owing to the extended limitation period, in circumstances where such complaints would have been previously refused as a result of being statute barred. However, the service to which the complaint relates must also not have expired or have been terminated more than six years before the date of the relevant complaint.

On 24 January 2019, the FSPO published 228 legally binding decisions from 2018. The FSPO stated that the aim in publishing the decisions was to enhance transparency of its powers and services. It can now award compensation of up to €500,000. It can also direct a regulated provider to rectify the conduct that is the subject of a complaint, and there is no limit on the value of the rectification that can be directed. The vast majority of complaints are successfully resolved at mediation.

The EU (Non-Financial and Diversity Information Disclosure) Regulations 2017 (the 2017 Regulations) came into operation on 21 August 2017 and apply in respect of all financial years commencing on or after 1 August 2017. The 2017 Regulations introduce two distinct obligations based on different qualifying criteria: non-financial reporting and diversity reporting. It is possible for a company to fall within the scope of both reporting regimes. The 2017 Regulations apply to companies that:

- a* qualify as a large company under Section 280H of the Companies Act 2014 (the Act);
- b* have an average number of employees that exceeds 500; and
- c* is an ineligible entity under the Act, meaning an undertaking that:
 - has transferable securities admitted to trading on a regulated market of any Member State;
 - is a credit institution; and
 - is an insurance undertaking, or is another type of undertaking specified in the Act, for example, an investment company.

The non-financial statement should contain information relating to environmental matters, social and employee matters, respect for human rights, and bribery and corruption matters, to the extent necessary for an understanding of the development, performance, position

and impact of the company's activity relating to these matters. A brief description of the company's business model, policies and an analysis of the non-financial key performance indicators relevant to the particular business should also be included.

The 2017 Regulations were amended, with effect from 17 October 2018, by the European Union (Disclosure of Non-Financial and Diversity Information by certain large undertakings and groups) (Amendment) Regulations 2018 (the 2018 Regulations). Most of the amendments introduced are technical in nature, designed to clarify perceived ambiguities in the drafting of the 2017 Regulations. There is now a requirement for non-financial information to be included in the director's report (in the Company's audited financial statements), or, in certain circumstances, in a separate statement.

As mentioned in subsection iii, the Minimum Competency Code 2017 and the Central Bank (Supervision and Enforcement) Act 2013 (Section 48(1) of the Minimum Competency Regulations 2017 (the Minimum Competency Regulations 2017)) replaced the existing Minimum Competency Code 2011 with effect from 3 January 2018. The Minimum Competency Code 2017 and the Minimum Competency Regulations 2017 form the Minimum Competency Framework.

The Minimum Competency Framework has been introduced to incorporate the implementation of the Insurance Distribution Directive (IDD), the Markets in Financial Instruments Directive II, the associated European Securities and Markets Authority Guidelines, and the European (Consumer Mortgages Credit Agreements) Regulations 2016.

The Minimum Competency Framework sets out certain minimum professional standards for persons providing financial services, in particular, persons exercising a controlled function on a professional basis. The revised framework aims to ensure that consumers obtain a minimum acceptable level of competence from staff acting for and on behalf of regulated firms in providing advice and information and associated activities in connection with retail financial products. The main changes under the revised Minimum Competency Framework relate to the qualification and experience requirements of the staff of financial services providers. All staff carrying out a relevant function must now:

- a* have a recognised qualification (as defined in the Minimum Competency Code 2017);
- b* comply with the grandfathering provisions; or
- c* comply with the new entrants' provisions, which includes participating in a training process.

Staff are also required to complete annual continuing professional development training, and regulated firms are required to maintain written records of this training and review their staff's development and experience needs. Additional standards must be complied with where staff exercise a controlled function involving:

- a* MiFID services and activities;
- b* mortgage credit;
- c* insurance and reinsurance undertakings and insurance intermediaries; and
- d* design of retail financial products.

Regulated firms are now required to conduct an annual review of their staff's development and experience needs. The Minimum Competency Code 2017 requires regulated firms to provide a certificate of such qualifications, if requested to do so by a consumer.

The EU Regulation on Packaged Retail and Insurance-Based Investment Products (PRIIPs) (the PRIIPs Regulation),² supplemented by the PRIIPs Regulatory Technical Standards 2017 (RTS),³ came into effect on 1 January 2018. The PRIIPs Regulation is a key piece of legislation, which aims to enable retail investors to understand and compare the key features and the potential risks and rewards of investment products, funds and investment-linked insurance policies.

PRIIPs introduce the obligation to provide a key information document (KID), which is a pre-contractual fact sheet that will inform retail investors of the main features, risks, reward profile and costs associated with a product in a clear and accessible manner. The form and content of the KID is standardised by the RTS in order to facilitate the comparison of similar products and coordinate disclosure requirements across the European insurance market. The wide definition of PRIIPs under the PRIIPs Regulation means that all manufacturers and financial intermediaries that distribute PRIIPs to retail investors fall within its scope. However, certain products, including non-life insurance products and pension products, are specifically excluded from its application and entities subject to the Undertakings for Collective Investment in Transferable Securities are not obliged to comply with PRIIPs until 1 January 2020.

Data protection is governed by the Data Protection Acts 1988 to 2018 (DPA), as amended from time to time, and the General Data Protection Regulation (GDPR),⁴ which came into force on 25 May 2018 (together with other EU Regulations, Directives, Decisions and Guidelines on data protection and data privacy, and guidance issued by the Irish Data Protection Commission (DPC) and the European Data Protection Board).

The GDPR is directly effective in Ireland, meaning that the Irish parliament did not have to implement national legislation for the GDPR to become law. However, the GDPR allows EU Member States to introduce national law derogating from some of its provisions and this has been done in Ireland through the DPA. It introduces a number of derogations, including an exemption, subject to suitable safeguards for data subject rights, to the general prohibition on the processing of data concerning health where the processing is necessary and proportionate for insurance and pension purposes.

Many of the principles relating to the processing of personal data under the GDPR are broadly the same as those set out under the EU Data Protection Directive⁵ (which was repealed by the GDPR). However, the GDPR enhances the EU data protection framework in a number of ways, including enhancing data subject rights and transparency, greater penalties for breach, and extraterritorial effect in certain circumstances. It also introduced the principle of accountability pursuant to which controllers and processors must be able to demonstrate compliance with their respective obligations under the GDPR.

With regard to enforcement of data protection laws, the DPA introduces enhanced powers for the DPC, and the government has significantly increased the DPC's budget in recent years. The DPC has indicated that it will continue to proactively undertake initiatives to build awareness of the GDPR, and has increased its staff numbers accordingly. These

2 No. 1286/2014.

3 Delegated Regulation 2017/653.

4 Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016.

5 Directive 95/46/EU.

developments reflect a commitment to enforcing compliance with the GDPR, and suggest that the DPC will be in a strong position to take action against controllers and processors that breach the rights of individuals under the GDPR.

vii Capital requirements

Insurance undertakings regulated by the Central Bank are required to meet the capital and solvency requirements set out under Solvency II and the Irish Regulations.

Irish-authorised insurance undertakings are required to establish and maintain technical provisions in respect of all insurance and reinsurance obligations towards policyholders and beneficiaries of insurance and reinsurance contracts. The value of technical provisions must correspond to the current amount an undertaking would have to pay if it were to transfer its insurance and reinsurance obligations immediately to another insurance undertaking. The Irish Regulations set out detailed provisions for the calculation of technical provisions.⁶

In accordance with Solvency II, Irish-authorised insurance undertakings are also required to establish and maintain a further solvency margin as a buffer, to ensure their assets are sufficient to cover their liabilities. The Solvency II capital requirements are calculated based on the specific risks borne by the relevant insurer and are prospective in nature (i.e., each insurer must make the relevant calculations at least once a year to cover both existing business and the new business expected to be written over the following 12 months). Solvency II imposes a solvency capital requirement (SCR) and a lower minimum capital requirement (MCR).

An insurance undertaking may calculate the SCR based on the formula set out in the Irish Regulations or by using its own internal model approved by the Central Bank. The SCR should amount to a high level of eligible own funds, thereby enabling the undertaking to withstand significant losses and ensuring a prudent level of protection for policyholders and beneficiaries. The MCR should be calculated in a clear and simple manner, corresponding to an amount of eligible, basic own funds, below which policyholders and beneficiaries would be exposed to an unacceptable level of risk if the undertaking was allowed to continue its operations.

An insurance undertaking must have procedures in place to identify and inform the Central Bank immediately of any deteriorating financial conditions. As such, the SCR and MCR provide for clear channels by which the Central Bank can monitor the financial state of insurance undertakings. In the event of a breach of the capital requirements, the Central Bank will employ an escalating ladder of supervisory intervention, allowing for the implementation of a recovery plan by an insurance undertaking, as approved by the Central Bank. Where there is a breach of the SCR or MCR, compliance must be re-established within six months or three months respectively, otherwise the Central Bank may restrict the free disposal of the assets of the undertaking and ultimately withdraw its authorisation.

6 Regulations 83–101, Irish Regulations.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Statute

In general terms, insurers retain significant freedom of contract; however, this has been tempered in recent years by legislation enacted to comply with EU law in the area of consumer protection including the Unfair Terms in Consumer Contracts Directive 1993/13/EC and the Distance Marketing of Financial Services Directive 2002/65/EC.

In circumstances where the insured is a consumer, the insurer must also comply with the Consumer Protection Code 2012 and Consumer Protection Act 2007. The Sale of Goods and Supply of Services Act 1980 is also applicable to insurance contracts.

With the exception of the transposition of EU legislation, there have been very few substantive legislative amendments to the law in this area in recent years. The Marine Insurance Act 1906 remains the most recent codification of general principles of insurance law.

The Law Reform Commission (LRC) has, however, recommended reforms to consumer insurance law and published a draft bill in July 2015. The LRC recommendations were largely incorporated into the Consumer Insurance Contracts Bill 2017 (the 2017 Bill), which was referred to the Select Committee on Finance, Public Expenditure and Reform, and Taoiseach in February 2017. The 2017 Bill is at the third stage before the Dáil, however, there is no clear timeline for implementation.

The definition of a consumer in the 2017 Bill is quite broad and includes individuals and small businesses with a turnover of less than €3 million (provided that these persons are not a member of a group having a combined turnover greater than €3 million). This is the definition used for the purpose of complaints to the FSPO and under the Central Bank's Consumer Protection Code 2012.

The European Union (Insurance Distribution) Regulations 2018 (as amended) (IDR) transposed the IDD into Irish law with effect from 1 October 2018. The IDD creates a minimum legislative framework for the distribution of insurance and reinsurance products within the European Union, and aims to facilitate market integration and enhance consumer protection.

The IDR introduces general consumer protection principles for all insurance distributors to act honestly, fairly and professionally, and in accordance with the best interests of the customer. Insurance distributors may not incentivise or remunerate their employees in a manner that would conflict with their duty to act in the customers' best interests. In addition, insurance intermediaries are required to disclose the nature of any remuneration received in relation to an insurance contract to the customer.

Insurance undertakings and intermediaries that manufacture any insurance product for sale to customers are required to implement product oversight and governance procedures prior to distributing or marketing an insurance product to customers. A target market must be identified for each product to ensure that the relevant risks to that target market are identified, assessed and regularly reviewed.

Common law

The law in relation to insurance contracts in Ireland is primarily governed by common law principles, the origins of which can be found in case law.

ii Making the contract

Essential ingredients of an insurance contract

Insurance contracts are governed by the general principles of contract law, common law and the principle of good faith. There are no specific rules for the formation of an insurance contract beyond these general duties. There is no statutory definition of a contract of insurance under Irish law, and the legislation does not specify the essential legal elements of an insurance contract. As a result, the courts have considered it on a case-by-case basis.

The common law definition of an insurance contract is of persuasive authority.⁷ 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*,⁸ and are as follows:

- a generally, the insured must have an insurable interest in the subject matter of the insurance policy;
- b payment of a premium;
- c the insurer undertakes to pay the insured party in the event of the happening of the insured risk;
- d the risk must be clearly specified;
- e the insurer will indemnify the insured against any actual loss (indemnification); and
- f the principle of subrogation is applied, where appropriate. This is generally not appropriate in relation to life assurance or personal injury policies.

There is no difference between an insurance contract and a reinsurance contract.

In the context of consumer policies, the 2017 Bill proposes to reform the area of insurable interests. Section 5 of that Bill provides that an insurer cannot reject an otherwise valid insurance contract on the basis that the insured does not or did not have an insurable interest. Where the contract of insurance is also a contract of indemnity, the insured must have an interest, however, it does not need to extend past a factual expectation of an economic benefit from preserving the subject matter or loss on its destruction damage or loss. In addition, an insurer may not refuse liability under a contract on the basis that the name of the person who may benefit is not specified in the policy.

An insurance policy will usually comprise a proposal form, policy terms and conditions, and supporting documentation provided to the insurer by the insured. The policy will typically contain express terms defining the cover being provided, exclusions to cover, excess, conditions or conditions precedent and warranties.

Information provided to the insurer at placement

The information provided to the insurer at placement depends on the risk and the requirements of the insurer in question; however, there has been a trend towards very short proposal forms that do not request detailed information about the risk. It was anticipated this would change in line with the changes in the UK driven by the Insurance Act 2015; however, it remains to be seen whether there will in fact be a significant change in Ireland.

7 *Prudential Assurance v. Inland Revenue* [1904] 2 KB 658.

8 [1991] ILRM 726.

Utmost good faith, disclosure and representations

Parties to contracts of insurance are subject to the duty of utmost good faith. As a result, the insured or proposer has a duty prior to renewal or inception to disclose all material facts. The remedy for breach of the duty is avoidance.

A material fact is one that would influence the judgement of a prudent underwriter in deciding whether to underwrite the contract; and, if so, the terms (such as the premium) on which it might do so.

The duty goes beyond a duty to answer questions on a proposal form correctly; however, the courts have confirmed that the questions posed on the proposal form will inform the duty. There is no requirement to show inducement under Irish law.

Misrepresentation is closely related to non-disclosure and attracts the same remedy. To rely on misrepresentation, the insurer must establish that there has been a representation of fact made by the insured that is untrue. Misrepresentations can be fraudulent, reckless or innocent. The common law position is that a misrepresentation is fraudulent if made with knowledge of its falsity or without belief that it was true or with reckless disregard as to whether it was true or false.

In practice, many insurance policies contain 'innocent non-disclosure' clauses that prevent the insurer from avoiding the policy for an innocent non-disclosure or misrepresentation.

In respect of consumer insurance only, the 2017 Bill proposes to replace the duty of disclosure with a duty to answer specific questions honestly and with reasonable care. The questions posed by the insurer should identify the material risk and the relevant information actually to be relied upon by the insurer. There is no duty to provide additional information on renewal unless specifically requested by the insurer. The 2017 Bill also proposes that in cases of innocent or negligent non-disclosure and misrepresentation, the principal remedy should be to adjust the payment of the claim taking account of the carelessness of the insured and whether the breach in question affected the risk. The 2017 Bill retains avoidance as a remedy for fraudulent breaches on public policy grounds.

Recording the contract

Insurance contracts are generally required to be evidenced by a written policy. There are various legislative provisions that impose mandatory requirements concerning the form and content of insurance contracts, some of which are derived from EU law. The 2017 Bill proposes to consolidate the essential requirements concerning the form of consumer insurance contracts in a single general legislative framework.

iii Interpreting the contract

General rules of interpretation

Insurance contracts are subject to the same general principles of interpretation as other contracts. The Supreme Court has confirmed in two judgments, *Analog Devices v. Zurich Insurance and ors* and *Emo Oil v. Sun Alliance and London Insurance Company*, that the principles of construction as set out by Lord Hoffman in *ICS v. West Bromwich Building Society* should be applied to the interpretation of insurance contracts.

In summary, interpretation is the ascertainment of the meaning that the document would convey to a reasonable person having all the background knowledge that would reasonably have been available to the parties in the situation in which they were at the time of

the contract. The background or ‘matrix of fact’ should have been reasonably available to the parties and includes anything that would have affected the way in which the language of the document would have been understood by a reasonable person. The previous negotiations of the parties and their declarations of subjective intent are excluded from the admissible background. The meaning that a document (or any other utterance) would convey to a reasonable person is not the same thing as the meaning of its words. The meaning of the document is what the parties using those words against the relevant background would reasonably have been understood to mean. The ‘rule’ that words should be given their ‘natural and ordinary meaning’ reflects the common-sense proposition that it is not easy to accept that people have made linguistic mistakes, particularly in formal documents. However, if it could nevertheless be concluded from the background that something must have gone wrong with the language, the law does not require judges to attribute to the parties an intention that they plainly could not have had.

The court will apply an objective approach to determine what would have been the intention of a reasonable person in the position of the parties.

Where a contractual term is ambiguous, the interpretation less favourable to the drafter is adopted using the *contra proferentem* rule.

Incorporation of terms

In general, there are no mandatory provisions that are implied by the law or regulation in insurance policies, although the following exist:

- a* implied restrictions contained in motor insurance policies;
- b* provisions in the Criminal Justice (Drug Trafficking) Act 1996 concerning minimum disclosure requirements; and
- c* professions whose professional bodies set professional indemnity insurance requirements. For example, practising solicitors, accountants and architects are required to have appropriate professional indemnity cover.

The all-important element in the declaration usually contained in a proposal form is the phrase that makes the declaration the ‘basis of the contract’. In making the proposal the basis of the contract, the proposer warrants the truth of his or her statements and, in the event of a breach of the warranty, the insurer can repudiate liability under the policy without reference to issues of materiality. However, basis of the contract clauses are considered to be very draconian by the courts and there is a judicial reluctance to enforce these clauses. The 2017 Bill proposes to abolish basis of the contract clauses in consumer insurance policies.

Types of terms in insurance contracts

Typically, insurers in the Irish insurance market have standard policy conditions for each product that have developed over time. These policy conditions are influenced by industry norms as well as Irish judicial decisions in cases involving contractual clauses. Further, most Irish insurers and reinsurers underwriting international business are familiar with London market terms (International Underwriting Association and Lloyd’s Market Association).

A policy will typically include express terms defining:

- a* coverage: the extent of the insurer’s potential liability to the insured;
- b* exclusions: matters expressly excluded from cover;
- c* excess: the initial amount of any loss that the insured must bear themselves;
- d* conditions precedent to cover, for example notification provisions; and

- e* warranties: statements of fact or continuing intention by the insured in relation to the risk underwritten, such as a warranty that certain precautions will be taken in respect of particular activities.

Warranties are construed very strictly by the courts in circumstances where the breach discharges the insurer from liability from the date of breach (irrespective of whether the breach is material to the loss) and they are thus considered to be draconian. The 2017 Bill proposes to abolish warranties in consumer insurance contracts and replace these with suspensive conditions.

Almost all insurance policies list terms of the contract as conditions. The effect of a breach of condition in an insurance policy depends on whether that condition is a condition precedent to liability. Breach of a condition precedent entitles the insurer to decline cover for a claim in the event of a breach without the necessity to demonstrate that the insurer has suffered any prejudice. The remedy for breach of a bare condition is in damages. The courts will not construe an insurance condition as a condition precedent unless it is expressed as a condition precedent, or the policy contains a general condition precedent provision.

'Follow the fortunes' and 'follow the settlements' clauses are common in reinsurance agreements.

iv Intermediaries and the role of the broker

Conduct rules

In order to undertake insurance and reinsurance distribution activities in Ireland, a person must be registered as an insurance and reinsurance intermediary pursuant to the IDR.

The IDR removed 'insurance policies' from the definition of investment instruments within the Investment Intermediaries Act 1995 (IIA), which means that certain intermediaries who were previously required to be registered under both the IIA and the IDR are now no longer required to be authorised under the IIA as well and have contacted the Central Bank to revoke their IIA registration.

Insurance and reinsurance distribution involves work undertaken in connection with entering into contracts of insurance and reinsurance, work undertaken prior to entering into such contracts, introducing persons to insurance and reinsurance undertakings or other insurance and reinsurance intermediaries with a view to entering into such contracts, or assisting in the administration and performance of such contracts (including loss assessing and dealing with claims under insurance contracts).

In fulfilling its statutory role, the Central Bank operates a robust authorisation process that requires applicants to demonstrate compliance with the authorisation standards set out in the legislation described above. Before the Central Bank will authorise an insurance or reinsurance mediator and enter it into the register, the applicant must satisfy the Central Bank that:

- a* the directors satisfy the Minimum Competency Framework as published by the Central Bank;
- b* the undertaking holds certain minimum levels of professional indemnity insurance;
- c* senior management and key personnel possess the requisite knowledge and ability; and
- d* the undertaking will implement internal procedures for the proper operation and maintenance of client premium accounts.

Agency and contracting

The general law on agency applies equally to insurance intermediaries in Ireland. An insurance intermediary means a person who, for remuneration, undertakes or purports to undertake insurance distribution. As discussed previously, any person carrying on insurance distribution activities in Ireland is required to comply with the requirements of the IDR.

The wide definition of insurance distribution under the IDR captures the activity of nearly all insurance agents who assist a customer in entering into an insurance contract with an insurance undertaking or provide services which are complimentary to an insurance product subject to specific exemptions.

An insurance intermediary can at different times act as agent of either client or the insurer.

Generally speaking, an agent is one who is authorised by a principal to enter into binding contractual relationship with a third party. For example, an insurance intermediary may only handle premium rebates due to consumers where there is an express agreement to act as the agent of the relevant insurance undertaking.

An agent's authority to act on behalf of the principal may be actual or apparent. Actual authority may be expressed or implied and is most commonly expressed in an agreement. Apparent or implied authority exists where the principal's actions or words would lead a reasonable person to believe that the agent was authorised to act.

An agent's duties are typically to the principal alone although this may not always be the case in an insurance context and depends on the nature of the party undertaking the activity. An insurance agent will be deemed to be acting as the agent of the insurer when he or she completes, or assists the proposer to complete, a proposal for insurance with the insurer (from whom the agent holds an appointment). In these circumstances, the insurer is responsible for any error or omission in the completion of the proposal. Similarly, an insurer will be responsible for any act of its tied agent with regard to a contract of insurance offered or issued by that insurer. An independent insurance intermediary may act on behalf of both their client and the insurer (eg, although acting for client, it will be the agent of the insurer when collecting premium).

The agent is entitled to remuneration from the principal as well as an indemnity from the principal for any expenses or losses incurred in action for the principal.

There are numerous types of insurance intermediaries in insurance law. For example, an insurance broker typically works independently from insurance companies when advising customers on the range of insurance products available on the market. Insurance brokers guide clients in selecting the most appropriate insurance product for their needs by obtaining quotes from a number of insurance companies and assessing the suitability of the various products for the individual customer. There is no defined number of insurance companies that the broker must review as part of its fair analysis of the market. In practice, it will be reviewed on a case-by-case basis and will depend on many factors such as the number of providers offering insurance products in that market.

On the other hand, a multi-tied insurance intermediary is an intermediary that has a limited number of exclusive arrangements in place with a small number of insurance undertakings, whereas a tied insurance intermediary is an intermediary that has an exclusive arrangement in place with the insurer.

Outsourcing is permitted provided that the insurance intermediary otherwise has an appropriate level of substance, such as a full-time Irish resident senior management team.

Generally, any functions of an insurance intermediary may be outsourced intra-group or to a third party provided that appropriate oversight and control is retained by an Irish registered intermediary.

Any outsourcing must not: (1) materially impair the insurance intermediary's system of governance; (2) cause an undue increase in operational risk; (3) impair the supervisory monitoring of compliance with obligations; or (4) undermine the continuous and satisfactory service to policyholders.

How brokers operate in practice

Intermediaries act as agents on behalf of insurance undertakings and are typically appointed by an insurance undertaking under the terms of a distribution agreement or claims administration agreement. An intermediary must be registered with the Central Bank as an authorised insurance intermediary (in accordance with the legislative provisions referenced above) before being permitted to advise consumers on insurance products and carry out other specified activities on behalf of insurance companies (e.g., loss-assessing and claims administration). Important requirements for registered intermediaries in Ireland include:

- a* ensuring the proper maintenance and reconciliation of designated client premium accounts;
- b* ensuring that the undertaking has sufficient professional indemnity insurance cover; and
- c* ensuring that senior management are sufficiently experienced to manage the business and to carry on activities on the intermediary's behalf.

v Claims

Notification

Notice requirements will vary depending on whether the policy in question is claims-made or losses-occurring. Claims-made policies typically require insurers to be notified of circumstances that may give rise to a claim within a short period of the insured becoming aware of the circumstances, and usually the policy will require notification of the circumstances and claims as soon as reasonably practicable. Some policies will specify time limits for notification.

Where the notice requirements are stated to be a condition precedent to cover, the insurer will be entitled to decline cover for a breach of these requirements without needing to establish that it has suffered prejudice as a result of the breach. If the notice requirement is not stated to be a condition precedent and is a bare condition, the only remedy available to an insurer for breach of a condition is damages.

The courts are reluctant to allow insurers to decline claims on the basis of a technical breach of notice conditions, particularly where that breach is failure to notify a circumstance. The test applied by the courts is objective, however the court will consider whether the insured had actual knowledge of the circumstance that allegedly should have been notified to the insurers. The knowledge of the insured is a subjective test.

Good faith and claims

While much of the case law regarding the duty of good faith is focused on the pre-contractual duty, the duty continues post-contract and is a mutual duty. There is, however, no common law duty on the insured to disclose changes in the risk insured during the policy period (although the contract may contain a requirement to this effect).

Once a contract of insurance has been concluded, the relationship between insurer and insured is predominantly governed by the terms of the policy and typically the policy will impose obligations on the insured in relation to matters such as payment of premium, notification of claims and claims cooperation.

The consequence of making a fraudulent claim is avoidance and the policyholder also forfeits the premium paid under the insurance contract.

As noted above, the duty of good faith is mutual in nature; however, in practice breach of the duty by the insurer is rarely ever pursued because the only remedy for breach of the duty of good faith is avoidance of the contract. There are no statutory rules that relate to the time in which a claim should be settled by an insurer, although provisions on claims settlement are included in the Central Bank's Consumer Protection Code 2012. In addition, the 2017 Bill proposes that, in the case of consumer insurance contracts, the insurer should be under a duty to handle claims promptly and fairly, and the insured should be entitled to damages where an insurer unreasonably withholds or delays payment of a valid claim.

Set-off and funding

As per Regulation 20 of the European Communities (Reorganisation and Winding-up of Insurance Undertakings) Regulations 2003, the right of creditors to demand set-off of their claims against the claims of the insurance undertaking where set-off is permitted by the law applicable to the insurance undertaking's claim is not affected by winding-up proceedings against the insurance undertaking. However, a creditor must be in a position to demonstrate mutuality of claims between the parties in order to be able to rely on statutory set-off.

Reinstatement

The principle of indemnity has, to an extent, been eroded by insurers offering policies on a 'new for old' or 'reinstatement as new' basis, without any deduction for betterment or wear and tear, particularly in the areas of property damage and motor insurance.

A policy written on a reinstatement as new basis is subject to the principle of indemnity in that the insured cannot recover more than his or her loss. The sum insured in the policy is the maximum sum payable by insurers, but not necessarily the amount paid. If the work of reinstatement is not carried out, or is not carried out as quickly as is reasonably practicable, the insurer is only liable to pay the value of the property at the time of the loss.

Dispute resolution clauses

Insurance policies often contain a dispute resolution clause enabling either party to refer a contractual dispute to a particular dispute resolution forum before proceeding to litigation. Arbitration clauses are the most common in this regard; however, mediation has developed into a common form of dispute resolution.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Any dispute arising under an insurance or reinsurance contract that contains an arbitration clause must be referred to arbitration. If court proceedings are brought and there is an arbitration agreement, the proceedings may be stayed in favour of arbitration. In circumstances where there is no arbitration clause in the contract, subject to the terms of the contract, the dispute will be brought before the Irish courts.

Mediation is also a common form of dispute resolution in Ireland, and since the introduction of the Mediation Act 2017 on 1 January 2018 solicitors are required to advise their clients on the merits of mediation as an alternative dispute resolution (ADR) mechanism prior to issuing court proceedings. In addition, to issue proceedings, the Mediation Act requires the solicitor to swear a statutory declaration confirming that such advice has been provided and this declaration must be filed with the originating document in the relevant court office.

Choice of forum, venue and applicable law clauses in insurance and reinsurance contracts are generally recognised and enforced by the courts in Ireland. However, where the insured is domiciled in an EU Member State, the following European regulations may limit the application of these provisions in insurance contracts:

- a* Regulation (EC) 44/2001 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (Brussels I Regulation);
- b* Regulation (EU) 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (Recast Brussels Regulation), which replaces the Brussels I Regulation in respect of proceedings and judgments in proceedings commenced after 10 January 2015;
- c* Regulation (EC) 593/2008 on the law applicable to contractual obligations (Rome I Regulation); and
- d* Lugano Convention (L339, 21/12.2007) on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

ii Litigation

Litigation stages

The jurisdiction in which proceedings are brought depends on the monetary value of the claim: the District Court deals with claims up to a value of €15,000 and the Circuit Court deals with claims up to a value of €75,000 (€60,000 for personal injuries cases).

Claims with a value in excess of the Circuit Court jurisdiction are heard by the High Court, which has an unlimited monetary jurisdiction.

The Commercial Court is a division of the High Court that deals exclusively with commercial disputes. The Court retains the discretion to refuse admission to the commercial list, for example where there is delay. Proceedings are case-managed and tend to move at a much quicker pace than general High Court cases. Insurance and reinsurance disputes may be heard in the Commercial Court if the value of the claim or counterclaim exceeds €1 million; and the Court considers that the dispute is inherently commercial in nature.

Insurance disputes before the courts are heard by a judge sitting alone and not a jury.

A Court of Appeal was established in 2014 to deal with appeals from the High Court. The Court of Appeal hears appeals from the High Court except when the Supreme Court believes a case is of such public importance that it should go directly to the highest court in the state.

Evidence

Except in the most limited circumstances evidence is to be given orally. Where the attendance of a witness is required at the trial of an action, the lawyer for either party can issue a witness summons on an individual resident in Ireland. If the person required to give evidence is out of the jurisdiction, it is not possible to require attendance through service of a summons. In such circumstances, it is possible to apply to take evidence on commission, or use letters rogatory, or in some cases, where the witness is in the United States, rely on a procedure under Title 28 of the United States Code 1782 to compel a witness in the US to give evidence or produce documents in proceedings before the Irish courts.

Where a party intends to rely on the oral evidence of a fact or expert witness at trial, a witness statements or expert reports must be served on the other party at least 30 days before the trial of the action.

Costs

The general rule is that costs follow the event (i.e., the loser pays). However, there is a growing body of case law, mainly emanating from the Commercial Court, that suggests that if the litigation is complex, the court should engage in a more detailed analysis and should not just award full costs to the winning side if the plaintiff has not succeeded in all claims.

Where the parties cannot agree on the costs incurred during the proceedings, the matter will be referred to taxation, where the taxing master will review the bill of costs and decide on the appropriate figure to be awarded to a party for its costs. The successful party will normally recover approximately 60 per cent of its recoverable costs known as party and party costs. These will usually be approximately 50 per cent to 75 per cent of the total costs incurred by the party in the litigation.

There are a number of tools that a defendant can use to put the plaintiff 'on risk for costs' including lodgements, tenders and Calderbank offers. In essence, all of these involve the defendant offering a figure to settle the matter; if the plaintiff rejects the offer and is then awarded a lower amount at the hearing of the action, the plaintiff is penalised for costs.

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 introduced increased finality to the arbitral process by restricting the basis for appealing awards and decisions, and reducing the scope for court intervention or oversight.

The High Court has powers for granting interim measures of protection and assistance in the taking of evidence, although most interim measures may now also be granted by the

arbitral tribunal under the 2010 Act. Once an arbitrator is appointed and the parties agree to refer their dispute for the arbitrator's decision, then the jurisdiction for the dispute effectively passes from the court to the arbitrator.

A contract that does not contain a written arbitration agreement is not arbitrable and is specifically excluded from the application of the 2010 Act. The arbitration agreement must be in writing whether by way of a clause in the substantive contract or by way of separate agreement. While Section 2(1) of the 2010 Act stipulates that these clauses should be in writing, this provision has been given a broad interpretation to include an agreement concluded orally or by conduct as long as its content has been recorded in writing.

Article 34 of the 2010 Act deals with applications to the court for setting aside an award. The grounds on which a court can set aside an award are extremely limited and correspond with those contained in Article V of the New York Convention, which requires the party making the application to furnish proof that:

- a* a party to the arbitration agreement was under some incapacity or the agreement itself was invalid;
- b* 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;
- c* the award deals with a dispute not falling within the ambit of the arbitration agreement;
- d* the arbitral tribunal was not properly constituted; or
- e* the award is in conflict with the public policy of the state.

Arbitration can be a more expensive option than litigation in circumstances where the arbitrator and the venue must be paid for while access to the courts is subject only to the payment of stamp duty, which is relatively modest in comparison with the costs of arbitration. Arbitration may be a favourable option, particularly for insurers, however, as the courts are traditionally seen as pro-insured in insurance disputes, given the draconian provisions in insurance contracts. There is also the benefit of confidentiality of the dispute in arbitration.

iv ADR

Mediation is the most common form of ADR for insurance disputes.

v Mediation

The role of the courts

As discussed above, the Mediation Act 2017 (which came into effect on 1 January 2018) requires solicitors to advise their clients of the merits of mediation as an ADR mechanism in advance of issuing court proceedings. Prior to issuing proceedings, the Act requires the solicitor to swear a statutory declaration confirming that such advice has been provided, and this declaration must be filed with the originating document in the relevant court office when issuing proceedings.

The courts cannot compel the parties to mediate disputes; however, in the High Court and Circuit Court, a judge may adjourn legal proceedings on application by either party to the action, or of its own initiative, to allow the parties to engage in an ADR process. When the parties decide to use the ADR process, the rules provide that the courts may extend the time for compliance with any provision of the rules. A party failing to mediate following a direction of the court can be penalised in costs.

V YEAR IN REVIEW

i Brexit

As mentioned in Section I, Brexit has resulted in a number of financial services firms considering re-establishing themselves in Ireland, including UK firms and branches of UK entities.

ii Developments related to litigation funding

Third-party professional litigation funding is not generally permitted. In July 2018, in the case of *SPV Osus Ltd v. HSBC Institutional Trust Services (Ireland) Ltd*, the Supreme Court called on the legislature to urgently reform the area, failing which the Supreme Court itself may intervene.

The High Court has previously made clear that after-the-event insurance (ATE) is valid; therefore, ATE insurance is the only valid third-party funding.

iii Representative actions in consumer litigation

The European Commission has published a draft Directive that proposes a new type of EU-wide collective redress mechanism for consumers. This would allow a 'qualified entity' to take a representative action before a Member State court on behalf of a group of consumers that has been affected by a breach of consumer protection laws, to seek redress for the affected group. This would increase litigation risk for industry sectors that are subject to EU regulation, including insurers. The draft Directive will require further consultation in the European Parliament and the European Council, and is likely to be amended prior to publication in the Official Journal. It is anticipated that it will be adopted prior to the next EU Parliament elections, scheduled for May 2019.

iv Civil Liability Amendment Act 2017

The Civil Liability Amendment Act 2017 came into effect in late 2018. The Act empowered the courts to make awards in catastrophic injury cases by way of periodic payments, rather than as a lump sum. The aim of the legislation is to ensure continuity of payment throughout the life of the plaintiff.

v The Insurance (Amendment) Act 2018

The Insurance (Amendment) Act 2018 came into force in July 2018, which amends and extends the scope of the law in relation to insolvent insurers.

vi Payment protection insurance

Following the UK Supreme Court decision in *Plevin v. Paragon Personal Finance Limited*, a further redress scheme in respect of payment protection insurance (PPI) is under way in the UK. On 26 June 2018, a judgment was handed down in the Manchester County Court in the case of *Doran v. Paragon Personal Finance* (unreported). The amount awarded in this case was higher than the amount that would have been awarded under the Financial Conduct Authority guidelines for a case similar to the *Plevin* case, and that would have been awarded by the Financial Ombudsman. It is possible, particularly in light of the changes to the limitation period for claims to the Financial Services and Pensions Ombudsman in relation to long-term financial products, that there could be further litigation in relation to the sale of PPI in Ireland.

vii Emerging risks

There was an increase in cybersecurity threats and data breaches in 2018. A regulated online sphere, in the context of cybersecurity and data privacy, is, therefore, becoming more important. It follows on from this that the flow of data between states and the control that governments should exercise over this data is an important consideration in 2019. The enforcement of the GDPR is also important in this context.

VI OUTLOOK AND CONCLUSIONS

The UK Part VII transfer under the Financial Services and Markets Act 2000 (the UK Act) has been a key part of UK insurers' Brexit contingency plan, enabling transfers of EU and EEA insurance business between the UK and Ireland through a court-sanctioned legal transfer process. To date, many UK Part VII insurance transfers have been completed, with more to be completed later in 2019.

Compared to 2018 levels, despite the uncertainty caused by Brexit, trade wars and protectionism, we anticipate an increase in the levels of insurance industry mergers and acquisitions (M&A) activity in the second half of 2019. While the lack of clarity about specific proposals under Brexit may be a short-term inhibitor of insurance M&A in the first half of 2019, proposed transactions that have been put on hold in the wake of Brexit are expected to continue and increase post-Brexit.

Technology has been identified as a key driver of M&A activity. Insurtech investments are also expected to lead to a more innovative approach, with examples of insurers buying insurtech start-ups increasing in 2018.

Cloud computing is gaining more significance in the insurance market. In light of this, a focus on upgrading talent in this area is likely to be a key focus in 2019. Insurers will also be expected to modernise and personalise their policies, as a result of increased customer expectations. Some products will become more reliant on data from connected devices.

We expect an increase in 2019 in Irish companies taking out cybersecurity cover and potentially related coverage disputes. In the next few years, we also anticipate litigation from insureds challenging claims decisions made by automated claims processing systems and on the interpretation of rights conferred by the GDPR on individuals in relation to automated decision-making.

ISRAEL

*Harry Orad*¹

I INTRODUCTION

The Israeli insurance market is an expanding and evolving environment, and one that presents new challenges to all those involved. In this area, the focus of both the legislature and the relevant regulator is on the protection of the individual consumer. Courts of law have traditionally followed suit with this public policy, although, in recent years, a slight shift can be perceived towards a more balanced construction of insurance policies.

II REGULATION

i The insurance regulator

The insurance market is regulated by the Commissioner of Capital Markets, Insurance and Savings, appointed by the Minister of Finance. Two bodies advise the Commissioner: a four-member advisory committee and the Advisory Council, which has 15 members, of whom no more than six may be government employees.

The Commissioner is competent to resolve disputes between insurers and assureds. In practice, it will refrain from assuming this role in fact-laden cases. Its decision may be appealed to the district court.

ii Licensing

Writing insurance requires a licence. Foreign insurance companies cannot write insurance business in Israel, but Israeli citizens may buy insurance abroad. Writing reinsurance business, however, does not require a licence and foreign insurers are therefore free to do so.

The Commissioner is authorised to license a foreign company if the latter is registered in Israel and subject to regulation in the country of origin.

In a unique act, the Israeli government enacted a regulation in December 1951 exempting Lloyd's underwriters from the stipulations of the Law of Controlling Insurance Service. The practical effect of this is that Lloyd's underwriters are permitted to write business directly in Israel.

With the objective of increasing competition in the insurance industry to lower premiums for consumers, the Commissioner reduced the minimal capital requirements for establishing new insurance companies in Israel. As a result, several new insurance companies commenced business in the past couple of years, some of them digital.

¹ Harry Orad is a founding partner at Gross Orad Schlimoff & Co.

iii Compulsory insurance

Israeli law imposes compulsory insurance requirements on professionals or individuals in several areas, including the following:

- a The capital market: insurance requirements are imposed on investment advisers and distributors; investment portfolio managers, mutual fund managers and trustees; provident funds and their managing companies; and underwriting companies. This compulsory insurance ensures protection of clients against negligent acts and omissions and infidelity of employees.
- b Bodily injury coverage: Israeli law imposes compulsory insurance requirements for the coverage of bodily injury in clinical trials on human subjects (insurance requirements are imposed on the clinical trial sponsor).
- c Motor accidents: the Israeli Road Accident Victims Compensation Law provides compensation for all victims of motor accidents on a no-fault basis. Compulsory insurance by all vehicle owners provides the source of compensation. Where such insurance was not placed, the injured party will receive compensation from a joint fund that receives a share from all premiums paid to insurers in the market. The joint fund will then have subrogation rights against the party that failed to take out insurance as required by law. In addition, sport events organised by registered sports authorities and organisations are subject to compulsory accident insurance. Schoolchildren are covered by compulsory personal injury insurance.
- d Banks: there is no statute that compels banks to acquire compulsory insurance; however, the Commissioner of Banks has issued a directive that requires banks to acquire employee dishonesty insurance.
- e Aviation: new regulations that will come into effect in June 2018 impose compulsory insurance on operators of commercial aircraft to, from or in Israel, in respect of passengers, baggage and cargo; third parties; and acts of hostility, war or terror.
- f Organised sport activities are subject to compulsory accident insurance.
- g School children are covered by compulsory accident insurance by the local authorities.

iv Directors' and officers' insurance

Directors' and officers' (D&O) insurance, although not mandatory, has become a prerequisite for most high-ranking directors and officers. Israeli courts have, in recent years, strictly applied reporting duties, and demanded accurate, full, updated reporting. The Business Judgement Rule (BJR) has been adopted by the Supreme Court and courts are hesitant to intervene in decisions of boards of directors that comply with the requirements of the BJR.

In *Better Place Israel Ltd. (in liquidation) et al v. Agassi et al.*² (September 2018) the District Court ruled that the BJR is a preliminary defence available to directors and officers of companies, which is intended to encourage them to take difficult business decisions and business risks. It was ruled that this defence can and should be raised at very early stages, before a trial. In this case, the claim was dismissed.

The significance of this decision is that the court was willing to dismiss a claim, which was filed by liquidators of a company, following receipt of the approval of the liquidation court, after extensive investigation against many officers of the companies and other employees, and by dismissal of the claim the court made a very clear statement to the Israeli

2 CA 47302-05-16.

business community: that Israeli courts will not intervene in informed business decisions reached by directors and officers in good faith and without conflicts of interest. This applies to companies conducting their businesses in Israel in general, and particularly to failed start-up companies. The claim was considered as a challenge made in hindsight on a failed business logic and therefore should be dismissed *in limine*. An appeal to the Supreme Court is still pending.

Recent years have seen an increase in the number of claims, derivative claims and class actions in respect of breach of duties by directors and officers. Most of these, end in settlements in which insurers play an important role.

The Israeli Companies Law prohibits the indemnification (as well as insurance and exemption) of a director or officer in respect of the following matters:

- a* breach of fiduciary duty towards the company, unless committed in good faith and with reasonable grounds to believe that the action would not prejudice the company's interests;
- b* acts committed intentionally or recklessly;
- c* acts committed with the intention of gaining unlawful personal benefit; and
- d* fines and penalties, including civil fines and monetary levies.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Israeli legal system is fundamentally a common law regime, without jury. However, throughout the years, civil law statutes have been enacted that adopt principles from various jurisdictions in Europe and elsewhere. The Insurance Contract Law (ICL) was passed in 1981, adopting principles of consumer protection. In conjunction with this, the Control of Financial Services (Insurance) Law was passed, which provides regulatory provisions for the market. The law applies to all types of insurance other than reinsurance, marine, aviation and insurance of diamonds or valuable metals.

ii Making the contract

The ICL does not specify a unique format for execution of the insurance contract. However, it does specify particular rules aimed at reinforcing consumer rights and imposing limitations on insurers, remedies and power. These rules aim to moderate the typical imbalance of power between the insurer and insured.

iii Duty of disclosure

The ICL imposes an explicit duty on the insured to answer the insurer's questions in full and truthfully, when presented in writing in respect of a material matter. A material matter is defined by the Law as one that could affect a reasonable insurer's willingness to assume the risk in general or to assume it under the terms specified by the policy.

The Law further stipulates that fraudulent concealment of a matter that the insured was aware of as being a material matter is regarded as an untruthful and incomplete answer. Israeli courts have interpreted this in conjunction with the questions posed by the insurer on the proposal form: a subject not mentioned in a proposal form has been deemed as immaterial and therefore, there can be no positive duty of disclosure regarding such a subject and no sanction for non-disclosure.

iv Interpreting the contract

An insurance contract is interpreted according to the (revised) Article 25 of the Law of Contracts and case law, which clarified rules of interpretation of insurance policies, such as *Cohen v. Migdal Insurance Company*³ and *MS Aluminium Products v. Arie Insurance Company*.⁴

The stages of interpreting a policy are as follows:

- a* The first stage is based on the subjective intention of the parties to the specific policy. If possible, the parties' intentions will be ascertained literally from the language of the insurance contract. Otherwise, for the subjective intention, the court will look at external circumstances, such as communications exchanged between the parties.
- b* Second, if the subjective intention of the parties cannot be ascertained, then the court will seek the objective intention of the parties, namely the intention of reasonable and honest parties with respect to the policy in question. The objective intention can be ascertained, for example, from common practice among other insurers in the relevant type of insurance.
- c* A policy construction that gives it force and effect is preferable over one that voids the policy provisions.
- d* Only if the court cannot ascertain the subjective or objective intention of the parties will the court interpret ambiguities in the policy against the drafter (usually the insurance company).
- e* Courts also refer to the doctrine of the reasonable expectations of the insured, but only if there are several reasonable interpretations and one of them meets the reasonable expectations of the insured. This is generally used together with other rules of interpretation.

v Warranties and conditions precedent

The ICL provides no basis for the doctrines of warranties and conditions precedent as implemented in common law countries. The Israeli law has adopted a proportionate remedy principle regarding both breach of contract terms and breach of duty of disclosure. The significance of this principle is that other than in cases of fraud, there is no automatic exemption of the insurer from liability.

Where the insurer alleges breach, the court will consider its extent and effect, and is authorised to reduce liability proportionately according to the ratio of the actual premium and the higher premium that would have been charged had the insured disclosed the material matter or had the insurer known that the policy condition would not have been adhered to. See Section VI below.

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.

3 CA 4688/02.

4 CA 453/11.

vi Intermediaries and the role of the broker

The licensing of insurance brokers is regulated by law, requiring a licence, which follows on from practical training and examinations. The licensing is in three areas of expertise: general insurance, marine and pension insurance brokerage.

The licence may be granted to an individual or to a corporation.

The activities of insurance agents are regulated by law. An insurance agent is defined as 'one who engages in insurance brokering between the insured and insurers, and as a liaison between the insurer and the insured'. It is considered an agent of the insurer with regard to the negotiations leading up to the formulating of the insurance contract, unless appointed in writing by the insured as an agent of the insured. As the agent of the insurer, any fact brought to its knowledge regarding a material matter will be considered as known by the insurer for the purpose of the insured's duty of disclosure.

Payment of premium to the agent is also considered as payment to the insurer.

The agent is considered the insurer's agent for the purpose of receiving notice of the identity of the insured and the beneficiary, unless the insurer informed the insured and the beneficiary in writing that notification must be sent to a different recipient.

The presumption that the insurance agent is the agent of the insurer serves as an obstacle that insurers must surmount to be allowed to rely on policy terms.

In *Clal Insurance Company Ltd v. Mussa Ally*⁵ the court ruled that the insured was not deemed as receiving a copy of the policy terms as the document had been sent to the agent and not to the policyholder. The fact that the agent in that case was a close relative of the policyholder did not suffice to overcome this obstacle. Furthermore, the insured had signed the section in the proposal form appointing the agent as his own agent. However, the court ruled that in the absence of clear-cut evidence that the insured fully understood the meaning of this waiver, the legal presumption prevailed, and the agent remained the agent of the insurer. As a result, the court did not allow the insurer to rely on stipulations in the policy making cover conditional upon the insured taking measures to alleviate the risk. The court ruled that as the policy had not reached the hands of the policyholder, the insurer had not fulfilled the duty to ensure that the policyholder was fully aware of these conditions and the consequences of non-compliance.

vii Claims

Notification

The ICL provides that the insured must notify the insurer of the insured event immediately after becoming aware of its occurrence. However, as with the approach to breach of policy terms or the duty of disclosure, the law does not sanction late notification with automatic dismissal of the claim. The burden of proof in this respect is on the insurer, who must prove substantive damage as a result of the failure to notify on time. To meet this burden, it is not sufficient to show a theoretical possibility that damage may be sustained by the insurer.

In any case, the claim will not be dismissed but reduced proportionately with regard to the extent of the damage caused by the delay. Furthermore, as with the majority of the provisions of the ICL, the above are reinforced as the Law mandates that these provisions cannot be modified by agreement unless such modification is in favour of the insured. The practical effect of these provisions is that, as a rule, insurers cannot rely on a 'late notification'

5 CA 2626/01.

argument unless their rights were significantly prejudiced as a result of such late notification. These provisions have been the subject of discussion in numerous Israeli court cases wherein the courts have consistently ruled that an insurer that wishes to benefit from the remedy provisions must show that its rights were actually prejudiced by the insured's non-compliance with the duty to notify.

The burden of proof borne by the insurer is not a light one. It must prove actual damage as a result of breach of the notification duty. Statements to this effect were made in several cases including *Hasneh Insurance Co v. Asulin*,⁶ where the burden imposed on the insurers to prove actual damage was emphasised.

In *Wile v. Phoenix Insurance Co*,⁷ the court again ruled that it is not sufficient for the insurer to merely prove the breach of the notification duty, rather, actual damage as a result of the breach must be shown to have occurred.

International Bank v. Prudential Insurance Co was an extreme case.⁸ 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 of the day on which the insurer is in possession of the information and documents required for the ascertainment of his or her liability. However, insurance benefits not disputed bona fide will be paid within 30 days of the day on which a claim is submitted to the insurer, and they may be claimed separately from the remainder of the benefits. (See subsection x, below.)

Insurer's duty to issue a coverage position letter

Coverage position letters have been the basis of limitations on insurers' practical rights and scope of defence in Israeli courts, where the coverage position letter did not meet the regulator's requirements. These requirements have been adopted by the courts as legally binding in the framework of the insured-insurer relationship. The Supreme Court added that insurers' obligations also apply to a third party that is entitled to direct privity with the insurer.

The first directive on the subject, issued in 1998, required the insurer to specify all grounds for denial of coverage, sanctioning failure to do so by precluding the insurer from raising any new argument in future litigation. The Commissioner cited the insured's right to receive all details to be able to seek advice regarding possible legal relief on the basis of the insurer's position as the rationale for this sanction.

6 CA 215/91.

7 CA 1438/02.

8 CF 7/88.

Later, a variation on the original directive was issued, clarifying that arguments based on events subsequent to the coverage position letter, or based on grounds that could not have reasonably been known to the insurer when issuing the coverage position letter, would be allowed to be introduced at a later stage.

The courts afforded the directives the power to limit the scope of insurers' rights to evoke defence arguments beyond those cited in the coverage position letter:

- a* the insurer is obliged to effectively investigate the circumstances of the loss or claim to form its coverage position as soon as possible after receipt of the claim;
- b* the coverage position must be provided to the insured in writing, within 30 days of receipt of information and documents required from insured;
- c* where coverage is declined (whether wholly or partially), all grounds for this position must be detailed therein;
- d* the insurer is precluded from raising any argument on circumstances, conditions or exclusions that were not mentioned in the coverage position letter; and
- e* the insurer will be able to broaden its defence only in rare cases where the circumstances material to its updated coverage position were not known and could not reasonably have been known. Such cases would certainly include intentional behaviour aimed at concealing material facts from the insurer.

viii Reinstatement

Reinstatement clauses are common in property insurance and provide coverage beyond the scope of the ICL. Reinstatement (i.e., 'new for old') is an additional cover and is subject to a time limit that may cause friction with the insurer. This type of cover was analysed in the precedential ruling in *Phoenix Insurance Co Ltd et al. v. The Deborah Hotel et al.*⁹

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.

⁹ CA 191/80.

The condition that reinstatement costs are due (beyond compensation for the actual damage) only after the insured covers his or her expenses independently and only after the reinstatement is complete is a basic condition for the implementation of reinstatement insurance.

The time limit will not apply where the insurer is found to have unlawfully denied insurance benefits and so prevented the insured from reinstating the damaged property. In *Hadar Insurance Co Ltd v. Ehad Ha'am Food and Investments Ltd*¹⁰ 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.

x Punitive interest

The amended Section 28 to the ICL stipulates that in personal insurance (life, auto, home, health – but not liability) the court is obliged to award, and in non-personal insurance the court may award, an additional interest award of up to 20 times the basic interest rate, when an insurer did not indemnify the insured the amounts not in dispute in good faith on the appropriate date (in long-term care insurance – up to 10 times). If the court decides not to apply this special rate, it should explain the reasons for its decision.

In *Dudi v. Phoenix Insurance Company Ltd*¹¹ (August 2019) – a claim for life insurance benefits – the court decided according to the amended Section 28a of the ICL that the insurer acted in bad faith delaying payment and ordered payment of 20 times the basic insurance rate on the undisputed benefits for the period of the delay. An appeal to the District Court is pending.

Section 27 provides that the insurance benefits will be paid 30 days after the insurer received all information and documents required to ascertain the insurer's liability under the insurance contract. For insurance benefits that are not in dispute, the payment should be made within 30 days of the date the insurance claim was notified to the insurer. If this Section is breached, the insurance benefits will accumulate the above-mentioned interest. According to a Supreme Court precedent, the 30-day period will be calculated from the date the insured notified the insurers regarding the insured event.

10 CA 7298/10.

11 CF 55587-11-18.

Insurance Arbitration Institute

A new bill proposed by the Ministry of Finance in 2018 stipulated the establishment of an Insurance Arbitration Institute and compulsory arbitration of insurance claims in this Institute (except for claims by big companies (according to turnover and number of employees) and claims against third parties). If, and to what extent, this proposed bill will be approved is yet to be determined.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

As a rule, insurance contracts, other than those concerning reinsurance, marine, aviation, diamonds and precious metals are subject to Israeli law. Jurisdiction is local and the competent court is determined by the amount claimed – up to 2.5 million shekels with the lower court and above this amount with the district court, as first instances.

ii Right of appeal

There is an automatic right of appeal against judgments of the court of first instance to the appeal court within 45 days. As a rule, the appeal court will not intervene on points of fact unless a severe and obvious error is clearly evident.

Leave to appeal is required to allow access to a second appellate instance and to appeal interim decisions. As a rule, the appellate court will only allow such appeals in exceptional cases. With regard to appellate judgments, the petitioner must show severe injustice or that the issue is one of importance to the public. The petition for leave to appeal must be filed within 30 days of handing down of the subject decision.

Most district courts will now complete hearing of an appeal within three years. At the Supreme Court, however, a case may take much longer.

The courts distinguish between lawyers' fees and costs and are authorised to award either or both to the winning party. Lawyers' fees are usually awarded as a percentage of the judgment.

iii Arbitration

Arbitration is very similar to a court process – evidence is brought, and discovery and testimony can be compelled by the arbitrator by using the court's mechanism. Rules of evidence do not apply where parties have not agreed otherwise.

The essential difference between arbitration and a court process concerns the options for appeal, amendment or annulment of a judgment, which for arbitration are rare and very difficult to obtain compared with a court judgment. There is, in essence, no route to appeal against an arbitral judgment except where the parties initially agreed to allow an appeal, this being limited to 'a fundamental error in application of the law which causes significant miscarriage of justice'. A motion for the annulment of a judgment will be allowed only in cases where the arbitration suffers from a serious procedural flaw as listed in the Law of Arbitration. Arbitration is significantly more expensive and time-consuming than mediation. (See Section III.x.)

As stipulated by the Commissioner, an insurance policy may not include a clause binding the insured to arbitration, in case of a future dispute. This clause is considered to be prejudicial to insured's rights. This stipulation does not apply when the insured specifically agreed to the arbitration clause.

iv Alternative dispute resolution

Mediation is the most common form of alternative dispute resolution and a recent amendment to the Civil Procedure Rules mandates referral of all litigants in all claims for over 75,000 shekels (excluding damages for victims of motor vehicle accidents) to hold a meeting with a mediator to discuss holding mediation talks. This is a general rule and not specific to insurance cases. This is a precondition for continuing to trial, but the court is not authorised to penalise parties for not agreeing to mediation or for not making an offer to settle.

A positive incentive for early settlement is afforded by rules regarding payment and refund of court charges. Court charges are levied on monetary claims at the rate of 2.5 per cent of the claim. Half of the court charges is paid on filing the claim and the second half is paid only if the case goes to trial. Furthermore, the first half of the court charges will be refunded automatically to parties that settle before three pretrial hearings have been held and the court is authorised to refund the entire charges paid if a resolution is reached, at any stage, by mediation or arbitration.

Mediation will normally be conducted by a lawyer with experience in the field or a relevant expert and will take much less time as meetings are held with the parties and the lawyers, with no need for testimony or any discussion of formalities, such as admissibility of evidence or discovery issues. It is also possible to have confidential discussions with the mediator, *ex parte*, which are effective in sounding out an objective party's point of view without the risk of unnecessarily revealing evidence to the counterparty.

V SUBROGATION

i Stricter rules

Subrogation by insurers is seemingly a simple matter of transferring rights from the insured to the insurer regarding the insured damage, against third parties. However, as depicted in a ruling by the Supreme Court in *Lloyd's Underwriters and IEC v. Ashdod Port* (December 2014),¹² as outlined below, the subrogating insurers may have to make additional efforts to prove the elements of the claim in order to ensure the full transfer of rights and benefits.

The Israel Electrical Company purchased equipment from Siemens in the amount of tens of millions of dollars for a new power production installation. While being unloaded at the Ashdod Port, the crates were dropped and damaged by impact. Siemens later determined that several units must be replaced, and others should undergo repair.

Under Israeli law, subrogation is contingent on the insurer establishing all of the following conditions:

- a* the obligation to pay insurance benefits on the basis of a valid policy;
- b* actual payment of insurance benefits on the basis of this obligation; and

12 CA 12/7287.

c proof of the insured's right for compensation from a third party in relation to the insured event or damage.

Regarding the reviewed case, all these conditions seem to exist. The District Court dismissed the subrogation claim and held that the insurers' considerations in regards to the payment were 'unreasonable'. The court found that the insurers failed to conduct an independent assessment of the damage and accepted Siemens' conclusions blindly, even though they were obviously an interested party.

The Supreme Court upheld the decision, specifically in regard to the fact that the insurance policy covered impact damage only and that no investigation had been carried out to determine whether indeed all the damage was caused by impact and not by other unrelated causes.

The Supreme Court judgment emphasises the fact that in order to preserve and ensure the prospects of subrogation, the insurer must invest efforts, beyond those necessary to determine coverage, in order to investigate and preserve evidence necessary for the future subrogation claim. The insurer must invest independent efforts to determine the exact nature of the damage and cannot rely on the advice of and interested party, such as the manufacturer or supplier of the damaged product.

ii Subrogation by a foreign insurer

Subrogation in Israel stems from Section 62 of the ICL, which transfers any rights that the insured may have for remedy in relation to the insured loss to the insurer upon payment of the insurance benefits. In *VIG – Vienna Insurance Group v. Sharon Drainage and River Authority* (October 2015),¹³ VIG filed a subrogation claim in Israel, and the action was denied by the District Court. The court ruled that Section 62 grants the subrogation right to an insurer, meaning an insurer registered by law in Israel and subject to local regulations. The court ruled that the rationale behind this was to grant rights of subrogation only to the companies that were also obliged to act within the confines of local regulatory rules.

This ruling was not the first of its kind in recent years in the lower courts; however, the appeal to the Supreme Court on this case was denied, creating a precedential binding rule, precluding foreign insurers from availing themselves of the right of subrogation in Israel.

Recently in *Teva Pharmaceutical Industries Ltd. et al v. Te&M Goshen – Security Services Ltd. et al* (November 2019),¹⁴ the District Court handed down an additional judgment, which clarifies and broadens the scope of the *VIG* precedent. The court ruled that also an 'indirect subrogation' claim was prohibited, namely even a claim filed by the insured for the benefit of the insurer is not allowed.

According to Section 72 of the Insurance Contract Act 1981, Section 62 is the only section of the law that applies to reinsurers. As a result, we hold the view that a foreign insurer wishing to insure risks in Israel and retain subrogation rights must do so via a local insurer as a fronting company which would later exercise the subrogation right.

It should be noted that this position may not apply to a subrogation claim of a foreign insurer against a foreign insured, as recently ruled in *Aras Romorkor Hizmetleri et al v. the ship 'Chrysopigi' et al* (November 2019).¹⁵

13 CA 53025-11-14; appeal (dismissed) 8044-15 (January 2017).

14 CF 67314-03-18.

15 CF 35583-11-18.

In this case, the District Court in Haifa stated that the foreign insurer has the right to claim in these circumstances, as the insurance agreement is not based on Israeli law, but on a foreign law.

Regarding Lloyd's underwriters, our view is that the legal position of Lloyd's underwriters in Israel is different from other foreign insurers because they are permitted to write insurance business in or from Israel on the basis of being exempt from the requirements of the Insurance Supervision Law.

VI YEAR IN REVIEW

i Civil procedure reform

The Rules of Civil Procedure were significantly reformed in 2018 but will only come into effect, following several delays, from September 2020. The overriding objective of this reform, as with the Lord Woolf reform in England, is to enable the court to deal with cases justly and at a proportionate cost, while improving the efficiency and speed which they are dealt with. The new procedure places severe time constraints on litigants while expanding the court's discretion regarding case management. It should be noted that some judges already apply principles of the reform in their courtrooms.

The reformed Rules of Civil Procedure are expected to accelerate proceedings owing to stricter time limits for preliminary proceedings and defence. The new rules warrant the particular attention of the claims departments of insurers, who will have to review claims handling procedures to meet the new requirements.

ii Reduction of interest rates

With respect to bodily injury claims, in calculating capitalisation of future loss, the fixed annual interest rate was 3 per cent for many years. Owing to the very low inflation rate, several courts have implemented a 2 per cent rate that substantially increases the compensation. Special official committees were appointed to submit their recommendations on this matter. As a result, many insurance companies increased their reserves accordingly.

In a recent decision in *The Motor Vehicle Insurance Pool v. John Doe* (August 2019)¹⁶ the Supreme Court upheld the capitalisation interest rate of 3 per cent, a decision which allowed those insurance companies to release hundreds of millions of shekels of the above-mentioned reserves.

iii New codification of insolvency and rehabilitation

The new Insolvency and Rehabilitation Law 2018 came into force in September 2019.

One of the main changes in this Law is the definition of insolvency, which now includes two alternative tests: the cash-flow test and the balance test.

The main relevant issue regarding D&O insurance is the provision in the Law relating to the directors' and the CEO's liability in case of insolvency, as defined under the Law.

16 CA 3752/17.

iv Cyber technology

The new Regulations for the Protection of Privacy (Information Security), enacted in 2017, became effective in May 2018. The Regulations establish, for the first time in Israel, a specific arrangement regarding protection of databases, including establishing organisational procedures and risk management enhancement steps in the management of databases. They also include a duty to report any severe data breach to the Database Registrar, and the Registrar may instruct that notification be given to the data subjects who may be affected.

This constitutes a substantial development in the data breach regulatory regime in Israel, which highlights why it is so important to purchase cyber insurance.

A new bill for amendment of the Israeli Privacy Protection Law suggests imposing a duty on database owners and holders to notify data subjects on data breach as soon as practicable following the breach. The bill includes financial sanctions for breach of the duty.

In addition, the EU General Data Protection Regulation, which also became effective in May 2018, applies to Israeli companies that either target the European Union (by offering goods or services to individuals from EU Member States) or monitor the behaviour of individuals from EU Member States (e.g., by tracking them online).

According to a survey of the Israel National Cyber Directorate regarding cyber insurance, only 13 per cent of Israeli companies purchase cyber insurance. We believe that penetration of cyber insurance is expected to increase as a result of the actions of the Israel National Cyber Directorate and the new regulations.

v D&O insurance

The new Insolvency and Rehabilitation Law, described in subsection iii, imposes liability on the directors and on the CEO of the company in any case where these individuals knew or could have known that the company is insolvent, and did not take reasonable measures to mitigate the scope of the insolvency. In such a case, the directors and CEO could be held liable towards the corporation for the losses sustained by the creditors, as a result of their failure to prevent or mitigate such losses. Certain provisions of the law provide a safe harbour defence for the directors and CEOs; however, the law prohibits the corporation from granting them exemption or indemnification.

Insurers that write D&O policies in Israel may wish to address the extended duties of directors and CEOs under the law.

There are also new duties attached to directors and officers of companies regarding cyber risk management and reporting, which should be included in the company and D&O insurance.

The new amendment to the Economical Competition Law (ECL – formerly known as the Anti-Trust Law), imposes a positive duty on an officer of a company to observe and to do his or her utmost to prevent violations of the law. In addition to criminal and financial sanctions that may be imposed on an officer who has breached the provisions of the ECL, the ECL establishes a duty on officers of a company (including any active manager, partner, etc.) to observe and to do his or her utmost to avoid perpetration of an offence by the company or any of its employees. The ECL further states that if an offence is committed by the company (or its employee) the officer will be deemed as having breached his or her duty unless he or she can prove that he or she took all possible measures to fulfil his or her duty.

This amendment dramatically changes the scope of duties attaching to the officers of a company by establishing another independent offence of non-observation as well as greatly expanding the scope of activity that must be performed in order to avoid an offence.

vi Breach of policy's conditions – proportionate benefits

In *Piccali v. Hachshara Insurance Company Ltd* (June 2019)¹⁷ a motor vehicle insurance included an age limitation provision. At the time of the accident, the driver who drove the car, was under the permitted age pursuant to the age limitation provision. The question under discussion was whether, under such circumstances, the policyholder is not entitled to insurance benefits or whether the fact that the driver was underage can be regarded as aggravation of the risk, pursuant to Section 18 to the Israeli Insurance Contract Law, hence is entitled to reduced insurance benefits in proportion to the premium paid in respect of a 'regular' policy and the premium paid in respect of a policy which includes an age limitation provision.

The Supreme Court ruled that the breach of this provision should not preclude the policyholder from his or her right to receive insurance benefits and that the non-compliance with the age limitation provision should be regarded as aggravation of the risk which entitles the policyholder to reduced insurance benefits in accordance with Section 18 of the ICL.

The Supreme Court interpreted Section 18 of the Law based on the principle of proportionality and on a pro-consumer approach.

It was also held that the term 'with a fraudulent intent' should be interpreted narrowly. If it can be proven that the non-compliance with the age limitation provision occurred on a regular basis, it may be regarded as a behaviour with fraudulent intent, which deprives the policyholder of insurance benefits in contradiction to a one-time error.

An appeal is scheduled for June 2020 before five Supreme Court judges.

vii The limitation period commences from the date the insurer issued its final coverage position to the insured

In *Mizaza v. Clal Insurance Company Ltd* (December 2019)¹⁸ a claim was filed against Clal Insurance Company Ltd to the Magistrate's Court. Clal filed a motion to summarily dismiss the claim, alleging that the claim was filed after the limitation period had elapsed. The court rejected Clal's motion and ruled as follows: Section 31 of the ICL provides that the limitation period of a claim for insurance benefits is three years after the occurrence of the insured event. The court ruled that although the claim was filed after the three-year limitation period had elapsed, during that period Clal had issued to the plaintiff the declination letter. The judge emphasised that only following receipt of the declination letter can the insured become aware of all the reasons for declining his insurance claim, and only then can the insured make an educated decision to sue the insurer. In view of this reasoning, the judge ruled that the limitation period of three years commences from the date the insured received the insurer's final coverage position.

Clal filed an appeal to the District Court on this ruling, which is still pending.

17 Motion for CA 9849/17.

18 CF 49200-03-18.

VII OUTLOOK AND CONCLUSIONS

Israel, as a start-up nation, is a leader in the number of insurtech start-up companies, developing innovative products and platforms for insurance companies and the insurance industry. These technologies are expected to bring significant changes to the insurance market. The most prominent changes are seen in personal insurance, direct marketing and sales of policies. In addition, new insurance products are being developed to catch up with the new risks resulting from the new technologies. The Commissioner of Insurance encourages innovation in insurance by the establishment of digital insurance companies in general, and particularly insurtech. We expect an increase in cyber insurance in the coming years.

Environmental and pollution insurance is increasing in Israel due to several significant class actions. Climate change may also result in acquisition of designated policies.

ITALY

*Alessandro P Giorgetti*¹

I INTRODUCTION

Italy's economy, which slowed over 2018 and remained at a standstill up to the end of 2019, was expected to stagnate in 2020 too with an expected maximum GDP growth of 0.4 per cent. These economic forecasts have been totally undermined so far in the first quarter of this year by the covid-19 pandemic that has resulted in the government imposing a total lockdown on the nation. The Italian economy that was on the edge of zero growth now risks falling into recession due to the consequences of the macroeconomic shocks of the pandemic upon the entire European economy, in which the Italian economy is strongly integrated.

The uncertainty of the Italian government's economic politics, in fully complying with the preventive actions required by the EU Stability and Growth Pact, on 23 March has been partially mitigated by the EU's activation of the general escape clause of the Stability and Growth Pact.

It remains to be seen whether both financial players' and manufacturing companies' confidence in Italy will be restored as a consequence of the immediate and draconian health and civil protection measures adopted by the Italian government to protect the population's health as well as the national economy. This might result in new opportunities for investment in and commitments to the country.

Restoring confidence will help to relaunch exports and industrial production in association with the important reduction in government bond yields, favouring economic activity, facilitating access to credit, as well as curbing the government interest expenditure.

The Italian economy is made up of small and medium-sized companies that produce high-technology and high-quality products. This productive foundation is characterised by the ability to quickly adapt to changing international scenarios, which will sustain export growth at a faster pace than global demand.

The continuous drop in the energy bill should also help to support Italian exports despite Brexit and US custom duties that will impact some Italian agrifood exports.

Notwithstanding these negative facts, Italian exports have been supported by positive factors such as: (1) the fact that Italy has a relatively small presence in non-EU markets where the slowdown has been more marked (Argentina, Iran Venezuela, and U.K. amongst the principals); (2) new export flows, especially from some Italian regions generated from some multinationals groups; (3) opportunities created by US duties to replace Chinese products; (4) anticipated sales to the UK in view of Brexit; and (5) new trade agreements with important countries such as Japan and China.

¹ Alessandro P Giorgetti is the managing partner at Studio Legale Giorgetti.

In the first half of 2019, the insurance market, due in part to the overall uncertainty permeating the Italian economy, had a total premium collection (life and non-life) of €74.9 billion with a minor decrease of 0.2 per cent compared to 2018. In detail, IVASS supervised companies collected premiums for €70 billion with an increase of +0.3 per cent compared to 2018; whereas SEE Representations had a collection of €4.9 billion, down -6.9 per cent. These later data might have been influenced by Brexit and the substantial uncertainty about the Lloyd's market.

In contrast with the expectations following what happened in 2018, in the first half of 2019 the life sector, prevalent with almost three-quarters of total premiums (€55.4 billion), in 2019, experienced a premium decrease on an annual basis (-1.5 per cent), which mirrored the tendential decline of the sector that had already manifested with more intensity in 2016 and in 2017.

It is evident that Italy, despite the difficulties in relaunching the national economy and thanks to the new opportunities, remains a fertile ground for insurance underwriters, and provides interesting opportunities for prudent insurers and reinsurers especially in the newly developing cyber and data protection insurance markets.

II REGULATION

i The insurance regulator

Decree-Law No. 95 of 6 July 2012² dissolved the Italian Private Insurance Regulatory Authority (ISVAP) and replaced it with the Institute of Insurance Supervision (IVASS),³ 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 Centre⁴ have been taken away from the insurance regulator's competence and passed on to the Concessionaire for Public Insurance Services.⁵

In accordance with the law, the *pro tempore* senior deputy governor of the Bank of Italy is also the president of IVASS.

2 Decree-Law No. 95 (the Spending Review Decree) was subsequently amended and converted into Law No. 135 of 7 August 2012. The government, which originally also considered dissolving the Commission for the Supervision of Pension Funds (COVIP), the regulator for pension funds, at the very last minute introduced an amendment to the Spending Review Decree and chose to keep COVIP, as its dissolution would not have reduced government expenditure.

3 IVASS address: 21 Via del Quirinale, Rome.

4 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 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 the National Association of Insurance Companies.

5 www.consap.it.

Other governing organs of the supervisory body are the Council and the integrated Directorate made up of directors of the Bank of Italy and IVASS advisers. The president promotes and coordinates the activities of the Council, which is responsible for the overall administration of the institute. The Directorate is competent to direct public body activities and adopt strategic decisions. IVASS should establish more focused supervisory controls on life and non-life insurance companies to bring down insurance costs and, consequently, premiums.

Having implemented a new regulation concerning its organisational structure, IVASS became quite active. In 2013, it issued the very first set of rules for the management of insurance services offered online. These norms implemented the provisions introduced by Article 22, Paragraph 8 of Development Decree No. 179 of 18 October 2012. This regulation lays down rules and minimal requirements to promote more effective management of insurance e-commerce or services offered electronically through insurance portals or the website of insurance and reinsurance companies.

IVASS then provided for imposed administrative fines and the application of disciplinary sanctions in respect of insurance and reinsurance intermediaries and the rules of functioning for the Guarantee Committee supervising the sanction proceedings.⁶ The regulatory activity of IVASS continued, introducing the obligation for intermediaries to adopt a certified electronic mail address along with the invitation (thus a measure 'not legally binding') to use an advanced electronic signature in all contracts.⁷ 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 then regulated the receivership of insurance companies.⁸

In 2014, IVASS intervened to regulate the obligations of adequate due diligence and anti-money laundering registrations on the part of insurance companies and insurance intermediaries,⁹ as well as regulating occupational requirements of insurance and reinsurance intermediaries respectively, with the goal of promoting insurance intermediaries' professional requirements, particularly taking into account the increasing spread of insurance relations to be handled electronically and concerning the internal identification of the organisational units responsible for administrative proceedings.¹⁰

After 2016, the year in which the EU Solvency II Directive (Solvency II) came into effect, IVASS concentrated its regulatory activity more on insurers' profitability and capitalisation, followed by a letter to the market on 10 August 2016 better illustrating how to determine the capital requirement using the standard formula, as well as the look-through approach dictated by Regulation No. 28/2016.

This trend continued throughout 2017, with Regulation No. 34/2017 on the corporate governance provisions relating to the valuation of assets and liabilities other than

6 Regulations Nos. 1 and 2.

7 Regulation No. 3.

8 Regulation No. 4.

9 Regulation No. 5.

10 Regulations Nos. 6 and 7.

technical reserves and their assessment criteria, and Regulation No. 35/2017 concerning the adjustment required for the loss-absorbing capacity of technical reserves and deferred taxes in the determination of the companies' Solvency Capital Requirement.

In 2018, IVASS concentrated its regulatory efforts on companies' internal compliance and the distribution of insurance products issuing: Regulation No. 38 laying down provisions on the system of governance of 3 July 2018 and Regulation No. 42 laying down provisions on the external audit of public disclosure related to the Solvency and Financial Condition Report of 2 August 2018. IVASS also issued two regulations regarding the implementation of Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (the Insurance Distribution Directive): Regulation No. 40/2018 laying down provisions on insurance and reinsurance distribution, with particular attention to the areas of training and professional education as well as the promotion and placement of insurance contracts by means of distance communication techniques; and Regulation No. 41/2018 on the pre-contract information duties of the insurance distributors, which shall apply to all insurance contracts, except tailor-made products that do not need any pre-contract information.

On 12 February 2019, IVASS issued both Regulation No. 43 implementing the provisions on the temporary suspension of capital losses in current securities and Regulation No. 44 on organisation, procedures and internal controls and customer due diligence.

Taking note of the concrete operational difficulties caused to insurers by the national lockdown due to covid-19, on 17 March 2020, IVASS took the following measures to support the activities of insurance companies and intermediaries:

- a* with regard to insurance distribution, as temporary derogation from the provisions of Article 90 Paragraph 5 of IVASS Regulation No. 40/2018, the verification tests for the professional training courses may be carried out remotely, in accordance with the provisions contained in the subsequent Articles 91, 92, 93 and 94 of the Regulation. Moreover, the deadline provided for by Article 46 of the Regulation for the transmission to IVASS of the report upon the insurer's distribution networks has been extended to 29 March 2020;
- b* with respect to home insurance, the deadline set forth by IVASS Regulation No. 41/2018 for the mandatory adoption by companies of reserved internet areas, originally set for 1 May, has now been extended to 1 July 2020; and
- c* with regard to complaints, the deadline set forth by ISVAP Regulation No. 24/2008 for the transmission to IVASS of the Report on complaints and related documents was extended to 29 March 2020.

On 23 March 2020, in respect of the deadlines set forth by ISVAP Regulations No. 24/2008 and 41/2018, IVASS conceded, temporarily, longer terms, respectively of 75 days to respond to customers' complaints and 45 days to answer clients' requests for information.

ii Position of non-admitted insurers

Only admitted insurers are entitled to provide insurance. More precisely, according to legislation, the admitted insurers should meet the existing requirements for authorisation, and have the minimal share capital or guarantee fund fully paid up in cash.

iii Requirements for authorisation

In general, only public companies, cooperatives and mutual insurance companies, or equivalent European or foreign companies, can apply to IVASS for an authorisation. Lloyd's syndicates are the sole exception, and they have been specially authorised because of their particular historical status and in accordance with the fundamental freedoms of the Treaty on the Functioning of the European Union.

New insurance and reinsurance companies that wish to undertake or start a new business in Italy can do so only after being authorised or licensed by IVASS through an order (if the undertaking has its head office in Italy), or by an acknowledgement of the formal communication made by the company along with confirmation of the supervisory authority of the state where the company has its registered office.

The order or the acknowledgement of the formal communication must be published in the Official Gazette, and the newly authorised or licensed insurance company may start underwriting insurance or reinsurance only after publication.

An insurance company that applies for authorisation must submit a number of documents to IVASS. The most important are:

- a* A certified copy of the memorandum and articles of association showing the insurance classes that the insurer will underwrite, and stating whether it also intends to offer reinsurance. It is forbidden to set up a company whose sole object is the exclusive pursuit of insurance business abroad.
- b* Evidence that the memorandum and articles of association have been deposited with the Registrar of Companies and that the incorporation has taken place in accordance with the Civil Code¹¹ provisions or the applicable local laws.
- c* A scheme of operations and a technical report drawn up pursuant to the ISVAP regulations, including the names of the persons charged with administration, management and internal control and corporate governance functions, as well as the names of the natural or legal persons who directly or indirectly have controlling interests or qualifying holdings in the company, with an indication of the amount of each holding.
- d* Proof that the company has a share capital or guarantee fund, fully paid up in cash, sufficient to meet the liabilities of the intended business plan, and proof that the company possesses the minimum organisation fund required by ISVAP Orders Nos. 97/1995 or 98/1995, or both, fully paid up in cash.
- e* For foreign companies, proof of the appointment of a general representative who must be domiciled at the address of the branch. If a company is appointed as general representative then the registered office must be within the territory of Italy.

If the application is incomplete or IVASS's requests for further information are not met, authorisation is usually denied. It is also refused if no proof is given that the share capital or guarantee fund has been fully paid up, or that the organisation fund is actually and immediately available to the company.

11 Royal Decree No. 262 of 16 March 1942 in Official Gazette No. 79 of 4 April 1942.

Equally, the authorisation or licence is denied if any persons charged with the administration, management and internal control functions do not meet the prescribed requirements,¹² or if the scheme of operations does not satisfy the financial needs and the technical rules for the correct management of an insurance business.¹³

A major role in the authorisation process is played by the laws, regulations and administrative provisions of any state to which the company or one or more of its shareholders is subject, and any difficulties in meeting such requirements may delay the application or even entail a final refusal.

An IVASS order refusing the authorisation is notified to the company by means of a registered letter with advice of receipt within six months of the date of the complete application with all documents required by law or with the additional documents and information requested by the authority. If six months elapse with no response received by the applicant company, then the authorisation will be considered refused.

iv Other notable regulated aspects of the industry

In accordance with the Private Insurance Code,¹⁴ 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.

12 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.

13 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.

14 Legislative Decree No. 209 of 7 September 2005, as amended by Legislative Decree No. 130 of 30 July 2012.

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.

With the introduction of Solvency II, and IVASS Regulation No. 24/2016 in June of the same year, insurers are now free to choose the most appropriate investment instruments, subject to the precondition that their immediately available capital is adequate to cover the risk underlying the investment.

Mergers and transfers of insurance portfolios that involve insurance companies operating in Italy are subject to IVASS's prior agreement, but if the merger may result in the company having a position of market dominance, the Italian Antitrust Authority might also have to give its preliminary authorisation. The sole financial requirement is that the incorporating company or the new company resulting from the merger has the necessary solvency margin, taking into account the merger and the consolidated liabilities.

In the case of a merger, the entire operation, the relevant arrangements, and the new memorandum and articles of incorporation must be presented to and reviewed by the insurance regulator, which can make observations to ensure conformity with the law and to guarantee the insured.

There are no restrictions regarding investments in or the acquisition of an insurance or reinsurance company, provided that the funding of the operation does not breach any anti-money laundering provision or public policy. In the event of a merger resulting in the setting up of a new company with its head office in Italy, the new company must be authorised before it can legitimately underwrite insurance, whereas if one of the parties in the merger has its head office in another EU Member State, IVASS's agreement to the operation can only be given after the relevant home supervisory authority has approved the merger.

While reviewing the merger, and the new memorandum and articles of incorporation, IVASS performs a limited background investigation of the officers and directors of the acquirer or of the new company to ensure that they all respect the Civil Code provisions and meet the applicable legal requirements.

If an insurance or reinsurance company enters into serious financial difficulties, Articles 245 to 265 of the Private Insurance Code provide for the administrative compulsory winding up of insolvent or financially troubled insurance and reinsurance companies.

With respect to reinsurance companies domiciled in Italy, the current regulatory requirements with respect to reinsurance ceded shall be found in Directive 2005/68/EC of 16 November 2005 on reinsurance, which amended Directives 73/239/EEC and 92/49/EEC and Directives 98/78/EC and 2002/83/EC, although the relevant provision at law has not yet been formally enforced in Italy.

On 10 March 2010, ISVAP published Regulation No. 33 on reinsurance, which implemented the provisions of the Private Insurance Code as modified by the adoption of

the EU Reinsurance Directive (2005/68/EC). The regulatory framework is complex, with its 143 articles detailing and providing for the exclusive conduct of reinsurance activities by companies with a registered office in Italy or Italian branches of companies with registered offices abroad (or both); the procedures for authorising such activities; and companies that have a registered office in Italy and authorisation exclusively to conduct reinsurance activities to carry on such activities in other EU Member States under the applicable regulations on freedom of establishment and freedom to provide services.

In Italy, only licensed or accredited reinsurers can provide reinsurance. Therefore, there is no need for collateral to allow a deduction from the liabilities stated on the reinsured company's statutory financial statement. However, collateral might become necessary with a retrocessionaire of the reinsurer that is neither licensed nor accredited. In this case, the retrocessionaire must provide some form of collateral to allow a deduction from the liabilities stated on the Italian reinsured company's statutory financial statement.

v The distribution of products

The distribution of insurance products is usually done through intermediaries, but in rare and limited cases insurance can be acquired directly from the insurer at the registered office agency.

During the distribution, a number of rules to protect consumers and unsophisticated customers must be respected. In particular, Article 182 of the Private Insurance Code obliges IVASS to ensure compliance with the principles of clarity, recognition, transparency and fairness of advertising and information on the conformity of the insurance contract with the advertising and in the pre-contract negotiations (with the information notice) and the execution of the insurance contract (policy conditions). The old secondary legislation providing for all those topics has been substituted by an organic and organised set of rules contained in IVASS Regulations Nos. 40 and 41 of 2 August 2018 (see Section II.i).

For some life products, such as pension funds, and some life policies, the index-linked products are subject to the supervision and control not only of IVASS but also of the Commission for the Supervision of Pension Funds.

vi Intermediaries

Among the principal duties of the Italian regulator is the supervision of insurance intermediaries, which to operate legitimately must be listed on the Sole Register of Insurance and Reinsurance Intermediaries (RUI).

The RUI was set up by the Private Insurance Code, implementing Directive 2002/92/EC on insurance mediation, and is mainly governed by ISVAP Regulation No. 5 of 16 October 2006. According to the regulations, any insurance and reinsurance intermediation activity is reserved solely to persons who have passed the ISVAP/IVASS national exam and consequently have been listed on the RUI.

Based on the Private Insurance Code, the RUI is divided into five sections as follows, and no intermediary may be recorded in more than one section:

- 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 licensed as insurance and reinsurance intermediaries in other EU or EEA Member States who have also been authorised by the regulator to pursue insurance mediation in Italy based on the freedom of establishment or freedom of services.

vii Compulsory insurance

A number of special laws impose compulsory insurance to be undertaken with private insurance companies.¹⁵

At other times, the private insured must instead take out an insurance contract with a public insurer, such as the National Institute for the Insurance of Accidents at Work,¹⁶ or take out a mutual insurance contract with a private insurer through a public contracting entity.¹⁷ Finally, an obligation to take out an insurance contract can be found in some national collective labour contracts stipulated between the trade unions, representing the employees, and the Industrial Association, representing all their members who will adopt the negotiated national collective labour contracts for the specific industry.¹⁸

Decree-Law No. 138 of 13 August 2011, converted into Law No. 148 of 14 September 2011, introduced compulsory insurance. According to the Law, all professionals had to take out a professional indemnity insurance contract by 13 August 2012, with the exception of physicians and lawyers.

15 Motor insurance was introduced in Italy by Law No. 990 of 29 April 1969 in Official Gazette No. 2 of 3 January 1970. It was subsequently modified, and the most recent amendment was introduced by Decree-Law No. 179 of 18 October 2012, which provided that a compulsory motor insurance contract for motor vehicles and boats cannot be tacitly renewed and cannot be underwritten for a period longer than a year; any eventual policy clauses in contrast with this provision are deemed to be null and void.

16 Domestic accidents compulsory insurance was introduced in Italy by Law No. 493 of 3 December 1999, which imposes, as of 31 January 2013, the obligation to take out a contract of compulsory insurance with the National Institute for the Insurance of Accidents at Work for persons between 18 and 65 years who work full-time in the family house. The policy costs around €1 per month.

17 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. This insurance is provided through the National Federation of the Hunters.

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.

18 For example, the national collective labour agreement for managers and executives, according to Article 18(7)(a), (b) and (c), obliges the enterprises party to a collective contract to take out, for the benefit of their employees, executive insurance against professional and extra-professional accidents.

For physicians, the duty to undertake errors and omissions insurance became effective on 15 August 2014, whereas for lawyers the obligation became effective after the Department of Justice issued a decree reforming the legal profession¹⁹ and a subsequent decree determining the minimum requirements for mandatory professional indemnity insurance for lawyers.²⁰

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 1961.²¹

Similar to any capital gain, financial yields resulting from life insurance contracts and capitalisation are subject to the substitutive tax provided for in Article 26 *ter* of Decree No. 600 of 29 September 1973. The tax due is up to 20 per cent of the capital gain, but was reduced to 12.5 per cent for the portion of income that related to the period between the date of subscription or purchase and 31 December 2011.

The Italian State Agency, through Ministerial Circular No. 41/2012, clarified that, according to Article 83 of Decree No. 68 of 29 March 2012, financial yields resulting from life insurance contracts and capitalisation of foreign insurance policies are also subject to the substitutive tax provided for in Article 26 *ter* of Presidential Decree No. 600 of 29 September 1973, even if paid by foreign insurers to persons residing in Italy.

ix Regulation of individuals employed by insurers

All employees are subject to a collective contract negotiated at national level between the most representative trade unions and the national association of the employers (in the case of the insurance market, the National Association of Insurance Companies). The national collective contract can then be integrated using a specific collective contract negotiated between the local trade unions and the representative of a specific insurance company or group of insurance agents.

Although the national collective contract for insurance employees expired at the end of June 2013, the binding effects of the contract were extended while the parties were negotiating.

On 22 February 2017, the National Association of Insurance Companies and the trade unions reached an agreement on the new contract terms and economic conditions for management employees.

19 In Official Gazette No. 116 of 19 May 2016, the Regulation governing the training period for access to the legal profession in accordance with Article 41, Paragraph 13 of the Law of 31 December 2012, No. 247 (Decree No. 70 of 17 March 2016) was published.

20 The Department of Justice Decree 22 of September 2016, published in the Official Gazette of 11 October 2016.

21 Percentages can vary enormously, from a minimum of 0.05 per cent for insurance stipulated on ships registered in Italy up to a maximum of 21.25 per cent for any insurance other than fire, theft, liability, machinery breakdown, personal accident, cargo and marine insurance (i.e., credit or bond insurance is subject to this rate).

The national collective labour contract for the employees of insurance agencies was concluded on 8 July 2014 for the agents of the Generali/Ina Group, and on 20 November 2014 for insurance agents in free management.²²

Furthermore, a national collective labour contract (see subsection vii) is integrated into all applicable labour laws. Of particular importance are Legislative Decree No. 626/1994 dealing with the safety and health of workers at work, the Jobs Act²³ 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:

- a* the Private Insurance Code;
- b* the Civil Code;
- c* the special legislation dealing with compulsory insurance;²⁴ and
- d* regulations issued until 21 December 2012 by ISVAP and from that date onward by IVASS.

ii Making the contract

The rules providing for insurance contracts and their drafting are all contained in the Civil Code.

The contract is not concluded until the two parties agree on the extension of the risk, and on the premium to be paid for the shifting of the risk from the insured onto the insurer.

The conclusion of the contract is a complex succession of events where the prospective insured will propose a risk, usually by completing a proposal form prepared by the insurer, who will evaluate the risk and quote the premium. In completing the proposal, the prospective insured must answer truthfully and completely to avoid being sanctioned for wilful non-disclosure according to Article 1892 of the Civil Code or negligent non-disclosure according to Article 1893 of the Civil Code.²⁵ Case law indicates that all information that is

22 National collective labour contract for employees of insurance agencies under free management (20 November 2014).

23 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'.

24 See, *inter alia*, the Motor Insurance Act No. 990 of 29 April 1969 or the Law on Hunting No. 157 of 11 February 1992.

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 on-site visit and survey might override the false or omitted declarations in the proposal form, as the insurer or its agent (the surveyor) should have checked and realised the differences between the proposed risk and the real risk.

Finally, it is important to mention the IVASS circular letter to the market of 5 November 2013 concerning the long-term property insurance reintroduced by Law No. 99/2009. IVASS, as a result of numerous protests made by insurers complaining about companies' refusal to grant them an early termination of insurance contracts of multi-annual duration, invited all insurance companies, by 31 December 2013, to 'specifically and with adequate graphic evidence' indicate in the policy whether the insured benefited from a discount because of the policy's long duration and the fact that, owing to the discount applied, the policyholder cannot exercise the right of early withdrawal from the contract for the first five years of the contract.

As mentioned in Section II.i, in accordance with IVASS Regulation No. 41/2018, as of 1 January 2019, all negotiations for standard contracts shall be accompanied by a pre-contract information package, except tailor-made insurance that only requires the completion of the proposal form.

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 regarding the object of the insurance or the scope and extension of the contract, and clearly excludes from the insurance any contractual terms that are not expressly incorporated into the policy wording. Notwithstanding this, there are some cases where the policies are badly drafted and the wording can pose problems. If a problem of interpretation arises, the contract will be interpreted using the general interpretation rules that are provided in the Civil Code for all contracts,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 a pro forma contract or whether the policy wording has been duly and totally negotiated between the parties, there will be some substantial differences in the interpretation and enforcement of the contract.

In the first case, whenever the insurer prepares policy wording or forms designed to uniformly regulate a number of contractual relationships principally with non-professionals, the basic rule is to interpret *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.

26 See Cass Civil No. 3165 of 4 March 2003; Cass Civil No. 4862 of 12 May 1999; and Cass Civil No. 10086 of 12 October 1998.

27 See Articles 1362 to 1371 of the Civil Code.

In addition, there are terms that are considered legal but onerous for the party against which these are drafted. These clauses are not binding on a party that has not accepted them and signed twice in accordance with Article 1341 of the Civil Code. This is usually to regulate the contractual terms stipulating a specific and particularly short period to comply with the contract provision, or that modify the court jurisdiction as per the general rules of law or create foreclosure terms. Notwithstanding a listing of clauses, this procedure was judicially extended to insurance underwritten on a claims-made basis, because although a legitimate contract, it deviates from the loss-occurrence basis chosen by the legislature as the typical way in which insurance shall operate.²⁸ This decision created the key question of whether claims-made clauses are legitimate or not. The United Sections of the Court of Cassation, with Judgment No. 22437 of 24 September 2018, decided that claims-made clauses delimit the object of the contract but do not limit the liability, and in view of their non-vexatious nature, do not require double approval in accordance with Article 1341 of the Civil Code.

The Court also affirmed that the contractual model based on the claims made is part of the historical background of civil liability insurance and while it represents a derogation from the 'loss occurrence' scheme provided for in Article 1917(1) of the Civil Code, it is nonetheless permitted pursuant to Article 1932 of the Civil Code. The legitimacy of the clause is also confirmed by legislation through the reform of the National Health Service implemented by the Gelli-Bianco Law. The Court also recalled its Judgment No. 9140 of 6 May 2016 and affirmed that the claims-made clauses are legitimate as they safeguard the interests of both the insured and insurer, hence the judge, case by case, will ensure that there is no asymmetry between the parties, or mechanisms that determine 'temporal gaps in the insurance coverage'. Under Italian law, there are no warranties, but rather conditions precedent or essential conditions. These must be marked and appropriately addressed in the policy so that the insured's attention is directed to the condition.

In setting the terms of an insurance contract, the parties, according to Article 1322 of the Civil Code, are free to negotiate the content of the insurance provided that a risk does exist, and that the terms do not breach internal public policy²⁹ or have an illicit scope.³⁰

Usually there are general conditions providing for all contracts falling within a specific class of business (professional indemnity), particular conditions for a specific group of insured

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 judgment No. 5264 of 23 December 2005, according to which claims-made clauses were deemed to be unfair contract terms and therefore invalid, and affirmed that the validity of claims-made clauses shall have to be assessed case by case, keeping in mind the specificity of the insurance contract scope and the factual elements of the case. However, the Supreme Court did not provide clear directions about the criteria that should support a validity test. Consequently, until this aspect is clarified by future case law, it would be prudent to have the insured accepting claims-made clauses in writing (by double signature) pursuant to Articles 1341 and 1342 of the Civil Code.

29 In the past, the nullity of kidnap and ransom insurance was grounded on ISVAP Regulation No. 246 of 22 May 2005 on the grounds that this type of insurance was inviting criminals to kidnapping insured persons with the aim of obtaining the indemnity payment. Today, Article 12 of the Private Insurance Code provides the same prohibition.

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.

(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 of the loss event. A lack of notice or late notice does not permit the insurer to deny liability unless prejudice has been suffered, and in this case the denial shall be proportional to reflect the prejudice suffered.

For all non-liability insurance, the insured event or the loss occurrence triggers the insurer's indemnity obligations if the insured knew of the event or occurrence, or the insured should have known of the event or occurrence. If the insured does not make a timely notification or does not enforce its right to the indemnity within two years of the loss event, any right under the policy will be covered by the statute of limitation.

A slightly different approach is adopted by Article 1917 of the Civil Code on liability insurance contracts underwritten on a claims-made basis, where the element triggering the insurance guarantee is a third-party claim against the insured made by way of a registered letter or service of a writ of summons.

Once notified of the claim, the liability insurer can decide to defend the third-party claim on behalf of the insured. The duty remains until the liability insurer has exhausted the policy limits, in which case it shall be obliged to defend until the end of the proceeding. The duty to defend also triggers a sub-limit for defence costs equal to one-quarter of the policy limit. If the judgment or arbitration award exceeds the policy limit, the defence costs are apportioned between the insurer and the insured according to their respective interests.

Third parties are not usually privy to the insurance contract, and have no right to make a claim and enforce it in a court of justice. In exceptional and very limited cases, when the policyholder or insured entity remains inactive where there is a risk that the right to indemnity will be time-barred, a third party may, through subrogation,³¹ assume the rights of the insured and claim the insurance coverage. Not even the policyholder can act unless expressly delegated to do so in the policy or by a proxy of the insured.

Further exceptions to the aforementioned rule are found in the special provisions of Law No. 990/69 on compulsory motor accident insurance and Article 149 of the Private Insurance Code (see Constitutional Court judgment No. 180/2009).

No specific sanction is provided for wrongful denial of a claim, but because litigation usually follows, the court might award interests for late payment (provided for by Legislative Decree No. 231 of 9 October 2002) either from the date on which the indemnity was due to the date of final settlement or (in accordance with the newly modified Article 1284 of the Civil Code)³² from the date of the lawsuit service to the date of final settlement.³³

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.

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 the clause would be in conflict with the law.

An example, according to which the freedom of the parties is limited, is in their choice of international jurisdiction, which in relation to the insurance shall be made in accordance with the provisions of Section 3 (Articles 10–16) of Council Regulation (EC) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, or territorial jurisdiction within Italy when the insured is a consumer.³⁵ 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-C463,³⁶ 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.

34 Inter alia, see Cass Civil No. 1081 of 18 January 2011.

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.

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.³⁷

Legislative Decree No. 28 of 4 March 2010,³⁸ implementing EU Directive No. 52 of 2008, imposes mediation for civil and commercial controversies. The Italian Constitutional Court declared the Decree unconstitutional for its abuse of power;³⁹ therefore, the government issued Decree-Law No. 69 on 21 June 2013 (converted into Law No. 98 on 9 August 2013), which restored the mediation process as a condition of admissibility but limited it to any proceedings in the areas listed in Article 5, Paragraph 1 of Legislative Decree No. 28/2010. Among the different conflicting issues listed are:

- a* insurance contracts;
- b* medical malpractice;
- c* directors' and officers' liability; 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 the opportunity, and may only oppose and resist the claim when appearing at the first hearing, which is either scheduled on the writ of summons or postponed *ex officio* by the court to meet the court calendar.

In the first hearing, the judge checks that all the necessary parties are present. Following this, the court may issue default orders against parties that have failed to attend and, if a duly summoned party to proceedings fails to attend, the court might consider some of the factual allegations and the documents produced as uncontested and ground his or her decision on such evidence. After that the discovery phase opens and the parties will have:

- 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, 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, they are discussed by the judge who will determine which evidence is relevant for the case, and hence admissible; in the same court order, the judge will decide if independent expertise is necessary, and if it is, he or she will fix a specific date to swear in the court expert, and to give instructions about the scope and object of the expert testimony. One independent expert is appointed by the court and one by each

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 No. 53 of 5 March 2010.

39 Constitutional Court judgment No. 272/2012 in the Official Gazette of 12 December 2012.

of the parties, and the court-appointed expert will lodge a written report to which the parties have a right of reply. If one or both parties disagree with the court-appointed expert, the latter might be called to the hearing to answer questions or to draft a supplement to the report.

Depending on the number of witnesses and questions, the evidentiary proceedings will be divided into one or more hearings scheduled generally every quarter.

Once the discovery is over, the case enters into the decision phase with a hearing where the court receives the parties' arguments. From that date, two terms start to run: 60 days to lodge the last written defence, and a further 20 days to rebut the final defences of the opponents.

Exceptionally, at the end of the discovery the court might elect to follow a fast-track proceeding pursuant to Article 281 of the Civil Procedure Code. In this proceeding, the parties shall lodge a short brief with the court 10 days before the hearing for arguments and, at the hearing after having given the arguments, the judge will listen to their oral pleadings and issue a decision, the reasoning for which will be explained in writing at the time of the publication of the judgment. In general, the decision process of a court takes from three to 14 months; however, much will depend on the complexity of the arguments raised by the parties and the court's workload. Typically, the entire litigation lasts from two to three years in first instance, and a little less at first appeal and before the Court of Cassation.⁴⁰

In litigation, costs follow the event; therefore, the losing party shall bear on top of its own costs the successful party's costs and court costs, including the cost of expertise, the court duties and the register tax on the judgment.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.

Since 1 January 2015,⁴² a series of tasks previously carried out on paper and in person must be done electronically and remotely (the Electronic Civil Process).

In fact, with the Electronic Civil Process, lawyers can:

- a* consult case court files online;
- b* receive telematics communications from judicial offices, and serve defences and judgments directly upon other lawyers;
- c* execute electronic payment of unified court duties; and

40 Usually an appeal lasts two years, and the Court of Cassation proceeding between one year and 18 months.

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.

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 *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.

- d* file defences, writs and pleadings along with the supportive documents packed into a specific ‘electronic envelope’ that is automatically electronically controlled and recorded by the national software system.

Despite a number of courts experiencing technical problems and interpreting the new rules differently, the technical instrument should guarantee a faster proceeding with less administrative personnel. The overall time between the service of summons and the issuing of judgments decreased from 1,075 days in 2015 to 840 in 2017, with a minor decrease to 817 days in 2018.

iii Arbitration

There are two forms of arbitration: formal arbitration, where the award has the nature of a court judgment; and informal arbitration, whose award has the nature of a contract and therefore can 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. While the formal arbitration procedure is regulated by the Civil Procedure Code⁴³ and the decision is rendered in accordance with the strict rule of the law, informal arbitration is not regulated and the parties can decide their own rules in the arbitration clause.

It is somewhat rare to encounter clauses in Italian policy wording that provide for formal arbitration for a number of reasons, including the risk of lack of independence of one or more of the arbitrators, and the costs of such procedures. Formal arbitration can, however, guarantee a first instance decision in a relatively short time (between six months and one year in the vast majority of the cases), as against the lengthy proceedings in a court of law (between two and 10 years).

Informal arbitrations are, however, quite common in property and business interruption insurance. Here, too, the costs of the procedure are usually high and reflect the work done in the loss-adjustment process.

iv Alternative dispute resolution

Alternative dispute resolution clauses, apart from contractual expertise clauses, do not feature in Italian insurance contracts.

In a contractual expertise clause, the parties provide referral to one or more third parties, chosen for their particular technical competence, the task of formulating a technical appreciation, evaluation or economic appraisal. It follows that, if the parties have referred to experts the determination of a value of the relevant things,⁴⁴ the extent of the damage suffered⁴⁵ or the indemnification,⁴⁶ the adjustment they make shall determine the value not in the abstract, but with reference to the specific loss event.

43 See Civil Procedure Code Title VIII: On Arbitration (Articles 806–840).

44 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.

45 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.

46 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 expert opinion can be attacked and challenged only through the typical actions for annulment, actions for breach of contracts, or both.

v Mediation and mandatory assisted negotiation

Article 5 of Legislative Decree No. 2 of 4 March 2010 includes a list of disputes subject to compulsory mediation. Among other controversies, the law mentions disputes relating to insurance contracts, and to compensation for damage caused by the circulation of vehicles, by medical malpractice, and because of the liability of directors and officers. If the case was litigated without prior recourse to mediation, the judge had to suspend the litigation and grant the parties a term of six months to mediate.

The Constitutional Court, with ruling No. 272 of 6 December 2012,⁴⁷ declared Legislative Decree No. 2 of 4 March 2010 unconstitutional for excess of legislative delegation, insofar as it provided for the compulsory nature of mediation. Following this binding precedent, mediation remained available to resolve insurance disputes, but because it was no longer compulsory it was little used and the rate of successfully mediated disputes, which was already low when the procedure was compulsory, dropped even further after the Constitutional Court judgment.

This situation was reversed by the Decree Law No. 69/2013, which reintroduced compulsory mediation for a number of types of controversies, including claims for medical malpractice, professional errors and omissions, damages for libel and slander, insurance, banking and financial contracts. Two novelties have been introduced by the new legislation: only mediation entities or bodies present within the territory of the judge competent to hear the eventual subsequent litigation can legitimately run a mediation; and the parties shall be assisted by a lawyer during the compulsory mediation sessions.

Decree Law No. 132/2014, as converted into Law No. 162/2014, introduced a new form of alternative dispute resolution as a condition of admissibility of any lawsuit, including payment of debts up to €50,000, but limited to any proceedings that are not listed in Article 5, Paragraph 1 of Legislative Decree No. 28/2010 (mandatory assisted negotiation). With this new alternative dispute resolution, the parties, with the assistance of one or more lawyers acting as facilitator, should try to negotiate a solution to their existing controversy within three months. If the assisted negotiation fails, the parties can then legitimately act in court to have the judge resolve the dispute.

V YEAR IN REVIEW

The year 2019 was not characterised by many legal changes on the legal and regulatory side, even though two notable changes had been introduced:

- a* IVASS Regulation No. 43 implementing the provisions on the temporary suspension of capital losses in current securities; and
- b* IVASS Regulation No. 44 on organisation, procedures and internal controls and customer due diligence.

Moreover, on 10 July 2019, IVASS and the China Banking and Insurance Regulatory Commission (CBIRC) entered into a memorandum of understanding setting forth the

⁴⁷ Judgment published in the Official Gazette of 12 December 2012.

basis for cooperation between the two supervisory bodies with the scopes of: (1) exchanging information on developments of the regulatory and supervisory framework in the two countries, and (2) cooperation regarding the supervision and oversight of insurance undertakings.

Similar to what has been available for the life insurance sector since 2015,⁴⁸ for motor accident personal injuries and since 2017 to boost the purchase of relevant products, the Stability law 2018⁴⁹ introduced for policies, which were stipulated from 1 January 2018, a new 19 per cent tax deduction in respect of insurance premiums related to home insurance against disasters. This law provision was actually applied for the first time with the tax declaration presented on 2 December 2019.

The legislature has introduced complementary pension scheme measures through the individual pension plan. This is aimed at parties who, regardless of their employment situation (e.g., employees or freelancers), want to save supplementary income. The tax benefits for these instruments include reduced taxation on contributions paid (i.e., 20 per cent instead of 26 per cent).

Finally, the insurance market throughout 2019 continued to benefit from the 2017 systemic actions, with reference to compulsory motor insurance and the introduction of the Electronic Civil Process, so the overall expenditure for motor accident was reduced despite the average increase of the indemnities awarded by the courts.

VI OUTLOOK AND CONCLUSIONS

In 2020, how the Italian economy will develop after the covid-19 pandemic has passed is unpredictable because of the general EU economic climate, and the increasing political uncertainties and tensions that characterise the EU's choices about a common economic politics.

At a national level, domotics (home automation and smart working) and new health insurance are currently rarely sold, but those products are expected to take off this year as a consequence of the lockdown to counter new risks posed by the internet of things at home and the constant reduction of resources available to the National Health Service.

The trend of a reduction in premiums for medium- to long-term insurance policies continues to slow down even if the average price for motor insurance on an annual basis should decrease (as in 2019). Interestingly this last trend seems unrelated to the black box discounts as only approximately 21 per cent of the stipulated contracts contains clauses for reducing the premium owing to the presence of the black box. No significant changes are expected in relation to black box installation in 2020.

The 2017 healthcare risk management and prevention reform full operativity was subject to a number of delegated decrees that should have regulated the medical liability for both public and private sector, and expedited the settlement of disputes through the recourse to regulated med-mal insurance. On 13 September 2019, the draft decree on the minimum guarantee requirements for insurance policies, set out in Article 10 of the Gelli Law, was finally ready albeit still under examination by the Ministry of Economic Development. The decree regulates the minimum guarantee requirements and the general conditions both in case of direct risk assumption, such as self-insurance and risk self-retention, or in case of

48 See Article 15, comma 1, lett. f), TUIR.

49 Law 205/2017.

insurance. There are rules for the transfer of risk in the event of the contractual takeover of an insurance company; provision dealing with the financial annual accounting of the risk fund and a fund consisting of the accrual of the compensation for the claims reported; and finally, the temporal operativity of the guarantee. Interestingly the insurer may exercise the right of recourse against the health professional who has not regularly fulfilled the Continuous Medical Education and Training and updated the current obligation on continuing education.

Interestingly, beside the General Terms and conditions of Insurance, the decree provides for policy limits that are established for different classes of risk, but that cannot be lower than:

- a* for outpatient facilities that do not perform services that can be delivered only in protected clinics; in other words, clinics located within hospitalisation and care institutions, including analysis laboratories, a policy limit of not less than €1 million per accident, and an aggregate for each year of not less than threefold that of the single claim;
- b* for structures that do not carry out surgical, orthopaedic, anaesthesiologic and childbirth activities, including residential and semi-residential socio-medical structures, as well as for outpatient structures that perform services that can only be provided in protected clinics, that is, clinics located within hospitalisation and care, or dental activity and for social and health care facilities, a ceiling of not less than €2 million per claim, and an aggregate for each year of not less than threefold that of the single claim;
- c* for structures that also carry out surgical, orthopaedic, anaesthesiologic and childbirth activities, a limit of not less than €4 million per claim, and an aggregate for each year of not less than threefold that of the single claim; and
- d* for claims in series, each claim and per year aggregate policy limit shall not be less than threefold that of the single claim referred to in (a), (b) and (c) regardless of the number of injured parties.

Similarly, the policy limits of the compulsory insurance contracts for those who carry out their business outside one of the public or private health or social-health structures, or who work within the same in a freelance professional regime, divided for the following class of risks are:

- a* for healthcare professionals who do not carry out surgical, orthopaedic, anaesthesiologic and childbirth activities, a ceiling of not less than €1 million per claim, and an aggregate for each year of not less than threefold that of the single claim;
- b* for health professionals who also carry out surgical, orthopaedic, anaesthesiologic and childbirth activities, a maximum of not less than €2 million per claim, and an aggregate for each year of not less than threefold that of the single claim; and
- c* for claims in series, each claim and per year aggregate policy limit shall not be less than threefold that of the single claim referred to in (a), (b) and (c) regardless of the number of injured parties.

The decree is expected to be licensed and become operative during 2020.

In connection with the implementation of the GDPR, IVASS has been active since 2018 in supervising insurance market awareness about the new legislation requirements, and especially the processes put in place to prevent data breaches and the eventual subsequent notifications and remedial action. In particular, aside from the more traditional interventions upon insurance and reinsurance companies, this action has been grounded in particular on Article 37 et seq. of IVASS Regulation No. 44/2019, where all aspects to be taken into

consideration to acquire information useful for assessing the purpose and nature of the relationship or operation are detailed in accordance with the provisions of other European countries. Specifically, Article 39 defines a detailed procedure for carrying out adequate remote control by means of digital audio/video recording tools, where reliable technologically innovative solutions are used. This procedure reflects that envisaged by the Italian Agency for Digital Innovation in the 28 July 2015 Regulation for the management of the SPID (Public Digital Identity System).

In conclusion, the insurance market and, as a consequence, the reinsurance market, are expected to benefit from all these changes throughout 2020.

JAPAN

Shinichi Takahashi, Takahiro Sato and Ayako Onishi¹

I INTRODUCTION

The Japanese life and non-life insurance markets are very competitive, involving a large number of companies. Although Japanese insurance companies are providing individual annuities in response to the expanding demands of an ageing population, the falling birth rate in Japan has had the effect of reducing demand for life and non-life insurance coverage. Accordingly, major Japanese insurance companies are seeking business opportunities overseas to expand their presence in the worldwide market, which has larger room for growth. At the same time, in their domestic strategies and with a view to streamlining, Japanese insurance companies have promoted mergers and acquisitions, which has led to their integration into some larger insurance groups, and they have sought more cost-effective sales channels for insurance contracts. To achieve a synergistic effect through integrated group management, insurance companies are undertaking cross-selling by sharing the clients of companies in the same group to ensure easy access thereto. Further, the style of solicitation has been diversified for efficiency and to respond to the needs of customers. Traditionally, sales of life insurance were made face-to-face by employees of life insurance companies that undertook solicitation activities on behalf of a sole insurance company. However, the use of agents, including bancassurance (that is, the selling of insurance products by a bank liberalised in December 2007) and those undertaking solicitation activities on behalf of multiple insurance companies, and direct marketing through several channels, which did not occur in the past, are becoming more common. As with the life insurance market, the non-life insurance sales channels are diverse.

As for the reinsurance market, there are two domestic reinsurance companies and a number of branches of foreign reinsurers in Japan. Non-life insurance companies also underwrite reinsurance. Japanese non-life insurance companies play an important role in the world's reinsurance market.

II REGULATION

i The insurance regulator

Insurance business is regulated under the Insurance Business Act (IBA), whereby the Financial Services Agency (FSA) takes the main role as the insurance regulator. Under the IBA, the Japanese Prime Minister (PM), who has the authority to supervise the entities or persons that conduct insurance business and related business in Japan, delegates most of his

¹ Shinichi Takahashi is a partner, and Takahiro Sato and Ayako Onishi are associates at Nishimura & Asahi.

or her authority (excluding certain important powers such as granting or cancelling insurance business licences) to the Commissioner of the FSA. The Commissioner further delegates a part of his or her authority to the directors of the Local Finance Bureau of the Ministry of Finance (LFB).

The FSA and the LFB have the authority to (1) demand reports from and inspect insurance companies, licensed branches of foreign insurers (licensed branches), small-amount and short-term insurance (SASTI) providers, subsidiaries thereof, service providers subcontracted by any insurance company, certain major shareholders of insurance companies, insurance holding companies, and insurance agents and brokers; and (2) take administrative action against insurance companies, licensed branches, SASTI providers, certain major shareholders of insurance companies, insurance holding companies, and insurance agents and brokers.

The FSA stipulates detailed regulations under the IBA. Additionally, the Comprehensive Guidelines for the Supervision of Insurance Companies and SASTI Providers (the Guidelines), set by the FSA, contain basic concepts, evaluation criteria and other guidelines relating to the supervision of insurance companies and SASTI providers, which should be observed when doing insurance business in Japan.

ii Position of non-admitted insurers

Insurance and reinsurance activities are only permitted to be undertaken by insurance companies, Japanese branches of foreign insurers and SASTI providers that have obtained licences in Japan. Foreign insurers not licensed in Japan under the IBA and without branch offices in Japan cannot conclude domestic risk insurance contracts (i.e., insurance contracts for persons resident or domiciled in Japan, or with property located, or vessels and aircraft registered, in Japan), with the exception of certain insurance contracts, such as:

- a* reinsurance;
- b* insurance covering international freight;
- c* overseas travel insurance; and
- d* 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:

- a* life insurance solicitors, such as life insurance agents, and officers and employees of life insurance providers;
- b* non-life insurance solicitors, such as non-life insurance agents, and officers and employees of non-life insurance providers;
- c* small-amount and short-term insurance solicitors; and
- d* insurance brokers.

Life insurance agents, officers and employees of life insurance providers, non-life insurance agents and SASTI solicitors must register with the PM through the LFB.

Unlike non-life insurance, from an insurance regulatory perspective, the officers (excluding officers with authority of representation, company auditors and members of audit committees) and employees of licensed life insurance providers are required to register.

Since these intermediaries listed above, except for brokers, are entitled to act as intermediaries for the conclusion of insurance contracts on behalf of insurance companies, licensed branches and SASTI providers, they are responsible for loss incurred by customers because of improper actions of intermediaries during the solicitation of insurance.

Brokers are independent from insurance companies. If a customer incurs loss because of the improper action of a broker, insurance companies are not responsible for the loss and the broker must indemnify the customer for the loss. Therefore, to ensure the resources to indemnify customers against loss, the IBA requires brokers to:

- 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 the means listed in points (a) or (b), or both).

iv Requirements for authorisation

Japanese insurance companies

Insurance companies must obtain from the PM either a life insurance business licence or a non-life insurance business licence.

The applicant must submit a licence application with the required attachments to the PM through the FSA. The required attachments include:

- a* 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

Permitted activities and subsidiaries

Insurance companies and licensed branches can carry out only the following types of business under the IBA:

- a* underwriting insurance and management of assets (typical business);
- b* incidental business, for example:
 - representing the business or performing services on behalf of other insurance companies and other entities carrying out financial business;
 - guarantees of obligations;
 - handling private placements of securities; and
 - derivative transactions; and
- c* business permissible under the IBA and other laws (e.g., certain securities trading business and trust business concerning secured bonds).

Insurance companies cannot hold subsidiaries other than those set out in the IBA, including:

- a* companies that engage in financial business (e.g., insurance companies, banks, securities companies and trust companies);
- b* companies that engage in business that is dependent on the business of their parent insurance companies and their subsidiaries;
- c* companies that engage in business that is incidental or related to financial business;
- d* companies that explore new business fields; and
- e* holding companies whose subsidiaries are limited to companies listed in points (a) to (d).

Since this rule was applicable to subsidiaries inside and outside Japan, and as major Japanese insurance companies tended to seek business opportunities overseas to expand their presence in the worldwide market as there is larger room for growth, it was pointed out that Japanese insurance companies, upon acquiring foreign insurance companies, found their competitive position impaired because they were forced to sell certain subsidiaries not qualified under the IBA. For this purpose, the reforms of the IBA in March 2012, and May 2014, loosened the restrictions on the business engaged in by subsidiaries of foreign financial institutions acquired by Japanese insurance companies, subject to approvals having been obtained. However, the approved foreign subsidiaries should be sold within five years after the date of the acquisition unless the insurance companies obtain approval from the PM to extend this period. This affords Japanese insurance companies greater flexibility in expanding overseas.

Neither insurance companies nor their subsidiaries can acquire or hold, on an aggregated basis, more than 10 per cent of the total voting rights of all shareholders of any other company in Japan, except companies that can be held as subsidiaries by insurance companies, as mentioned above. The Anti-Monopoly Law imposes similar restrictions.

Ownership

A shareholder of a Japanese insurance company or insurance holding company that holds more than 5 per cent of the total voting rights must file a notification with the LFB or (in certain cases) the FSA, and file a report each time there is a change to the notification. If the person or entity is to acquire directly or indirectly (through other entities) at least 20 per cent of the total voting rights of a Japanese insurance company (or 15 per cent in certain cases) (major shareholder threshold), they must obtain prior authorisation from the FSA. The IBA provides a certain review standard for the authorisation to ensure sound and appropriate management of the insurance company's business.

Acquisitions of SASTIs must be pre-approved by the LFB when the major shareholder threshold is surpassed.

Further, the acquirer or holder must file an *ex post* notification with either the FSA or LFB respectively, if either (1) the person or entity acquires more than 50 per cent of the total voting rights of a Japanese insurance company or SASTI provider; or (2) the number of voting rights held becomes equal to or less than 50 per cent, or less than the major shareholder threshold.

With respect to insurance holding companies, the following must obtain prior authorisation from the PM: a company that intends to become a holding company with an insurance company as its subsidiary; and a person who intends to establish such a holding company.

In the case of SASTI providers, pre-approval is required from the LFB.

After becoming an insurance holding company, notification is necessary when the company makes an insurance company its subsidiary.

The holding company must file a notification if an insurance company or a SASTI provider ceases to be its subsidiary.

Approval requirements

Under the IBA, insurance companies must obtain approval for the following:

- a* transactions that are not generally conducted in the ordinary course of business (such as a transfer of insurance contracts, transfer of insurance business or entrustment of insurance business); and
- b* corporate actions that involve:
 - a reduction of the capital of stock insurance companies;
 - entity conversion of a stock insurance company into a mutual insurance company (and vice versa); or
 - a merger, company split or liquidation.

Issuance of any equity triggers an *ex ante* notification obligation only when the insurance company increases its stated capital with such an issuance of equity. Debt security also requires an *ex ante* notification, but only if it is in the form of bonds with share warrants.

Capital requirements and solvency margin requirements

Japanese insurance companies must hold more than ¥1 billion in either (1) stated capital (in the case of a stock company); or (2) total amount of *kikin* (the funds held by a mutual insurance company, equivalent to the capital held by stock companies) including a reserve for redemption of *kikin* in the case of a mutual company.

The IBA provides for a solvency margin ratio as a standard to assess the soundness of an insurance company's business. The solvency margin ratio is calculated by dividing the total amount of stated capital, *kikin*, reserves and other amounts by the amount available to cope with possible risks, exceeding the standard predictions that may occur because of insurance accidents. Insurance companies must maintain a solvency margin ratio of at least 200 per cent. In practice, however, all insurance companies maintain a higher ratio. The formula for calculating the solvency margin ratio is as follows:

$$\text{Solvency margin ratio (\%)} = \frac{\text{the total amount of margin} \times 100\%}{\text{the total amounts of risk} \times 1/2}$$

The group solvency margin requirement on a consolidated basis has been applicable to an insurance company and insurance holding company since the fiscal year end of 31 March 2012, which means the solvency margin ratio of a group with an insurance company or insurance holding company at the top should be calculated on a consolidated basis (i.e., the insurance holding company and its subsidiary or the insurance company and its subsidiary).

Similar ongoing requirements apply to licensed branches and SASTI providers.

III INSURANCE AND REINSURANCE LAW

i Sources of law

IBA

The IBA and related regulations provide for the supervision and regulation of the insurance and reinsurance business. The definition of an insurance business under the IBA includes insurance and reinsurance activities. Therefore, the IBA regulates insurers and reinsurers in the same way.

Insurance Act

The Insurance Act generally regulates insurance contracts entered into after 1 April 2010.

ii Making the contract

Essential ingredients of an insurance contract

While the IBA does not define what constitutes an insurance contract, an insurance contract under the Insurance Act is defined as an insurance contract, a mutual aid contract or any other contract in whatever name, under which both:

- a 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
- b 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 interest is decided on a case-by-case basis, so that those in need of cover are not unduly restricted from accessing sufficient cover.

There is no definition of a contract of reinsurance in either the Insurance Act or the IBA. However, a contract of reinsurance is a type of non-life insurance.

Information provided to the insurer at placement

Under the Insurance Act, applicants are required to provide material information that is related to the possibility of an accident or loss to the extent specified by an insurance company at the time of placement (Article 4).

Utmost good faith, disclosure and representations

As stated above, policyholders and the insured are obliged to disclose material facts that are specifically requested by an insurer in relation to the insurance, at the time of concluding an insurance contract (the duty of disclosure). In this regard, under Japanese law, the duty of disclosure is generally considered not as a representation of utmost good faith, but rather as a legal mechanism to correct information asymmetry so that the insurers can have adequate information held only by policyholders or the insured.

Recording the contract

To avoid being exposed to a moral hazard, insurance companies have introduced a system for recording certain insurance contracts with the Life Insurance Association and the General Insurance Association, and share the information of the insurance contracts between the members of those associations for reference in conclusions of insurance contracts and claims handling, or for checking the overinsurance.

iii Interpreting the contract

General rules of interpretation

Generally, it is understood that an insurance policy should be interpreted in a uniform manner so that insurance contracts between a number of policyholders are read as the same, and policyholders and the insured under the same insurance policy are treated equally. Accordingly, the intentions or understanding of an individual policyholder are not considered in the interpretation of insurance contracts.

Incorporation of terms

Policy conditions

While insurance policies are not required to be in writing, insurance contracts are generally concluded with policy conditions predetermined by the insurance company and approved by the FSA, or, instead of the approval, certain types of insurance contracts can be sold either:

- 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 any contradicting policy provisions are null and unenforceable. Further, unilateral compulsory provisions make invalid and unenforceable any provisions in the policy that are less favourable to the insured or policyholders than the unilateral compulsory provisions. That said, however, unilateral compulsory provisions in favour of the insured or policyholders are not applicable to certain commercial lines of insurance, including:

- a* marine insurance;
- b* insurance concerning aircraft or air cargo;
- c* insurance concerning nuclear facilities; and
- d* business activities insurance.

It is often the case that reinsurance is interpreted as ‘business activities insurance’.

Policy conditions consist of both:

- a* general policy conditions in which the basic terms of the insurance policy are stipulated; and
- b* special policy conditions by which the terms of the general policy conditions are amended or supplemented.

Insurance certificate

Under the Insurance Act, if an insurance contract is concluded, the insurance company must deliver an insurance certificate to the policyholder, where the policy conditions do not exclude the application of this provision. The insurance certificates set out basic information, including the insurance premium, insurance period, risks covered, insured amount and policyholder’s name.

Types of terms in insurance contracts

General policy conditions commonly include clauses relating to the following matters:

- a* scope of the insurance and exclusions;
- b* limit of the insurance company’s liability;
- c* commencement and termination date of the insurance;
- d* calculation of the amount of the insurance claim;
- e* procedure for payment of the insurance claim;
- f* duty of disclosure;
- g* duty of notification;
- h* insurance subrogation;
- i* invalidity, expiry or termination of the insurance contract; and
- j* resolution of disputes and governing law.

Warranties

As stated above, under the Insurance Act, policyholders and the insured are bound by the duty of disclosure. Where a policyholder or insured party has breached the duty of disclosure or misrepresented matters subject to the duty of disclosure because of malicious intent or gross negligence, the insurance providers can cancel the insurance contract, provided, however, that the insurance providers cannot terminate the insurance contract for breach of the duty of disclosure, if their insurance agent either:

- a* prevented the insured or policyholders from disclosing material facts; or
- b* advised the insured or policyholders not to disclose material facts or to misrepresent material matters.

As a result, upon the cancellation, the insurer will not be liable for damage caused by insurance accidents that arise from matters not notified because of the breach of the duty of disclosure (Articles 4, 28, 37, 55, 66 and 84 of the Insurance Act). However, the insurer is still liable for damage caused by insurance accidents that are not relevant to the matters subject to the duty of disclosure. Since the provisions above are categorised as unilateral compulsory provisions in favour of the insured or policyholders, policy terms less favourable to the insured or policyholders are invalid and unenforceable.

Conditions and conditions precedent

Where the insurance policy imposes, as a policy condition, a duty of notice on policyholders and the insured to the effect that when there are any changes in the subject matter of the duty of disclosure that relate to the increase of risk, then the policyholders and the insured are required to give notice to insurers (the duty of notice upon increase of risk). Where the policyholders or the insured have breached the duty of notice upon increase of risk, because of malicious intent or gross negligence, the insurers can cancel the insurance contract. As a result, upon the cancellation, the insurer is not liable for damage caused after the increase of the risk. However, the insurer is still liable for damage caused by accidents that are not relevant to the increased risk (Articles 29, 31, 56, 59, 85 and 88 of the Insurance Act). Since the above provisions are categorised as unilateral compulsory provisions, policy terms less favourable to the insured or policyholders are invalid and unenforceable.

As stated above, policy conditions should not contradict the compulsory provisions or unilateral compulsory provisions in favour of the insured or policyholders, and if they do so, they will be unenforceable. Major compulsory provisions and unilateral compulsory provisions, and simple explanations thereof, are provided in the following paragraphs. In addition, if any of the terms set out in the Insurance Act are omitted from insurance contracts or reinsurance contracts, they will be implied by the Insurance Act.

Retrospective insurance

According to Articles 5, 39 and 68 of the Insurance Act, an insurance contract is null and void if either (1) the policyholder is aware that any accident to be covered by the insurance has already occurred; or (2) an insurance company is aware that an accident to be covered by the insurance will never occur.

Overinsurance

According to Article 9 of the Insurance Act, in relation to non-life insurance, if an insured amount exceeds the value of the object insured, a policyholder can cancel the excess part of the insurance contract, unless either (1) the excess is caused by the malicious intent or gross negligence of the policyholder; or (2) there is an agreement regarding the value of the object insured.

Right to reduce insurance premiums because of decreasing insurance value

If a non-life insurance value is reduced in a significant way, the policyholder can claim for reducing insurance premiums at the level of reduced insurance value (Article 10 of the Insurance Act).

Right to reduce insurance premiums because of decreasing insurance risk

If an insurance risk is reduced in a significant way, the policyholder can claim for reducing insurance premiums at the level of reduced insurance risk (Articles 11, 48 and 77 of the Insurance Act).

Extinguishment of the insured objects after the occurrence of covered damage

In relation to non-life insurance, insurers must pay insurance reimbursements if the insured objects are extinguished after the covered damage has occurred (Article 15 of the Insurance Act).

Statutory lien for liability insurance

In relation to liability insurance, those damaged by covered accidents are entitled to obtain a lien over claims for insurance reimbursements. Therefore, the insured are allowed to exercise their claim against the insurer only with the consent of those damaged by covered events or to the extent that they have indemnified those damaged by covered events.

In addition, liability insurance claims against insurers cannot be transferred, subject to a pledge or sequestered, except in certain cases (Article 22 of the Insurance Act).

Insurance subrogation

In relation to non-life insurance, if an insured can claim against another person with respect to the loss covered by the insurance and an insurance company has paid the insurance claim, the insurance company will be subrogated to the rights held by the insured against the other person to an extent that does not prejudice the rights of the insured, but only to the extent of the amount paid (Article 25 of the Insurance Act).

Right to cancel by the insurer

An insurer can cancel the insurance contract when (Articles 30, 57, and 86 of the Insurance Act):

- a* 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).

Right to cancel by the insured

In certain circumstances, when the insured is not the same person as the policyholder, the insured can cancel the insurance contract (Articles 34, 58 and 87 of the Insurance Act). This applies to non-life accident and health insurance, life insurance, and fixed-benefit accident and health insurance.

iv Regulations on insurance solicitation

Conduct rules

The solicitation of insurance should be conducted in an appropriate manner in accordance with the rules provided under the IBA and the Guidelines, including:

- a* persons carrying out insurance solicitation should provide information and an explanation of important items necessary for the customers to determine whether to conclude an insurance policy;
- b* no false statement should be made with respect to important items;
- c* policyholders and the insured should not be encouraged to make a false statement, or be prevented or discouraged from disclosing a material fact to insurers; and
- d* no discounts or rebates on insurance premiums or any other special benefits should be offered to policyholders or insured parties.

The Life Insurance Association of Japan provided clarification of 'special benefits' (referred to in point (d) above) in its Voluntary Guidelines on 8 March 2017, in response to a request by the FSA. In light of this, special benefits include not only prepaid payment instruments under the Payment Services Act, such as e-money, book coupons and coupons for goods, but also points that can be exchanged for money or e-money even if they do not fall under prepaid payment instruments. Moreover, it also stated that whether other types of benefits are included under special benefits should be assessed based on the range of usage of the services, and whether the economic value and contents of the services exceed social norms.

Obligations to provide information

In the past, regulations on the provision of information were worded as negative obligations under the IBA. However, the 2014 amendment of the IBA, which entered into force on 29 May 2016 with the related Cabinet Order and other Ministry Ordinance, imposes positive obligations. Under the revised IBA, persons carrying out insurance solicitation must provide their customers with the contents of insurance contracts and other helpful information for policyholders. Details of the exact information required to be supplied under this obligation are delegated to subordinate regulations.

Obligation to check intentions of customers

Insurance companies and solicitors are required to confirm the intentions of customers when soliciting insurance. This rule expects insurance solicitors to:

- a* understand the motivation and purposes behind new customers seeking insurance policies (i.e., the risks that the customer has identified and would like to cover by purchasing insurance);
- b* offer insurance policies that are suitable for such purposes;
- c* provide explanations of the policies to customers; and
- d* prior to the conclusion of insurance contracts offer opportunities for the customers to confirm that the insurance policies are in line with their original purposes, or in cases where there are differences between them, to explain the differences and the reasons for the differences.

Unlike other major requirements for insurance solicitation, detailed requirements are not provided for this obligation; instead, the supervisory authority anticipates that insurance solicitors will adopt innovative approaches and come up with reasonable and appropriate measures depending on the types of insurance policies and solicitation channels.

Restrictions on consignment

Under the IBA, consignment of insurance solicitations is allowed only where they are made directly by the insurance companies, for the purpose of ensuring the appropriateness of the solicitation by means of direct control by the insurance companies.

However, the direct consignment rule is not applicable where (1) an insurance company consigns insurance solicitations to another insurance company, (2) both of the insurance companies belong to the same group, (3) the insurance solicitation is carried out by insurance solicitors (e.g., insurance agents) of the consigned insurance company, and (4) they obtain authorisation from the PM. This will enhance the cost-effective group management of insurance companies.

Regulations on multi-tied agents

Multi-tied agents have often professed to be ‘impartial and neutral’ advisers to customers, but there have been cases in which some have recommended insurance policies from which they derive greater benefits, such as policies involving a high commission and policies provided by an insurer who has a financial interest in the multi-tied agent. Concerns have been raised about a lack of transparency in the sales processes of multi-tied agents and, further, that multi-tied agents have been known to make misleading representations, suggesting they are acting for customers rather than insurance providers. To address these concerns, IBA regulations were introduced that require multi-tied agents to explain why they are recommending certain insurance policies above others that are available to them. There are two ways to select an insurance policy. One is to select a policy in line with the customer’s stated needs. In such cases, multi-tied agents should select, from the insurance policies they handle, policies aligned with the customer’s stated needs and explain how the recommended policies fulfil the customer’s requirements. For example, if customers request a life insurance policy with a low premium, multi-tied agents should select a low-premium life insurance policy from the products they handle. The other is to select insurance policies based on the multi-tied agent’s own interests. In such cases, the multi-tied agent may recommend insurance policies regardless of the customer’s requirements but should frankly disclose to the customer why

they have recommended such products. For example, if the multi-tied agent's policy selection is motivated by a financial interest held by the insurer, or a high commission, this must be disclosed to the customer. The above rule does not apply to insurance brokers who act on behalf of customers. Insurance brokers have a fiduciary duty to provide the best advice to customers, therefore they must not select policies on the basis of their own self-interest.

Regulations on telemarketing

Insurance companies and intermediaries engaging in telemarketing solicitation are required to establish solicitation procedures, including measures to address anticipated problems that may arise when dealing with clients who are solicited via telephone, and to identify problems at an early stage, as well as to provide appropriate education, control and guidance to the persons making telephone calls. In addition, insurance intermediaries utilising telemarketing should focus on:

- a* establishing scripts for discussions;
- b* ensuring there is a 'do not call' registry;
- c* recording telephone conversations;
- d* analysing the reasons for complaints and sharing with the persons making the telephone calls measures to prevent such complaints; and
- e* conversation monitoring by personnel who are not party to the conversations, with a view to implementing appropriate measures to address any problems identified by the monitoring.

v Claims

Notification

Under the Insurance Act, notifications of loss are required where policyholders or the insured perceive the loss, thereby giving insurers the opportunity to investigate the accident and determine the loss, or to prevent further extension of the loss. In the event of a default of this notice obligation, the insurance company may:

- 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 moneys.

Good faith and claims

It is generally understood that the parties to an insurance agreement should act in good faith so as not to harm the other parties, although there are no explicit rules that are specifically applicable at the stage of making an insurance claim.

Set-off and funding

A right to set off mutual debts and credits is generally recognised in Japan if certain conditions are met (Article 505 of the Civil Code). These conditions include the satisfaction of both obligations that are due.

Payment of insurance reimbursements must be forthcoming after a reasonable period required for investigations (Articles 21, 52, and 81 of the Insurance Act).

Reinstatement

A basic and very common policy condition of life insurance is a provision that allows policyholders to reinstate an insurance contract in abeyance because of non-payment of an insurance premium. Detailed conditions, effects and procedures are not regulated by law.

Dispute resolution clauses

Arbitration clauses in insurance and reinsurance agreements are enforceable in Japan. Although arbitration clauses are not commonly provided in insurance policies, reinsurance contracts often stipulate the clauses in relation to disputes between ceding companies and reinsurance companies.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Claims for insurance reimbursement against an insurance company must generally be filed in the jurisdiction of the debtor's residence, unless expressly provided in the insurance policy (Article 5 of the Code of Civil Procedure of Japan). Insurance policies sometimes stipulate the choice of forum and venue as the headquarters of the insurance company or, simply, Japan. These arrangements are valid and enforceable in Japan, subject to the FSA approval and notification requirements for the policy conditions, provided that they are not prejudicial to consumers' interests under the Consumer Contract Act, which does not apply to commercial lines (including reinsurance contracts).

Choice of law is often stipulated in non-life insurance policies, and is also valid and enforceable in Japan, subject to the FSA approval and notification requirements for the policy conditions. If not, it is assumed that Japanese law applies to both life and non-life (except for marine) insurance contracts. A choice of foreign law may be void in insurance policies with consumers under the Consumer Contract Act.

Although arbitration clauses are not commonly provided in insurance policies, reinsurance contracts often stipulate these clauses in relation to disputes between cedent companies and reinsurance companies. Generally, arbitration clauses in insurance and reinsurance agreements are enforceable in Japan.

ii Litigation

Japan's litigation system essentially consists of three stages: district courts (first instance), high courts (courts of appeal) and the Supreme Court (court of final appeal). Depending on the complexity of the case and the actions of the other party, it might take a year or more until the conclusion of a case in the court of first instance. In addition to this, if either of the parties refuses to accept the judgment of the court of first instance, it may appeal the case to a higher court, and again to the Supreme Court. Anticipated costs also depend on the situation and include the costs of translation into Japanese, since documents filed in a Japanese court must be in Japanese.

According to litigation practice in Japan, if a policyholder files an action for an insurance claim, he or she must prove all of the following facts:

- a* existence of a valid insurance contract;
- b* occurrence of an insurance event during the insurance period;

- c* occurrence and quantum of loss; and
- d* causal relationship between the insured event's occurrence and the loss.

iii Arbitration

Parties are entitled to agree to submit disputes to arbitration even after occurrence of a dispute; however, an arbitration agreement is required to be in writing for a Japanese court to dismiss a file that is subject to an arbitration agreement, where either party has filed a lawsuit in a Japanese court.

Under the Arbitration Act, parties are free to agree on the procedure to be followed by the arbitral tribunal in conducting the arbitral proceedings, subject to the provisions relating to acts against the public order.

iv Alternative dispute resolution

In October 2010, the Financial Alternative Dispute Resolution System under the IBA was introduced in Japan. Under this System, insurance companies and reinsurance companies are required to do the following:

- a* conclude a contract with the designated institution for dispute resolution designated by the FSA; and
- b* comply with the procedure of the designated institution for dispute resolution to resolve insurance or reinsurance complaints, or disputes arising from insurance business.

However, insurance companies and reinsurance companies are guaranteed the right of access to a court. The Life Insurance Association of Japan, the General Insurance Association of Japan, the Insurance Ombudsman, and the Small Amount and Short Term Insurance Association of Japan are the designated institutions for dispute resolution in insurance business.

In addition, there are some alternative dispute resolution (ADR) forums for insurance complaints and disputes, such as:

- a* the Japan Centre for the Settlement of Traffic Accident Disputes;
- b* the Automobile Liability Insurance and Mutual-aid Dispute Settlement Mechanism; and
- c* the Dispute Resolution Committee established by the National Consumer Affairs Centre of Japan.

v Mediation

For mediation, the court will form a mediation panel consisting of one judge and two other persons to settle disputes amicably; however, this procedure is not commonly used in insurance claims.

V YEAR IN REVIEW

On 31 May 2019, an amendment to the IBA was passed. This amendment expanded the scope of business of insurance companies and increased the type of subsidiaries insurance companies are allowed to hold. With respect to the scope of business of insurance companies, businesses that (1) provide third parties either with customers' information after the insurance company obtains the approval of the customers, or with the information that insurance companies hold; and (2) contribute to the advancement of insurance business or the convenience of customers were added to the businesses that insurance companies may engage in.

In addition, although insurance companies or their subsidiaries cannot together acquire or hold more than 10 per cent of the total voting rights of any other company in Japan (except certain companies listed in the IBA), a company is added to the above list of exceptions if it engages in businesses that either (1) use information technology and other technologies and that contribute (or appear to contribute) to the advancement of insurance business; or (2) that improve (or appear to improve) the convenience of customers.

These amendments were to respond to the development of use of information and data in society, and to expand the scope of fintech/insurtech businesses in which insurance companies' subsidiaries may engage.

VI OUTLOOK AND CONCLUSIONS

On 1 April 2020, comprehensive amendments to the law of obligations in the Civil Code will enter into force. Since insurance contracts are regulated by the Civil Code as the basic law concerning rights and obligations, the amendments entering into force will also affect insurance contracts. The amendments are extensive. The following are the main points of the amendments that will affect insurance contracts.

The concept of 'standard terms of contract' will be introduced to the Civil Code for the first time. The new Civil Code will regulate (among others) the following:

- a* under what conditions standard terms of contract bind the parties;
- b* the obligation of the party that has prepared standard terms of contract to provide the standard terms to the other party;
- c* under what circumstances standard terms are deemed invalid; and
- d* how to amend standard terms of contract.

Insurance contracts usually fall within the 'standard terms of contract' concept. However, since Japanese insurance companies must obtain approval regarding general policy conditions from the FSA, and current insurance policies of Japanese insurance companies will likely bind the parties in accordance with their terms, this amendment will not in practice materially affect those current insurance policies.

The statute of limitations for claims will change pursuant to the amendments. Before the amendments, extinctive prescription starts when it becomes possible to exercise a right, and specific periods were provided separately in the Civil Code, the Commercial Code and so on. After the amendments, the provisions providing for specific periods contained in the Civil Code and the Commercial Code will be deleted, and new provisions will be added to the Civil Code, including the following:

- a* extinctive prescription will take place five years after a creditor becomes aware that he or she can exercise a right; and
- b* extinctive prescription will take place 10 years after it becomes possible to exercise a right.

However, with regard to the Insurance Act, extinctive prescription of insurance-related claims (such as the right to claim loss or benefit payments from an insurance company and the right to claim the return of insurance premiums from an insurance company) is considered to start from when it becomes possible to exercise a right. This will remain the same after the amendments in respect of major claims that insurance companies have to deal with.

Therefore, this amendment to the Civil Code will not materially affect the insurance industry. However, insurance companies should be aware that extinctive prescription of claims other than those defined in the Insurance Act will be regulated by the new Civil Code.

There are other amendments as well that could generally affect companies, so it is advisable for companies conducting business in Japan to make themselves aware of these amendments.

MALTA

Edmond Zammit Laferla and Petra Attard¹

I INTRODUCTION

The insurance industry in Malta has experienced appreciable growth over the past 15 years and has been delivering excellent results. The insurance sector forms an integral and important part of the Maltese financial services industry, which currently contributes just over 12 per cent of Malta's gross domestic product. It has gradually evolved from a small number of local set-ups to approximately 68 insurance and reinsurance undertakings, of which 46 underwrite risks situated outside Malta. Another 503 foreign insurers based in the European Union are underwriting direct risks in Malta, making use of their 'passporting' rights on a services or establishment basis.

In recent years, the financial services single regulator, the Malta Financial Services Authority (MFSA), has introduced a number of innovative corporate structures including: protected cell companies; incorporated cell companies; and reinsurance special purpose vehicles set up either as stand-alone structures or as cells of securitisation cell companies.

With Brexit effectively taking place on the 31 January 2020, Malta is the only remaining EU Member State to offer protected cell legislation.² A protected cell company (PCC) allows for the creation of separate and segregated cells. The individual cells do not have separate legal personality, and business is written through the PCC. This allows each cell to utilise the PCC's passport licence to write business directly throughout the European Union. The legal segregation of the cells means that the assets and liabilities of each cell are ring-fenced from each other, with each cell having a distinct pool of assets and liabilities that remain separate from the assets and liabilities of other cells and from the core of the PCC. A cell is only required to satisfy its own notional solvency capital requirements, and the cells are not required to individually satisfy the minimum capital requirements which can be satisfied by the PCC as a whole. Also, there may be situations where a PCC may permit its cell or cells to utilise a part of the excess capital held by the core to meet their capital requirements under the EU Solvency II regime (Solvency II).

Another company cell structure is the incorporated cell company (ICC).³ The structure is based on corporate principles that are similar to the PCC structure. However, in an ICC structure, each incorporated cell of an ICC is deemed to have a separate legal personality that

1 Edmond Zammit Laferla is a partner and Petra Attard is a senior associate at Mamo TCV Advocates.

2 Companies Act (Cell Companies Carry on Business of Insurance) Regulations, 2010, SL 386.10.

3 Companies Act (Incorporated Cell Companies Carry on Business of Insurance) Regulations, 2010, SL 386.13.

is distinct from that of the core and the other incorporated cells. As a direct consequence of this important distinguishing feature, each incorporated cell would be required to satisfy own funds and solvency capital requirements in its own right.

A securitisation cell company can be set up to assume risks as a reinsurance special purpose vehicle from a ceding undertaking through reinsurance contracts or utilised to assume risks through similar arrangements.⁴ The assets and liabilities of each cell would be segregated from those of other cells, and those assets are not available to creditors of other cells.

II REGULATION

i The insurance regulator

The MFSA⁵ is the single regulator for both insurance undertakings and intermediaries. The Insurance and Pensions Supervision Unit is tasked with the approval process including, inter alia, approval of applications, acquisitions and disposals, and appointment of key function holders, directors and senior management of licensed financial services entities, as well as being responsible for prudential matters, while the Conduct Unit is responsible for conduct of business issues.

The Insurance Business Act⁶ (IBA) and the Insurance Distribution Act⁷ (IDA), together with the Regulations, Insurance Rules and Insurance Distribution Rules issued by the MFSA under the respective Acts, create the legal and prudential framework for regulating insurance business and insurance intermediaries activities in Malta. The IBA is largely modelled on UK statute and implements Solvency II.

The Maltese legal and regulatory regime is fully compliant with Solvency II. Local authorised firms are, however, permitted to adopt the proportionality principle in a number of areas (e.g., system of governance, risk management, supervisory reporting and public disclosure).

ii Position of non-admitted insurers

In Malta, only admitted insurers are entitled to conduct insurance activities. The regulatory regime prohibits the performance of insurance business or insurance distribution activities in or from Malta by unauthorised firms. Exceptionally, reinsurance treaties, contracts covering 'large risks', or contracts of insurance entered into with the approval of the MFSA or the minister responsible can be underwritten by a non-admitted insurer through a broker licensed in terms of the IDA.

EU and EEA insurers and intermediaries authorised by their home Member State are able to 'passport' into Malta, on a freedom of establishment (branch) or freedom of services basis. The MFSA has a secondary regulatory role primarily on conduct and marketing issues.

4 Securitisation Cell Companies Regulations, 2014, SL 386.16 and Re-Insurance Special Purpose Vehicles Regulations, 2016, SL 403.19.

5 Established by the Malta Financial Services Authority Act (Chapter 330, Laws of Malta).

6 Chapter 403, Laws of Malta.

7 Chapter 487, Laws of Malta.

iii Position of brokers

Insurance intermediaries such as insurance agents, insurance brokers and tied insurance intermediaries are required to be authorised by the MFSA. Introducers are not required to seek authorisation; however, the activities they may carry out are limited to making introductions to insurers and insurance agents and brokers. In addition, the Insurance Distribution Directive (IDD), which came into force on 1 October 2018, has also introduced the concept of ancillary insurance intermediaries (AIIs) (see Section III.iv).

iv Requirement for authorisation

The MFSA may grant authorisation to a company with its head office in Malta to carry on insurance business in or from Malta, or to a company whose head office is in a country outside Malta to carry on insurance business in or from Malta.

The following are prerequisites for the granting of a licence under the IBA:

- a* submission of application to the MFSA in the prescribed application form;
- b* submission of a scheme of operations to the MFSA in the prescribed form;
- c* satisfaction of the prescribed minimum own funds requirement;
- d* company's objects are limited to insurance business and operations arising directly therefrom;
- e* all qualifying shareholders, controllers and persons who will effectively direct the business are fit and proper to ensure its sound and prudent management; and
- f* disclosure of any close links.

The documents and information required for the enrolment of an insurance broker or insurance agent broadly follow that of insurers.

The duration of the approval process depends on whether the undertaking is being established as a direct insurer, in which case the MFSA is to consider an application within six months; or a reinsurer or captive, in which case the time period imposed is reduced to three months. The approval process for intermediaries is to be concluded within three months.

Insurers and reinsurers are to hold eligible own funds covering the Solvency II capital requirements, which are calculated using the standard formula or using a full or partial internal model as approved by the MFSA. Insurers and reinsurers must also hold eligible basic own funds to cover the minimum capital requirement.

Insurance intermediaries are required to satisfy applicable own fund requirements. Brokers and agents are to maintain own funds equivalent to €58,250 or 4 per cent of the annual gross premiums receivable, whichever is the higher. The minimum own funds required to be held by insurance managers ranges from €17,000 to €58,250 depending on whether the insurance manager is managing solely captive insurers or whether it has been granted a binding authority to enter into insurance contracts on behalf of the insurers.

v Regulation of individuals employed by insurers

Persons occupying senior management posts, members of the board of directors of an insurer or insurance intermediary and key function holders must all be approved by the MFSA, prior to being appointed. Enrolled insurance intermediaries must have an individual who is registered in the managers, brokers or agents register, as the case may be.

vi The distribution of products

The distribution of products in Malta is carried out both through intermediaries or directly from an insurer at its principal office or at one of its branches. The implementation of the IDD has introduced additional requirements to both insurer and intermediaries carrying on distribution activities, the aim of which is additional consumer protection. The distribution of products is further regulated by the Conduct of Business Rulebook, which is applicable to insurers and intermediaries, as well as European insurance undertakings carrying on insurance business in Malta through the Freedom of Establishment regime. The Rulebook also implemented the conduct of business provisions set out in the IDD.

As of 1 January 2018, producers and distributors of packaged retail investment and insurance products (PRIIPs) are required to comply with the EU Regulation on key information documents for PRIIPs,⁸ which obliges those who produce or sell investment products to provide investors with key information documents.

Following the implementation of the IDD, producers and distributors of non-life products are required to produce an Insurance Product Information Document (IPID).

vii Compulsory insurance

A number of sector-specific laws impose compulsory insurance cover to be undertaken. These include sea vessels, third-party cover for motor vehicles and aircraft. Several professionals are also required to take out a professional indemnity cover. These include accountants, notaries, engineers, trustees and healthcare professionals.

Furthermore, under the IDA, one of the continuing obligations of licensed insurance agents and brokers is to maintain a professional indemnity insurance cover or some other comparable guarantee.

viii Compensation and dispute resolution regimes

Where an insurer or intermediary is unable to satisfactorily resolve a customer complaint, an eligible customer (natural person or micro enterprise) may lodge a complaint with the Office of the Arbiter for Financial Services.⁹

In the case of insolvency of an insurer, recourse by a qualifying person¹⁰ can be made to the Protection and Compensation Fund,¹¹ the objectives of which are to affect payments of claims remaining unpaid by reason of the insolvency of an insurer and to affect compensation to victims of road traffic accidents.

8 Regulation (EU) No. 1286/2014.

9 The Office was introduced on 18 April 2016 by the Arbiter for Financial Services Act (Chapter 555, Laws of Malta). Prior to that complaints were addressed to the Consumer Complaints Manager within the MFSA.

10 A qualifying person is: (1) an insured of the insolvent insurer eligible for protection; (2) a person other than the policyholder, to whom payment in respect of any sums falling due under the policy could have been made in accordance with the policy (e.g., beneficiary); or (3) a person to whom the insolvent insurer is liable to pay any sum or other consideration in respect of the insured's legal liability to such person under the policy of insurance (e.g., third party). In the case of general business protected risks, payments shall be made to every qualifying person who is an individual and to every non-corporate body or association of persons if all such persons are individuals.

11 Set up by the Protection and Compensation Fund Regulations 2003.

ix Taxation of premiums

Stamp duty in the amount of €0.11 for every €100 or part thereof of the sum assured is payable by the insured on policies of insurance (other than life insurance policies). The minimum duty chargeable is generally €13. Duty on life insurance policies that are not renewable every year is payable where the policyholder is resident in Malta or incorporated in Malta at the rate of €0.10 for every €100 or part thereof. The minimum duty chargeable is generally €11.65.

Insurance policies issued by Maltese insurers insuring risks that are situated outside Malta are exempt from Maltese stamp duty or any other form of Maltese insurance premium tax. Furthermore, policies of aviation, marine cargo, marine hull or boat, export credit, suretyship and medical cover are exempt from the payment of stamp duty, even where the risk is deemed to be situated in Malta.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Maltese legal system has foundations in both English common law and civil law. The basis of insurance law is general contract law. There is no generic insurance contract law. However, in 2005, a number of amendments were added to the Maltese Civil Code aimed at regulating life insurance contracts.

Case law precedents are not binding and courts are free to interpret the law, which could result in the same issue being treated differently by the courts.

The elements of contract law are governed by civil law doctrine contained in the Civil Code.¹² The IBA and IDA, and the Rules and Regulations issued thereunder by the MFSA, also deal specifically with compulsory insurance.¹³

ii Making the contract

Essential ingredients of an insurance contract

A contract of insurance means an agreement in which an insurer agrees, for a consideration, to pay to or for the account of the insured a sum of money or other consideration, whether by way of indemnity against loss, damage or liability or otherwise, on the happening of a specified event with respect to which there is an element of uncertainty as to when or whether it will take place.¹⁴

The rules of contract law apply to contracts of insurance and reinsurance. Hence, for a contract to be valid the following essential elements must be satisfied:

- a* the parties must have capacity to contract;
- b* there must be the consent of the parties;
- c* there must be a certain element that constitutes the subject matter of the contract; and
- d* there must be a lawful consideration.

12 Chapter 16, Laws of Malta.

13 See, inter alia, the Motor Vehicles Insurance (Third-Party Risks) Ordinance (Chapter 104, Laws of Malta).

14 Article 2(1), IBA.

Together with the Civil Code elements, Maltese jurisprudence has established the importance of the common law principles of insurable interest and utmost good faith in contracts of insurance.

Recording the contract

Generally speaking, a contract can be concluded verbally;¹⁵ however, the IBA requires a written policy document to be issued by the insurer to the policyholder.

iii Interpreting the contract

General rules of interpretation

Insurance and reinsurance contracts are subject to the same general rules of interpretation that apply to other contracts, as provided for in the Civil Code. Where the terms of an agreement are clear and words in the agreement are attributed the meaning attached to them by usage at the time of the agreement, there shall be no room for interpretation.¹⁶ Where the literal meaning differs from the common intention of the parties as clearly evidenced by the whole of the agreement, preference shall be given to the intention of the parties.¹⁷ In case of any doubt, the agreement shall be interpreted against the obligee (insurer) and in favour of the obligor (insured).¹⁸

Types of terms in insurance contracts

It is common practice for an insurance policy to include clauses relating to policy limits, excess amounts and other general exclusions, indemnity limit and period of insurance, warranties, conditions precedent and consumer complaints' process.

iv Intermediaries and the role of the broker

The IDA regulates insurance brokers, insurance agents, tied insurance intermediaries and insurance managers. Insurance distribution activities means the activities of introducing, proposing or carrying out other work preparatory to the conclusion of contracts of insurance, or of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim.¹⁹

Insurance agents are persons appointed by an insurer to be its agent with the authority to enter into contracts of insurance on its behalf. Insurance brokers are those who acting with complete freedom as to their choice of insurers, bring together persons seeking insurance and insurers, who carry out work preparatory to the conclusion of insurance and reinsurance contracts and who assist in the administration and performance of such contracts, in particular in the event of a claim.

Tied insurance intermediaries (TIIs) are defined as persons carrying on insurance intermediary activities for or on behalf of one or more insurers in the case of insurance products that are not in competition. These persons may collect premiums or amounts

15 However, the Civil Code specifically requires that a number of agreements be concluded in writing, either by means of a private writing or public deed.

16 Article 1002, Civil Code.

17 Article 1003, Civil Code.

18 Article 1009, Civil Code.

19 Article 2(1), IDA.

intended for the policyholder; however, they cannot make any insurance commitments towards or on behalf of the public. Insurance brokers are prohibited from appointing tied insurance intermediaries but can set up branches and appoint introducers. Under the IDD, insurance brokers are now permitted to appoint AIIIs.

An AII is not considered to be an insurance intermediary but a specific type of intermediary operating under specific conditions (e.g., a travel agent, car rental company or motor vehicle dealer). The activities of AIIIs are described as the activities of persons who, for remuneration, take up or pursue insurance distribution activities on an ancillary basis, acting under the full responsibility of authorised undertakings, for the products that concern them, provided that all of the following conditions are met:

- a* the principal professional activity of the natural or legal persons does not comprise insurance distribution activities;
- b* the natural or legal persons only carry out insurance distribution activities in relation to certain insurance products that are complementary to a good or service; and
- c* the insurance products concerned do not cover long-term insurance business or liability risks, unless that cover complements the good or service that the natural or legal persons provide as their principal professional activity.

Insurance managers can provide services to either an insurer or an insurance broker. In the former case, an insurance manager can accept an appointment from an insurer to manage any of its business and may have the authority to enter into contracts of insurance on behalf of the insurer. Insurance managers may also accept an appointment from an insurance broker with certain limitations specified in the law.

v Claims

Notification

The procedure for filing insurance claims is typically set out in the insurance contract itself. It is common practice for contracts of insurance and reinsurance, especially liability policies, to require that the insured notifies his or her insurer of a claim within a given time frame, for the claim to be valid. Prompt notification of an event that may or is likely to give rise to a claim is usually included in the contract as a condition precedent.

In terms of the Civil Code, the prescriptive period for filing a judicial action for damages for breach of contract is typically five years. If the damages are in tort, the prescriptive period is two years, which may be extended if the action for compensation is related to a personal injury. The aforementioned time periods may be suspended or interrupted in certain cases as prescribed by law.

Good faith and claims

The insured is required to provide the insurer with full, complete and correct information both pre-contractually and claims stage. Providing false information will result in the denial of claim, cancellation ab initio of the policy and could give rise to criminal liability for insurance fraud.

Set-off, funding and reinstatement

Article 1166(c) of the Civil Code grants the insurer an automatic right of subrogation on payment of an indemnity. Nonetheless, a subrogation clause is included in most insurance contracts. Upon payment of an insurance claim by the insurer, the insurer may claim indemnity from a third party for the loss covered by the insurance contract. An act or omission on the part of the insured that could prejudice the insurer's subrogation rights may forfeit policy coverage.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Choice of law in insurance contracts is regulated by the Rome I Regulation (Rome I), where parties to an insurance contract that falls within the ambit of Article 7(3) of Rome I are provided with a limited list of applicable laws.²⁰

The provisions of Article 7(3) of Rome I are in conflict with the applicable provisions of the Civil Code. Malta has not introduced any further legislation following the coming into force of Rome I pursuant to Article 7(3)(2). Despite the fact that, to date, there has been no judgment delivered by the Maltese courts that has resolved this conflict, it has been argued that Article 7(3)(1) of Rome I should prevail over the provisions of Civil Code with respect to the choice of law applicable to contracts of life insurance.

ii Litigation

The procedure regarding the institution of court proceedings is regulated by the Code of Organisation and Civil Procedure.²¹ Generally speaking, court proceedings are initiated by the filing of a sworn application, with the defendant having 20 days from date of service to file a sworn reply. An application to appeal a judgment delivered by a court of first instance is to be filed within 20 days of delivery of the judgment.

iii Arbitration

There are two forms of arbitration, mandatory arbitration and voluntary arbitration.²² Motor vehicle claims, not arising in connection with a claim for damages for personal injuries, are subject to mandatory arbitration, provided that the value does not exceed €11,646.87 in the event that the dispute arises from:

- a* a collision between vehicles;
- b* involuntary damage to property involving vehicles; or
- c* any such claim against:
 - an authorised insurer;
 - an assurance company;
 - an approved underwriter; or

20 Regulation (EC) No. 593/2008 of the European Parliament and of the Council of 17 June 2008 on the law applicable to contractual obligations.

21 Chapter 12, Laws of Malta.

22 Arbitration Act, Chapter 387, Laws of Malta.

- the liable person in accordance with the Motor Vehicles Insurance (Third-Party Risks) Ordinance (Chapter 104, Laws of Malta).

Arbitration proceedings are governed by the Arbitration Act, which provides rules for both domestic and international arbitration. International arbitration is governed by the UNCITRAL Model Law, which is implemented by the First Schedule to the Arbitration Act.

In the case of mandatory arbitration, the parties may appeal to the Court of Appeal in certain limited circumstances contemplated under the Arbitration Act. However, in the case of voluntary arbitration, if the parties to the insurance contract would have expressly excluded the right of appeal, the decision of the arbitrator will be final and no appeal to the Court of Appeal can be made.

iv Alternative dispute resolution

Besides arbitration, mediation and conciliation, eligible customers (natural persons or micro enterprises) may file a complaint with the Arbiter for Financial Services. The Office of the Arbiter is required to invite the claimant and the financial service provider to resolve the dispute through mediation. When the mediation proves unsuccessful or the parties do not wish to pursue this option, the Office of the Arbiter will proceed with the investigation and decision on the complaint.

v Mediation

Mediation is seldom resorted to by the parties to an insurance contract. Mediation is regulated by the Mediation Act.²³ Mediation can be resorted to either voluntarily, following an order of the court or by law. The applicable forum is the Malta Mediation Centre.

V YEAR IN REVIEW

The year 2019 was interesting and challenging. With its efficient regulatory environment and stable financial services sector, Malta continues to be an attractive destination for insurance companies, including PCCs, which have seen sustained growth, especially among market players wishing to improve their economies of scale and streamline their operations. The insurance industry in Malta was also impacted by Brexit in that a number of insurers and intermediaries carrying on insurance business in the United Kingdom through the EU passporting regime have either chosen to redomicile in Gibraltar or set up undertakings in the United Kingdom while UK insurers and intermediaries seeking to retain their EU passport licence have had to set up operations in an EU Member State, with Malta being one of the preferred jurisdictions.

The MFSA's pragmatic approach is being seen in the way the principle of proportionality is being adopted within the insurance market. It has been possible to see how the proportionality principle can be applied while ensuring that policyholders remain protected.

The MFSA continues to develop and strengthen a comprehensive risk-based and preventive approach to prudential and conduct of business supervision.

The IDD was implemented in 2018, which brought more onerous requirements on product oversight, training, disclosures and amendments to sales process for manufacturers

23 Chapter 471, Laws of Malta.

and distributors of insurance products. The requirement of producing an insurance product information document, and the need to satisfy the knowledge and ability requirement and continuing professional training and development, were some of the hot topics following the implementation of the IDD, which continued to be an area of focus in 2019 for many manufacturers and distributors of insurance products.

VI OUTLOOK AND CONCLUSIONS

The industry is constantly exploring ways of reinventing itself, including using digitisation to remain ahead of competition. Technological innovation is perceived to be a major driver in the insurance sector, carrying both risks and opportunities. The utilisation of insurtech and blockchain technology has attracted much interest, and the government has been proactive in making Malta one of the first jurisdictions to introduce legislation regulating distributed ledger technology platforms, virtual financial assets and initial coin offerings. Investor protection remains a top priority for the MFSA and insurance and reinsurance companies are, for the time being, prohibited from dealing in virtual currencies for their clients or their own accounts.

An area of particular focus, research and discussion has been the use of blockchain technology as a tool in the streamlining of complex processes and improving transparency and efficiency through the development of smart contracts, improved risk assessment, fraud detection, information flows and claims handling.

Cyber risk concerns have also been at the top of insurers' agendas both in the need to manage their clients' as well as their own data, but also as underwriters of cyber risk.

MEXICO

*Yves Hayaux-du-Tilly*¹

I INTRODUCTION

It has been five years since Mexico's legal framework incorporated standards of the EU Solvency II Directive. After a period of uncertainty, the market seems now to have assimilated the legal framework.

The Insurance and Surety Companies Law (LISF), effective since 4 April 2015, and its implementing regulation has proved to be ineffective in improving insurance penetration in Mexico, and the new administration, while recognising the solidity of the insurance industry in Mexico, is looking at ways in which it can improve such penetration, with a special emphasis on financial inclusion, through insuretech and other mechanisms, and is also showing interest in the growth of certain lines of business such as health insurance and evaluating mechanisms to manage catastrophic risks and protecting vulnerable communities.

The Mexican market continues to rely heavily on reinsurance and 'fronting' arrangements to cope with the complexity of new risks and the increase in additional lines of business that are capital-intensive or require added capacity, such as catastrophic insurance. There are no indications that the foregoing scheme will change.

The Mexican market reliance on reinsurance through fronting arrangements creates challenges in the adjustment and settlement of certain claims, as there are natural disagreements between the reinsurance market and the insured due to the inconsistency in the underlying insurance being placed and the terms of the reinsurance arrangement, not only because of the errors in the translation of the reinsurance arrangements into a direct insurance, but also because of the difference in the applicable law to the direct insurance and the practices of the reinsurance market. There have been abusive practices from certain reinsurers and markets and their advisers that have created additional tension and concerns from the Mexican market; there is also raised awareness from the cedents on the enormous risks they are facing by permitting these 'fronting' arrangements that may seem to be profitable but undertake high risks.

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.

II REGULATION

i The insurance regulator

Insurance and reinsurance operations in Mexico are regulated by both the Ministry of the Treasury and Public Credit (SHCP) and the CNSF. The SHCP has authority to interpret, implement and execute the provisions of the LISF for administrative purposes. The CNSF has authority to grant and revoke authorisations to incorporate and operate insurance companies in Mexico, and to register reinsurance companies with the General Registry of Foreign Reinsurance Companies to take Reinsurance and Rebonding from Mexico (the Reinsurance Registry), to take reinsurance from Mexican insurance companies. The CNSF is also responsible for supervising the operation of insurance and reinsurance companies and has authority to supervise, investigate and issue regulations applicable to the operations of Mexican insurance and reinsurance companies. All the applicable regulations issued by the CNSF are compiled in a single regulatory circular (the Circular).

ii Position of non-admitted insurers

Article 20 of the LISF provides that only those entities duly licensed by the Mexican federal government through the CNSF to operate as insurance companies may undertake active insurance operations within Mexican territory.²

If a non-licensed insurance company operates in Mexico on a non-admitted basis and carries out active insurance operations in Mexico, it shall be deemed to be breaching Mexican law and the transaction shall be null and void. Furthermore, such conduct would constitute criminal liability on the part of: (1) the non-admitted foreign insurer; (2) the insurance intermediaries (broker or agent); and (3) the officers, managers, directors, representatives and agents of the entities referred to in (1) and (2).

iii Position of brokers

As a general rule, insurance companies may only pay brokerage fees to insurance brokers duly authorised as such by the CNSF. Individual agents and entities require a licence to act as insurance brokers. To obtain the licence to act as an agent or broker, the individual or entity must file an application with the CNSF, which must comply with the requirements set out in the Regulation of Insurance and Surety Brokers (the Brokers Regulation). The legal provisions applicable to insurance brokers are contained in Chapter 32 of the Circular.

Reinsurance intermediaries are entities licensed to provide reinsurance intermediation services (Article 106, LISF). To incorporate and operate a reinsurance intermediary, the prior authorisation of the CNSF is required, and to obtain the authorisation an application must be filed with the CNSF. The application must comply with the requirements set out in the 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.

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.

iv Requirements for authorisation

Pursuant to the LISF, to incorporate and operate an insurance company in Mexico, an application must be filed with the CNSF. The application must comply with the requirements set out in Article 41 of the LISF. The CNSF has discretionary authority to grant or deny the authorisation. These authorisations are regulated in Chapter 2 of the Circular.

An insurance company must start operations within three months of receiving the relevant authorisation from the CNSF. Before starting its operations, the CNSF must carry out an inspection visit and confirm that the insurance company has the infrastructure, procedures and systems required to operate according to Article 47 of the LISF.

Under the LISF, Mexican insurance and reinsurance companies and foreign reinsurance companies registered with the Reinsurance Registry may cede or take risks in reinsurance to and from Mexican insurance companies. Pursuant to the Circular, foreign reinsurance companies may not take reinsurance in Mexico when they intend, or when they effectively carry out, on a majority or exclusive basis, reinsurance operations with Mexican insurance companies with whom they have financial or business ties. Although it is not clearly explained in the LISF, the 'majority or exclusive' operations referred to in this provision refer to the global reinsurance activities undertaken by foreign reinsurance companies, and not only their reinsurance activities in Mexico. The reason for this provision is to prevent the proliferation of captive reinsurance companies.

Insurance companies authorised in Mexico are allowed to carry out reinsurance operations in the same lines of business in which they have a licence to take insurance. However, a licence to exclusively operate reinsurance business can also be obtained. There are currently only two Mexican insurance companies authorised to exclusively operate reinsurance: Reaseguradora Patria and Der Neue Horizont Re.

The registration of foreign reinsurance companies with the Reinsurance Registry is governed by the LISF and the Circular. To register with the Reinsurance Registry, foreign reinsurance companies must file an application with the CNSF in the terms set forth in Article 107 of the LISF and Chapter 34.1 of the Circular. The CNSF may grant or deny this registration on a discretionary basis. The registration of foreign reinsurance companies is valid until 31 December of the year of registration and must be renewed every year.

v Regulation of individuals employed by insurers

Title 3, Chapter 1, Section II of the LISF and Chapter 3.7 of the Circular provide basic requirements of experience, expertise and knowledge in finance, law, administration or insurance for the eligibility of directors, officers and statutory examiners within an insurance company, and also prescribe which individuals may not be appointed as such. Insurance companies must give notice to the CNSF on any such appointment and provide sufficient evidence to the CNSF that the individual complies with the requirements under the LISF to serve in the relevant capacity. The insurance company must maintain a file for each individual with supporting documentation and evidence of their qualifications and representations and annually confirm to the CNSF that its directors and officers comply with the requirements set forth in the LISF and the Circular to serve in their respective positions.

vi The distribution of products

Pursuant to the LISF and Chapter 4 of the Circular, standard-form contracts, collective and group contracts and surety insurance must be registered with the CNSF.

Insurance products registration must comply with the following documentation (contractual documentation):

- a* general conditions and model contracts, containing the general and particular conditions under which the insurance product will be commercialised;
- b* a technical note, containing the technical and financial hypothesis for the calculation of the premium and the ongoing risk reserve;
- c* a legal opinion, certifying that the insurance product complies with all applicable legal provisions; and
- d* a 'congruency opinion' that certifies that both the technical note and the legal opinion are consistent.

Insurance companies may use, sell and distribute insurance products immediately upon their registration. The CNSF may at any time suspend the registration of an insurance product if, in its opinion, the insurance product does not comply with applicable laws and regulations.

The LISF requires that standard-form insurance contracts are filed with the National Commission for the Defence and Protection of Financial Services Consumers (Condusef), for their registration with the Standard-Form Contracts Registry.

vii Compulsory insurance

The main difference between compulsory insurance and other insurance products, other than the fact of the insurance coverage being required by law, is that compulsory insurance contracts shall continue in full force and effect until their termination, and may not be terminated, even when the corresponding premium is not paid when due or within the cure period set forth under the LISF. Compulsory insurance premiums may not be paid in instalments.

Compulsory insurance includes social security (e.g., life, health and disability), which is mandatory for employers with respect to their employees; professional liability insurance to practise certain professions; and automobile insurance to circulate on roads and highways under federal jurisdiction, and in some of the states of Mexico.

viii Taxation of premiums

Insurance companies are subject to income tax and value added tax. Income tax is levied at 30 per cent on insurance companies' accrued income less authorised deductions. The Income Tax Law provides special rules for deductions applicable to insurance companies.

Value added tax is levied at 16 per cent on all insurance services paid for by customers, except for agricultural insurance, mortgage and financial guarantee insurance, and life insurance.

Mexican reinsurance companies receive the same tax treatment as insurance companies. Income tax is applicable to foreign reinsurance companies when they receive premiums from a Mexican resident or from a foreign resident with a permanent establishment in Mexico. The income tax is calculated by applying a 2 per cent withholding rate on the gross amount paid to reinsurers with no deductions.

The person paying the premium to the reinsurers must withhold and pay the income tax at the applicable rate. Depending on the jurisdiction in which the reinsurance company is incorporated, there might be a double taxation treaty that applies to the payment of premiums to foreign reinsurance companies and that supersedes the general provisions referred to herein.

Insurance and reinsurance brokers are subject to the same taxes and to the same rates as insurance companies but are not subject to special deductions applicable to insurance companies.

ix Other notable regulated aspects of the industry

Insurance companies must maintain a minimum paid-in capital stock. That minimum paid-in capital stock is regulated in Chapter 6 of the Circular.

The following are the (approximate) minimum paid-in capital requirements for each line of business applicable for 2020, until new capital requirements are issued by the CNSF, which should be before June 2020:

- a* Life: 43.62 million pesos.
- b* Pensions: 179.17 million pesos.
- c* Accidents and health:
 - personal accident or medical expenses: 10.90 million pesos; and
 - health, including personal accident or medical expenses: 10.90 million pesos.
- d* Property and casualty:
 - one line: 32.71 million pesos;
 - two lines: 43.62 million pesos;
 - three or more lines: 54.52 million pesos;
 - mortgage insurance: 78.06 million pesos; and
 - financial guarantee insurance: 212.44 million pesos.

Insurance companies authorised exclusively for reinsurance operations are required to maintain 50 per cent of the applicable minimum paid-in amount, as listed above.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Mexican insurance and reinsurance companies are governed by the LISF. The LISF was published in the Official Gazette of the Federation (DOF) on 4 April 2013 and entered into effect on 5 April 2015, repealing the General Insurance and Mutual Companies Law, which had been in effect since 1935.

The Insurance Contract Law (LCS), enacted by Decrees dated 29 December 1934 and 1 January 1935, also published in the DOF on 31 August 1935, is applicable to all insurance contracts subject to Mexican law, except for maritime insurance, which is governed by the Navigation and Maritime Commerce Law published in the DOF on 1 June 2006.

Reinsurance contracts are governed by the applicable law expressly agreed by the parties in the contract. Generally, the parties agree on Mexican law as the law governing the reinsurance contract.

ii Making the contract

Article 1 of the LCS defines insurance contracts as agreements in which an insurance company agrees to indemnify or pay for damages, or to pay an amount of money on the occurrence of a risk covered under the terms of the contract, in exchange for the payment of a premium.

The reinsurance contract is not a regulated contract, which generates many disputes in practice. The reinsurance contract is defined in Article 2, Section XXV of the LISF, as the

contract in which an insurance company assumes totally or partially a risk that is covered by another insurance company, or the liability exceeding the amount insured by the direct insurer.

Article 25 of the LISF provides a general classification of insurance contracts as follows:

- a* Life.
- b* Accidents and health, including:
 - personal accidents;
 - medical expenses; and
 - health.
- c* Property and casualty, including:
 - civil liability and professional;
 - maritime and transportation;
 - fire;
 - agriculture and livestock;
 - automobiles (motor insurance);
 - credit insurance;
 - surety insurance;
 - mortgage insurance;
 - financial guarantee insurance;
 - earthquake and other catastrophic risk;
 - miscellaneous; and
 - risks declared by the SHCP as specialty risks.

Essential elements of an insurance contract

Under the LCS, insurance policies must contain:

- a* the name and address of the contracting parties and the signature of the insurance company;
- b* a description of the insured asset or person;
- c* a description of the risks insured;
- d* the effective date of coverage and its duration;
- e* the amount insured;
- f* the insurance fees or premium; and
- g* any other clauses required by law or agreed by the parties.

It is common to find the following clauses in insurance policies:

- a* coverage limits and exclusions;
- b* form and terms under which the premium must be paid;
- c* insured's right to be informed about commissions paid to intermediaries;
- d* insured's right to revise the policy if its terms differ from the agreed terms;
- e* competence of Condusef and choice of jurisdiction clause; and
- f* special clauses required for specific lines of business.

Utmost good faith, disclosure and representations

The duty of utmost good faith is an implied principle applicable to all insurance contracts. This duty demands diligent and honest conduct from both parties, including the duty of the insured to disclose to the insurer any fact that may help the underwriter to evaluate the risks and determine the premium.

iii Interpreting the contract

General rules of interpretation

To the extent that the terms and conditions of the agreement are clear and there is no question as to what the intent of the parties was, the insurance policy must be interpreted in accordance with its terms:

- a* if the terms of the insurance policy seem contrary to the evident intent of the parties, the intent of the parties shall prevail over the terms of the insurance policy;
- b* if the insurance policy is generic in its terms, its interpretation must be limited to the purposes of the insurance policy;
- c* if the insurance policy permits various interpretations, it must be interpreted in the most convenient manner for the insurance policy to be effective;
- d* the terms and conditions of an insurance policy, including those terms that are not clear, must be interpreted in a manner that is consistent with the interpretation of the insurance policy as a whole;
- e* the terms of an insurance policy that may have different meanings must be interpreted in a manner consistent with the nature and purposes of the insurance policy;
- f* ambiguities of the insurance policy may be interpreted taking into consideration the customs of the country; and
- g* if it is impossible to construe the insurance policy using the rules set out above, the insurance policy must be construed in favour of the interpretation that provides reciprocity of interests between the parties.

Incorporation of terms

Compliance with the LCS is mandatory, therefore any agreement contrary to the LCS is null and void, unless otherwise permitted under the LCS. Taking this into account, it is implied that insurance contracts are subject to the provisions of the LCS.

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 this authorisation, an application must be filed with the CNSF. The Intermediaries Rules set forth the requirements and information that the application for authorisation must contain. A reinsurance intermediary must be incorporated as a limited liability company with a residence in Mexico.

Agencies and contracting

As a general rule, intermediation of insurance products may only be carried out by insurance brokers certified and licensed by the CNSF. Insurance companies may only pay commission arising from the sale of insurance policies to insurance brokers.

How brokers operate in practice

To carry out brokerage services in Mexico, insurance brokers must be authorised by the CNSF. To this end, an application must be filed with the CNSF. The requirements and information that the application must contain is set forth in the Brokers Regulation. The authorisation may be granted to:

- a* individuals acting as employees of an insurance company or independent individuals operating with a service agreement with an insurance company; and
- b* limited liability companies incorporated under Mexican law.

The authorisation to act as an insurance broker is granted for three years for individuals (renewable at the request of the insurance broker) and, in the case of legal entities, the CNSF can grant the authorisation for an indefinite period.

Article 12 of the Brokers Regulation lists entities and individuals that cannot participate, directly or indirectly, in the capital stock of an insurance broker legal entity; these include Mexican insurance companies and financial entities subject to approval by the corresponding Mexican authority; foreign governments or authorities; and foreign financial entities.

v Claims

A claim is triggered on the occurrence of a peril covered by the policy. Insurable interest is required to make a valid claim and demand payment under a policy.

The statute of limitations of claims is two years after the date of the occurrence of the loss, except for life insurance, where it is five years (Article 81, LCS). The statute of limitations can be interrupted for the following reasons:

- a* on appointment of experts as a result of a loss;
- b* if a claim is filed with the specialised unit of the corresponding insurance company or Condusef;
- c* by initiating an action or proceeding before competent courts, on service of process to the insurance company; or
- d* by the express acknowledgment of the rights of the insured or its beneficiaries by the insurance company.

Good faith and claims

The LCS establishes the obligation of the insured (1) to give timely notice of the occurrence of the casualty; (2) regarding property and casualty insurance, to prevent or reduce the damage; and (3) not to modify the status of the assets. If, when acting in good faith, the insured omits to give timely notice of the occurrence of the casualty or to carry out reasonable actions to prevent or reduce the damage, or modifies the status of the insured asset, the insurance company may reduce the indemnity in proportion to the damage that could have been mitigated or avoided by the insured. If the insured were to act fraudulently, the insurance company would be released from its obligations under the policy.

The consequences of bad faith may:

- a trigger the right to terminate the insurance contract;
- b allow the parties to recover premiums paid or request payment of damages and loss of profit; and
- c release the parties from their obligations under the insurance contract.

Set-off and funding

The parties can set off mutual debts and credit as long as both are due and payable.

Reinstatement

The LCS does not regulate reinstatement, but it may be included in the insurance contract. Reinstatement generally operates when the insured pays the outstanding premiums, provided the risk has not changed.

If any risk takes place prior to reinstatement of the insurance contract, the insured is not entitled to obtain any compensation, since he or she was not covered by the insurance.

Dispute resolution clauses

Clauses regarding choice of forum, jurisdiction and applicable law are valid and enforceable in Mexico in insurance and reinsurance contracts. Furthermore, the parties in insurance and reinsurance contracts can convene to solve potential disputes through an arbitration. Mexico is a contracting state of the Hague Convention on Choice of Court Agreements (2005) and of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the New York Convention 1958).

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

The parties in a reinsurance contract are free to agree the terms and conditions of the contract as long as they do not breach any mandatory legal provision or go against public policy. Arbitration clauses are enforceable in insurance and reinsurance agreements. The terms and conditions of an insurance contract are subject to and shall comply with the LCS, which is mandatory. As a general rule, agreements contravening the LCS shall be null and void.

ii Litigation

Insurance and reinsurance disputes are regulated by the Code of Commerce. If one of the parties breaches a contract, the non-defaulting party can initiate ordinary commercial proceedings. This judicial process has four basic stages: filing of the claim by the plaintiff and response from the defendant; submission and presentation of evidence of any kind; pleadings; and award.

The parties can appeal any ruling to a higher tribunal, unless the aggregate amount is less than 682,646.89 pesos.

Each party pays its own litigation costs and the losing party may be required to indemnify the winning party, including for attorneys' fees, subject to certain established thresholds and the decision of the court.

iii Arbitration

The insured and the respective beneficiaries can file claims with the insurance company, Condusef and Mexican courts.

Claims filed with Condusef or before a competent court interrupt the statute of limitations.

Condusef can act as a mediator in disputes resulting from an insurance contract if the amount in dispute is less than 6 million Mexican investment units (approximately 38.36 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.

Reinsurance claims can be resolved in judicial proceedings through arbitration or through other alternative dispute resolution mechanisms, such as mediation and conciliation.

iv Mediation

There is an important increase in mediation as an alternative mechanism for settling international reinsurance disputes and claims involving Mexican cedants and the London market. Mediation has proven to be an efficient alternative.

v Alternative dispute resolution

Even though Article 17 of the Mexican Constitution refers to means of alternative dispute resolution, there is no federal regulation regarding alternative dispute resolution processes. However, several states of Mexico have enacted specific laws on this matter.

The most popular alternative dispute resolution procedures are arbitration and mediation (see subsections iii and iv).

V YEAR IN REVIEW

i The insurance sector

According to the CNSF, as at September 2019, the Mexican insurance sector comprises 103 insurance companies licensed to operate in Mexico, of which 59 are subsidiaries of foreign insurance companies, and more than 238 foreign reinsurance companies registered with the Reinsurance Registry, including Lloyd's of London. Ten atomic pools (nuclear insurance pools) were also registered with the Reinsurance Registry to take reinsurance in Mexico. Direct premiums in the insurance and surety sectors increased had by 8.4 per cent by the end of September 2019 compared to the same period in 2018. The overall annual growth in the

Mexican insurance industry from January to September 2019 was 8.7 per cent in real terms. From the total amount of premiums by the end of September 2019, 98.2 per cent came from direct insurance and only 1.8 per cent from reinsurance.

By the end of September 2019, life insurance had increased by 9.1 per cent in real terms compared to the previous year; health insurance increased by 3.5 per cent; and property and casualty increased by 10.7 per cent. By excluding motor insurance, the property and casualty line increased by 20.4 per cent.

The penetration of insurance with respect to Mexico's gross domestic product is 2.2 per cent. The Mexican Association of Insurance Institutions, together with the CNSF, are working on a strategy to increase penetration to 2.8 per cent by 2022.

There was also substantial M&A activity during 2019, driven mostly by international transactions with effects on the Mexican market.

ii Lloyd's

Probitas Syndicate 1492 became in 2018 the first Lloyd's syndicate to open a representative office in Mexico. In July 2019, Newline Group established a local presence in Mexico, joining Lloyd's representative office in Mexico City. Newline will serve its clients in Latin America and the Caribbean through Mexico. Taking into account the constant conflicts arising from inadequate placement of reinsurance policies in Mexico, having a local presence will contribute to a more efficient and transparent operation for the benefit of the Lloyd's market and the local cedants. Two Mexican groups, Grupo Nacional Provincial and Reaseguradora Patria, currently have investments in Lloyd's.

iii Change in government

As a result of the federal elections in July 2018, the National Regeneration Movement (MORENA) took control of Congress and its presidential candidate Andrés Manuel López Obrador won by a landslide, taking office on 1 December 2018. As a result of the changes in government, Ricardo Ernesto Ochoa Rodríguez was appointed president of the CNSF, replacing Norma Alicia Rosas Rodríguez. All vice presidents and certain senior officers of the CNSF resigned from their positions, creating uncertainty and adding pressure on the CNSF, which already had a very heavy workload.

During 2019, the CNSF went through a process of adjustment after appointing new vice presidents and senior officers, which had an impact on the efficiency of the CNSF. As this change of government has wide-reaching implications, the public policies of the CNSF, and consequently the impact on the insurance industry, are yet to be determined. So far, we have experienced both efficiencies and inefficiencies in regulatory authorisations before the CNSF. While in certain areas the process has been streamlined and in certain proceedings the CNSF has become extremely pragmatic and efficient, in others, due to the lack of human resources and the learning curve of the new personnel, combined with an extensive rotation of personnel, there are inefficiencies and delays that affect the market.

Some of the measures adopted by the new administration have also produced mixed effects in the market; for example, while some insurance companies have been affected by the cancellation of private medical insurance for public officers and the reduction of other fringe benefits in public officers' compensation packages, others have benefited from an increase in their portfolio due to the need for individual coverage by those wanting to maintain their insurance coverage.

We have seen a growing interest in the new administration in identifying ways in which it can improve penetration of the insurance industry, financial inclusion and risk management mechanisms to protect vulnerable communities and cover risks stemming from catastrophic risks, including those stemming from climate change.

VI OUTLOOK AND CONCLUSIONS

i Regulatory

The changes in public policy will have an important impact on regulatory changes. The current administration has an opportunity to carry out significant changes to the regulation to effectively increase penetration, and in particular we perceive a concern in working on those areas that will improve financial inclusion and on proper risk management for vulnerable groups, maintaining operational costs of insurance companies at reasonable levels to permit growth while improving penetration. While it is a priority of regulators to protect customers and expand insurance protection to the general population, there will be also more intervention of the state in the development of insurance solutions and risk management mechanisms to ensure protection of vulnerable groups, and proper management of catastrophic risks by federal and state governments and state-owned companies.

The regulators are aware of the potential of insurtech to give access to vulnerable groups to the benefits of insurance products. Unfortunately, the regulatory regime in effect has become a hurdle rather than an incentive for the development of insurtech products and projects, therefore, coping with compliance and regulatory challenges, and a strict regime on anti-money laundering regulation, data protection and privacy regulations makes it difficult for start-ups to flourish in a very regulated industry. Notwithstanding the foregoing, we see how new risks continue to demand innovative products, presenting new challenges to the regulators in a country with a solid and well capitalised industry that continues to disappoint in terms of penetration, inclusion and innovation.

We have seen a growth in appetite from funds to work with insurance companies and benefit from insurance companies as institutional investors. The insurance industry has not fully embraced its potential as a key institutional investor, with the exception of a few insurance companies actively investing in private equity, venture capital and other securities, such as development trusts and real estate trusts. There is an interest for regulators to enhance and give incentives to insurance companies and we still expect to see changes in the investment regime of insurance companies, aligned with the interest of the current government in financing long-term infrastructure projects.

ii Case law

We continue to see a growth in insurance and reinsurance related disputes and litigation arising therefrom, resulting in the development of court precedents on insurance and reinsurance related matters. The courts are very active in developing the concept of moral damages (similar to that of punitive damages) – the concept now forms part of most claims, with important consequences for the insurance industry.

The *contra proferentem* principle in insurance continues to be applied, affecting insurance claims that are being argued before the courts.

Ongoing cases related to violent acts that took place in the context of demonstrations and protests against the government that occurred in January 2018, as a consequence of a substantial rise in the price of petrol, are contributing to the judicial interpretation of the

exclusion of the risk of terrorism (terrorism exclusion clause or endorsement) in insurance policies. These cases are relevant to the insurance industry as the Mexican precedents do not reflect international market practices. We have seen regional growth of these claims and the decisions currently pending in Mexican courts will be of relevance to ensure correct wording in terrorism and all risk policies.

Courts have confirmed that insurance and reinsurance are two separate and independent contracts by analysing the concept of *litisconsorcio* (joinder of parties) and confirmed that the policyholder of the direct insurance has no direct action against the reinsurer.

iii Reinsurance claims

As previously identified, one of the main sources of conflicts in reinsurance stems from fronting arrangements widely used in Mexico in the context of a legal framework where the insurance company maintains its liability before the insured despite the fact that, technically, it is just fronting the risk. This particular state of affairs – where there is a lack of understanding by reinsurers of Mexican law, and no diligence in the underwriting of policies to ensure that the wording takes into consideration the effects that Mexican law has with regard to the English wording of the reinsurance placement used through fronting arrangements – has consistently and continuously raised inconsistencies between insurance and reinsurance policies and Mexican law, and is the origin of a number of disputes between the London and Mexican markets, coupled with abusive practices in the handling of claims by the reinsurance market in prejudice of the insurance company that placed the business through fronting arrangements.

We have seen some interesting developments in Mexican anti-money laundering regulation aligned with international standards that may contribute to harmonise local placements with limitations of liability under international reinsurance programmes.

There is an opportunity to effectively use and promote alternative dispute resolution mechanisms in Mexico specialised in insurance and reinsurance claims, including mediation and arbitration and the use of the Mexican chapter of the Insurance and Reinsurance Arbitration Society (ARIAS Mexico), by including arbitration clauses in insurance and reinsurance agreements to resolve disputes in arbitration, as a consequence of the ongoing conflicts arising in reinsurance contracts, and also to prevent certain situations in global insurance programmes. However, the reinsurance market is still generally reluctant to include mediation and arbitration clauses in reinsurance policies.

In November 2019, the Principles of Reinsurance Contract Law (PRICL) were published by the Project Group (a joint venture set up by several universities and professors, primary insurance companies' representatives, reinsurance companies and reinsurance brokers and special advisers) in cooperation with the International Institute for the Unification of Private Law (UNIDROIT). The PRICL set specific reinsurance rules applicable to contract law, aiming to help such areas where reinsurance practitioners felt the need to improve legal certainty. The PRICL have been drafted as soft law, which means they will work as an optional guide of reinsurance contract law when chosen by the parties, and for these principles to have binding effect, the contracting parties should voluntarily choose to do so. However, there is also the possibility that the PRICL may be applied by courts or arbitral tribunals, as the case may be, even in cases where the parties have not chosen to apply them.

iv Distribution

There have been no changes and the distribution channels in Mexico continue to be extremely regulated and limited, resulting in a lack of penetration of insurance within small and medium-sized companies, which contribute around 52 per cent of the national GDP. There is still no effective solution to the ongoing problem of enforcing mandatory automobile insurance and other mandatory insurance products.

Bancassurance 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.

Insurance distribution through brokers is still the most common channel for distribution; however, there is an interest in developing insurtech products and shifting to online forms of distribution. Various projects aiming to exploit the untapped, and therefore underserved, health insurance market were launched during 2019.

v Consolidation

We have seen an active insurance market with various M&A transactions and joint ventures. We expect to see further consolidation, growth or a combination in the current market players in Mexico. In particular, we expect health insurance to be a key driver of growth of the insurance industry in the years to come.

vi Product development

We have been very active working with reinsurance and insurance companies and brokers in the development of parametric insurance products for catastrophic risks that will be launching in 2020. We expect the offer of parametric products to continue growing.

NEW ZEALAND

*Tom Hunt and Marika Eastwick-Field*¹

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 adviser regime (which can include insurers and insurance intermediaries).²

¹ Tom Hunt and Marika Eastwick-Field are partners at Russell McVeagh. The authors would like to thank and gratefully acknowledge the assistance of Ling Yan Pang, Nicole Browne, Che Ammon and Sharnika Leleni.

² Until 29 June 2020 the regulation of financial advisers and brokers will be governed by the existing Financial Advisers Act 2008 (FAA) regime. From 29 June 2020, the Financial Services Legislation Amendment Act 2019 (FSLAA) will repeal the FAA and introduce a new regime for the regulation of financial advisers and brokers into the Financial Markets Conduct Act 2013 (FMCA). This chapter focuses on the position applicable from 29 June 2020 under the new regime.

ii Regulation and authorisation

IPSA

The IPSA requires each person who carries on insurance business in New Zealand to be licensed as an insurer.³ Whether an insurer ‘carries on insurance business in New Zealand’ (a concept that encompasses both insurers and reinsurers) is a question of fact that must be decided having regard to all of the insurer’s circumstances.

To obtain a licence, an insurer must apply to the RBNZ and provide information to establish that it meets certain requirements, including those relating to solvency and credit 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).⁴

Overseas insurers may be eligible for exemptions from parts of the licensing requirements if they are supervised by a recognised overseas regulator and they meet certain standards in their home jurisdictions.

There are also specific rules that allow Lloyd’s to obtain a licence on behalf of all Lloyd’s underwriters.

FPSA

Insurers must register on the Financial Service Providers Register (FSPR) in accordance with the FPSA. Insurers that provide services to retail clients are also required to be members of an approved dispute resolution scheme.

Companies Act 1993

As corporate entities carrying on business in New Zealand, insurers must be registered with the Companies Office. This requirement also applies to insurers that are incorporated outside New Zealand but that carry on business in New Zealand.

FMCA

The FSLAA was enacted in 2019 to repeal and replace the current FAA regime for the regulation of financial advisers and brokers (including in relation to insurance products). The FSLAA will incorporate the new regime into the FMCA and is aimed at simplifying and streamlining the existing regime. The changes include replacing the current types of financial advisers with three new types (financial advice providers, financial advisers and nominated representatives), permitting the provision of robo-advice to retail customers, introducing a fit-for-purpose licencing structure, imposing conduct and competence obligations on anyone who provides financial advice and creating shorter, simplified disclosure requirements.

Under the new regime, anyone giving financial advice (which could include insurers, brokers or other intermediaries) will need to be licensed as, or engaged by, a ‘financial advice provider’. Financial advice providers can engage individuals as ‘financial advisers’ and/or ‘nominated representatives’ to provide financial advice on their behalf, but will remain liable

3 IPSA, Section 15.

4 IPSA, Part 2, Subpart 1.

for the acts or omissions of those individuals. Financial advice providers and financial advisers are also required to be registered under the FSPA. The new regime comes into effect from 29 June 2020 with a transitional period of two years.

iii Position of non-admitted insurers

As mentioned in subsection ii, owing to the requirement that each person who carries on insurance business in New Zealand must be licensed, non-admitted insurers are effectively prohibited from operating in New Zealand. In addition, the IPSA also places restrictions on the use of certain words including ‘insurance’, ‘assurance’, ‘underwriter’, ‘reinsurance’ or any word that has the same or a similar meaning. Subject to some limited exceptions, it is an offence for a person to carry on any activity in New Zealand (either directly or indirectly) using a name or title that includes a restricted word unless the person is licensed or permitted to do so under the IPSA.⁵

iv Position of brokers

Brokers are primarily regulated under the Insurance Intermediaries Act 1994 (IIA), the FSPA and, from 29 June 2020, the FMCA.

The IIA governs insurance intermediaries and brokers. It is primarily focused on ensuring that the risk of the default or insolvency of the intermediary or broker falls on the insurer rather than the insured. The IIA does not impose any registration requirements and no regulator has specific jurisdiction for monitoring compliance with the IIA. The IIA’s obligations are, instead, most commonly raised in civil disputes between insurers, insureds and insurance intermediaries. If an entity is an insurance intermediary, certain deeming provisions apply in relation to payments made to or received by that intermediary in order to bind the insurer in the event of default by the intermediary. Obligations on brokers are more onerous and include duties in relation to payments due to the insured and operating of client broking accounts. Reform of the IIA is proposed as part of a general review of insurance contract law in New Zealand.⁶

The FSPA imposes regulatory requirements on brokers who fall within its ambit (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 advise retail clients. The FSPR enables the public to check that financial service providers are registered, along with certain other details including the types of financial services that they are registered to provide.

As discussed above, from 29 June 2020 the FMCA will impose licensing and conduct obligations on brokers that provide financial advice on insurance products.

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

⁵ IPSA, Section 219.

⁶ Discussed in Section V below.

the certification is based must be specified in the insurer's fit and proper policy).⁷ The RBNZ has powers to take action against persons appointed to these roles that it views as being inappropriate to be involved in the management or governance of an insurer. The RBNZ may also apply to the district court for a person to be banned from participating in an insurance business in relation to certain wrongdoings.⁸

Employees of insurers that provide financial advice are regulated under the FMCA (from 29 June 2020) and FSPA. Individuals can also be liable for 'involvement' in a contravention of the FMCA by another.

vi Compulsory insurance

Unlike some jurisdictions, there is no compulsory motor vehicle or workers compensation insurance in New Zealand. The government operates a 'no fault' accident compensation scheme for personal injury by accident suffered by any New Zealand resident or visitor to New Zealand. The scheme is administered by the Accident Compensation Corporation under the Accident Compensation Act 2001, and is funded through levies and taxation. No private legal proceedings can be brought for personal injury covered by the scheme, and there is therefore only limited need for personal injury liability insurance.

Where residential buildings and personal property are insured against fire, the property is also deemed to be insured against earthquake and other natural disaster under the Earthquake Commission Act 1993. The insured pays a premium for this cover to the Earthquake Commission through the insurance company.⁹

The Maritime Transport Act 1994 imposes certain insurance requirements in respect of oil pollution liabilities and for offshore marine installations.

vii Compensation and dispute resolution regimes

As discussed in subsection iv, insurers that provide services to retail clients are required by the FSPA to be a member of an approved dispute resolution scheme.¹⁰ There are four approved schemes, though most insurers are members of the Insurance and Financial Services Ombudsman Scheme (the IFSO Scheme),¹¹ 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 IFSO 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.

7 IPSA, Section 37.

8 IPSA, Section 222.

9 As discussed in Section V.ii, there is currently a public inquiry into the Earthquake Commission's operational practices.

10 FSPA, Section 11.

11 As of February 2019.

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.¹²

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); and
 - a policyholder base (representing income derived for the benefit of policyholders);
- d* the timing of recognition of the income of life insurers, which seeks to address the timing and allocation issues inherent with life insurance products, particularly in respect of participating life policies; and
- e* certain life insurance premiums paid to underwriters at Lloyd's of London (addressed below).

Where a non-resident general insurer derives a premium with a New Zealand source that is not attributable to a fixed establishment of the insurer in New Zealand, 10 per cent of the gross premium is income of the insurer. This income is given separate treatment for income tax purposes and the insurer is not permitted any deductions against this income. Therefore, this is the net amount subject to tax. If the non-resident general insurer does not file a return and pay the relevant New Zealand tax, New Zealand deems certain persons to be agents of the insurer and requires the agent to file a return and pay the tax. Under these rules the person paying the premium may be liable for the non-resident insurer's tax liability. Similar rules also apply to certain life insurance premiums derived by underwriters at Lloyd's of London. If those rules apply, 10 per cent of the gross premium is income of the insurer, the insurer is not permitted deductions against that income and the person paying the premium may be required to calculate the income tax payable, file a tax return and pay the insurer's tax liability.

Insurance premiums are generally subject to New Zealand's goods and service tax (GST) (currently at a rate of 15 per cent), with the exception of premiums for life insurance. The provision of life insurance is not subject to GST (either because it is exempt or because it is zero-rated for GST purposes, depending on the particular circumstances). Some other exceptions can also apply, for example in relation to certain credit-related insurance contracts.

12 As of February 2019, companies are subject to an income tax rate of 28 per cent.

ix Other notable regulated aspects of the industry

Under the IPSA, approval must be obtained from the RBNZ in relation to a change of control, or change in corporate form, of any licensed insurer.¹³ This allows the RBNZ to consider the same matters as when it first licenses an insurer to ensure the change in control or corporate form will not affect the insurer's ability to operate effectively.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Insurance law in New Zealand is governed by a combination of common law, statute and voluntary code.

The foundation for insurance law is the general law of contract, supplemented by insurance-specific principles, such as the doctrine of utmost good faith and the principle of indemnity.

Marine insurance is treated as a distinct subset of insurance law and is governed by the Marine Insurance Act 1908. There is no equivalent code in New Zealand relating to non-marine insurance. However, there are a number of statutes that are relevant to the terms of non-marine insurance, including the Life Insurance Act 1908, the Insurance Law Reform Acts of 1977 and 1985, and the Fair Trading Act 1986 (FTA).¹⁴ Reform of these statutes is proposed as part of the proposed general review of insurance contract law in New Zealand.¹⁵

Members of the Insurance Council of New Zealand (ICNZ) also agree to adhere to the Fair Insurance Code. The ICNZ currently has 30 members and three associate members.¹⁶ 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. The public made submissions on the updated version of the Code in 2019, with the updates to be implemented in 2020.

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.¹⁷ This definition generally accords with the position at common law.

An insurance contract generally requires an insuring clause, and must identify the property or liability to be insured and the scope of the indemnity. This information is customarily set out in the policy schedule (which contains details specific to the particular

13 IPSA, Sections 26 to 27.

14 As discussed in Section V.iii, as at March 2019 some of the provisions of these statutes are being reviewed.

15 Discussed in Section V below.

16 www.icnz.org.nz/about-us/our-members.

17 IPSA, Section 7.

insured) and the policy wording (which sets out further details as to the nature and scope of the insurance cover, as well as claims conditions and other provisions relevant to the insurance).

Recording the contract

Insurance contracts are usually recorded in a written document or combination of documents (usually a policy schedule signed or stamped by the insurer, together with a document containing the policy wording). However, the only express legislative requirement is found in the Marine Insurance Act 1908, which requires that a contract of marine insurance is signed or sealed by the insurer.¹⁸

Regulation of contractual terms

The Life Insurance Act 1908 contains provisions relating to the assignment of life insurance policies, in relation to life policies taken out by or for the benefit of minors, and protecting the surrender value of life insurance policies if premia are not paid.

The Insurance Law Reform Act 1977 limits an insurer's ability to avoid a policy because of misstatements by the insured, or to decline a claim in reliance on certain types of exclusions or because of non-compliance with time limits for making a claim. It also provides that arbitration clauses in insurance policies (other than those entered into by the insured in trade) are not binding on the insured.

The Insurance Law Reform Act 1985 abolishes the common law requirement for an insurable interest in policies of life insurance and indemnity (other than where the Marine Insurance Act 1908 applies). It restricts the application of 'average' clauses in policies for dwelling houses and allows purchasers of land and fixtures to have the benefit of the vendor's insurance during the period between the contract of sale and settlement.

In March 2015, the FTA was amended to prohibit unfair contract terms in standard form consumer contracts. These prohibitions apply to a limited extent to consumer insurance contracts (although the legislation recognises that there are some terms that are necessary to protect the insurer and that will therefore not be considered unfair, such as provisions that identify the subject matter or risk insured, impose obligations of good faith, specify the sum insured or applicable deductible, or describe the basis on which claims are settled).

As mentioned, a review of insurance contract law is under way, which is discussed in Section V.

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.¹⁹ 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.²⁰

18 Marine Insurance Act 1908, Section 24.

19 Law Reform Act 1936, Section 9. This is also part of the review of insurance contract law – see Section V.

20 See *BFSL 2007 Ltd v. Steigrad* [2013] NZSC 156.

The court decisions that clarified the application of this legislation and its impact on defence costs have resulted in significant changes to the structure of liability policies in recent years. Whereas it was previously common to issue liability policies with aggregate limits of cover for both defence costs, and damages and compensation, it is now common for insureds to purchase separate or additional defence costs cover.

Reform of the statutory charge under the Law Reform Act 1936 is proposed as part of the general review of insurance contract law in New Zealand.²¹

Prohibited insurance

Certain types of insurance are prohibited by statute. For example, insurance that purports to indemnify a person for liability to pay a fine or infringement fee under the Health and Safety at Work Act 2015, or the Employment Relations Act 2000, is unlawful and of no effect. As a result of recent amendments, there is a similar prohibition in the Credit Contracts and Consumer Finance Act 2003.²²

The Companies Act 1993 contains restrictions on a company's ability to effect insurance for its (and its related companies') directors and employees.²³ A company must be authorised by its constitution, and have the prior approval of its board, before effecting the insurance. A company cannot effect insurance for its directors and employees in respect of criminal liability (e.g., fines) or defence costs in respect of criminal proceedings unless the director or employee is acquitted. The directors who vote in favour of effecting the insurance must certify that the cost of the insurance is fair to the company.

Similar restrictions apply under the Financial Markets Conduct Act 2013 (in respect of conduct regulated by financial markets legislation) to 'specified persons' (e.g., issuers, offerers and licensees) that are not companies subject to the Companies Act 1993.²⁴

Information provided to the insurer at placement

The insured is subject to a general duty to disclose any material fact to the insurer.²⁵ The insured's duty of disclosure extends beyond the answering of questions specifically asked by the insurer. Failure to disclose material facts can entitle the insurer to avoid the policy. However, where an insured discloses facts that reasonably point toward the existence of further relevant facts, the insurer may be treated as having waived disclosure if it did not make further enquiries.²⁶

This duty of disclosure is codified in respect of marine insurance in the Marine Insurance Act 1908, which also expressly states that the following circumstances do not have to be disclosed in the absence of enquiries: circumstances that diminish risk; circumstances that are known or presumed to be known to the insurer; and any circumstance that is superfluous to disclose by reason of any express or implied warranty.²⁷

21 Discussed in Section V below.

22 Credit Contracts and Consumer Finance Act 2003, Section 107E.

23 Companies Act 1993, Section 162.

24 Financial Markets Conduct Act 2013, Sections 526 to 530.

25 *Quinby Enterprises Ltd (In Liquidation) v. General Accident Fire and Life Assurance Corporation Public Ltd* [1995] 1 NZLR 736.

26 *Jaggar v. QBE Insurance International Ltd* [2007] 2 NZLR 336.

27 Marine Insurance Act 1908, Section 18.

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.²⁸ While the Contract and Commercial Law Act 2017 imposes a general right to damages for misrepresentation (which could provide a pecuniary remedy for a breach of the duty of utmost good faith),²⁹ such remedies are unlikely to be available for breach of a simple failure to disclose unless it can be established that there was a positive misrepresentation that there was nothing further to disclose.

As noted above, the Insurance Law Reform Act 1977 precludes an insurer's right to avoid a policy for misstatement by the insured unless the misstatement was substantially incorrect and material (and, in the case of life insurance policies, made either fraudulently or within three years of the date that the policyholder dies or the contract is sought to be avoided).

The scope of the insured's duty of disclosure, and the consequences of non-disclosure, are part of the review of insurance contract law in New Zealand.

iii Interpreting the contract

General rules of interpretation

There are no special rules that apply to the interpretation of insurance contracts.³⁰ Accordingly, insurance agreements are interpreted according to the general law of contract, which aims to ascertain the meaning that the document would convey to a reasonable person having all the background knowledge that would have been reasonably available to the parties at the time they entered into the agreement.³¹

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.³²

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.³³ In *Vector Gas Ltd v. Bay of Plenty Energy Ltd*,³⁴ 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.³⁵ While the decision in *Firm PI 1 Ltd v. Zurich Australian Insurance* re-emphasises the focus that will be given to the

28 *Pan Atlantic Insurance Co Ltd v. Pine Top Insurance Co Ltd* [1995] 1 AC 501.

29 Contract and Commercial Law Act 2017, Section 35.

30 *QBE Insurance (International) Ltd v. Wild South Holdings Ltd* [2014] NZCA 447, [2015] 2 NZLR 24 at [18].

31 *Investors Compensation Scheme Ltd v. West Bromwich Building Society* [1998] 1 WLR 896 (HL) at 912 per Lord Hoffman.

32 *Firm PI 1 Ltd v. Zurich Australian Insurance Ltd* [2014] NZSC 147, [2015] 1 NZLR 432 at [63], [79]; *Zurich Australian Insurance v. Body Corporate 398983* [2013] NZCA 560, [2014] NZLR 289 at [35].

33 *Gibbons Holdings Ltd v. Wholesale Distributors Ltd* [2007] NZSC 37, [2008] 1 NZLR 277.

34 *Vector Gas Ltd v. Bay of Plenty Energy Ltd* [2010] NZSC 5, [2010] 2 NZLR 444.

35 Jessica Palmer and Andrew Geddis 'What Was That Thing You Said? The NZ Supreme Court's Vexing Vector Gas Decision' (2012) 31 UQLJ 287 at 294.

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 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.³⁶ 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.³⁷

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. In 2019, the government introduced the Financial Markets (Conduct of Financial Institutions) Amendment Bill. The Bill will allow the Governor-General to prescribe regulations relating to incentives (defined as including a commission, benefit, or other monetary or non-monetary incentive) and introduces an obligation on financial institutions and intermediaries to comply with any relevant incentives regulations. The content of these regulations is not yet known.

iv Claims

Notification

Insurance policies in New Zealand commonly include express requirements for prompt notice of claims to be given to the insurer. However, where an insurance contract prescribes a time limit within which notice of any claim must be given, the time limit will only apply where the insurer has been prejudiced by the insured's delay (and will not be binding in respect of time limits for notification following death in life insurance policies).³⁸ Unless the policy provides otherwise, there is no particular form in which notice must be given.

Good faith and claims

An insured is under a general duty not to make fraudulent claims.

It is accepted that an insurer is under a duty to admit liability and to pay promptly, failing which there is a liability in damages for breach of an implied term of the contract to the extent that the delay is the fault of the insurer.³⁹ In *Young v. Tower Insurance Ltd*, the court confirmed that a duty of good faith on the part of the insurer is implied in every insurance

36 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).

37 Insurance Law Reform Act 1977, Section 10(2).

38 Insurance Law Reform Act 1977, Section 9.

39 *Dome v. State Insurance General Manager* (1987) 5 ANZ Insurance Cases 60-835; *Rout v. Southern Response Earthquake Services Ltd* [2013] NZHC 3262.

contract. While the court did not delineate the full scope and limits of that duty, at a bare minimum it requires the insurer to disclose all material information that the insurer knows or ought to have known and to act reasonably, fairly and transparently (in both cases, including the initial formation of the contract, and during and after the lodgement of a claim), and to process the claim in a reasonable time.⁴⁰

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Many insurance contracts contain express jurisdiction and choice of law clauses. Some insurance contracts also contain provisions requiring any disputes to be determined by arbitration rather than by the courts. These provisions in retail insurance contracts will not be binding on an insured under the Insurance Law Reform Act 1977, unless the parties have agreed to submit a dispute to arbitration after the dispute has arisen. As discussed in Section II.vii, dispute resolution schemes, such as the IFSO Scheme, are available for retail insurance clients where disputes are not resolved through the insurer's internal dispute resolution processes.

There are no specific limits on an arbitrator's jurisdiction. The district court has jurisdiction to hear civil claims where the quantum does not exceed NZ\$350,000. Claims that exceed NZ\$350,000 are heard in the High Court.

ii Litigation

Litigation stages

Proceedings are usually commenced by the filing and service of a statement of claim and notice of proceeding (although other processes are also available, depending on the nature of the claim). Following the filing of pleadings, the parties are usually required to complete discovery. Written briefs of evidence will then be exchanged, before a hearing at which witnesses will give evidence (and be cross-examined) and legal argument will be presented.

An unsuccessful party may, subject to the rules applicable to the court, appeal a judgment to a higher court. In some cases, this will require obtaining leave of the court.

Evidence

In civil cases, evidence is often given by way of a signed written brief of evidence (which is either taken as read or forms the basis of the oral evidence given by the witness at trial). The opposing party will have an opportunity to cross-examine the witness.

A party to proceedings can call expert witnesses. Experts must adhere to a code of conduct and may be required to confer prior to the hearing.

40 *Young v. Tower Insurance Limited* [2016] NZHC 2956, [2018] 2 NZLR 291.

Costs

Generally, costs follow the event; that is, the unsuccessful party will be required to pay the costs of the successful party. Costs are often ordered on a 'scale' basis in accordance with applicable rates set out in the relevant rules of the court, although the court has the ability to award increased or indemnity costs in certain circumstances.

iii Arbitration

Format of insurance arbitrations

The Arbitration Act 1996 provides the framework for the arbitration of disputes held in New Zealand. Certain provisions of the Arbitration Act 1996 apply automatically to all arbitrations governed by the Act, whereas the application of other (more procedural) rules depends on whether the arbitration is a domestic or international arbitration and whether the parties have chosen to exclude or adopt those rules.

Procedure and evidence

The Arbitration Act 1996 provides that parties are free to agree on the procedure of the arbitral tribunal. Failing such agreement, the tribunal has the power to conduct the proceedings in the manner considered appropriate.⁴¹ 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.⁴²

Costs

Under the Arbitration Act 1996, unless the parties agree otherwise, the costs and expenses of the arbitration can be fixed by the tribunal in its award. In the absence of an award on costs, each party will bear their own expenses and will share the cost of the arbitral tribunal in equal parts.

iv Alternative dispute resolution

Mediation is a commonly utilised disputes resolution process in New Zealand whereby parties seek to resolve their dispute by agreement with the assistance of an independent facilitator. The District Court Rules 2014 also encourage parties to attempt to resolve disputes by agreement by utilising the judicial settlement conference process available through the courts.

V YEAR IN REVIEW

The New Zealand insurance industry has been the subject of significant regulatory scrutiny and legislative change over the past 12 months in the wake of the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry and the FMA's and RBNZ's joint review of conduct and culture within life insurers.

41 Arbitration Act 1996, Schedule 1, Clause 19.

42 Arbitration Act 1996, Section 7.

The New Zealand government's response has been to signal that it will be 'fast-tracking' the incorporation of customer protections measures in the financial sector.⁴³ The proposed legislative reform includes the following.

i Reform of insurance contract law

In December 2019, MBIE released a report on the reform of insurance contract law which proposes the repeal and consolidation of New Zealand's existing insurance statutes (including the IIA, the Insurance Law Reform Acts of 1977 and 1985, the Life Insurance Act 1908, and Part 3 of the Law Reform Act 1936). One of the key proposals is the eradication of the pre-inception duty of disclosure on insureds and its replacement with a less onerous duty to answer questions truthfully and accurately.⁴⁴ The report proposed that requiring insureds to 'take reasonable care not to make a misrepresentation' was more appropriate than requiring insureds to ascertain what was 'material' to disclose. The report also proposes that insurers' remedies be proportionate to the nature of any non-disclosure, an approach currently adopted in the United Kingdom.

ii Financial Markets (Conduct of Institutions) Amendment Bill

Draft legislation (the Financial Markets (Conduct of Institutions) Amendment Bill) was introduced in late 2019 to provide for a new conduct regime for banks, insurers, non-bank insurers, non-bank deposit takers and their intermediaries. The Bill introduces a new licensing requirement for financial institutions that undertake services such as the provision of consumer credit contracts, credit-related insurance and 'consumer insurance contracts'. A fair conduct principle will be introduced, as well as new duties concerning the establishment, compliance with, publication and review of fair conduct programmes. Other notable inclusions are additional protections for whistle-blowers, and restrictions (to be elaborated on in regulations, yet to be published) relating to commissions and remuneration.

iii Focus on solvency

The recent Financial Stability Report released by the RBNZ in November 2019 highlighted that 'solvency ratios have declined for many life and general insurers, leaving insurers with low buffers over regulatory minimums, and further falls . . . likely for some life insurers due to recent falls in interest rates.'⁴⁵ This raises 'concerns about the ability of insurers to meet the minimum requirement in the event of an adverse shock or a major loss of event' and it is the view of the RBNZ that this, as well as declining long-term interest rates, are demanding stronger solvency standards to be introduced.⁴⁶

43 New Zealand Government 'Australian Royal Commission findings concerning, but NZ move to protect consumers already in train' (4 February 2019) <https://www.beehive.govt.nz/release/australian-royal-commission-findings-concerning-nz-moves-protect-consumers-already-train>.

44 Ministry of Business, Innovation and Employment 'Insurance Contract Law Reforms' (4 December 2019) at 4-5, 18-27.

45 Reserve Bank of New Zealand Financial Stability Report (November 2019) at 38.

46 At 39.

iv Assignability of replacement benefits

The Supreme Court has recently clarified the assignability of replacement benefits. In *Xu v. IAG*, the Supreme Court considered the effect of a purported assignment of an IAG ‘standard replacement policy’, which allowed the insured to elect between the recovery of ‘replacement benefits’ (in the event the insured elected to reinstate the property) or an indemnity payment (if they did not reinstate). In *Xu*, the original policyholders, the Bryants, had sold their earthquake-damaged property and assigned their insurance policy to the Xus. The Bryants had made a claim under the policy prior to assignment, but had not yet elected to reinstate. The Supreme Court considered whether, as assignees, the Xus could subsequently elect to reinstate the property and thereby claim replacement benefit cover. The majority ultimately found that they could not, as the right to replacement benefits was conditional on the original policyholder electing to reinstate the property. In principle, the Court accepted that an accrued right to payment under an insurance policy may be assigned. The Court considered, however, that the entitlement to replacement benefits is entirely contingent on reinstatement by the insured (and not their assignee). The Court’s reasoning largely derived from the judgment of Cooke P in *Bryant v. Primary Industries Insurance Co Ltd*, where His Honour found that the right to replacement was personal to the insured. The Supreme Court, in *Xu*, were dissuaded from departing from this decision, arguing that to abut from this principle would have a destabilising effect on the insurance industry, given *Bryant* was clearly ‘influential’ as to the terms on which insurers offered replacement insurance.

v Focus on Wellington property insurance

In 2019, the Wellington Insurance Taskforce, including expert advisers from the science, engineering, insurance, law, and academic fields, as well as apartment owners and property developers, was convened in response to growing anecdotal evidence about cost and availability of insurance for some in Wellington City. The Taskforce released a Discussion Document in November 2019⁴⁷ which recommended the establishment of an integrated Wellington Risk Leadership Group to lead a shift of focus to a holistic approach to risk management and resilience and oversee the design of an implementation plan.

VI OUTLOOK AND CONCLUSIONS

The New Zealand insurance industry is currently in a state of significant change and reform. The proposed legislative changes in insurance regulation will require all industry participants to assess not only their statutory compliance programmes but, in many cases, also their business models and approach.

⁴⁷ <https://wellington.govt.nz/-/media/your-council/news/files/2019/insurance-taskforce-recommendations.pdf?la=en>.

PORTUGAL

*Miguel Duarte Santos*¹

I INTRODUCTION

The Portuguese insurance and reinsurance market is based on a developed industry, and is supported by:

- a* an established insurance tradition and market acceptance;
- b* a relevant display of compulsory insurances; and
- c* the presence of large national and international financial groups in the sector, and of several of the major international insurance companies and insurance intermediaries in the market.

Life insurance distribution is still mostly performed through banks, acting as intermediaries. Despite this, life insurance, investment products and pension funds schemes have been gathering more acceptance and relevance in the market.

With regard to non-life insurance, compulsory insurance products make up the bulk of the operations. They mainly concern civil liability products; however, there are large portfolios of health, damage and loss insurance products in the market, mainly placed through banks and big retailers, acting as intermediaries or under the connected contract exemption.

Despite this, new products have become more popular, such as bond insurance, investment products and cyber insurance products.

The legal framework enjoys some stability and benefits from acts being updated and adapted fairly frequently. The Insurance and Reinsurance Access and Exercise Legal Framework Act (the Insurance Legal Framework), which is the main piece of legislation, entered into force in 2016 (last updated in 2018); and the Insurance Contract Legal Framework Act (ICLF), which establishes the general framework on insurance contract execution and performance, entered into force in 2009 and was last updated in 2015. Notwithstanding this, the market operators and the legal framework are adjusting to several pieces of EU legislation that became applicable from the second half of 2017 to the second half of 2018, in particular: Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 (the Insurance Distribution Directive (IDD)), and Regulation (EU) No. 1286/2014 of the European Parliament and of the Council of 26 November 2014 on key information documents for packaged retail and insurance-based investment products (the PRIIPs Regulation).

¹ Miguel Duarte Santos is a managing associate at Gouveia Pereira, Costa Freitas & Associados, Sociedade de Advogados, SP, RL. The information in this chapter was accurate as at April 2019.

II REGULATION

The Portuguese regulatory framework is based on Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 (Solvency II), and its delegated, implementing and transposing acts.

The general provisions on prudential and market behaviour regulation are set forth in the Solvency II transposing act and the Insurance Legal Framework.

The Portuguese Insurance and Pension Funds Supervisory Authority (ASF) is the main supervisory and regulatory authority related to prudential and market conduct rules compliance by insurance and reinsurance undertakings and intermediaries, covering both the access and the pursuit of insurance and pension funds distribution in Portugal, or in EU territory when the activity is pursued by Portuguese companies and persons.

The ASF is also the supervisory and regulatory authority concerning market conduct rules for insurance-based investment products and open pension funds distribution.

Although the Ministry of Labour, Solidarity and Social Security supervises the distribution of provident and mutual benefit products similar to insurance products, where they are provided by authorised provident and mutual benefit institutions, the ASF shares the supervision over provident and mutual benefit institutions whose quotas or financing funds surpass the amounts determined in the new Mutual Benefit Institutions Code approved under Decree-Law 59/2018 of 2 August 2018.

i Position of non-admitted insurers

Only authorised insurance undertakings and authorised provident and mutual benefit institutions can provide insurance and similar products in Portugal.

According to the Insurance Legal Framework, the provision of insurance products or insurance schemes by non-authorised insurers is a crime punishable by a sanction of up to five years in prison or a fine.

Furthermore, the company that commits the infraction may be subject to compulsory administrative liquidation, and the company and the persons involved may be subject to a five-year prohibition on insurance activities.

ii Position of brokers

Insurance and reinsurance mediation was governed by Decree-Law 144/2006 of 31 July 2006 (the Insurance Mediation Law), and by the ASF's Regulation 17/2006-R of 29 December 2006, both implementing the rules set forth by Directive 2002/92/EC (the Insurance Mediation Directive), although the market commenced the gradual implementation of the IDD rules transposed through the Insurance and Reinsurance Distribution Legal Framework (IRDLF), approved through the Law No. 7/2019 of 16 January.

The legal and regulatory framework establishes three types of insurance mediators: brokers, who are fully independent insurance mediators; agents, who are insurance mediators that pursue mediation in the name of and on behalf of one or more insurance undertakings; and insurance intermediaries, who are 'tied insurance mediators' as defined under the Insurance Mediation Directive.

The different types of mediators are subject to different rules pertaining access to the market, namely those regarding prudential requirements and authorisation procedures, as well as regarding market conduct.

iii Requirements for authorisation

The ASF is responsible for the authorisation and registration of Portuguese insurers, reinsurers and brokers, as well as for the authorisation and registration of foreign insurers, reinsurers and brokers established or providing services in Portugal, and some provident and mutual benefit institutions.

Authorisation is required for any creation or implementation measure. There are several prudential conditions that must be complied with in order for the authorisation to be provided, covering the type of company, system of governance, funds, fit and proper requirements and other aspects.

The ASF authorises insurers to render services regarding specific types of cover. Therefore, insurers must appoint the types of cover that they propose to distribute, and prepare the application and respective submission documents accordingly. Insurers may request alterations to their authorisation, which, if minor, do not require further authorisation, although they may require a notification to the ASF.

EU insurers, reinsurers and brokers enjoy EU passporting rights, which provide a simplified procedure for access to the Portuguese market and other EU markets via freedom of establishment and freedom to provide services rights.

EU companies providing services in Portugal under the right of establishment or freedom of services (FOS) are subject to market behaviour rules set forth in Portuguese law, as well as other general interest conditions concerning compulsory insurance provisions, such as claims handling procedures and other aspects of insurance distribution. Most of the prudential regulation rules are set forth by the principal company legal and regulatory framework, although the ASF must be notified of relevant alterations that may have an impact on Portuguese market sustainability or the conditions for the rendering of services in Portugal.

However, EU companies accessing the Portuguese market under FOS must appoint a claims representative who must reside or be established in Portugal, and, when providing motor liability insurance, EU companies must also become associated with the Portuguese Green Card Bureau.

iv The distribution of products

Portugal has only approved the laws, regulations and administrative provisions necessary to comply with the IDD in 2019. Nevertheless, the market commenced adjusting to the preliminary IDD transposition draft law (the IDD Draft Law) released by the ASF in 2018.

The IDD Draft Law authorises the ASF to approve and publish the regulations deemed necessary in order to duly and fully transpose the IDD, but no draft regulation has been disclosed so far.

The IDD Draft Law and the IRDLF establish new rules concerning insurance products approval, adequacy assessment and distribution, and information requirements, including information on intermediaries' fees and the obligation to deliver the insurance product information document. They also set new rules regarding authorisation procedures and requirements, system of governance, fit and proper requirements, and conflict of interest rules.

Finally, the IRDLF alters the previously existing connected contract exemption (CCE), setting less restrictive rules for the applicability of the new ancillary insurance intermediaries exemption conditions set forth in Article 1(3) of the IDD.

v Compulsory insurance

The non-life insurance market in Portugal is based on compulsory insurance products. There are dozens of compulsory insurance products, including classes (as defined under Solvency II) for accident; fire and natural forces; other damages to property; motor vehicle liability; and suretyship.

Under the Insurance Legal Framework and the ICLF, compulsory insurance products distributed in Portugal are subject to the applicable Portuguese legal and regulatory provisions concerning the compulsory insurance.

The insurer must deliver the terms and conditions of any compulsory insurance in the Portuguese language, unless the parties agree that it shall be worded in another language and the policyholder requires the delivery of the policy in another language.

The ASF has the power to issue standardised policies and command any insurer to comply with these standardised policy terms. Insurers are obliged to register the general terms and conditions of any compulsory insurance products with the ASF, which in return must declare whether the terms and conditions are compliant with the applicable rules.

Furthermore, insurers offering compulsory insurance distribution in Portugal by way of FOS are required to appoint, register with the ASF and divulge the identity of a claims representative and a client ombudsman, both of which must be resident or established in Portugal.

vi Compensation and dispute resolution regimes

Under the Insurance Legal Framework, the ASF is responsible for any mitigation, recovery or liquidation process concerning insurance and reinsurance companies. Despite this, there is no general compensation regime for the event of an insurer or a mediator bankruptcy.

Nonetheless, there are several applicable compensation and dispute resolution regimes concerning specific insurance products, such as motor insurance and accidents at work and occupational diseases insurance, which cover any payments owed by the insurer to the insured person or company, the beneficiary or the injured party.

Regarding motor insurance, the Portuguese Motor Insurance Legal Framework, approved under Decree-Law 291/2007 of 21 August 2007, established the Motor Insurance Guarantee Fund, to which all insurers that provide motor insurance in Portugal must contribute. It is responsible for compensating for damage suffered by the injured persons whenever the person liable for the damage caused by a motor vehicle is unknown, fails to comply with the obligation to enter into a valid compulsory motor insurance or, for some reason, is exempt from this obligation.

Insurers do enter into non-binding compensation regimes, in order to expedite claim-handling and payment. The most relevant example is the Insured Person Direct Liquidation Protocol (the Liquidation Protocol),² applicable, under certain requirements, when the persons involved in a motor vehicle accident between two vehicles duly covered by motor insurance contracts agree on the circumstances of the accident, and under which the insurer of the injured party directly compensates the damage suffered and subsequently obtains reimbursement from the insurer of the liable persons.

2 <http://avbseguros.com/files/Protocolo%20IDS%202006.pdf>

As established under the Liquidation Protocol, any dispute arising between insurers concerning the interpretation and execution of the compensation regime shall be committed to arbitration.

The existing general and mandatory dispute resolution regimes are applicable to disputes opposing insurers and policyholders, insured persons, beneficiaries or injured parties, and, as such, will be addressed below.

vii Proposed changes to the regulatory system

There is an ongoing discussion regarding the necessity of a new financial supervisory and regulatory structure, and the general principles and positions that should be followed on this matter.

For the time being, there are no final decisions on a new financial supervisory and regulatory structure. The current structure comprises three authorities, the ASF, the CMVM and the Bank of Portugal, and a consultation and coordinating entity, the National Council of Financial Supervisors. The Financial Supervision Reform Working Group favours the substitution of the current sectorial supervision with a twin-peaks supervision model, where insurance, banking and securities market behaviour supervision would be assumed by a single authority.³

The CMVM's supervisory and regulatory functions pertaining to market conduct rules for insurance-based investment products and open pension funds distribution have been transferred to the ASF, which also has supervisory and regulatory responsibilities for some significant provident and mutual benefit institutions. Considering these proposed changes, it is expected that the ASF will regulate insurance distribution, particularly concerning insurance-based investment products, open pension funds, and provident and mutual benefits in 2019.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Portuguese legal framework is based on statutory law. There are no binding case law precedents, and customary law is subject to highly restrictive requirements.

There are several insurance contracts ruled under specific statutes, such as motor liability, bond and credit, and marine insurance contracts. Despite this, the basic insurance law framework is set out in the ICLF as amended, approved under the Decree-Law 72/2008 of 16 April 2008, which establishes the general rules regarding insurance contracts, specific rules applying to damages and personal insurance, and several special rules applying to certain covers.

The ICLF shall apply to any insurance contract regulated under specific legislation, and, whenever the ICLF does not cover the subject matter, the Civil Code and the Commercial Code shall apply.

There are also several ASF and CMVM regulations establishing relevant provisions concerning insurance contracts, notably the ASF regulations on compulsory insurance standardised policies.

3 FSRWG Report: www.gpeari.gov.pt/consulta-publica/relatorio-do-grupo-de-trabalho-para-a-reforma-da.

ii Making the contract

The ICLF does not define the concept of an insurance contract, although it expressly determines that should be a contract through which the insurer undertakes to perform the agreed obligation (which might be a pecuniary charge) in the event of a specified uncertain future event (although Portuguese law admits past events to be covered, under very strict requirements). The policyholder undertakes the obligation to pay the premium (which will always consist of a pecuniary charge that can be paid through cash, bank cheque, postal order or payment services transactions).

The making of the contract commences with the provision of legally and regulatory compliant pre-contractual information to the policyholder, as well as any information and clarifications that might be necessary for the policyholder to comprehensibly understand the contract. Whenever the insurer is distributing an investment product, it must also provide the policyholder with the key information document.

The policyholder is required to file and deliver to the insurer a contractual proposal with the information considered necessary by the insurer. In contrast to other countries' legislative frameworks, according to the ICLF, the policyholders are subject to a pre-contract obligation to provide the insurer with any information that the policyholder is aware of and can reasonably find relevant for the insurer to evaluate the risks to be covered, regardless of whether this information is expressly requested by the insurer.

Whenever the policyholder delivers to the insurer or the broker the filed contractual proposal and any other required information and documents, the insurer has 14 calendar days to accept, deny or require any further information or documents. The omission of any action determines the contract to be considered accepted.

After the contract is entered into by the parties, the insurer is required to issue and deliver the insurance policy to the policyholder immediately (or in 14 calendar days, when the insurance is a 'mass-insurance' contract), worded under specific legal and regulatory requirements, comprising all the contractual terms. The policyholder has 30 calendar days to submit any complaint regarding the insurance policy. After this period has elapsed, the insurance policy is considered to validly reflect the parties' agreement, and this assumption can only be challenged with written documents containing divergent information.

The Insurance Legal Framework requires the insurer to number the contracts and maintain an insurance and investment products electronic register, containing information on the parties and in the contract itself.

iii Interpreting the contract

Although the contract may be concluded in any form the parties choose, the insurer must always issue and deliver the insurance policy, which will serve as the basis for the contract interpretation. Nevertheless, insurance contracts are normally construed under general terms and conditions proposed by the insurer.

Insurance contract interpretation should be based on the insurance policy and should be construed objectively, with the meaning that a normal policyholder in the conditions of the specific policyholder would give to the terms. However, under the rules applicable to general terms and conditions, dubious terms shall be interpreted in the most favourable way for the policyholder.

Insurance policies usually contain three sets of terms and conditions: general terms, special terms (setting specific rules on certain covers, premium payments or other items of the contract) and particular terms ('schedule'), which comprehend the concrete aspects of the

insurance contract, such as the identity of the policyholder, insured persons and beneficiaries, the premium amount or calculus method, the insured good, the insurance period or the insured amount. Special and particular terms cannot change the nature of the cover as determined by the insurance type.

General terms and conditions declared null in judicial courts are registered and divulged so that claimants and insurers are informed of the judicial interpretation. Although there is no case law precedent in Portugal, decisions involving insurance contracts clauses are considered by insurers when drafting new terms and conditions.

iv Intermediaries and the role of the broker

Portuguese Law allows for three types of registered insurance mediators, as well as non-registered intermediaries acting under the Insurance Mediation Directive CCE.

Insurance mediators can act on behalf of the insurer or on behalf of the policyholder. When doing so, the mediator must comply with the information obligations that the party he or she represents is subject to.

Alongside this, the Insurance Mediation Law provides a number of conduct rules for insurance mediators, such as:

- a* the obligations to provide information to clients, insurers and the ASF;
- b* the prohibition to intermediate the conclusion of insurance contracts that fail to comply with any legal or regulatory rules;
- c* the obligation to act accordingly with the orders received, namely from the policyholder, and to render accounts;
- d* the obligation to keep a record of the contracts that he or she has intermediated; and
- e* a prohibition on imposing an insurance contract crossed sale.

The intermediary is subject to the anti-money laundering (AML) prevention obligations set forward in EU and Portuguese law and, as such, must comply with the applicable customer due diligence measures.

Although an intermediary does not necessarily assume the representation of one of the parties in the insurance contract, whenever it acts in the name of the insurer or of the policyholder, any communication that might be delivered to it is considered to have been delivered directly to the party it represents.

In the event of a false representation, the actions performed by or through the intermediary are deemed contractually ineffective, although the insurer can ratify the performed actions. Despite this, the ICLF establishes that an insurance contract entered into through an intermediary that has presented itself as acting in the name of an insurer can be binding to the insurer, provided that there are objectively valid and acceptable reasons to sustain the policyholder's belief in the intermediary's good faith and legitimacy, and if the insurer has in any way contributed to the formation of such conviction.

v Claims

Under the ICLF, the policyholder, the insured person and the beneficiary must present any claim to the insurer within eight calendar days of becoming aware that the insured event has occurred, or in a wider period determined in the insurance contract.

The claimant must state the causes, circumstances and consequences of the event, as well as render to the insurer any clarifications that it might request.

The ICLF does not establish a specific consequence for failure to present the claim in the given period, but the insurance contract may establish the reduction of the due instalment according to the damage suffered by the insured because of the delay. The contract may also determine the exclusion of coverage whenever the delay is wilful and causes significant damage to the insurer. However, these contractual terms cannot be opposed (1) when the insurer has taken knowledge of the event or (2) in any circumstances, to injured persons in order to prevent payment of instalments due under civil liability compulsory insurances contracts.

The insurer must pay within 30 calendar days of having determined the causes, circumstances and consequences of the claim. To ensure correct and fair claim handling and overall market behaviour by the insurer, Portuguese law imposes the obligation to create, register, implement and divulge claim and complaint policies.

There are also several provisions established in the law to guarantee that the policyholders, insured persons, beneficiaries and injured persons are aware of their rights, with emphasis on motor insurance or life insurance products and schemes registers.

The ICLF determines that the pre-contractual document and the insurance policy must indicate the claim presentation procedures and channels, as well as the procedures and channels for presenting complaints regarding claim handling by the insurer.

Insurers also have an obligation to appoint a client ombudsman to serve as an appeal instance regarding claim-handling disputes.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

The general rules on international jurisdiction are set out in Articles 10 to 16 of EU Regulation No. 1215/2012 of the European Parliament and of the Council of 12 December 2012, on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (recast).

Portuguese law states that the injured party whose damages are covered by a liability compulsory insurance can always bring actions directly against the insurer or be joined in proceedings held against the insured. These possibilities are extended to liability non-compulsory insurance when the insured has previously informed the injured party on the existence of the insurance, and the injured party and the insurer have commenced negotiations.

In some cases (e.g., insurance contracts covering large risks), the parties are allowed to commit the dispute to a different jurisdiction, although the requirements for a valid choice of jurisdiction are narrow.

The general rules on choice of law are set out in Article 7 of the Rome I Regulation, and in Articles 5 to 10 of the ICLF.

Insurance contracts covering large risks are governed by the law chosen by the parties, or, in the absence of choice, by the law of the country where the insurer has its habitual residence, unless the contract is manifestly more closely connected with another country, in which case the law of that country shall apply.

Other insurance contracts are governed by the law chosen by the parties, although the parties can only choose from certain specified laws.

In the absence of a valid choice of law, the insurance contract shall be governed by the law of the Member State in which the risk is situated at the time of conclusion of the contract.

There are three provisions of the ICLF that establish rules of the upmost importance with regard to choice of law:

- a* the ICLF determines that consumer protection mandatory rules are to be considered as overriding mandatory provisions;
- b* compulsory insurance is governed by Portuguese law; and
- c* regardless of whether they are covered by Portuguese law, insurance contracts offering cover that is forbidden in Portugal are null.

When contracts are submitted under Portuguese law, the ICLF allows the parties to commit the dispute to arbitration, whatever the type of insurance, cover or claim.

ii Litigation

Most disputes arising from an insurance contract interpretation or execution demand a judicial review of the circumstances and, therefore, demand a declarative proceeding to be held.

Portuguese law establishes specific proceedings and jurisdiction for claims against public and private persons or entities regarding their liability for acts and omissions in the exercise of state authority. Other civil proceedings are regulated under the general provisions of the Portuguese Civil Procedure Code. Nonetheless, all declarative proceedings are adversarial and comprehend mandatory mediation phases held by the trial judge.

Generally, the burden of proof relies on the plaintiff and written evidence does not bear higher evidential value than other types of evidence. However, written evidence tends to supersede oral evidence.

The parties can appeal the decisions before the higher court and, under certain circumstances, before the Supreme Court of Justice. Final decisions are directly enforceable.

Portugal has successfully diminished the duration of proceedings by creating the CITIUS platform, an internet platform through which proceedings actions concerning almost all civil proceedings must be performed. Despite this, civil proceedings are still perceived as costly for natural persons. To reduce the negative impact, the law establishes higher court costs for mass litigators and establishes that the winning party can demand that the losing party reimburse the incurred costs.

iii Arbitration

Law 63/2011 of 14 December 2011 establishes the general rules on voluntary arbitration. Parties can submit disputes arising from insurance contracts to arbitration, although the arbitration, when applied to consumers, cannot diminish consumers' procedural guarantees as provided by state proceedings.

A valid arbitration clause prevents the parties from submitting the dispute to state jurisdiction if they fail to agree on the submission, and the arbitration decision is enforceable, although the parties can appeal the decision before state courts.

Insurance arbitration is fairly well developed in Portugal. The most representative private insurance arbitration centre is the Centre for Insurance Information, Mediation, Ombudsman and Arbitration (CIMPAS), which settles disputes concerning motor insurance, and, up to certain claim amounts, multi-risk and civil liability insurance. It may settle disputes arising from other types of insurance, with the exception of large-risk insurance. In addition, it does not settle disputes arising from events that have not occurred in Portugal or that have resulted death or permanent disability.

The arbitration is always preceded by a mandatory mediation phase, which is usually expedited (three to six months until the final decision), and the arbitration fees are settled as 3 per cent of the claim amount.

iv Alternative dispute resolution

The most significant alternative dispute resolution (ADR) system is the client ombudsman, which serves as a voluntary instance to which policyholders, insured persons, beneficiaries and injured parties can appeal claim-handling decisions and actions taken by the insurers.

Any insurer that provides services in Portugal must create, implement, register and divulge a client ombudsman policy, and appoint a client ombudsman habitually resident or established in Portugal.

Other than the client ombudsman, the law and the insurance market have established, developed and implemented arbitration and mediation systems that have been increasingly embraced by insurance claimants.

v Mediation

Law 29/2013 of 19 April 2013 establishes the general rules on civil and commercial mediation. Under its provisions, parties can only submit to mediation disputes concerning material interests, and the submission of disputes to mediation is always based on free and informed consent by the involved parties, that the parties can retract at any time and by any cause. Nevertheless, if the parties agree on the mediation, the decision is enforceable through state courts.

Voluntary mediation is developing in Portugal as consumers become more aware of the existence of state-held and private mediation centres, such as the mediation centre provided by justices of the peace and CIMPAS.

Portuguese declarative proceedings have a mandatory mediation phase, led by the trial judge before the trial hearings.

V YEAR IN REVIEW

The Portuguese insurance and reinsurance market grew consistently throughout 2018, although it had to adjust to the Fourth Anti-Money Laundering Directive (4th AML Directive), the PRIIPs Regulation, the IDD and the General Data Protection Regulation, in a time-consuming and resource-intensive process that is still underway.

The exposure of insurance companies to foreign financial markets and the broad restructuring of European insurance companies and banks has continued to determine portfolio sales and mergers and acquisitions (M&A) operations between insurance undertakings. This is expected to continue in the coming years and will result in more concentration in the Portuguese market.

The insurance industry is based on mandatory insurance products and banking operations-related insurance products, which means that many of the most relevant life insurance companies in the Portuguese market are part of larger financial corporate groups and have banks as their main distributors.

Regarding non-life insurance companies, the main players have a large number of compulsory insurance products.

The relevance of compulsory insurance products and the concentration of the market on non-life insurance brings some risks – the Portuguese Competition Authority has initiated proceedings against five insurance undertakers for alleged constitution of a cartel aimed at market share and price-fixing.

VI OUTLOOK AND CONCLUSIONS

The year 2018 was exceptionally challenging for insurance undertakings and distributors as regards to their respective adjustments to the EU and Portuguese insurance legal and regulatory frameworks, in a process that will continue throughout 2019.

As mentioned in Section V, the implementation of the 4th AML Directive, the PRIIPs Regulation, the IDD and the GDPR have introduced significant changes to insurance undertakings and distributors market-behaviour rules, requiring demanding operations, policies, procedures, terms and conditions, marketing strategies and documentation, and distribution arrangements, which means they must be reviewed and restructured.

In addition, the prudential and market-behaviour supervisory and regulatory powers of the ASF will require the authority to accommodate the supervision and regulation of new matters previously subjected to the CMVM or the Ministry of Labour, Solidarity and Social Security.

Therefore, market operators will have to continue to adjust to the regulatory provisions during 2019.

However, despite the above, the Portuguese insurance market is consistently growing and attracting international players. M&A activity and portfolio sales are expected to continue throughout 2019. There are also expected to be innovations regarding insurtech, namely risk management, predictive models, fraud prevention, and marketing strategies and procedures.

SPAIN

*Jorge Angell*¹

I INTRODUCTION

In the past, the Spanish insurance and reinsurance industry was very fragmented and weak, and did not have the financial capacity to cover the risks of the market. Consequently, the risks were largely ceded abroad and local insurers fronted for foreign carriers. This changed slowly following an extensive restructuring and consolidation in the 1980s, and there are now Spanish players competing in the international market.

This financial weakness led to the creation of the Insurance Compensation Consortium, a wholly state-owned entity whose main task is to cover what are known as extraordinary risks.

The legal system endeavours to protect consumers while participants on equal negotiating terms are not subject to the otherwise mandatory insurance provisions concerning those risks classified as large risks.

Generally speaking, the insurance industry is heavily regulated and supervised.

II REGULATION

i The insurance regulator

Law 20/2015 of 14 July, on regulation, supervision and solvency of insurance and reinsurance entities (Law 20/2015) entered into force on 1 January 2016. At the same time, the Regulation and Supervision of Private Insurance Act 2004, was abrogated, except for a few provisions that are still in force.

Responsibility for the day-to-day regulation of insurance and reinsurance business conducted in Spain is delegated to the Directorate-General for Insurance and Pension Funds (DGIPF), which is a division of the Ministry of Economic Affairs and Digital Transformation.

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.

¹ Jorge Angell is the senior partner at LC Rodrigo Abogados.

European Economic Area (EEA) insurers operating in Spain either by way of establishment or providing services are subject to the disciplinary power of the DGIPF in coordination with the relevant EEA supervisory authority.

ii Position of non-admitted insurers

Policies issued by non-authorised insurers are null and void by law. However, the effects can differ from the general civil rules on nullity of contracts: if no loss has occurred, the insured is not required to pay the agreed premium or has the right to recover any premium paid. However, if a loss that would otherwise have been covered had the policy been valid occurs before the premium is returned, the non-authorised insurer may keep the premium, but would be required to pay an indemnity, the quantum of which would be determined in accordance with the void policy terms. The insured may also claim any other relevant damages sustained by reason of the void policy. Both the company and the directors or officers that permitted the policy to be issued shall be jointly and severally liable for those obligations.

iii Position of brokers

Insurance and reinsurance brokers are wholly independent intermediaries between purchasers of insurance and reinsurance, on the one hand, and insurers and reinsurers, on the other.

Insurance and reinsurance brokers are required to be registered in the administrative register that covers insurance, reinsurance and ancillary insurance intermediaries, which is handled by the DGIPF. It is not an authorisation proper, but a formal requirement to be able to carry out their activity. See Section III.v.

iv Requirements for authorisation

Insurers or reinsurers based in the EEA who are duly authorised to write business in their countries will be entitled to carry out business in Spain under either the freedom of establishment regime (as a branch) or the freedom to provide services regime (FOS) subject to complying with the EU notification procedure. In both cases, they must abide by the regulations dictated by Spain, as the host Member State, for reasons of the general good, as well as the applicable regulatory rules. To set up an insurance branch, it is necessary that the DGIPF, after the EU appropriate notification procedure has been completed and all other applicable requirements have been met, enters the branch office on the Administrative Register of Insurance Entities. Further, the branch office must be recorded with the Companies Register.

However, EEA reinsurers 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.

Insurers and reinsurers from non-EEA countries are required to obtain an authorisation from the Ministry of Economic Affairs and Digital Transformation if they wish to set up a branch in Spain. However, reinsurers may carry out business in Spain from the country in which their head office is located.

v Regulation of individuals employed by insurers

Law 20/2015 establishes that those who are in charge of the effective management of insurance and reinsurance companies must be commercially and professionally trustworthy, and have the appropriate professional qualifications, knowledge and experience to ensure sound and prudent management.

Generally, individuals employed by insurers are subject to the same rules as any other employee, namely the Workers' Statute 2015 and the relevant collective bargaining agreement, if any. There is a specific collective agreement for insurance and reinsurance companies. The system is highly protective of employees although the rules have been somewhat relaxed by the current government.

vi The distribution of products

Insurance and reinsurance distribution activities are subject to Royal Decree-Law 3/2020 of 4 February, which transposes into Spanish law Directive 2016/97/EU on Insurance Distribution (IDD). The new Act entered into force on 6 February 2020. It repealed the Private Insurance and Reinsurance Mediation Act 2006.

The new Act extends the scope of application to all distributors of insurance and reinsurance products: insurance and reinsurance companies, insurance and reinsurance intermediaries (which includes agents and brokers), and ancillary insurance intermediaries to the extent that they do not fall within the exclusions provided for in the law (e.g., travel or car rental companies). Likewise, distribution of insurance products through insurance comparison websites is subject to the insurance distribution regime.

vii Compulsory insurance

There are a number of forms of compulsory insurance including third-party motor insurance, air navigation, 10-year building cover, travel insurance and professional liability (for auditors, lawyers, engineers, architects, etc., if they practise in professional firms). Civil liability insurance is required to own or use certain properties (e.g., recreational and sports boats and personal watercraft); to keep potentially dangerous animals (e.g., dogs); to obtain authorisation for certain business activities (e.g., sea transportation, travel agencies, public shows and leisure activities, exploration, prospecting and exploitation of hydrocarbons, installation or maintenance services of telecommunications equipment or systems); and for many other activities.

viii Compensation

The Insurance Compensation Consortium (ICC) is in charge of the winding up of insurance companies with the ICC undertaking the role of liquidator, in the cases set forth by Law 20/2015 and by the ICC Statute approved by Royal Legislative Decree 7/2004 of 29 October, as amended.

The main goal of the winding-up proceedings as handled by the ICC is the timely payments of the creditors' rights under the relevant insurance policies (the insured, beneficiaries and injured third parties). The ICC purchases the creditors' rights in accordance with the foreseeable net liquidation balance without having to wait for the winding-up

procedure to be completed. Payments are made with the ICC's resources and then the ICC is subrogated to the creditors' rights. Any recoveries will belong to the ICC. This is a significant improvement on ordinary insolvency proceedings.

ix Dispute resolution regimes

Section 97 of Law 20/2015 provides for dispute resolution mechanisms in insurance matters. These are litigation, arbitration (subject to certain limitations in the case of consumers), and mediation. See Section IV.

In addition, pursuant to Section 97, insurers are required to receive and resolve any claims and complaints of the insured. Insurers operating under the FOS regime are not required to set up a customer service department in Spain. It would be sufficient to provide to the insured full details of the insurance broker or the underwriting agency (i.e., the place where such complaints can be sent).

The insurer may appoint a customer ombudsman – either an entity or recognised independent expert – who shall handle and resolve the claims and complaints submitted to it. If this is the case, the policy must provide the address and the email of the customer ombudsman. The DGIPF should be informed of this appointment.

The insurer or the customer ombudsman must respond to a complaint within two months from the date it is filed. After this period has elapsed, if the insured's claim or complaint is not answered or is dismissed, the claimant can submit a complaint to the complaints service of the DGIPF. The policy must indicate the insured's right to proceed in this way.

x Taxation of premiums

There is an insurance premium tax (IPT) that currently amounts to 6 per cent of all premiums collected in Spain in non-exempt lines. The IPT is ultimately paid by the insured but the insurer is required to collect and deliver it to the Treasury. For this purpose, the insurer must file returns on a periodical basis (monthly plus one annual summary).

The following transactions are exempt from the IPT:

- a* those related to the compulsory social security insurance and collective insurances for alternative systems to pension plans and pension funds;
- b* life insurance;
- c* capitalisation operations based on actuarial techniques;
- d* reinsurance operations;
- e* surety;
- f* export credit insurance;
- g* insurance operations related to international transport of goods or passengers;
- h* insurance operations related to international shipping or air travel, with the exception of private navigation or aviation for leisure purposes;
- i* insurance operations of medical care assistance and disease; and
- j* operations related to insured provision plans.

Insurers are also required to pay to the ICC a levy or surcharge of 0.15 per cent on all premiums for the insurance of risks located in Spain other than premiums for life and export credit insurance, which is intended for the financing of the winding up of insurance companies.

Finally, insurers are required to collect from the insured and turn over to the ICC a tariff (in fact a premium) for the coverage of extraordinary risks. This tariff is paid on certain lines only.

The levies and tariffs payable to the ICC are ultimately payable by the insured but the insurer is directly liable to the ICC.

xi Proposed changes to the regulatory system

Of particular interest for the financial industry in 2020 is the draft bill for the Law on Measures for the Digital Transformation of the Financial System. The draft bill regulates the creation and implementation of a regulatory sandbox that allows fintech or financial companies to test innovative products in the market without the risk of infringing on regulatory requirements. The draft bill is in Parliament at the time of writing.

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.

The Law on Standard Contract Terms applies to both consumers and non-consumers.

Incorporation of terms

Terms implied by statute are fairly common under Spanish civil law. Notably, this is the case of contracts for sale. There are some limited cases in insurance law (data protection rules, protection for extraordinary risks in connection with certain lines) and virtually none with regard to reinsurance contracts.

The courts could imply and incorporate terms when interpreting, construing or integrating the contract, but this is rare. Incorporation by usage (of principles such as 'follow the fortunes' or 'follow the settlements') would be feasible in principle under Section 1258 of the Civil Code, subject to evidence and consistent observance in the relevant market.

Types of terms in insurance contracts

A fundamental distinction is whether the insurance contract involves a large risk (as defined in the Solvency II Directive and Law 20/2015), or a mass or consumer risk.

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 always to the general limits to party autonomy and the basic principles of insurance law; 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, it will be understood that the clause has not been included in the contract and the insured will not be bound by it. It is a requirement to include a statement that the policyholder or insured has read the limitative clauses, if any, and agrees to them. In addition, Section 8 of the ICA, as amended by Law 20/2015, provides that the policy must describe, in a clear and comprehensible manner, the guarantees and covers and the applicable exclusions and limitations, which must be highlighted.

On the other hand, contractual clauses limiting or restricting the insured's rights, or exclusions contained in the policy that by nature do not delimit and specify the coverage afforded by the insurer, cannot necessarily be raised against the third party who has the right to claim directly from the insurer (in the context of civil liability policies). Clauses specifying the risk are those relating to the subject matter or object of the insurance, the sum insured, the period of insurance and the geographic scope, etc. The rest may be limitative clauses or exclusions. In these cases the insurer may recover from the insured but cannot oppose the third party's claim on the basis of such clauses. Case law (e.g., decision of the Supreme Court of 30 November 2011, RJ\2012\3519) has drawn a subtle (and not always clear) distinction between clauses delimiting cover and clauses delimiting the rights of the insured or providing for exclusions. Occasionally, these exclusions have been described as delimiting cover objectively and therefore, theoretically, they could be raised against the third party. A key exercise is therefore to examine each contract on a case-by-case basis. This is particularly true in the case of motor insurance, for example.

Extreme care should be taken when incorporating legal concepts and principles from other jurisdictions into Spanish policies. These principles may mean little or nothing in Spain and, even worse, they can lead to misinterpretations.

Parties to a reinsurance contract are not subject to the otherwise mandatory provisions of the ICA. Therefore, party autonomy fully operates subject to the general limits to party autonomy (the law, public morality and public policy).

Warranties, conditions precedent and conditions

Warranties and conditions precedent do not have the same meaning and effect in Spain as those envisaged in English law.

Under Spanish law, a condition precedent (e.g., 'it is a condition precedent to liability under this policy that the insured notifies the insurer') is not a condition proper although there are similarities. Technically, there will be a condition proper (suspensive) if the effects of the contract depend on a future and uncertain event, or on an event that has actually taken place without it yet being known to the parties. In the first case the contract cannot go into operation until after the event; in the second case, the obligation is effective from the day on which it was undertaken, but it cannot be enforced until the event is known. In any case, the occurrence of the event must not be subject to the will of any of the parties. In this sense, a condition will be void if the occurrence of an event depends on the exclusive will of the other party (Section 1115, Civil Code).

A court could also find the condition precedent to be limitative in nature (of the rights of the insured), if it has not been adequately singled out in the contract and accepted specifically in writing by the policyholder, and thus could set it aside. Alternatively, it could take the view that the clause is detrimental to the insured and, for this reason, null and void. The Law on Standard Contract Terms could also be applicable to the extent the terms of the contract are imposed by one contracting party to the other. Under this Law, for these clauses to be valid, the party that adheres to the agreement must accept them explicitly. Otherwise the contract may be deemed null and void.

However, there is no reason why a well-drafted clause, providing for these conditions, should not be valid and enforceable, if incorporated into an insurance contract involving a large risk where the parties are not bound by the otherwise mandatory provisions of the ICA.

v Intermediaries and the role of the broker

Conduct rules

Royal Decree-Law 3/2020 (RDL 3/2020) establishes new rules of conduct and information requirements for insurance distributors. See Section II.vi.

As a general principle, RDL 3/2020 requires insurance distributors to act honestly, fairly and professionally in accordance with the best interest of their customers. In addition, it sets out that all information provided to customers or potential customers must be fair, clear and not misleading and the marketing communications shall always be clearly identifiable as such. Moreover, in line with the IDD, RDL 3/2020 establishes that insurance distributors cannot be remunerated in such a way that conflicts with their duty to comply with the customers' best interest.

RDL 3/2020 regulates the information that must be provided to customers prior to the conclusion of the insurance contract. Moreover, the insurance distributor is required to provide the customer with relevant information about the insurance product in a comprehensible form to allow the customer to make an informed decision. In addition, prior to the sale of an insurance product, the insurance distributor must provide the customer with a personalised recommendation explaining why a particular product would best meet the customer's demands and needs. The distribution of insurance-based investments products is subject to additional requirements.

RDL 3/2020 classifies insurance and reinsurance intermediaries into three categories: insurance agents, insurance brokers and reinsurance brokers.

Insurance brokers must provide independent and objective advice to whomever demands insurance. They are independent actors.

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.

The broker's remuneration may be paid by both the client and the insurance company.

RDL 3/2020 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.

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.

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 RDL 3/2020. Reinsurance brokers normally act for the cedent although their commission is paid by the reinsurer.

vi Claims

Notification

As a general rule, insurance claims must be reported within seven days of the moment the insured knew about the loss (Section 16, ICA). A longer term can be agreed for the benefit of the insured. Shorter terms could be agreed in the case of a large risk. In practice, however, many policies insert imprecise wording of the type 'as soon as possible or practicable' or similar, which conceivably could be longer than the statutory seven days.

The late notification of the loss would not per se entitle the insurer to rescind the contract, but only to claim damages, if any (Section 16, ICA). As an exception to the general rule, the prompt notification of the loss can be made a condition precedent to liability of the insurer if the risk in question concerns a large risk.

The law does not provide for the case of reinsurance. It will depend on the agreement of the parties.

Good faith and claims

The policyholder or the insured have the duty to provide all information available on the circumstances and consequences of the loss. The breach of this duty with gross negligence or bad faith on the part of the insured would release the insurer from its obligation to indemnify (Section 16, ICA).

The foregoing provision is connected with the general duty of salvage in casualty and property insurance, which is to be understood as the duty to diminish or minimise the loss (Section 17, ICA). If the insured breaches that duty, the insurer will be entitled to reduce

the indemnity in the relevant proportion taking into account the significance of the damages derived from the breach and the degree of fault of the insured. If the insured had the intent to prejudice the insurer, the latter will be released from its obligation to indemnify.

Once the loss has occurred, and within five days of the notification of the loss, the insured or the policyholder is required to send a list of the existing objects at the time of the loss and of the objects saved, and an estimate of loss, to the insurer. The insured is required to prove the pre-existence of the objects. However, the policy itself will constitute a presumption in favour of the insured where no further evidence could reasonably be provided. The insured must also provide all relevant information on the circumstances of the loss at the request of the insurer. The insurer is bound to pay the indemnity at the end of the investigations and adjustments necessary to establish the existence of the loss and the quantum thereof, if any. If the parties disagree on the quantum, expert adjusters designated by the parties will sort out the issue.

The law provides nothing about the reporting of facts and circumstances that could eventually give rise to a claim. Policies usually require the reporting of facts and circumstances and attach certain legal consequences to such reporting.

As a general rule, Section 19 of the ICA excludes from cover losses caused by the insured acting in bad faith. This is also the first standard exclusion in all insurance policies.

Case law has ruled that the fraudulent or bad faith exclusion in an insurance policy cannot be raised against an injured third party. In such a case, the insurance company is left to recover the losses from the insured.

As regards reinsurance claims, fundamental principles of the reinsurance contract, particularly in the case of treaty reinsurance, have traditionally been the community of risk created by the contract and the follow the fortunes principle in the frame of the utmost good faith, which also compels the reinsured to protect the interests of the reinsurer.

The ICA does not make any reference to follow the fortunes or follow the settlements principles, nor does there appear to be any case law offering guidance in this regard. The former Section 400 of the Commerce Code, which dealt with fire insurance and was abrogated by the ICA, did provide that the reinsurer was to follow the settlements of the insurer but did not specify either the requirements or the consequences thereof.

The effects of a follow the settlements clause are, therefore, uncertain. It is commonly held in Spain that this clause would compel the reinsurer to accept and be bound by the settlements reached by the insurer provided the insurer is, in effect, liable under the direct policy and the risk is covered by the reinsurance contract. It would also be possible to contend that the reinsurer is not bound if the settlement is not concluded in a businesslike manner (namely in the event of *ex gratia* payments), but there are no authorities confirming this.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Jurisdiction

Insurance disputes related to consumers (mass claims) are normally resolved by litigation in court. Within the Spanish territory, any disputes arising out of the contract between the insurer and the insured must be referred to the courts for the domicile of the insured (Section 24, ICA). Any agreement to the contrary shall be deemed null and void.

Also of relevance are the special jurisdictional rules set forth in Council Regulation (EU) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (the Brussels I Regulation recast).

With regard to insurance contracts involving a large risk, the parties are free to refer the dispute to the courts of their choice.

Choice of law

The parties to an insurance contract involving a large risk may freely choose the governing law and are not subject to the otherwise mandatory provisions of the ICA.

In the event of conflicts of laws, Regulation (EC) No. 593/2008 of the European Parliament and the Council of 17 June 2008 on the law applicable to contractual obligations (Rome I) applies to insurance contracts concluded as from 17 December 2009. The Rome Convention 1980 applies to insurance contracts concluded before that date and to those countries that opted out of the Regulation (Denmark), but its rules do not apply to insurance contracts covering risks located in the territories of the Member States of the European Union.

Arbitration clauses

The Arbitration Act (AA) approved by Law 60/2003 of 23 December, as amended, recognises the freedom of parties to submit to arbitration any disputes related to matters that they can freely dispose of in accordance with the law.

For insurance, this general principle was confirmed by Section 97.4 of Law 20/2015, both with regard to large and mass (consumer) risks, although the latter with qualifications. In the event of mass risks (consumers), any disputes between insurers and consumers may be referred to the Consumers Arbitration System as set out in the consolidated text of the Law on the Protection of Consumers and Users. Insurance disputes concerning large risks tend to be (but are not always) resolved by arbitration. The parties to a contract involving a large risk are free to submit their disputes to arbitration having regard to the general rules set forth in the AA.

The parties to a reinsurance contract are free to refer the dispute to the courts of their choice, or to arbitration or any other alternative dispute resolution method.

ii Litigation

Litigation stages

Generally, the Spanish civil litigation system is more adversarial than inquisitive. The civil first instance courts are the competent courts to hear insurance disputes.

A civil proceeding starts with the filing of the statement of claim with the Register of the Court. The claimant should attach to the statement of claim all documents on which the claimant bases his or her claim, or designate the private or public records where this documentary evidence may be found. The defendant has the same burden regarding the documents related to his or her defence. Therefore, the parties should disclose all the evidence they have at the beginning of the process in order to avoid procedural 'ambushes'.

The main steps of the proceedings include pleadings (claim, defence and, eventually, counterclaim and response to the counterclaim), the case management conference and the trial.

In the ordinary procedure for claims exceeding €6,000, which is the main declaratory procedure, once the defendant has been served with the claim, the defendant has 20 working days to file his or her defence, and a counterclaim, if any. In the latter case, the claimant will then have 20 working days to respond to the counterclaim.

The defendant is required to set out his or her defence arguments following the order of the claim (accepting or rebutting the corresponding arguments) and to file all of the documents in his or her possession supporting his or her defence (this rule also applies to the counterclaim and the answer to the counterclaim).

The parties must disclose to their opponents in the pleadings phase those documents they rely on.

After the allegations (pleadings) phase has been completed, the court will call the parties to a case management conference (CMC), which should take place within 20 days. This term is rarely, if ever, observed in practice. The purposes of the CMC are reaching a settlement if possible, sorting out any procedural technicalities and submitting the evidence the parties intend to avail themselves of (namely the documents filed with the pleadings, witnesses and expert witnesses). If the court deems that the controversy relates solely to points of law or the parties only produce documentary evidence with their respective allegations, the lawsuit could be called to an end and judgment passed on the issue. If not, the court will fix a date for the trial where all evidence submitted and admitted is to be taken (testimonies, interrogatories, etc.) and then the parties' attorneys will orally summarise their conclusions. The time frame to trial is variable, from three to 10 months, depending on the nature and complexity of the case. Judgments should be handed down within 20 days of the trial. This term is almost never observed in practice.

Parties are entitled to appeal against any adverse court decision. An appeal can be lodged on questions of fact or of law.

In some limited cases (where, for instance, the amount involved exceeds €600,000 or the matter involves a special legal interest) there is a further and final appeal to the Supreme Court. There is also a special appeal to the Constitutional Court in the event that constitutional rights are violated by the courts.

Evidence

Each party bears the burden of proving those facts supporting the position that they are defending in the proceedings.

The courts have wide discretion when assessing evidence, subject to reasoning founded on the applicable law and the relevant facts.

Evidentiary means are interrogation of the parties, public documents, private documents, experts' reports, judicial examination and witnesses. Further, any means for reproducing words, images and sounds, as well as instruments for the storage and retrieval of data, words, figures, and mathematical operations carried out for accounting purposes or others relevant for the proceedings, can be presented as evidence.

Costs

The general rule is that the losing party pays the costs of the other party, unless the court appreciates that the case presented serious factual or legal doubts.

If the claim is admitted in part, each party pays its own costs and half of the common costs, if any (e.g., experts designated by the court), unless there is merit to impose these on the party that in the court's view litigated recklessly.

Costs are capped in that they cannot exceed one-third of the total quantum of the claim. If the nature of the claim does not permit it to be quantified, then the claim for these sole purposes will be valued at €18,000, unless the court decides otherwise in light of the complexity of the case.

iii Arbitration

Format of insurance arbitrations

The AA lays down rules for arbitrations, both domestic and international. The AA is strongly influenced by the UNCITRAL Model Law of 1985, as amended.

Procedure and evidence

The main principles of an arbitration procedure are the following:

- a* The essential principles of the procedure are the right of the parties to be heard, the right of the parties to contradict each other and equal standing. The parties can agree to have the dispute resolved under legal principles or based on equity (fairness and justice). They may set out the procedural rules (ad hoc arbitrations). Parties may entrust the administration of the arbitration to an institution, in which case its rules will apply.
- b* The taking of evidence upon motion of the parties or the arbitrators. The arbitrators may reject irrelevant evidence or that which is not admissible under the law. Witnesses, experts and third parties participating in the proceedings will be able to use their own language both in oral and written evidence (in which case interpreters will be provided).
- c* The arbitrators may order interim or provisional measures (injunctions).
- d* The procedure may involve jurisdictional cooperation; the intervention of the courts is limited to certain support and control functions (inter alia, appointment of arbitrators, taking of evidence, interim measures notwithstanding the power of arbitrators to grant them, recognition and enforcement, and annulment of awards).
- e* The award must be issued within six months of the statement of defence, unless the parties agree to extend the term. The late issuance of the award does not constitute per se a ground for annulment, without prejudice to the arbitrators' liability.
- f* The award must be in written form and must always be reasoned, even if it is solely based on fairness and equity, unless the parties reach a settlement and agree that it be reflected in the form of an award.
- g* With regard to the annulment of an award, the grounds on which an award can be challenged in court with the intent to vacate it in full or in part are rather limited (Section 41, AA).

Costs

The general rule is that subject to the agreement of the parties, the arbitrators shall decide in the award on the allocation of costs (Section 37.6, AA). In the case of institutional arbitrations, the arbitrators will follow the institution's rules on costs.

iv Mediation

The role of the courts

Although mediation as a form of resolving civil and commercial disputes has a long history, in its current form, method and approach, it is fairly new in Spain. The Mediation in Civil and Commercial Matters Act was approved by Law 5/2012 of 6 July. Section 97.3 of Law 20/2015 recognises the freedom of parties to submit their disputes to a mediator in the terms provided by Law 5/2012.

Mediation can either result from the agreement of the parties or be suggested by the court hearing the dispute. Mediation is free and voluntary and nobody may be compelled to continue in the mediation procedure and conclude an agreement. The mediator must be impartial and independent.

The parties will have to notarise the agreement reached if they need to enforce it in court. The Spanish notary public will previously have to verify the fulfilment of the requirements under the Mediation Act and that its content is not contrary to the law. This will add some red tape to the procedure.

The court's intervention is limited to the enforcement of the mediation agreement, or to homologate (endorse) the agreement when it has been reached in the course of litigation.

V YEAR IN REVIEW

Political instability in Spain (there have been three general elections in four years) have adversely affected the legislative activity. Consequently, very limited regulatory changes affecting the insurance industry have been approved during 2019.

On 16 June 2019, the Real Estate Credit Agreements Law (Law 5/2019 of 15 March), entered into force. This Law introduces relevant changes in the regulation of real estate credits or loans, particularly those secured by a mortgage. The Law transposes into Spanish law Directive 2014/17/EU on credit agreements for consumers relating to residential immovable property. The Law also introduces changes to mortgage rules, not specifically envisaged in the Directive, such as the mandatory rules on default interest, the early maturity of mortgage loan agreements and the distribution of the loan expenses, among other aspects.

For 2019, the compensation amounts set forth by the assessment system of personal injuries in the case of road accidents (the *baremo* system), has been updated by 1.6 per cent, pursuant to the Resolution of 20 March 2019.

VI OUTLOOK AND CONCLUSIONS

Following the exit of the UK from the EU on 31 January 2020, a relevant issue for the insurance sector is the implementation or transition period which is open for around eight or nine months. During this period, the EU and the UK must negotiate and come to an agreement on their future relationship. During the implementation period the UK will maintain its rights and obligations as an EU Member State, except those concerning its involvement in the EU institutions and the governance of the EU. According to Part Four of the Withdrawal Agreement, the implementation period will expire on 31 December 2020 and can be extended once, if decided before July 2020 by mutual agreement, and for up to two years, but during this extension the UK will not be able to participate as a Member State but rather as any other third country. However, there is some uncertainty as to whether the

EU and the UK will be able to reach agreement on their future relationship, given that the UK is against an extension after 31 December 2020, and there have been recent declarations from the Prime Minister that may jeopardise the negotiations.

SWEDEN

*Peter Kullgren, Anna Wahlbom and Joonas Myllynen*¹

I INTRODUCTION

The Swedish insurance industry comprises approximately 320 companies, investing more than 4,500 billion kronor in the Swedish and global economy. Approximately 220 of these companies are non-life insurance companies.² The market is dominated by the four largest non-life insurance companies, which together represent more than 80 per cent of the market based on premium income. The life insurance market, however, does not provide for the same concentrated dominance; the four life insurance companies reporting the highest premium income together represent around 50 per cent of the market.³

The reinsurance market can be divided into non-life and life reinsurance. There is currently no Swedish company authorised by the Swedish Financial Supervisory Authority (SFS) to conduct business as a reinsurance company (i.e., a company licensed to conduct reinsurance activity only). Instead, the reinsurance market in Sweden is dominated by large international reinsurers.

About 50 insurance companies on the Swedish market are members of Insurance Sweden, an industry organisation working to promote good business conditions. Together these insurance companies account for more than 90 per cent of the Swedish insurance market.⁴

II REGULATION

i Applicable regulation

Regulation of insurance and reinsurance companies

Insurance and reinsurance companies are regulated through the Insurance Business Act⁵ implementing the Solvency II Directive (2009/138/EC) into national law. The Insurance Business Act sets out the framework for:

- a* authorisation;
- b* operation within another Member State of the European Economic Area (EEA);

1 Peter Kullgren is a partner, Anna Wahlbom is a senior lawyer and Joonas Myllynen is an associate at Advokatfirmaet Schjødt.

2 <https://www.svenskforsakring.se/globalassets/statistik/forsakringsmarknaden/forsakringsmarknaden-2019k3.pdf>.

3 <https://www.svenskforsakring.se/globalassets/rapporter/forsakringar-i-sverige/forsakringar-i-sverige-2019.pdf>.

4 <http://www.svenskforsakring.se/en>.

5 SFS 2010:2043.

- c* investment and debt coverage;
- d* capital base;
- e* solvency capital requirement;
- f* system of governance;
- g* portfolio transfers; and
- b* supervision.

In addition, insurance and reinsurance companies are subject to certain requirements under the Insurance Business Ordinance,⁶ and the SFSA's regulations and general guidelines.

Regulation of insurance and reinsurance intermediaries

On 1 October 2018, the Swedish Insurance Distribution Act⁷ entered into force implementing Directive (EU) 2016/97 (the Insurance Distribution Directive (IDD)) into national law. The Insurance Distribution Act changed the market for insurance and reinsurance intermediaries through its extended scope of application, by also including insurance and reinsurance companies' distribution. The Insurance Distribution Act sets out the framework for:

- a* authorisation;
- b* operation across borders;
- c* operational requirements;
- d* information requirement and suitability assessment;
- e* additional requirements when distributing insurance-based investment products;
- f* additional requirements when distributing certain pension insurance products; and
- g* supervision.

In addition, insurance and reinsurance intermediaries are subject to certain requirements under the Insurance Distribution Ordinance,⁸ and the SFSA's regulations and general guidelines.

ii Regulating body

The SFSA supervises both insurance and reinsurance companies' and insurance intermediaries' compliance with applicable requirements in Sweden. However, it does not supervise insurance business carried out under legislation other than the Insurance Business Act and the Act on Undertakings of Foreign Insurers and Institutions for Occupational Retirement Provision in Sweden, such as state social insurance schemes regulated through the Social Insurance Code.⁹

The SFSA maintains a register¹⁰ covering all companies authorised to conduct insurance and reinsurance, and insurance intermediary activities in Sweden. The register includes the following information related to undertakings that have authorisation:

- a* name, contact details, corporate ID and identification number at the SFSA;
- b* date and type of authorisation;

6 SFS 2011:257.

7 SFS 2018:1219.

8 SFS 2018:1231.

9 SFS 2010:110.

10 <https://fi.se/en/our-registers/company-register/>.

- c* details of cross-border business; and
- d* details of employees conducting insurance mediation.

iii Requirement for authorisation

Insurance and reinsurance companies

Insurance and reinsurance business can only be carried out in Sweden with the authorisation of the SFSA. In order for the SFSA to grant authorisation the applicant must satisfy the following requirements under the Insurance Business Act:

- a* it must be incorporated as an entity that can be authorised (e.g., a limited liability company or a mutual insurance company);
- b* it must have articles of association or statutes that comply with applicable legislation;
- c* it must comply with the requirements under the Insurance Business Act and other applicable regulations;
- d* if it is a limited liability company, its qualified owners must be deemed fit to exercise significant influence on its management;
- e* its proposed board of directors, chief executive officer, any deputies for these positions and key function holders must be deemed fit and proper to perform their respective duties; and
- f* it cannot have a close link (i.e., be part of the corporate structure) that prevents the SFSA from exercising effective supervision.

As part of its application the applicant is required to provide a wide range of information to the SFSA, such as its articles of association, business plan, corporate governance policies and, when applicable, internal rules on anti-money laundering.

The SFSA normally reaches a decision within five months of the completed application being submitted. However, the review period may be extended if additional information is required from the applicant during this period.

It is possible under the Insurance Business Act to apply for an advance ruling by the SFSA on whether the intended business requires authorisation.

Insurance intermediaries

Insurance intermediary activities generally require authorisation from the SFSA. However, a few exemptions apply. Authorisation can be granted to both individuals and entities. A separate requirement for authorisation applies under the Insurance Distribution Act depending on whether the applicant is an individual or an entity.

An individual must satisfy the following requirements:

- a* not be underage (i.e., under 18 years old), disqualified to conduct business, bankrupt or in receivership;
- b* not have a criminal record for financial crime – he or she must have proven good care in financial affairs;
- c* have suitable knowledge of the intended business;
- d* comply with requirements on continuous professional training and occupational development;
- e* possess adequate liability insurance;
- f* be suitable to conduct insurance intermediary activities; and
- g* not have a close link that prevents the SFSA from exercising effective supervision.

An entity must satisfy the following requirements:

- a* not be in bankruptcy or liquidation;
- b* possess adequate liability insurance;
- c* not employ as members of the management and any deputies thereof those that have a criminal record for financial crime – they must have proven good care in financial affairs (in addition, they must possess sufficient knowledge and competence to be part of the management in an entity conducting insurance distribution activities and, in general, be considered suitable to conduct such business);
- d* ensure that employees carrying out insurance and reinsurance distribution activities on its behalf comply with the requirements in points (a) to (d) of the previous list applying to individuals; and
- e* not have a close link that prevents the SFSA from exercising effective supervision.

The SFSA is required to reach a decision on authorisation within three months of the completed application being submitted. If authorisation is granted, the individual or entity is required to register with the Swedish Companies Registration Office before commencing any insurance intermediation activities.

Insurance and reinsurance companies are not required to seek separate authorisation for the distribution of their insurance products. However, they are required to comply with the applicable requirements under the Insurance Distribution Act.

iv Exemptions from authorisation

Entities domiciled and authorised to conduct insurance and reinsurance business in another EEA Member State are not required to seek authorisation from the SFSA. These entities can conduct insurance and reinsurance business in Sweden through the establishment of a branch or agency, or based on the freedom to provide services.

Entities domiciled and authorised to conduct insurance and reinsurance intermediary activities in another EEA Member State are not required to seek authorisation from the SFSA. These entities can conduct business in Sweden through a branch, other permanent presence or based on the freedom to provide services.

Although exempted from authorisation, both EEA insurers, and insurance and reinsurance intermediaries, are required to complete a notification process before conducting any insurance business or intermediary activities in Sweden. The SFSA supervises business carried out in Sweden by EEA insurers and insurance intermediaries.

v Non-EEA insurance and reinsurance companies and insurance intermediaries

Non-EEA insurers and reinsurers can only conduct insurance business in Sweden through a local branch or agency after obtaining authorisation from the SFSA. The same applies when a non-EEA insurance intermediary wishes to conduct activities in Sweden through a branch or permanent presence.

However, non-EEA insurers and reinsurers may apply for authorisation with the SFSA to conduct marketing activities in Sweden for insurance for which the risk is situated therein, if these activities are conducted through mediation by an insurer authorised in Sweden, and both parties are part of the same group or have entered into a cooperation agreement.

The SFSA will supervise the business carried out in Sweden by a non-EEA insurer or reinsurer, or insurance intermediary.

vi Restrictions on ownership and control

Ownership in insurance and reinsurance companies is subject to restrictions under the Insurance Business Act that may impact the authorisation process and may affect the companies in a merger and acquisition. An acquirer must obtain the approval of the SFSA before:

- a* acquiring, directly or indirectly, 10 per cent or more of the share capital or voting rights of an insurance or reinsurance company (qualified holding);
- b* increasing its direct or indirect holdings to, or above, 20 per cent, 30 per cent or 50 per cent of the share capital or voting rights of an insurance or reinsurance company; or
- c* increasing its holdings in a way in which the insurance or reinsurance company becomes a subsidiary.

The SFSA will approve the acquisition if the acquirer is deemed fit and proper to exercise significant influence over the management of the insurance or reinsurance company, and the acquisition is financially sound.

The SFSA is required to provide its decision on an application for acquisition within 60 business days of the day the application is deemed complete. If the acquirer is required to submit additional information in order for the SFSA to reach a decision, the assessment period can be extended.

Furthermore, a direct or indirect owner is required to notify the SFSA in writing if it decides to dispose of a qualified holding or reduce its holdings below any of the thresholds listed above.

Acquisitions or increases in holdings of non-EEA insurers authorised to conduct business in Sweden are not subject to the SFSA's approval. However, the SFSA must be notified of proposed acquisitions and changes in control of these insurers. See subsection iii for more information about applicable requirements on ownership and control in the authorisation process.

There are no similar restrictions on ownership and control for entities authorised to conduct insurance or reinsurance intermediary activities.

vii Recent changes to the regulatory system

Life insurance companies manage approximately 75 per cent of the total assets on the local occupational pension market. Insurance companies that conduct business covering both occupational pension and life insurance (mixed insurance activities) have been given the possibility to apply a transitional rule to their occupational pension business, through which they can apply a number of pre-Solvency II requirements, until the end of 2022. The time period under which the transitional rule applies is a result of Directive (EU) 2016/2341 on the activities and supervision of institutions for occupational retirement provision (IORP II), which entered into force in Sweden on 15 December 2019.

How the implementation of IORP II will affect the Swedish insurance industry is still somewhat unclear, especially as insurance companies conducting mixed insurance activities have been provided with an opportunity to transform their business into an occupational pension company, which would mean a change in form and applicable regulatory regime.

As mentioned earlier, another recent development has been the implementation of the IDD into Swedish law. One noteworthy aspect of the Swedish implementation of the IDD

is that the scope of application for some of the rules in Chapter VI of the IDD (additional requirements in relation to insurance-based investment products) has been expanded to cover certain insurance-based pension products.

III INSURANCE AND REINSURANCE LAW

i Sources of law

The Insurance Contracts Act¹¹ is the main source of law in Sweden when it comes to provisions covering insurance contracts. The provisions of the Insurance Contracts Act are mandatory for the benefit of the policyholder, its assignee and the insured, unless otherwise expressly stated in the Act.

The Insurance Contracts Act includes provisions on both non-life and life insurance contracts as well as special requirements in relation to group insurance contracts. In relation to each type of insurance contract (life and non-life), the Act outlines the main applicable requirements for the insurance contract, such as:

- a* the insurer's duty to provide information;
- b* the policyholder's disclosure obligations;
- c* rights under the insurance contract;
- d* limitation of the insurer's liability;
- e* premium payments;
- f* claims management; and
- g* statute of limitations.

Specific national legislation applies to contracts covering motor vehicle liability insurance and patient insurance.

In contrast to insurance contracts, reinsurance contracts are not specifically regulated under Swedish law, which means that the contracting parties enjoy a great degree of flexibility when entering into them. Although not specifically regulated, general requirements following from the Contracts Act apply,¹² as well as general principles of contract law.

ii Making the contract

The Insurance Contracts Act does not provide any requirements governing how an insurance contract should be concluded with the policyholder. However, generally it is concluded as a result of an insurance seeker applying for insurance cover with an insurer or through an insurance intermediary, and receiving an offer that is subject to acceptance by the insurance seeker.

There is no codified principle of utmost good faith under Swedish insurance law, although the contracting parties have a general duty of loyalty. Although this principle is not codified, it is to some extent reflected in the Insurance Contracts Act through the provisions governing the insured's pre- and post-contractual duty to disclose information to the insurer.

11 SFS 2005:104.

12 SFS 1915:218.

In relation to reinsurance contracts, a duty of utmost good faith can be implied under a 'follow the fortunes' clause, as it involves a unique business partnership between the cedant and the reinsurer.

iii Interpreting the contract

The provisions of the Insurance Contracts Act are mandatory for the benefit of the policyholder, its assignee and the insured, unless otherwise expressly stated in the Act. Consequently, a court will set aside a clause in the insurance contract that is in violation of the mandatory provisions of the Act.

If the wording of an insurance contract does not explicitly contradict the provisions of the Insurance Contracts Act, the court may still at its own discretion set aside any contractual clause that it deems to be manifestly unreasonable. However, such decisions are rare in insurance cases.

The Insurance Contracts Act does not cover any provisions on mandatory clauses to be covered by the insurance contract, only general information regarding its form and content. Although insurance companies are free to set the content of their respective insurance contracts the wording of the Insurance Contracts Act is usually incorporated. Commonly found clauses are:

- a* applicable definitions;
- b* policy period;
- c* insured interests;
- d* claims trigger;
- e* geographical scope;
- f* premium payments;
- g* dual insurance coverage;
- h* exclusions and limitations of coverage (e.g., for increase in risk, acting with gross negligence and breach of applicable safety requirements);
- i* statute of limitations; and
- j* terms and conditions.

As described in subsection i, reinsurance contracts are not regulated under Swedish law, which means that how these contracts should be concluded between the cedant and the reinsurer is also not regulated. According to accepted market practice, the following clauses are generally found in reinsurance contracts:

- a* disclosure requirements (e.g., regarding the cedant's underwriting activities);
- b* right of the reinsurer to inspect the records of the cedant company;
- c* 'follow the fortunes' and 'follow the settlement' clauses;
- d* claims cooperation or claims control clauses;
- e* premium levels and premium payments;
- f* profit commission;
- g* provisions on portfolio transfers;
- h* statute of limitations; and
- i* choice of law and dispute resolution mechanisms.

iv Intermediaries and the role of the broker

As described in Section II, insurance intermediary activities in Sweden can be conducted by an entity or an individual authorised by the SFSA, an ancillary insurance intermediary or a tied insurance intermediary. It is quite common in Sweden for insurance companies to use tied insurance intermediaries (e.g., banks), for which they are liable for any damage inflicted as a result of the intermediary activities.

Insurance intermediaries are required to act in accordance with conduct rules as stipulated in the Insurance Distribution Act. Generally, insurance intermediaries are required to conduct their business in accordance with good insurance distribution practice and with due consideration of the customer's interests. Furthermore, an insurance distributor must act honestly, fairly and professionally. If an insurance intermediary is part of the Swedish Insurance Intermediaries Association (SFM) and InsureSec – an organisation established by SFM and the larger Swedish life insurance companies using intermediaries for insurance distribution – additional industry regulations apply with the purpose of facilitating adequate advice on insurance coverage.¹³ InsureSec also established a disciplinary forum for its registered members in the event of violations of industry regulations.

On the Swedish market, insurance products are distributed by the insurance companies themselves and through different types of insurance intermediaries. In practice, it is common for insurance seekers to ask insurance intermediaries for advice on suitable insurance cover and on which insurance company provides an insurance contract that matches its needs.

v Claims

A claim of insurance coverage under an insurance contract can be made as a result of an insured event. The definition of an insured event as well as information about how to make a claim are usually covered by the conditions of the insurance contract. An insurance contract can also provide for a time period under which a claim must be notified to the insurance company. The remedy for a late notice is a reduction of indemnification, which is proportionate to any loss incurred by the insurer as a result of the late notice.

The ultimate deadline to notify a claim to the insurer is regulated by the statute of limitations under the Insurance Contracts Act. The statute of limitations for an insured to bring legal proceedings against the insurer is within 10 years of the date when the claim was triggered, according to the insurance contract. If a claim has been notified within that time, the insured has at least six months to bring legal proceedings from the date of receipt of the insurer's final decision.

The insured bears the burden to prove that an insured event has occurred under the insurance contract and the insurer generally has the burden to prove whether, for example, an exclusion applies or whether the indemnification should be reduced as a result of the insured's breach of the insurance contract. The burden of proof is lower for consumers claiming indemnification.

With regard to non-consumer (business) insurance, the insurer is allowed to include a clause in its insurance policy stipulating that it is entitled to deny a claim if the insured has failed to notify the insurer within one year of the occurrence of the insured event.

13 <https://www.sfm.se>; <http://www.insuresec.se/om>.

An insurer furthermore has the right of subrogation to the insured's claim for damages resulting from loss, if the claim is covered by the insurance contract and has been indemnified by the insurer.

Insurance companies usually have internal procedures for the management of disputes relating to insurance claims (e.g., a review committee). If a dispute cannot be resolved by the insurer, different dispute resolution forums are available. Information about applicable dispute resolution forums is generally covered by the insurance contract and may differ depending on the type of insurance and whether the insured person is a natural or legal person.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

Clauses regarding choice of jurisdiction, competent court and applicable law are normally both recognised and enforceable. Nevertheless, these clauses must comply with Regulation (EC) No. 593/2008 on the law applicable to contract obligations and Regulation (EU) No. 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

Arbitration clauses in insurance and reinsurance contracts are both common and enforceable, with the exception of consumer insurance (save for certain types of group insurance).

ii Litigation

There is no specific litigation procedure for insurance disputes. Accordingly, insurance disputes are litigated in the same way as any other commercial dispute, namely in general courts, governed by the Swedish Code of Judicial Procedure. The general courts are organised in a three-tier system: district courts, courts of appeal and the Supreme Court.

Swedish litigation proceedings can be summarised as follows in non-complex matters. Upon filing a summons application and a statement of defence, the parties will typically file one additional submission with the court. The parties will be summoned to a preliminary hearing, usually held within three to five months after the statement of defence has been submitted to the court. The purpose of the preliminary hearing is to resolve any ambiguities as regards, for instance, what the disputed facts of the case are. Subsequent to the preliminary hearing, the parties will be required to submit a complete list of evidence and respond to any issues raised during the hearing. The main hearing will usually be held six months after the preliminary hearing. Conclusively, it normally takes at least one year from the submission of the summons application until the award is rendered.

In complex matters, involving additional written submissions by the parties and sometimes further preliminary hearings, the length of the proceedings is considerably longer – usually two to three years.

A review permit is required in order to appeal a decision reached by a district court or a court of appeal. Generally, the deadline to appeal a decision is three weeks from when the decision has been rendered or, where applicable, when it has been served. A leave to appeal will only be granted if any of the following conditions apply:

- a* there is reason to believe that the district court has come to an erroneous conclusion;
- b* it is not possible to assess the correctness of the district court's decision;

- c* it is important to establish an award that may provide guidance to Swedish courts; or
- d* any other extraordinary reason.

However, a court of appeal's decision is only appealable in the event of points (c) and (d), above. Consequently, the Supreme Court rarely grants leave to appeal.

The principle of oral proceedings is most frequently applied in litigation proceedings in Sweden, in contrast to depositions, which are rare.

There is no discovery or disclosure of documents phase in Swedish litigation. Accordingly, there is no general obligation to disclose documents. Nevertheless, a party is able to request the court to order a counterparty or a third party to disclose specific documents if certain criteria are met.

The law applies a loser-pays principle (with exceptions), therefore the winning party is entitled to full compensation from the losing party for reasonable litigation costs (costs for counsel, experts, witnesses and the party's own costs, etc.). By default, the successful party is also entitled to interest.

iii Arbitration

Arbitral proceedings are governed by the Swedish Arbitration Act. The UNCITRAL Model Law on International Commercial Arbitration has, to a large extent, influenced this Act. Similarly to litigation proceedings, there are no specific arbitral proceedings for insurance arbitrations. Arbitral proceedings in Sweden are commonly governed by the Arbitration Rules of the Arbitration Institute of the Stockholm Chamber of Commerce (SCC), available on its website.¹⁴

Generally, arbitration is more expedient than litigation. For instance, in 2018 more than 50 per cent of the awards under the SCC Arbitration Rules were rendered within 12 months of the time of registration of the case.

Another important difference between arbitration and litigation is that the former allows for greater flexibility as regards evidence. As mentioned in subsection ii, there is no discovery phase in litigation and depositions are rarely used. However, the parties in an arbitration are free to implement a discovery phase, as well as depositions.

The cost of arbitration consists of arbitrators' fees and, under the assumption that the arbitral proceedings are governed by the SCC rules, fees to the institute and possible expenses. The costs can be determined by using a 'calculator' on the SCC website.¹⁵

iv Alternative dispute resolution

If a dispute between an insurer and a customer cannot be resolved, the customer can refer the matter to the National Board for Consumer Disputes.¹⁶

Furthermore, the following boards deal with specific types of claims:

- a* the Board for Personal Insurance;
- b* the Board for Legal Protection Insurance;

14 <https://sccinstitute.com/dispute-resolution/arbitration>.

15 <https://sccinstitute.com/dispute-resolution/calculator>.

16 <https://www.arn.se/om-arn/Languages/english-what-is-arn>.

- c* the Board for Counsel Expenses; and
- d* the Board for Bodily Injury Liability Insurance.

Although a ruling by one of the boards listed above is not legally binding, insurance companies commonly reconsider their decisions in accordance with a ruling.

Finally, disputes can also be handled by the courts or arbitral tribunals, as applicable.

v Mediation

The district courts have a general obligation to attempt to negotiate a settlement between the parties in any commercial dispute, including insurance disputes. These negotiations are always held during the preliminary hearing but also frequently in the main hearing.

V YEAR IN REVIEW

The most significant regulatory change during the past year was the new Occupational Pension Company Act,¹⁷ implementing IORP II into national law, which came into effect on 15 December 2019. As part of the introduction of IORP II, insurance companies that conduct business covering both occupational pension and life insurance (mixed insurance activities) have been given the possibility to apply a transitional rule to their occupational pension business, through which they can apply a number of pre-Solvency II requirements, until the end of 2022. After the transitional period, companies conducting mixed insurance activities need to either apply Solvency II requirements to all their insurance activities or streamline their insurance activities to include only occupational pension activities, in which case they will be able to transform the business into an occupational pension company. While some effects on the market of this new regulatory regime were already seen at the end of 2019, we expect to see further effects over the coming year with some companies transforming into occupational pensions companies as well as portfolio transfers that are driven by these regulatory changes.

VI OUTLOOK AND CONCLUSIONS

The Swedish insurance and reinsurance market has, during the past couple of years, been subject to substantial regulatory changes affecting different aspects of the insurance business. Although it is likely that there will be fewer regulatory changes in the year ahead, insurance and reinsurance companies must continue to improve and refine their business in order to ensure compliance with applicable requirements and market practice.

It is expected that both insurers and insurance intermediaries will increase their presence on the web by providing automated advice in the insurance field. The SFSA has already today taken a more active role in this area by investigating pros and cons, risks and legal requirements.

There are also developments in the area of insurtech, although they are not believed to be progressing as quickly as in the fintech sector. In general, the Swedish insurance industry and the products provided are very traditional, which means it will take some time before there are developments mirroring those in the fintech area.

17 SFS 2019:742.

SWITZERLAND

*Lars Gerspacher and Roger Thalmann*¹

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 does not consist solely of large, internationally orientated companies; in addition to a broad midfield, a large number of small, locally established companies are characteristic of Switzerland's insurance landscape. Some of these companies were founded as social self-help organisations and are run on cooperative lines to this day.²

In 2018, the total number of insurance companies under supervision was 199 (of which 47 were branches of foreign insurance companies). The total number of reinsurers was 54 (of which 27 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 European Union (EU) or the European Economic Area (EEA), the freedom of services regime and the possibility to apply for local passporting rights do not apply. Although there are bilateral treaties between the European Union and Switzerland in place, there is no single passport of licences between EEA Member States and Switzerland. The only exception is the bilateral treaty between Switzerland and the Principality of Liechtenstein, where both countries give each other freedom of services in insurance matters. In addition, the Agreement between the EU and Switzerland concerning direct insurance of 10 October 1989 is in place, which lays down the conditions necessary

1 Lars Gerspacher is a partner and Roger Thalmann is an associate at gbf Attorneys-at-law Ltd.

2 'Nothing works without insurance', Swiss Insurance Association, 2010, at p. 16.

3 FINMA insurance market report 2018, dated 5 September 2018, at p. 4.

4 www.finma.ch.

and sufficient to enable insurers whose head offices are situated in an EEA Member State to establish branches in Switzerland and vice versa. This Agreement is particularly important for determining the jurisdiction in which an insurance activity is given.⁵

Insurance supervision is regulated by the Insurance Supervisory Act (ISA) and the respective Insurance Supervisory Ordinance (ISO). According to Article 2 of the ISA, the following insurance undertakings fall under the supervision of FINMA: Swiss insurance companies that have their seat in Switzerland and carry out direct insurance or reinsurance business; and foreign insurance companies (without their seat in Switzerland) that conduct insurance activities in Switzerland (and are therefore doing Swiss business).

Business is considered to be Swiss business if the policyholder or any of the insureds is domiciled in Switzerland or if the insured property is located in Switzerland.⁶ Whether the product is physically distributed in Switzerland is irrelevant.

Exempt from supervision are foreign insurance companies (i.e., companies that have their seat abroad) if they only operate reinsurance in Switzerland⁷ or write as primary insurer the following risks in relation to marine, aviation and international transport: risks lying abroad (irrespective of whether the policyholder or the insured is domiciled in Switzerland), and war risks.⁸

If none of the above-mentioned exceptions apply, the insurance company is subject to Swiss supervision and needs to obtain approval from FINMA before it commences insurance activities.⁹ If a foreign insurance company does not intend to apply for authorisation it is, apart from the above-mentioned exceptions, only permitted to write business in Switzerland as a reinsurer. Policies would then have to be issued by a Swiss licensed fronting company, and the foreign insurance company would act as a reinsurer and be exempt from Swiss supervision.

Insurance intermediaries also fall under the supervision of FINMA. The law basically draws a difference between those that are affiliated with insurance undertakings and those that are not (i.e., brokers). Both fall under the supervision of FINMA, but only non-affiliated intermediaries need to be registered in the register of insurance intermediaries.¹⁰ The supervision of FINMA only relates to the intermediary's activities in Switzerland; activities of the intermediary performed abroad are not supervised by FINMA even if the intermediary is based in Switzerland.¹¹

An insurer or reinsurer seeking approval to carry out insurance or reinsurance activities has to submit an application to FINMA together with a business plan.¹² The application and the business plan are based on a number of standardised forms.

With regard to taxation, the Swiss tax authorities levy Swiss federal stamp duty at a rate of 5 per cent on insurance premiums. This does not apply to reinsurance premiums, and there are certain exceptions for primary insurance as well (such as cargo, health, life and accident insurance). VAT is not levied on insurance or on reinsurance premiums.

5 Cf. Article 8.2 of this treaty.

6 Article 1(1) ISO.

7 Article 2(a) ISA.

8 Article 1(2) ISO.

9 Article 3(1) ISA.

10 Articles 42 and 43 ISA.

11 Article 182 ISO.

12 Article 4(1) ISA.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Switzerland is a civil law country and, as such, the law recognised as authoritative is statutory law passed by the competent legislature, which may be at the cantonal or federal level depending on what is provided for in the Federal Constitution of the Swiss Confederation. The legislation for private insurance is in the competence of the federal state.¹³

The key source of private insurance contracts is the Federal Act on Insurance Contracts (ICA). Complementary to that, the Swiss Civil Code and the Code of Obligations (CO) have to be considered. The ambit of the ICA is limited by its Article 100, according to which reinsurance contracts are not regulated by the ICA but by the CO. In an international context the Federal Act on Private International Law Act (PILA) has to be consulted to determine the relevant governing law.

In a broader sense, insurance law is composed of not only these core provisions, but also of the law of special subjects. Examples include, but are not limited to, consumer protection law, data protection law and the law against unfair competition.

ii Making the contract

Conclusion of the contract

Where an offer is made by the insured and no time limit is set, it remains binding on the offerer for 14 days.¹⁴ If the insurance requires a medical examination, the application period is extended to four weeks.¹⁵

The conclusion of an insurance contract necessitates mutual consent with respect to the essential terms and the expression thereof by the parties.¹⁶ For this reason, an insurance contract is reached if the parties agree that by the occurrence of a specified event the insurer has to deliver a specific performance and, in return, the insured has to pay the premium.

Pre-contractual duty of disclosure and representations

In the ambit of the ICA, Swiss law differs from the risk-declaration paradigm adhering to the doctrine of utmost good faith and its associated subdivision of representations and non-disclosure.

The insurer is responsible for obtaining the necessary information to assess the risks.¹⁷ With respect to the relevant risk factors, a customer only has to disclose information that the insurer explicitly requests in writing.

However, the principle of utmost good faith is relevant in the field of reinsurance business. The insurer is obliged to disclose all information needed by the reinsurer to make its underwriting decision (e.g., tariffs, contract terms or underwriting guidelines).¹⁸

¹³ Article 98(3) Federal Constitution of the Swiss Confederation.

¹⁴ Article 1(1) ICA.

¹⁵ Article 1(2) ICA.

¹⁶ Article 1(1), Article 2(1) and Article 18(1) CO.

¹⁷ Article 4(1) ICA.

¹⁸ Stephan Fuhrer, *Schweizerisches Privatversicherungsrecht*, Zurich/Basle/Geneva 2011, No. 18.30; Rolf Nebel, in: Heinrich Honsell, Nedim Peter Vogt, Anton K Schnyder (ed), *Kommentar zum Schweizerischen Privatrecht, Bundesgesetz über den Versicherungsvertrag (VVG)*, Basle/Geneva/Munich 2001, Article 101 No. 35.

Further, the concept of ‘warranty’ as such is not known to Swiss law. What appears to best correspond with this concept are the duties that insureds take on at the conclusion of a contract for loss avoidance. However, the infringement of this duty only has an effect if it has an impact in a concrete insured event.¹⁹

Recording of the contract

Freedom of formality

Article 11 of the CO states the freedom of formality. Thereafter, the CO does not require parties to follow a specific form to achieve legally binding contracts unless the law provides otherwise. Since neither the CO nor the ICA demand observance of form, insurance contracts can be effected orally or even without using words by consenting behaviour. However, the insurer has to inform the insured before or at the conclusion of the contract about the identity of the insurer and the essential terms of the insurance contracts (i.e., the insured perils, the premiums as well as the inception and termination of the insurance contract).²⁰

Decisiveness of the insurance policy

On conclusion of an insurance contract, the ICA commits the insurer to issue an insurance policy that records the parties’ rights and obligations. Thereby, the policy performs the function of an instrument of evidence, and in conjunction with the insurer’s signed offer it gives certain alleviations in recovery proceedings for premiums.²¹

Pursuant to Article 12 of the ICA, the policyholder has to claim correction within four weeks in the event that the policy deviates from the original contract terms. In cases of default, the insurance policy has constitutive effect in the sense that its purport shall be deemed approved.

iii Interpreting the contract

Article 18 of the CO provides that the genuine will of the parties to the contract is key to any interpretation. Accordingly, a judge has first and foremost to establish the parties’ real intent, which might differ from their written legal act.

If a court cannot ascertain the parties’ intentions or if there is no consensus, the court will resort to the parties’ presumptive intent. The court thereby establishes objectively how the parties, considering all circumstances, could and should have understood the contract’s contested clause or clauses in good faith.²²

In interpreting the contract, a judge avails himself or herself of different means and rules. The primary instrument with precedence over the other means relates to the wording used by the parties. All the circumstances under which the contract has been concluded also need to be considered. For that reason, the judge particularly takes into account the

19 Article 29 ICA.

20 Article 3 ICA.

21 Stephan Fuhrer, op cit. 17, No. 3.96.

22 Peter Gauch, Jörg Schmid, Susan Emmenegger, Schweizerisches Obligationenrecht Allgemeiner Teil, Vol. I, 9 Ed., Zurich/Basle/Geneva 2008, No. 207; Federal Supreme Court judgments, reported at BGE 133 III 675, at p. 681; and at BGE 122 III 106, at p. 109.

purpose of the contract and the parties' interests in the performance thereof;²³ the history of the contractual negotiations and the conduct of the parties before entering into the contract (historical interpretation);²⁴ and usages in the specific field.

Findings based on these means of interpretation are subject to further rules of interpretation. The most important are as follows:

- a The 'principle of trust', which is particularly important. Based on this principle a statement made by one party is to be interpreted from the addressee's objective point of view.
- b Contract provisions. These provisions should be interpreted with regard to the place they occupy in the contract's structure and the purpose they serve within that structure (systematic interpretation).
- 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.²⁵ This rule of interpretation does not extend to mandatory statutory provisions, as these will apply in any event and take precedence over the contract's terms.
- 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.²⁶ For insurance matters, this rule is specifically reflected in Article 33 of the ICA.

The field of direct insurance agreements essentially consists of the practice of two types of contract terms: those in separate agreements; and the insurers' general standard terms and conditions (GTCs). The latter only take effect if they are being specifically referred to on the occasion of concluding the contract and only insofar as no other specific individual agreement exists.²⁷

The admissibility of GTCs in insurance contracts is further subject to Article 8 of the Federal Act Against Unfair Competition (UCA). According to that norm, GTCs shall be deemed abusive where they create a significant and unjustified disparity between contractual rights and obligations to the detriment of consumers in a manner that breaches the principle of good faith. This norm empowers the courts to review the content of GTCs in business-to-consumer contracts and to void any clauses that do not meet the requirements of Article 8 of the UCA.

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.

23 Federal Supreme Court judgments, reported at BGE 129 III 702, at p. 707; and at BGE 119 II 368, at p. 373.

24 See, for instance, the Federal Supreme Court judgment, reported at BGE 114 II 265, at p. 267.

25 Gauch et al, op cit. 21, No. 1230.

26 Federal Supreme Court judgments, reported at BGE 119 II 368, at p. 372, and Federal Supreme Court Judgment No. 4C.215/2002 of 11 November 2002, consid. 2.4.

27 Gauch et al, op cit. 21, Nos. 1128 et seq. and 1138 et seq.

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.²⁸ Affiliated insurance intermediaries, on the other hand, are free to register (tied agents). Rules as to the question of when affiliation is assumed can be found in Article 183 of the ISO. Especially noteworthy are Letters (a) and (b) of Paragraph 1, which state that no registration is required if the majority of the commissions the intermediaries receive during a calendar year are predominately from one or two insurers; and if the intermediaries receive compensation or other financial advantages from insurers that do not conform to customary compensation for insurance intermediation, and that therefore could affect their independence.

From a regulatory point of view, brokers are obliged to disclose to potential customers at first contact various information (i.e., the broker's or the insurer's identity, persons that can be held liable for negligence or information regarding the processing of personal information).²⁹

Many Swiss brokers are members of the Swiss Insurance Brokers Association,³⁰ which has its own conduct rules.³¹ These rules set out ethical standards, the duties of the broker (providing risk analysis, drafting of policies, customer support and assistance in claims handling), and his or her relationships with the insured and the insurer.

The qualification of intermediaries as either tied agents or brokers has an impact on their duties while contracting. The relation between broker and customer is deemed a mandate under Swiss law that provides a duty of care of the brokers for the customer's interest in a comprehensive manner. Failing to do so may lead to liability. Since this liability arises in connection with commercial activities conducted under official licence, any exclusion thereof may apply at most to slight negligence.³² To cover these claims, brokers are, under regulatory law, obliged to have professional indemnity insurance or similar financial security.³³

The loyalties and duties of a tied agent as against a prospective client are far more limited. Since agents are to assign to the legal sphere of the insurer, the duty to advise ranges only over their own products. Market expertise is not required. Unlike with brokers, a breach of a duty of care may be attributed to the insurer, which can be held liable for it.³⁴

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 the incident and the resulting claims.³⁵ Unless otherwise agreed, there is no procedure that has to be followed. Negligent delay in providing this information entitles the insurer to reduce claims to the extent that the loss could have been avoided or mitigated in the case of timely notification.

28 Article 43(1) ISA.

29 Article 45 ISA.

30 See www.siba.ch.

31 The Swiss Insurance Brokers Association has published its Code of Conduct at www.siba.ch/index.php?id=14.

32 Article 101(3) CO.

33 Article 44 ISA.

34 Article 34 ICA.

35 Article 38(1) ICA.

At the insurer's request, the beneficiary must disclose all circumstances relevant to the course or the future development of the incident in question.³⁶ 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.³⁷

In the event of a partial loss, both the insurer and the policyholder may terminate the insurance policy.³⁸

Insurance payments are due four weeks after the date the insurer received sufficient information to legitimate a claim under the policy.³⁹ Should there be outstanding premiums, the question of set-off arises. In line with Article 120 of the CO, where two persons owe each other sums of money, and provided that both claims have fallen due, each party may set off their debt against their claim (i.e., a person who has undertaken an obligation in favour of a third party may not set off that obligation against that party).⁴⁰ 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.⁴¹

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.⁴² 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.⁴³ 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.⁴⁴

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.⁴⁵ The Convention includes a special chapter concerning insurance disputes. The consumer-related norms in Article 15 et seq. do not apply.

36 Article 39 ICA.

37 Articles 39 and 40 ICA.

38 Article 42 ICA.

39 Article 41 ICA.

40 Article 122 CO.

41 Article 18(3) ICA.

42 Article 31 of the Civil Procedure Code.

43 Article 12 CPC.

44 Article 32 CPC.

45 Convention of 30 October 2007 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

Jurisdiction clauses have to be in line with the body of law applicable according to the situation. In purely domestic situations, the Civil Procedure Code (CPC) has to be consulted. International disputes demand the consideration of the PILA or international treaties. In European matters, the Lugano Convention is again relevant.

Choice of law

Choice of law under consumer contracts is prohibited.⁴⁶ In all other cases, parties may diverge from the general rules.⁴⁷ However, provisions of Swiss law – the application of which, owing to their particular purpose, is compulsory irrespective of the governing law designated by the parties – remain unaffected.⁴⁸ Relevant case law in this respect has yet to be established.

ii Litigation

Stages

The cantons may designate a special court (as in Zurich, Berne, Aargau and St Gallen) that has jurisdiction as sole cantonal instance for commercial disputes (the commercial court). Commercial proceedings are considered insurance matters with a value in dispute of at least 30,000 Swiss francs and involving parties registered in the Swiss Commercial Registry or in an equivalent foreign registry.⁴⁹ If only the defendant is registered and the value in dispute is reached, the claimant may choose between the commercial court and the ordinary court.⁵⁰ In Zurich, the ordinary courts are the district courts and, for proceedings where the sum in dispute is less than 30,000 Swiss francs, the single-judge courts. All these courts have the function of trial courts.

Appeals in line with Article 308 et seq. of the CPC are admissible against final decisions of ordinary courts if the value of a claim in the most recent prayers for relief is at least 10,000 Swiss francs.⁵¹ These appeals may be filed on grounds of incorrect application of law or incorrect establishment of the facts.⁵²

No internal cantonal remedy is given for commercial court decisions – that is, the remedies mentioned only apply if claims are filed with the ordinary courts.

Commercial court and high court final decisions are subject to appeal to the Federal Supreme Court if the dispute value is at least 30,000 Swiss francs.⁵³ With respect to allegations of infringement of federal law, the judges' cognition is not limited. Factual findings of a prior instance may only be overruled if they are obviously wrong.⁵⁴

46 Article 120(2) PILA.

47 Article 116 PILA.

48 Article 18 PILA.

49 Article 6(1) CPC.

50 Article 6(2) CPC.

51 Article 308 CPC.

52 Article 310 CPC.

53 Article 74 Federal Supreme Court Act.

54 Article 105(2) Federal Supreme Court Act.

Evidence

Testimonies, physical records (documents), inspections, expert opinions, written statements, and questioning and statements of the parties are all admissible evidence. Testimonies, expert opinions and physical records form the primary type of evidence in insurance proceedings. Statements of the parties are of minor importance.

Costs

Procedural costs include court and party costs that the unsuccessful party must bear. In both cases, the courts mostly award costs by reference to a cantonal tariff. The courts have discretion to amend the amount payable under the tariff by reference to a number of factors, such as the complexity of the case, the number of hearings and the number of documents processed.

The fee agreement between clients and lawyers can be made without regard to cantonal tariffs and provisions. It is most common to agree on an hourly rate. Lump-sum agreements are admissible as long as such fee is in line with the estimated services being rendered by the lawyer.

The limits within which success fees are allowed are unclear under Swiss law. However, it can be stated that these fees are permitted if there is an agreed hourly fee (which must cover the lawyer's costs), and an incentive payment comes only in addition to the hourly rate, and is not of predominant significance to the extent that conflicts of interest could arise.

Funding the process

A person is entitled to legal aid if he or she does not have sufficient financial resources and the case does not seem to be devoid of any chances of success.⁵⁵

If the person seeking aid wins, the losing party pays the successful party's legal fees. If the person seeking aid loses, his or her legal fees will be paid by the canton. An indemnity for the opposing party, if any, still has to be paid by the person seeking aid.⁵⁶ Rendered legal aid must be reimbursed as soon as the beneficiary is in a position to do so.⁵⁷

The costs of a lawsuit can be insured by means of legal assistance insurance, although such insurance in Switzerland usually provides a waiting period of three months or more.

Third-party funding is lawful in Switzerland, and is not specifically regulated.

iii Arbitration

Although it would be permissible to provide an arbitration clause in an insurance policy, this is not seen very often. However, arbitration clauses sometimes appear in directors' and officers' liability insurance and other financial lines of business policies.

A special form of arbitration is compulsory in legal assistance insurance where the insurer and policyholder have different opinions in respect of the measures to be used for the handling of the claim.⁵⁸

In reinsurance matters, arbitration is the usual means to resolve potential disputes. Swiss arbitration is, however, not very often seen, but usually arises in retrocession agreements. If

55 Article 117 CPC.

56 Article 122 CPC.

57 Article 123 CPC.

58 Article 169(1) ISO.

the parties agree on Swiss arbitration, they usually prefer ad hoc rather than institutional arbitration. If the reinsurance contract does not provide in detail the type of proceedings they would like to follow, the arbitrators will decide how they will proceed⁵⁹ 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 orders⁶⁰ or where evidence can only be taken with the assistance of the courts).⁶¹ Further intervention of the national courts could be for the appointment, removal or replacement of an arbitrator in the event that one of the parties defaults.

The grounds for appeal against awards in international arbitration are very much restricted. The only remedy would be an appeal to the Federal Supreme Court, and the grounds for appeal would be limited to a violation of fundamental procedural rights as follows:⁶²

- a* the sole arbitrator was designated or the arbitral tribunal was constituted in an irregular way;
- b* the arbitral tribunal wrongfully accepted or declined jurisdiction;
- c* the arbitral tribunal decided on points of dispute that were not submitted, or it left undecided prayers for relief that were submitted;
- d* the principle of equal treatment of the parties or the right to be heard was violated; or
- e* 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.⁶³

iv Alternative dispute resolution

Methods for alternative dispute resolution (including mediation) are rarely used in the wording of primary insurance policies.

In reinsurance contracts, the parties are usually obliged to try to settle their claims amicably or go to a mediator before they initiate arbitration. However, the binding effect and consequences of a breach of this obligation are not very clear, apart from the fact that the obligation could not prevent one party from initiating arbitration without having followed the required methods laid down in the reinsurance contract.

59 Article 182(2) PILA.

60 Article 183(2) PILA.

61 Article 184(2) PILA.

62 Article 190(2) PILA.

63 Article 192(1) PILA.

v Mediation

Mediation is not very established in commercial matters (including insurance and reinsurance), and there are no known mediation centres in Switzerland. If the parties intend to go to a mediator they would do so abroad (particularly in England, the United States or Singapore).

The Swiss courts do not encourage parties to go to mediation. However, some judges (in particular in the Zurich and Berne Commercial Courts) prefer to summon parties to a hearing and try to convince them to settle the claim.

V YEAR IN REVIEW

The Swiss Federal Council's plan to completely revise the ICA (after it was amended in 2006) ultimately raised too many controversial issues, and it was requested to prepare a partial revision, which was presented on 28 June 2017. At the time of writing, it is uncertain when the revised ICA will enter into force. Since the first quarter of 2018, it has been under discussion in Parliament and could come into force in 2021. The revised bill will extend the right of injured parties to directly claim against insurers only partially (the original bill provided a general possibility for direct claims). An amendment of considerable significance relates to the recourse possibilities of insurers. This amendment would also be in line with a 2018 ruling of the Federal Supreme Court that facilitated the recovery rights of insurers against liable parties.⁶⁴ Previously, their right of recourse was restricted; for instance, the insurer covering damage was not able to take recourse against the responsible person if it was only liable based on strict liability or if it was contractually liable but did not act through gross negligence.⁶⁵ The revised ICA will provide for a norm that leads to full subrogation rights by putting insurers into the shoes of the insureds and, thus, also enabling property insurers to take recourse actions in matters such as those mentioned above (see the Article 95c of the ICA).

VI OUTLOOK AND CONCLUSIONS

Switzerland has long been an important centre for the reinsurance industry for a variety of reasons. The trend of moving reinsurance business to Switzerland was originally started by companies with large exposures in the United States. The process is known in Switzerland as 'redomestication', as under Swiss corporate law it is possible to move a foreign domiciled company into Switzerland without dissolving it. Currently, Brexit and its effect on the insurance industry is being widely discussed.

64 Federal Supreme Court judgment of 7 May 2018 (Case No. 4A_602/2017).

65 Cf. Federal 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.

TURKEY

*Pelin Baysal and Ilgaz Önder*¹

I INTRODUCTION

i Nature of the insurance and reinsurance market

There are 62 active insurance companies incorporated in Turkey, consisting of 38 non-life insurers, 17 life and pension insurers, five life insurers and two reinsurers.²

The premiums collected in 2019 amounted to approximately 69.2 billion Turkish lira, an increase of 26.7 per cent compared with the previous year.³ Of this aggregate value, approximately 57.9 billion Turkish lira was derived from non-life insurers, whereas approximately 11.3 billion Turkish lira was derived from life insurers.⁴ These values include the premiums collected from both inside and outside Turkey.

Insurance sales in Turkey are conducted via direct sales, agencies, bancassurance and brokers. Agencies had the biggest share in 2019, with their total sales accounting for over 50 per cent of the total, and worth around 35 billion Turkish lira.⁵ This significant amount of sales is because of the strong presence of agencies in Turkey; there were more than 15,000 actively operating agencies as at 2019.⁶

Agency sales are followed by bancassurance sales. Bancassurance grew from 23 per cent to 26 per cent from 2018 to 2019, exceeding 18.2 billion Turkish lira in total sales.⁷ As

1 Pelin Baysal is a partner and Ilgaz Önder is an associate at Gün + Partners.

2 Annual Report About Insurance and Private Pension Activities, 2018, Republic of Turkey Ministry of Treasury and Finance, Insurance Supervision Board, available at: <https://ms.hmb.gov.tr/uploads/2019/07/Sigortac%C4%B1l%C4%B1k-ve-BES-Faaliyet-Raporu-B%C3%B6l%C3%BCm-I.docx>.

3 Premiums Based on Sales Channel, Insurance Union of Turkey, [https://www.tsb.org.tr/Document/istatistikler/2%20Sat%C4%B1l%C5%9F%20Kanal%C4%B1%20Baz%C4%B1nda%20Primler%202019-12%20\(11120Ay122019\).xlsx](https://www.tsb.org.tr/Document/istatistikler/2%20Sat%C4%B1l%C5%9F%20Kanal%C4%B1%20Baz%C4%B1nda%20Primler%202019-12%20(11120Ay122019).xlsx).

4 *ibid.*

5 *ibid.*

6 Chain of distribution, Insurance Union of Turkey, available at: https://www.tsb.org.tr/images/Documents/Komite%20sunumu_Da%C4%9F%C4%B1t%C4%B1mKanallar%C4%B1Komitesi_20190206.pdf.

7 Premiums Based on Sales Channel, Insurance Union of Turkey, [https://www.tsb.org.tr/Document/istatistikler/2%20Sat%C4%B1l%C5%9F%20Kanal%C4%B1%20Baz%C4%B1nda%20Primler%202019-12%20\(11120Ay122019\).xlsx](https://www.tsb.org.tr/Document/istatistikler/2%20Sat%C4%B1l%C5%9F%20Kanal%C4%B1%20Baz%C4%B1nda%20Primler%202019-12%20(11120Ay122019).xlsx).

of 2015, bancassurance has been the main life-insurance distribution channel⁸ having an 83.4 per cent share in 2019.⁹ Banks function as agents bringing together insurers and clients, demanding simple and low-cost products from trusted financial institutions.

Bancassurance, just like other distribution channels, is under close scrutiny of the Ministry of Treasury and Finance. In December 2019, the Ministry issued an administrative fine of 187 million Turkish lira to Yapı ve Kredi Bankası A.Ş. and 94.7 million Turkish lira to Akbank T.A.Ş. The latter had also been ordered to suspend its insurance-related activities for 15 days.¹⁰ According to public announcements made by the banks in question, the sanctions were due to violation of the Insurance Act concerning unfair trade and competition practices.

Having only two active reinsurance companies in the Turkish reinsurance market, reinsurance cover is mostly provided to Turkish insurance companies by foreign reinsurers. Statistics reveal that 73 per cent of the reinsurance market is dominated by reinsurance companies with foreign capital. The remaining coverage is provided mostly by Milli Re, established with local capital.¹¹

Turk Re, the other local reinsurance company was established on 6 September 2019 with a capital of 600 million Turkish lira by the Ministry of Treasury and Finance as the sole shareholder. Reportedly, Turk Re aims to keep 1.2 billion Turkish lira out of 8 billion Turkish lira transferred abroad through reinsurance. At the first stage, Turk Re has been designated for the management of the pool of natural disaster risks and contribution to domestic reinsurance capacity for the agricultural insurance. Ultimately, it is expected to serve for the purpose of 'healthy and sustainable growth' in the insurance market as stressed by the New Economic Programme introduced by the Ministry of Treasury and Finance.

In recent years, foreign investors' interest has grown significantly thanks to efforts to comply with the European Union regulations and the considerable insurance potential in Turkey. The foreign share in the insurance sector at the end of 2018 totalled 67.9 per cent of active insurance companies whereas it was 61.29 per cent in 2013.¹² The premium to gross domestic product (GDP) ratio in Turkey, however, is still low, demonstrating potential for growth in the future.¹³ The ratio of gross premiums, which has increased by 18.4 per cent since 2012, constitutes only 1.5 per cent of GDP.¹⁴ While the Turkish insurance market is still underpenetrated, it witnesses fierce competition among market players, some of whom received turnover-based monetary fines levied by the Competition Board on 23 January 2020

8 www.insuranceeurope.eu/sites/default/files/attachments/European%20Insurance%20-%20Key%20Facts%20-%20August%202015.pdf.

9 Premiums Based on Sales Channel, Insurance Union of Turkey, [https://www.tsb.org.tr/Document/istatistikler/2%20Sat%C4%B1%C5%9F%20Kanal%C4%B1%20Baz%C4%B1nda%20Primler%202019-12%20\(11120Ay122019\).xlsx](https://www.tsb.org.tr/Document/istatistikler/2%20Sat%C4%B1%C5%9F%20Kanal%C4%B1%20Baz%C4%B1nda%20Primler%202019-12%20(11120Ay122019).xlsx).

10 <https://www.bloomberght.com/yapi-kredi-ve-akbank-a-sigortacilik-kanununun-ihlal-cezasi-2245011>.

11 2018 Annual Report of Milli Reasürans T.A.Ş., available at http://www.millire.com/FaaliyetRaporu_TR_2018.pdf.

12 Annual Report About Insurance and Private Pension Activities, 2018, Republic of Turkey Ministry of Treasury and Finance, Insurance Supervision Board, available at: <https://ms.hmb.gov.tr/uploads/2019/07/Sigortac%C4%B1%C4%B1k-ve-BES-Faaliyet-Raporu-B%C3%B6l%C3%BCm-I.docx>.

13 Investment Support and Promotion Agency of Turkey, 'The Financial Services Sector in Turkey: May 2019', <https://www.invest.gov.tr/en/publications/lists/investpublications/financial-services-industry.pdf>.

14 Investment Support and Promotion Agency of Turkey, 'The Financial Services Sector in Turkey: May 2019', <https://www.invest.gov.tr/en/publications/lists/investpublications/financial-services-industry.pdf>.

due to their agreements and concerted practices distorting or restricting fair competition in the field of facultative insurance for big projects with high risk capacity (including project financing).

The Turkish government has an objective to be the 10th largest economy in the world by 2023, aiming to generate US\$2 trillion worth of gross national product.¹⁵ In line with this objective, the government has the insurance sector, among others, in its sights. It is expected that structural reforms and initiatives taken, including promotion of a personal pension scheme, will foster the development of the market. Despite growing awareness of insurance, however, there is a significant lack of legal and practical experience, particularly with respect to various types 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 lengthy process. The vast majority of insurance disputes are handled by 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) leads, in addition to other hurdles of Turkish litigation, to a considerable level of uncertainty with respect to the outcome of court proceedings.

Out-of-court settlements are therefore frequently used. Courts cannot force parties to settlement or alternative dispute resolution but are required to remind them of their options at the end of the preliminary examination. Apart from arbitrary and voluntary settlement prospects, the legislature introduced a mandatory mediation for commercial disputes preceding the court litigation (see Section IV.vi for more information about mediation).

In 2007, a voluntary insurance arbitration system was introduced as an alternative to court proceedings. The total number of disputes settled by the Insurance Arbitration Commission reached 195,775 as at 30 September 2018¹⁶ and 321,741 as at 31 December 2019.¹⁷ This dramatic and constant increase over the past years clearly reveals that arbitration is becoming more popular. Traffic insurance and car insurance disputes accounted for approximately 98 per cent of the applications.¹⁸

II REGULATION

i The insurance regulator

The insurance regulatory agency in Turkey was the Undersecretariat of Treasury (the Undersecretariat) until 10 June 2018. Then, the Undersecretariat merged with the Ministry of Finance, forming the Ministry of Treasury and Finance (the Ministry) assuming all the regulatory duties and powers. On 18 October 2019, the Insurance and Private Pension Regulation and Supervision Agency (IRSA) was established by Presidential Decree No. 47 and became the new insurance regulatory agency. Pursuant to this Decree, all references previously made to the Ministry the Undersecretariat in the field of insurance shall be made to IRSA.

15 Turkey's 2023 Export Strategy and Sectoral Breakdown, Turkish Exporters Assembly https://www.tim.org.tr/files/downloads/2023/2023_english.pdf.

16 <http://www.sigortatahkim.org.tr/E-BULTEN-35.html>.

17 <http://www.sigortatahkim.org.tr/E-BULTEN-40.html>.

18 <http://www.sigortatahkim.org.tr/files/isttstk40.pdf>.

An insurance company in Turkey can only operate in the form of a joint-stock company or, in the case of mutual insurance funds, a cooperative company. Before incorporation, insurance companies must obtain approval from the authority. They must also apply to IRSA for licensing in each insurance licence class. Companies that fail to apply for an insurance licence within one year of their incorporation lose their right to use 'insurance' in their commercial names, as well as becoming 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 Turkish lira, paid in cash.

A foreign insurance company can only operate in Turkey by opening a branch, by incorporation of a company in Turkey or by acquisition of shares of a local insurance company. However, IRSA, according to the Undersecretariat's Circular No. 2007/5, does not consider it to be an 'operation' conducted in Turkey if the foreign reinsurance company, without engaging in any marketing activities in Turkey, merely receives – and accepts – a proposal from the local insured or broker to underwrite a risk in Turkey.

Insurable interests of residents in Turkey must be insured by insurance companies established in Turkey with a limited number of exceptions, such as the import and export of freight, ship chartering and life insurance. Therefore, fronting arrangements are frequently made between foreign and local insurance companies especially for facultative insurance for big projects with high risk capacity.

There are a considerable number of areas of compulsory insurance in Turkey, particularly for hazardous activities. The most widespread type of compulsory insurance is cover for motor vehicles. In addition, earthquake insurance for private dwellings, third-party liability for passengers on intercity and international transport, medical malpractice, professional indemnity insurance for independent auditors and those providing services to banks are other types of compulsory insurance.

In 2015, to enhance working conditions and ensure workers' safety after the mining disaster in Soma (Manisa), which is Turkey's worst-ever industrial accident resulting in the deaths of 301 miners, the Council of Ministers introduced compulsory personal accident insurance for miners. Furthermore, in 2015, the amendment to the Regulation on the Tracing of Compulsory Insurance specifically stipulated that those insurance companies authorised to provide insurance services covering an area of compulsory insurance, cannot refrain from issuing compulsory insurance and cannot amend insurance policies in such a way that excludes risks related to the compulsory insurance.

The Insurance Act provides security funds as a precaution for losses to be indemnified because of compulsory liability insurance. For instance, injured persons can resort to the fund for physical injuries if the injury cannot be attributed to anyone or those responsible for the injury are uninsured, or for physical injuries and pecuniary damages in the event the insurance company is bankrupt or its licence is cancelled owing, for instance, to insolvency.

Various activities including transactions related to the commencement of operations; voluntary windings-up or mergers and acquisitions; acquisition by another company with its assets and liabilities; and the transfer of insurance portfolio are all subject to authorisation by IRSA.

ii Taxation

Insurance company transactions remain exempt from VAT but are subject to a banking and insurance transaction tax (BSMV) and fire insurance tax. Save for the specific exemptions, the general rate of BSMV is determined as 5 per cent of the insurance companies' transactions and the fire insurance tax, levied at 10 per cent, shall apply to insurance premiums collected on fire insurance purchased for movable and immovable properties within municipal boundaries and adjacent areas.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Turkey adopts a continental law system, and legislation is the principle and primary source of law. The provisions of the Turkish Code of Obligations shall be applicable on the insurance contracts where the Insurance Chapter of TCC is silent. The principles of freedom of contract apply subject to the mandatory and protective measures of these Codes.

Although court decisions are in principle not binding, in giving their judgments, local courts tend to rely heavily on the judgments of the Court of Appeal. However, established and consistent case law is lacking with regard to analysis and interpretation of insurance terms and conditions in most of the disputes, especially if the dispute requires technical or engineering expertise; because such disputes are mostly resolved by means of out-of-court settlements.

Turkish law does not explicitly contemplate reinsurance contracts. With the exception of the special provisions under Agriculture Insurance Act No. 5363, the only and main provision that particularly concerns reinsurance agreements is included in the TCC. Accordingly, insurance companies may reinsure the risk on whatever terms and conditions are deemed fit and necessary (Article 1403). Despite the wording of this particular provision and the fact that there is no other provision that directly concerns reinsurance agreements, many academics take the view that the reinsurance agreements are ultimately subject to the mandatory pro-insured provisions governing insurance agreements. Therefore, in addition to the general rules of contract law, insurance law provisions in the TCC would, to the extent possible, apply to reinsurance relations by analogy. It is, however, not clear to what extent and how provisions of insurance law in each case would apply to reinsurance.

The Insurance Act and subsidiary legislation provide the regulatory framework of the insurance and reinsurance industry.

ii Making the contract

Insurance contracts are defined in the TCC as:

[A] contract under which the insurer undertakes, in exchange for a premium, to indemnify a loss caused by the occurrence of a danger or risk, harming an interest measurable in monetary terms of a person concerned or to effect payment or to fulfil other performances based on the lifetime or upon occurrence of certain events in the course of the lifetime of one or several persons.

The insurer must issue an insurance policy, recording the mutual rights, obligations (including default and special provisions) and general conditions predetermined by IRSA and signed by the insurer. Written form is not a condition for validity but a regulatory requirement, as a tool for evidencing the content and scope of the coverage, for the protection of the insured.

In this respect, the Insurance Act requires insurance contracts to be drafted in Turkish and devoid of any words in a foreign language. Similarly, the Law on Compulsory Usage of Turkish Language among Commercial Entities,¹⁹ an old law that is still in force and taken into account by the courts, also requires all private law contracts to be drafted in Turkish. Scholars suggest that the provision in the Insurance Act stipulating the form of the policies should not apply to policies concluded abroad. However, they are concerned that Law No. 805, which is an imperative piece of Turkish law, by reason of its particular purpose of public order, is applicable regardless of the designated law and place of execution. The courts, according to the recent precedents, apply this requirement for the contracts concluded with the entities established under the laws of foreign states. There is no concrete consequence of violation of this requirement; however, use of foreign language, depending on the circumstances, may cause the exclusions incorporated into the contract or insurance policy to be deemed void or interpreted to the detriment of the insurer.

The following can be identified as the main elements of insurance to be taken into account when drafting the contract or insurance policy, apart from formal requirements.

Insurable interest

The Code refers to an ‘interest measurable in monetary terms’. According to established doctrinal views and practice, an insurable interest in indemnity insurance consists of proprietary, intellectual or personal rights and receivables that are measurable in monetary terms and capable of enforcement by legal action.

With respect to life insurance, the TCC provides that the policyholder can take out insurance on its own life or on the life of another person (person subject of the risk) against death or survival. In the case of insurance on the life of 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 is paid or the contract is concluded.

The insurer’s obligation to indemnify is subject to the occurrence of the identified risk and the occurrence of a loss as a result of the occurrence of the risk. However, if the risk occurs because of intentional acts of the insured, the insurer shall be released from liability and shall not reimburse the premiums paid.²⁰

As insurance and reinsurance contracts are contracts of utmost good faith, one of the statutory duties of the policyholder is the duty of disclosure and not to misrepresent facts known or reasonably expected to be known to him or her before the conclusion of the contract.

19 Law No. 805 published in Official Gazette No. 353 dated 22 April 1926.

20 Under Article 1429 of the TCC, the common rule is stipulated as ‘Unless otherwise agreed, the insurer shall pay losses arising from the negligence of the insured, the insured, the beneficiary and the persons for whose acts these persons are legally liable.’

The TCC imposes a duty of disclosure on the insured at three different stages, namely, before the conclusion of the contract, during the contract and at the time of occurrence of the risk.

Regarding the duty of disclosure before policy inception, the TCC provides that the policyholder is under a duty to disclose important facts that are, or should be, known to him or her. The TCC also provides that questions asked verbally or in writing by the insurer are presumed to be important unless proven otherwise.

The TCC, after confining the duty of the policyholder to the questions in a list provided by the insurer, explicitly provides an exception where facts were concealed in bad faith. In cases of non-compliance with the duty of disclosure before policy inception, the TCC provides alternative rights for withdrawal of the policy or asking for a change in the premium, both to be used within 15 days of becoming aware of the non-disclosure of important facts. When the request for a change in the premium has not been accepted within 10 days, the insurance will terminate automatically.

When breach of the duty of disclosure has been discovered after the occurrence of the risk, a reduction on the insurance indemnity will be made according to the degree of negligence of the policyholder in its failure to disclose, provided that the negligence has the potential to affect the occurrence of the risk or the amount of the indemnity. When the policyholder acted wilfully, the insurer has no liability for insurance indemnity provided that there is a connection between the non-disclosure and the occurrence of the risk. When there is no connection, the indemnity shall be paid taking into consideration the proportion of the paid premium and the premium that should have been paid if the circumstances had been disclosed.

Insurance sum

The insurance sum is subject to the limit of the insured value and the actual loss in indemnity insurance. The TCC forbids agreeing on an insurance sum exceeding the value of the insurable interest.

Insurance premium

The TCC provides that 'unless otherwise contracted, liability of the insurer starts at the time of actual payment of the premium or the first instalment'.

Compliance with the payment schedule is crucial for the insured in order to retain coverage because, subject to certain notification prerequisites, the TCC provides the insurer with the opportunity to avoid the insurance contract without any legal consequence if the insured or policyholder fails to pay the premium instalments.

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 trying to establish the actual meaning of the wording, the definitions of the Turkish Language Association are considered. When ambiguity or contradictions exist in the wording, interpretation in favour of the insured prevails because the primary duty of providing proper wording is on the insurer. The principles of protection of the insured and keeping the insurance contract

alive are dominant. One of the main points to be considered in the interpretation is the principle of balance between the risk carried by the insurer during the term of the contract, the premium collected and the interests.

Incorporation of terms

Each and every insurance contract should refer to a set of general conditions, which are approved by IRSA. Apart from the general conditions, it is possible to incorporate special provisions according to needs of the insured within the framework of the mandatory provisions under the TCC; however, insurers should ensure that there is no ambiguity when interpreting the contracts.

The Insurance Act provides that the insurer should not content itself with merely writing down the risk covered under the contract; it must also expressly mention the exclusions. If exclusions are not mentioned by the insurer, they shall be deemed to be part of the insurance coverage.

The TCC provides that, in case of any discrepancy between the policy and the insured's proposal form, the terms and conditions included in the policy that do not exist in the proposal form shall be deemed invalid.

The insurer, when negotiating and concluding the insurance contract, is under a strict duty to enlighten the insured about the details of the coverage; in the absence of which, the insured is entitled to rescind the insurance contract owing to the undesired terms incorporated into the insurance policy within 14 business days.

Types of terms in insurance contracts

Special provisions of insurance contracts have to be drafted in accordance with the standard general terms approved by IRSA and the mandatory provisions of the TCC. Non-compliance with mandatory provisions may render the contract or the relevant contract provision invalid. There are various legal provisions that cannot be contracted out contrary to the interests of the policyholder, the insured or the beneficiary.

Warranties – conditions precedent

Sanctions attached to certain warranties or conditions precedent to cover do not necessarily give the terms the intended effect and may be caught by semi-mandatory or mandatory provisions of the TCC. Where a condition or warranty relates to the duties already provided for by the TCC, such as the duties of disclosure and notification before and during the contract (regarding any increase in the risk) and upon the occurrence of the insured-against event, then semi-mandatory provisions that cannot be amended contrary to the interests of the policyholder, the insured or the beneficiary with respect to such duties and sanctions are highly likely to be applicable. These provisions prevent the insurer from simply rejecting cover on the basis of non-compliance and subject sanctions to various conditions, such as a causal link between the failure in compliance and the occurrence of the risk or the amount of indemnity.

The TCC introduces a specific provision in that regard and provides that where the insurance contract provides for partial or entire avoidance of the contract by the insurer for non-compliance with the contractual duties by the insured (where the sanction of non-compliance with such duties has not already been specifically provided for in the TCC – as explained above), avoidance shall not take effect unless the non-compliance is based on fault. Where non-compliance is based on fault, the right to avoid the policy will cease when

it has not been used within one month of learning of the circumstances. Also, the insurer will have no right to avoid the policy unless the non-compliance had any effect on the occurrence of the risk and the extent of the obligations of the insurer.

iv Intermediaries and the role of the broker

Position of brokers

According to the definition of the Insurance Act, a broker is the person who acts independently and impartially to appoint the insurance companies for contracting insurance policies.

Pursuant to the Regulation on Insurance and Reinsurance Brokers (the Brokers Regulation) enacted in mid 2015, brokers must obtain a brokerage licence from IRSA.

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 Turkish lira and 50,000 Turkish lira for any additional type of insurance.

Agencies and contracting

Agencies operate on behalf of insurers, on the basis of a contractual relationship between them and the insurance company.

Agencies can be a real person or a legal entity. The headquarters of legal entity agencies should be located in Turkey. Legal entity agencies also need to be incorporated as joint-stock or limited liability companies and obtain the approval of IRSA, and shall be registered on the Agency Registry indicating whether or not the agencies are granted power to conclude contracts and collect premiums. The approval shall be then promulgated by the Turkish Union of Chambers and Commodity Exchanges.

In April 2013, insurance agencies were prohibited from engaging in business other than agency work in the insurance sector.

v Claims

Duty of disclosure

Apart from the disclosure duties regarding the conclusion of the contract (as set forth in subsection ii, 'Risk'), the TCC provides for the duty of immediate notification of the increase of the risk during the term of the contract and provides that the insured and the policyholder must refrain from acts that would increase the amount of insurance indemnity by way of aggravating the risk or current conditions. When the increase has been learned subsequently, the policyholder must notify the insurer within 10 days of learning at the latest.

The insurer has the right to terminate the policy or request premium difference within one month of becoming aware of the increase in the risk. When the non-disclosure was wilful, the insurer will keep the paid premium. When payment of the premium difference has not been accepted within 10 days, the policy will be deemed terminated.

When the increase has been learned of after the occurrence of the risk, the insurance indemnity will be reduced according to the gravity of negligence in the failure to disclose, provided that the non-disclosure is of such gravity that it may affect the amount of the insurance indemnity or the occurrence of the risk. When the policyholder was intentional in its non-disclosure, the insurer has the right to terminate the policy, provided that there is a connection between the increase in the risk and the occurrence of the insured event. In such cases, the insurer will not pay any indemnity and not return the paid premium. When there is no connection, however, the insurer must pay the indemnity, taking into consideration the proportion of the paid premium and the premium that should have been paid.

When the risk has occurred before the right of termination has taken effect or within the period for use of the right of termination, insurance indemnity must be paid taking into consideration the ratio between the paid premium and the premium that should have been paid, provided that there is a link between the increase and the occurrence of the risk.

The policyholder also has a duty of disclosure at the occurrence of the risk that relates to the disclosure of the facts affecting the occurrence of the loss.

In the case of liability insurance, the TCC provides that the policyholder has a duty to immediately notify the insurer upon learning of the occurrence of the risk, and in the case of property insurance, the policyholder must notify the insurer without delay. As regards third-party liability policies, the TCC introduces a new duty on the insured to also notify events that may give rise to his or her liability within 10 days of learning of the event. When the notification of occurrence of the risk has not been made or the policyholder was late in his or her notification, a reduction will be made in the indemnity according to the degree of negligence in the failure to disclose, provided that the failure caused an increase in the insurance indemnity.

Good faith and claims

Even though the insured's interest is covered in exchange for the payment of premiums, he or she must still take appropriate precautions and not negligently cause further losses or aim to achieve enrichment upon the occurrence of the risk.

In the event that risk materialises or that materialisation of risk becomes highly probable, the policyholder must, as long as circumstances permit, take measures to prevent the loss or the increase in its likelihood, to mitigate the loss, and to protect the insurer's rights of recourse against third persons.

Set-off and funding

The insurer is entitled to deduct the premium due from the indemnity amount or the fixed sum to be paid with the exception of liability insurance. Set-off may be applicable even in the event where the insured and the beneficiary are different persons.

IV DISPUTE RESOLUTION

i Choice of jurisdiction

The Turkish Civil Procedure Code, applicable to local disputes, restricts the freedom of choice of local jurisdictions to agreements between merchants and agreements between public legal entities. Insurance agreements with no foreign element concluded with those who do not qualify as merchants shall therefore be subject to the jurisdiction rules provided for in the Civil Procedure Code and cannot be contracted out. Accordingly, the courts of the place

where the insurable interest or risk is located are vested with jurisdiction, as an alternative to the courts of the respondent's domicile and the place of performance agreed under the contract.

The Code on International Civil Procedure, regulating conflict of laws, provides with respect to insurance contracts involving a foreign element that the following jurisdiction rules cannot be avoided by contract: (1) claims against insurers are subject to the jurisdiction of the courts at the insurer's principal place of business or the place of incorporation of the insurer's branch or Turkish-incorporated agent that concluded the contract; and (2) where the claim is against the policyholder, the insured or the beneficiary, the courts that have jurisdiction are the courts of its domicile in Turkey.

Regarding the choice of arbitration in insurance and reinsurance contracts, see subsection iv.

ii Choice of applicable law

Unlike jurisdiction agreements, there is no specific restriction on the law applicable to insurance contracts. The main limitation to the application of foreign law would generally be the absence of a foreign element and Turkish public policy. The general approach under Turkish law is that mandatory rules are not necessarily matters of public policy. Where, however, the insured is not a merchant but a real person, consideration of public policy and the law on 'standard contract terms' protecting the weaker party of the contract may prevail for the sake of protection of the insured.

The requirement of the existence of a foreign element, however, is controversial. In a decision of the Court of Appeal in an insurance case filed by an insured, it was concluded that the choice of a foreign law between two Turkish parties, by itself, would suffice for the fulfilment of the 'foreign element requirement' even if there is no foreign element with respect to the dispute.

Reinsurance agreements with a foreign element are much less likely to be subject to the above restrictions of applicable law although there would obviously be issues of back-to-back cover where different rules could potentially apply to the local insurance.

iii Litigation

Claims to be pleaded directly towards the insurer

With regard to liability insurance, the TCC provides that third parties are entitled to direct their claims to the third-party liability insurer of the person responsible for the loss.

Notification before the pleading

The insured shall notify the loss that is thought to be within the insurance coverage as soon as possible. Maturity of the indemnity payment arises upon conclusion of the insurer's investigations into the scope of the indemnity and, in any case, 45 days after notification of the occurrence of the risk. The investigation of the insurer must be concluded within three months of notification.

Stages of litigation

Insurance disputes are, in principle, dealt with by the first instance commercial courts.

Stages of litigation before the commercial courts are as follows:

- a* The parties submit a written submission of their claim, defence, rebuttal and rejoinder, and evidence.
- 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' evidence. At the preliminary hearing, the judge will also encourage the parties to settle or resort to mediation. In this stage, the parties can amend their evidence and assertions only if the counterparty gives its consent.
- c* The courts almost always revert to court-appointed expert examinations even in legal matters. Hearings are held on the disputed elements of the case, where the court can hear witnesses and obtain expert reports.
- d* Upon assessment of all evidence and facts, the court delivers a short judgment followed by a reasoned judgment.
- e* According to the Turkish civil procedure law, which was introduced on 4 February 2011 by the Civil Procedural Code and became operational for judgments rendered after 20 June 2016, the appeal procedure is to be conducted by a two-tier system comprised of regional appellate courts²¹ and the Supreme Court.²² Accordingly, the decisions of first instance courts concerning a dispute amounting to no less than 5,390 Turkish lira can be appealed before the regional appellate courts. Decisions of the regional appellate courts can be appealed before the Supreme Court, provided that the dispute amounts to no less than 72,070 Turkish lira.

Despite being operational since 2016, the positive effects of the judicial system are yet to be seen. It is expected to decrease the workload of the appellate courts and accelerate the appeal stage. For this purpose, the Ministry of Justice, referring to European Commission for the efficiency of justice guidelines, implemented new measures on 3 September 2018 for judicial time management and set target lengths for judicial proceedings for the first instance courts. The target for each individual proceeding was made available to parties on 1 January 2019. Mediation was introduced as a compulsory remedy to be resorted to before filing a lawsuit in commercial matters to decrease the workload of the judicial bodies (see subsection vi).

This would also enable the Supreme Court to evaluate the merited issues of a dispute and prepare more diligent reasoning for their awards, which may hopefully develop case law where legislation or practice is ambiguous. This is particularly important for insurance law, because the Supreme Court has not, thus far, provided guiding principles for complex insurance disputes that often require a considerable effort to interpret the facts and contracts in order to solve a wide range of issues (e.g., deductibles, exclusions, subrogation).

21 Article 341 of the CCP.

22 Article 361 of the CCP.

Evidence

Under Turkish civil law, the adversarial system prevails.

The burden of proof of the existence of the contractual relationship, the occurrence and amount of the loss lies with the insured. The insurer, on the other hand, must prove the lack of cover and application of exemptions. Every transaction exceeding 4,480 Turkish lira must be proven by a deed. Witness evidence would only constitute supportive evidence.

Turkish courts frequently refer disputes to a court-appointed panel of experts, even in legal matters. As a novelty, the parties are granted the opportunity to submit expert views subject to the questions of the judge and the parties (without any common-law-style cross-examination procedure)²³ as supportive evidence without the need to obtain a judge's order in this regard.

Costs

Of the claimed amount, 6.831 per cent must be paid as court fees.²⁴ One-quarter of this amount must be paid to the court in advance by the claimant. Court fees and court expenses (the most significant of which are expert fees – approximately 4,000 to 5,000 Turkish lira per expert examination) are recoverable in the event of the case being found in favour of the claimant. The court orders legal fees in favour of the winning party (or to the extent of acceptance by the court of the claimed amount) in accordance with an official tariff. The parties cannot recover actual fees they may have paid to their lawyers. Lawyers' fees ordered by the court belong to the lawyers unless agreed otherwise between the lawyers and their clients.

Claimants who are of foreign citizenship may also be obliged to submit a warranty to the court, the amount of which shall be determined by the court, subject to exemptions provided by bilateral and multilateral agreements (such as the Hague Convention on Civil Procedure).

iv Arbitration

Pursuant to Law No. 6570 dated 29 November 2014, the Istanbul Arbitration Centre²⁵ was established and parties have the opportunity to refer disputes, in addition to ad hoc arbitrations and conventional arbitration institutions, to the Centre or to the Insurance Arbitration Commission, whose functions are explained below. The Centre presents an efficient alternative to court litigation, as the costs are low and the length of proceedings is short.

Arbitration clauses

Parties can refer to arbitration for the resolution of insurance disputes by inserting an arbitration clause into the insurance and reinsurance agreement or concluding a separate arbitration agreement between themselves. As mentioned in subsection i, provisions of the

23 Umar, Bilge; HMK Şerhi sayfa 801 vd.

24 www.gib.gov.tr/index.php?id=1079&cuid=pMzD40A9M4IP6oCJ&type=teblig.

25 <http://istac.org.tr/en>.

Civil Procedure Code apply to parties in arbitration in local disputes, whereas the International Arbitration Act²⁶ applies if there is a foreign element in the dispute, particularly in disputes between local insurers and foreign reinsurers where the place of arbitration is Turkey.

Insurance Arbitration Commission

The Insurance Act foresees an institutional arbitration proceeding irrespective of the existence of an arbitration clause. Even if the insurance company is not a member of the arbitration system, the insured shall benefit from the relevant arbitration procedure regarding the disputes arising from compulsory insurance. Since proceedings before the Insurance Arbitration Commission lack certain elements of traditional arbitration, as no arbitration agreement is concluded between the parties and the arbitrators are appointed by the Commission, instead of the parties, from the arbitrators registered in the Commission's list, this procedure is regarded as a unique, ombudsman-like dispute resolution mechanism, instead of regular arbitration. The total number of disputes settled by the Insurance Arbitration Commission reached 293,698 as of 30 September 2019.²⁷

Format of insurance arbitrations

The Commission may appoint a tribunal consisting of a minimum of three arbitrators specialised in life or non-life insurance in cases of arbitration based on the Insurance Act. However, where the disputed amount is equal to or above 15,000 Turkish lira, it is compulsory to form a tribunal. The tribunal decides by majority. According to the Regulation Amending the Regulation on Insurance Arbitration, which was published in 2019, insurance arbitrators are subject to the criteria of (1) having five years of uninterrupted experience in insurance law; or (2) having 10 years of uninterrupted experience in the insurance sector.²⁸

Procedure and evidence

The requirement for application to the Commission is a partial or total rejection of the insurance claim.

Applications may not be filed with the Commission regarding disputes that have been referred to a court or to the Arbitration Committee for Consumer Problems.

The application to the Commission shall be first examined by rapporteurs. Applications that cannot be settled by rapporteurs are referred to the insurance arbitrators. Arbitrators have to issue their awards within four months, at the latest, of the date they have been commissioned.

In addition to the procedure of arbitration adopted by the Civil Procedure Code, the arbitrator may consider the case on submitted documents only. Unless otherwise agreed, the tribunal or the sole arbitrator can decide on the provisional injunctions or evidence determination.

26 Drafted in consideration of the UNCITRAL Model Law on International Commercial Arbitration, the International Arbitration Act is applicable to those disputes involving a foreign element.

27 www.sigortatahkim.org.tr/E-BULTEN-39.html.

28 Regulation Amending the Regulation on Insurance Arbitration, published on 18 April 2019, <https://www.resmigazete.gov.tr/eskiler/2019/04/20190418-26.htm>.

Costs

Attorneys' fees ordered in favour of the party whose request is partially or wholly accepted are one-fifth of the attorneys' fees that would be rendered if the dispute had been resolved before the state court.

The application fee is determined by IRSA and varies from 100 Turkish lira to 350 Turkish lira, or even more in certain cases, depending on the amount of the dispute.²⁹

The fees of arbitrators are paid by the Commission. Arbitrators shall decide on the additional costs as regulated under the Civil Procedure Code.

Awards

Most of the awards rendered in 2019 by the Commission concerned car insurance policies, compulsory traffic insurance, and property insurance policies. Compared with court judgments, the awards contain more comprehensive examinations and reasoning.

v Alternative dispute resolution

Complaints of the insured

If the insured has a complaint arising from interpretation of the regulations or conduct of an insurance company, it can apply to the Insurance General Directorate, incorporated under the Ministry of Treasury and Finance.

vi Mediation

Mediation was recognised in Turkish law for the first time by the Mediation Act, which entered into force in June 2013. With the amendment of the TCC,³⁰ which entered into force on 1 January 2019, mediation became a compulsory remedy for all commercial claims (including insurance disputes) that had to be resorted, leaving filing a lawsuit before the state courts as a last resort, as a cause of action that must be exhausted before the proceedings are commenced.

The compulsory mediation for commercial disputes under the TCC is designed to be finalised within six weeks, and this can be extended by two weeks if deemed necessary by the mediator.

In the event of a settlement at the end of mediation, the parties may request an annotation regarding the execution of the agreement from the court at the place of jurisdiction. The annotation gives the agreement the power of a court judgment.

V YEAR IN REVIEW

In the last quarter of 2018, the Ministry of Treasury and Finance announced the New Economic Programme, which outlines that 2019 to 2021 will be years of fiscal discipline accompanying a rebalancing of the economy to overcome rapid inflation and reduce the budget deficit. Within the scope of this programme, Berat Albayrak, the Minister of Treasury and Finance, announced that the Turkish insurance and reinsurance market will undergo a transformation as, thus far, it has failed to provide sufficient cover for every type

29 www.sigortatahkim.org/index.php?option=com_content&view=article&id=67&Itemid=92.

30 Law on Starting Legal Proceedings for Monetary Receivables Arising from Subscription Agreements No. 7155, published in the Official Gazette No. 30630, dated 19 December 2018.

and magnitude of risk. This is why building completion insurance policies, among others, have not gained momentum until now.³¹ Against this background, Turk Re was established on 6 September 2019, with a capital of 600 million Turkish lira and its sole shareholder being the Ministry of Treasury and Finance. Ms Selva Eren, general manager of Turk Re, has stated that they plan to keep 1.2 billion Turkish lira domestically out of 8 billion Turkish lira transferred abroad through reinsurance.³²

As another feature of the transformation, IRSA was incorporated on 18 October 2019 with Presidential Decree No. 47 to act as the new insurance regulatory agency in replacement of the former Undersecretariat of Treasury. As the most significant benefit, IRSA is expected to adopt a friendlier approach towards the market participants and react more quickly to the market's needs for secondary legislation. At the same time IRSA aims to foster the popularity of insurance and enhance awareness on the part of consumers.

Referring to the New Economic Programme, the Turkish Wealth Fund announced in December 2019 that insurance and personal retirement insurance companies controlled by public banks were being merged into one under the Fund. Reportedly, this merger will give birth to a strong insurance movement capable of offering building completion insurance, surety insurance, credit insurances and the like, which have long been awaited by the real sector. On a broader scale; this transaction ultimately aims to increase the share of the insurance market in financial services, which is currently 4 per cent and underachieving.

Building completion insurance policies, credit insurance policies and short-term trade credit for small and medium-sized enterprises (SMEs) were introduced in 2015 as products, serving the purpose of limiting the effects of economic slowdown and currency volatility.³³ Building completion insurance, in particular, was aimed at providing relief to the construction sector. However, the contractors' access to this tool was very limited as the insurance companies were reportedly unable to secure reinsurance coverage for themselves. Similar difficulties in obtaining insurance and reinsurance cover had been reported in other sectors, such as textiles and chemicals.³⁴ However, the endeavour for transformation of the local (re)insurance market, which now involves a state-owned reinsurance company, is seen as a promising development. In this vein, IRSA took over the flag from the Undersecretariat, which issued a communiqué on 24 December 2018, effective as of 1 January 2019, setting the guidelines and tariffs to be adopted by insurance companies for credit insurance foreseen for SMEs.³⁵

Apart from the above cornerstones of structural reforms, the Ministry highlighted legal protection insurance in its 2018 Activity Report.³⁶ Although this insurance tool, together with the approved general conditions, was announced back in 2006, it turned out to be a dead duck because of its incompatibility with the practice and lack of awareness on the part of

31 <http://www.hurriyet.com.tr/yazarlar/noyan-dogan/milli-sigorta-devi-kuruluyor-41089661>.

32 Interview with Selva Eren dated 30 October 2019, available at: <http://www.hurriyet.com.tr/yazarlar/noyan-dogan/doviz-cikisini-engelleyecemiz-41340329>

33 Turkish Insurance Market Outlook 2016–17, p. 33, http://www.jlt.com.tr/upload/files/Turkish_Insurance_Market_Outlook_2016-17.pdf.

34 <http://www.hurriyet.com.tr/yazarlar/noyan-dogan/milli-reasurans-sirketi-kuruluyor-41038431>.

35 Official Gazette No. 30635 dated 24 December 2018.

36 <https://ms.hmb.gov.tr/uploads/2019/05/Hazine-ve-Maliye-Bakanl%C4%B1%C4%9F%C4%B1-2018-Y%C4%B1%C4%B1-Faaliyet-Raporu.pdf>.

consumers. Against this backdrop the Ministry currently endeavours to adopt the existing general conditions to the market needs and relevant legislation as well as taking actions to increase awareness and education on this specific insurance tool.

Another concept on which the Ministry conducted studies was the concept of surety insurances. The Ministry announced that it had included surety insurances in its agenda, as specified in the Export Master Plan.³⁷ With the amendment made to the Public Procurement Law published in the Official Gazette on 5 December 2017, it was allowed for companies to give surety policies to the banks instead of letters of guarantee. Recently, the Association of Insurance, Reinsurance and Pension Companies announced it was working on a system that will enable verification of the validity and authenticity of the security bonds that are presented as security in tenders.³⁸

One of the main hot topics continues to be the private pension scheme that became compulsory for employees and public servants. The government is encouraging private pension systems and annuity products by providing contributions to the premiums paid by the policyholders and introducing compulsory pension schemes. With the amendment of the Personal Pension Savings and Investment System Law,³⁹ employees under 45 were automatically included in the pension system, the premium for which is deducted from the insured's salary. The latest finance news, however, reports that this product has not been as successful as hoped, as 60 per cent of the insureds opted to abandon the scheme shortly after their automatic inclusion.⁴⁰ The number of contracts has been at a standstill since 2017.⁴¹ Being unsatisfied with the level of remaining participants, the Presidency recently issued a new regulation which allows those who leave the system to re-enter the system with further incentives.⁴² With the new 'Supplementary Pension Scheme', on the other hand, it is projected that employer contribution will be integrated into the participants' savings in addition to the current governmental incentives and wage stoppages.⁴³

Another hot topic on the insurance sector's agenda was cybersecurity. The cyberattack on 27 October 2019 targeting some banking and telecommunication institutions in Turkey brought to the fore the importance of the issue. The attacks have caused the banking systems and communication operators to stop serving, and disabled access to their digital channels. The experts reiterated the importance of investing in cyber infrastructure and drawing up a cybersecurity strategy. Being aware of the demands and the necessity, the private sector took the initiative to place insurance products covering the damages incurred due to attacks targeting digital platforms.

37 Turk Eximbank's Role in 11th Development Plan and Export Master Plan, <https://www.eximbank.gov.tr/content/files/3b3a03cc-8819-464c-baaf-1198853cc7d2/turk-eximbank-s-role-in-11th-development-plan-and-export-master-plan-20-09-2019>.

38 <https://www.sigortacigazetesi.com.tr/kefalet-senetlerinin-internette-dogrulanabilmesi-icin-yeni-bir-sistem-hayata-gecirilecek/>.

39 Law No. 4632.

40 <http://www.hurriyet.com.tr/yazarlar/noyan-dogan/yepte-otomatik-bes-zorunlu-oluyor-40965509>.

41 KPMG, Sectoral Outlook 2020, page 13, <https://home.kpmg/tr/tr/home/gorusler/2020/01/sektorel-bakis-2020-sigortacilik.html>.

42 Regulation Amending the Regulation on Private Pension Scheme published on the Official Gazette dated 27 December 2018.

43 <http://www.hurriyet.com.tr/yazarlar/noyan-dogan/kideme-guney-kore-modeli-41204469>.

Climate change is the other critical field where the private sector took the initiative. In September 2019, one of the insurance companies introduced the first ever climate insurance in Turkey, in the context of a social responsibility project named ‘Respect for Earth’.

VI OUTLOOK AND CONCLUSIONS

According to the European Commission’s Turkey 2019 Report, ‘Turkey has a good level of preparation in the area of financial services’ while noting that there has been no progress during the reporting period.⁴⁴ Some progress was made in the previous period, notably with regard to making it compulsory for employers to automatically enrol employees in pension schemes.⁴⁵

The government has an objective to be the 10th largest economy in the world by 2023, aiming to generate US\$2 trillion worth of gross national product. In line with this objective, the government is focusing on the insurance sector, among others. Because of the increase in foreign investment and developments in the Turkish economy, it is expected that the insurance sector will gain momentum in the coming years.

Newly emerging risks, disasters that have been experienced and the economic climate are important motives when shaping the underlying legislation and insurance tools. In that vein, in 2019 the government aimed at enhancing insurance regulations to incentivise participants in the insurance market and to develop new products that will create opportunities for insurance companies.

The dynamics, age and growth of the population is encouraging for all the stakeholders to accomplish the goals set by the government. That being said, low risk awareness and level of insurance knowledge stand as the biggest obstacles in the way. With the revival of the economy throughout 2020 and the structural developments, the insurance sector is projected to make a bolder move forward in the coming year.

44 Turkey 2019 Report, p. 71, https://www.ab.gov.tr/regular-progress-reports_46224_en.html.

45 Turkey 2018 Report, p. 71, <https://www.ab.gov.tr/siteimages/kapbtblolar/20180417-turkey-report.pdf>.

UNITED ARAB EMIRATES

Sam Wakerley, John Barlow and Shane Gibbons¹

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).

There are effectively three separate insurance jurisdictions: the onshore UAE market; the Dubai International Financial Centre (DIFC) and the Abu Dhabi Global Market (ADGM), of which the latter two are largely wholesale 'offshore' reinsurance centres. Only licensed insurers can write business 'onshore' in the UAE and the issuance of new licences is heavily regulated.

There is also a growing Islamic insurance market within the UAE. 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.²

ii The legal landscape for insurance and reinsurance disputes

The UAE's 'onshore' legal system

The onshore legal system is founded upon civil law principles with a statutory code as the primary source of law. The court system is influenced by shariah law and operates in the UAE's official language of Arabic. The legal framework of the UAE's justice system operates via two systems: a federal judiciary presided over by the Federal Supreme Court in Abu Dhabi and local judicial departments at the local government level, such as the Dubai courts. There is no system of binding precedent although the doctrine of *jurisprudence constante* does apply, meaning that decisions of higher courts can be persuasive on lower courts. In addition, the doctrines of reservation of rights and without prejudice correspondence are not expressly recognised under 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 client without the client's consent.

1 Sam Wakerley and John Barlow are partners and Shane Gibbons is an associate at HFW.

2 See, for instance, Article 9, Insurance Authority Board Resolution No. 4 of 2010 Concerning the Takaful Insurance Regulations.

DIFC and ADGM courts

While the onshore courts operate a civil law system, the UAE is home to a series of free zones governed by their own regulations. In the case of the DIFC and the ADGM, these financial free zones have their own civil laws (i.e., non-criminal) and their own common law courts to administer those laws. The DIFC and ADGM court systems are predominantly based on English common law and substantive civil law and procedure. In relation to binding precedent, which is applicable in the DIFC and ADGM courts, the body of case law continues to grow. In the event that the law is silent, the DIFC and ADGM judiciary has the power to call upon English common law precedent to help determine disputes. In contrast to the UAE onshore court system, the doctrine of privilege and the doctrine of reservation of rights and without prejudice correspondence are recognised concepts in the DIFC and ADGM courts.

II REGULATION

i The insurance regulator

The UAE insurance market is regulated by the Insurance Authority (IA), which monitors and oversees onshore insurance business. While the IA was established in 2007³ and remains in its infancy, there has been a steady increase in regulation, creating a robust framework in which to operate. The scope of IA governance includes insurance and reinsurance companies, insurance intermediaries and other insurance related entities located or operating in the UAE.

In addition to the IA, there are separate dedicated regulators for the health insurance sector in some of the individual Emirates; at present, these are the Dubai Health Authority, the Department of Health of Abu Dhabi and the Sharjah Health Authority.

Further, the Dubai Financial Services Authority (DFSA) and the Financial Services Regulatory Authority (FRSA), respectively, regulate DIFC and ADGM-based insurers. Each regulator has its requirements for the authorisation and regulation of companies offering insurance services.

ii Position of non-admitted insurers

Insurers conducting insurance business in the UAE must be licensed by the IA. This applies to all types of insurance business.⁴ The DIFC and ADGM also prohibit non-licensed insurers operating within their jurisdictions.

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

3 Federal Law No. 6 of 2007 on Establishing the Insurance Organisation and Regulating Insurance Activities (as amended) (the Insurance Law).

4 Article 26 of Federal Law No. 6 of 2007 provides that: 'It is not permissible to carry out insurance with an insurance company outside the state on property in the state, or on the liabilities arising from the same. It is not permissible either to broker for insuring such property or liabilities except with a company registered in accordance with the provisions hereof.' In practice, the Insurance Authority prohibits any insurance products from being provided by foreign insurers irrespective of the type of risk being insured.

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. Onshore reinsurance business is regulated by the Reinsurance Regulations.⁵

iii Position of brokers

Brokers operating in the UAE are also required to be licensed by the IA. The primary piece of legislation governing insurance brokers is the Broker Regulations.⁶

iv Requirements for authorisation

Insurance and reinsurance activities may be exercised within the UAE by any of the following persons who are licensed and registered with the IA:

- a* a public joint-stock company;
- b* a branch of a foreign insurance company; or
- c* an insurance agent.⁷

Insurers are required to hold regulatory capital pursuant to IA regulations. In relation to branches of a foreign insurance company, the parent company of a branch office must comply with solvency margins and minimum guarantee fund requirements as set out in IA regulations.⁸

v Regulation of individuals employed by insurers

The IA must approve any individual working in certain roles, including directors, chief executive officers, compliance officers, finance officers and money laundering officers of an insurer or broker. In addition, an insurer regulated by the IA must circulate the IA's Code of Conduct and Ethics to be observed by Insurance Companies operating in the UAE (the Code of Conduct)⁹ to its employees. They are also required to develop internal professional codes of conduct for the company and its employees.¹⁰

vi Distribution of products

Insurance products can only be distributed in the UAE by licensed entities.

5 Insurance Authority's Board of Directors Decision No. 23 of 2019 Concerning Instructions Organising Reinsurance Operations.

6 IA Board of Directors Resolution No. 15 of 2013 Concerning Insurance Brokerage Regulations (as amended) (the Broker Regulations).

7 Article 24 of the Federal Law No. 6 of 2007 on Establishing the Insurance Authority and the Regulation of its Operations as amended by Federal Law No. 3 of 2018.

8 Article 3, Cabinet Resolution No. 42 of 2009 Concerning Insurance Company Minimum Capital Requirements.

9 Article 3(12) of the Insurance Authority's Board Resolution No. 3 of 2010 Board Resolution No. 3 of 2010 – Instructions Concerning the Code of Conduct and Ethics to be Observed by Insurance Companies Operating in the UA (the Code of Conduct).

10 Article 3(12) of the Code of Conduct.

vii Compulsory insurance

In the UAE, third-party liability insurance in respect of motor vehicles is compulsory.¹¹ Health insurance is also compulsory in the emirates of Dubai¹² and Abu Dhabi.¹³

viii Compensation and dispute resolution regimes

Complaints

The IA mandates that each insurance company must maintain a register of complaints from its clients, and should investigate each complaint within 15 days of the date of its submission. Once investigated, insurers must issue a decision in respect of all insurance claims, in accordance with the Code of Conduct. If a claim is fully or partially rejected, insurers must provide reasons for the rejection in writing. Complainants may appeal decisions to the IA dispute resolution committees if the insurance company rejects their complaint.¹⁴

Dispute resolution

The IA has recently formed specialised dispute resolution committees that can settle complaints brought by an insured against insurers, relating to rejected or partially rejected claims.¹⁵

The regulations set out a three-step process for resolving disputes:

- a* first, the complainant must submit a complaint to the IA (see above);
- b* if this does not lead to a resolution, the matter will be referred to a dispute resolution committee, who will initially attempt to resolve the dispute by conciliation; and
- c* if not settled by conciliation, the committee will commence dispute resolution procedures and issue a formal decision on the merits of the claim.

Either party may appeal the decision of the IA committee to the local courts, which will process the claim in accordance in general court principles.

ix Taxation of premiums

On 1 January 2018, the UAE introduced value added tax (VAT) at the rate of 5 per cent.¹⁶ All insurance and reinsurance premiums are subject to VAT with the exception of life insurance.

x Proposed changes to the regulatory system

There are a number of regulatory reforms being considered by the federal authorities at present, most notably in relation to the sale of electronic insurance. These potential reforms are considered in more detail in Section V, below.

11 Insurance Authority Board of Directors' Decision No. (25) of 2016 Pertinent to Regulation of the Unified Motor Vehicle Insurance Policies.

12 Dubai Health Insurance Law No. 11 of 2013.

13 Abu Dhabi Health Insurance Law No. 23 of 2005.

14 See Article 110 of Federal Law No. 6 of 2007 on Establishing the Insurance Organisation and Regulating Insurance Activities (as amended).

15 Article 110(2) of Federal Law No. 6 of 2007 on Establishing the Insurance Authority and the Regulation of its Operations as amended by Federal Law No. 3 of 2018.

16 Federal Decree-Law No. 8 of 2017 on Value Added Tax.

xi Other notable regulated aspects of the industry

The UAE has a separate regulatory system for health insurance third-party administrators.¹⁷

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.¹⁸ Under the UAE Commercial Code, the hierarchy of laws is as follows:

- a* the Commercial Code;
- b* the agreement of the parties (i.e., the policy);
- c* rules of commercial customs and practices (with specific or local customs and practices superseding general practices); and
- d* the Civil Code,¹⁹ 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 Code²⁰ and therefore, in practice, the insurance provisions of the Civil Code²¹ are generally given greater attention than the Commercial Code.

Marine insurance law in the UAE is set out in the Maritime Code.²² It can be helpful to consider these provisions in the context of non-marine insurance in the event that the Civil Code and the other insurance laws do not address a particular issue.

Many policies written in the UAE still incorporate London market wordings. In the event that UAE law is completely silent on a point, it can be instructive to consider the relevant English law on the basis that it may represent commercial custom, although the extent to which a UAE court will be guided by English law is limited.

Further, the principles of shariah law can also be relevant when considering insurance law. Although there is a presumption that where there is a codified provision of UAE law dealing with an issue, that provision is considered to be compliant with Islamic shariah, courts may nevertheless look to shariah principles for guidance in interpreting and applying the law.

17 Insurance Authority Board Resolution No. 7 of 2015 on the Amendment of Some Provisions of the Insurance Authority Board Resolution No. 9 of 2011 Concerning the Instructions for Licensing Health Insurance Third Party Administrators and Regulation and Control of their Business.

18 Federal Law No. 18 of 1993 issuing the Commercial Transactions Law (the Commercial Code).

19 Federal Law No. 5 of 1985 Promulgating the Civil Transactions Law of the United Arab Emirates State (the Civil Code).

20 Articles 1026–1055 of the Civil Code.

21 Along with the Insurance Law and the Code of Conduct.

22 Articles 366–420 of the Maritime Commercial Code (Federal Law No. 26 of 1981 Concerning Commercial Maritime Law) (the Maritime Code).

ii Making the contract

Essential ingredients of an insurance contract

Under UAE law, insurance is a contract whereby the insured and insurer cooperate in addressing an insured risk or event. The insured pays to the insurer a specified sum or periodical instalments (i.e., the premium) and, in return, if the specified risk materialises, the insurer is bound to make payment (i.e., the claim).²³ The general provisions in relation to formation of contracts under the Civil Code²⁴ will apply to insurance contracts, insofar as they do not contradict those specific provisions in the insurance sections of the Civil Code.

Although not explicitly stated, there must also be a fortuity (i.e., an element of risk or uncertainty) present in an insurance contract.

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’.²⁵

In the case of liability insurance, the obligations of the insurer only arise when the injured third party makes a claim against the insured.²⁶ The precise meaning of ‘claim’ is unclear from the legislation. ‘Claim’ can include a legal judgment awarded against the insured but it has been held in certain cases that this is not strictly required.²⁷

Requirement of insurable interest

There is no express concept of insurable interest within UAE law; however, Article 1026(1) of the Civil Code does reference the sharing of insured risks between insurers and the insured.

Further, 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.²⁸ 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.

Good faith

Parties to an insurance policy are obliged to perform their obligations in a manner consistent with the requirements of good faith.²⁹ There is also an express obligation on an insurance company to carry out its business on the basis of absolute good faith.³⁰

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.³¹

23 Article 1026(1) of the Civil Code.

24 Articles 125–148 of the Civil Code.

25 Article 1026(1) of the Civil Code.

26 Article 1035 of the Civil Code.

27 Court of Cassation judgment No. 281 of 1993.

28 Article 368 of the Maritime Code.

29 Article 246(1) of the Civil Code.

30 Article 3 of the Code of Conduct.

31 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 (but misrepresentation, for example, can be proved) in relation to a marine insurance policy, an insurer is still entitled to retain half of the premium, as well as requiring that the policy be cancelled.³²

To give a degree of protection to insureds, there is an obligation on the insurer to include all of the necessary questions relating to material facts, required by the insurer to assess the risk, within the proposal form. The proposal form must also set out the consequences on coverage of giving incorrect or inaccurate information.³³

Recording the contract

A contract of insurance is recorded by way of a written document. Insurance policies in the UAE are required to be in Arabic although they may be accompanied by a translation. In the event of a discrepancy between the translations, the Arabic version will prevail. Notwithstanding this rule, the Director General may exempt some insurance policies from being written in Arabic³⁴ (see Section V.iii, below).

As a result of the enactment of the Electronic Transactions and E-Commerce Law,³⁵ contracts between parties can be executed electronically; for example, contracting by 'click-to-accept' (where an insurer indicates their consent to the insurance contract by ticking a box online). The Electronic Transactions and E-Commerce Law permits such electronic documentation as evidence.

The content of insurance policies is governed by the Code of Conduct, 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.³⁶ 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.³⁷

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

32 Article 388 of the Maritime Code.

33 Article 6(3) of the Code of Conduct.

34 See Administrative Decision No. 140 of 2019 concerning the exclusion of some insurance policies from the requirement to be written in Arabic.

35 Federal Law No. 1 of 2006.

36 Article 7 of the Code of Conduct.

37 Article 373 of the Maritime Code.

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.⁴⁰ Any doubt arising in cases of ambiguity will be resolved in favour of the obliging party.⁴¹ 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).⁴²

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.⁴³ However, there are a number of notable terms that have additional requirements.

For example, clauses in the policy exempting the insurer from liability must be written in bold characters, in a different print colour and initialled by the insured.⁴⁴

The following provisions in an insurance policy are void:

- a* any provision excluding cover for a breach of the law, other than a felony or deliberate misdemeanour;
- b* a late notification provision where there is a reasonable excuse for the delay; and
- c* any arbitrary provision, breach of which was not causative of the occurrence of the incident insured against.⁴⁵

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.⁴⁶

Types of terms in insurance and reinsurance contracts

UAE law does not specifically distinguish between types of terms in the same way as may be found under English law (e.g., conditions, terms, innominate terms), nor are conditions precedent or warranties expressly recognised.

The applicability and enforceability of a term under UAE law will depend upon its effect. Any term that purports to permit an insurer to avoid cover will be subject to the formalities for exclusion clauses (i.e., in a different font or colour⁴⁷).

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 Code of Conduct.

44 Article 1028(c) of the Civil Code and Article 28(2) of the Insurance Law.

45 Article 1028 of the Civil Code.

46 Article 246(2) of the Civil Code

47 Article 7(2)(a) of the Code of Conduct.

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 licensed and registered with the IA.⁴⁸

Agencies and contracting

Under UAE law, a broker is an independent intermediary that mediates insurance or reinsurance contracts between the insured and insurer or the reinsured and reinsurer, which is paid a commission by the insurer or 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.⁴⁹

How brokers operate in practice

The primary piece of regulation governing insurance brokers in the UAE is the Broker Regulations. The Broker Regulations contain provisions dealing with licensing and registration, claims handling and brokers' duties.

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.⁵⁰ 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 or offshore within the DIFC and ADGM). Therefore, generally, a reinsurance broker's functions and duties will be determined by the contractual arrangements between it and the reinsured, a producing broker or the reinsurer, as the case may be.

v Claims

Notification

The procedure for providing notice of a claim will usually be set out in the insurance policy itself. The Code of Conduct provides that insurers must set out a clear mechanism for processing claims, including documentation requirements and time periods.⁵¹

Currently, there are no specific consequences for late notification in relation to insurance contracts. Instead, the general principles relating to breach of contract will apply.

48 Article 70 of the Insurance Law.

49 Article 3(3) of the Broker Regulations.

50 Article 3(4) of the Broker Regulations.

51 Article 9 of the Broker Regulations.

However, a term in the insurance policy that permits insurers to avoid the policy in the event of late notification will be void under UAE law, provided the insured has a reasonable excuse for the delay.⁵²

The limitation period for issuing legal proceedings under insurance contracts is three years from the occurrence of the incident, or from the date of the insured having knowledge of that occurrence.⁵³ The limitation period in respect of marine insurance is generally two years from the date of the incident (with specific provisions dealing with claims in relation to vessels and cargo), or where a third party makes a claim against the insured.⁵⁴ Further, limitation is suspended under marine insurance by 'registered letter or delivery of other documents relating to the claim',⁵⁵ or a 'legal excuse'.⁵⁶

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.⁵⁷ 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 UAE courts have jurisdiction over any dispute arising out of an insurance policy where the insured property or domicile of the insured is within the jurisdiction.⁵⁸ The courts also have jurisdiction over insurance-related claims brought against UAE nationals (i.e., a UAE legal entity) and foreign legal entities with a domicile or place of residence in the UAE.⁵⁹ Any agreement to the contrary is void under UAE law.⁶⁰

In theory, UAE law recognises choice of law clauses. However, the courts will not apply laws that are contrary to shariah or public policy (a concept that is broadly construed). Moreover, there are specific matters where a court will not uphold a foreign choice of law clause, for example real property or contracts entered into or performed in the UAE. In practice, foreign choice of law provisions will likely be ignored by a UAE court.

The parties can also choose arbitration as the method of dispute resolution. The Arbitration Law⁶¹ recently came into force, and significantly strengthens the position of

52 Article 1028(1)(b) of the Civil Code.

53 Article 1036 of the Civil Code.

54 Article 399(1) of the Maritime Code.

55 Article 399(3) of the Maritime Code.

56 Article 399 of the Maritime Code.

57 Articles 246 and 1034 of the Civil Code, Article 3 (2) of the Code of Conduct.

58 Article 37 of Federal Law No. 11 of 1992 (the Civil Procedure Law).

59 Article 20 of the Civil Procedure Law.

60 Article 24 of the Civil Procedure Law.

61 Federal Law No. 6 of 2018.

arbitration under UAE law. However, there is still some uncertainty as to how arbitration agreements are to be incorporated into insurance contracts and whether they need to be in a separate agreement from the general printed terms of the policy.⁶²

ii Litigation

Litigation stages, including appeals

Litigation in the UAE is divided into three stages:

- a Court of First Instance;
- b Court of Appeal; and
- c Supreme Court (colloquially referred to as the Court of Cassation in the emirates, which have their own separate judicial system).

Substantive proceedings are commenced in the UAE court by the filing of a statement of claim along with a power of attorney (POA) issued in favour of a local advocate and the appropriate court fee. Once these are filed, the court will schedule a hearing date and the defendant will be served with the claim.

Either party has an automatic right to appeal judgments of the Court of First Instance to the Court of Appeal.⁶³ 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).⁶⁴

Evidence

A party is required to present evidence that it relies on in support of its claim or defence and there is no obligation to disclose documents that are relevant or helpful to the other party. The court may be asked to order the specific disclosure of a document in certain circumstances.⁶⁵ 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 may be required.⁶⁶

All submissions to the court, including documentary evidence, must be filed in Arabic. Any supporting evidence in any other language will need to be translated and certified by a legal translation company registered and certified with the Ministry of Justice.

Experts may be appointed by the court from a panel of experts according to their particular specialisation⁶⁷ in order to provide an opinion required for deciding a case (particularly for technical matters). As litigation in the UAE is characterised by exchanges of written submissions with little advocacy, experts are an essential part of the litigation process.

62 See Article 1028(1)(d) of the Civil Code, which states that, in respect of contracts of insurance, an arbitration clause shall be void unless contained in a special agreement separate from the policy of insurance.

63 Article 158 of the Civil Procedure Code.

64 Article 173 of the Civil Procedure Code.

65 Article 18(1) of the Law of Evidence in Civil and Commercial Transactions (Federal No. 10 of 1992) (the Law of Evidence).

66 Article 20 of Cabinet Decision No. 57 of 2018 on the Regulation of Federal Law No 11/1992 on the Civil Procedure.

67 Federal Law No. 7/2012 on the Regulation of Expertise before the Judicial Authorities.

While the opinion of the expert is not binding on the court,⁶⁸ the court will usually follow the recommendations in the expert's report. Significantly, the factual findings of an official document (which are those in which a public official or person employed in public service certifies what has taken place before him or her or what he or she has been informed of by the parties concerned within the limit of his or her authority and jurisdiction, such as a police report) are binding upon a UAE court.⁶⁹

Costs

In the UAE, only nominal legal costs are recoverable by a successful party 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

Arbitration proceedings in the UAE (i.e., onshore) are governed by the Arbitration Law. Both international and domestic arbitral awards must be ratified by the UAE courts before they can be enforced.⁷⁰

Procedure and evidence

There are a number of arbitration centres and institutions, both onshore and offshore. Onshore centres and institutions include the Dubai International Arbitration Centre, the Abu Dhabi Commercial Conciliation and Arbitration Centre, and the Centre for Amicable Settlement of Disputes in Dubai. There are also other domestic arbitration centres in Sharjah and Ras Al Khaimah. Examples of offshore institutions include the DIFC-LCIA Arbitration Centre and the ADGM Arbitration Centre.

The UAE has been party to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards since 2006. While there has been some 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.⁷¹ UAE arbitral awards should also be enforceable in other Convention signatory states.

Costs

Arbitrators can award costs at their discretion. A party may apply to the courts to vary the tribunal's assessment of costs; however, the usual position is that the unsuccessful party pays the successful party's costs.

iv Alternative dispute resolution

Arbitration and mediation are recognised dispute resolution mechanisms in the UAE.

68 Article 90(1) of the Law of Evidence.

69 Articles 7 and 8 of the Law of Evidence.

70 Article 55 of the Arbitration Law.

71 For example, see Case No. 693 of 2015 where the Court of Cassation recognised for enforcement a London-based arbitration award.

v Mediation

Mediation is a voluntary process and as such, parties can opt to mediate disputes with several centres offering mediation services within the UAE such as the Abu Dhabi Commercial Conciliation and Arbitration Centre, and the Centre for Amicable Settlement of Disputes in Dubai.

V YEAR IN REVIEW

i Administrative fines

In January 2020, the IA issued Cabinet Resolution No. 7 of 2019 Concerning the Administrative Fines Imposed by the Insurance Authority. The Resolution sets out a comprehensive list of offences, as well as the details of the monetary fine associated with each offence. For instance, a fine of 50,000 dirhams shall be imposed for failing to issue an insurance policy in Arabic (subject to certain exceptions – see below).

Any fine issued in accordance with the Resolution may be appealed within 15 days of notification of the decision.

ii Dispute resolution committees

In July 2019, the IA published Board Resolution No. 33 of 2019 Concerning the Regulation of Committees for the Settlement and Resolution of Insurance Disputes. These regulations provide detailed guidance on the procedure for processing insurance claims and the operation of the new dispute resolution committees.

The IA has granted extensive powers to the new dispute resolution committees, including the power to compel documentation as necessary, to seek the assistance of experts and witnesses and to adopt any alternative measures required for the settlement of disputes. The language of the committees is Arabic.

The committees will sit predominantly in Abu Dhabi and Dubai; however, there is scope to conduct sessions in other emirates when required. We understand that a number of disputes are currently ongoing before the dispute resolution committees in Abu Dhabi and Dubai.

iii Translation of policies

In October 2019, Administrative Decision No. 140 of 2019 Concerning the Exclusion of Some Insurance Policies from the Requirement of Being Written in Arabic was released. The following policies are now expressly excluded from the requirement to be written in Arabic:

- (a) *Marine hull, and the related machinery, their missions, equipment and the related liabilities insurance*
- (b) *Aviation hull insurance and the likewise, and the related machinery their missions, equipment and the related liabilities insurance.*
- (c) *Satellites, balloons and spaceships, and the related machinery, their missions, equipment and the related liabilities insurance.*
- (d) *Oil Insurance, including all insurance that is normally considered oil insurance.*

- (e) *Insurance policies of an international nature which are required to be written in the English language.*⁷²

For all other policies, underwriters should continue to ensure that these policies are issued in Arabic. They should also be mindful that the Arabic version, rather than any other version, will prevail in the event of any dispute on interpretation of the policy.

VI OUTLOOK AND CONCLUSIONS

In general, we anticipate that the IA is likely to continue its proactive approach to the regulation and management of insurance disputes.

In particular, we await with interest the implementation of the IA's life insurance and family takaful regulations in April 2020. These regulations place an upper limit on commission paid to financial advisers and stipulate that commissions will be paid over the term of the product rather than as an upfront cost. There are also new provisions regarding the transparency of information provided to customers, so that they are aware of fees and commissions. This is intended to give investors more clarity on how their insurance-based investments, savings and life products are structured.

Further, we believe that innovation in the insurance industry will be driven by technological development in 2019. This development extends to the supervision of the industry, as the IA is in the process of establishing a sophisticated electronic financial database on the insurance industry that would facilitate its supervision of the sector in accordance with international best practices. Developments in business technology, the fintech and cybersecurity sectors will require insurers to offer products and services to keep up to date with the market.

Finally, we expect that the IA will finalise the Electronic Insurance Regulations in the coming year, which have the potential to significantly alter the way in which insurance products are sold online in the UAE. Various drafts have been in circulation in the past year, with the most recent being issued in December 2019. We believe that the Electronic Insurance Regulations will introduce much-needed guidance on how electronic insurance is marketed and sold in the UAE.

72 Article 1 of Administrative Decision No. 140 of 2019 Concerning the Exclusion of Some Insurance Policies from the Requirement of Being Written in Arabic.

UNITED STATES

*Michael T Carolan, William C O'Neill, Martha E Conlin and Thomas J Kinney*¹

I INTRODUCTION

The United States insurance market is one of the largest financial markets in the world. In 2018, US insurers underwrote approximately US\$1.47 trillion in life and non-life direct premiums, accounting for 28.29 per cent of the global insurance industry.² To put that number in perspective, the US\$1.47 trillion in underwriting amounted to roughly 7.16 per cent of the total US gross domestic product.³ Yet even these premiums fail to capture the full scale of the US insurance market. In 2018, the total cash and invested assets of US insurers reached US\$8.5 trillion.⁴ As such, the US insurance market plays a significant role in the global economy.

In 2018, the US insurance market included US\$604.6 billion in life and health insurance premiums, including annuities.⁵ This dynamic and highly competitive segment of the marketplace includes more than 1,000 insurance companies competing to underwrite a wide variety of products.⁶

The 2018 US insurance market also wrote US\$612.6 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.⁷ Competition within the highly fragmented property and casualty market is significant, with approximately 2,500 different insurance companies competing for business.⁸

1 Michael T Carolan, William C O'Neill and Martha E Conlin are partners and Thomas J Kinney is an associate at Troutman Sanders LLP.

2 Insurance Information Institute, World Insurance Marketplace, available at <https://www.iii.org/publications/insurance-handbook/economic-and-financial-data/world-insurance-marketplace> (last visited 23 February 2020).

3 The World Bank, Data, GDP (current US\$), available at <http://data.worldbank.org/country/united-states?view=chart> (last visited 23 February 2020).

4 Insurance Information Institute, Insurance Industry at a Glance, available at <https://www.iii.org/fact-statistic/facts-statistics-industry-overview> (last visited 23 February 2020).

5 id.

6 id.

7 id.

8 id.

The underwriting of US reinsurance is also robust, with net premiums written to unaffiliated reinsurers totalling approximately US\$63.2 billion in 2018.⁹ Reflecting the heightened complexity of reinsurance offerings, lower demand for reinsurance products, and intense international competition, this market is concentrated in substantially fewer companies than the direct-side market.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,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.’¹² Since passage of the McCarran-Ferguson Act, regulation of insurance and reinsurance companies is primarily performed at the state level with additional federal regulation applying only to certain topics.¹³

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. 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

9 Reinsurance Association of America, *Reinsurance Underwriting Review: A Financial Review of US Reinsurers, 2018 Industry Results*, at 1, 10 (2019) (based on results of US reinsurance organisations with over US\$50 million of unaffiliated reinsurance premium and US\$250 million of policyholder surplus).

10 *id.* at 10.

11 15 U.S.C. § 1011 *et seq.*

12 *id.* § 1011.

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.

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 public by regulating insurer business practices while monitoring their solvency. The goal is twofold; first, to regulate the terms of insurance contracts to maintain fairness between the insurance company and the consumer, and second, to assure that the insurance company will be available to pay the valid claims of consumers when they are presented.

In practice, these goals are met through regulations on a variety of topics, outlined below.

Company licensing

Insurance companies are generally required to obtain licences from state insurance regulatory authorities before transacting insurance in a given state.¹⁴ 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.

Producer licensing requirements vary from state to state, and producers typically have to meet separate licensing requirements for each state in which they sell insurance. In most

14 The most important exception is for surplus lines.

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, all states prohibit rates that are inadequate, excessive or unfairly discriminatory. Individual states do not set mandatory rates. Instead, insurance companies choose the rates they intend to use in a particular 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 rate filing requirements whatsoever.

With respect to insurance product regulation, state regulators often require pre-approval of certain life and property and casualty insurance products offered in their individual state, to assure that offered products can be readily understood by consumers. That pre-approval process includes, among other things, a review of policy forms and marketing materials.

Market conduct regulation

States also regulate the business of insurance by prohibiting insurance companies from engaging in unfair, deceptive, or anticompetitive conduct. To enforce these regulations, states perform market conduct examinations of licensed or admitted carriers and producers. States also use enforcement actions to compel insurance companies to adhere to specific standards with respect to the interactions between the companies and their consumers or policyholders. In some states, enforcement actions may also be brought by the state attorney general under laws outside of insurance-specific regulations.

Solvency and accreditation

All 50 states and the District of Columbia have adopted financial reporting laws that require insurance companies to file quarterly and annual financial statements on the forms authored by the NAIC. Likewise, insurance companies must calculate their risk-based capital in accordance with procedures set by the NAIC.

These coordinated financial requirements are part of the NAIC's accreditation programme. Accreditation is a certification issued to a state insurance department once it has demonstrated that it has met and continues to meet a variety of legal, financial, and organisational standards as determined by the NAIC. Accreditation is necessary so that when an insurance company is domiciled in an accredited state, the other states in which the insurance company is licensed or writes business can be assured that the domiciliary state is adequately monitoring the financial solvency of that company. As of January 2020, all 50 states plus the District of Columbia and Puerto Rico are accredited.

Financial examinations

Each of the 50 states and the District of Columbia require insurance companies operating within their state or territory to submit to a full financial examination at least once every five years. These examinations are designed to verify the companies' financial statements.

Uniform standards, including the NAIC Model Law on Examinations and the NAIC's Financial Condition Examiners Handbook, apply to financial examinations by almost all 50 states. These standards specify both when a financial examination is to be conducted and what guidelines and procedures are to be used by the state when conducting 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. However, when multiple financial examinations are necessary, they are coordinated to some extent into group examinations.

Credit for reinsurance and collateral requirements

Historically, most US states required unauthorised reinsurers (reinsurers not licensed or accredited in a ceding insurer's domicile) to post 100 per cent collateral for any reinsured liabilities in order for the ceding insurer to get full financial statement credit for its reinsurance placements. This allowed state-based insurance regulators to indirectly regulate transactions with reinsurers outside its jurisdiction.

Then in September 2017, the US and the European Union announced that they had formally signed a bilateral covered agreement regarding the regulation of insurance. The agreement called for an end to collateral and local presence requirements for EU and US reinsurers.¹⁵ It also affirmed 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.¹⁶

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.¹⁷ The agreement also eliminates collateral and local presence requirements for EU and US reinsurers.¹⁸ The agreement encourages supervisory authorities in the US and the EU to exchange information regarding insurers and reinsurers that operate in both markets. Over the

15 'US and EU Sign Covered Agreement on Insurance Regulation', Insurance Journal, available at <https://www.insurancejournal.com/news/national/2017/09/22/465195.htm> (last visited 23 February 2020).

16 id.; see also, Statement of the United States on the Covered Agreement with the European Union (22 September 2017), available at https://www.treasury.gov/initiatives/fio/reports-and-notice/US_Covered_Agreement_Policy_Statement_Issued_September_2017.pdf (last visited 23 February 2020).

17 id.

18 id.

60-month implementation plan, the US and the EU will identify and roll back inconsistent or pre-empted legislation.¹⁹ Finally, the agreement establishes cross-conditionality between provisions as an enforcement mechanism, to ensure equal compliance and equal benefits.²⁰

On 11 December 2018, the US and the UK announced that they had reached terms on a similar bilateral covered agreement, which includes the same material terms as the US and EU agreement, and follows the same implementation plan.²¹

As of January 2019, 48 states had passed legislation to implement revised reinsurance collateral provisions focused on the solvency risk of reinsurers as opposed to their admitted status.²² Additionally, in June 2019, the NAIC announced updates to its Credit for Reinsurance Model Law and Regulation.²³ These changes serve to conform the Model Law and Regulation to the terms of the US-EU and US-UK covered agreements and also enable reinsurers domiciled in NAIC-qualified jurisdictions other than within the EU to take advantage of similar reinsurance collateral reductions.²⁴

Insurance insolvency

Insurance company insolvencies are exempt from federal bankruptcy law. Instead, the rehabilitation and liquidation of insurance companies has been specifically delegated to the states. Thus, domiciliary state laws establish the process for the receivership or liquidation of an insolvent insurance company.

Notably, the insolvency clause standard in almost all US reinsurance contracts may require the reinsurer to indemnify an insolvent insurer's estate for the full amount of any covered claim allowed in the proceeding, despite the fact that the estate in liquidation may actually pay only a fraction of the allowed amount to its policyholder.

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.

19 See Gloria Gonzalez, 'US-EU covered agreement adds clarity but will take time to implement', *Business Insurance* (19 October 2017), available at <http://www.businessinsurance.com/article/20171019/NEWS06/912316622/US-EU-covered-agreement-adds-clarity-but-will-take-time-to-implement> (last visited 23 February 2020); see also Statement of the United States on the Covered Agreement with the European Union, at 1.

20 See *Bilateral Agreement between the European Union and the United States of America on Prudential Measures Regarding Insurance and Reinsurance – Fact Sheet*, US Treasury Department, at 4.

21 See 'Treasury, USTR Finalize Bilateral Agreement with the UK on Prudential Measures Regarding Insurance and Reinsurance', United States Department of Treasury, available at <https://home.treasury.gov/news/press-releases/sm570> (last visited 15 January 2019).

22 NAIC Statement on Covered Agreement on Reinsurance Consumer Protection Collateral, available at https://www.naic.org/cipr_topics/topic_covered_agreement.htm (last visited 23 February 2020). The NAIC has approved seven countries as qualified jurisdictions: Bermuda, Germany, Switzerland, the United Kingdom, France, Ireland and Japan. Reinsurers that are licensed and domiciled in these jurisdictions are eligible for reduced reinsurance collateral requirements. *Id.*; see also NAIC List of Qualified Jurisdictions, available at http://www.naic.org/documents/committees_e_reinsurance_qualified_jurisdictions_list.pdf (last visited 23 February 2020).

23 See NAIC Updates to Credit for Reinsurance Model Law and Regulation, available at https://www.naic.org/Releases/2019_docs/credit_reinsurance_model.htm (last visited 23 February 2020).

24 *id.*

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.²⁵ Examples of direct federal insurance involvement include terrorism risk insurance,²⁶ flood insurance²⁷ and crop insurance.²⁸

Liability Risk Retention Act

In 1986, the US Congress enacted the Liability Risk Retention Act of 1986 (LRRRA). The LRRRA 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.

Federal Insurance Office

The Federal Insurance Office (FIO), an organisation within the US Treasury Department, is responsible for monitoring all aspects of the insurance industry in order to identify issues or gaps in the regulation of insurance companies that could lead to a systemic crisis in the insurance industry or the US financial system. While the FIO does not have any express regulatory authority over the insurance industry, it is responsible for coordinating international insurance agreements, monitoring access to affordable insurance for traditionally underserved communities and reporting to the US Congress about vital issues in the insurance industry.

Financial Stability Oversight Council

The Financial Stability Oversight Council (FSOC) identifies and responds to risks to the financial stability of the US. The FSOC has the authority to subject a 'non-bank financial company', including an insurance company, to supervision by the Federal Reserve if it determines that the company is a 'systemically important financial institution' (SIFI) through a multistage determination process. Once a company is identified as an SIFI, it is subject to enhanced prudential standards, including specific reporting requirements, risk-based capital

25 The examples cited herein of direct US federal government participation in insurance markets are illustrative and not exhaustive.

26 Initially enacted in 2002, the Terrorism Risk Insurance Act of 2002 (TRIA), Pub. L. 107-297, 116 Stat. 2322, was reauthorised in 2007 and 2015, and was most recently extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019. The programme is now authorised to run through the year 2027.

27 Originally enacted in 1968, the National Flood Insurance Program (codified at 42 U.S.C. § 4011) was reauthorised and reformed in 2012 through the Biggert-Waters Flood Insurance Reform Act of 2012, Pub. L. 112-141. On 21 March 2014, the Homeowner Flood Insurance Affordability Act of 2014 was signed into law. Among other things, this 2014 law repealed and modified certain provisions of the Biggert-Waters Act.

28 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.

requirements, liquidity requirements, risk management requirements, leverage limits and credit exposure limits. The FSOC previously designated three insurers as SIFIs, but none of them remain subject to Federal Reserve supervision.²⁹

Nonadmitted and Reinsurance Reform Act – surplus lines and reinsurance

All 50 states allow issuance of surplus lines business by unlicensed or non-admitted insurance carriers. Generally, consumers must use a specially licensed insurance broker and demonstrate that they are unable to find the specified coverage through the admitted market. Once the exceptional need is demonstrated, the risk can be placed with non-admitted carriers.

In situations where the risk placed with a surplus lines carrier is located in multiple states, the exclusive taxing authority with respect to surplus lines and non-admitted insurance policies is in a policyholder's 'home state'. In addition, surplus lines insurance is subject only to the regulatory requirements of the policyholder's home state (except for workers' compensation business) and large commercial insurance purchasers that meet certain conditions may directly access the surplus lines market.

With respect to reinsurance, if an insurer's domicile recognises credit for reinsurance for the insurer's ceded risk, then no other state may deny the credit for reinsurance, provided that the domiciliary state is NAIC-accredited, or has solvency requirements substantially similar to those required for NAIC accreditation. The laws and regulations of non-domiciliary states are also pre-empted to the extent that they (1) restrict or eliminate the right to resolve reinsurance disputes pursuant to reinsurance contractual arbitration provisions, (2) require that a certain state's law shall govern the reinsurance contract, or (3) attempt to enforce a reinsurance contract on terms different than those set forth in the reinsurance contract itself. Finally, the exclusive authority to regulate the financial solvency of a reinsurer is in the reinsurer's domiciliary state.

III INSURANCE AND REINSURANCE LAW

i Sources of law

Each state has both statutory and common law applicable to insurance issues. State common law is a significant source of law for the purpose of resolving disputes. In broad terms, it applies to issues such as legal duties, the interpretation of contracts, procedure and damages. Individual state statutes applicable to insurance, though they vary in breadth and focus, generally regulate insurance companies operating within the state. Common state statutes include provisions requiring companies to be licensed or barring insurers from acting or marketing their products in a deceptive manner.

Under the US Constitution, federal statutes may pre-empt state statutes and laws where they overlap. Thus, a federal statute may pre-empt inconsistent state laws. Federal common law, while fairly narrow in scope, impacts insurance and reinsurance companies indirectly.

29 See Andrew G Simpson, 'Treasury Erases 'Too-Big-to-Fail' Label on Prudential', *Insurance Journal* (18 October 2018), available at <https://www.insurancejournal.com/news/national/2018/10/18/504916.htm> (last visited 23 February 2020).

One example is federal common law relating to the application of the Federal Arbitration Act, which guides decisions on whether policyholders or cedents are bound to arbitrate a dispute with insurers or reinsurers.

ii Making the contract

The requirements for the creation of an enforceable insurance or reinsurance contract mirror those of most written contracts – offer, acceptance, consideration, legal capacity and legal purpose. In practical terms, an application or submission and the tender of the initial premium represent the offer to contract. Acceptance is generally demonstrated through execution of the policy or agreement. Without an offer and acceptance, there is no meeting of the minds and no contract.

Insurance and reinsurance contracts are negotiated and placed both directly and through intermediaries. In either case, prospective policyholders or cedents provide the information requested by the insurance carrier or reinsurer for the placement. If necessary, the insurance carrier or reinsurer's underwriter can (but is not necessarily required to) seek more information. At all times, the prospective policyholder or reinsured generally is under an obligation to disclose all material information relating to the risk being covered.

Following the agreement on terms, the insurance or reinsurance contract is documented. In most individual consumer insurance markets, the insurance policy is initially crafted by the insurance company. In other instances, a manuscript policy may be negotiated.

iii Interpreting the contract

Because of variations among state laws, there are no overarching rules of insurance contract interpretation. In general, the rules of interpretation applicable to commercial contracts apply to insurance policies. State or federal courts that interpret contract provisions typically try to determine the objective intent of the parties. Unambiguous insurance policy provisions are generally enforceable. While these principles apply generally to reinsurance agreements as well, it is important to note that reinsurance disputes are typically viewed through the prism of industry custom and practice. Indeed, in reinsurance arbitrations the arbitrators' charge is often to view the parties' agreement as an 'honourable engagement' and they are often directed to interpret the contract without a need to follow strict rules of law and with a view to effecting the purpose of the contract in reaching their decision.

iv Intermediaries and the role of the broker

Insurance intermediaries, including agents and brokers, play a key role in the US insurance and reinsurance markets. Currently, there are more than 2 million individuals and more than 236,000 businesses licensed to provide insurance services in the US.³⁰

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

30 Producer Licensing and NARAB II, NAIC (12 June 2017), available at https://www.naic.org/cipr_topics/topic_producer_licensing_narab_II.htm (last visited 23 February 2020).

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.³¹

The conduct of insurance intermediaries is regulated through state statutes and laws. Typically, an agent or broker has a duty to faithfully carry out the instructions of its client. Depending upon the circumstances, a heightened ‘fiduciary duty’ may also apply.

v Claims

The laws regarding insurance and reinsurance claims issues vary from state to state. The key issues include notice, good faith and dispute resolution.

With respect to notice, both insurance and reinsurance claims generally require that a policyholder or cedent provide reasonably timely notice of claims or other information. For insurance claims, timely notice is considered a condition precedent to coverage in many states and, in the absence of reasonably timely notice, a claim may not be covered. For reinsurance claims, in some jurisdictions, unless timely notice is stated to be a condition precedent in the reinsurance contract, a reinsurer seeking to avoid a claim on account of late notice must prove that it was economically prejudiced.

Both insurance and reinsurance claims may involve issues of good faith and fair dealing. Insurance companies, for their part, must respond to the claims of their policyholders consistent with contractual good faith and fair dealing requirements. In reinsurance, the duty of utmost good faith applies to both cedents and reinsurers. Thus, while cedents must fully disclose all material information about the ceded risk, for most lines of business reinsurers have a concomitant duty to ‘follow the fortunes’ of their cedents, which requires indemnifying cedents for all businesslike, good faith, reasonable claim payments.

IV DISPUTE RESOLUTION

i Jurisdiction, choice of law and arbitration clauses

A few key issues relating to insurance and reinsurance dispute resolution are (1) the forum in which a suit can or must be brought, (2) the law that will govern the dispute and (3) the dispute resolution process. In that regard, some insurance policies and most reinsurance 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.

31 Depending upon the facts, a broker may also act for the insurance company or reinsurer.

ii Litigation

The judicial system is made up of two different court systems: the federal court system and the state court systems.

In the federal system, there are three levels of courts: the district courts, which are the federal trial courts; the interim appellate courts, called the circuit courts of appeal; and the US Supreme Court, the final appellate court. Only two types of cases are heard in the federal system. The first is cases dealing with issues of federal law. The second is cases between citizens of two different states or between a US citizen and a foreign entity, provided the amount in dispute meets a minimum threshold. In total, there are 94 US district courts throughout the 50 states. There are 13 US circuit courts of appeal, each with separate jurisdictional coverage. There is one Supreme Court. Notably, the right to appeal to the Supreme Court typically is not automatic; the Supreme Court must agree to hear the case.

Typically, state court systems are made up of two sets of trial courts: trial courts of limited jurisdiction (probate, family, traffic, etc.) and trial courts of general jurisdiction (main trial-level courts). Most states also have intermediate appellate courts. All states have one final appellate state court.

Each state has its own rules of evidence for cases tried in its courts. Each state likewise has its own rules of procedure for cases progressing through its court system. The federal district courts, however, have a unified set of evidence rules and a unified set of rules of procedure.

Except in certain limited circumstances, the general rule in the US is that each party pays its own costs of litigation.

iii Arbitration

The most widely used alternative dispute resolution process is arbitration. There are numerous types of insurance and reinsurance arbitrations. The differences between each type generally relate to the following: the number of arbitrators; arbitrator selection procedures; arbitrator neutrality; and the arbitration hearing procedure.

Generally, US insurance and reinsurance arbitrations are conducted before either one arbitrator or three arbitrators. The selection process varies; in some instances, there is a process managed by an independent third party for selection of the entire panel, in other instances, the parties choose and organise the selection process. Two prominent and independent groups that certify arbitrators and in varying degrees organise insurance and reinsurance arbitrations in the US are the American Arbitration Association and the AIDA Reinsurance and Insurance Arbitration Society.

Typically, in the single-arbitrator process, the arbitrator is neutral and often has expertise in the particular type of dispute. Where the arbitration panel consists of three arbitrators, the general process is that arbitrators are either all neutral, or the parties each appoint a single arbitrator and follow a process for selection of a neutral umpire. In the latter process, it is common for both parties to be able to communicate with their appointed arbitrator prior to the hearing, but in the end, party-appointed arbitrators are expected to rule based on their view of the merits of the dispute. Although there are grounds to vacate or modify an arbitration award under the Federal Arbitration Act (or similar state statutes) and the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (also known as the New York Convention), unless there is a prior agreement otherwise, arbitration decisions are considered binding.

In most instances, arbitrators are not bound by strict rules of evidence during the hearing. It is also common for witnesses appearing at an arbitration hearing to be questioned by the presenting party's attorney, the opposing party's attorney and the arbitration panel.

Finally, the general rule is that each party pays its own costs for insurance and reinsurance arbitrations. However, insurance and reinsurance contracts may specify otherwise.

iv Mediation

Most state and all federal courts have adopted mediation processes designed to encourage dispute resolution without a trial. In general, the process is voluntary and the mediator is an independent third party without court affiliation. However, in a number of states, parties in commercial disputes are required to participate in at least one mediation or settlement conference prior to moving forward with trial. In addition, parties to an insurance dispute will often agree to retain a private mediator to help resolve one or more issues.

v Alternative dispute resolution

A range of dispute resolution techniques are used. Beyond arbitration and mediation, alternative dispute resolution procedures include early neutral evaluations, peer review and mini-trials. A number of industries – including the construction, maritime, and securities industries – have adopted these procedures to handle intra-industry claims.

V YEAR IN REVIEW

There were significant developments for the US insurance industry in 2019. While a comprehensive review of developments in the industry exceeds the scope of this chapter, the following is a sampling of the key emerging issues and events that will be on the minds of insurers throughout 2020.

i American Law Institute adopts the first Restatement of the Law, Liability Insurance

In May 2018, the American Law Institute (ALI) approved a final draft of the first-ever Restatement of the Law, Liability Insurance. The Restatement describes itself as a set of guidelines designed to help courts navigate liability insurance law issues. While the ALI has historically published Restatements covering many different areas of the law, the Liability Insurance Restatement was controversial. The controversy that surrounded the adoption of the Restatement continued in 2019, as courts considered whether to utilise and perhaps adopt Restatement provisions, and opponents pushed state legislatures, regulators and courts to ignore or overrule the provisions. Now, the National Conference of Insurance Legislators has spoken out against the Restatement, and several state legislators have similarly responded, both formally and informally.

Several states have reacted with formal measures to lodge objection or prevent use of the Restatement. Ohio recently amended the state insurance statute to provide that the Restatement 'does not constitute the public policy of this state and is not an appropriate subject of notice.' Tennessee also amended its insurance statute to add provisions advocating a 'plain meaning' approach to the determining insurer coverage and defence obligations. North Dakota also approved a bill instructing courts to disregard the Restatement. Finally, the Kentucky House of Representatives adopted a Resolution explicitly opposing the Restatement.

Several other states participated in less formal shows of opposition. This year, the governors of the states of South Carolina, Maine, Texas, Iowa, Nebraska and Utah submitted a joint letter to the ALI stating concern that the Restatement alters fundamental principles of insurance law. Similarly, the Insurance Commissioners of the states of Michigan, Idaho and Illinois wrote to the ALI to express concerns that the Restatement goes beyond the codification of the law and could adversely impact the insurance system.

US insurance professionals will be carefully monitoring responses to these measures over the next year.

ii Connecticut high court affirms decision on the ‘unavailability exception’ to pro rata allocation

The appropriate manner for allocating losses arising from long-tail liabilities (such as environmental contamination or asbestos bodily injuries) is a contested insurance coverage issue. Generally, US courts have recognised two distinct methods for allocating loss. Under the ‘all sums’ allocation method, policyholders can seek coverage for all of their losses under any triggered insurance policy. Under the pro rata allocation method – which is based on the fact that some liability policies provide coverage for loss occurring ‘during the policy period’ – losses that span multiple policy periods are allocated based on each insurer’s relative time on the risk.

Last year, we reported on divergent decisions from New York and New Jersey and noted that additional rulings might help resolve this question. In March 2018, the New York Court of Appeals closed the door on the ‘unavailability exception’ to pro rata allocation in *Keyspan Gas East Corporation v. Munich Reinsurance America, Inc.*³² In *Keyspan*, the New York Court of Appeals sided with the insurers, unanimously finding that because ‘the very essence of pro rata allocation is that the insurance policy language limits indemnification to losses and occurrences during the policy period the unavailability rule cannot be reconciled with the pro rata approach’. In contrast, in June 2018, the New Jersey Supreme Court affirmed New Jersey’s unavailability exception to pro rata allocation in *Continental Insurance Co et al v. Honeywell International Inc.*³³ The *Honeywell* majority found that the unavailability exception was a matter of established law in New Jersey, and that while it ‘would not hesitate to revisit’ this approach if it proved inefficient or unrealistic, this case ‘does not present a compelling vehicle to reconsider our precedent on allocation’.³⁴

In 2019 a decision from the Connecticut Supreme Court affirmed the ‘unavailability of insurance’ exception to time-on-risk pro rata allocation: *RT Vanderbilt Company, Inc v. Hartford Accident and Indemnity Co.*³⁵ *Vanderbilt* also involved long-tail liabilities subject to pro rata allocation and the question of how to treat periods where insurance was purportedly unavailable to cover the risk. Like the New Jersey Supreme Court in *Honeywell*, the *Vanderbilt* court affirmed the appellate decision, ruling that damages and defence costs should not be allocated to any period where insurance was unavailable in the market. In *Vanderbilt*, the court wholly adopted the reasoning of the 2017 appellate decision on this issue. Significantly, the court ruled that the policyholder bears the burden of proving that it was unable to obtain coverage at times when it was generally available in the marketplace. Moreover, the court

32 *Keyspan Gas East Corporation v. Munich Reinsurance America, Inc, et al*, APL-2016-00236 (NY).

33 *Continental Insurance Co v. Honeywell International Inc*, 234 N.J. 23, 188 A.3d 297 (2018).

34 id. at 61.

35 *RT Vanderbilt Company, Inc v. Hartford Accident and Indemnity Co, et al*, PSC-16-0445 (CT).

recognised the potential for an ‘equitable exception’ to the unavailability rule. In the asbestos context presented by the *Vanderbilt* matter, such an exception could arise if the insured had continued to manufacture or distribute asbestos-containing products after it knew the products were hazardous. The court did not find such facts existed and denied the application of the exception and ultimately spread costs across only those periods in which insurance was available.

iii New York court requires non-parties to appear and produce documents before a reinsurance arbitration panel

In *Washington National Insurance Co. v. Obex Group LLC*,³⁶ the US District Court for the Southern District of New York enforced two arbitration summonses issued by a reinsurance arbitration panel and ordered two non-parties to appear before the panel and produce documents required by the panel.

The underlying dispute involved Washington National Insurance Company’s allegation that it was fraudulently induced into a reinsurance agreement with Beechwood Re. In support of evidence sought by Washington National, the arbitration panel issued non-party subpoenas to Obex Group and Randall Katzenstein, requiring them to appear as witnesses at a hearing and to produce documents. Although Obex Group and Katzenstein produced some documents, Washington National asserted that they failed to produce others and the arbitration panel issued two summonses requiring Obex Group and Katzenstein to appear at a hearing in New York City and to bring additional documents, finding that the documents and information sought ‘are relevant’ to the issues in the arbitration and that the summonses ‘should be enforced by a Court of appropriate jurisdiction’. Washington National then filed a petition to enforce the summonses.

Obex Group and Katzenstein moved to dismiss and to quash the subpoenas, arguing in part that the summonses were impermissible pre-hearing discovery and that only the Court, not the arbitration panel, had the power to rule on the merits of their objections. The Court disagreed, noting that the question of whether a summons seeks impermissible pre-hearing discovery is governed by three factors: (1) whether the witnesses ‘were ordered to appear for depositions . . . outside the presence of the arbitrators’; (2) whether the arbitrators ‘heard testimony directly from the witnesses and ruled on evidentiary issues’; and (3) whether the testimony ‘became part of the arbitration record’ such that the arbitration panel used it in determining the dispute. Concluding that the summonses at issue were ‘proper’ under Section 7 of the Federal Arbitration Act, the Court explained: ‘The panel summoned respondents to a hearing before the arbitrators – not to a deposition’ and that the panel’s order ‘stated that the panel was prepared to receive testimony and documentary evidence . . . and the panel was prepared to rule on evidentiary issues,’ with a court reporter ‘ready to record the hearing’ so it would be part of the arbitration record used by the Panel. While Obex Group and Katzenstein argued that Washington National’s willingness to waive the hearing and just receive documents meant that the arbitration panel’s hearing order ‘evidences a subterfuge’, the Court disagreed, averring that it would not ‘prejudice [the] petitioner for its sensible willingness to negotiate.’

Finally, the Court held that even if it had the authority to ‘independently assess’ the materiality of the summonses, courts in the Second Circuit generally declined to exercise

36 *Washington National Ins. Co. v. Obex Group LLC*, 2019 U.S. Dist. LEXIS 9300 (S.D.N.Y. Jan. 18, 2019).

that authority and instead deferred to the arbitrators, and that it would do the same. It was enough for the Court that the arbitration panel ‘stated the evidence was relevant and that the summonses should be enforced by a court of appropriate jurisdiction.’

iv Georgia Supreme Court rules that an insurer can't be sued for failing to settle within policy limits unless it receives a valid settlement offer

In a highly watched case by counsel and insurers following trends in bad faith litigation, the Georgia Supreme Court ruled that an insurer is not responsible for excess coverage or bad faith damages for failing to settle a claim against its policyholder unless it first receives a valid settlement offer.

The case – *First Acceptance Insurance Co. of Georgia Inc. v. Hughes* – involved a vehicle crash that killed one man and injured six others.³⁷ The responsible driver's insurance policy had liability limits of US\$25,000 per person and US\$50,000 per accident. The plaintiff's attorney sent a demand for payment of policy limits, but did not set a deadline by which the insurer was required to respond to the offer, which was required. The matter went to trial and resulted in an award of US\$5.3 million. The plaintiff sought recovery from the insurer for the liability in excess of its policy limits due to its alleged bad faith failure to settle. The Georgia Supreme Court denied the claim and, in a unanimous opinion, found that the insurer did not act negligently or in bad faith when failing to settle. The Court held that ‘an insurer's duty to settle arises only when the injured party presents a valid offer to settle within the insured's policy limits.’ Specifically, the Court reasoned that because the offer in this case did not include a time limit, there was no valid offer.

Insurers hope that this decision will curtail the practice by some plaintiff attorneys of submitting untenable settlement offers, presuming insurers will not accept the offer, in order to later allege that the insurer failed to settle and seek damages for bad faith.

VI OUTLOOK AND CONCLUSIONS

The US insurance and reinsurance markets continued to grow and evolve in 2019. As this growth and evolution will no doubt continue in 2020 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.

37 *First Acceptance Insurance Co. of Georgia Inc. v. Hughes* 305 Ga. 849 (2019).

ABOUT THE AUTHORS

JORGE ANGELL

LC Rodrigo Abogados

Jorge Angell is the senior partner of LC Rodrigo Abogados, and specialises in corporate and commercial law, insurance and reinsurance law, private international law, litigation and arbitration. He graduated in law in 1971. He is a member of the Madrid (Spain) and Lima (Peru) Law Societies.

He frequently acts as an expert in Spanish law before foreign courts, especially English and US courts, and as arbitrator and party counsel in domestic and international arbitrations. He is listed in the arbitrators' roster of the Arbitration Court of the Chamber of Commerce and Industry of Madrid, of the Madrid Law Society and of the Arbitration Court of the Chamber of Commerce of Lima. He is a member of ICC Spanish National Committee, the London Court of International Arbitration and the European-Latin American Arbitration Association.

He was formerly chairman of the Reinsurance Working Party of the International Insurance Law Association (AIDA) and is currently honorary chair. He is a member of the following LPD Committees of the IBA: Business Organisations, Insurance, Litigation (co-chair for 2006 to 2007) and Arbitration. He is also a member of the FDCC and current International Rep for Spain, vice chair of the International Activities Committee and former vice chair of the Reinsurance, Excess and Surplus Lines Section. He is also a member of SEAIDA (the Spanish section of AIDA); and the Credit Insurance Working Party of AIDA, as well as an adjunct member of the International Association of Claim Professionals (IACP); and a member of the Spanish Arbitration Club.

He was nominated in the 2001 *Guide to the World's Leading Litigation Lawyers*, the 2002, 2004, 2006, 2015–2017 and 2019 editions of *Expert Guide: Insurance and Reinsurance*, and the 2013–2018 editions of *Expert Guide: Commercial Arbitration*. He has also been nominated in *Who's Who Legal: Litigation* (2004, 2006, 2014–2019) and *Who's Who Legal: Insurance and Reinsurance* (2011, 2013–2018).

He speaks Spanish and English fluently.

GEORGE ASPROUKOS

Herring Parry Khan Law Office, trading as Ince

George specialises in wet and dry shipping litigation and dispute resolution before the Greek Courts. His main area of expertise is advising leading shipping companies, charterers, operators, P&I clubs and classification societies in claims relating to charterparties, bills of lading, major casualties and marine accidents. He also advises on the establishment of foreign companies in Greece.

PETRA ATTARD

Mamo TCV Advocates

Petra Attard is a senior associate in the corporate and insurance law practice group of Mamo TCV Advocates. She regularly assists clients in the insurance industry on corporate and regulatory matters, advising on corporate governance matters, compliance and regulatory matters, product structuring, financing and M&A transactions.

CARLOS EDUARDO AZEVEDO

Pinheiro Neto Advogados

Carlos Eduardo Azevedo has been an associate of the corporate area of the firm since 2001. Carlos is specifically allocated to the insurance practice and has been involved in the most relevant and recent insurance transactions sponsored by the firm. He is also the main associate involved in the firm's insurtech acceleration programme. Carlos has an extensive transactional background and, through his years at the firm, has assisted local and foreign clients of different industries. He graduated from Pontifícia Universidade Católica de São Paulo in 2003 and holds an LLM degree from The University of Chicago, US (2012). As part of his international professional experience, Carlos was a foreign associate at Kirkland & Ellis LLP in NY/US in 2013.

BRUNO BALDUCCINI

Pinheiro Neto Advogados

Bruno Balduccini has been a partner since 2001 in the corporate area of the Pinheiro Neto Advogados office in São Paulo. His fields of expertise are banking regulations, business law, corporate law, financing, investments, M&A, exchange controls, credit cards, insurance and reinsurance. In addition to his practice in Pinheiro Neto Advogados, he has been a standing member of the São Paulo Lawyers Institute since 2004, where he participates in the banking law committee. Mr Balduccini graduated with an LLB from the Pontifical Catholic University of São Paulo (1992), and holds a master's degree in international banking law from Boston University (1998). He was admitted to the Brazilian Bar Association in 1993. Mr Balduccini was a foreign associate at Sullivan & Cromwell in New York for one year between 1998 and 1999. Mr Balduccini has been consistently named a leading lawyer by *Chambers Latin America*, *Chambers Global*, *Latin Lawyer*, *The Legal 500*, *Who's Who Legal* and *Advocacia 500*.

JOHN BARLOW

HFW

John 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, which assists insurers, brokers and MGAs wishing to establish a presence in the DIFC. John and his team's work includes advising on set ups and compliance and guides clients from the initial approach to the Dubai Financial Services Authority to the obtaining of the required licence.

In addition to his claims handling experience and dispute resolution, John has considerable experience in the development of leading financial institution insurance products that encompass the coverage of exposures of IFAs, banks, investment banks and sovereign financial institutions. John has developed market leading products in connection with bank operational risk programmes including products that address regulatory capital issues for banks, traders and commodities companies.

John has considerable experience of political risk, trade credit, trade finance, sovereign guarantee and protracted payment insurances, as well as the development of captive insurance programmes.

John is qualified in England and Wales.

PELIN BAYSAL

Gün + Partners

Pelin Baysal has been with the firm since 2006 and has been a partner since 2013. She is chair of the firm's insurance and reinsurance, and co-chair of the dispute management, and corporate and M&A practices.

She has acted as party counsel in and advised on numerous commercial and corporate disputes before the Turkish courts and ICC arbitration, involving M&A disputes, shareholders' disputes, joint venture disputes, distribution agreements, compensation cases, white collar crimes, insurance disputes, directors' and officers' liability disputes and enforcement of foreign court judgments and arbitral awards.

Pelin has acted for numerous reinsurers and insurers with respect to various types of insurance under Turkish law, and advised on the litigation and arbitration aspects thereof. She is also experienced in handling coverage issues with respect to different types of policies including, but not limited to, general third-party liability, professional third-party liability, credit insurance, fire all-risks, mechanical breakdown, construction all-risks, D&O and Bankers Blanket Bond policies. She regularly advises global insurance companies with regard to their entry in the Turkish market, and assists insurance companies on regulatory matters, particularly compliance. She advises national and international insurance and reinsurance companies on the localisation of insurance and reinsurance policies in Turkey. She has vast experience in insurance litigation and arbitration. In addition, she is the only listed lawyer from Turkey in *Who's Who Legal: Insurance & Reinsurance*. The publication, which is based upon an independent survey of general counsel and private practice lawyers, profiles the foremost practitioners in the insurance and reinsurance community. They noted that Pelin Baysal is highly sought after by clients, who commend her 'sharp and comprehensive analysis' as well as 'the clarity of her advice' when it comes to insurance disputes.

NEIL BERESFORD

Clyde & Co LLP

Neil Beresford is a specialist in high-value Colombian litigation. He has worked in Colombia for almost 20 years and runs cases in almost every jurisdiction including civil courts, administrative courts, criminal courts, the Constitutional Court, arbitration tribunals, the Controller's Office, the Superintendence of Industry and Commerce and the Prosecutor's Office.

Neil works with international reinsurers doing business in Colombia and also with Colombian companies doing business abroad. He has worked with Colombian insurers on the structure of global property programmes for multilatin corporations.

In recent years, Neil's practice has focused on the Controller's Office. He is also representing insurers and reinsurers in a long-running insurance dispute relating to the Central Bank of Colombia and its role in the collapse of the UPAC lending system in the 1990s.

Neil is actively involved in the development of Colombian insurance and reinsurance law and speaks regularly on the subject.

NICOLAS BOUCKAERT

Kennedys

Nicolas Bouckaert is a partner at Kennedys, whose Paris office he co-founded in October 2017. He is qualified as a French *avocat à la cour* and a solicitor in England and Wales, having studied in England (University of Oxford and University of York) and trained at a magic circle firm in London.

Nicolas is regularly instructed in complex and international disputes, both before French courts and arbitration tribunals. He acts for leading insurers and reinsurers, brokers, major policyholders and manufacturers. His practice includes coverage disputes (insurance and reinsurance), defence work, subrogation claims and general commercial litigation. It spans several key industry sectors (aerospace, construction, real estate, finance and manufacturing), with a particular focus on product and professional liability, and political violence and trade credit risks. Nicolas also has significant experience of complex court-appointed technical investigations, specifically relating to industrial risks.

Nicolas publishes regularly on insurance and reinsurance law and is, inter alia, one of the co-authors of *The International Comparative Legal Guide to Insurance & Reinsurance*, *The Class Actions Law Review* (3rd ed.) and the *FARAD Private Life Insurance Handbook* (2nd ed.). He is bilingual in English and French, and also speaks Italian. He is a member of the International Insurance Law Association (AIDA), the Insurance and Reinsurance Legacy Association (IRLA), the Association for the Management of Risk and Assurance of Enterprise (AMRAE), the British Association of Insurance Law (BILA) and the Franco-British Lawyers Society (FBLS).

GRÁINNE CALLANAN

Matheson

Gráinne Callanan is a partner in the financial institutions group and leads Matheson's Cork office. Gráinne advises a wide range of leading domestic and international financial institutions doing business in and from Ireland, including life and non-life insurance and reinsurance companies, captive insurers and intermediaries on corporate transactions, regulatory and compliance and corporate governance.

Gráinne has extensive expertise in the areas of new authorisations, portfolio transfers, cross-border mergers, corporate restructurings, distribution arrangements and health insurance. She has advised on a wide range of innovative transactions in the insurance market in recent times and has advised clients on a number of significant acquisitions of closed books of life insurance businesses.

Gráinne lectures at the Law Society of Ireland and the Insurance Institute of Ireland. Gráinne is also a member of the Cork Financial Services Forum.

MICHAEL T CAROLAN

Troutman Sanders LLP

Michael T Carolan is a partner in Troutman Sanders' insurance and reinsurance group, where he concentrates his practice on litigating, arbitrating and resolving domestic and international disputes involving reinsurance, complex insurance coverage and brokers' liability. He also counsels clients on regulatory issues, business and settlement strategy, insolvency and liquidation issues, and bad faith exposures. Michael has represented company and intermediary clients across the life, health, and property and casualty markets in litigation and arbitration in state and federal courts as well as a variety of US and foreign arbitral settings. He has also written on reinsurance issues related to credit default swaps and financial products. Michael received his JD from the George Washington University Law School in 2006.

MARTHA E CONLIN

Troutman Sanders LLP

Martha E Conlin is a partner in Troutman Sanders' insurance and reinsurance group. Martha has extensive experience in the insurance and reinsurance industry covering everything from general liability, product liability, technology and media liability and construction to property, asbestos, environmental, reinsurance, mass tort and contribution claims. Martha received her JD from Northwestern University School of Law and her BA from St. Mary's College.

SHARON DALY

Matheson

Sharon Daly is a partner and heads the commercial litigation insurance team, which is described by *The Legal 500* as 'second to none' with Sharon being personally commended for her ability to respond creatively to complex disputes.

Sharon and her team have been involved in some of the most significant commercial litigation before the Irish courts in the past 10 years, including defending a major financial institution in a multibillion, multi-jurisdictional dispute arising from investment in Bernard

L Madoff's business. Sharon also acted for insurers in the largest property damage dispute to come before the Irish courts in relation to the liability of hydroelectric dams and flood damage arising therefrom.

Sharon and her team advise a wide range of clients on insurance issues including coverage, policy disputes and defence of large complex claims. Sharon and her team also advise on regulatory issues for insurers and support commercial transactions for insurers buying and selling their businesses.

As a member of the Matheson's Brexit Advisory Group and a council member of the Dublin Chamber of Commerce, Sharon is working with government and other key stakeholders to encourage UK-based multinationals to relocate to Dublin in order to facilitate the growth of Dublin as a leading global business centre, building on Brexit and beyond.

CHEN JUN

AnJie Law Firm

Chen Jun is a partner at AnJie Law Firm. She has great experience in insurance compliance. She serves as legal counsel to many insurance institutions, such as Anbang Insurance Group Co, Ltd, China Joint Property Insurance Co, Ltd, Sunshine Property Insurance Co, Ltd, China Huanong Property & Casualty Insurance Co, Ltd and Generali China Insurance Co, Ltd. She also specialises in the utilisation of insurance funds.

Chen Jun practises in insurance and reinsurance, and corporate compliance. Her educational background includes Heilongjiang University, School of Law (LLM) and Southwestern University of Finance and Economics, School of Economics (LLB).

SIMON COOPER

Ince

Simon Cooper has over 35 years' experience of advising clients in the London and international insurance and reinsurance markets. He has extensive experience of acting in large-scale disputes in the English Commercial Court and appellate courts, in ad hoc arbitrations and in overseas jurisdictions. Many of these disputes have involved multiple parties and complex issues of fact and law. He also has comprehensive experience of mediation and other forms of alternative dispute resolution.

Mr Cooper's practice has included most areas of non-marine insurance and reinsurance, including PI and cyber, property, and space risks. He is recommended in various guides including *Chambers Guide* (in which he is recognised as a Notable Practitioner) and *The Legal 500*. He is a member of the IUA clauses subcommittee and edited the second edition of *Reinsurance Practice and the Law*. He writes and lectures frequently on insurance and reinsurance law.

JOHN DYKSTRA

Maples Group

John Dykstra is a partner in the finance team at Maples and Calder, the Maples Group's law firm, in the Cayman Islands. He specialises in structured finance, investment funds and corporate and commercial transactions, with an emphasis on catastrophe bond transactions and other insurance-linked securities, CLO transactions, securitisations, derivatives,

structured debt and repackagings. John is recommended for insurance and reinsurance by *Who's Who Legal* and is noted in *Chambers Global* and *The Legal 500* for catastrophe bond transactions.

MARIKA EASTWICK-FIELD

Russell McVeagh

Marika Eastwick-Field is a commercial litigation specialist with particular expertise in insurance, banking and financial markets, and real estate litigation.

Marika represents clients in a variety of commercial disputes, both in the courts and in arbitrations. She also advises on a range of contentious and non-contentious matters including contract, company and securities law, banking, leasing and insurance.

MARKUS EICHHORST

Ince

Markus Eichhorst joined Ince 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. He has significant experience in negotiating, litigating and arbitrating insurance, commercial and shipping disputes, such as marine and non-marine coverage disputes under P&I, D&O and other liability policies as well as property insurance policies. Mr Eichhorst is an officer of the insurance committee of the International Bar Association. He is especially recommended for arbitration and mediation in the *Best Lawyers* survey 2013.

ANTOINE FONTAINE

Bun & Associates

Antoine Fontaine is Bun & Associates' practice leader for the insurance, labour, tax, and healthcare 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 assisted the first insurance broker, agent, and fully privately owned life insurance company to enter into Cambodia; as well as the first three micro-insurance companies and many other insurance brokers and most of the international life insurers.

He has worked in Cambodia for 20 years. He co-founded Bun & Associates after working for AXA Insurance as a 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 Asia-Pacific 2019* as a wonderful lawyer, very pragmatic, realistic, and very committed and available in cases of urgency for his clients. He is a member of the Paris Bar and the former chair of the French Cambodian Chamber of Commerce, and he currently chairs the French Foreign Trade Adviser Committee in Cambodia appointed by the French prime minister and legal counsel of the French Embassy in Cambodia. He is fluent in French and English, and conversant in Khmer.

ANDRÉS GARCÍA

Clyde & Co LLP

Andrés García is a dual qualified England and Wales and Colombia associate at Clyde & Co in London. Andrés graduated from Los Andes University in Bogotá and holds a master's degree in administrative law from Pontifical Xavierian University and an LLM from University College London.

Before joining Clyde & Co, Andrés practised at Palacios Lleras (2010–2013) and Arrieta Mantilla y Asociados (2015–2017), two of the most prestigious boutique law firms in Colombia, where he acquired a wide experience in commercial and administrative litigation.

NATASCHA GARO

Schönherr Rechtsanwälte GmbH

Natascha Garo joined Schönherr in March 2019 as an associate in the insurance practice group. Previously she worked for insurers in various sectors and the Austrian Insurance Association as an expert for legal expenses insurance for many years. After studying law in Vienna (graduating in 1996), she completed a course in insurance economics at the Vienna University of Economics and a course in General Management Competences at the University of Krems. She passed the trade licence for insurance broker and after several years of practice she passed the Bar exam in 2007.

DAVID GERBER

Clayton Utz

David Gerber is a partner in the Sydney office of Clayton Utz. He is a specialist insurance lawyer with experience in both general and life insurance, including reinsurance. In 2014, he was named a 'Rising Star' for insurance and reinsurance in *Expert Guides: Insurance and Reinsurance*. According to *Best Lawyers*, for the past seven years he has been selected by his peers for inclusion in *The Best Lawyers in Australia* in the area of insurance law. From 2016 to 2020, he has been ranked by *The Legal 500 Asia Pacific* as one of Australia's 'Leading Individuals' in insurance. *Chambers and Partners* ranks Mr Gerber as a Band 4 Insurance practitioner in the Asia-Pacific region.

Mr Gerber helps clients both with their corporate insurance issues and resolving disputes, including insurance coverage disputes. This includes advice on policy interpretation, insurance claims, indemnity and risk issues, insurance regulation, product development and distribution, captives, reinsurance, portfolio transfers, the insurance aspects of major projects, M&A and other commercial transactions, and regulatory investigations. He also acts for the insurance industry in corporate restructuring and insurance-linked securities transactions, alternative risk transfer arrangements, regulatory engagement and enforcement matters, and has advised local and international clients on regulatory compliance.

He holds bachelor of arts and bachelor of laws degrees from the University of Natal, South Africa. He is admitted to practise in the Supreme Court of New South Wales and the High Court of Australia.

LARS GERSPACHER

gbf Attorneys-at-law Ltd

Lars Gerspacher is a partner at gbf Attorneys-at-law Ltd and focuses his activities on the areas of insurance and reinsurance law, aviation and maritime law, and transport and trade law.

He is on hand to advise and give support to his clients whenever needed, conduct international proceedings and represent clients in litigation or arbitration in various lines of business (such as marine, aviation, D&O liability, E&O, fidelity and other financial lines). He also specialises in policy drafting and regulatory work for the insurance and reinsurance industries, where he advises upon any aspect of regulation by the Swiss Financial Market Authority. He handles authorisations in Switzerland and Liechtenstein, including the drafting and submission of required business plans to the competent regulators. In particular, he advises reinsurers in re-domesticating their business to Switzerland.

Mr Gerspacher is recognised in, among others, *Who's Who Legal: Insurance & Reinsurance* as one of the leading practitioners in the above-mentioned fields.

SHANE GIBBONS

HFW

Shane joined the insurance and reinsurance litigation team in Dubai in January 2018 as an associate. Shane advises both insurer and reinsurer clients on claims, defence work and coverage issues. He also has experience of acting in complex commercial litigation cases before the English High Court, Irish High Court and DIFC Courts as well as assisting with local court litigation. Shane is a qualified lawyer in Ireland and is eligible for admission to the roll in England and Wales.

DIMITRIS GIOMELAKIS

Herring Parry Khan Law Office, trading as Ince

Dimitris specialises in wet and dry shipping litigation and dispute resolution. He has extensive experience advising major local and international shipping companies, clubs, operators, charterers, underwriters and classification societies in litigation before the Greek courts. He has considerable experience in all aspects of Greek civil law and procedure and his expertise extends to litigation with government authorities arising from fines and tax and social security disputes. He also represents big insurance companies before the Greek courts.

ALESSANDRO P GIORGETTI

Studio Legale Giorgetti

Alessandro P Giorgetti is a graduate of Milan State University, where he studied private international law. He both graduated and was admitted to the Milan Bar in 1983. He subsequently studied commercial law at Robinson College, Cambridge University. He is a member of the special Bar for the High Courts in Italy.

Mr Giorgetti practises insurance and reinsurance law, and has acted as principal consultant or litigator in some of the major Italian cases.

He works in English, French and Italian. He is an active member of the International Association of Defense Counsel, of which he has been a past international vice president; the Defence Research Institute; and the International Bar Association. Mr Giorgetti also belongs

to the Association of Fellows and Legal Scholars of the Center for International Legal Studies in Salzburg, and 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. Giuffè (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 Università degli Studi di Milano, 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 Graziadei 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 Association of Foreign Insurance Companies. Mr Gonçalves has been consistently named a leading lawyer by *Chambers Latin America*, *Chambers Global*, *Latin Lawyer*, *The Legal 500*, *Who's Who Legal* and *Advocacia 500*.

YVES HAYAUX-DU-TILLY

Nader, Hayaux & Goebel

Yves Hayaux-du-Tilly is a partner of the Mexican independent law firm Nader, Hayaux & Goebel, the only Mexican law firm with an office in London.

Yves specialises in insurance and reinsurance, both in contentious and non-contentious matters. Yves currently represents the following Mexican affiliate insurance companies on an ongoing basis in transactional work, mergers and acquisitions, product development and general regulatory, corporate governance and compliance-related matters: AXA Seguros Mexico, Assurant Daños Mexico, Assurant Vida Mexico, BUPA Mexico, Cardif Mexico Seguros de Vida, Cardif Mexico Seguros Generales, Dentegra Seguros Dentales, Der Neue Horizont Re, Genworth, Grupo Nacional Provincial, Grupo Sudamericano de Inversiones (Grupo SURA), LandAmerica Mexico (in liquidation), Mapfre Asistencia, MetLife Mexico, Panamerican Life Mexico, Seguros Azteca, Seguros Principal, Principal Pensiones, Prudential Seguros Mexico and Zurich Mexico.

Yves also represents Mexican and foreign insurance and reinsurance companies, and has experience in arbitration and mediation.

Yves is former chairman, vice chairman and board member of the Mexican chapter of International Insurance Law Association (AIDA), former vice chairman of Ibero-Latin American Committee of AIDA (CILA), and was responsible for establishing the Mexican chapter of the Insurance and Reinsurance Arbitration Society (ARIAS Mexico). He is also a member of the presidential council of AIDA and 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 special counsel 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.

DANIEL HÖHNL

Schönherr Rechtsanwälte GmbH

Daniel Höhnl has been an associate in Schönherr's Vienna office since 2016 and his main area of practice is insurance. Daniel graduated from the University of Vienna (Mag. iur. 2014). Before joining Schönherr as an associate he worked as a paralegal in Schönherr's insurance team, and worked as a summer intern and paralegal in well-known national law firms in Vienna.

TOM HUNT

Russell McVeagh

Tom Hunt is a corporate finance, financial regulation 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.

SEBASTIAN JACKWERTH-FEIGE

Schönherr Rechtsanwälte GmbH

Sebastian Jackwerth-Feige has been with Schönherr since 2018 and his main area of practice is insurance law. Before joining the insurance team, he worked for two national law firms, and as a legal technology employee at Freshfields Bruckhaus Deringer LLP. Sebastian graduated from University of Vienna (Mag. iur.). After completing his studies, he completed his court practice at the Vienna Higher Regional Court.

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 1,500 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.

THOMAS J KINNEY

Troutman Sanders LLP

Thomas J Kinney is an associate at Troutman Sanders in the insurance and reinsurance group. His practice involves litigation, arbitration, and counselling on a wide variety of insurance and reinsurance issues, and includes pre-dispute advice as well as insurer and reinsurer representation in complex disputes. Tom received his JD from the George Washington University Law School and his BA, with honours, from the University of New Hampshire. Prior to joining the firm, Tom clerked for the Honourable Noel T Johnson and the Honourable William C Nooter of the District of Columbia Superior Court.

SIGRID MAJLUND KJÆRULFF

Poul Schmith

Sigrid Majlund Kjærulff acts for Danish and international clients in the insurance industry, for the public sector and the Danish government. Having worked in the insurance industry as a claims manager, Sigrid is focused on matters involving the defence of liability, policy-based disputes and coverage issues, including within the maritime sector. Sigrid also has in-depth knowledge of public insurance schemes, particularly workers' compensation and patients' insurance. Sigrid's dispute resolution practice includes leading cases before the High Courts of Western and Eastern Denmark and numerous cases before the Danish City Courts. Sigrid has the right of audience before the Danish Supreme Court.

PETER KONWITSCHKA

Schönherr Rechtsanwälte GmbH

Peter Konwitschka is a partner of Schönherr, Vienna, where he specialises in insurance law, corporate law and M&A. He has been a member of the Vienna Bar since 1999 and graduated from the University of Vienna (Dr. iur. 1997). Peter is a lecturer at the University of Vienna, Anwaltsakademie and Research Assistant at the University of Vienna. Furthermore, he has authored several articles on corporate, antitrust and insurance law. Peter has acted on behalf of various insurance companies in regulatory proceedings with the Austrian Financial Market Authority (FMA). A focus of his activity has also been insurance supervisory law, the structuring of insurance distribution channels under the freedom to provide services and ongoing advice for the Austrian Insurance Association (VVO) with regard to all kinds of life insurance products.

PETER KULLGREN

Advokatfirmaet Schjødt AS

Peter Kullgren is a partner in Schjødt's finance and capital markets practice, and assists Swedish and foreign financial companies, banks, insurance companies (both direct insurance and reinsurance), insurance intermediaries, brokerage firms, funds and payment service providers. Peter's specialist expertise and experience in both financial markets and regulatory affairs means that he is qualified to assist his clients in the best possible way.

DANIEL LACKNER

Schönherr Rechtsanwälte GmbH

Daniel Lackner has been associate at Schönherr since 2018. Daniel's main area of practice is insurance. He worked for a small national law firm in Vienna during his law studies. Daniel graduated from the University of Vienna in 2016 (Mag. iur.), where he earned additional degrees in corporate and civil law, mediation and alternative forms of dispute resolution, and human rights. Thereafter he completed his clerkship and worked as an associate at a national law firm in Vienna before joining Schönherr.

CAROLINE LICHTENBERG

Schönherr Rechtsanwälte GmbH

Caroline Lichtenberg has been an associate with Schönherr since 2018. During her law studies she has worked for several years in various companies within the financial services industry. She graduated from law school in 2016 (LLM). Afterwards she worked as a judicial clerk and as an associate within a consulting company.

MARIANA MAGALHÃES LOBATO

Pinheiro Neto Advogados

Mariana Magalhães Lobato is an associate from the corporate area that specialises in insurance and reinsurance. Mariana primarily focuses on transactional and regulatory insurance, advising national and international clients. She is also an active member of the firm's insurtech acceleration programme. Mariana graduated from Fundação Getulio Vargas in 2017 and is currently attending the MBA programme specialised in insurance and reinsurance law at Escola Nacional de Seguros in São Paulo.

DARREN MAHER

Matheson

Darren Maher is a partner and head of the financial institutions group at Matheson. He has advised a wide range of leading domestic and international insurance and reinsurance companies on all aspects of insurance law and regulation, including establishment and authorisation, development and distribution of products, compliance, corporate governance and reorganisations including cross-border mergers, schemes of arrangement, portfolio transfers, and mergers and acquisitions. Darren is a member of the firm's Brexit Advisory Group, and is advising a significant number of the world's leading financial services firms on their plans to establish a regulated subsidiary in Ireland in order to maintain access to the EU Single Market in advance of the Brexit date.

Darren frequently publishes articles in insurance and reinsurance publications and is co-author of the Irish chapter of PLC's *Cross-border Insurance and Reinsurance Handbook*. Darren lectures at the Law Society of Ireland and the Insurance Institute of Ireland.

NIKOLAOS MATHIOPOULOS

Herring Parry Khan Law Office, trading as Ince

Nikolaos advises P&I clubs, shipowning companies and charterers and represents them before Greek courts on a wide range of wet and dry shipping disputes. He is experienced in claims arising in relation to charterparties, bills of lading, cargoes, shipbuilding contracts, sale and purchase agreements and labour disputes, as well as accidents at sea and maritime casualties. He also advises clients on insurance and reinsurance matters and their entry into commercial contracts including sale, lease and services agreements.

APRIL MCCLEMENTS

Matheson

April McClements is a partner in the insurance and dispute resolution team. She is a commercial litigator and specialises in insurance disputes.

April advises insurance companies on policy wording interpretation, complex coverage disputes (in particular relating to financial lines policies), D&O claims, cyber, professional indemnity claims, including any potential third-party liability, and subrogation claims. April also manages professional indemnity claims for professionals, including insurance brokers, architects and engineers, for a variety of insurers.

April has been involved in obtaining High Court approval for various insurance portfolio transfers or schemes of arrangement arising from reorganisations or mergers and acquisitions involving life, non-life and captive insurers. April also works in the area of general commercial litigation with a particular focus on contractual disputes, most of which are litigated in the Commercial Court. She is also a strong advocate of ADR and has acted for clients in mediation and arbitration.

April is a member of the Law Society of Ireland, the Insurance Institute of Ireland and the British Insurance Law Association. She has contributed to various industry publications and has participated in seminars as a speaker on insurance issues. She is a lecturer on the Law Society of Ireland Insurance Law Diploma course.

JOONAS MYLLYNEN

Advokatfirmaet Schjødt AS

Joonas Myllynen is an associate in Schjødt's finance and capital markets practice, and assists Swedish and foreign financial companies, banks, insurance companies (both direct insurance and reinsurance), insurance intermediaries, funds and payment service providers.

ILGAZ ÖNDER

Gün + Partners

Ilgaz Önder has been a senior associate at Gün + Partners since 2013. His practice focuses on insurance and reinsurance, corporate and M&A, and dispute management.

He mainly concentrates on commercial litigation in various fields, including insurance and reinsurance, where civil law and criminal law often overlap. Within the scope of his practice, Ilgaz not only assists clients in disputes subject to adjudication, but also oversees debt collection procedures following high-profile disputes. He provides the clients with legal advice on employment law and in-depth analysis of business immigration.

WILLIAM C O'NEILL

Troutman Sanders LLP

William C O'Neill is a partner in Troutman Sanders' insurance and reinsurance group. Bill is recognised as a top insurance and reinsurance attorney in *Chambers USA*, *Euromoney's Guide to the World's Leading Insurance and Reinsurance Attorneys* and *Who's Who Legal: Insurance & Reinsurance*. He regularly handles arbitrations and litigations involving many lines of business, including property and casualty, life, trade credit and health insurance. In the past several years, he has successfully taken significant life, property and casualty, and health disputes through hearing and final award, while resolving numerous additional disputes on favourable terms short of hearing. Bill often counsels clients regarding business, strategy and regulatory matters. Bill received his JD from Cornell Law School in 1997.

AYAKO ONISHI

Nishimura & Asahi

Ayako Onishi is an associate at Nishimura & Asahi and was admitted to practise in 2018. Ayako's areas of practice include capital market and insurance.

HARRY ORAD

Gross Orad Schlimoff & Co

Harry Orad began his legal career as a commercial lawyer specialising in corporate and property law. He also served as a municipal court justice. In 1983 he joined the highly acclaimed National Fraud Unit of the Israeli Police, rising to the rank of chief superintendent, where he investigated complex financial institution fraud and white-collar crimes. Since 1986 Harry has specialised in insurance and reinsurance law. He drafted some of the first D&O policies in Israel and later redrafted these policies to comply with new legal provisions. He has lectured on corporate governance issues in Israel and abroad. Between 1988 and 1989, Harry worked in London as a consultant to one of the major insurance law firms.

Harry's expertise in insurance law includes D&O liability, banking insurance (bankers' blanket bonds), financial institutions, crime insurance, credit insurance, product liability, and pollution and contamination.

Harry has acted for underwriters and insurers worldwide on complex financial insurance matters and has been inducted into the Hall of Fame of *The Legal 500*.

MARILENA PAPAGRIGORAKI

Herring Parry Khan Law Office, trading as Ince

Marilena specialises in wet and dry shipping litigation and dispute resolution. She advises major local and international shipping companies, clubs, operators, charterers, underwriters and classification societies in litigation before the Greek courts. Marilena brings a thorough understanding of the broader regulatory framework of international law to her practice, having a background in shipping, trade, insurance and investment.

MONA PATEL

Ince

Mona Patel is a partner within Ince's corporate practice. She is a transactional corporate and commercial lawyer with over 18 years' experience. Working for both UK and international clients, in the insurance sector she has acted for insurers, brokers and claims handlers. Over the years she has advised on a number of cross-border acquisitions, disposals, joint ventures, management buyouts and buy-ins, and restructurings including applicable regulatory issues (e.g., authorisation, Section 178 applications and approval/controlled functions). She also has a broad commercial practice assisting insurance as well as commercial clients with their commercial contracts and intellectual property.

Ms Patel also works for clients in a number of other business and industry sectors including energy, shipping, aviation, international trade, e-commerce and technology. She is recommended in various publications including *The Legal 500* (where she is recognised as a Next Generation Partner) and *Acritas* (where she is an Acritas Star Stand Out Lawyer).

JULIA PERIC

Schönherr Rechtsanwälte GmbH

Julia Peric has been an associate at Schönherr since 2018. As a member of the insurance practice group, her main areas of practice are insurance law and civil law. Before joining Schönherr, she gained experience in the field of corporate law as an associate at another national law firm. Julia holds degrees from the University of Vienna (Mag. iur. 2014) and University of Kent (Diploma of Law 2013). She is fluent in German, English and Croatian.

PETER ROGAN

Ince

Peter's legal career spans over 40 years, during which time he was widely recognised as a leading authority in insurance and reinsurance law having been consistently identified by *Chambers and Partners* and *The Legal 500* as one of London's leading practitioners. Peter was

the senior partner of Ince & Co between 2000 and 2008 and since his retirement from the partnership has continued to advise on a consultancy basis and most recently acted as interim chair of Ince's board leading to the merger with Gordon Dadds.

Peter sits on the board of Gordon Dadds PLC and is also on the panel for JAMS Inc in London and New York as an arbitrator and mediator.

RICARDO ROZAS

Jorquiera & Rozas Abogados

Ricardo Rozas is a partner at Jorquiera & Rozas Abogados. He is very experienced in marine and non-marine insurance and reinsurance topics, including assisting the global reinsurance market on a regular basis and in some of the biggest cases in Chile's insurance history. Among other things, he advises in all the related areas, including but not limited to policy coverage advice, liability defence and assessment, wordings and policy structures, and dealing with the Chilean compulsory adjustment procedure and the Chilean regulator. He also focuses on the industrial sector in respect of property or business interruption and liability covers, and has broad experience in a variety of complex disputes and litigation with both local and international dimensions.

Mr Rozas has been awarded with the ILO Client Choice Awards 2011 and 2020, selected for inclusion in *Who's Who Legal: Insurance & Reinsurance* (2011–2016 and 2019), and recommended among 'Leaders in their Field' for *Chambers Latin America* 2014. He is a past chair of the maritime and land transport committee of the International Bar Association (IBA). In addition, he is member of the insurance committee of the IBA; of the maritime committee of the International Bar Association; of the Latin American Maritime Law Institute; of the International Association of Insurance Law; and of the Chilean Maritime Law and Bar Associations.

He graduated from the School of Law of the Catholic University of Chile (LLB) and holds an LLM from Southampton University, 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 Rubio has worked on high-value Colombian litigation for the past 12 years. She has extremely close ties with the Colombian insurance and reinsurance market, and experience of almost every jurisdiction in Colombia, from the civil courts to the Constitutional Court, the Prosecutor's Office, the Superintendence of Industry and Commerce, and the Controller's Office.

Raquel advises global corporations doing business in and out of Colombia. She is currently advising a Colombian energy company on issues arising from a wind farm development in Central America. Last year, she advised a Colombian insurer on its Hurricane Harvey exposures.

Raquel has particular experience before the Controller's Office. She is involved in almost 20 active cases, including a US\$6 billion corruption investigation that is the largest case ever heard in Colombia.

Raquel is actively involved in the development of Colombian insurance and reinsurance law and was a speaker at the 2018 Fasesolda conference in Cali.

MIGUEL DUARTE SANTOS

Gouveia Pereira, Costa Freitas & Associados, Sociedade de Advogados, SP, RL

Miguel Duarte Santos is a managing associate at Gouveia Pereira, Costa Freitas & Associados, Sociedade de Advogados, SP, RL – GPA Law Firm, working in the areas of insurance, banking, finance and securities law.

He specialises in insurance and banking law, with eight years of experience advising and representing insurance companies, claims representatives and insurance brokers (national and foreign) on the applicable supervisory and regulatory provisions of the Fourth Anti-Money Laundering Directive, the General Data Protection Regulation, consumer protection, complaints management, conclusion of distance contracts, and other applicable legal and regulatory frameworks.

Miguel also advises on the drafting, conclusion and performance of insurance contracts and ensures the judicial follow-up of legal actions and arbitration proceedings concerning life and non-life insurance, as well as capitalisation operations.

He has significant experience in assisting national and international companies on access to the Portuguese insurance market, namely on the authorisation procedures via freedom of establishment and freedom to provide services rights, as well as on the relevant legal and regulatory provisions for the rendering of the insurance activity.

Miguel has also published several scientific papers on related areas.

TAKAHIRO SATO

Nishimura & Asahi

Takahiro Sato is an associate at Nishimura & Asahi and was admitted to practise in 2010. Takahiro's practice areas include insurance and structured finance transactions.

MARGUERITA SEDRATI-MÜLLER

Schönherr Rechtsanwälte GmbH

Marguerita Sedrati-Müller joined Schönherr as an attorney at law in April 2018 after spending several years in a national law firm in Vienna. Marguerita has more than six years of experience as a lawyer, mainly focusing on insurance law as well as dispute resolution. She specialises in insurance contract, insurance regulatory and distribution law, and mainly advises national and international insurance undertakings on product development (e.g., D&O, cybercrime) and distribution matters. Marguerita also represents clients in court in all insurance-related disputes as well as civil law matters. Marguerita completed her law degree (Mag. iur, 2005) as well as her bachelor's degree in communication science and is an admitted mediator with the Austrian Ministry of Justice. She is a lecturer at the Austrian imh Institut, and is also author of various articles on insurance regulatory and insurance contract law as well as civil procedure.

IRINA STOEVA

Stoeva, Tchompalov & Znepolski

Irina Stoeva has over 25 years of experience in insurance law and in all forms of dispute resolution related thereto, as well as in corporate and commercial law. She has also extensive experience in healthcare and pharmaceutical, data protection, employment, and public procurement.

Irina co-founded Stoeva, Tchompalov & Znepolski Attorney Partnership in November 2017, after having worked for 13 years as a partner at Stoeva, Kuyumdjieva & Vitliemov law firm. Her previous professional experience comprises four years of work as a senior lawyer at one of the biggest Bulgarian law firms, and before that six years as an in-house lawyer at Bulstrad Insurance Company (currently Bulstrad Vienna Insurance Group).

Irina has represented clients at all levels of the Bulgarian courts and at all stages of insurance and commercial litigation. In relation to insurance, she advises multinational and local insurers, insurance brokers and large policyholders on various matters, such as on policy interpretation, claims, regulation and regulatory investigations.

According to *The Legal 500* (2016 and 2017), clients appreciate Irina's 'profound knowledge of the local and European regulations in the insurance litigation space'.

Irina holds an LLM from the University of Sofia, Faculty of Law (1994). She was admitted to Sofia Bar in 2000 and is currently practising law in Bulgaria.

KAYLEIGH STOUT

DAC Beachcroft LLP

Kayleigh Stout is a coverage and defence lawyer, who advises the insurance and reinsurance markets on losses and disputes worldwide. Working in Portuguese and Spanish, she advises primarily on Latin American and European losses involving traditional and renewable energy, construction, aviation, infrastructure and environmental sectors.

DUNCAN STRACHAN

DAC Beachcroft LLP

Duncan Strachan advises on litigation defence and coverage issues across Latin America. He is fluent in Spanish and also works in written Portuguese. Regularly dealing with large and complex cases across Latin America, the Caribbean and the United States, Mr Strachan manages exposures on behalf of the London, European and Miami reinsurance markets.

His Latin American expertise covers the energy industry, the utilities sector, financial services and aviation losses. He is a ranked lawyer in *Chambers* for work in Latin America, where clients report 'Duncan has a vast depth of legal knowledge, which he applies in a sensible and commercial way.'

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 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 fields of insurance and reinsurance law, and transportation and corporate law, with a special interest in liability matters. His work includes both consulting and litigation.

He received his law degree from the University of Zurich. Before joining gbf Attorneys-at-law Ltd, he worked at a district court in the canton of Zurich. He speaks German, English, Italian and French.

HENRIK NEDERGAARD THOMSEN

Poul Schmith

Henrik Nedergaard Thomsen is head of Poul Schmith's insurance team. He acts for Danish and international clients in the insurance industry, for the public sector and the Danish government in contentious and non-contentious matters involving coverage issues and the defence of liabilities. Henrik's dispute resolution practice encompasses litigation, national and international arbitration, more than 150 Supreme Court cases, and he is a certified arbitrator. He is a board member of the Association for Liability and Insurance Law, a member the Association of Danish Law Firms' committee for liability and insurance law and a member of the Danish Supreme Court Bar Association.

ABRAHAM THOPPIL

Maples Group

Abraham Thoppil is a partner in the funds and investment management team at Maples and Calder, the Maples Group's law firm, in the Cayman Islands. He has been involved with Cayman Islands reinsurance, insurance and alternative risk transfer products, and insurance M&A transactions. His experience includes working with insurance managers, brokers, hedge fund sponsored reinsurers and domestic insurers. He also has assisted with the legislative drafting process relating to a number of Cayman Islands laws. Abraham has been recommended for insurance and reinsurance by *The Legal 500*.

NEERAJ TULI

Tuli & Co

Mr Neeraj Tuli is the firm's senior partner. Before setting up Tuli & Co in 2000, Mr Tuli was a partner at Kennedys in London. Mr Tuli's contentious work and coverage advice ranges across a wide variety of policies including trade and credit, MD, BI, CPM, E&O, D&O, CGL, product liability, public liability, DSU, ALOP, EAR and CAR. He has handled litigation and arbitration in India, London, Paris, New York, San Francisco, Hong Kong, Singapore and Papua New Guinea, and is currently managing claims on behalf of insurers and reinsurers in India, the United States, Chile, the United Kingdom, Germany, Ireland, Finland, Italy, Japan, Kuwait, the United Arab Emirates, Australia and New Zealand.

Mr Tuli also acts as an arbitrator and was appointed on behalf of one of India's largest public sector manufacturing and engineering companies in relation to two energy disputes with a Russian enterprise, where his co-arbitrators are both English QCs.

Mr Tuli is recognised as a leading lawyer for product liability, and a leading lawyer for insurance and reinsurance in India. He has been invited to be the first president of the Insurance Law Association of India being formed in association with the British Insurance Law Association, and he is a member of the Confederation of Indian Industry's National Committee on Dispute Resolution.

ALEXIS VALENÇON

Kennedys

Alexis Valençon is a partner at Kennedys and co-founder of its Paris office. He is an insurance and reinsurance specialist with extensive expertise in complex litigation and arbitration. He advises leading French and foreign insurance and reinsurance companies, brokers, major policyholders, manufacturers, and industrial companies on a broad range of issues, ranging from insurance and reinsurance disputes (litigation and arbitration) to product liability, financial lines, construction, cyber risk, fraud and professional liability. He also assists his clients in complex court-appointed investigations relating to industrial risks, drafting insurance contracts that comply with French law and setting up activities in France.

He teaches judicial procedure and insurance litigation and arbitration at the Paris Insurance Institute and the Law Faculties of Le Mans University and Montpellier University. He is also regularly invited to speak at conferences and colloquiums on matters of insurance and reinsurance law and litigation. He is one of the co-authors of the *Lamy Assurances* (France's leading textbook on insurance and reinsurance law) and regularly contributes to various international reference books on insurance and reinsurance law and product liability.

Alexis is a member of the International Insurance Law Association (AIDA), the Insurance and Reinsurance Legacy Association (IRLA), the Association for the Management of Risk and Assurance of Enterprise (AMRAE), the International Bar Association (IBA), the French Arbitration Committee (CFA) and the Professional Association of Reinsurers operating in France (APREF).

He speaks French, English and Spanish.

ANNA WAHLBOM

Advokatfirmaet Schjødt AS

Anna Wahlbom is a senior lawyer in Schjødt's finance and capital markets practice, and assists Swedish and foreign financial companies, banks, insurance companies (both direct insurance and reinsurance), insurance intermediaries, funds and payment service providers. Anna's experience as a former in-house legal counsel at one of Sweden's life insurance companies qualifies her to assist clients in an in-depth manner regarding legal matters and especially in matters of regulatory implementation.

SAM WAKERLEY

HFW

Sam is an English qualified lawyer and head of insurance and reinsurance for HFW in the Middle East. He has been based in the Dubai office since 2005 and has advised on some of the region's largest energy, marine, property, liability, construction and PI insurance claims as well as complex reinsurance disputes. Sam also advises on shareholder, joint venture and other commercial disputes. His work involves general advisory work, all forms of arbitration, supervising local court litigation, DIFC Court work, English High Court work and mediation.

Sam is also a DIFC Court registered practitioner with rights of audience before the DIFC Courts (Part II).

WAN JIA

AnJie Law Firm

Wan Jia is a partner at AnJie Law Firm. Wan Jia has extensive experience in the field of insurance and reinsurance law services. She has represented parties in a great number of insurance disputes before Shanghai High People's Court, Jiangsu High People's Court and other high-level people's courts. She has also rendered legal services to insurance issues valued at over 1 billion yuan.

Wan Jia practises in insurance and reinsurance, and litigation and arbitration. Her educational background includes the College of William & Mary (LLM), Zhongnan University of Economics and Law (LLB) and Huazhong University of Science and Technology (Bachelor of Engineering).

WANG XUELEI

AnJie Law Firm

Wang Xuelei is a partner at AnJie Law Firm. He has great experience in litigation and arbitration. He represents different insurance companies in insurance subrogation dispute cases, property all risks insurance dispute cases, personal life insurance dispute cases, liability insurance dispute cases and some other non-insurance contentious cases.

Wang Xuelei practises in insurance and reinsurance, and litigation and arbitration. His educational background includes Shijiazhuang University of Economics, School of Law (LLB).

YU DAN

AnJie Law Firm

Yu Dan is a partner at AnJie Law Firm. She has great experience in insurance compliance. She serves as legal counsel to many insurance institutions such as the People's Insurance Company (Group) of China Limited, Taikang Life Insurance Co, Ltd, PICC Property and Casualty Company Limited, PICC Life Insurance Company Limited, China Life Property & Casualty Insurance Co, Ltd and China United Property Insurance Company Limited. She also specialises in the utilisation of insurance funds.

Yu Dan practises in insurance and reinsurance, and corporate compliance. Her educational background includes Wuhan University, School of Law (LLB).

EDMOND ZAMMIT LAFERLA

Mamo TCV Advocates

Edmond Zammit Laferla is a partner with Mamo TCV Advocates and is part of the corporate and insurance law practice group. His areas of specialisation include all aspects of corporate, civil and commercial litigation, and he regularly assists clients in a variety of related matters. Edmond provides advice to local and foreign clients on various corporate matters, including corporate governance. He has also been involved in privatisation procedures, and in the negotiation and drafting of major contracts. He assists clients with respect to validity and enforceability of agreements and arrangements related to commercial and corporate issues. Edmond is also regarded as one of the leading lawyers in the insurance practice area and provides legal support to a number of local and foreign insurance players by providing advice on insurance-related matters, including litigation, and regulatory and compliance issues.

ZHAN HAO

AnJie Law Firm

Zhan Hao is the managing partner of AnJie Law Firm. He specialises in litigation and arbitration of insurance and reinsurance cases, M&A relating to insurance companies, establishment of domestic and foreign-funded insurance organisations in China, utilisation of insurance funds and insurance compliance, etc. He also has great experience in antitrust filings with MOFCOM, defence of investigation on monopoly agreements (cartels) and abuse of dominance, antitrust private litigation, antitrust compliance, antitrust analysis from an economic perspective and anti-unfair competition. As an arbitrator of CIETAC and an experienced litigator, Zhan Hao has handled many complicated cases, some of which were heard by the Supreme People's Court.

Zhan Hao practises in the following areas: insurance and reinsurance, antitrust and dispute resolution. His educational background includes Tehua Research Centre (post-doctoral researcher, economics); Peking University, School of Law (PhD, economic law); China-EU Jurisdiction and Law Cooperation Programme (officially selected and supported by the government to study in the United Kingdom, France, Belgium, Germany, Denmark and Spain); and Wuhan University, School of Law (LLM and LLB).

He has been awarded 'Insurance Lawyer of China' by *Chambers and Partners*, 'World's Leading Insurance & Reinsurance lawyers' by *Who's Who Legal*, 'Top 10 Power List of Lawyers' by ALB and 'Best Insurance & Reinsurance Lawyer in China' by *Expert Guides*.

ZHANG XIANZHONG

AnJie Law Firm

Zhang Xianzhong is a partner at AnJie Law Firm. He has great experience in the utilisation of insurance funds. He also represents some private equity funds to invest in car parking projects, wholesale market products, outdoor media advertising projects and others. He also represents a security company in its investment in a company in Tianjin for first-class development of land, an asset company in its investment of insurance funds in public housing project supported by Jiangsu Nanjing government, an insurance company in its purchase of office buildings, obtaining land-use rights, relevant construction work and other projects.

Zhang Xianzhong practises in utilisation of insurance funds, corporate M&A and PE investment, real estate, and telecommunications and the internet. His educational background includes Temple University, United States (LLM) and China University of Political Science and Law (LLB).

MANUELA ZIMMERMANN

Schönherr Rechtsanwälte GmbH

Manuela Zimmermann joined Schönherr as attorney at law at the beginning of 2010 after spending several years at an international law firm in Vienna. Manuela has more than six years of experience as a lawyer, mainly focusing on insurance and German law. She specialises in insurance contract and insurance regulatory law and primarily advises national and international insurance companies on their market entries and daily legal matters in Austria and Central and Eastern Europe. In recent years, she has gathered valuable professional experience in advising insurance companies on their cross-border business activities. Manuela also represents clients in court in all insurance-related disputes and has several years of experience as an attorney at court. Manuela completed her law degree (Mag. iur. 2000) as well as her law state exam (2004) in Dresden, Germany. Since 2004, she has been working in Austria, first as a European lawyer and since 2007 as an Austrian qualified attorney. She is admitted to the Bar in Austria and Germany.

Appendix 2

CONTRIBUTORS' CONTACT DETAILS

ADVOKATFIRMAET SCHJØDT AS

Hamngatan 27
101 33 Stockholm
Sweden
Tel: +46 70 868 48 31 / +46 76 883 09 31
/ +46 701 82 51 51
peter.kullgren@schjodt.com
anna.wahlbom@schjodt.com
joonas.myllynen@schjodt.com
www.schjodt.com

ANJIE LAW FIRM

19F, Tower D1, Liangmaqiao Diplomatic
Office Building
No. 19 Dongfangdonglu
Chaoyang District
Beijing 100600
China
Tel: +86 10 8567 5988
Fax: +86 10 8567 5999
zhanhao@anjielaw.com
wangxuelelei@anjielaw.com
yudan@anjielaw.com
junchen@anjielaw.com
wanjia@anjielaw.com
zhangxianzhong@anjielaw.com
www.anjielaw.com

BUN & ASSOCIATES

29 Street 294
PO Box 2326
Phnom Penh
Cambodia
Tel: +855 23 999 567
Fax: +855 23 999 566
fontaine@bun-associates.com
www.bun-associates.com

CLAYTON UTZ

Level 15
1 Bligh Street
Sydney
New South Wales 2000
Australia
Tel: +61 2 9353 4000
Fax: +61 2 8220 6700
dgerber@claytonutz.com
chine@claytonutz.com
www.claytonutz.com

CLYDE & CO LLP

The St Botolph Building
138 Houndsditch
London EC3A 7AR
United Kingdom
Tel: +44 20 7876 5000
Fax: +44 20 7876 5111
neil.beresford@clydeco.com
raquel.rubio@clydeco.com
andres.garcia-arias@clydeco.com
www.clydeco.com

DAC BEACHCROFT LLP

The Walbrook Building
25 Walbrook
London
EC4N 8AF
United Kingdom
Tel: +44 20 7894 6876
dstrachan@dacbeachcroft.com
kstout@dacbeachcroft.com
www.dacbeachcroft.com

GBF ATTORNEYS-AT-LAW LTD

Hegibachstrasse 47
8032 Zurich
Switzerland
Tel: +41 43 500 48 50
Fax: +41 43 500 48 60
gerspacher@gbf-legal.ch
thalmann@gbf-legal.ch
www.gbf-legal.ch

**GOUVEIA PEREIRA, COSTA FREITAS
& ASSOCIADOS, SOCIEDADE DE
ADVOGADOS, SP, RL**

Edifício Amoreiras Square
Rua Carlos Alberto da Mota Pinto, 17 – 3º B
1070-313 Lisbon
Portugal
Tel: +351 213 121 550
Fax: +351 213 121 551
miguel.santos@gpasa.pt
www.gpasa.pt

GROSS ORAD SCHLIMOFF & CO

Gibor Sport Building
7 Menachem Begin Road
Ramat Gan 5268102
Israel
Tel: +972 3 6122 233
Fax: +972 3 6123 322
harry@goslaw.co.il
www.goslaw.co.il

GÜN + PARTNERS

Kore Şehitleri Cad 17
Zincirlikuyu 34394
Istanbul
Turkey
Tel: +90 212 354 00 00
Fax: +90 212 274 20 95
pelin.baysal@gun.av.tr
ilgaz.onder@gun.av.tr
https://gun.av.tr

HFW

HFW Middle East LLP
Level 8, Building 6, Emaar Square
Sheikh Zayed Road
PO Box 53934
Dubai
United Arab Emirates
Tel: +971 4 423 0555
sam.wakerley@hfw.com
john.barlow@hfw.com
shane.gibbons@hfw.com
www.hfw.com

INCE

Grosse Elbstrasse 47
22767 Hamburg
Germany
Tel: +49 40 38 086 0
Fax: +49 40 38 086 100
markuseichhorst@incegd.com

Herring Parry Khan Law Office, trading
as Ince

Livanos Building
47–49 Akti Miaouli
Piraeus 185 36
Greece
Tel: +30 210 455 1000
Fax: +30 210 429 3318
dimitrisgiomelakis@incegd.com
nikosmathiopoulos@incegd.com
georgeasproukos@incegd.com
marilenapapagrigoraki@incegd.com

Aldgate Tower
2 Lemn Street
London E1 8QN
United Kingdom
Tel: +44 20 7481 0010
Fax: +44 20 7481 4968
simoncooper@incegd.com
monapatel@incegd.com
peterrogan@incegd.com

www.incegd.com

JORQUIERA & ROZAS ABOGADOS

Av Isidora Goyenechea 3250, 4th Floor
Las Condes
Santiago
Chile
Tel: +56 2 580 9300
Fax: +56 2 580 9311
rrozas@jjr.cl
www.jjr.cl

KENNEDYS

31 rue de Lisbonne
Paris 75008
France
Tel: +33 1 84 79 37 80
alexis.valencon@kennedyslaw.com
nicolas.bouckaert@kennedyslaw.com
www.kennedyslaw.com

LC RODRIGO ABOGADOS

Calle de Lagasca, 88 – 4th floor
28001 Madrid
Spain
Tel: +34 91 435 54 12
Fax: +34 91 576 67 16
jangel@rodrigoabogados.com
www.rodrigoabogados.com

MAMO TCV ADVOCATES

Palazzo Pietro Stiges
103 Strait Street
Valletta VLT 1436
Malta
Tel: +356 2540 3000
Fax: +356 2124 4291
edmond.zammitlaferla@mamotcv.com
petra.attard@mamotcv.com
www.mamotcv.com

MAPLES GROUP

PO Box 309, Ugland House
South Church Street
Grand Cayman KY1-1104
Cayman Islands
Tel: +1 345 949 8066
Fax: +1 345 949 8080
john.dykstra@maples.com
abraham.thoppil@maples.com
www.maples.com

MATHESON

70 Sir John Rogerson's Quay
Dublin 2
Ireland
Tel: +353 1 232 2119 / 2398 / 2638 /
2050
Fax: +353 1 232 3333
sharon.daly@matheson.com
darren.maher@matheson.com
april.mcclements@matheson.com
grainne.callanan@matheson.com
www.matheson.com

NADER, HAYAUX & GOEBEL

Paseo de los Tamarindos 400-B, 7th floor
Bosques de las Lomas
05120 Mexico City
Mexico
Tel: +52 55 4170 3000
Fax: +52 55 2167 3099

Salisbury House
29 Finsbury Circus
London EC2M 5QQ
United Kingdom
Tel: +44 2037 40 1681

yhayaux@nhg.com.mx
www.nhg.com.mx

NISHIMURA & ASAHI

Otemon Tower
1-1-2 Otemachi
Chiyoda-ku
Tokyo 100-8124
Japan
Tel: +81 3 6250 6200
Fax: +81 3 6250 7200
s_takahashi@jurists.co.jp
ta_sato@jurists.co.jp
a_onishi@jurists.co.jp
www.jurists.co.jp

PINHEIRO NETO ADVOGADOS

Rua Hungria 1100
São Paulo 01455-906
Brazil
Tel: +55 11 3247 8401 / 8967 / 8407
Fax: +55 11 3247 8600
bbalduccini@pn.com.br
dgoncalves@pn.com.br
ceazevedo@pn.com.br
mlobato@pn.com.br
www.pinheironeto.com.br

POUL SCHMITH

Vester Farimagsgade 23
1606 Copenhagen V
Denmark
Tel: +45 33152010
Fax: +45 33156115
hnt@poulschmith.com
smk@poulschmith.com
mail@poulschmith.com
www.poulschmith.com

RUSSELL MCVEAGH

Level 30, Vero Centre
48 Shortland Street
PO Box 8
Auckland 1140
New Zealand
Tel: +64 9 367 8000
Fax: +64 9 367 8163
marika.eastwick-field@russellmcveagh.com

Level 24, Dimension Data House
157 Lambton Quay
PO Box 10-214
Wellington 6143
New Zealand
Tel: +64 4 499 9555
Fax: +64 4 499 9556
tom.hunt@russellmcveagh.com

www.russellmcveagh.com

**SCHÖNHERR RECHTSANWÄLTE
GMBH**

Schottenring 19
1010 Vienna
Austria
Tel: +43 1 53437 50248
Fax: +43 1 53437 66248
p.konwitschka@schoenherr.eu
m.zimmermann@schoenherr.eu
m.sedrati-mueller@schoenherr.eu
n.garo@schoenherr.eu
d.hoehnl@schoenherr.eu
s.jackwerth-feige@schoenherr.eu
d.lackner@schoenherr.eu
c.lichtenberg@schoenherr.eu
j.peric@schoenherr.eu
www.schoenherr.eu

**STOEVA, TCHOMPALOV &
ZNEPOLSKI**

111 Evlogi and Hristo Georgievi Blvd
1st floor
Sofia
Bulgaria
Tel: +359 2 954 6160
irina.stoeva@stzlaw.eu
www.stzlaw.eu

STUDIO LEGALE GIORGETTI

Via Fontana 28
20122 Milan
Italy
Tel: +39 2 54 57 734 / 923
Fax: +39 2 55 18 02 82
giorgetti@giorgettilex.com
www.giorgettilex.com

TROUTMAN SANDERS LLP

401 9th Street NW, Suite 1000
Washington, DC 20004
United States
Tel: +1 202 274 2863
Fax: +1 202 274 2994
michael.carolan@troutman.com
william.oneill@troutman.com
martha.conlin@troutman.com
thomas.kinney@troutman.com
www.troutman.com

TULI & CO

7 Lotus Towers, Community Centre
New Friends Colony
New Delhi 110 025
Tel: +91 11 4593 4000
Fax: +91 11 4593 4001
neeraj.tuli@tuli.co.in
celia.jenkins@tuli.co.in
www.tuli.co.in

THE LAWREVIEWS

For more information, please contact info@thelawreviews.co.uk

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Marc Hanrahan
Milbank LLP

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Mark F Mendelsohn
Paul, Weiss, Rifeind, Wharton & Garrison LLP

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Paul Dickson
Slaughter and May

THE ASSET TRACING AND RECOVERY REVIEW

Robert Hunter
Edmonds Marshall McMahon Ltd

THE AVIATION LAW REVIEW

Sean Gates
Gates Aviation LLP

THE BANKING LITIGATION LAW REVIEW

Christa Band
Linklaters LLP

THE BANKING REGULATION REVIEW

Jan Putnis
Slaughter and May

THE CARTELS AND LENIENCY REVIEW

John Buretta and John Terzaken
Cravath Swaine & Moore LLP and Simpson Thacher & Bartlett LLP

THE CLASS ACTIONS LAW REVIEW

Camilla Sanger
Slaughter and May

THE COMPLEX COMMERCIAL LITIGATION LAW REVIEW

Steven M Bierman
Sidley Austin LLP

THE CONSUMER FINANCE LAW REVIEW
Rick Fischer, Obrea Poindexter and Jeremy Mandell
Morrison & Foerster

THE CORPORATE GOVERNANCE REVIEW
Willem J L Calkoen
NautaDutilh

THE CORPORATE IMMIGRATION REVIEW
Chris Magrath
Magrath LLP

THE CORPORATE TAX PLANNING LAW REVIEW
Jodi J Schwartz and Swift S O Edgar
Wachtell, Lipton, Rosen & Katz

THE DISPUTE RESOLUTION REVIEW
Damian Taylor
Slaughter and May

THE DOMINANCE AND MONOPOLIES REVIEW
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