Your World First

C/M/S/

Law.Tax

Ten things every insurer should know

2018

Welcome

CMS is a recognised market leader in providing legal services to the insurance industry. We understand the insurance market, how it operates and the issues you face.

We have made a point of developing close personal working relationships within our international network so that we are able to achieve a measure of uniformity in the services that we offer to our insurance clients, particularly on claims and coverage advices. We have significant expertise in co-ordinating multi-jurisdictional matters on behalf of clients, "hubbing" international matters in an efficient, seamless way.

As the insurance market constantly evolves and expands into new regions, so does CMS' geographic footprint and this latest edition reflects our expansion into the Americas. We are well placed to advise on the set up of local offices and meeting regulatory requirements, as well as the localization of international policy wordings to support the launch of new product lines.

As we've made it our business to know the insurance market inside out, our clients tell us that we have the in-depth knowledge they need to support their business on an international basis. We speak the industry's language and our cross-regional insurance practice advises many of the sector's major players.

This document provides a sample of that expertise, comparing and contrasting ten key insurance issues across some of the jurisdictions in which we operate. We hope you find it useful.

Alex Denslow
Head of CMS Insurance Sector Group
T +44 20 7367 3050
M alex.denslow@cms-cmno.com

Bas Baks
Deputy Head of CMS Insurance Sector Group
T +31 30 2121 202
M bas.baks@cms-dsb.com

Contents

Albania

1. Introduction

The insurance industry in Albania has a relatively recent history. Prior to 1990 there were no specialised insurance companies operating in Albania. After the so-called "liberalisation" of the market in 1999, the insurance market was subject to material changes with reference to the quality of the services and selection of insurance products. Today, many international insurance companies are active in the Albanian market, mostly by way of acquisition of the existing local insurance companies.

An insurance business may be set up in two ways. The first option is to duly incorporate a joint stock company in Albania. Prior to incorporation it is essential to obtain initial incorporation approval by the Insurance Supervisory Authority ("AMF" – Albanian acronym), the local regulator. This procedure may take up to six months and usually involves professional assistance, since the required documentation to be submitted is relatively vast and the language is in Albanian. Failure to comply with the requirements will mean that the insurer cannot be registered in the Trade Registry. Such companies should also meet certain financial requirements.

The alternative method for a foreign insurance company is to open and register a branch in Albania. The abovementioned procedures also apply. Additional information, however, is required such as data concerning the financial situation of the mother company, and its last three year audited financial statements, the future strategy of the parent company and the development of the insurance market in the country where the parent company has been incorporated. The branch can only perform the same activities as that of its parent company.

Incorporation and registration procedures at the Trade Registry usually take 24 hours. Following the incorporation, the insurer files a written request (including the relevant documentation) with AMF to be granted a licence to carry out insurance activity. This procedure takes up to two months from the date the request is filed. The AMF may extend the term by up to three months. The insurer licensed to provide MTPL services shall become a member of the Albanian Insurance Bureau.

Following Albania's application for EU membership, additional legal amendments are necessary to adapt local law to EU regulation. In fact, a new law on insurance or reinsurance (52/2014) was implemented by the Parliament on 22 May 2014.

2. Effect of misrepresentation and/or non-disclosure

Prior to executing an insurance agreement, the insurance company shall inform the insured/policyholder of the merits of their insurance products, the special and general terms and conditions of the agreement, the expenses and profits of the insurance contract, as well as of the circumstances which are necessary to assess the risk which is known to the insured or policyholder, or under the circumstances could have not remained unknown by him.

Where, following the execution of the insurance contract, it emerges that the insured has intentionally provided inaccurate/misleading information in the request or documents submitted by him based on which the insurance contract has been executed, the insurer, within three months after it becomes aware, is entitled to:

a) amend the amount of insurance premium, insurance amount or insurance period;
b) terminate the insurance contract, if having been aware of the correct information, it would not have entered into the contract. In such a circumstance, the insurance premium related to the termination period, does not need to be returned to the insured.

3. Effect of breach of warranty and condition precedent

The insurance contract is invalid if, before the expiring of the same, the risk assured did not exist or has ceased to exist.

4. Consequences of late notification

The insurance agreement envisages the notification term, as well as the consequences for late notification. The policyholder is obliged to properly notify the insurer on the occurrence of the insured event within the due term. The insurer may refuse to indemnify the insured or may require damage compensation should the insurer suffer damages for late notice.

5. Entitlement to bring a claim against an insurer

Pursuant to the insurance agreement, the insured or the life-insurance beneficiary is usually entitled to raise direct claims against the insurer. However, third parties affected may enforce the same right. Should the insurance agreement be executed for third-party liabilities, the latter may raise a direct claim against the insurer for the suffered damages due to the activities of the insured covered by the policy.

6. Entitlement to damages from an insurer for the late payment of claim

Regarding insurance agreements, Albanian law does not envisage particular procedures for loss adjustment. Such provisions might be incorporated and drafted accordingly in the insurance agreement.

7. General rules concerning the limitation period for claims

Albanian law does not differentiate between types of insurance agreements with respect to the limitation period for claims. The Albanian Civil Code envisages that the limitation period for payment of compensation under the insurance contract is two years starting from the date when the insured event occurs or when the insured/third party becomes aware of the insured event.

8. Policy triggers with respect to third-party liability insurance

Albanian law does not explicitly regulate policy triggers. Usually the policy is triggered by the occurrence of the insured event. However, the law does not limit parties' rights to agree on other policy triggers as long as it is in compliance with Albanian law. The other types of policy triggers are less common than occurrence-based policies. MTPL policy can only be triggered by the occurrence of the insured event.

9. Recoverability of defence costs

This policy is not envisaged by Albanian law.

10. Insurability of penalties and fines

Albanian law is currently silent on this, but within the insurance market, many insurers offer coverage for civil fines and penalties, mainly in two forms:

i) **Professional Liability Insurance.**
This insurance covers the insured in the event of damage caused to third parties due to the exercise of his/her professional activity.

ii) **Product Liability Insurance.**
This insurance covers the activity of manufacturers, indemnifying consumers for damages caused by their products.

Contacts

Mirko Daidone
E mirko.daidone@cms-aacs.com

Edita Poro
E edita.poro@cms-aacs.com

Austria

1. Introduction

Since joining the EU in 1995, Austrian insurance regulations are to a large extent predetermined by EU legislation. Insurers are regulated by the Austrian Insurance Supervisory Act *(Versicherungsaufsichtsgesetz* – VAG). Insurance mediation activities are governed by the Austrian Trade Code *(Gewerbeordnung* – GewO). According to the Austrian Insurance Association's Annual Report 2016, the Austrian insurance business has generated a premium income of approximately EUR 17bn.

Generally, the provision of insurance and reinsurance activities in Austria requires a licence granted by the Austrian Financial Market Authority (FMA) prior to commencement of these activities. The FMA is the regulatory body for insurers and reinsurers in Austria. The duration of the licensing procedure depends on the individual facts of the case. However, a licence will usually be granted within a four-month period. Insurers having their registered seat in another EEA member state may passport their home Member State licence into Austria. Once passported, the foreign insurance company can provide insurance services in Austria under its home Member State licence. Such services can either be provided through branch offices established in Austria or on a freedom of services basis from outside Austria.

Insurance business in Austria may only be carried out by legal entities in the form of a joint-stock company, a registered European Company or a mutual insurance association *(Versicherungsverein auf Gegenseitigkeit)*. Any other legal form is excluded – in particular, insurance activities may not be undertaken by individuals or limited partnerships. This does not apply to insurers having their registered seat in another EEA member state that have passported their home Member State licence into Austria, as long as the insurer has adopted one of the legal forms set out in Annex III of the Directive 2009/138/EC of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II).

2. Effect of misrepresentation and/or non-disclosure (retitled)

In general, there is an obligation on the insured to disclose any information known to him in connection with the insured risk, in particular information that is relevant to the insurer for writing the insured risk. Any circumstances which may possibly influence the insurer's decision to enter into the insurance contract at all or under the agreed terms are relevant. If in doubt, circumstances the insurer has explicitly and in written form asked for are deemed relevant. Breach of these disclosure duties may entitle the insurer to withdraw from the insurance contract. This withdrawal right must be exercised within one month after the insurer learns about the breach of the information duty. If the insurer withdraws from the insurance contract after the insured event has occurred, it is still obliged to pay or perform under the insurance contract, if the circumstance the insurer had previously not been informed about have not had any influence on the occurrence of the insured event or the scope of the performance of the insurer.

If there is a misrepresentation by the insured, the insurer might not be liable to pay the indemnity. Following case law, intentional misrepresentation is categorized as deception. Intentional misrepresentation in order to receive unjustified indemnities from an insurer is a criminal offence in Austria.

3. Effect of breach of warranty and condition precedent

The nature and scope of a warranty depend on the wording of the insurance contract and the intention of the parties to the insurance contract. The party breaching a warranty may be liable for damages to the other contractual party, which must be assessed on a case-by-case basis.

Parties to an insurance contract may agree on conditions precedent. This means that a mutually defined or determined legal consequence will not take place, unless this condition precedent is met. Breach of the condition precedent prevents the legal consequence from taking place. In addition, the contract party breaching the condition precedent may, under certain circumstances, be liable for damages to the other contractual party, if there is fault on the part of this party and if and to the extent that said breach has caused a damage to the other contractual party. The exact determination of what is a condition precedent and the consequences of its breach will always depend on the wording of the insurance contract and must be assessed on a case-by-case basis.

4. Consequences of late notification

As a general rule, the insured is obliged to notify the insurer of the occurrence of an insured event *immediately,* i.e. without any undue delay, as soon as the insured becomes aware of it. Special rules providing for exact time periods within which such notification to the insurer must be made, beginning with the occurrence of the insured event irrespective of whether the insured is aware of it, apply to third-party liability, fire and livestock insurances and in the case of life insurances if according to the insurance contract the death is the insured event *(Ablebensversicherungen).*

The late notification of an insured may, under certain circumstances, release the insurer from its liability to pay any indemnity or otherwise perform under the contract, as long as such consequence was previously agreed upon in the insurance contract, which is usually the case in Austria. The burden of proof that the insured knew about the insured event and did not immediately notify the insurer about it, i.e. that the notification was too late, is on the insurer.

This will only apply if the insured has intentionally or with gross negligence failed to notify the insurer in a timely way of an insured event. Insurers remain liable to pay the indemnity if the insured is found to have been negligent only.

Even when the insured acted with intent or gross negligence, the insurer may still be liable to pay the indemnity, fully or partly, if the insured can prove that their failure to immediately notify the insurer of the insured event has not influenced
(i) the determination of the insured event, or
(ii) the determination or the scope of the insurer's obligation to perform under the insurance contract.

The insurer cannot rely on a contract provision releasing it from its performance obligations due to an insured's failure to notify, if the insurer has otherwise become aware of the insured event in a timely manner.

5. Entitlement to bring a claim against an insurer (retitled)

Each individual insurance contract will determine which person is entitled to raise a claim under the insurance contract.

6. Entitlement to damages from an insurer for late payment of claim

Payment from an insurer is due following the surveys necessary to determine the insured event and the scope of the performance of the insurer. However, this being said, payment becomes due if, within two months after the insured has requested payment from the insurer under the insurance contract, the insurer is unable to explain why these surveys have not been completed, having one month to provide such explanation.

If the surveys are not finished by one month after the insured notified the insurer about the insured event, the insured can claim an advance payment from the insurer equal to the minimum amount that the insurer, considering the facts of the case, will have to pay. This advance payment is deducted from the total claim against the insurer.

If the insurer defaults on payment or in case of late payment, the insured can maintain the insurance contract, request payment and claim default interest of 4% if the insured is a consumer or 8% if the insured is a company. The insured may also claim the default interest that was contractually agreed upon in the insurance contract. Alternatively, the insured may withdraw from the insurance contract. The insurer is then liable to pay damages to the insured, if there is fault on his part. Such damages may consist in the damages caused by the delay of payment or by non-performance.

7. General rules concerning the limitation period for claims

The limitation period for a claim arising out of an insurance contract is three years. If a third party has a claim under an insurance contract, the limitation period starts as soon as the third party is aware of its right to claim. There is a long-stop limitation period of ten years, even if the third party was not aware of its right to claim.

Where the insured has made a claim to the insurer, the limitation period will be stayed until the insurer has issued a decision in written form setting out at least the facts on which the denial of the claim are based and the relevant statutory or contractual provision. In any event, there is a long-stop limitation of ten years.

The insurer is no longer liable to perform under the insurance contract if the claim is not brought to court within a period of one year starting from the date the insurer denies the claim in written form as set out above and informs the insured of the legal consequences of such a lapse in time.

The limitation period will be stayed during settlement discussions and for the time period the insured is unable, without fault on his part, to enforce its claim under the insurance contract in a timely manner.

8. Policy triggers with respect to third-party liability insurance

There is no general rule concerning policy-triggers with regard to third-party liability insurance, since this is subject to the individual insurance contract. However, for certain risks there is an obligation to insure third parties, primarily in motor insurance.

With regard to claims-made coverage, insurers should be aware that for some professional liability cover, run-off insurance is required, (e.g., lawyers, notary publics, patent lawyers, etc.).

9. Recoverability of defense costs

As a general rule, each party to court proceedings in Austria has to bear its pre-trial costs and the costs incurred during the court proceedings. However, following the applicable "loser-pays-rule" the losing party, whether wholly or partly unsuccessful, must compensate the other party for all recoverable costs necessarily incurred by this other party in taking the appropriate legal actions, which in essence means court, experts' and lawyers' fees and expenses. An insurer that has successfully defended a claim in court proceedings is, therefore, allowed to recover its defense costs from the claimant.

The judge in the first instance determines the compensation amount based on the amount claimed by the winning party and issues a cost decision in writing. The applicable rules in this respect are in detail very complex. The decision on costs can be appealed. Payment becomes due once the decision on costs has become final and binding.

10. Insurability of penalties and fines

Austrian law does not contain any definition of an uninsurable interest. However, as a basic rule, any insurance contract providing for coverage which is deemed to be contrary to good morals, or which would cover administrative or penal fines, is void.

This view was confirmed by the FMA in 2004, when the authority prohibited the sale of a specific service by a Liechtenstein based company in Austria. The company had offered, under certain circumstances, to at least partly reimburse its customers for paid radar and parking penalties up to a certain amount. The FMA qualified this as an insurance business and held that such "insurance" was contrary to public policy as it would undermine the purpose of the penalty.

Contacts

Daniela Karollus-Bruner
E daniela.karollus-bruner@cms-rrh.com

Thomas Böhm
E thomas.boehm@cms-rrh.com

Belgium

1. Introduction

Insurance activities in Belgium can be undertaken by a Belgian company as well as by a foreign company either through a branch office or directly without any establishment in Belgium, provided that a licence has been obtained from the National Bank of Belgium (NBB).

The licence can only be obtained if certain criteria regarding solvency margins and organisation are met. The licence is granted for a branch or a group of branches of insurance undertakings.

Specific rules apply to insurance companies that undertake insurance activities in Belgium but are based in another Member State of the EEA. Such companies can operate with the licence obtained in their country of origin, but nevertheless need to observe Belgian legal provisions protecting the general good. Before the insurer commences activities in Belgium, its home country regulator must submit a file to the NBB. Although the supervision of these companies is based on the 'home country control' principle, the NBB retains the power of supervision over these companies and must inform the European Commission if certain measures are taken against such companies.

It is forbidden for a Belgian insurance company to undertake both life insurance and non-life insurance activities, except if both activities were already carried out before 15 March 1979 and provided that the management and accounting of the life and non-life business are split. It is similarly forbidden for Belgian branches of non-EEA insurance companies to undertake both life insurance and non-life insurance activities, without any exception available.

From 2015, insurers and insurance intermediaries have become subject to more constraining rules of conduct, inspired by the MiFID rules. This regime anticipates certain rules of the Insurance Distribution Directive and will have to be adjusted upon implementation of the directive (by January 2018 at the latest). The Financial Services and Markets Authority monitors compliance with these rules.

Belgian insurance contracts are governed by the 2014 Insurance Act, which contains a number of mandatory provisions (e.g. regarding non-payment of premiums, misrepresentation or non-disclosure of risks and late notification).

2. Effect of misrepresentation and/or non-disclosure

In addition to the general principles of Belgium law that declare an agreement void due to material error or fraud, insurance law has specific rules with respect to misrepresentation and non-disclosure of risks. These allow the insurer to amend, terminate or annul the insurance contract if there have been omissions or errors in the disclosure or representation of the risk made by the insured.

If the insured deliberately fails to disclose a risk or deliberately misrepresents the risk, the insurer can request the annulment of the insurance contract if the deliberate misrepresentation or non-disclosure has misled the insurer in its assessment of the risk. In this case the insurer retains the paid premiums and has the right to claim for the premiums due until the misrepresentation was brought to his attention.

If the risk was unintentionally misrepresented or not disclosed, the contract will either be amended or terminated. The insurer is entitled to propose an amendment to the contract within one month after the misrepresentation or the non-disclosure has come to the insurer's knowledge. The amendment will often be an adaptation of the premium. If the insured refuses the proposed amendment (or does not respond within one month after having received the proposed amendment), the insurer can terminate the contract within 15 days after the refusal by the insured (or in case of non-response of the insured, within 15 days after expiry of the one-month response period). The contract can also be terminated by the insurer within one month after having gained knowledge of the misrepresentation or the non-disclosure, if the insurer can prove that it would not have entered into the policy if it had known about the non-disclosed or misrepresented circumstance or event. If the insurer does not propose an amendment nor terminates the contract within the one-month period, the contract will continue at the terms and conditions as originally agreed between parties.

Losses that occurred prior to the entry into force of the proposed amendment or termination of the contract shall have to be compensated by the insurer if the misrepresentation or non-disclosure is not imputable to the insured. If the misrepresentation or non-disclosure is however imputable to the insured, the insurer shall only be held to pay on the basis of the ratio between the paid premium and the premium that the policyholder would have had to pay if he had disclosed the risk properly. If the insurer can however prove that it would under no circumstances have insured the risk should the risk have been disclosed properly, the insurer shall only be held to pay an amount that is equal to the paid premiums.

3. Effect of breach of warranty and condition precedent

Belgian insurance law is silent on breach of warranties. A breach of warranty will likely be construed as a misrepresentation of the risk, giving rise to the effects and consequences applicable to such misrepresentation (see above).

Likewise, condition precedents are not explicitly foreseen under Belgian insurance law. In the absence of any specific (mandatory) insurance law, general contract law is applicable which allows condition precedents in a contract.

The insurance contract can also impose a specific obligation on the insured and can link a loss of right to the non-respect of this obligation insofar there is a causal link between the non-respect of the obligation and the occurrence of the loss.

4. Consequences of late notification

The law obliges the insured to notify the loss to the insurer as soon as possible and in any event within the period provided for by the contract. If this time period is not complied with, the insurer is entitled to reduce the coverage by the amount of damages suffered by the insurer as a result of the late notification, unless the insured has notified the loss as soon as was reasonably possible. If the insurer can prove that the insured has acted with fraudulent intent, coverage can be denied.

5. Entitlement to bring a claim against an insurer

Under a liability insurance, a third party can file a direct claim against the insurer for compensation for damages suffered as a result of an insured event. The claimed monies must be paid directly to the third party with no possibility for any creditors of the insured to claim any part of such payment.

The enforceability vis-à-vis the third party of the defences (such as nullity of the contract, loss of rights or exemptions) an insurer would have against the insured under the law or the insurance contract, depends on whether the respective liability insurance is mandatory or not. Under mandatory liability insurance (for example public buildings and motor vehicles) the insurer cannot rely on the same defences against the third party, with the exception of any annulment, termination or suspension of the contract that dates from before the occurrence of the loss (this can be invoked against the third party). Under non-mandatory insurance, the insurer can rely on defences regarding nullity or loss of rights in order to refuse coverage if they relate to events occurred prior to the loss.

6. Entitlement to damages from an insurer for late payment of claim

The insurance pay-out is a monetary debt payable by the insurer to which the general principles regarding late payment shall apply. Excluding any other type of damages, the insured (or beneficiary) shall be entitled to late payment interests in case of late payment of a claim by the insurer. In the absence of any contractually agreed interest rate, the interest rate shall be the statutory rate.

7. General rules concerning the limitation period for claims

As a general principle, the limitation period for a claim arising from an insurance contract is three years. The starting point of the limitation period is the day of the occurrence of the event giving rise to the right to make a claim. If the party making the claim can prove that it was not aware of the occurrence of that event up to a certain date, then that date will be the starting point of the limitation period. There is a long stop limitation period of five years from the occurrence of the event which gives rise to the right to make a claim.

8. Policy triggers with respect to third-party liability insurance

As a general principle, the policy trigger is the occurrence of a loss. The loss is covered if it occurs during the policy period, even if the claim is made after the end of the policy period.

Parties can agree on a claims-made policy, except in private civil liability insurance, non-industrial fire insurance and civil liability insurance for motor vehicles. However, Belgian law provides for a mandatory period of at least 36 months after the policy term, during which claims for damages having occurred during the policy term are also covered under a claims-made policy.

9. Recoverability of defence costs

Under a liability insurance, the insurer is legally obligated to compensate the costs related to civil proceedings, as well as the fees and costs of lawyers and experts, but only insofar as these costs have been incurred by the insurer or with the insurer's consent or, in the event of a conflict of interests that is not imputable to the insured, insofar as these costs have not been made unreasonable. These costs and/or fees must be paid by the insurer even when they exceed the insured limits. For liability insurances other than the mandatory civil liability insurance for motor vehicles, the insurance contract can however limit these costs (and notably the amount of their exceedance of the insured limits) in accordance with the maximum amounts stipulated in the law.

An insured can also enter into a separate legal expenses insurance policy for coverage of his legal expenses (which do not result from a claim covered under a liability policy).

10. Insurability of penalties and fines

Mandatory Belgian insurance law stipulates that fines or settlements related to criminal proceedings cannot be the subject of an insurance contract, except for those which are borne by the person who is civilly (but not criminally) liable for the infraction and which are not related to road traffic or road transport.

There are no specific legal provisions related to the insurability of administrative penalties or fines. The majority of Belgian legal doctrine nevertheless accepts that administrative penalties or fines that have a criminal nature (which depends on the nature of the infringement and the nature and severity of the sanction) are subject to the same principles as criminal sanctions and can thus not be insured. Administrative penalties or fines that do not have a criminal nature can on the contrary be insured, as can purely contractual penalties (e.g. penalties for late-delivery).

Insurance contracts that provide coverage for criminal penalties, and fines or administrative penalties and fines of criminal nature, shall be null and void. Given that there are however no specific legal provisions related to the insurability of administrative penalties or fines, nor any leading case-law related hereto, it is to date still open for debate whether administrative penalties and fines (of whatever nature) can be insured.

Contact

Virginie Frémat
E virginie.fremat@cms-db.com

Carl Leermakers
E carl.leermakers@cms-db.com

Bosnia and Herzegovina

1. Introduction

Bosnia and Herzegovina (BiH) consists of two separate and distinct administrative entities: the Federation of Bosnia and Herzegovina (FBiH) and the Republic of Srpska (RS). Formally, Brčko District is a unique administrative unit of local government under the sovereignty of BiH. The two entities and the Brčko District have their own governmental structures as well as legislation and regulations, which means that insurance, as well as some other areas of law, are subject to legal regulations at entity level and relevant state legislation, depending on applicable law.

Insurance activity in BiH can be undertaken by insurance companies established in the form of joint-stock companies. The minimum share capital requirement in FBIH ranges from BAM 4m to BAM 6m depending on the type of risk insured, and the minimum share capital requirement in RS ranges from BAM 2m to BAM 3m depending on the type of risk insured. The business of insurance is generally conducted by standard-type joint-stock companies. However, the business of insurance can be performed jointly by two or more insurance companies (co-insurance).

Co-insurance exists when two or more insurance companies jointly guarantee the financing and compensation for an agreed insured event on the basis of the 'principle of mutuality'.

The most important prerequisite imposed on insurance companies is to obtain prior approval from the Insurance Supervisory Agency of FBiH (in the case of companies established in the territory of FBiH) or the Insurance Agency of RS (in the case of companies established in the territory of RS) (the 'Agency' or

'Agencies'). An insurance company can be established by a domestic or foreign natural person or legal entity. The Agencies will review the application within 60 days from the date the application is submitted and issue a resolution approving, rejecting or requesting a change or amendment of the application. If the Agency issues an approval, the insurance company is obliged to pay them a fee for performing this business activity.

It is important to note that approval from the Agencies is a pre-condition for entering an insurance company in the Register of Business Entities. This approval becomes effective only upon the conclusion of the registration procedure for a newly-founded insurance company. Another requirement that insurance companies must meet is the obligation imposed on every insurance company to determine a solvency margin in respect of its entire operation corresponding to the total company assets. Moreover, insurance companies have to establish a guarantee fund which constitutes one third of the solvency margin. The guarantee fund in FBIH ranges from BAM 2m to BAM 6m, while in RS it ranges from BAM 1m to BAM 3m. However, the amount of the guarantee fund depends on the types of insurance offered by the insurance company. The Agencies also request companies to submit financial reports and other documents necessary to exercise detailed supervision over companies throughout the course of their business dealings and to audit them.

The legislation allows insurance companies with a corporate seat in one entity to establish a branch office in the other entity. This can be done on the condition that the Agency supervising insurance business in one entity forwards the submitted request and the relevant documents (mainly concerning the insurance company's business operation, business plan, membership in the relevant institutions as well as its liquidity) to the Agency of the other entity which will ensure that the branch office is duly established and operates in accordance with the relevant state and entity legislation.

Current legislation provides that companies with a corporate seat outside BiH can perform insurance business activities in the form of a branch office if they obtain the approval of the Agency. In order to establish a branch office for conducting insurance business, the companies with a corporate seat outside BiH must ensure that the branch office is operated by two persons authorized by the founding foreign company, while the branch office must be properly equipped with the competent personnel and technical features required to conduct the business of insurance. Furthermore, the branch must have deposited funds amounting to one and a half times the founding capital at its disposal and must own property amounting to at least half of the guarantee fund.

2. Effect of misrepresentation and/or non-disclosure

The insurance-specific provisions in the law of obligations specify that in the case of an insured's intentional, inaccurate or complete failure to provide notification of the occurrence of an insured event, the insurer may, within one month from the day of finding out about the event, terminate the contract or propose a premium increase proportionate to the increased risk. Moreover, if the insured has deliberately misrepresented or failed to disclose a circumstance of such nature that the insurer would not have concluded the contract had it known about it, the insurer can request an annulment of the insurance contract. In this case, the insurer retains the paid premiums and has the right to request payment of the premium for the insurance period within which it requested annulment of the contract.

3. Effect of breach of warranty and condition precedent

The insured is obligated to exercise prescribed, contracted and any other measure to prevent an insured event from occurring as well as to protect and salvage insured items. If an insured event occurs, the insured is bound to limit the damage and harmful consequences as reasonably possible in order to diminish the harm incurred. If the insured fails to prevent the occurrence of an insured event and provides no reasonable justification for it, the liability of the insurer is reduced to the extent of the excess damage. If an insured event occurs and the insured has taken all reasonable measures to prevent such event, and has done everything to reduce further damage and harmful consequences, the insurer is obligated to compensate the insured for all damages incurred and further incurred costs that resulted from an attempt to prevent the occurrence of an insured event. In any case, a criminal intent by the insured is, as a general rule, a basis for non-compensation when insured events occur, if the insurer can prove that the insured acted with criminal intent. When an insured item contains defects or flaws and the damage results from them, then the insurer is not obligated to compensate the insured, unless agreed otherwise.

In the area of life insurance, a breach of warranty is constituted when the insured wrongfully states its age in a life insurance contract, since such information is important to the insurer in assessing the insurance risk. In this case, the insurer is not bound and obligated to compensate the insured. Furthermore, the insurer is not obligated to compensate the beneficiary of the life insurance contract if the insured commits suicide or if the beneficiary intentionally causes the death of the insured. The insurer is exempt from the obligation to compensate the beneficiary if the insured's death is caused by war related actions.

4. Consequences of late notification

The insured is obliged, except in cases of life insurance, to notify the insurer of the occurrence of an insured event within a maximum three-day period from the day it found out about the same. If it fails to do so within the given deadline, the insured is obliged to compensate the insurer for the damage which the latter incurred as a result.

5. Entitlement to bring a claim against an insurer

The general rule is that in the case of a breach of the provisions of the insurance contract, the injured party, i.e. the insured, has a direct right of claim against the insurer. Moreover, the Law on Insurance of FBiH and the Law on Insurance Companies of RS prescribe a right of privileged claim for the insured against the investments of the insurance company with a priority over all other general or special privileged claims. The exception to this rule occurs if a liquidation or bankruptcy procedure is initiated against the insurance company whereby the claim for costs of the 'special liquidation/bankruptcy procedure' will be given priority. Moreover, in the case of liability-type insurance, an injured third party can file a direct request against the insurer for compensation for damage suffered as a result of an event the insured is responsible for, with the maximum amount claimed being the insurer's limit of liability.

6. Entitlement to damages from an insurer for late payment of claim

As a general rule, when the insured event happens, the insurer is obligated to compensate the insured within the deadline agreed in a contract which cannot be longer then 14 days from the time when the insurer was notified of the event.

Specifically, for cases of compensation for car accidents, the insurer is obligated to compensate the insured within 90 days from the time when the insurer was notified of a car accident or elaborate why it is unable to do so. If the insurer fails to fulfil its obligations for just compensation, it will be sanctioned with a monetary fine in accordance with the Law on Vehicle Insurance of the Federation of Bosnia and Herzegovina and the Republic of Srpska.

When the insurer is late with the payment of a claim, the insured is entitled to the contracted default interest as well as statutory default interest from the date of the claim maturity.

If the insurer fails to compensate the insured regarding the claim in a timely manner or fails to pay the pertaining contracted or statutory default interests, the insured is entitled to initiate a lawsuit against the insurer.

7. General rules concerning the limitation period for claims

The limitation period for claims of the insured or third parties arising out of life insurance contracts against insurers is five years. The limitation period for claims arising out of other insurance contracts is three years as of the first day after the expiry of the calendar year in which the claim arised. If the interested party proves that it was not aware of the occurrence of an insured event up to a certain date, the statute of limitation is calculated from such date when the insured became aware, while the claim will become time-barred in any case after the expiry of the period of ten years (for life insurance) and five years (for other insurance claims) from the day of the general limitation period. In the case of an injured third party requesting compensation from the insured, the statute of limitation period for the insured's claim against the insurer begins on the day the injured party requested compensation from the insured in court.

8. Policy triggers with respect to third-party liability insurance

Normally, the occurrence of an insured event as specified in the policy and a beneficiary's claim for reimbursement of damage represent a trigger for third-party liability insurance.

9. Recoverability of defence costs

According to the Law on Civil Procedure of the Federation of Bosnia and Herzegovina and the Republic of Srpska, a party in a litigation proceeding who loses the lawsuit is obligated to compensate the court costs and attorney's fees for all parties involved. If a party partially wins the lawsuit, the court can order that each party settles its own costs and fees, or that one party compensate the other only proportionate share of costs. Regardless of the outcome of a lawsuit, the party that caused costs or damage to the other party by its wrongdoing is obligated to compensate the other party that sustained the damage. If the claimant withdraws or renounces its legal claim, then the claimant is responsible for all court costs and attorney's fees for all parties involved. If a lawsuit results in a court settlement, then each party settles its own costs. In FBIH the attorney's fees cannot be collected from the opposing party if the fee amount is larger than the average income in FBIH according to the latest issued data. However, such limitation does not exist in RS.

10. Insurability of penalties and fines

As a general rule, penalties and fines are not insurable, therefore the insurance companies in BIH do not offer this type of insurance.

Contact

Andrea Zubović-Devedžić
E andrea.zubovic-devedzic@cms-rrh.com

Ana Terzić
E ana.terzic@cms-rrh.com

Brazil

1. Introduction

The Brazilian insurance market is regulated by two agencies that report to the Ministry of Finance. These are the Superintendence of Private Insurance (SUSEP) and the Private Insurance National Council (CNSP). The agencies were created by the enactment of Decree Law No. 73/1966. The role of SUSEP is to manage the operation of the insurance market in Brazil by supervising the activities of insurance and reinsurance companies. SUSEP carries out its functions by executing the policies determined by CNSP. CNSP's role is to provide strategic direction on insurance policy in Brazil. In its overarching capacity, CNSP formulates and adjudicates the guidelines for private insurance policies, determines the general features of insurance and reinsurance contracts and regulates those acting as brokers for insurance and reinsurance. CNSP carries out its regulation of the market function by issuing resolutions. CNSP also has the capacity to hear appeals on decisions made by SUSEP.

The insurance market is governed by Articles 757-802 of the Brazilian Civil Code (BCC), Commercial Code 1850 (only for maritime risks), Decree-law 73/66, Consumer Defence Code and CNSP resolutions. All contracts of insurance and reinsurance are regulated, with greater protection given to contracts of insurance with consumers. Where a contract of insurance between a business and a customer occurs, the automatic presumption is that consumers will have less bargaining power than businesses and as such, should receive greater protection. In matters of reinsurance, the contract will be negotiated business to business. In this situation, the presumption is that the parties will be on an equal footing when entering into contracts, so they do not require the additional protections afforded to consumers. As operators of the insurance market, insurers, reinsurers and brokers are also regulated. Prior to commencing operations, each must seek prior authorisation to operate from SUSEP, as well as obtaining all applicable local business permits to operate in Brazil.

Until 2008, the reinsurance sector in Brazil was monopolised by the government-controlled IRB Brazil RE. The enactment of Complementary Law No. 126/2007 opened up the reinsurance sector in Brazil to private enterprise. The reinsurance market in Brazil is still subject to prescriptive controls on the movement of premiums intergroup and caps on local reinsurance requirements. Resolution No. 325 sets the limit on premiums that can be contracted intergroup, at 30% until 31 December 2017. This percentage will be increased by 15% a year, up to a maximum of 75%, from 1 January 2020. Similarly, the resolution also requires that a minimum percentage of each reinsurance contract be ceded to local reinsurers. The percentage stands at 30% until the end of 2017, and will decrease by 5%, to a minimum percentage of 15%, from 1 January 2020.

The issuance of all types of insurance products in Brazil is another component of the market that is highly regulated. Insurance companies have the freedom to draft custom contracts. However, the clauses drafted must not operate in an adverse manner to those set out by SUSEP in its standard conditions. Once an insurance product of any type has been prepared, it must be approved by SUSEP before it can be offered to the public. Any subsequent amendment to the product must be resubmitted to SUSEP for approval, before it can be offered to the public.

Insurance law in Brazil may be subject to significant change in the coming years if Statute Project n. 8.290/2014 is accepted by Congress. If passed, it would become the first specific Brazilian Insurance Law. The draft of this project was initiated back in 2004 (through Statute Project n. 3555/2004) and has subsequently been under discussion and evaluation by the market and relevant authorities for a considerable period of time. If approved, the new law would come into force one year after the date of its publication.

2. Effect of misrepresentation and/or non-disclosure

Article 765 of BCC provides that insurers and insured parties must conduct dealings in line with the principle of utmost good faith, both before and after agreeing to the contract. In accordance with article 766 of BCC, the effect of a material misrepresentation or non-disclosure is that the insured shall lose the right to indemnification when the insured party omits circumstances or provides incorrect information that might influence the insurer's acceptance of the risk or valuation of the premium.

Although insurers can rely on the concept of utmost good faith, ambiguities and imbalances in contracts of insurance should be avoided as judicial interpretation of clauses tends to favour the insured rather than the insurer. Additionally, Brazilian courts have previously found that only a wilful omission made in bad faith can trigger the insurer's right to decline payment of cover. Further, art. 762 of BCC establishes that a contract guaranteeing a risk arising out of a wilful act of the insured shall be annulled. Art. 768 of BCC also states that the insured shall lose the right to indemnification when they intentionally aggravate the risk.

When seeking to contest the omission, the insurer will bear the burden of proof to demonstrate that the insured has not acted in utmost good faith.

3. Effect of breach of warranty and condition precedent

Conditions precedent and warranties are not specifically provided for under Brazilian law. Breaches of policy conditions will entitle the insured to seek damages for the loss, provided that this is proven, and subject to the general rules of contractual law.

4. Consequences of late notification

Where an insured suffers loss as a result of an insured event occurring, subject to loss of their right to be indemnified, the insured should make a claim as soon as they become aware of the occurrence of the loss (art. 771 of BCC). Failure to do so may lead to the insured losing the right to be indemnified for the loss. Art. 771 of BCC does not expressly set out a longstop deadline by which a claim should be notified to the insurer. Consequently, the Brazilian courts will only enforce the forfeiture of the insured's rights where the insurer proves that the impact of the late notification led to an increase in the insured's loss. The loss may be considered amplified where the claims adjuster is no longer able to properly handle the claim. Alternatively, where the late notification of the loss hinders or prevents the insurer's investigation this may also result in the insurer validly refusing to pay the coverage.

5. Entitlement to bring a claim against an insurer

At the current time, there is no statutory provision in Brazil which provides third parties with a legal right to sue insurers directly and exclusively in the context of non-compulsory contracts of insurance. For non-compulsory contracts of insurance in Brazil, a claim would be filed by the insured against the insurer, or by a third party against the insured, but not usually between a third party and the insurer.

In 2015, the Superior Tribunal of Justice (STJ) issued Súmula n. 529, a form of a non-binding but persuasive statement. In accordance with the Brazilian Civil Procedure Code (CPC), both judges and the courts are required to observe the Súmulas and statements of the STJ. The effect of Súmula 529 has been to prevent third parties who have suffered injury, in cases involving facultative civil liability insurance, from directly and exclusively filing a suit against the insurer. The basis of the judgment given in Súmula n. 529 is that an insurer will only be obliged to indemnify the insured party for damages owing to a third party where the insured has been found liable. Consequently, without the involvement of the insured in a direct claim against an insurer by a third party, the proceedings would likely fail. Failure to include the insured would most likely breach the principles of Due Legal Process and Full Defence, which are provided for in the Brazilian Federal Constitution (art. 5, LV). It is especially likely that a breach of these principles would occur where, without the insured being available, the insurer would only have access to limited information about the underlying incident. This may prevent the insurer from providing an adequate defence to any allegations made in a third-parties statement of claim. It is, however, possible at the current time to join an insurer as co-defendant in a suit brought by a third party against an insured party.

The position of third parties will be amended, if and when, Statute Project 8.290 of 2014 ultimately passes. Paragraph 1 of art. 107 of the proposed legislation would provide third parties with a right to make a direct claim against insurers, within the cap on liability established in the contract of insurance. The same article gives the claimant the option to summon the insured as co-defendant.

6. Entitlement to damages from an insurer for late payment of claim

SUSEP regulates the maximum time period for the claims adjustment proceedings to take place. The time limit varies depending on the type of insurance product under which the claim is being brought. Insurers usually have a period of thirty days in which to carry out the claims adjustment procedure. The thirty days commences on the date which the insurer receives documents requested from the insured or the beneficiary of the insurance. During the claims adjustment proceedings, the previously noted window will be suspended for a one-off period commencing, when the insurer requests further documentation and ending when these documents are supplied to the insurer. According to the BCC the insured can claim extra contractual damages (such as loss of profit and interest) arising from late payment, as long as such delay is considered unlawful.

7. General rules concerning the limitation period for claims

The general time limit to file an insurance claim is one year (art. 206, BCC). The first exception for claims relates to air transportation risks, as per the Brazilian Aeronautical Code. The start date from which this normal thirty-day limitation period runs from is unclear as it is not formally set out in the BCC. In cases where an insurer formally declines coverage, the limitation period starts from this point. In almost all other cases, the time limit runs from the time that the insured has knowledge of the loss. There are however, exceptions made to claims related to civil liability. In these cases, time runs from the date the insured is summoned to respond to the third-party claim, or from the date the insured indemnifies the third-party, duly authorised by the insurance company. A special period of three years applies to claims brought by (i) a beneficiary or (ii) third parties in compulsory liability insurance. For cases involving life insurance, the time limit is extended to five years.

In what is considered a somewhat controversial decision of the STJ, contracts of reinsurance were held to be contracts of insurance and therefore subject to the same one year limitation period as detailed above (Special Appeal 1.170.057/MG).

8. Policy triggers with respect to third-party liability insurance

The general rule is that occurrence of the loss to the insured triggers the claim. In civil liability insurance, identification of the trigger can be more complex. The time at which knowledge of the insured is determined to have occurred may rest on circumstances outside of the insured's control. Equally, it can be hard to correctly predict, or quantify the extent of the damage the insured has suffered immediately. Therefore, in practice, policies are agreed on a claims-made basis with limitation periods. It should be noted that the concept of claims-made basis is still a relatively recent introduction to Brazil. In May 2017, SUSEP issued a Circular (553) requiring D&O policies to be issued on a claims-made basis. Insurers in Brazil are now explicitly prohibited from issuing D&O policies triggered by occurrence/event.

9. Recoverability of defence costs

The insured can recover defence costs when these are covered by the policy. Before Circular SUSEP 553, the Brazilian regulatory authority required defence costs to be provided in addition to D&O coverage. This created uncertainty in relation to the possibility of offering this coverage independently from the indemnity coverage. After Circular 553, coverage for defence costs may be provided in the basic coverage of D&O policies; thus, clarifying the point on the possibility of providing coverage for defence costs only.

Insurers in Brazil have historically faced difficulties when trying to recover amounts advanced to cover defence costs. Circular 553 now expressly requires that when defence costs coverage is provided, the policy shall provide the insurer with the right to subrogate against the insured, in situations where the damages result from a wilful act or when the insured acknowledges his liability.

10. Insurability of penalties and fines

Before Circular 553, SUSEP's understanding was that coverage for fines and penalties would eliminate the disciplinary nature of such sanctions. In practice, the market used to consider such prohibition only in case of wilful acts, meaning there would not be any impediments to indemnify an insured party against the non-intentional acts. The most relevant and debatable change introduced by SUSEP Circular 553 relates to the authorization of D&O coverage for civil and administrative fines and penalties, provided they relate to non-intentional acts.

Contact

Ted Rhodes
E ted.rhodes@cms-cmno.com

Bulgaria

1. Introduction

Bulgaria has a well-developed insurance market. At the beginning of 2016, a new Insurance Code was adopted and entered into force implementing all requirements under the EU Directive Solvency II and other fundamental EU Regulations and Directives. According to the Insurance Code, there are several ways to undertake insurance activity in Bulgaria.

The first option is by incorporating a company in Bulgaria and obtaining the necessary licence from the Bulgarian Financial Supervision Commission (BFSC). An insurer can provide only the types of insurance that are permitted by its license. A single insurer is not allowed to provide both life and non-life insurance (with one exception: life insurers can also be licensed to sell non-life "Accident" and "Illness" insurance). Insurance companies must be joint-stock companies with registered book entry shares and must meet certain capital and liquidity requirements.

Another common option available to foreign (non-EU) insurers is the incorporation of a local branch office. The branch shall obtain a licence in order to provide insurance services in Bulgaria. The branch can provide only those types of insurance which its parent company provides in its jurisdiction and must comply with certain requirements regarding the branch's financial resources and manager(s). Opening a branch is a more simplified procedure than incorporating a new company, with fewer stipulated requirements as to the financial resources and general management. Because a branch is not a separate legal entity but represents a subsidiary unit of its parent company, it has a simpler organisational and management structure.

An EU insurer may undertake in Bulgaria the activity for which it has been licensed in its home country, either on a freedom-of-services basis or by establishing a local branch. For this purpose, a procedure of exchange of information between the supervising authority in the home member state and the BFSC must be completed. The BFSC exercises supervision

over insurance and reinsurance companies from EU member states, which operate in Bulgaria, save for supervision over their financial stability, which is performed by the supervising authority in the home country.

The new Insurance Code also introduced the option for establishing a captive insurance company and/or a captive re-insurance company. A captive insurer is a joint-stock insurance company owned by (i) a financial undertaking, which is not an insurer or a reinsurer, or (ii) an insurance or a reinsurance group, or (iii) a non-financial undertaking, whereby the joint-stock company concerned has the objective of providing insurance coverage exclusively for the risks of its owner/s or the person/s from the group to which the captive insurer belongs. The provisions applicable to joint-stock insurance companies or to reinsurers respectively shall also apply to captives.

A European company (SE), Self-insurance cooperative, or European Cooperative Society (SCE) may also conduct insurance business in Bulgaria, subject to obtaining the necessary licence.

2. Effect of misrepresentation and/or non-disclosure

The effect of misrepresentation or non-disclosure are different depending on whether this was deliberate or unintentional.

Wilful misrepresentation or non-disclosure of material circumstances will release the insurer from the obligation to provide indemnity where there is a connection between the misrepresented/undisclosed circumstances and the insured event. If the misrepresented/undisclosed circumstances have resulted only in an increase to the loss, then the insurer is entitled to reduce the payment accordingly. If the insurer becomes aware of the misrepresentation or the non-disclosure prior to the occurrence of the insured event, the insurer is entitled to terminate or require an amendment of the policy accordingly.

In the case of unintentional misrepresentation or innocent non-disclosure, the insurer is entitled to reduce the payment by taking account of the circumstances, but cannot refuse indemnity.

3. Effect of breach of warranty and condition precedent

The Bulgarian Insurance Code does not envisage the terms "warranty" and "condition precedent". Generally, the insurance contract may not impose conditions and requirements (including those related to the insured event and its ascertainment) if it may be assumed that such conditions and requirements are not significant to limiting the risk of the insured event occurring or its ascertainment, or are legally prohibited or factually impossible. The specific consequences of misrepresentation or non-disclosure have been outlined in question two above.

In life insurance there are few clauses regulating the effect of breach of condition precedents. Life or accident insurance policies that cover the death of an under-aged person or a person under custody, or the risk of miscarriage or stillbirth are invalid by operation of law. In case of wilful non-disclosure/breach the insurer has the right to deduct the value of the expenses incurred in concluding the insurance contract from the premium which is subject to reimbursement. In another case, when the age of the insured person (which is condition precedent) is falsely stated, the payment by the insurer shall change in the ratio of the premium that would have been due and payable for the true age to the premium agreed upon in the contract. In the case of falsely stated age, the insurer may terminate unilaterally the contract, as long as the insurer would not have concluded the contract were the true age of the person stated.

4. Consequences of late notification

In property insurance, the insurer is allowed to refuse to provide indemnity in the event of the insured's failure to notify it of an insured event within the specified term, if (i) this was done with the intention to impede the insurer's verification of the relevant circumstances of the event's occurrence and its consequences; or (ii) this has made it impossible for the insurer to verify the circumstances of the event's occurrence and its consequences.

5. Entitlement to bring a claim against an insurer

The general rule is that the insured has the right to raise a claim resulting from an insurance contract directly against the insurer. However, there are some exceptions, namely where the creditor of an insured can make a claim and in third-party liability insurance. A prospective third-party claimant who has suffered loss as a result of the actions and/or omissions of the insured, which are alleged to be covered by the liability policy, has a right to step into the position of the insured under the insurance contract and to raise a claim directly against the insurer. The third party's insurer also has a right of regress claim.

The Insurance Code requires that insurance claims should mandatorily be filed in writing first with the insurer and then, if not satisfied, with the court.

6. Entitlement to damages from an insurer for late payment of claim

As a general rule, the insurer is obliged to indemnify the insured according to the policy within a term not exceeding 15 business days from the date of receiving the insured's claim and all necessary evidence under the policy terms, if cover is confirmed. If all the required documents were not provided to the insurer, the insurer must render its decision within six months as of the filing of the claim in the general case; or within three months in case of motor third-party liability insurance. These rules do not apply for high risk insurance.

In case of late payment, the insured or the third-party beneficiary shall have the following rights: (i) to file a complaint against the insurer before the regulator; and/or (ii) to seek damages in court, i.e. a compensation in the amount of the statutory interest for delay.

7. General rules concerning the limitation period for claims

The limitation period for an insured's claim against an insurer is five years following the occurrence of an insured event of life, accident, illness and third-party liability insurance; or three years following the occurrence of an insured event for other classes of insurance. The limitation period for claims for interest on the insurance indemnification is also three years.

8. Policy triggers with respect to third-party liability insurance

As a general note, Bulgarian law does not explicitly regulate policy triggers. The Insurance Code refers to an "insured event" which is defined as the occurrence of a covered risk during the insurance coverage period. It is generally accepted that whether this event is the occurrence of the loss or the claim depends on the drafting of the policy and the intention of the parties to it. In general, claims-made policies are less common in Bulgaria than occurrence-based policies.

Motor third-party liability insurance is deemed triggered with the occurrence of the damage, caused by the insured's vehicle to a third party during the policy period.

9. Recoverability of defence costs

As per the Insurance Code, the third-party liability insurer is obliged to cover the defence costs of the injured party, up to the limit of coverage, and if the insurer was involved in the litigation.

There is a stand-alone class of insurance covering legal expenses. The insurer covers the insured's costs incurred in non-insurance related litigation.

10. Insurability of penalties and fines

Penalties, fines, confiscation and other pecuniary damages imposed by the state or municipal authorities are not insurable in Bulgaria.

Contractual liability might be covered as an exception, subject to an agreement with the third-party liability insurer.

Contact

Nevena Radlova
E nevena.radlova@cms-cmno.com

Antonia Kehayova
E antonia.kehayova@cms-rrh.com

Chile

1. Introduction

Insurance companies in Chile must be incorporated as public corporations or be authorized as Agencies of a foreign insurance company, both regulated by Statutory Decree *(Decreto con Fuerza de Ley)* No. 251 of 1931 and its amendments, and supervised and controlled by the Superintendency of Securities and Insurance *(Superintendencia de Valores y Seguros,* or "SVS", for its acronym in Spanish). Insurance contracts are regulated by articles 512 to 601 and 1157 to 1201 of the Commercial Code, and the general terms and conditions of the policies must be those registered by the insurance companies in the SVS; however in the case of "large insurance", where the insured is a legal entity and the annual premium is not less than 200 U.F. *(Unidad de Fomento,* a unit of account used in Chile), (approx. USD 8,000), the terms and conditions can be freely agreed by the parties.

Foreign insurance companies cannot offer coverage in Chile, with the exception of insurance related to international maritime, commercial aviation, goods in transit, and satellite and its load insurance. Chilean residents can freely contract insurance coverage with foreign insurance companies, paying the corresponding taxes on the premiums (22%).

The insurance companies are legally classified between those providing general insurances, and those providing life and health insurance.

The loss adjustment process is regulated by law, and the loss adjusters are independent of the insurance companies, and perform their function under the supervision of the SVS.

All disputes related to insurance contracts, with the exception of minor coverage, are subject to arbitration in Chile, and the applicable law is Chilean law.

Insurance contracts are consensual, and can be proved by any kind of written document.

2. Effects of Misrepresentation and/or non-disclosure

The general rule is that the insured, under the requirement of the insurance company, must provide all the information within its knowledge related to the risk to be covered, which will allow the insurance company to make a correct assessment of the risk, its characteristics and extension.

Failure to fulfil this obligation by the insured will allow the insurance company to withdraw from the insurance contract or to reduce or modify the extension of the coverage and request an increase in the premium. The relevant information is that related to relevant circumstances that will make it advisable for the insurer to enter into the insurance contract at all or under the agreed terms.

3. Effect of breach of warranty and condition precedent

Warranties are legally defined in Chile as the conditions agreed by the parties to restrict, specify or reduce the risks to be covered in an insurance contract, and that must be fulfilled by the insured to obtain the payment of an indemnification in the case of a loss.

When these types of warranties or conditions precedent are incorporated into the terms and conditions of the insurance contract for the cover of a loss, they are fully applicable in the case of a dispute between the insurance company and the insured.

In the case of large insurance, the parties quite often agree to introduce these warranties and conditions precedent, which have been previously agreed by the insurers with the reinsurers in the reinsurance contract which supports the primary coverage of the insurance contract.

4. Effect of late notification

The general rule in this market is that the insured must promptly notify the occurrence of an insured event, as a way to avoid fraud and to support the determination of the loss or the rights of the insurance company to recover against third parties.

That said, the actual effect of a reasonable late notification will be measured in relation to the material adverse effects of it, and how it actually affects the insurance company's contractual right, not only in relation to compliance with a formal obligation of the insured.

Calculations of Premiums

There is a fully free market, and the premiums are determined by insurance companies, depending on the risk to be covered, the administrative cost of the insurer and the cost of reinsurance protections, etc. Premiums must be invested in the Technical Reserves established by law and supervised by the SVS.

In the event of early termination of the policies, the insured will be entitled to a reimbursement of the unused part of the premium.

5. Entitlement to bring a claim against an insurer

The insured is contractually entitled to initiate an action against the insurance company under the insurance contract. It will also entitle any person who after the occurrence of the loss, acquired those rights from the insured, or any person who in the case of large insurance is contractually designated for that purpose.

In the case of life insurance, the general rule is that beneficiaries designated in the policy, or the successors if there is not a beneficiary, will be entitled to file a claim or collect the payment of contractually agreed indemnities.

6. Entitlement to damages from an insurer for late payment of a claim

This is a matter that will be resolved during the arbitration process, and will depend on whether or not the insurance company denying the coverage is acting in accordance with the recommendation given in the loss adjustment report. If the insurance company is acting with the support of the loss adjustment report, it will probably not be ordered to pay damages, but only the contractual indemnity plus interest, assuming that the insurance company has a legitimate reason to dispute the payment; on the other hand, if the insurer denied the coverage against the recommendation of the loss adjustment report, it will likely be ordered to pay damages.

Insurable Interest

The insured must have an economically valuable interest in the conservation of the thing, right or property, object of the insurance contract or coverage. Without insurable interest the insurance contract is null and void.

In life insurance the insurable interest is not applied, and the insured can freely select the beneficiaries.

7. General rules concerning the limitation period of claim

In accordance with the Commerce Code, the statute of limitations is four years, calculated from the date of the final loss adjustment report.

8. Policy trigger with respect to third-party liability insurance

The general rule in massive insurance, whose terms and conditions are duly registered in the SVS, is "claim occurrence"; the insurance policy will cover the civil liability of the insured that originates in an event during the term of the insurance contracts; in the case of large insurance, whose terms and conditions are freely agreed between the parties, it is quite common in certain types of coverage, medical liabilities, to use "claim made" triggers, where the coverage will be given by the existing policy on the date of the claim. The type of trigger will normally depend on the terms and conditions of the reinsurance contract that protects the primary coverage.

9. Recovery of defence costs

It will depend on the arbitration award and on the basis of the existence of legitimate cause to litigate. Normally, it is not considered in the coverage of the policy, with the exception of D&O policies that cover, in certain conditions, the defence costs incurred by the insured in defending against the civil liability claim.

10. Insurability of Penalties and Fines

The general rule is that penalties and fines are not covered by insurance companies in Chile; wilful misconduct or gross negligence and its effects will never be covered by an insurance policy. In large insurance, some administrative fines have been exceptionally covered.

Contacts

Ramón Valdivieso
E ramon.valdivieso@cms-ca.com

Fernando De Carcer
E fernando.decarcer@cms-ca.com

Colombia

1. Introduction

Under Colombian law, the insurance contract is a commercial contract regulated in Title V of Book IV of the Commercial Code and it is described as a bilateral, consensual, and aleatory contract, for consideration and of continual performance.

The Commercial Code regulates the general principles common to land insurance, damage insurance, and personal insurance. Suggest: The law deals with the contractual parties, the essential parts of the contract, the policy documents, its requirements and annexes, risk status disclaimers, definition and effects of warranties, the obligations of the insured event at the occurrence of the event, a statute of limitations, payment of the policy, and non-insurable acts, among others.

We proceed to answer the following questions which involve essential knowledge required for anyone interested in acquiring an insurance policy issued under Colombian law, taking into consideration:

- that the parties to the contract are the insurer; a corporation legally authorized to assume the risk and supervised by the financial regulator; and the policy holder, the party that on behalf of itself or others, allocates the risk [1]
- that the contract has four essential elements: a), an insurable interest b) an insurable risk c) a premium paid by the policy holder in exchange for the transfer of risk and d) an agreement on the part of the insurer to pay an indemnity, [2]
- the general principles and regulation of the contract's common elements.

[1] Colombian Commercial Code, Article 1036
[2] Colombian Commercial Code. Article 1045

2. Effects of misrepresentation and/or non-disclosure

The policy holder is under an obligation to truthfully disclose all material facts. If a form is used to asses risk, any misrepresentations or non-disclosure of material facts on the part of the policy holder will invalidate the contract and it will be voidable at the insurer's discretion. If no form is used, the contract will be voidable in the case of fraudulent or negligent misrepresentation or non-disclosure. Innocent misrepresentation or non-disclosure will not void the contract, but a proportional remedy applies; the insurer is only required to pay the claims in proportion to the actual level of risk covered by the premium under truthful circumstances. The insurer's remedies will not apply if, before the formation of the contract, the insurer knew or ought to have known the actual facts and circumstances in question, or if, once known, the insurer tacitly or expressly accepts the terms, or allows an opportunity to cure.[3]

The policy holder has an obligation to notify the insurer in writing of any facts or circumstances which materially alter the risk contemplated in the agreement. The insurer has the option to cancel the policy or adjust the terms of the premium. Non-disclosure of any such fact or circumstance will cause the termination of the contract.[4]

3. Effect of breach of warranty and condition precedent

The concept of warranty was created to provide more safety for the purposes of insurance, therefore the insured should be diligent and their actions should be aimed at avoiding the occurrence of the claim. Article 1061 of the Colombian Commercial Code establishes that the warranty is a "promise under which the insured is obligated to do something specific, or meet certain requirements, or by which affirms or denies the existence of a particular factual situation…"

As a "promise," the effect that the law contemplates for a breach of warranty is the voidance of the contract, unless the exception of article 1062 applies: "Non-compliance with the warranty will be excused when, by virtue of changed circumstances, it is no longer applicable to the contract or its implementation has come to mean a violation of law after the conclusion of the contract".

When the warranty refers to an event subsequent to the contract's celebration, the insurer may terminate the contract at the moment of breach.

The Colombian Commercial Code does not consider the warranty as a condition precedent, as Common Law does, where the consequences of a breach will be different.

4. Consequences of late notification

The insured or beneficiary is required to notify the insurer of the occurrence of an insured event within three days following the day on which the insured or beneficiary became aware or should have became aware of the occurrence of the event. This term may be extended, but not reduced, by the parties.

If the insurer performs salvage operations or confirms the occurrence of the insured event within the established notification term, the delay or omission of notice may not be used as an excuse to contest or deny payment. However, as a delay or omission of notice constitutes a breach by the insured, the insurer may deduct from the payment of the claim the amount of damages generated by the breach.

5. Entitlement to bring a claim against an insurer

The insured is the person entitled to bring a claim against the insurer. The insured must prove the occurrence of the harm and the amount of damages. Once proven, the insurer's obligation to pay the amount of the claim is triggered.

In order to contest a claim, the insurer is required to show the facts and circumstances which relieve its liability.

[3] Colombian Commercial Code. Article 1058
[4] Colombian Commercial Code. Article 1060

6. Entitlement to damages from an insurer for late payment of claim

The insurer is under obligation to make payment by the end of the month following the date on which the insured or the beneficiary proved its loss (or within 60 days for policies with a sum in excess of USD 3.5m at the current exchange rate)[5]. In case of late payment, the insured or beneficiary is entitled to either: (1) interest at a punitive moratorium rate, equal to 1.5 times the commercial lending rate, or (2) recover damages which may include reliance (actual loss, damnum emergens) and expectation damages (loss of profit, lucrum cessans).[6]

7. General rules concerning the limitation period for claims

In Colombia, insurance claims have (1) a general limitation period of two years from the date on which the interested individual knew or ought to have known the facts giving rise to the claim, and (2) a special limitation period of five years from the date on which the right arises, applicable to all persons regardless of their knowledge of the facts.[7]

The Supreme Court has defined the difference between the two periods as both objective and subjective. The general limitation period has a subjective element, as it applies only if there is actual or presumed knowledge of the facts, whereas the special limitation period is objective, as it applies to everyone, regardless of the knowledge they have of their rights, and of their legal capacity.[8]

8. Policy triggers with respect to third-party liability insurance

Monetary damages arising out of third-party contractual or tort claims over which the insured is liable are policy triggers with respect to third-party liability insurance.[9] While the insured or beneficiary's gross negligence is insurable, wilful intent, or voluntary acts are not.[10] [11]

9. Recoverability of defense costs

According to article 1128 of the Colombian Commercial Code, when dealing with liability insurance, the insurer must assume the defense costs of any legal process that third parties initiate against the insured or the insurer, even if it exceeds the insured amount.

However, the insurer is not obliged to cover such costs when: (i) the liability is caused with intent; (ii) the liability is expressively excluded from the insurance contract; (iii) if the insurer initiates the process against the express order of the insurer; or (iv) if the penalty for the damages caused to the third party exceeds the insurer's responsibility; in such a case it will only take on defense costs in proportion to its compensation share.

In that sense, in the event in which it is found that the insured acted with intent or fraud, the insurer is entitled to recover defense costs from the insured.

10. Insurability of penalties and fines

Any insurance contract pursuing the protection of the insured against penalties and fines for felonies or misdemeanors is invalid under Colombian law. However, fines and penalties of a different nature are considered insurable.

Contacts

Sergio Rodríguez-Azuero
E sergio.rodriguez@cms-ra.com

[5] Organic Statute of the Financial System. Article 185
[6] Colombian Commercial Coder. Article 1080
[7] Colombian Commercial Code. Article 1081
[8] Colombian Supreme Court. Justice Fernando Giraldo Gutierrez, Case 00457-01. April 4, 2013
[9] Colombian Commercial Code. Article 1127
[10] Colombian Commercial Code. Article 1055
[11] Colombian Supreme Court. Justice Fernando Giraldo Gutierrez, Case 2005-00425. July 5, 2012

Croatia

1. Introduction

Insurance activity in Croatia may be undertaken through: (i) a local insurance company that has obtained the authorisation of the Croatian Financial Services Supervisory Agency (HANFA), (ii) a branch of a foreign (non-EU) insurance company that has obtained authorisation from HANFA to perform insurance activity in Croatia, or (iii) an EU/EEA insurance company that has either established a branch in Croatia or is authorised to directly carry out insurance business in the territory of Croatia on a freedom of services basis. The companies authorized to perform insurance activities in Croatia can be established as a joint stock company, European company (SE) or as a mutual undertaking.

Insurance companies are only authorised to carry out insurance business within the classes of insurance for which they have been granted authorisation by the competent authority (in their home country).

The authorization process for a local insurance company may take up to three months.

An EU/EEA insurance company may directly perform insurance activity in Croatia upon receipt of confirmation from its home country supervisory authority that it has submitted the required documentation to HANFA.

2. Effect of misrepresentation and/or non-disclosure

In the event of an intentional violation of disclosure obligations, providing untrue information or concealing important facts, the insurer may rescind the insurance contract. This only applies if the insurer would not have entered into the insurance contract had it been aware of the undisclosed information. The insurer's right to rescind the insurance contract is time barred (three months starting from the day on which the insurer became aware of misrepresentation and/or violation of the disclosure obligation). If the contract is rescinded the insurer has a right to keep and charge the premiums up to the day of requesting rescission of the contract. However, the insurer is obligated to pay the insurance premium if the insured event occurs before the day of the rescission request (insurer is not entitled to decrease the premium as in the case of unintentional misrepresentation or non-disclosure)

In the event of an unintentional violation of the disclosure obligation, providing untrue information or concealing important facts, the insurer may terminate the insurance contract or request an increase of the premium within one month starting from the day that it became aware of misrepresentation and/or violation of the disclosure obligation. In case of termination, the insurer is obligated to return the premium for the remaining insurance period. If the insured event occurred before the insurer became aware of the misrepresentation and/or violation of disclosure obligation or before contract termination/increase of premium, the insurance premium shall be decreased in proportion to the rate of the premium paid and the rate of the premium that should be have been paid according to the real risk.

Specific non-disclosure rules apply to life insurance. Life insurance contracts shall be null and void if the actual age of the insured exceeds the insurable age. If the insured is older than reported but she/he is still insurable, only the insured amount (and premiums) shall be adjusted. If the age of the insured is younger than reported, the premium shall be decreased and the insurer must return the premium difference.

3. Effect of breach of warranty and condition precedent

The Croatian legal system does not proscribe for the effects of breach of warranty and condition precedent with regard to insurance contracts. Hence, the parties should agree on the effects of such a breach between themselves.

4. Consequences of late notification

Save for life insurance, the insured must notify their insurer of the occurrence of an insured event within three days of becoming aware of it, unless a longer notification period is stipulated in the general insurance terms and conditions. In case of late notification, the insured is obliged to reimburse the insurer for any damages caused.

Contractual provisions that deprive an insured of their right to compensation (or insurance benefit) are null and void if he fails to fulfil any of his obligations after the occurrence of an insured event.

5. Entitlement to raise a claim against an insurer

The insured (and the beneficiary in whole life insurance) has the right to raise a claim against the insurer under the insurance contract. In third-party liability insurance, the third party is automatically entitled to raise a claim directly against the insurer.

6. Entitlement to damages from an insurer for late payment of claim

The insurer is obliged to complete the loss-adjusting proceedings within the timeframe agreed in the insurance contract, but not later than 14 days after receiving notification of the insured event. If unable to complete within 14 days, the insurer is obliged to pay the insured the contracted insurance premium within 30 days of receipt of the claim or inform the insured that his claim is unfounded. If the amount of the insurer's obligation has not been determined within the mentioned timeframes (14/30 days), the insurer is obligated to pay the insured an advance payment of the indisputed amount, immediately. The damages for late payment of claims consist of the insurer's obligation to pay default interest from the day of receipt of the notification of the insured event as well as compensation for damages that are a consequence of the insurer being late with the payment of the claim.

In regards to transport insurance, the insurer is obligated, within sixty days, to determine if the claim is founded or not, the amount of the claim and to deliver the claimant an offer for damages (responsibility and the amount are indisputable) or a response to the claim (responsibility or the amount are disputable). If the insurer does not abide by his aforementioned obligation, then the injured party has a right to file a lawsuit against the insurer. If the insurer does not pay the injured party the amount of damages or the iindisputed amount of damages within sixty days, the injured party has a right, along with the owed amount of damages, to default interest from the day of filing the claim.

7. General rules concerning the limitation period for claims

The limitation period for claims expires three years after the first day following the calendar year in which the claim originated. The limitation period for claims arising from life insurance is five years. If the insured person was unaware of the insured event having occurred, the limitation period begins on the day on which the insured person became aware of it. In any case, the limitation period expires after five years, or ten years in the case of life insurance. The insurer's claim arising from the insurance contract expires in three years.

In the case of third-party liability insurance, where an injured person claims and obtains compensation from an insured person, the limitation period of three or five years for the insured's claim against the insurer runs from the day the injured person filed a claim against the insured person, or when the insured person reimbursed the damages.

The limitation period for a direct claim for damages by an injured party against an insurer expires three years after the injured party became aware of the damage and of the person responsible. In any case, the limitation period expires after five years following the damage. If the damage was caused by a criminal offence, a longer limitation period will apply.

8. Policy triggers with respect to third-party liability insurance

There are two triggers: (i) the occurrence of an insured event; and (ii) a beneficiary's claim for reimbursement of damage.

9. Recoverability of defence costs

In third-party liability insurance, the insurer shall, within the amount of the insurance premium, bear the proceedings costs and other justifiable costs made in order to determine the insured's responsibility.

10. Insurability of penalties and fines

Under D&O insurance policies, it is possible to cover amounts ordered by the court for breach of law, administrative and misdemeanour fines that are insurable according to Croatian law. However, penalties within the scope of the Criminal code shall not be covered.

Contacts

Sandra Lisac
E sandra.lisac@bmslegal.hr

Marija Mušec
E marija.musec@bmslegal.hr

Czech Republic

1. Introduction

In general, insurance activity in the Czech Republic can be undertaken by (i) an insurer with a Czech insurance licence granted by the Czech Insurance Market Regulator, the Czech National Bank (the "CNB"); (ii) an insurer based in another EU or EEA member state which has established a branch in the Czech Republic; (iii) an insurer based outside the EU or EEA which has established a branch in the Czech Republic and has obtained a Czech insurance licence; and (iv) an insurer based in the EU or EEA that has undertaken insurance business in the Czech Republic on a temporary basis.

The CNB (as the Czech Insurance Market Regulator) can grant a Czech insurance licence to a joint-stock company, a cooperative established under Czech law or a Czech branch of the insurance company based outside the EU or EEA. The process of establishing a Czech joint-stock company or cooperative and obtaining a Czech insurance licence from the CNB can be rather costly and may take several months.

Insurers based in EU and EEA member states can operate in the Czech Republic through a branch established in the Czech Republic. They do not need to obtain a special licence from the CNB to establish a branch. However, they must fulfil information obligations with respect to the Insurance Market Regulator in their home member state before undertaking insurance activities in the Czech Republic. It is less expensive for an insurer from the EU or EEA to establish a branch office in the Czech Republic, rather than obtaining a licence from the CNB. Insurers from countries outside the EU and the EEA can also establish a branch in the Czech Republic but this is usually rather lengthy and costly as it involves obtaining a special licence from the CNB.

2. Effect of misrepresentation and/or non-disclosure

The policyholder and the insured are obliged to provide true and complete answers to all of the insurer's written questions concerning the insurance to be provided. If the policyholder or the insured provides untrue or incomplete answers either deliberately or due to negligence during negotiation of the insurance contract, the insurer is entitled to withdraw from the insurance contract (if the insurer proves that it would not have otherwise provided the cover).

The insurer can refuse to pay insurance benefits under an insurance contract if the insured event was caused by a material fact which the insured failed to disclose (either deliberately or negligently) and if the insurer would not have provided cover in knowledge of the event when concluding the insurance or if this information would have resulted in the insurer providing cover on different terms.

The insurer has the right to reduce insurance benefits accordingly, if: (i) a lower premium has been determined by the insurer as a result of untrue or incomplete answers provided by the policyholder or the insured to the insurer's written questions concerning the insurance cover provided; (ii) the breach of obligations of the policyholder or the insured to provide true and complete information to the insurer had a material impact on the occurrence of an insured event, its course or on the increase in the scope of its consequences and/or the establishment or determination of the amount of insurance benefits.

3. Effect of breach of warranty and condition precedent

Czech insurance law does not recognise such concepts as warranties in the insurance contract or conditions precedent to coverage.

Therefore, general civil law principles set out in the Czech Civil Code shall apply. In this respect, parties to an insurance contract may agree on conditions precedent. In cases where the parties agree on certain warranties, any breach of such clause would have similar impacts as the aforementioned breach of obligation to present true and complete information to the insurer. Czech law does not restrict usage of warranties, conditions precedent or subsequent provided that such clauses are in line with good morals and other mandatory rules of law. Every insurer should analyse usage of such clauses when dealing with consumers, considering the consumer protection laws.

4. Consequences of late notification

The beneficiary under a contract is obliged to: notify the insurer without undue delay or within a period of time agreed in the insurance contract of an insured event; give truthful explanation of the occurrence and scope of the consequences of this event and the rights of third parties arising as a result of the event and other insurance (if any); submit necessary documents; and proceed in the manner agreed in the insurance contract. If the beneficiary is not the insured and the policyholder, the insured and the policyholder have the same obligation.

If a breach of the above obligations has a material impact on the consequences of the insured event and/or the establishment or determination of the amount of relevant insurance benefits, the insurer can reduce the insurance benefits proportionately to reflect the impact of such a breach on their obligation to provide benefits

5. Entitlement to bring a claim against an insurer

In general, the beneficiary (usually the insured) has the right to bring a claim resulting from an insurance contract directly against the insurer. This would be typical in liability insurance such as MTPL insurance.

6. Entitlement to damages from an insurer for late payment of claim

Czech law establishes that the insurer is obliged to investigate the claim within three months from the notification of occurrence. The insurer may extend its inquiries and investigations if there are material reasons for doing so. In such a case, the insurer must pay an advance payment of up to 100% of the indemnity to the beneficiary upon the beneficiary's request, although the insurer may later reject the claim and demand the advance payment back from the beneficiary.

The insurer is liable to pay damages to the insured if there is fault on the insurer's part. Such damages may consist of the damages caused by the delay of payment or by non-performance. However, Czech practice is not very favourable to such types of claims.

7. General rules concerning the limitation period for claims

In the Czech Republic the right to benefit from an insurance contract lapses after three years or after ten years for life assurance. In the case of liability insurance, the right to benefit lapses at the latest on the lapse of the insured's right to damages under the insurance contract.

The limitation period in respect of the right to insurance benefits begins one year after the occurrence of the insured event. This applies also if the injured party became directly entitled to the payment of insurance benefits or if the insured requests reimbursement of the amount provided as compensation.

8. Policy triggers with respect to third-party liability insurance

The parties to an insurance contract are free to agree the insurance as an occurrence based policy (i.e. based on the moment when the insured becomes liable for damages to a third party) or as a claims-made policy.

Claims-made coverage is not expressly envisaged by Czech insurance law. However, there are no particular difficulties regarding claims-made coverage. In practice, claims-made policies are a market standard, for example in respect of D&O insurance.

9. Recoverability of defence costs

Defence costs are not standardly recoverable under Czech law. The Czech insurance practice does however recognise the insurance of legal costs.

In general, any party to court proceedings in the Czech Republic has to bear costs it has incurred during the proceedings. Following the applicable "losing party-pays-rule", the entirely or largely losing party has to compensate the other party for all recoverable costs necessarily incurred by the winning party in taking the "appropriate legal actions". This means, for example, costs incurred relating to court, expert and lawyer fees and expenses. Similarly, an insurer that has successfully defended a claim in court may recover its costs from the claimant.

However, courts award compensation on a fixed basis in accordance with the applicable ordinance of the Ministry of Justice. As a result, defence costs standardly do not fall into any category of damage per se.

10. Insurability of penalties and fines

Czech insurance regulations do not set out any explicit rule in this regard but we note that it is very likely that coverage of fines and penalties for criminal and administrative liability would contradict public policy. Insurance terms standardly exclude coverage for any liability for criminal or administrative offence, tort etc. Although we are aware that in 2010, one Czech insurer introduced insurance against certain (unintentional) misdemeanours, prompting another renowned insurer to condemn this and state officially that they do not support or prepare such products. The Ministry of Finance of the Czech Republic commented that one of the major elements of insurance is randomness whereas actions leading to liability for torts and misdemeanours lack this element. The said insurer no longer offers such coverage.

On the other hand, D/O insurance or various assistance services are common parts of insurance products in the Czech Republic.

Contact

Tomáš Matějovský
E tomas.matejovsky@cms-cmno.com

Petr Benes
E petr.benes@cms-cmno.com

England and Wales

1. Introduction

Insurers are dual regulated firms in the UK. They are authorised and regulated from a prudential perspective by the Prudential Regulation Authority ("PRA") and are regulated from a conduct perspective by the Financial Conduct Authority ("FCA"). The regulation of insurers operates under the framework of legislation established by the Financial Services and Markets Act 2000 ("FSMA") and, more recently, the Financial Services Act 2012 ("FSA 2012"). FSMA is heavily influenced by the large body of EU insurance directives, which sought to put in place a harmonised regime of insurance regulation across the EU.

The FCA decided some years ago to introduce a modern risk-based approach to financial requirements for UK insurers based on individual capital assessment by firms adjusted, where necessary, by capital guidance from the FCA. In many respects the UK regime anticipated many of the techniques in Solvency II, which was implemented in the UK in January 2016. Despite this, the implementation of Solvency II did pose a major challenge for UK insurers and the PRA continues to monitor its effects to ensure that gaps in the regulatory framework do not emerge.

One feature of UK insurance is the unusual structure of the Lloyd's insurance market. This is expressly recognised in the EU Directives, which include the association of underwriters known as Lloyd's as a permitted form of insurer. The structure of the Lloyd's market does, however, give rise to complexities both under domestic arrangements and when applying the EU and UK prudential regime to the different participants in the Lloyd's market – at the level of the Society, underwriting members, syndicates and managing agents.

In the UK, insurance regulation comprises not just regulation of an insurer itself but also the personal regulation of certain individuals, such as those holding senior insurance manager functions (who fall within the PRA's Senior Insurance Managers Regime) and those otherwise exercising significant influence (who fall within the FCA's Approved Persons Regime), within the firm. This aspect of insurance regulation is specific to the UK rather than being derived from the EC Directives, and it effectively requires directors, non-executive directors and others holding certain defined functions to make an individual promise that their firm will be run compliantly.

Customers that are dissatisfied with insurers may, in certain circumstances, take their complaint to the Financial Ombudsman Service (the "FOS"), which was established under FSMA. The FOS has jurisdiction over:

— consumer claims
— claims by micro-enterprises, i.e. businesses employing fewer than ten people and with a turnover or annual balance sheet that does not exceed EUR 2m
— charities with an annual income of less than GBP 1m at the time of the relevant complaint
— a trustee of a trust which has a net asset value of less than GBP 1m at the time of the relevant complaint.

The FOS has jurisdiction to make awards of up to GBP 150,000 (excluding interest and costs). It provides a scheme whereby disputes between qualifying insureds and insurers may be resolved quickly and with minimum formality by an independent body, without recourse to UK courts. The FOS is not bound by precedent, but rather must determine cases based on what the Ombudsman considers to be fair and reasonable in the particular circumstances of the case. As a result, FOS decisions can be unpredictable and there is a perception that they tend to favour the complainant.

In addition, the London Market through the Contract Certainty Steering Committee and Market Reform Group (a cross London Market organisation) has implemented a code of practice called the Contract Certainty Code of Practice along with a template insurance contract, the Market Reform Contract. The idea is to (a) ensure that contract terms are clear and unambiguous by the time the offer is made to enter into the insurance contract, or the offer accepted; and (b) have the contract documentation provided to the insured promptly. This means within seven working days for retail customers and 30 calendar days for all other client classifications, with the timescales measured from the later of the date on which the contract is concluded or the policy incepts (and where there is more than one participating insurer, the date on which the final insurer enters into the contract). The Market Reform Contract sets out certain policy terms which must be separately and clearly labelled.

Scotland

Although there are separate legal systems and procedural differences between the jurisdictions of the UK, the law relating to insurance in England, Wales and Scotland is substantially the same. Most insurance in the UK is written out of London and is consequently governed by English law.

Following a review of insurance law by the English and Scottish Law Commissions (the Law Commissions), a number of key changes were brought into effect by the introduction of the Consumer Insurance (Disclosure and Representations) Act 2013 (CIDRA) on 6 April 2013 and by the Insurance Act 2015 (the Insurance Act) on 12 August 2016. The Insurance Act applies to all policies entered into on or after 12 August 2015 and, in respect of the duty of fair presentation, to any variations to existing policies. The law pre-dating the Insurance Act (the Marine Insurance Act 1906) will continue to apply to policies entered into before that date. For a comprehensive review of the Insurance Act please see the following link: http://www.cms-lawnow.com/insuranceact2015.

2. Effect of misrepresentation and/or non-disclosure

Under sections 18 and 20 of the Marine Insurance Act 1906, the insured was obliged to disclose all material circumstances that it knew or ought to have known in the ordinary course of its business. The insured was also obliged not to make a misrepresentation to the insurer.

To rely on a misrepresentation or non-disclosure, the underwriter must have been 'induced' by that misrepresentation or non-disclosure, i.e. had they known the true position, the underwriter would have amended the terms or not have written the risk at all.

The insured was not required to disclose matters that:

1. diminished the risk;
2. were known by the underwriter;
3. were matters of common notoriety;
4. were waived by the insurer; or
5. were superfluous because of a warranty in the policy.

Where an insured had made a non-disclosure and/or misrepresentation, the insurer's only remedy was avoidance of the policy 'ab initio'. The insured was entitled to avoid even where the insured acted innocently. This means that the policy was treated

as never having existed and the insurer must refund the premium (save where the insured acted fraudulently).

Non-consumer Insureds

For policies entered into on or after 12 August 2016, non-consumer insureds are subject to a new duty of fair presentation. A fair presentation is one:

1. that discloses every material circumstance that the non-consumer insured knows or ought to know (based on what would have been revealed by a reasonable search for information and what was known to the non-consumer insured if an individual or senior management in the case of an entity), or gives sufficient disclosure to put a prudent insurer on notice that it needs to make further enquiries;
2. that makes the disclosure in a reasonably clear and accessible manner to a prudent insurer; and
3. in which every material representation as to a matter of fact is substantially correct and every material representation as to a matter of expectation or belief is made in good faith.

Non-consumer insureds are not required to disclose matters that:

1. diminish the risk;
2. are actually known by the insurer;
3. ought to be known by the insurer (what an insurer ought to know is defined in the Insurance Act and imposes a positive duty on employees of an insurer to pass on knowledge to the relevant underwriters and also includes information that is held by the insurer and readily available.);
4. the insurer is presumed to know; or
5. have been waived by insurers.

If the insured acted deliberately or recklessly in breaching the duty of fair presentation, the insurer can avoid the policy and keep the premium. Otherwise, the insurer's remedy depends on what it would have done had it been fully apprised of the facts:

— if the insurer would not have entered into the contract of insurance at all, it can avoid the policy but must return the premium; or
— if the insurer would have written the policy but on different terms or for different premium, it can treat the policy as if those different terms applied and can reduce any claims payments in proportion to the additional premium that it would have charged (i.e. if the insurer would have doubled the premium, it can half all claims payments under the policy).

Consumer Insureds

CIDRA defines a "consumer" as an individual who enters into a contract of insurance wholly or mainly for purposes unrelated to the individual's trade, business or profession.

For consumer insureds, CIDRA replaces the duty to disclose material facts with a duty to take reasonable care not to make a misrepresentation to the insurer before the insurance contract is entered into. A statement can be a misrepresentation if it is incomplete, even if it is literally true.

The insurer's remedy depends on whether the breach of the duty not to make a misrepresentation is deliberate or reckless; or careless.

1. Deliberate or reckless: the insurer can avoid the contract (and retain premium paid, unless that would be unfair to the consumer). Deliberate or reckless means that the insured either knows that the misrepresentation is untrue or misleading (or does not care whether it is) and knows that what is misrepresented is relevant to the insurer (or does not care whether or not it is). This is for the insurer to prove.
2. Careless: a scheme of proportionate remedies applies, depending on what the insurer would have done if the insured had complied with the duty. If the insurer would not have entered into the contract on any terms, it can avoid the contract and refuse to pay claims (but must return the premium). If the insurer would have entered into the contract on different terms (for example by including an exclusion or excess), the policy is treated as though the different terms apply. In addition, if the insurer would have charged a higher premium, a claim is reduced proportionately using the formula set out in CIDRA. If, for example, the insurer would have charged a premium of GBP 200 but the premium actually charged was only GBP 100, the claim is reduced by 50%.

If a misrepresentation is careless but does not relate to an outstanding claim and the insurer would not have written the risk (or only on different terms) or charged a higher premium, the insurer can either give notice to that effect to the insured (in which case the insured has the option to terminate the contract); or (except in the case of life insurance policies) give reasonable notice to terminate the contract.

3. Effect of breach of warranty and condition precedent

The Marine Insurance Act 1906 defines a warranty as a term *"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 negates the existence of a particular state of facts"*. A bare condition, on the other hand, stipulates an obligation. It would normally state what the insured's conduct during the term of the policy should be, such as in relation to a claim submission. Some conditions may be stated to be a condition precedent to risk or liability; these are collectively called conditions precedent. Conditions precedent to the risk are those that must be satisfied before the insurer comes on risk, for example, payment of a premium. Conditions precedent to liability are those that need to be satisfied before the insurer liability for payment arises (but once the insurer is already on risk). It may, for example, state that the insured is to submit any claim within two weeks of becoming aware of it.

Breach

Warranty: For policies entered into (including renewals) before 12 August 2016, warranties must be "exactly complied with" pursuant to section 33 of the Marine Insurance Act 1906. Thus any inaccuracy would discharge the insurer from all liability for loss from the date of the breach of warranty regardless of whether or not the breach of warranty was in any way connected to any loss(es) suffered by the insured or whether the breach was remedied before any loss was incurred.

The law pre-dating the Insurance Act was considered outdated and too insurer friendly by the Law Commissions and the following changes were introduced in the Insurance Act for both consumer and non-consumer insureds (although it should be noted that reliance on a breach of warranty or condition precedent against a consumer insured is unusual):

1. "basis of contract" clauses were abolished. A "basis of contract" clause is one that converts a pre-contractual representation by the insured into a warranty, for example, a clause incorporating the responses in a proposal form as warranties in the policy. It is not possible for the parties to contract out of the abolition of basis-of-contract clauses
2. breach of warranty no longer terminates the insurer's liability from the date of breach, rather, it suspends the insurer's liability until the breach is remedied. Where the breach is remedied before a loss, the insurer is liable to pay the claim
3. if the term (whether a warranty, condition precedent or other term) was intended to reduce the risk of loss of a particular kind, at a particular location or at a particular time, the insurer cannot rely on breach of the term if the non-compliance could not have increased the risk of the loss that actually occurred

Condition: If insurers can demonstrate that they suffered prejudice, breach of a condition will give rise to a claim in damages, for breach of contract.

Condition Precedent: For policies taken out before 12 August 2016, failure to comply with a condition precedent amounted to an absolute bar to making a claim although, in practice, insurers' reliance on a condition precedent would depend on the circumstances.

However, under the 2015 Act, and therefore from 12 August 2016, a breach of condition precedent will not release an insurer from liability if the breach did not affect the loss for which the insured is claiming.

4. Consequences of late notification

Insurance policies will usually contain loss or claim notification obligations imposed on the insured. These may impose specific time limits in which a notification must be made (for example within 30 days of the insured under a professional indemnity policy first becoming aware of a claim against it or a circumstance which may give rise to a claim). Alternatively, it may require notification 'immediately' or 'within a reasonable time'. The consequences of late notification will depend on whether the clause is designated a condition precedent to liability or not. If the clause is not a condition precedent, then the breach will entitle the insurer to damages only. To claim damages, the insurer must have suffered prejudice. For more information on breach of conditions precedent, please refer to item 3 above.

5. Entitlement to bring a claim against an insurer

A claim under an insurance contract is a claim for damages for breach of contract, even where the insurer admits liability. Damages are categorised as the insurer's promise to indemnify the insured.

In the case of non-indemnity insurance (e.g. life, accident or health, which pay out a fixed sum in the event of a loss), the claimant recovers the amount stated in the policy. In the case of indemnity insurance, the claimant recovers the amount of his actual loss, subject to the maximum sum insured (the limit of indemnity) and to any deductible provisions (the amount for which the insured is liable before recovery can be made from the insurer). Although, as a general rule, a contract of property insurance is a contract of indemnity, the parties are free to contract out of this by agreeing that a certain sum is payable in the event of a loss. This is known as a valued policy.

6. Entitlement to damages from an insurer for late payment of claim

A new section 13A was added to the Insurance Act by the Enterprise Act 2016, which came into force on 4 May 2017. It implies a term into all consumer and non-consumer insurance contracts that the insurer must pay any sums due in respect of a claim within a reasonable time.

Section 13A does not define "reasonable time" but says that it will depend on the relevant circumstances. This is in line with the approach that has generally been taken by the courts when interpreting the phrase, for example, where notification of a claim is required to be within a reasonable time. The section sets out the following, non-exhaustive, examples of factors that the courts may take into account:

— The type of insurance;
— The size and complexity of the claim;
— Compliance with any relevant statutory or regulatory rules or guidance; and
— Factors outside the insurer's control.

Section 13A states that a reasonable time will include a reasonable time to investigate and assess the claim. In addition, if the insurer can show that it had reasonable grounds for disputing the claim (including how much is payable), it will not be in breach of the implied term but the insurer's conduct may be a relevant factor in deciding whether the implied term had been breached.

For commercial insurance, insurers can contract out of the new duty and exclude or limit their liability for late payment of claims if:

— they satisfy the transparency requirements, and
— they have not acted deliberately or recklessly

An insurer would act deliberately or recklessly if it knew it was in breach of the duty to pay a claim within a reasonable time or did not care whether or not it was.

Parties to consumer insurance contracts cannot contract out of the late payment of claims provisions and substitute terms that would put the consumer in a worse position than they would be in under the Insurance Act.

7. General rules concerning the limitation period for claims vs Insurers

The limitation period for an action for breach of contract is six years (Limitation Act 1980, Section 6). Under a liability policy (third-party loss), a cause of action does not accrue until the liability of the insured is established, whether that is by judgment, arbitration or agreement. In all other forms of insurance (including property, life and marine) the insurance policy is to be construed as insurance against the occurrence of an insured event. The occurrence of that event is treated as equivalent to a breach of contract by the insurer. Therefore, absent any specific terms in the policy, for non-liability policies the limitation period begins to run as soon as the insured event occurs, even if the insured has not made a claim.

There is also a one-year time limit for bringing a claim against the insurer for late payment of claims. The one-year period for bringing a claim will run from the date when the insurance claim is settled. The intention behind the time limit is that it will assist insurers in reserving for claims where there is a risk of a claim for late payment. The one-year time limit will operate in addition to the usual limitation period of six years from the date of breach of contract so that a claim for late payment will be time-barred by whichever period ends soonest. For example, a claim under a policy is made on 31 January 2016 and settled by the insurer on 31 January 2020. The limitation period for breach of contract (six years) would expire on 31 January 2022 but under the new rule (one year from settlement of the claim) would expire on 31 January 2021. A claim for damages for late payment would have to be brought by the earlier date, in this case 31 January 2021.

8. Policy triggers with respect to third-party liability insurance

There are broadly three common ways in which cover under a third-party liability cover is triggered.

The first is on a 'claims made' basis, where the claim against the insured is first made during the policy period even if the event giving rise to the claim occurred prior to the policy period. This type of cover is common in professional indemnity and directors and officers insurance policies, for example. In addition, the policy may extend cover to include circumstances notified during the policy period which 'may' or 'are likely to' (or some other causal link) give rise to a claim, even if the claim subsequently materialises after the end of the policy period. This is commonly known as a 'deeming provision'.

Secondly, the policy may be a 'losses occurring' policy. This requires the third party to have suffered injury during the policy period.

Thirdly, the policy may provide cover where the event giving rise to the loss occurs during the

policy period, even where the loss does not occur until after the policy period. These are 'event occurring' policies.

The difference between 'losses occurring' and 'event occurring' policies may be important in exposure cases under employers' or public liability policies where the third party is exposed to a harmful substance (such as asbestos) for a number of years but there is no injury until a later date.

9. Recoverability of defence costs

Insurance policies governed by English law usually include cover for the costs incurred by the insured in defending a claim, if such claim would (at least in principle) be covered by the relevant policy. Some policies will include limitations to such defence cover, however, including the requirement for use of one of the insurer's solicitor's panel firms or a cap on solicitor fees.

At least some of the legal costs incurred when defending a claim may be recoverable by the defendant insured (and the insurers themselves, consequently, if they provided defence cover) if the defendant is successful. The court will govern the recovery process, but it tends to include the costs of legal representatives (including solicitor and counsel's charges) and disbursements incurred in defending the claim, such as for experts' opinions and the costs incurred in instructing foreign lawyers.

Note that the defendant, if the successful party, is only entitled to recover the costs he or she has actually incurred, i.e. no profit can be made out of a successful court decision. In practice, a full payment of the costs incurred will rarely (if ever) occur as the losing party will normally challenge the winning party's costs and the award of costs is subject to:

— the conduct of the parties;
— the reasonableness of the costs incurred;
— whether the "losing party" has succeeded on part of his/her case; and
— any admissible offer to settle made by a party which is drawn to the court's attention.

10. Insurability of penalties and fines

The general position is that the *ex turpi causa non oritur actio* defence (which prohibits a party from recovering damages which are a consequence of that person's own illegal or unlawful act) is likely to apply, meaning that insurance contracts covering criminal fines are unenforceable.

With respect to administrative fines, and subject to any regulator specific rules, the application of the *ex turpi causa non oritur actio* defence is not as clear as the insurability of an administrative fine will depend on a number of factors, such as whether:

— the law bringing about the fine is enacted for the protection of the public interest;
— the breach of law is intentional/malicious and causes significant harm ("moral reprehensibility"); and insurability prevents an organisation from taking their obligations seriously.

Contacts

Alex Denslow
E alex.denslow@cms-cmno.com

Alaina Wadsworth
E alaina.wadsworth@cms-cmno.com

Liliane Fozard
E liliane.fozard@cms-cmno.com

France

1. Introduction

The French regulatory and supervisory authority in charge of insurance activities is the '*Autorité de contrôle prudentiel et de résolution*' (ACPR), with competence for supervising insurance companies and insurance intermediaries. The French regulations that apply to insurance activities are based on the provisions of the Insurance Code. Insurance activities can be performed in French territory by:

— French companies that have been granted an insurance licence by the ACPR. Licensing requirements include the obligation to submit a business plan. The ACPR assesses the adequacy of the technical and financial means of the applying company with the proposed business plan and takes into account the allocation of corporate capital and the shareholders. The granting of the licence may be conditional on specific commitments imposed on the applying company. The duration of the licensing procedure cannot in principle exceed six months from the moment the application file is completed. Licensed French insurance companies can perform their activities in France either through their French headquarters or through a branch established in another EU Member State.

— EU insurance companies licensed in their home country that have passported their activities licensed under their home country regulations. Such companies can perform their activities in France (subject to the relevant home country authorities notifying the ACPR) either through a French branch (on a freedom-of-establishment basis) or directly through their home country headquarters or through a branch established in another EU Member State (on a freedom-of-services basis). If operating via a French branch, EU insurers must appoint a general representative who must be a French resident (either an individual or a corporate entity having its registered office in France and represented by a French resident individual).

— Insurance companies licensed in an EEA, but non-EU, country. Such companies can establish a branch in France subject to a licence being granted by the ACPR (the licensing requirements are lighter than those applying to non-EEA insurers. This includes Swiss insurance companies). Alternatively, they can provide their services directly from their home country headquarters (on a freedom-of-services basis), and do not require a licence for large risks (i.e. risks related to airplanes, trains, ships and vessels, freight, credit insurance to professionals or the activities and assets of large businesses as identified by turnover, number of employees and total balance) or subject to prior licensing by the ACPR for mass risks.
— Non-EEA insurers acting through a French branch licensed by the ACPR and that have appointed a French resident as their general representative in France, who must be agreed on by the ACPR.
— Any foreign insurer that wishes to insure motor vehicles in France must appoint a special representative based in France for claims management purposes.

2. Effects of misrepresentation and/or non-disclosure

Where the insured has intentionally misrepresented or not disclosed a fact that would impair the insurer's assessment of the risk, the insurance contract is void and the insurer is entitled to keep all paid and outstanding premiums.

In the case of non-intentional misrepresentation or non-disclosure, the insurer is entitled to increase the premium, provided the insured agrees to the increased premium, or to terminate the insurance contract with a pro-rata reimbursement of the premium. If the insurer becomes aware of the misrepresentation or non-disclosure only after a loss has occurred, the insurer is entitled to reduce the claim payment by taking the premium actually paid as a percentage of the premium that would have been due had the misrepresentation or non disclosure not occurred; for example, if a premium of EUR 100 would have increased to EUR 150, the claim payment will be reduced by a third.

3. Effect of breach of warranty and condition precedent

The concepts of "warranty" and "condition precedent" do not exist as such under French law but both fall into the category of condition for guarantee.

A breach of a condition for guarantee entitles the insurer to deny liability even if this breach is not related to the loss claimed (unless provided otherwise in the insurance contract). It lies on the insured to prove that the condition has been complied with.

There is a very thin line between the notions of "condition for liability" and "exclusion" under French law, courts having full power to qualify the nature of the provision at stake. If the provision is qualified as an exclusion clause, it shall be void if it is not written in apparent letters, and if its terms are not precise and limited. Moreover, it lies on the insurer to prove that the claim falls under the exclusion clause.

4. Consequences of late notification

The parties to an insurance contract can agree that the insurer has the right to refuse to pay a claim where the insured notifies late (although where the insured was late in providing documentation following notification of the claim to the insurer, an insurer cannot refuse to pay a claim, but can reduce the claim payment in proportion to the amount of loss suffered by the insurer). However, such clause cannot apply if the delay is the result of a force majeure or fortuitous event, or if it has not actually been prejudicial to the insurer. The time limit for notifying a loss must be clearly stated in the insurance contract and cannot be less than five working days.

5. Entitlement to bring a claim against an insurer

Third parties do not usually have a right to bring a claim directly against an insurer. However, under third-party liability insurance contracts, third parties who have suffered a loss have the right to bring a claim directly against the insurer. Beneficiaries also have direct rights against an insurer under life insurance contracts.

6. Entitlement to damages from an insurer for late payment of claim

In case of late payment of a claim, the insurer can be subject to the payment of default interests and, possibly, of compensatory damages. The default interest rate can be provided in the insurance contract. Otherwise, the legal rate applies. Default interests run from the date of the payment demand made by the insured. The insurer may also be sentenced to pay compensatory damages where the insured suffered a specific loss and late payment resulted from the insurer's bad faith.

7. General rules concerning the limitation period for claims

The limitation period for all claims arising out of an insurance contract is two years.

This period starts on the date that the insured became aware of the loss or, for third-party liability insurance, on the date the third party commences court action against the insured or is indemnified by the insured.

For life insurance, the limitation period within which the third-party beneficiary must bring a claim is ten years.

8. Policy triggers with respect to third-party liability insurance

Under third-party liability insurance, where the insured is an individual and the insurance contract is not a professional indemnity policy, the policy trigger will be the occurrence of the insured event. In other cases, the parties can agree whether the insurance contract will be a claims-made or occurrence based policy.

Claims-made policies must provide for a run-off period starting from the date of termination of the policy and having a minimum duration of five years (for some professional liabilities this is increased to ten years). Claims made during the subsequent period are insured only if they relate to insured events that occurred during the policy period. The limit of indemnity during the run-off period must be the same as the limit during the last year of the policy.

9. Recoverability of defence costs

In principle, the party who loses court proceedings shall compensate the legal costs incurred by the opposing party. However, courts enjoy full discretion as to the amount awarded to compensate such legal costs, and often grant lower allowances than the amount of fees actually incurred. The court may also rule that equity imposes that each party shall bear its own costs.

10. Insurability of penalties and fines

As a general principle, criminal penalties and fines are not insurable where the insured is the person held criminally liable. However, it is debated whether penalties and fines are insurable where the insured is not personally criminally responsible, but is civilly liable for the penalties imposed on third parties (e.g. the employer for some offences committed by its employees).

Contacts

Jean-Fabrice Brun
E jean-fabrice.brun@cms-fl.com

Laurent Mion
E laurent.mion@cms-fl.com

Anne Renard
E anne.renard@cms-fl.com

Germany

1. Introduction

An insurer can undertake insurance activities in the Federal Republic of Germany with an insurance licence granted by the Federal Financial Supervisory Authority (BaFin). BaFin can grant a licence to a joint stock company, a European company (SE), a mutual association or a corporation under public law. The process of establishing a German joint stock company or mutual association and obtaining a German insurance licence can be costly and may take several months.

Insurers based in EU and EEA countries can undertake insurance activities in Germany on a freedom-of-services basis. This is relatively inexpensive and does not require a complex formal procedure. Insurers based in EU and EEA countries can also operate through a branch established in Germany (freedom of establishment). In both cases, the insurers do not need to obtain any special licence from BaFin.

However, the home country regulator is required to submit information to BaFin before the insurer commences its activities in Germany. If the insurer establishes a branch, this branch also has to be incorporated in the local commercial register.

In March 2011, updated in August 2017, BaFin informed about the laws and provisions insurers based in EU or EEA countries must comply with for the general good, if they carry on direct insurance business in Germany through a branch or cross-border provision of services.

Insurers from countries outside the EU and EEA can also establish a branch in Germany, but need a special licence from BaFin. 'Home-foreign insurance/insurance by correspondence' (insurance written in one country on property or risks located in another country) can be undertaken by insurers from outside the EU and EEA without a branch in the EU and EEA countries, as long as the policy has been taken out on the insured's

initiative. Accordingly, insurers from outside the EU and EEA cannot act on a freedom-of-services basis in Germany.

2. Effect of misrepresentation and/or non-disclosure

Under German insurance law there can be contractually agreed duties for the insured but these are not legally enforceable. However, the insured should endeavour to fulfil these duties, otherwise, in specific circumstances, the insurer may be entitled to terminate cover under the insurance contract.

Under the German Insurance Contract Act (VVG), there is an obligation on the insured to provide information when seeking cover. The insured must inform the insurer of all known circumstances which are relevant for the insurer's decision to write the risk, and which the insurer has expressly asked for in 'textform' (as defined under German law to mean in writing, via fax or email). The insured is not obliged to disclose any circumstances or risks that the insurer did not ask for in writing.

Case law precludes brokers from using their own forms when requesting information from a potential insured. In cases where a broker is involved in the process of a potential insured seeking cover and uses its own form, it is necessary for the insurer to at least adopt the questions as 'its own' and that this is clear to the insured. It is advisable for insurers to prepare questions on their own and provide brokers with their question forms.

If the insured fails to inform the insurer of all known circumstances which the insurer requested in writing, the insurer will be entitled to avoid the contract only if the insured has acted with gross negligence. In the event of an innocent breach or simple negligence on the part of the insured, the insurer will only be entitled to cancel the contract but will still be liable for claims arising out of insured events that have already occurred and have been notified.

Unless there has been deliberate misrepresentation and non-disclosure, the insurer cannot avoid or cancel the contract if, being aware of the actual circumstances, it would have written the risk albeit on a different basis. In this situation, upon the insurer's request, the cover can be amended retrospectively.

However, if the premium increases by more than 10%, the insured may cancel the contract.

In each case the insurer must inform the insured in writing of the possible consequences of breach of the duty to notify. Further, if the insurer was independently aware of the misrepresentation or non-disclosure, it cannot rely on the breach.

Under the German Insurance Contract Act, if there is an increase of risk, and the insured becomes aware of this, the insured is obliged to notify the insurer without undue delay.

If the insured does not comply with this obligation, the insurer may cancel the contract, demand a higher premium, or exclude the increased risk from the cover. These rights are available to the insurer for one month from the time that the insurer becomes aware of the increase in risk, and will cease if the risk reverts to its original level.

If a claim is made after an increase in risk, and the insured deliberately caused the increase in risk, the insurer is released from its obligation to provide cover. If there has been gross negligence on the part of the insured, the extent of the insurer's release from their obligation to provide cover will depend on the circumstances of the individual case. The insurer is entitled to reduce cover in proportion to the extent of the insured's negligence. In both cases, the increase in risk must have caused the loss or the extent of the loss. The insurer remains obliged to pay if a claim is made and the insurer has not cancelled the contract within one month.

3. Effect of breach of warranty and condition precedent

An insurance contract may contain contractual obligations to perform precedent to the insured event. (These are different from the English concept of 'conditions precedent', which refers to an event or state of affairs that is required before something else will occur and which must occur, unless its non-occurrence is waived, before any contractual duty arises). In German law, the contractual duty of the insurer may arise even if the contractual obligation precedent to the insured event has not been fulfilled. If there is an intentional or grossly negligent breach of the contractual obligation, the insurer may cancel the contract within one month from the time it became aware of the breach.

An intentional breach of any contractual obligation of the insured (not just the conditions precedent to the insured event) will release the insurer from its obligation to perform. If there has been gross negligence on the part of the insured, the insurer is entitled to reduce cover. The breach must have caused the loss or increased the extent of the loss. The insurer must notify the insured in writing of the possible consequences of a breach in order to be able to rely on the breach.

4. Consequences of late notification

The insured is obliged to notify the insurer without undue delay as soon as he becomes aware of the claim. However, there is no legal or statutory penalty for breach of the obligation of notification. If there is no contractual agreement between the parties, the insurer cannot decline cover. The parties need to agree contractually as to the consequences of late notification but may only stipulate the consequences of the breach of contractual obligations as provided for in the German Insurance Contract Act (see above).

The insurer cannot decline cover if he is notified of the claim by another source.

5. Entitlement to bring a claim against an insurer

The insured (and the beneficiary in whole life assurance) has the right to raise a claim against the insurer under the insurance contract.

In third-party liability insurance, the third party is not automatically entitled to raise a claim directly against the insurer but must raise a claim against the insured. This does not apply to compulsory motor liability insurance, where the third party may raise a claim directly against the insurer of the motor vehicle as well as against the insured.

6. Entitlement to damages from an insurer for late payment of claim

Claim monies are due when loss adjusting proceedings are finalised. If the insurer does not pay then, he can be liable for damages according to the principles of German civil law laid down in the Civil Code. He is usually only liable for damages if he has not paid following a warning notice from the insured. Bringing an action for performance or serving a demand for payment in summary debt proceedings for recovery of debt have the same effect as a warning notice. There is, inter alia, no need for a warning notice if the insurer seriously and definitely refuses performance. The insurer is only liable, however, if he is responsible for the delay or non-payment. If the civil law requirements for default are fulfilled, the insurer is liable for all resulting damages. At least, the insured can claim default interest which cannot be less than the amount foreseen by law.

7. General rules concerning the limitation period for claims

Under the German Civil Code, the limitation period is three years, beginning with the end of the year that the claim comes into existence. When a claim under an insurance contract is notified to the insurer, limitation is stayed until the insured obtains the insurer's decision in 'textform'.

8. Policy triggers with respect to third-party liability insurance

There are four common ways in which cover under a third-party liability policy is triggered.

- Occurrence basis: This principle is the most common one in Germany. It requires the occurrence of a loss where a third party suffers damage. It is possible to take out run-off insurance to limit the risk of late claims under an expired policy.
- Claims-made basis: The claim against the insured is covered when it is first made during the policy period, even if the event giving rise to the claim occurred prior to the policy period. In addition, the policy may extend cover to include circumstances notified during the policy period which 'may' or 'are likely to' (or some other causal link) give rise to a claim, even if the claim subsequently materialises after the end of the policy period. This is commonly known as a 'deeming provision'. This type of cover is common in D&O insurance and in industrial third-party liability policies. The 'claims-made' principle is controversial but case law has recently found that the 'claims-made' principle can be agreed by the parties. However, there is some doubt as to whether this provides sufficient protection in professional indemnity insurance.
- Act-committed basis: This requires that the act that caused the damage is committed during the policy period. This is common in professional indemnity policies.
- Discovery basis: This requires that the damage is discovered during the policy period. This is common in environmental pollution policies.

9. Recoverability of defence costs

The insured must, upon the occurrence of the insured event, ensure that the loss is avoided or minimised wherever possible. In this regard, he has to follow the instructions of the insurer, where reasonable, and obtain instructions if the circumstances permit this. In return, the insurer has to reimburse the insured´s expenses, even if they remain unsuccessful, to the extent that the insured could deem them necessary. Upon request of the insured, the insurer has to advance the amount of the necessary expenses.

However, the expenses are not reimbursed if the insurer is not obliged to pay the claim. If the insurer is entitled to reduce the claim, he may also reduce the amount of the reimbursed expenses. Expenses incurred by the insured on account of his following the insurer's instructions are to be reimbursed in full even if they exceed the sum insured, taken together with the other compensation.

10. Insurability of penalties and fines

Penalties and fines are, according to the prevailing view, not insurable. This is due to the fact that such an insurance would violate the sanction character of penalties and fines and thus would infringe the so-called morality principles and ordre public.

Contacts

Winfried Schnepp
E winfried.schnepp@cms-hs.com

Tobias Bomsdorf
E tobias.bomsdorf@cms-hs.com

Hungary

1. Introduction

As of 1 January 2016 a new Insurance Act entered into force in Hungary, which provides common regulation to both insurance and reinsurance companies. The new Act basically aimed to implement Solvency II regulation and modernize the insurance-related legal environment. Along with the new Civil Code (of 2014), which updated insurance contract law, the Insurance Act really streamlined the regulation of the insurance sector in Hungary.

In Hungary, insurance companies can only operate in the following forms: (i) a private company limited by shares (most common form), (ii) a European private company limited by shares (SE), (iii) a cooperative, (iv) an association, (v) a branch office of a third-country insurer. In addition, EU Member State insurers and reinsurers may provide their services through FOE or FOS protocol (branch or cross border service). In both cases, the EU Member State insurer/reinsurer can pursue its insurance activity in Hungary primarily under the supervision of its home country regulator, but the HNB also exercises supervision over the activity (in particular from the consumer protection point of view).

Going through the licensing process with Hungarian National Bank (HNB), the integrated financial services authority, is a prerequisite for both insurers and reinsurers. The full licence is provided in two phases: in the first phase, the company must submit detailed supporting documentation and an application to the HNB for obtaining a foundation licence. In the second phase, within 90 days of receiving its foundation licence, the applicant needs to submit a request for an operational licence to undertake insurance/reinsurance. The administrative deadline for each phase is three months, however the HNB may extend the review period in each phase to an additional three months.

Reinsurance companies can operate in the form of: a private company limited by shares, a European private company limited by shares (SE), a cooperative or a branch office of a third-country reinsurer.

Third-country reinsurers may also provide reinsurance services in Hungary without having a local branch provided that an international agreement enables them to do so.

2. Effect of misrepresentation and/or non-disclosure

As an overall rule for all types of insurance, the contracting party (policyholder) must disclose, at the time of conclusion, all relevant and important circumstances that are known or should have been known by the party. The policyholder can make this declaration by virtue of truthfully filling out the questionnaire provided by the insurance company that is otherwise fully in line with market standards. As a special condition, simply leaving the questions unanswered (blank) does not constitute a violation of the disclosure obligation. Similar liability applies to notification of changes during the policy period. The breach of those obligations would lead to the insurer's exemption from its payment obligation unless the policyholder proves that the company was aware of the concealed or undisclosed circumstance at conclusion, or such circumstance did not impact the occurrence of the insurance event at all. The reporting duties apply both to the policyholder and the insured person.

Nevertheless, for life and health insurances, the law stipulates a five-year period as term of preclusion. If the insurer later gains knowledge of any material circumstance that existed at the date of conclusion, the company is entitled to exercise its related rights arising therefrom only during this first five-year period. If the insurance event occurs after this five-year period, the company's obligation takes effect notwithstanding any infringement of the disclosure obligation.

3. Effect of breach of warranty and condition precedent

If a warranty or condition precedent are associated with an insurance contract (policy), the effect of any respective breach might impact the policy, basically under conditions as freely set by the parties. The legal terminology for insurance does not use the term "warranty" and this needs to be rather interpreted as misrepresentation, with consequences as discussed earlier. Unlike warranty, the condition precedent impedes a right or duty to be fulfilled, until the certain conditions are met. Any respective breach might lead to the cancellation of the underlying provision or liability of their policy, which may result in consequences either set by the law or the insurance contract. From a protection perspective, consumer contracts would have limitations, to the benefit of individual (private) parties.

4. Consequences of late notification

Late claim reporting might affect the release of the payment or lead to a claims rejection if either the policyholder or the insured person fails to (i) report the occurrence of an insured event within the time period stated by the contract, or (ii) provide sufficient information, or (iii) facilitate verification of the information provided if a lapse in time makes the material circumstances unclear to the insurer. Either deliberate or negligent misconduct will give grounds to such a claims rejection.

5. Entitlement to bring a claim against an insurer

This depends on the specific contractual demand, as usually only the policyholder, the insured or the beneficiaries may bring a claim against the insurer. As a consequence, a third party is not entitled to make a direct claim against the insurer, irrespective of what relationship this third party holds with the insured. Liability insurance is the exception in this regard: (i) mandatory motor vehicle liability insurance automatically grants, as dictated by the law, the right to the injured third party (claimant) to bring such a claim directly against the insurer; and (ii) other liability insurance also provides such entitlement to a third party, as long as a declaration is made at the time when the damages covered by the policy are caused.

6. Entitlement to damages from an insurer for late payment of claim

In general, Hungarian law gives liberty to the parties to define the appropriate period or deadline for payment of an insurance claim. Insurers usually set a 15 day period from the date of the receipt of the last materially important document, by the end of which payment should be made. More complex contracts may require a longer period for payment. If the company fails to meet the predefined deadline and becomes delayed with the payment, the general consequences apply. Interest on delay becomes due, equals to the National Bank's basic interest rate as officially published on the first day of the half-year when the delay occurred. The rate is recalculated in each consecutive half-year until the full payment is made. Nevertheless, the claimant may demand or file a lawsuit against the company, if the delay causes direct, indirect or even consequential damages, and the case is appropriately proven. It is worth mentioning that HNB might, upon examining a customer's

complaint or audit finding, impose fines or initiate action against the company when such delays are significant or recurring.

7. General rules concerning the limitation period for claims

The general limitation (lapse) period for claims in Hungary is five years. The law provides the possibility to shorten or extend this period according to the will of the parties, but exclusion of limitation is not permitted. For life, accident and health insurances, a two-year lapse period is generally admitted. The limitation period starts on the date on which the relevant event occurs and the claim becomes due. In respect of claims for compensation the limitation period commences upon the occurrence of the damage/loss.

However, a couple of complementary rules also apply to grant some extension of limitation periods:

(i) if the claimant was unable to exercise his/her right within the predefined limitation period due to circumstances falling outside his/her control, then the claimant is provided with an additional one-year period to raise the claim; the additional period starts from the date when such circumstances ceased to hinder the claimant in exercising their respective rights; (ii) some events interrupt the ongoing lapse period which later, once the interruption ends, recommences (for instance, if an action is brought for the enforcement of the claim and the court has adopted a final and binding decision).

8. Policy triggers with respect to third-party liability insurance

Indemnity policies (including PI and D&O policies) are mostly underwritten on a mixed occurrence and claims-made basis. The insured is entitled to indemnity under the policy, provided that the loss occurred and the claim was made during the policy period, even if the judgment or settlement establishing liability occurs after that period. Liability policies may contain a 'deeming' provision which enables the insured to notify the insurer of circumstances that are likely to give rise to a claim and to have insurers provide cover in relation to any later claim arising out of the circumstances within the policy period during which they were notified. It is also common practice for the insurers to provide a discovery period provision in return for an extra premium, which extends the reporting period up to a maximum of 72 months following the expiration of the policy.

9. Recoverability of defence costs

Defence costs are generally recoverable by court decision provided that the cost is proven, reasonable and proportional. Upon request, those expenditures are added to the insured's or beneficiary's principal claim previously awarded. The attorney's fees usually represent the dominant part of such additional claims and the courts pay particular attention that these are judged in line with the aforementioned principles. The decision on fees is case specific and takes into account the nature, length and complexity of the case, as well as the amount of work performed by the acting counsel.

10. Insurability of penalties and fines

Insuring against penalties and fines are basically subject to the parties' free will, in harmony with the principle of contractual freedom, and the law does not regulate this in detail. The need for such coverage often arises in the field of property and liability insurance, and is usually limited to civil penalties (not criminal) under special conditions, limitations and exclusions (e.g. intentional wrongdoing or negligence will not be covered). Policies consider such coverage as auxiliary loss or damages, in connection with the principal risk, under the condition that such exposure is insurable by the applicable laws. Nevertheless, this is a limited insurance business in Hungary and the policies need to have carefully worded language that is line with other general legal principles and requirements, such as fairness, good faith and prohibition of misuse of laws.

Contacts

Gabriella Ormai
E gabriella.ormai@cms-cmno.com

Istvan Pozsgay
E istvan.pozsgay@cms-cmno.com

Italy

1. Introduction

Insurance activity can be undertaken in Italy by i) an Italian insurance company that has met all the conditions set by the applicable Italian law and regulations and that has been admitted by the Italian Insurance Supervising Authority (IVASS); ii) an EEA insurance company that has notified the regulator in its home country that it intends to carry on business in Italy under either the right of establishment regime (by establishing a branch office or in case of any permanent presence on the Italian territory, including the organisation of an office managed by the undertaking's own staff or by a person who is independent but has permanent authority to act for the undertaking) or directly on a freedom-of-services basis; iii) a non-EEA insurance company that has been given permission by IVASS to set up a branch office.

Setting up a domestic insurance company in Italy requires that several legal and financial conditions be met (including setting up as a specific type of company, a minimum paid-up capital and a head-office within Italy). The specific licensing process with IVASS can be lengthy. A domestic insurance company is also subject to IVASS regulation.

Foreign insurers from EEA countries may also undertake insurance activities in Italy either by establishing a branch office or by providing insurance activities directly. In both cases, insurers are permitted to carry out the same activities in Italy as in their home country provided (i) they have notified their home country regulator of their intention, and (ii) the home country regulator has notified IVASS of their intention.

Insurers can start the activity in Italy (i) as soon as IVASS is notified on a freedom-of-services basis, or (ii) after 30 days from notification if establishing a branch office. It is cheaper and quicker to undertake insurance activities in Italy by using the EEA passporting schemes or for a non-EEA company to establish a branch office, than it is to obtain full IVASS authorisation. There is no minimum capital requirement under these schemes and the relationship with IVASS is considerably less demanding. In principle, insurers acting under these schemes are subject only to the control of their home country regulator. However, within 30 days from the receipt of the home country regulator's notification, IVASS may set further specific conditions to be met by a branch office, to protect the general interest, on a case by case basis.

Companies from non-EEA countries are only entitled to undertake activity in Italy by establishing a local branch.

The Italian general good provisions, listed by IVASS, must be met also by both EEA and non EEA insurance companies.

2. Effect of misrepresentation and/or non-disclosure (retitled)

Before and during the policy period, the insured must disclose all the relevant information to the insurer. Pursuant to artt. 1892 and 1893 failure to do so, in case of fraud or gross negligence by the insured, may result in the insurer being able to claim a total or partial release from their obligation to provide cover whilst remaining entitled to the premium for the entire policy period. A misrepresentation not ascribable to either wilful misconduct or gross negligence, instead allows the insurer to request rescission from the Insurance contract.

3. Effect of breach of warranty and condition precedent

The condition precedent of the policy is the risk covered. This must be correctly represented and described by the Insured before the conclusion of the Insurance contract. The insurer has to be informed of any change in risk. A lower risk might entitle the insured to a lower premium unless the Insurer recedes from the contract. On the other hand, if the insured does not inform the insurer of an increase of risk which would have caused the insurer to refuse to provide a policy, or to require a higher premium, this will allow the insurer to recede from the contract. Fraud or gross negligence by the insured may result in the insurer being able to claim a total or partial release from its obligation to provide cover whilst remaining entitled to the premium for the entire policy period.

4. Consequences of late notification

If no other term is agreed, the insured is required to notify the insurer within three days of either the occurrence of the insured event or of the date the insured becomes aware of the insured event. Usually policies provide for a longer period, between 30 and 90 days. Moreover, article 1915 of the Italian Civil code states that any delay in notifying the claim entitles insurers to deny cover only in the case of a wilful/intentional delay and entitles them to reduce the indemnity sought in the case of negligent delay only if a prejudice has been suffered due to the late notification.

The burden of proof is on the Insurers. Proving an intentional or at least a grossly negligent delay on the part of the insured is not easy, so this needs to be assessed very carefully.

5. Entitlement to bring a claim against an insurer (retitled)

The Italian system does not entitle the claimant to bring an action against the insurers. Only the insured can summon the insurers before Court and/or exercise any right arising from the policy. However, there is an exception for motor vehicle third-party liability insurance, and other specific cases, where the third party that has suffered damage can bring a claim directly against the insurer.

6. Entitlement to damages from an insurer for late payment of claim

The insured is entitled to seek reimbursement for the damages suffered because of the late payment of claims. This can happen, for example, if the insured has to pay a higher sum to the Claimant, due to interest arisen in the meantime. If such a delay is attributable to the insurer, the sum to be paid might also exceed the policy limits. In the case of a motor claim, which is the only case which allows the claimant to act directly against the insurer, the claimant is also entitled to ask the insurer for interest and/or for increased damages suffered because of the delay in paying the claim.

7. General rules concerning the limitation period for claims

Any claim deriving from the insurance contract is subject to a two-year limitation period starting either from the date the loss occurred or, for third-party liability insurance, from the date the third party's claim is notified to the insured. Notification by the insured to the insurer of the third party's claim stays the two-year limitation period, until the claim becomes due and payable or the third party's claim against the insured (or the insurer for motor vehicle liability insurance) becomes time barred. In life policies, however, the limitation period is extended to ten years.

The right to the payment of premium instalments is subject to a one-year limitation period starting from the maturity of each instalment.

8. Policy triggers with respect to third-party liability insurance

In general, the occurrence of an insured event during the policy period is the default policy trigger in third-party liability insurance. However, it is possible and increasingly common in some insurance contracts, for the parties to agree to other policy triggers. This is the case of claims-made policies, allowed by the Italian legal system as long as the relevant clause is specifically signed by the parties. In claims-made policies a claim is usually defined by the policy as a request for damages, received by the Insured for the first time during the policy period. Sometimes it is not so easy to assess whether a request can be considered as a proper claim which triggers the policy. The Supreme Court has pointed out, in this regard, that any request which contains a brief description of the facts, explains the reasons of the insured's liability and allows an estimation of the potential damage is to be considered as a claim under the policy.

9. Recoverability of defence costs

Pursuant to art. 1917 civil code the Insurer must cover the insured's defence costs. The claim can then end positively for the insured and award him with defence costs which have to be paid by the losing party. In this case the decision itself is the enforceable instrument which allows the insured to recover these sums. If the insured does not cooperate in order to recover the aforementioned sums, the policy usually provides for a subrogation clause which allows the insurers to be subrogated in the rights to reimbursement of the insured up to the limits of the amounts paid. In this case the insured must sign all the necessary documents and shall do everything necessary to formalise and maintain this right, including the signature of those deeds which permit the Insurers to legally act in place of the insured.

10. Insurability of penalties and fines

Pursuant to art. 12 of the Italian Code of Private Insurance covering the risks of payment of administrative penalties is not allowed. Considering the personal, distressing and dissuasive nature of administrative penalties, insurances aimed at transferring said risk are denied. The reasoning behind this provision is that the author of the unlawful behaviour shall bear the consequences (i.e. penalties and fines) provided by the applicable law. Otherwise, the protection of the public interest set out by the law will be avoided.

Contacts

Laura Opilio
E laura.opilio@cms-aacs.com

Luxembourg

1. Introduction

Luxembourg's insurance market developed in the 1990s. Since then, Luxembourg authorities have created a prosperous environment that has contributed to growth. Insurances activities in Luxembourg can be carried out by Luxembourg companies as well as by foreign companies, either through a branch office or directly without any establishment in Luxembourg, provided that they have been duly approved by or, as the case may be, the exercise of their activities has been duly notified to, the Luxembourg Insurance Regulator (in French *'Commissariat aux Assurances'*, the **CAA).**

Authorisation is granted for each specific insurance field provided certain conditions are met:

- The company must be effectively managed in and from Luxembourg. This means that the effective management and central administration must be carried out in Luxembourg;
- The direct and indirect shareholding of the company structure must be transparent, and the shareholders' identities must be disclosed to the CAA;
- The company must be effectively managed by one or more persons meeting the required conditions for integrity, qualifications or professional experience;
- Any natural or legal person determined to directly or indirectly take over a characterised holding (described by Luxembourg law as 'grasping directly or indirectly holding in an insurance company 10% or more of the capital or voting rights, or any other potential for exerting significant influence over the company in which a participating interest

is held') in an insurance company must ensure the sound and prudent management of the company;
- The company must appoint an independent statutory auditor *('réviseur d'entreprises');*
- Insurance companies wishing to operate in Luxembourg must comply with specific rules regarding solvency margins, assets and accounting principles.

Insurance companies based in a non-member state of the EEA that carry out insurance activities in Luxembourg must fulfill specific standards. Although they will mainly be governed and controlled by their home country authorities, the CAA maintains a certain competence to oversee these companies and must inform the European Commission and the European Insurance and Occupational Pensions Authority (EIOPA) if certain measures are taken against such companies. They must also comply with Luxembourg legal provisions. Before the insurer can initiate its activities in Luxembourg, the authorities of the country of origin will have to submit a file to the CAA in order to be authorised.

It is illegal for a Luxembourg insurance company to carry out both life insurance and non-life insurance activities.

2. Defining insurable interest

With respect to indemnity insurance, insurable interests are defined under Luxembourg law as economic interests in the conservation of the insured property or in the entirety of the estate. There is an insurable interest when, as a consequence of future and or uncertain events, there could be a potential financial loss upon the destruction of the protected good.

The existence of a risk is a fundamental element in the insurance contract and where the risk does not exist or has already materialised, the insurance contract is deemed to be null and void.

3. Calculation of premiums

Premiums are calculated on the basis of the assessment of the risk and may substantially vary if there is a decrease or increase in the risk. In this respect, if an increased risk had existed at the time of underwriting the contract, the insurer would have only granted cover under different terms.

The contract may provide the insurer with the right to increase the premium rates for an existing contract.

An insurance undertaking that wishes to increase the premium rates for an existing contract may only do so with effect from the next annual renewal date of the contract. The insurance undertaking must notify the policyholder of the proposed amendment at least thirty days before the date when the new premium rates shall apply.

Following the date of the notification, the policyholder shall be entitled to terminate the contract within sixty days.

If the increase in rates has not been explicitly mentioned in the renewal date notification, the policyholder may terminate the contract without penalty at any time after the renewal date, but not later than sixty days after the renewal date of the contract.

4. Consequence of misrepresentation and/or non-disclosure

Luxembourg insurance law provides that the insured has the obligation to disclose accurately all the information that may have a direct impact on assessment of the risk value. The policyholder is not required to disclose circumstances already known by the insurer or that the insurer should reasonably be expected to know.

However, on the other hand, where intentional omission or inaccuracy shall mislead the insurer in his evaluation of the risk, the insurance contract shall be deemed to be null and void.

Within one month of the date of becoming aware of any unintentional omission or inaccuracy, the insurer shall propose a contract amendment, to take effect on the aforementioned date.

If the insurer is able to produce evidence that on no account would he have insured the risk, being fully aware of the circumstances, he may terminate the contract within the same time limit.

If the policyholder refuses the proposed contract amendment, or if, at the end of a period of one month from receipt of the proposal, it has still not been accepted, the insurer may terminate the contract within fifteen days.

5. Consequences of late notification

The insured must notify as soon as possible, or in any event, within the timeframe fixed by the policy, any damage occurred to the insured goods. If the policyholder fails to notify the insurer on time and this results in damage for the insurer, the insurer will have the right to claim a reduction of the services to be rendered. The insurer could even decline payment if the insured misconduct was intentional and/or unlawful.

6. Requirements regarding loss-adjusting proceedings

The insurer must effect payment of the contractual benefits as soon as he has all the relevant information on the occurrence and circumstances of the claim, and where applicable the value of the damages.

In any case, the amounts due must be paid within thirty days of their assessment. Beyond this period, interest on overdue payments at the current legal interest rate shall be payable.

7. Entitlement to raise a claim against an insurer

Third parties are not usually entitled to raise a claim against the insurer resulting from the insurance contract. Nevertheless, under liability insurance contracts, damaged third parties are empowered to claim against the insurer. In the event of mandatory civil liability insurances, the exceptions, annulments or losses contained either in the laws or in the insurance contract will not be applicable against the damaged person. For the rest of non-mandatory civil liability insurance the exceptions, annulments or losses contained in the laws and in the insurance contract will be applicable provided they were previous to the accident.

8. General rules concerning the limitation period for claims

In principle, any claims resulting from an insurance contract may be raised up until three years from the day the event that gives rise to the claim occurred. However, this timeframe will start on the date the claimant becomes aware of the event where the claimant provides evidence that he had not been aware of the event, but this timeframe shall not exceed five years from the occurrence of the event (except in case of fraud).

The insurer could raise a claim against the policyholder within three years, starting from the date the policyholder receives payment. Contracts drawn up with minors and persons legally incapable will not be valid.

9. Policy triggers and coverage issues

Luxembourg law opted for the occurrence principle; the insurance cover shall relate to damage or loss occurring during the term of the contract, even if a claim shall be lodged after the expiry of the contract. Notwithstanding the above, save for third-party liability insurance on motor vehicles operating on land, parties can agree on a claims-made policy in stating that the cover shall be limited to claims lodged within three years of the occurrence of the damage or loss.

10. Reinsurance regulations

Reinsurance companies are subject to specific rules regarding solvency margins, accountancy and management. They must obtain an authorisation from the CAA and will be subject to its supervision. Reinsurance companies from third-party countries that want to operate in Luxembourg through a branch must be authorised to carry out reinsurance activities in their country of origin.

Contact

Nicolas Gerique
E nicolas.gerique@cms-dblux.com

Vivian Walry
E vivian.walry@cms-dblux.com

The Netherlands

1. Introduction

Under Dutch law, the parties that have rights under a contract are those that are expressly party to it. These are the policyholder and the parties entitled to coverage in accordance with the terms and conditions of the insurance contract (the insured parties). The policyholder pays the premiums to the insurer, but the insured parties do not necessarily pay. The policyholder and the insured are the parties entitled to claim under the insurance contract.

2. Effect of misrepresentation and/or non-disclosure

Before concluding an insurance contract, the policy holder must disclose to the insurer all information which he knows or ought to know and which may be material to the decision of the insurer to underwrite the risk or to underwrite it on particular terms.

Where the cover relates to the interests of a third party whose identity is known, the policy holder is also required to disclose facts which the third party knows or ought to know and which will be material to the decision of the insurer wen entering into the contract.

These disclosure obligations do not extend to facts which the insurer already knows or ought to know, facts which would not have a detrimental effect on the policy terms and conditions for the insured, and facts which are confidential under the Medical Examinations Act. The insured is obliged to disclose facts concerning their or a third party's criminal history dating back eight years before inception of the policy, and this only if the insurer has expressly raised a question in unambiguous terms about such history.

The insurer may only invoke the consequences of non-disclosure if the insurer has informed the policyholder of the breach within two months after the discovery thereof, including the possible consequences of non-disclosure.

The consequence of non-disclosure with intent to mislead the insurer is termination of the insurance contract with immediate effect, within two months after the discovery. Where the insurer would not have concluded the insurance contract if he had been aware of the true state of affairs, the insurer may also terminate the contract. This termination becomes possible two months after the discovery of the breach of the obligation to disclose.

In case of innocent non-disclosure regarding the assessment of the risk, the agreed payment must be made in full. Furthermore, if the insurer would have stipulated a higher premium or stipulated a lower repayment sum had been aware of the true state of affairs, the payment shall be proportionally reduced.

However, no payment will be due if the insurer would not have concluded the contract had he been aware of the true state of affairs.

If risk is evaluated on the basis of a questionnaire drafted by the insurer (as most policies are), the insurer cannot decline a claim on the basis that questions were not answered, or that facts in respect of which no question was raised were not disclosed, or that the answer to a question couched in general terms was incomplete, unless there was intent to mislead the insurer. A general catch-all question ('Are there any facts or circumstances that may be important to the insurer that you have not mentioned so far?') does not resolve this lack of information.

3. Effect of Breach of Warranty and condition precedent

Dutch insurance law does not recognize the concept of conditions precedent and warranties as such, which is why it is a matter of interpretation of the insurance contract on how condition precedents and/or warranties precisely work and what the consequences of a breach are.

In this respect, the difference between primary coverage descriptions and secondary coverage descriptions could be relevant. If a condition precedent and/or a warranty can be qualified as a primary coverage description, the insurer may be able to deny coverage. Courts are reluctant to overthrow such denial on the part of the insurer because an insurer should be able to define the boundaries wherein the insurer is prepared to provide coverage. In exceptional cases, a court might regard breaches of a condition precedent unacceptable according to the principles of reasonableness and fairness. [1]

Condition precedents might also be interpreted as forfeiture clauses in which case it is possible that an insurer can only rely upon the consequences of a breach if the insurer is prejudiced by the breach of the condition precedent.

In light of the abovementioned, it is important that insurers check whether the description of conditions precedent are defined in accordance with the risk they are prepared to cover.

A breach of warranty does not always represent a valid reason for the insurer to deny coverage. Only in cases whereby the breach of a warranty and the damage causing event are causally linked is the insurer allowed to deny coverage. [2]

4. Consequence of late notification

From the moment the policy holder or the insured knows or ought to know of the occurrence of the insured event, he is obliged to notify the insurer, as soon as reasonably possible. The insured must provide the insurer with all the information and relevant documents within a reasonable period to enable the insurer to consider the claim.

When the insured fails to notify the insurer on time, the insurer may reduce the insurance payment by any loss he suffers as a result of the late notification. The insurer may only stipulate that the right to payment will lapse on failure to perform these if a reasonable interest is prejudiced.

Furthermore, if the insured fails to notify on time or to provide adequate information with the intention to mislead the insurer, the insurer is not obliged to pay the claim (unless this is inequitable).

5. Entitlement to bring a claim against an insurer

For liability insurance involving claims for personal injury and/or death, once the insurer has been notified of the claim and is liable to pay the claim, a third party can request the insurer pay the claim directly to the third party. The insurer may still rely on the terms and conditions of the insurance contract. If the third party commences proceedings against the insurer, the third party must ensure that the insured is summoned in time to appear at the proceedings.

If the third party has not exercised this right, the insurer may pay the insured and be released from its obligation to provide indemnity, however, only if it first requests the third party to confirm whether

[1] DSC 23 April 2010, ECLI:NL:HR:2010:BL:6024.
[2] DSC 27 October 2000, ECLI:NL:HR:2000:AA7915.

the third party will exercise or waive such a right, and the insurer receives no response within four weeks of the request. The insured may not settle the claim with the insurer to the detriment of the third party, if the claim relates to a loss resulting from death or injury.

6. Entitlement to damages from an insurer for late payment of claim[3]

Under Dutch law insurers can be liable for damage caused by late payment of a valid claim, either on the basis of breach of insurance contract or on the basis of tort. Article 6:119 DCC provides that damage due to delay in the payment of a sum of money shall consist of statutory interest on that sum over the period in which the obligor has been in default of payment. This means that in principle the amount of damages is fixed on the statutory interest and no other damages may be awarded.

However, this can be different if there are additional circumstances and other allegations against the insurer than just late payment of the claim. If the additional circumstances justify compensation of extra costs the standards of reasonableness and fairness provide that such compensation is allowed. However, this is a high threshold which will not easily be met.

7. General rules concerning the limitation period for claims

A right of action against the insurer for obtaining payment expires three years from the day after the insured became aware of the payment becoming due. Limitation shall be stayed by the insured demanding payment from the insurer in writing. A new limitation period starts running the day after the insurer either admits or denies the claim in unambiguous terms.

In the case of liability insurance, the limitation period shall be stayed by every negotiation between the insurer and the insured or the third party. A new limitation period of three years will commence the day after the insurer either admits the claim or notifies the other party – and if that is not the insured also the insured – ending the negotiations in unambiguous terms.

The limitation period for claims under a life insurance is five years from the day after the insured became aware of the payment becoming due and payable.

8. Policy triggers with respect to third party liability insurance

All kinds of policy triggers with respect to third parties are allowed. In particular, claims-made coverage is allowed under Dutch law.

9. Recoverability od defence costs

The Dutch Code of Civil Procedure provides the main rules. As a starting point, the losing party shall pay the costs of the court and the costs of the other party, but these costs are fixed within certain boundaries. As a result, the recoverability of defense costs is, in principle, limited. These rules are also applicable in disputes regarding insurance contracts.

10. Insurability of penalties and fines

Whether it is possible to insure penalties and fines will depend on the circumstances of the case. Insurance coverage for wilful misconduct and violation of criminal laws is against public policy and the obligation to pay is therefore void (art. 3:40 DCC). However, the Dutch Supreme Court argued that certain degrees of wilful misconduct are insurable. Actions whereby the insured caused the damage with an intention to do so are not insurable. Actions of the insured that would constitute a possible or probable consequence of the damage are insurable. Some authors argue that regulatory fines are insurable, however there is no case law that confirms this view.

Contacts

Bas Baks
E bas.baks@cms-dsb.com

[3] D.C. Theunis, R.J.G. van Brakel and A. Denslow 'Application of the Dutch insurance law policies taken out in the London Market', TAV 2016/3, p. 32.

Peru

1. Introduction

Insurance activity in Peru is under the supervision and control of the Peruvian State through the Superintendence of Banking, Insurance and Pension Funds Administration **("SBS").** Most matters related to Insurance Agreements are regulated under Law N° 29946, the "Insurance Agreement Law", as well as Law N° 26702, "Law of Finance and Insurance Systems and of the SBS".

While the content of policies and the calculation of premiums are, as general rule, determined by the market and by the private autonomy of the parties involved therein, it is worth mentioning that the Insurance Agreement Law, in force as of May 2013, presents a regulatory framework with a strong orientation in favour of insured parties with mandatory provisions that can only be overruled if the results grant more rights to the insured parties or are more beneficial for them.

According to the Insurance Agreement Law, due to special considerations, its provisions apply to all insurance matters, not only prevailing over civil law regulation, but also over consumer protection regulation.

2. Effect of misrepresentation and/or non-disclosure (retitled)

During the execution process of an insurance agreement, all policy holders and insured parties shall appropriately inform or reveal the real status of the potential insured risk in order for the insurer to accurately assess it.

In case of wilful or grossly negligent misrepresentation and/or non-disclosure *(declaración inexacta o reticencia)* it is possible to invalidate the agreement, making it null and void, as long as the insurer can prove that, had they been aware of the true circumstances, they would have requested a higher premium or not concluded a contract at all. Insurers have 30 days from the day they receive complete information on the status of the insured risk to make a decision.

If the alleged misrepresentation or non-disclosure was not caused by wilful misconduct or gross negligence of the insured party, the validity of the agreement is not affected, but the insurer is entitled to propose a review of the agreement (Offer to Amend). If such proposal is not accepted the insurer has the right to terminate the agreement without returning any previously paid premiums. In this case, if the real status of the insured risk becomes known after the occurrence of the insured event, any claim will be paid in the same proportion as the premiums that would have been amended.

Finally, the law provides several cases in which the review or resolution of the agreement due to misrepresentation or non-disclosure is not applicable, for instance, if the misrepresentation or non-disclosed information does not increase but diminishes the insured risk or if the insurer, under reasonable diligence, should have been aware of the real status of the insured risk.

In the specific case of life insurance, after two years from the execution of the insurance agreement, the misrepresentation/non-disclosure regime does not apply, unless misrepresentation or non-disclosure is due to wilful or gross-negligent conduct.

3. Effect of breach of warranty and condition precedent

Within the frame of an insurance agreement, under Peruvian regulation, the policy may contain warranties, obligations *(cargas)* or condition precedents to be complied with by the insured party.

- Warranties are oriented to promote avoidance of the the occurrence of an event. The policy may be subordinated to warranty compliance or it may be a condition for the application of the policy.
- Obligations *(cargas)* entail actions to be undertaken by the insured party for the cause of legal action, before a potential claim may subsist; or for the insurer not to be released from its obligation to indemnify; as applicable.
- Conditions precedents are *sine qua non* requirements, without which the insurance coverage is not generated (no-insurance situation).

Insurance Agreement Law provides that the obligations *(cargas)* should be reasonable, while warranties and safety conditions are to be complied with materially or substantially, not formally. Non-compliance with warranties and safety conditions only leads to the rejection of a claim, as long as compliance would not have prevented the event in any case.

Not to implement or maintain the warranties or comply with the obligations *(cargas)* may entail losing the right to be indemnified, or cause the latter to lapseas the result of wilful or gross-negligent conduct which generates effective damage to the insurer. If non-implementation of the warranties or non-compliance with the obligations (cargas) is due to ordinary negligence or out of the policy holder or insured party's control, then the right to be indemnified upon the occurrence of an insured is not affected.

4. Consequences of late notification

According to industry customs, and as provided under the Insurance Agreement Law, occurrence of an insured event shall be communicated to the insurer in a timely manner *(oportunamente).* This notice can be made by any person. If such notice is not officially made, the right to be indemnified lapses and the insurer is released from its obligation to indemnify. If the notice is not made due to gross negligence, the right to be indemnified lapses only if this late notification entails an effective prejudice to the insurer. There is no negative consequence for late notification if there is proof that the insurer became aware of the event occurrence by other means. If the late notification is due to ordinary negligence, the right to be indemnified is not affected, but the indemnification may be reduced in line with damages suffered by the insurer. According to specific regulations issued by the SBS, the required term of notice should be at least three days, except as regards car insurance, in which case notice shall be made immediately, as permitted by the conditions.

Finally, under no circumstances is coverage affected if late notification is not the fault of the insured party.

5. Entitlement to bring a claim against an insurer

As per the entitlement to bring a case against the insurer, indemnification is due to the insured party as titleholder of the insurable interest, therefore the latter -as beneficiary- is the one who has direct right to claim *(acción directa)* its collection (unless there has been an endorsement *(endoso)* or assignment of the right to be indemnified, as in the case of a mortgage holder's life insurance). Without prejudice to the above mentioned, according to civil law, any creditor of the insured party may file an indirect claim looking to collect its debtor's credit, and by doing so, to satisfy its own interest up to the amount of its own credit.

This differs in the case of life insurance, where the beneficiary may make a claim.

In non-contractual civil liability insurance matters, following a trend in comparative law, the Insurance Agreement Law provides that the party suffering damages – despite not being the insured party – has direct right to claim against the insurer (up to the limit of the policy).

6. Entitlement to damages from an insurer for late payment of claim

As long as the insured party submits all required documentation, without prejudice to the insurer's right to investigate, the general rule as provided under the Insurance Agreement Law is that the insurer shall make a decision on the claimed coverage and respective payment within 30 days of such submission. On the contrary, silence will be deemed as an acceptance of the claim and the insurer will be obliged to proceed with the payment (including legal interest). This situation is called "consented claim", although although it will still be necessary to determine whether the claim requires an adjustment agreement or not. In any case, the insurer can request aterm extension to respond to the claim from the SBS. If the authority does then not reply on time, the term extension is deemed granted.

Due to several criteria of interpretation developed around the idea of a"consented claim", this does not apply when coverage under the claim has not been agreed or if there are grounds for nullity (*nulidad de pleno derecho).*

7. General rules concerning the limitation period for claims

Legal actions based on an insurance agreement, unless otherwise provided by law, are limited to a ten year period from the date they become enforceable. In the case of payments resulting from an insured event, such term is counted from the occurrence of the event. Exceptionally, in case of life insurances, such term is counted from the day the beneficiary is informed of the existence of the insurance.

8. Policy triggers with respect to third-party liability insurance

According to the Insurance Agreement Law, and subject to the individual nature of the contracted insurance, the purpose of (non-contractual) civil liability insurance is to indemnify the insured party upon any third-party claim of damages, as a result of a damaging event occurring during the term of the policy and up to the limit of the agreed coverage, as long as damages are not the result of a wilful misconduct (excluded risk, being null and void any pact to the contrary). With this type of contract, the insurer obligation to indemnify is due once the insured party's obligation to indemnify the third party is accrued. It is worth mentioning that in (non-contractual) civil liability matters a judicial ruling does not create, but declares rights and allows liquidating damages. Hence the coverage can even be triggered by an authorized transaction before or after the judicial process.

It has already been stated before that the law recognizes third parties' rights to direct legal action against the insurers, despite them not being considered insured parties or beneficiaries.

9. Recoverability of defence costs

As per the Insurance Agreement Law, coverage of (non-contractual) civil liability insurance comprises, among others, the defence costs of the insured party, even if it is not found liable; and in the case that the insured party is found guilty and it is ordered to pay damages, coverage shall pay part of the third-party damages expenses and defense costs, proportionally.

Moreover, according to the terms and conditions of the agreement, the insurer must guarantee to protect the insured party's assets in case of injunctions or seizures, as an extension of the obligation to keep the insured party's assets indemnified up to the limit contracted.

10. Insurability of penalties and fines

There is no express regulation on the insurability of fines, penalties or sanctions. Nevertheless, the possibility of this situation should be harmonized with the principle according which the insurance is related to the possibility of occurrence of an accepted eventual risk, provided that such event does not depend on the insured party will. The contrary will eliminate randomness from the risk assumption by the insurer.

Contact

Marco Antonio Ortega
E marcoantonio.ortega@cms-grau.com

Raúl Ferreyra
E raul.ferreyra@cms-grau.com

Poland

1. Introduction

Insurance activity in Poland is undertaken by establishing a local joint-stock company or mutual insurance company and obtaining a permit from the Polish Financial Supervision Authority (PFSA). Although there are certain advantages to establishing a local insurance company (it is perceived by the market as demonstrating a commitment to Poland), it is an expensive course of action.

The legal and actuarial fees are relatively high and there is a minimum capital requirement. It is also necessary to go through a lengthy and cumbersome licensing process, which may take several months. Finally, a domestic insurance company is subject to regulation by the PFSA.

Foreign insurers from EU and EEA countries may also undertake activity in Poland through a branch on the freedom of establishment basis or directly on the freedom-of-services basis. They are then permitted to carry out activities in Poland to which they are entitled in their home country on the basis of a relevant permit from the supervising authority of their home country. Insurers that intend to benefit from the freedom-of-services may start operating in Poland after the PFSA has received a notification from the relevant home country supervising authority. Insurers, who intend to establish a branch on the freedom of establishment basis, to start providing services, must additionally receive information concerning the conditions governing insurance activity in Poland.

Regarding operational aspects, a branch works in the same way as a local company. However, the costs are much lower – a branch does not require any initial capital and has a simplified organisational structure. Foreign insurers from EU and EEA countries that conduct activity in Poland on a freedom of establishment or freedom-of-services basis are regulated by their home country supervisory body. However, they have to follow general good rules which protect policyholders, insureds and beneficiaries under insurance contracts. Nonetheless, the Polish regulator is empowered

to audit such foreign insurance companies except for their financial management. It can also enforce general 'best practice' rules, which are designed to protect policyholders, insureds and beneficiaries under insurance contracts.

Foreign insurers from countries outside the EU and EEA may undertake insurance activity in Poland only through a 'main branch' subject to a permit issued by the PFSA, or establish a subsidiary insurance company in Poland. The procedure of establishing a 'main branch' differs significantly from the procedure of establishing a branch of a foreign insurer from an EU or EEA country.

2. Effect of misrepresentation and/or non-disclosure (retitled)

Before the execution of an insurance contract, the policyholder and the insured (where different) must disclose all matters indicated in the motion for execution of insurance contract (or other insurer-produced form), which are relevant to the insurer's assessment of risk. Non-disclosure of material circumstances will release the insurer from the obligation to provide indemnity for any loss suffered if there is an adequate connection between the undisclosed circumstances and the loss.

3. Effect of breach of warranty and condition precedent

Polish insurance law does not recognise legal constructions such as warranties and conditions precedent in the meaning of common law. Therefore, it also does not provide for any remedies connected with the infringement of warranties and conditions precedent. However, the insurer may impose on the policyholder or on the insured particular duties related to the performance of an insurance contract (e.g. duty to secure car keys or duty to comply with fire regulations) that are similar to warranties and conditions precedent. If the insured or the policyholder breaches the above duties, the insurer is free from liability for damage adequately connected with the breach.

In addition, regulations regarding the payment of insurance premiums are similar to conditions precedent. Polish insurance law provides that the insurer's liability does not start, if the premium or its first instalment is not paid. It means that if damage is caused before the payment of the premium, the insurer is free from liability. However, the parties may agree otherwise and stipulate that the insurer is liable also for damage caused before payment.

4. Consequences of late notification

Under an insurance contract or general insurance terms and conditions, the policyholder and the insured (where different) may be obliged to notify the insurer about an insured event within a specified time. The insurer is allowed to reduce the indemnity in cases of intentional or grossly negligent failure to give notice of an insured event as required, as long as the failure to give notice either increased the loss or made it impossible for the insurer to establish the circumstances of the event's occurrence and its consequences.

5. Entitlement to bring a claim against an insurer

In general, only an insured has a right to raise a claim resulting from an insurance contract directly against an insurer. However, in the case of third-party liability insurance, a prospective third-party claimant who has suffered a loss as a result of the actions and/or omissions of the insured, which are covered by the liability policy, has a right to raise a claim directly against the insurer (so-called *actio directa).*

6. Entitlement to damages from an insurer for late payment of claim

As a rule, the insurer is obliged to complete loss-adjustment proceedings and make a payment within 30 days of receiving a notification of an insured event. If this is not possible due to the complex nature of the claim or any other reasons, the insurer is obliged to inform the claimant. Then the insurer must complete the loss-adjustment proceedings within 14 days of the day the insurer clarified the circumstances necessary to determine its liability or the amount of the indemnity. However, any non-disputed parts of the indemnity should be paid out within the original deadline, i.e. within 30 days of receiving the notification of the insured event. If the insurer does not pay damages within the above period, the policyholder or the insured is entitled to receive interest for the late payment of claim.

7. General rules concerning the limitation period for claims

There are two separate statutes of limitation. The first pertains to the insured's claims against the insurer. These claims are time-barred three years after the day on which they became enforceable. The second pertains to the third-party claimant's right to claim against the insurer under the actio directa principle (see above). These claims are subject to the same rules as those governing the statute of limitation of the third-party's claims against the insured. As a result, a third-party claimant's claim against the insurer becomes time-barred when it is also time-barred in relation to the insured. For example, if the third party's claim is based on the tort liability of

the insured, it becomes time-barred three years after the date that the third party became aware of both the damage and the person responsible for redressing it (i.e. the insured). However, this period cannot be longer than ten years after the occurrence of the event that caused the damage (this long-stop date does not relate to personal injuries).

The limitation period for a claim for indemnity against an insurer ceases to run if the claim or the insured event is reported to the insurer. The limitation period re-commences on the day the party reporting the claim or the insured event receives written notification from the insurer either granting or refusing indemnity under the policy.

8. Policy triggers with respect to third-party liability insurance

The occurrence of an insured event is a default policy trigger in third-party liability insurance. However, it is possible for the parties to base third-party liability insurance entirely on other triggers, such as when the loss occurred or manifested itself or when a claim is made.

9. Recoverability of defence costs

Defence costs are not recovered to the policyholder under standard insurance contracts in Poland. To have defence costs recovered, in practice the policyholder must extend cover under third party liability insurance to such costs. It is also possible to purchase legal expenses insurance, which may include, in particular, expenses related to defence in criminal proceedings or associated with representation of the insured before civil, criminal and administrative courts.

10. Insurability of penalties and fines

There are no Polish legal provisions that explicitly prohibit insurers from insuring penalties and fines. However, it is deemed that criminal penalties and fines are non-insurable. This conclusion derives from the personal nature of the criminal liability. On the other hand, the insurability of administrative penalties and fines is not questioned under Polish law. In practice, many insurance products (e.g. D&O insurance) cover damage associated with such penalties and fines.

Contact

Małgorzata Surdek
E malgorzata.surdek@cms-cmno.com

Katarzyna Kucharczyk
E katarzyna.kucharczyk@cms-cmno.com

Ewa Świderska
E ewa.swiderska@cms-cmno.com

Portugal

1. Introduction

The primary statutes applicable to the insurance business in Portugal are Law 147/2015, which regulates the activity of insurance companies and Decree-Law n. º 72/2008[1], which contains the law on insurance contracts.

The 'Autoridade de Supervisão de Seguros e Fundos de Pensões (ASF)' is the Portuguese regulatory authority tasked with supervising the activities undertaken by insurance and reinsurance companies. This does not rule out the supervision carried out by the 'Comissão do Mercado de Valores Mobiliários' ('CMVM') – the Portuguese regulatory authority responsible for the supervision of the stock market – to insurance agreements in connection with unit-linked products.

Insurance and reinsurance services in Portugal may be undertaken in Portuguese territory by the following entities:

— A public limited liability company or a mutual insurance company authorised by ASF;
— An EU-based company headquartered in another EU country, provided it meets all the necessary requirements;
— Branches of insurance companies headquartered in other EU countries, provided it meets all the necessary requirements;
— Branches of insurance companies headquartered in non-EU countries, which are expressly authorised under the terms of the Portuguese Insurance Law;
— Publicly funded insurance companies, created under Portuguese Law, carrying out activities relating to the undertaking of insurance business in identical conditions as carried out by private companies.

Foreign EU-based insurance companies conducting activities related to mandatory insurance contracts, such as professional liability or motor-vehicle insurance, must appoint a representative to ASF in order to be able to undertake insurance business on a freedom of services basis. Irrespective of the nature of the risk,

[1] With the amendments implemented by Law no. 147/2015.

foreign EU-based insurance companies acting on a freedom of services basis must contribute to all insurance funds intended to ensure the payment of claims.

In order to undertake insurance services through a branch established in Portugal, the foreign EU-based insurance company must request its home country's authority to inform ASF of the insurer's intention. Within two months from receipt of the request, ASF shall inform the relative home country authority of any special provisons that will apply to the branch.

For companies headquartered outside the EU, the authorisation to establish a branch must be provided, upon request, to ASF.

Finally, a special rule applies to Swiss insurance companies and requires them to conduct the process of authorisation for non-life insurance operations with ASF.

2. Effect of misrepresentation and/or non-disclosure

The insurer is required to disclose accurately every circumstance that he knows or ought to know of and that is material for the estimation of the risk by the insurer. Such duty applies regardless of the information being requested in a proposal form.

The remedies for misrepresentation and non-disclosure are proportionate and will depend on the nature of the breach.

In cases of deliberate breach, the insurer may terminate the insurance contract upon communication to the insured of such a decision within three months from when the insurer became aware of the breach if no trigger event has occurred. If a trigger event has already occurred, the term would be one year.

In the event that the insurer terminates the contract due to misrepresentation or non-disclosure, it may also deny liability for any claims made before the moment when the insurer became aware of the breach.

In case of a deliberate breach of duty of disclosure (and only under this circumstance) the insurer may terminate the contract and claim all the premiums due until the end of the legal periods, unless a deliberate action or gross negligence from the insurer are found.

On the other hand, where the insured negligently misrepresented or failed to disclose, the insurer may, after notifying the insured within three months from the date the insurer became aware of the breach:

i) propose an amendment of the policy, establishing a deadline of no less than 14 days, for the insured to approve or, if allowed by the insurer, provide a counter-offer; or
ii) terminate the insurance agreement, if the insurer is able to show that it would not have entered the contract had it known of the non-disclosed or misrepresented circumstance.

The insurance contract is deemed to be terminated after 30 days from the insured's notice or within 20 days after the insured's failure to respond to the amendment proposed by the insurer.

In general, the insurer cannot rely upon a breach that arises out of:

i) a failure to answer a question in a proposal form;
ii) an unclear answer to a very broad question;
iii) and apparent contradiction or inconsistency in an answer to a proposal form question;
iv) non-disclosure or misrepresentation that is known by the agent of the insurer at the time of the contract; or
v) a breach in connection with circumstances known to the insurer, in particular when of common notoriety.

The insurer also owes duties to the policyholder to provide information or clarification and to give certainty over insurance coverage, limits and exclusions, payment conditions, the duration of the contract and the applicable law.

Finally, the insurer is required to inform the insured of the duty of disclosure/not to misrepresent and the consequences of breach of such duty.

If the insurer fails to comply with the above duties, it will be liable to the insured for damages.

3. Effect of breach of warranty and condition precedent

The Portuguese Insurance Law does not provide any specific effects of breach of warranty and/or condition precedent. The effects have to be determined case by case through the relevant rules of interpretation applicable.

Notwithstanding please note that the payment of the premium, although it is not a condition for the effect of the insurance contract, is a condition for the effectiveness of the risk coverage. This means that if the insured fails to pay the initial premium or the first instalment of it, it determines the automatic termination of the insurance contract.

4. Consequences of late notification

The insured is required to notify the insurer in accordance with the deadline set forth in the insurance contract or, in its absence, within eight days after acknowledging the insured event.

The notification claim shall address the material circumstances that gave rise to the triggered event, the possible causes thereof and any relevant damages/consequences. In addition, the insured is required to comply with further enquiries carried out by the insurer in connection with the insured event and consequences thereof.

There are no legal or statutory penalties for late notifications, but the insurance contract may include a term that establishes that the insurer may offset the damages caused by the late notification in the amount to be paid for the claim and/or the avoidance of the claim, when the breach arises from a deliberate action and results in substantial damage for the insurer.

However, the insurer cannot rely upon the referred terms where he was made aware of the trigger of cover by any other means besides the insured's notification and within the period applicable thereof, or where the insured is able to provide evidence that the notification could not have been brought sooner.

In any case, the late notification is not enforceable against a third-party claim under compulsory third-party liability insurance, without prejudice of the insurer's rights of recourse against the liable party for the payments made under the claim.

5. Entitlement to bring a claim against an insurer

The general rule under Portuguese Law is that only the insured is entitled to raise a claim against the insurer under the insurance contract, even when the contract is effected on behalf of a third person, in which case a claim by the policyholder can only be sought with the insured's consent. However, for compulsory third-party liability insurance, the injured third party is allowed to seek relief directly from the insurer. Additionally, in liability insurance contracts, the parties may expressly provide the third party the right to bring a claim against the insurer, solely or jointly with the insured, for the benefit that accrues from the insurance agreement.

In the case of indemnity insurance, the insurer is only liable to pay for the loss suffered, up to the amount covered, whereas in life insurance the policy may be written on a contingency basis, where the parties may fix a sum to be paid upon the happening of the insured event.

6. Entitlement to damages from an insurer for late payment of claim

In the event the insurer fails to comply with the terms set out in the contract and does not provide the payment of claim in time, interests shall be paid, according to the general terms of the Portuguese civil law.

However, there are certain insurance contracts that foresee a specific entitlement to damages from an insurer, which is, for example, the case of compulsory motor third-party liability insurance. In this case, if the insurer fails to comply with the payment of compensation within the specific deadline previewed in the insurance contract or by the court, interests are due by twice the statutory rate applicable to the case.

7. General rules concerning the limitation period for claims

The limitation period for claims that arise from the breach of the insurance contract is five years from the date the claimant becomes aware of the breach and must be sought within twenty years from the occurrence of the insured event.

In case of liability insurance, the claim must be brought three years running from the knowledge of the event by the offended and within twenty years from the occurrence of the event.

8. Policy triggers with respect to third-party liability insurance

Unless otherwise agreed, the trigger for third party liability coverage is written on an occurrence basis. Thus, the insurance contract covers the losses for which the insurance contract covers the losses for which the insured is liable during the policy period, irrespective of when the claim is asserted against the insured for that occurrence.

Nonetheless, the parties may agree to terms that alter the period of cover, such as terms regarding the cause or manifestation of the loss and the claim notification.

Therefore, the cover of a third-party liability insurance contract may alternatively be written in the moment in which the claim is made, unless otherwise stated by law or statue and provided that, in case of renewal or further insurance agreement, the cover of insured events that occurred unnoticed during the policy period is awarded, even if the claim is brought about in the following year of the term of the insurance contract.

9. Recoverability of defence costs

As a general rule, the losing party shall bear the court costs incurred by the counterparty during proceedings. Therefore, the law allows the successful party to recover from the losing party the court costs disbursed in advance to the court and a certain amount for lawyers' fees based on a percentage of the court fees paid, which is related to the claim value.

10. Insurability of penalties and fines

The Portuguese law expressly prohibits insurance coverage of criminal, administrative or disciplinary liability. Therefore, fines and penalties cannot be insured.

This is related to the principle established under the Portuguese law that the insured must have an interest worthy of legal protection regarding the risk covered.

Contacts

Cristina Rogado
E cristina.rogado @cms-rpa.com

Joaquim Shearman de Macedo
E joaquim.macedo@cms-rpa.com

Romania

1. Introduction

Insurance activities in Romania may be carried out only by (i) Romanian legal entities authorised by the Romanian Financial Supervisory Authority (the **'FSA'**); (ii) insurers authorised in other EU/EEA States operating in Romania on the basis of (a) freedom of establishment or (b) freedom of services; (iii) branches of insurance companies registered in third-party states (i.e. a non EU/EEA states), which have been authorised by the FSA; (iv) subsidiaries of insurers registered in third-party states, authorised by the FSA; or (v) insurers organised as SEs *(Societas Europaea).*

A. Romanian-based insurers

Setting up a Romanian-based insurer is subject to a procedure involving (a) prior approval from the FSA; (b) subsequent registration of the company with the competent Trade Registry; and (c) subsequently obtaining an insurance authorisation from the FSA.

An insurer cannot be registered with the Trade Registry prior to having obtained the approval from the FSA. This may take several months and usually involves legal assistance and legal representation of the insurer before the regulator. Incorporation procedures before the Trade Registry may take several days (once the incorporation file is complete), and there are minimum capital requirements for incorporation depending on the type of insurance (life/non-life) to be performed. Following incorporation, a specific insurance authorisation must be obtained from the FSA prior to engaging in the provision of insurance on the market. The authorisation procedure is customarily a time-consuming process which may span over the course of several months (the maximum deadline being four months from submission of the complete authorisation file). During this procedure, the applicant is required to produce substantial documentation, including with respect to its shareholders, business plan, feasibility study, etc. Filing taxes also apply and, due to the complexity of the authorisation procedure,

for which qualified legal assistance would be recommended, legal fees for representing the insurer before the FSA may also need to be considered.

B. EU/EEA insurers

As a member of the European Union, Romania recognises the right of insurers/reinsurers registered in another EU/EEA state (and authorised by the competent authority in such state) to operate in Romania, on the basis of the freedom of establishment, through a branch opened in Romania, or directly on the basis of the freedom of services, without any other formalised presence. Branches of EU/EEA-based insurers remain subject to the supervision of the regulator in the country of origin, but the FSA must be notified about the establishment of the branch to ensure compliance with Romanian insurance legislation. An EU/EEA-based insurer may also undertake insurance activity in Romania on a freedom-of- services basis by direct selling/managing insurance policies without any corporate presence in Romania. In this case, the FSA must be notified of the insurer's undertakings in Romania, but the EU/EEA insurer itself remains under the supervision and jurisdiction of its origin state's regulator.

Both alternatives enjoy significant benefits (in terms of timeline and costs of authorisation, regulatory constraints and supervision) as compared to insurance businesses run through a Romanian subsidiary.

C. Third-party insurers acting through a Romanian branch or subsidiary

Expectedly, branches and subsidiaries of insurers registered in states other than EU/EEA states are subject to increased scrutiny and regulatory supervision, and a stricter authorisation regime.

2. Effect of misrepresentation and/or non-disclosure

As a general rule, the insured is obliged to respond in writing to the insurer's questions, as well as declare, at the date of conclusion of the policy, any information or circumstances of which the insured is aware and which are essential to allow the insurer to adequately assess the risk. If essential conditions regarding the insured risk change during the course of the insurance policy, the insured is bound by law to notify the insurer in writing with respect to the same.

An insurance policy is null and void for inaccurate statements or bad-faith withholding of information by either the insured or the policyholder, provided that the inaccurate or withheld information relates to circumstances which – had they been known to the insurer – would have led to the latter not concluding the policy or issuing it under different terms. It is irrelevant in this context whether the giving of inaccurate information or the with holding of relevant information had any bearing on the occurrence of the insured risk. In this case, the insurer may retain any premium already paid, as well as request any premium due by the policyholder up to the moment when the insurer became aware of the relevant information.

If the party in default has not acted in bad faith, and the insured risk has not yet occurred, the insurer is entitled to ask for a premium adjustment or it may choose to terminate the contract unilaterally with ten days' prior notice to the insured. In this case, the insurer must reimburse the policyholder for the amount of premium paid for such period which is no longer covered under the policy. In case the misrepresentation/non-disclosure is discovered after the occurrence of the insured event, the indemnification to which the insured is entitled shall be reduced proportionally.

3. Effect of breach of warranty and condition precedent

The effects of a breach of warranty or condition precedent will generally be those afforded to such events by the contract. Parties to an insurance contract are free to contract on the terms which they agree to.

Under Romanian law, a right or obligation which is subject to a condition precedent does not arise and is not enforceable until and unless such condition precedent is satisfied (or the party in whose benefit it is stipulated waives it). If the insurer's liability is subject to (for example) the condition precedent that payment of the insurance premium be made first, then the insurer's liability is not born even if – after conclusion of the insurance contract – the insured event occurs.

Romanian law does not address "warranties" separately – a breach of warranty may therefore either qualify as a misrepresentation (if it refers to a statement on which a party to the insurance contract relied in its decision to enter into contract, or which affected the terms on which such party would have entered into the contract), or a separate condition of the insurance contract.

A misrepresentation would have the effects/consequences discussed in Section 2 above. If a "warranty" were in fact an undertaking by a party to do or not to do something as a condition to a certain performance (e.g. the payment of the insurance indemnity), then a breach of such warranty would amount to cause for refusal to effect such performance.

4. Consequences of late notification

The policyholder must inform the insurer as to the occurrence of the insured event within the timeline provided by the insurance policy. Late notification may allow the insurer to refuse indemnification, but solely to the extent such delay makes it impossible for the insurer to establish the cause of the insured event or the extent of the losses.

5. Entitlement to bring a claim against an insurer

Generally, the insured (or the beneficiaries of the policy) is/are entitled to raise claims based on the insurance contract against the insurer. For third-party liability insurance, the third party suffering a loss covered by such a policy may file a direct claim against the insurer within the limits and in accordance with the terms of the policy and the law.

6. Entitlement to damages from an insurer for late payment of claim

In accordance with the Romanian Civil Code (2011), if the insured event occurs (and all other conditions of the contract are met), the insurer must assess and pay the insurance indemnity in accordance with the terms of the insurance contract concluded between the parties. The law does not prescribe mandatory payment terms except in very limited circumstances (i.e. payment under third- party motor liability insurance).

In case of disagreement, the competent court shall determine the amount due to the insured. The Romanian Civil Code does provide, however, that the undisputed part of the insurance indemnity will be paid to the insured, even if the full amount has not yet been agreed or determined in a court of law.

If the insurer fails to make payment within the terms of the contract, the insured may request that the insurer be liable for delay penalties - such penalties shall be calculated in accordance with the contractual provisions or, in the absence thereof, by the court (or the enforcement officer), in accordance with Romanian statutory rules on penalising interest. Under Romanian law, in the absence of express contract provisions, the legal interest rate for failure to effect payment or a certain performance by the due date is the reference interest rate communicated by the National Bank of Romania, plus 4%.

If the court finds that the insurer refused or limited payment of the insurance indemnity (as awarded by the court), then interest would be payable on the amounts found to be owing to the insured, calculated as from the date of filing the court case.

7. General rules concerning the limitation period for claims

The statute of limitation applicable under Romanian law to insurance/reinsurance claims is of two years as from the date when payment of premium/ indemnification became due according to the contract. However, claims by the aggrieved party based on a mandatory third-party liability insurance contract for motor vehicles are subject to the general three-year statute of limitations.

8. Policy triggers with respect to third-party liability insurance

The law does not contain specific provisions related to policy triggers in the particular case of third-party liability insurance. In practice, the only known exception would be mandatory third-party liability insurance for motor cars, which are usually triggered on the basis of the "loss occurrence" rule. Other than that, as a general rule, third-party liability insurances are governed by the terms and conditions established by the parties within the insurance contract.

9. Recoverability of defence costs

To the extent the insured has been forced by the insurer's conduct (limiting or refusing a claim for indemnification) to bring suit against such insurer, then the insured should be able to request – in addition to the principal claim – payment also of defence costs (consisting of legal/attorney fees, stamp duties and other costs).

Defence costs may be awarded by the court in full or in part. While stamp duties and other disbursements (e.g. translation or notarisation costs) do not usually render themselves well to a reduction by the court, attorney fees may be censored by the court. Under the Civil Procedure Code, the court may – even ex officio, without a request to this effect by the relevant party – reduce the attorney fees if they are "evidently disproportionate" par rapport to the value or complexity of the case, or with the activity carried out by the attorney.

10. Insurability of penalties and fines

In principle, based on the principle of contractual freedom, parties are free to decide on the scope of their relationship and the terms of the contract. However, under general principles of Romanian law, any contract (including therefore an insurance contract), must have a lawful and moral cause, and it should not be concluded to avoid the application of mandatory laws. Also, no person is allowed to invoke its own turpitude (fault) to escape an obligation.

While this is not settled in Romanian law, it may be held that allowing a party to shield from liability for a breach of law, by insuring the risk of receiving a fine or penalty, is a matter of public order or public morale. It could be held that the public objective of the law in prescribing a fine or a penalty (which is to deter future misconduct and induce compliance) is eliminated if a person can insure that risk (and therefore, not bear the consequences of a breach of law).

This approach certainly appears legitimate when the misconduct in question is of a criminal nature (and the insured risk is a criminal fine), but may be debatable in case the fine refers to a misdemeanour or other offence not of the same gravity as a criminal offence (and the misconduct is not intentional).

We would note, in this sense, that under the Romanian Civil Code, in asset insurance and third-party liability insurance, the insurer may refuse payment of the indemnity if the insured event has been produced intentionally by the insured or the beneficiary of the insurance (or a member of the management of the insured entity).

Contacts

Gabrial Sidere
E gabriel.sidere@cms-cmno.com

Christina Popescu
E cristina.popescu@cms-cmno.com

Russia

1. Introduction

Russian insurance law is in the transition stage. In accordance with the Protocol of the Accession of the Russian Federation to the World Trade Organisation (WTO), within 9 years from 22 August 2012 Russia has to ease most of the restrictions applicable to foreign investors into the insurance sector.

Currently, there are no limitations on cross-border supply of insurance of risks connected with international passenger transportation and liability arising therefrom, international transportation of goods, international commercial air transportation and liability arising therefrom as well as liability within the international green card system. Also, upon expiry of a four-year transition period in 2016, Russia lifted limitation on insuring risks associated with domestic commercial air and maritime transportation, including insurance of goods being transported, the vehicle transporting the goods and any liability arising therefrom, except insurance of the air carrier's liability and life and health insurance of the aircraft crew. Finally, as of August 2017 foreign-owned Russian insurance companies may be involved in life insurance, state-funded and compulsory motor liability insurance.

Russian insurance law restricts foreign penetration into the Russian insurance market by setting a market quota. The market quota is calculated referring to the aggregate charter capital of all insurance companies. The law states that if a share of "foreign capital" in the aggregate charter capital of all Russian insurance entities exceeds 50 per cent, the regulator stops licensing insurance companies controlled by non-Russian entities. According to the latest available data, as of 1 January 2016 this quota amounts to 20.93 per cent. Russian insurance law states that a preliminary consent from the regulator must be obtained for a foreign investor to contribute to the charter capital of a Russian insurance company. This consent may only be denied if that contribution results in the 50 per cent quota being exceeded.

Russian insurance law also imposes the following restrictions:

— shares in the charter capital of an insurance company should be paid for only in Russian Roubles;
— foreign investors should have at least five years of experience on their domestic market.

The process of establishing a subsidiary and obtaining an insurance licence takes approximately four to six months.

2. Effect of misrepresentation and/or non-disclosure

Upon conclusion of the contract, the Insured shall inform the insurer of the circumstances known to the insured that have material significance in determining the likelihood of the occurrence of the insured event and the amount of possible damages from such an occurrence (insurance risk), if these circumstances are not within the knowledge and awareness of the insurer.

If the insured was aware, prior to entering into the insurance contract, of circumstances that were likely to give rise to a claim under the policy but knowingly did not report them, the insurer may rescind the contract.

The recent court practice has introduced an implied duty of the insurer to verify information provided by the insured. Failure to do so often deprives the insurer from the misrepresentation defence.

If the insured did not respond to a particular question of the insurer prior to entering into the insurance contract but the contract was nevertheless executed, the insurer cannot avoid liability.

3. Effect of breach of warranty and condition precedent

Russian law does not recognise such concepts as warranties in the insurance contract or conditions precedent to coverage. However, a concept of grounds for the release from liability could be considered as a Russian law analogue to warranties. Article 964 of the Civil Code provides that, unless the law or the contract provides otherwise, the insurer is released from liability the insurer is released from the liability to pay the insurance indemnity if the insurable event occurs as a result of a nuclear explosion, radiation or radioactive contamination; military operations, as well as manouevres or other military activities; civil war, civil unrest of any kind or strikes; withdrawal, confiscation, requisition, seizure or destruction of the insured property following the orders of the state bodies.

Over the years, the courts have developed diametrically opposite approaches to interpreting Article 964 of the Civil Code. The prevailing approach suggests that the list of the grounds for releasing the insurer from the liability to pay the insurance indemnity is exhaustive and cannot be extended by the insurance contract. According to the reverse approach, the parties to an insurance contract can provide for other grounds in addition to those mentioned in this Article.

As regards conditions precedent to coverage, Article 929 of the Civil Code provides that the only condition precedent to the obligation of the insurer to pay the indemnity is the occurrence of an insured event. Any provisions in the insurance contract that purport to extend this rule to other circumstances would most likely be stricken out by the courts.

4. Consequences of late notification

Article 961 of the Civil Code requires prompt notification of the occurrence of an insured event and a breach of this requirement entitles the insurer to avoid liability unless it is established that the insurer was indeed independently aware of the insurable event or that the lack of notification did not prejudice its ability to provide indemnity under the policy. Russian courts have developed an approach that shifts the burden of proof of prejudice onto the insurers and they have to prove that they were not aware and that their ability to provide indemnity was prejudiced by late notification. In some extreme cases related to MTPL the courts have awarded indemnity to the insured where no notice of the loss was ever made to the insurer.

5. Entitlement to bring a claim against an insurer

The insured or the beneficiary is entitled to bring a claim against the insurer.

In liability insurance, the affected third party has a right to claim directly from the insurer, where such liability insurance is compulsory, e.g. MTPL.

6. Entitlement to damages from an insurer for late payment of claim

The insurer's obligation to pay a claim is a pecuniary obligation. In commercial lines of insurance, it is subject to the general rule on default interest introduced by Article 395 of the Civil Code. Unless the insurance contract provides for a different default interest rate, the insured is entitled to the key interest rate of the Central Bank.

In personal lines of insurance the insured is entitled to 1% per each day of delay and a penalty of 50% of the sum awarded by the court.

7. General rules concerning the limitation period for claims

The limitation period for claims arising from a property insurance contract is two years. The limitation period for claims arising from third-party liability insurance is three years. The limitation period starts at the date when the insurer declines cover but not later that the date on which it is supposed to communicate the coverage decision.

8. Policy triggers with respect to third-party liability insurance

Most of the existing liability insurance policies are triggered by the occurrence of an insured event. However, it is possible to define the insured event as a claim made against the Insured. This mainly applies to products such as D&O insurance.

9. Recoverability of defence costs

Russian procedural law entitles the winning party to recover defence costs from the opposite side including state duties, legal fees, travelling costs, etc. It can also claim costs associated with collection of evidence (e.g. notary fees, legalisation fees, etc.).

Defense costs may be claimed together with the main claim as well as within six months after the final court ruling comes into force.

As a rule, the court cannot reduce the claimed amount unless the other side proves that defense costs are excessive. However, the court may interfere if the claimed amount is clearly unreasonable judging by the evidence in the court file.

Generally, defence costs are considered reasonable if similar amounts are usually recovered for the same legal services in similar circumstances such as complexity and duration of the case, scope of services rendered, etc.

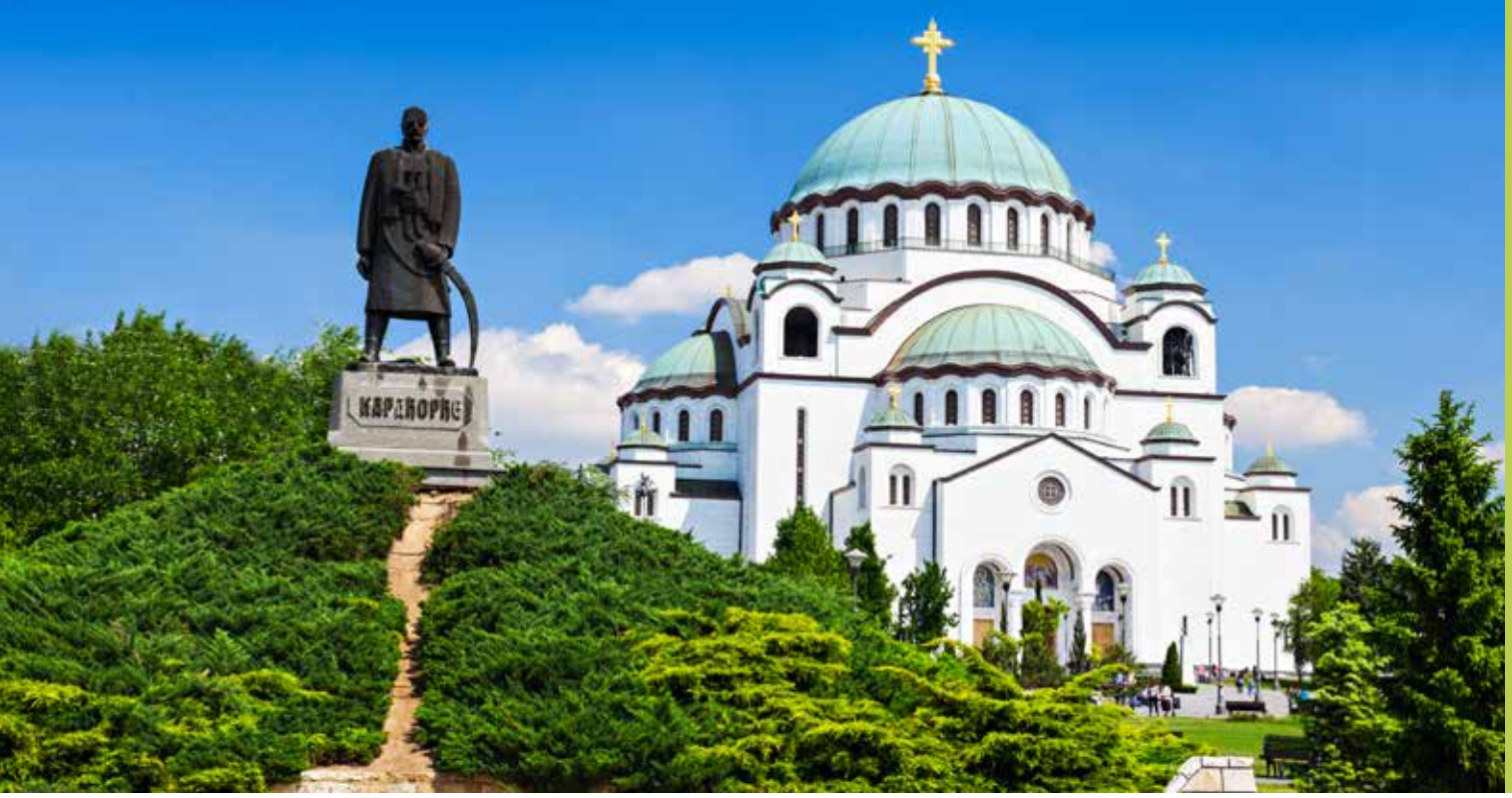
10. Insurability of penalties and fines

Russian law prohibits insurance of illegal interests. It is widely understood by the insurers and the courts that as insurance against any kinds of administrative and criminal penalties and fines would result in eliminating the punishment effect of such sanctions it is not possible to provide such cover.

As regards civil law penalties (e.g. default interest or contractual fines), they are not insurable pursuant to Article 932 of the Civil Code which does not allow insurance against a breach of contract unless the law expressly provides otherwise. For instance, it is possible to insure contractual liability of a private investor in public-private partnerships.

Contact

Leonid Zubarev
E leonid.zubarev@cmslegal.ru



Serbia

1. Introduction

Under currently applicable legislation, there is only one way to undertake insurance activity in Serbia and that is to establish a local insurance company. A local insurance company must be organised in the form of a joint-stock company and it must meet the prescribed minimum capital requirements. An insurance company can only undertake insurance activities that it has been licensed for by the regulator. The same insurance company cannot undertake life insurance and non-life insurance activities.

Establishing a local insurance company is a somewhat burdensome and time-consuming procedure. Legal and actuarial fees may be high while the licensing process with the National Bank of Serbia which acts as the regulator and supervisor, may take up to several months.

2. Effect of misrepresentation and/or non-disclosure

Prior to the conclusion of an insurance contract, the policyholder is obliged to disclose to the insurer all circumstances which are material for assessing the risk, and which were known, or could not have been unknown, to the policyholder. The consequences of non-disclosure of relevant circumstances depend on whether the relevant circumstances remained undisclosed intentionally or unintentionally. In the first case, the insurer may request an annulment of the contract and retain the premiums paid. In the latter case, the insurer may request termination of the insurance contract or request a premium increase.

3. Effect of breach of warranty and condition precedent

Effects of breach of warranty and condition precedent are regulated in each separate insurance agreement.

4. Consequences of late notification

A policyholder is obliged to notify the insurer of the occurrence of an insured event within three days of the date the policyholder becomes aware of the occurrence of an insured event. If the policyholder fails to notify the insurer of the occurrence within the above period, the policyholder is obliged to compensate the insurer for the loss they sustained due to the late notification. However, the insurer may not refuse to provide indemnity under the insurance policy.

5. Entitlement to bring a claim against an insurer

Generally, only an insured or a life-insurance beneficiary is entitled to raise direct claims against the insurer. Exceptionally, in case of third-party liability insurance, a direct claim against the insurer can also be raised by a third party who has suffered a loss due to the activities of the insured covered by the policy.

6. Entitlement to damages from an insurer for late payment of claim

The insurer is obliged to indemnify the insured within the period stipulated in the contract, which should not exceed 14 days, counting from the day the insurer receives notification of the occurrence of the insured event. However, if determining the existence or the amount of the claim requires time, the said period shall run from the day which the existence and the amount of the claim have been determined.

If only the amount of the claim is uncertain, the insurer is obliged to pay the indisputable part of the amount of the claim as in advance.

If the insurer does not pay the amount of the time claim within in the provided period, the insured has the right to statutory default interest which can be claimed before the competent court.

7. General rules concerning the limitation period for claims

Claims of the insured or beneficiaries under life insurance contracts have a five-year time bar while, under other insurance contracts, there is a three-year time bar, starting from the first day following the calendar year in which the respective claim was incurred. Nevertheless, if an interested party is able to prove that they were not aware of the occurrence of the insured event, such time starts running from the day they become aware of the occurrence. Absolute time limitation is set to years under life insurance contracts and five years under other insurance contracts, from the first day following the calendar year in which the respective claim was incurred. Claims of the insurer under insurance contracts have a three-year time bar.

A direct claim of a third party which sustained loss towards the insurer in third-party liability insurance is subject to the same statute of limitation rules governing third-party claims against the insured.

8. Policy triggers with respect to third-party liability insurance

In third-party liability insurance, coverage is triggered by the occurrence of an insured event.

An insured event is usually defined either as an act committed or occurrence of loss. Claims-made coverage is not common and there are concerns it may not be in compliance with mandatory provisions of Serbian law, particularly in relation to the limitation periods.

A direct claim of a third party which sustained loss towards the insurer in third party liability insurance is subject to the same statute of limitation rules governing third-party claims against the insured.

9. Recoverability of defence costs

Defence costs may be recovered in line with the terms and conditions agreed between the parties. The insurer shall reimburse all costs of civil proceedings if the insurer pursued the lawsuit or if it gave approval to the insured to pursue the lawsuit, even in the case the claim was unfounded. If the lawsuit was pursued without the insurer's knowledge and approval, insurance shall cover costs of the lawsuit only within the limits of the sum insured, and only if pursuing of the lawsuit and the incurred costs were justified. Upon discharge of his obligation by paying out the sum insured and appropriate portion of costs, the insurer shall be exempt from further duties for reimbursement of costs per single insured event.

10. Insurability of penalties and fines

In Serbia, insurance coverage is not available for fines and penalties.

Contact

Milica Popovic
E milica.popovic@cms-rrh.com

Slovakia

1. Introduction

The basic way of undertaking insurance activity in Slovakia is by establishing a local joint-stock company. It is also necessary to obtain a permit from the National Bank of Slovakia, which is the supervisory body for financial markets and the insurance market in particular.

Insurance companies established after 1 April 2000 cannot undertake life and non-life insurance activities simultaneously, except for the following: (i) insurers providing life insurance (such insurers may obtain a special certificate that allows them to offer accident and illness insurance as well); (ii) insurers providing accident and sickness insurance (such insurers may obtain a special certificate that allows them to offer life insurance as well); and (iii) insurers providing both life and and non-life insurance simultaneously in accordance with the current legislation.

Although there are certain advantages in establishing a local insurance company (it is perceived by the market as demonstrating a commitment to Slovakia as well as a sign of capital strength) it is an expensive course of action. The legal and actuarial fees are relatively high and there is a minimum capital requirement. It is also necessary to go through a lengthy and cumbersome licensing process, which may take several months. Finally, a domestic insurance company is subject to regulation by the National Bank of Slovakia.

Foreign insurers from the EU as well as from EEA countries may also undertake activity in Slovakia through a branch or on a freedom-of-services basis, under the supervising authority of their home country. Foreign insurers may start operating in Slovakia through a branch or on a freedom-of- services basis following notification to the National Bank of Slovakia from the relevant home country supervising authority.

In terms of market perception and many operational aspects, a branch works in the same way as the establishment of a local company.

However, the cost is much lower – a branch does not require any initial capital and has a simplified

organisational structure. The branch is regulated by the parent company's domestic regulator. With effect from 1 January 2009, the branch of a foreign insurer based in the EU must always include the phrase *'pobočka poisťovne z iného členského štátu'* ('branch of the insurer from another EU Member State') as part of its business name, in the place of its seat and in written communication.

Foreign insurers conducting business in Slovakia on a freedom-of-services basis are also regulated by their home country's supervisory body, while the local Slovak regulatory body can enforce general 'best practice' rules, which are designed to protect the insured. This method of conducting insurance activity in Slovakia is the cheapest; however, it is not perceived by the Slovak market as permanent. Foreign insurers from other states may only undertake insurance activity in Slovakia through a 'main branch' authorised by the National Bank of Slovakia.

The area of insurance is regulated in several acts, regulations and decrees in Slovakia. The main laws in this respect are the Insurance Act, which regulates insurance companies, and the Civil Code, which regulates insurance contracts. The Insurance Act became effective on 1. January 2016, and replaced the previous Act on Insurance. The main reason for this change was the implementation of Solvency II (including its solvency requirements for insurance companies) into the Slovak legal system.

2. Effect of misrepresentation and/or non-disclosure

Before the execution of an insurance contract, the policyholder and the insured (where different) must disclose all matters indicated in the proposal form (or other insurer-issued document), which are relevant to the insurer's assessment of risk. Misrepresentation and non-disclosure of material circumstances or other relevant conditions before the execution of the insurance contract may entitle the insurer to reduce the insurance benefit for the loss suffered, if on the basis of untrue or incomplete answers a lower premium was determined.

If the insurer learns after the insured event that the occurrence of the insured event had a causal connection to the undisclosed circumstances, which the insurer could not have known at the time of conclusion of the insurance due to intentionally untrue or incomplete answers being provided by the insured, and which were material to the assessment of risk, the insurer is entitled to refuse to pay the insurance benefit. Refusing to pay the insurance benefit will result in termination of the insurance contract.

In the event of an intentional violation of disclosure obligations by the insured, providing untrue information, or concealing important facts prior to the conclusion of the insurance contract, the insurer may rescind the insurance contract, if it would not have entered into the insurance contract had it been aware of the undisclosed information. The insurer may benefit from this right within three months from the date of discovery of the non-disclosure. If the insurer fails to rescind by this point, the right to do so will expire.

3. Effect of breach of warranty and condition precedent

Slovak law does not recognise the concept of breach of insurance warranties and conditions precedent.

As a general rule, the insured is obliged to fulfil all the conditions agreed in the insurance contract or stated in the legislation or general terms of insurance. Any intentional breach of the respective obligation may result in the insurer appropriately reducing the insurance benefit, if the breach could have had a material impact on the occurence of the insured event or on the extent of the consequences of the insured event.

4. Consequences of late notification

Under the insurance contract, the policyholder and the insured (where different) may be obliged to notify the insurer about the insured event in writing with undue delay, give a true explanation of its occurrence and the extent of its consequences and provide the necessary documents that the insurer may request. General terms of insurance shall impose additional obligations related thereto. The insurer is allowed to reduce insurance benefit in cases of intentional failure to notify the insured event as required, as long as the failure either increased the loss or had significant impact on the occurrence of the insured event.

The Insurance Act became effective on 1. January 2016, and replaced the previous Act on Insurance. The main reason for this change was the implementation of Solvency II (including its solvency requirements for insurance companies) into the Slovak legal system.

5. Entitlement to bring a claim against an insurer

In general, only the insured has a right to bring a claim directly against the insurer (unless otherwise specified in the general terms of insurance). However, there are statutory exceptions where a person other than the insured is entitled to bring a claim against the insurer. Those exceptions apply to property insurance and insurance of persons, in particular where the death of the insured is stipulated as the insured event. With respect to third-party liability insurance, if it is stipulated by a special law (e.g. motor vehicle third-party liability insurance), a prospective third-party claimant who has suffered a loss as a result of the actions and/or omissions of the insured which are covered by the liability policy, has a right to raise a claim directly against the insurer.

6. Entitlement to damages from an insurer for late payment of claim

The claim is payable within 15 days after the date when the insurer finished the investigation of the insured event. The investigation must be performed without undue delay after notification of the insured event by the insured. In case the investigation cannot be finished within one month after the notification date, the insurer is obliged to provide the insured with an adequate advance payment upon request. Slovak legislation is silent as to the entitlement of the insured to claim damages from an insurer for late payment of claim. The law provides for claiming damages once loss is suffered and in cases of late fulfillment of contractual obligations (including payments) one is entitled to claim statutory interest (unless agreed otherwise in the insurance contract).

7. General rules concerning the limitation period for claims

There are two separate statutes of limitation. The first one pertains to the insured's claims against the insurer. These claims are time-barred (three years from the date on which they became enforceable). In the case of rights to benefit from insurance, the limitation period starts one year after the occurrence of the insured event. The second pertains to the third-party claimant's right to claim against the insurer. These claims are subject to the same rules as those specified above, i.e. those governing the statute of limitation of the insured's claims against the insurer. As a result, the third-party claim against the insurer becomes time-barred when it is also time-barred in relation to the insured. For example, if the third party's claim is based on the tort liability of the insured, it becomes time-barred three years after the date on which the claim became enforceable (in the case of the right to benefit from insurance, the limitation period starts one year after the occurrence of the insured event).

8. Policy triggers with respect to third-party liability insurance

The occurrence of an insured event is a default policy trigger in third-party liability insurance. However, it is possible for the parties to base insurance entirely on other triggers, such as when the loss occurred or manifested itself or when a claim is made.

Nevertheless, there are concerns that a claims-made trigger may not comply with other provisions of Slovak law, particularly in relation to compulsory limitation periods.

9. Recoverability of defence costs

Under Slovak law, the party that succeeds in the civil dispute is entitled to recover defence costs from the losing party. Such entitlement includes e.g. legal fees, notary fees or travel costs. The court of first instance shall decide on the amount of defence costs after the final court ruling comes into force.

10. Insurability of penalties and fines

Insurability of administrative penalties and fines is not excluded by law. However, most insurers include the risks of administrative fines and sanctions in their insurance exclusions. Nonetheless, there is, in fact, such an insurance product on the Slovak market, with one insurance company providing insurance against sanctions by the regulatory body for a breach of obligations concerning data protection.

Contacts

Martina Novysedláková
E martina.novysedlakova@cms-cmno.com

Michaela Némethová
E michaela.nemethova@cms-cmno.com

Slovenia

1. Introduction

The Slovenian Insurance Act (Zakon o zavarovalništvu, "ZZavar-1") provides a legal framework for the conducting of insurance business, while the Obligations Code (Obligacijski zakonik, "OZ") regulates insurance agreements.

Insurance activity in Slovenia may only be performed (i) by an insurer that has obtained authorisation to conduct insurance activity by the Slovenian Insurance Supervision Agency (Agencija za zavarovalni nadzor, "AZN"), (ii) by an insurer based in another EU or EEA member state that has established a branch in Slovenia or may perform insurance activity in Slovenia directly or (iii) by an insurer, based in a third country, that may perform insurance activity in Slovenia directly or has established a branch in Slovenia and has obtained authorisation to conduct insurance activity from the AZN.

AZN may grant an insurance licence to a joint-stock company, societas europea or mutual insurance company.

2. Effect of misrepresentation and/or non-disclosure

When concluding an insurance agreement, the policyholder must inform the insurer of all the circumstances, necessary for the risk assessment that were known to him or that could not have remained unknown to him.

An insurer may demand termination of the insurance agreement if a policyholder intentionally made a false declaration or did not disclose a circumstance of such nature that the insurer would not have concluded the insurance agreement if it had known the state of the situation. In such case, an insurer has the right to claim the payment of the premium for the insurance period in which the termination of the agreement was demanded. The insurer's right to terminate the insurance agreement ceases three months after an insurer becomes aware of the false declaration or non-disclosure.

In cases where a false declaration or omission of the notification were not committed intentionally, an insurer may, within one month of learning of the falsehood or incompleteness of information, either withdraw from the insurance agreement or propose a premium increase in proportion to the greater risk. The insurance agreement terminates 14 days after an insurer notifies the policyholder of withdrawal or, if the policyholder does not accept the proposed premium increase, within 14 days of receiving the notification. In this case, an insurer must return the part of the premium pertaining to the time remaining to the end of the insurance period.

With respect to property insurance, the policyholder is obliged to notify an insurer of every change of circumstance which might be significant for the risk assessment. With respect to personal insurance, the policyholder is obliged to notify an insurer only if the risk increases due to a change in the policyholder's work. The policyholder must immediately notify an insurer if the risk has increased due to the policyholder's action, whereas in cases where the risk occurred without his/her involvement, the notification must be made within 14 days of becoming aware of the risk. An insurer may either (i) withdraw from the insurance agreement if the risk increase was such that the insurer would not have concluded the insurance agreement in the first place or (ii) propose a premium increase if, being aware of such circumstances, it would have concluded the insurance agreement only subject to a higher premium. The insurance agreement terminates if the policyholder does not accept the proposed premium increase within 14 days.

If the insured event arises before the insurer was notified of the risk increase or after the insurer was notified, but before the insurer withdrew from the insurance agreement or before an increase in the premium was agreed, the insurance payment is reduced proportionally.

3. Effect of breach of warranty and condition precedent

General civil law principles set out in OZ apply with regard to warranties and condition precedents in insurance agreements. However, please note that the concepts of warranties and condition precedents are not the same as under English law. Parties of an insurance agreement may agree on conditions precedent unless the conditions precedent would breach any mandatory provisions. The same applies for the agreement on certain warranties. Any breach of warranty or condition precedent would have a similar effect as misrepresentation and/or non-disclosure in no. 2. Insurers should consider consumer protection laws as well when dealing with consumers.

4. Consequences of late notification

A policyholder must (except in cases of health and life insurance) notify an insurer of the insurance event within three days of becoming aware of it, whereby the general terms and conditions of the insurer may provide a longer period. In case of late notification, a policyholder must reimburse an insurer for any damages.

Provisions in the insurance agreement which would cause the loss of the insured's right to compensation or an insurance sum in the case of non-fulfilment of obligations by the insured after the occurrence of the insurance event, are null and void.

5. Entitlement to bring a claim against an insurer

Generally, the insured (and the beneficiary, in the case of the life insurance) has the right to raise a claim against an insurer resulting from an insurance agreement. However, in third-party liability insurance, the injured person also has a right to raise a direct claim against the insurer of the person responsible for the damage.

6. Entitlement to damages from an insurer for late payment of claim

When an insurance event occurs, the insurer must pay the insurance sum or compensation within the agreed deadline, which must not be longer than 14 days from the day of the receipt of the notification about the occurrence of the insurance event.

In case that specific period of time is needed to determine the existence of the insurer's obligation or its amount, this deadline runs from the day the existence and amount of the obligation were determined.

If the amount of insurer's obligation is not determined within 14 days from the day of the receipt of the notification that the insurance event occurred, the insurer must, at the beneficiary's request, pay to the beneficiary the undisputed part of the obligation as an advance.

The insurer is liable to pay damages to the insured if there is fault on the insurer's part. Such damages may consist of the damages caused by the delay of payment or by non-performance.

7. General rules concerning the limitation period for claims

The limitation period for claims expires three years after the first day following the calendar year in which the claim originated. The exception is claims arising from life insurance which expire in five years. If a person did not know that the insurance event occurred, the limitation period begins to run on the day the insured person became aware of the insurance event. In any case, however, the limitation period expires after five years, with an exception for claims regarding life insurance, which expire after ten years.

An insurer's claim arising from the insurance agreement expires after three years.

If in a third-party liability insurance an injured person claims and obtains compensation from an insured person, the limitation period of three years runs from the day the injured person filed a claim against the insured person or when the insured person reimbursed the damages.

The limitation period for a direct claim for damage of an injured party against an insurer expires three years after the injured party became aware of the damage and of the responsible person. In any case the claim expires five years after the damage occurred. If the damage was caused by a criminal offence requiring a longer limitation period for prosecution, the same period applies; such longer limitation period shall apply also to damage claims.

8. Policy triggers with respect to third-party liability insurance

Two triggers are obligatory for the occurrence of insurer's obligations: i) the occurrence of an insurance event and ii) the beneficiary's claim to reimbursement of damages.

Generally, liability insurance is concluded as an occurrence-based policy with the exception of D&O insurance, where the claims-made principle is predominantly used in practice. Note, however, that the claims-made principle is at the time of being discussedcontroversial, but there is no publicly available case law on this subject yet.

9. Recoverability of defence costs

In general, any party of the court proceedings in Slovenia has to bear its costs, incurred within the proceedings. The losing party has to compensate the costs to the winning party, however only to the extent as set out in the attorneys-at-law tariff, meaning the actual costs incurred may be much higher than recovered.

The Slovenian ZZavar-1 defines insurance of legal procedure as an insurance covering costs of attorneys-at-law and other expenses and costs of legal proceedings.

In practice, the following costs are covered: costs of attorneys-at-law, notary costs, costs of court-appointed experts and experts' opinions, costs of witnesses, costs of court interpreters, additional material costs, court costs, payment of bail, travel expenses for proceedings abroad, and costs of out-of-court settlements, which are imposed by the court.

10. Insurability of penalties and fines

Slovenian law does not set any rules on insurability of penalties and fines, however, according to the Slovenian legal theory, an insurance may not cover the contractual penalty, money fine or any other claim which would have the nature of sanction.

Contacts

Aleš Lunder
E ales.lunder@cms-rrh.com

Spain

1. Introduction

Insurance activity in Spain is regulated under the Act 20/2015, of 14 July on the organisation, supervision and solvency of insurance and reinsurance companies and under the Royal Decree 1060/2015, of 20 November, which approves the regulation on organisation, supervision and solvency of insurance and reinsurance companies. Additionally, the Act 50/1980, of 8 October on insurance agreement, governs the content of insurance agreements, rights and obligations of the parties and related issues.

There are various alternatives available for carrying out insurance activity in Spain. This depends on the origin of the company undertaking the business.

To carry out insurance activities in Spain, Spanish companies must obtain a licence granted by the Ministry of Economy, Industry and Competitiveness (Ministerio de Economía, Industria y Competitividad). Such activities will be limited to the classes of insurance that are expressly authorised by the licence. On their incorporation, Spanish insurance companies must adopt a specific legal form which shall be: public limited companies; mutual companies; cooperatives; or a social welfare mutual society. This is one of the requirements for obtaining the licence.

Insurance companies based within the EEA already authorised by their home country regulators will be entitled to carry out insurance activity in Spain through the incorporation of a branch in Spain (on a freedom-of-establishment basis) or directly from their home country (on a freedom-of-services basis). In these cases, EEA insurance companies will be allowed to conduct insurance activities in Spain in accordance with the licence granted by their home country regulator, after notification has been made by this regulator to the Spanish General Directorate of Insurance and Pension Funds (Dirección General de Seguros y Fondos de Pensiones) communicating their intention to conduct insurance activity in Spain.

For an EEA insurer, it is more time-consuming to incorporate and obtain a licence from the Spanish Ministry of Economy, Industry and Competitiveness than to proceed on a freedom-of-establishment or freedom-of-services basis, where the home country regulator notifies the Spanish Ministry of Economy, Industry and Competitiveness of the intention of the company.

Companies based outside the EEA are required to establish a branch and obtain a licence from the Ministry of Economy, Industry and Competitiveness in order to carry out insurance activities.

2. Effect of misrepresentation and/or non-disclosure

Prior to the execution of the insurance contract, the insured must disclose all circumstances that are material to the risk to be covered by the insurer. This information is commonly gathered by insurers in the form of a proposal form to be completed by the policyholder. If any information is not requested by the insurer or is not raised in the proposal form, the policyholder is not obliged to disclose it. The insurer will have the right to propose a partial amendment of the insurance contract to the policyholder to reflect any new circumstances of the risk arising from the information thus disclosed. This proposal must be made by the insurers within the two-month period following the disclosure of the information. After receiving the proposal, the policyholder will be entitled to accept or reject the proposal within the following 15 days.

If an insured event occurs and the policyholder has not disclosed all the above information, the insurer has the right to adjust the claimed payment in proportion to the difference between the premium paid and the premium that the insured would have had to pay if the proper information had been disclosed. During the policy period, the policyholder must disclose all new circumstances that increase the risk that would have affected the insurer's decision to underwrite the risk if the insurer had been aware of it during the placement of the risk. Likewise, the policyholder is also entitled to disclose circumstances that lower the risk that would have resulted in more beneficial terms and conditions for the insured if the insurers had been aware of the circumstance during assessment of the risk.

3. Effect of breach of warranty and condition precedent

The legal effectiveness of the insurance agreement may depend on certain warranties or conditions precedent. Please note that Spanish insurance regulations do not provide for explicit provisions about the enforcement of warranties and conditions precedent and, therefore, general civil law principles set out in the Spanish Civil Code shall apply.

In case any warranty has been included in the contract shall be construed as an explicit contractual agreement, without the insurer being discharged from liability in case of breach. However, when a specific precedent condition has been explicitly agreed by the parties, the effectiveness of the insurance contract may depend on the fulfilment of said condition.

4. Consequences of late notification

The Policyholder is obliged to notify the insurer of the occurrence of an insured event within a maximum of seven days, unless the parties agree a different term in the insurance contract. In the event of breach, the insurer may claim the damages arising from late notification.

Similarly, the policyholder may provide insurers with all the information about the circumstances and the consequences arising from the insured event.

5. Entitlement to bring a claim against an insurer

The beneficiary appointed in the insurance contract may claim compensation for loss arising from the insured event.

However, for third-party liability policies, the third party has the right to directly claim against the insurer where said third party has suffered a loss resulting from acts and/or omissions of the insured which are covered by the policy. The insurer may subsequently claim against the insured if the damages were caused by wishful misconduct of the insured.

An insurer may not oppose to the damaged third party those exceptions that it holds vis-à-vis the policyholder or the insured. However, insurers may challenge the claim on the grounds that the third party was solely responsible for the event and also oppose any other exceptions that the insurers may hold vis-à-vis the claimant.

For the purposes of the exercise of the direct action, the insured must notify the third party or its heirs of the existence of the insurance contract and its content.

6. Entitlement to damages from an insurer for late payment of claim

Spanish law on insurance contract establishes that the insurer is obliged to pay the compensation to the beneficiary within three months from the occurrence or, in the case it has not paid the minimum compensation due within 40 days as from the notification of the occurrence. In those events, the insured shall be entitled to damages.

Said damages are calculated as the annual legal interest rate increased by 50%. Furthermore, after two years from the occurrence, the applicable annual interest rate shall not be less than 20%.

The interests are accrued on a daily basis from the date of the occurrence, unless the policyholder, the insured or the beneficiary does not communicate it on time to the insurer.

If the insurer pays the minimum compensation due within the 40 days following the notification of the occurrence, interest shall not accrue any more at the time of payment. If the insurer does not pay at this time, the interests shall accrue until the company pays all the compensation. However, the insurer shall not be obliged to pay this default compensation if the delay arises by due cause or it is not attributable to the insurer.

7. General rules concerning the limitation period for claims

Claims resulting from an insurance contract covering loss or damage must be made by the insured within two years of the date the insured is able to notify the occurrence of the event to the insurer. For life and personal insurance, claims must be made within five years.

The same limitation periods apply for claims made by the insurer against the insured.

8. Policy triggers with respect to third-party liability insurance

For third-party liability contracts, coverage is triggered either (i) by the occurrence of an insured event, or (ii) by a third party notifying the insured of their intention to make a claim for reimbursement of damages.

Spanish law allows claims-made policies if they meet certain requirements relating to the limitation periods for covering the damages: (i) if the claims-made clause establishes that the insurance contract shall cover the events that occurred following the expiration of the insurance policy, the additional coverage period shall be not less than one year from the expiration of the contract; (ii) similarly, if the claims-made clause establishes that the insurance contract will cover any events occurring prior to the enforceability of the policy, the policy must cover any insurance event which occurred within, at least, the one-year period before the enforceability of the policy.

On the other hand, 'losses-occurring' policies should also be considered. These policies require the third party to provide evidence that the damage was suffered during the enforceability period of the policy and any damages arising out of this period are rejected.

9. Recoverability of defence costs

In order for the insured to recover the cost of judicial or extrajudicial proceedings, it is necessary that the policy provides for defence cost cover. Moreover, the insurer could settle different constraints for this coverage, for example, the insured can recover only a limited portion of the fees.

This type of cover usually imposes that the insured's choice of legal advisor be authorised, or, at least, communicated to the insurer, prior to the beginning of legal proceedings.

10. Insurability of penalties and fines

Spanish insurance regulations do not set out any explicit rule in this regard. Therefore, the general provisions of the Spanish Civil Code regarding the autonomy of the parties shall apply. Said principle shall be, in any case limited, by any agreement contradicting law, morality or public policy.

On a non-binding consultation, the Spanish General Directorate of Insurance and Pension Funds declared in 2008 that the coverage of fines and penalties for criminal and administrative liability would be forbidden, since it would contradict public policy. Said argument was based on the potential reduction of the punitive effect of fines and penalties in case their effects are insured and, therefore, assumed by a third party.

Notwithstanding the above, since said criteria is not binding and no explicit prohibition is currently in place, penalties and fines cover is usually offered in the Spanish contract. (e.g. data protection, driving, etc.), being applicable the limits of wilful misconduct or gross negligence.

Contacts

Carlos Peña
E carlos.pena@cms-asl.com

Rafael Sáez
E rafael.saez@cms-asl.com

Switzerland

1. Introduction

Since Switzerland is not part of the EU or EEA, insurance companies with their domicile in any EU or EEA member state may not conduct business through a branch office or cross-border on the basis of the EU passport principle and home state regulator regime (with exceptions for the Principality of Liechtenstein). Therefore, insurance companies domiciled abroad intending to engage in insurance activities in or from Switzerland require authorisation from the Swiss Financial Market Supervisory Authority (FINMA) to do so.

An insurance activity in Switzerland exists, regardless of the type of contract and where it is concluded, if:

— a natural person or legal entity domiciled in Switzerland is among the policyholders or insured persons or if
— property located in Switzerland is insured.

A foreign insurer can establish a Swiss branch office if it is licensed to undertake insurance activities in its home country. To qualify for a licence from FINMA, the foreign insurer must meet the respective requirements, including minimum capitalisation, adequate solvency margins and various personal requirements for the staff members. It must further appoint a fully authorised representative who must reside in Switzerland and manage the business of the branch office.

A few narrow exceptions apply to this general rule for insurance companies domiciled abroad with no Swiss branch office: mere reinsurance activities conducted in Switzerland, mere insurance of marine, air transportation, international transports and war risks as well as risks located abroad.

Under another exception, which is in practice hardly relevant, an insurance business which engages in

insurance activities in Switzerland which are of little economic importance or which affect only a small group of insureds may, if the specific circumstances justify, be exempted from supervision by FINMA.

2. Effect of misrepresentation and/or non-disclosure

Based on written questionnaires presented by the insurer, the insured is obliged to disclose to the insurer in writing all facts of which he or she is aware or ought to be aware and that are material to the assessment of the risk to be insured. All facts which the insurer unambiguously asks for are deemed relevant for the assessment of the risk and are, therefore, subject to disclosure.

If the insured fails to inform the insurer about such material facts, or if the insured makes misrepresentations about such material facts, the insurer may terminate the contract by written notice. The right to terminate the insurance contract expires four weeks after the insurer has become aware of the non-disclosure of the insured.

If the insurer terminates the contract, its obligation to indemnify any losses that have already occurred ceases, provided that the non-disclosed material fact caused or increased the loss. If the insurer has already indemnified the insured, it is entitled to claim back the payments made (specific provisions apply to life insurance).

Where the non-disclosure or misrepresentation only relates to one specific risk under an insurance contract covering several risks (Kollektivversicherungsvertrag), the insurer may only terminate the insurance contract relating to such specific risk. Under certain circumstances (e.g. if the insurer was aware of the non-disclosed facts), the insurer is not entitled to terminate the insurance contract, even though the insured made a material misrepresentation or failed to disclose material facts.

3. Effect of breach of warranty and condition precedent

The concept of warranties (in the UK sense) does not exist under Swiss law; a warranty clause e.g. in an English policy that is governed by Swiss law needs to be interpreted from a Swiss law perspective. According to the Swiss Insurance Contract Act, an insurer may e.g. exclude certain risks from cover. There is, in general, no requirement of negligence or causation for such exclusions. The Insurance Contract Act requires, however, that the exclusion is unambiguous (and any ambiguities will be construed against the insurer).

A condition precedent differs from an exclusion of coverage since it requires a certain behaviour of the insured. If e.g. the insured does not comply with duties/obligations stipulated in the insurance contract, the insurer can only deny coverage or limit its indemnification due under the insurance contract if the insured acted negligently. Further, the insurance contract act specifically requires a causal link between the non-compliance of the insured and the loss/damage in some situations. Therefore, even if a duty of the insured is styled as "condition precedent" (in the UK sense), the policy wording seldom provides a strong defence for insurers.

4. Consequences of late notification

Upon occurrence of the insured event, the insured is, based on the Insurance Contract Act, required to notify the insurer as soon as (i.e. 'immediately after') he or she becomes aware of the event.

If the insured negligently breaches such duty to notify the insurer, the insurer is entitled to reduce its indemnification to the hypothetical value of the loss, had the claim been notified on time. As this can be difficult to prove, the law allows the parties to agree in the insurance contract to reverse this burden of proof in the event of a negligent late notification.

Swiss law also allows defining other consequences for negligent breaches of duties of the insured, and in particular notification duties. Provided that the insurance contract is clearly worded and that the respective clause is covered by the parties' consensus, late notification may also result in the loss of the insurance coverage. Please note, however, that such disadvantage shall have no effect, if the violation according to the circumstances is not the result of the insured's negligence.

5. Entitlement to bring a claim against an insurer

The insured has a right to bring a claim under the insurance contract directly against the insurer. If a third party is covered by the insurance policy, the policyholder may generally only bring a claim against the insurer with the consent of the third party. Exceptions apply if (i) the policyholder took out the insurance policy with the authorisation of the third party or (ii) there is a statutory obligation to provide insurance cover for the third party or (iii) the third party and the policyholder have agreed that the policyholder should be entitled to bring a claim against the insurer irrespective of the third party's consent.

6. Entitlement to damages from an insurer for late payment of claim

According to the Swiss Insurance Contract Act, the payment of an Insurer under the insurance contract is due no later than four weeks after the insurer received the necessary information to investigate and verify the respective claim of the insured. In case of a late payment, the insured is entitled to receive interest at 5% of the outstanding payment per year. If the insured can prove that he or she suffered any damages due to the late payment of the insurer, the insured may claim to be compensated for such damages.

7. General rules concerning the limitation period for claims

The statutory limitation period for a claim against the insurer under the insurance contract is two years. The limitation period starts running on the date on which the insured event took place. In practice, the parties often agree on a longer limitation period (e.g. five years) for claims against the insurer under the insurance contract.

8. Policy triggers with respect to third-party liability insurance

The parties are generally free to agree on the trigger in the insurance contract. In particular, the parties are free to agree whether the policy trigger is the occurrence of the event that gives rise to the liability of the insured (occurrence-based policies) or the claim of the third party made against the insured (claims-made policies).

9. Recoverability of defence costs

The Swiss Insurance Contract Act does not explicitly address the recoverability of defence costs. Third party liability insurance contracts in Switzerland generally provide cover for defence cost (against covered claims against the Insured). The cover for defence costs is usually limited to reasonable and necessary costs and expenses, which are incurred with prior written consent of the insurer.

10. Insurability of penalties and fines

According to the prevailing view in Swiss case law and amongst Swiss scholars, penalties and fines are not insurable. If an insurer provides cover for penalties and fines such cover may, thus, be null and void. Further, the insurer takes a risk that such cover is regarded as a criminal offence (assisting/encouraging offenders).

Contacts

Clemens von Zedtwitz
E clemens.vonzedtwitz@cms-vep.com

Jodok Wicki
E jodok.wicki@cms-vep.com

Turkey

1. Introduction

Under the Insurance Law No. 5684 *("Insurance Law")* insurance companies can only operate in the Turkish market by establishing a joint stock company or a cooperative. Furthermore, pursuant to the Council of Ministers' Decision on the International Activities in the Insurance Sector, foreign insurance companies can also operate in Turkey by establishing a branch office. While, there is no license requirement for establishment, an insurance company, once established, must obtain an appropriate license from the Undersecretariat of Treasury in order to commence its operations. There is a variety of licenses available; each license is specific to a certain branch of insurance (i.e. life, non-life, life-pension or re-insurance) and every insurance company must hold all licenses applicable to its insurance products.

The Insurance Association of Turkey is a professional organisation and, as per the Insurance Law, all insurance and reinsurance companies established in Turkey must be a member of the Insurance Association of Turkey.

Pursuant to the Insurance Law, only insurance companies established and operating in Turkey are permitted to insure the insurable interests of Turkish citizens or other residents of Turkey. However, there is a notable exception for life insurance, which can be purchased from abroad. Other exceptions include transportation insurance for goods subject to export and import and third-party liability insurances arising from the operation of ships.

2. Effect of misrepresentation and/or non-disclosure

The Turkish Commercial Code No. 6102 *("TCC")* regulates the notification requirements of the policyholder to the insurer. Pursuant to the TCC, there is an obligation on the policyholder to provide all material information to the insurer that is known, or ought to have been known, by the policyholder that would affect the conclusion of the insurance contract or may require the contract to be concluded on different terms and conditions. If the insurer provides a written list of questions to the policyholder, the questions and the policyholder's responses will be considered material information and the policyholder will not be obliged to provide additional information to the insurer. If upon receipt of the policyholder's responses the insurer requires additional information, the insurer may ask the policyholder additional questions in writing. Furthermore, the policyholder is not required to provide information on any issue that is already known to the insurer. However, in all cases there is an overarching obligation on the policyholder not to withhold material information in bad faith, regardless of whether or not the insurer provides a specific list of questions.

The TCC states that, actions of the insured (under third-party insurances) or the beneficiary (under life insurances), shall be taken into account in terms of the performance of this obligation, provided that they are informed about the insurance. Therefore, although not expressly stated under the TCC, it is accepted in practice that the insured and the beneficiary will be under the same obligations as the policyholder under such circumstances.

The remedies available to the insurer in instances of misrepresentation and/or the non-disclosure of material information depend on when the insurer becomes aware of the misrepresentation and/or non-disclosure.

If the insurer becomes aware of the misrepresentation and/or non-disclosure *before* the occurrence of an insured event, the insurer may either:

i) rescind the insurance contract within fifteen days of becoming aware of the misrepresentation and/or non-disclosure; or
ii) request from the policyholder or the insured, as the case may be, the amount of the additional insurance premium that would have been paid by the policyholder had the misrepresentation and/or non-disclosure not occurred.

In cases where the insurer becomes aware of the misrepresentation and/or non-disclosure after the occurrence of an insured event under the insurance contract, and the misrepresentation and/or non-disclosure has an effect on the quantum of the policyholder's/insured's/beneficiary's claim or on the occurrence of the insured event itself, the insurer will either:

i) be entitled to reduce the insurance proceeds by the difference between the insurance premium paid by the policyholder and the insurance premium that would have been paid by the policyholder had the misrepresentation and/or non-disclosure not taken place; or
ii) if there is evidence of bad faith on the part of the insured and causality between the misrepresentation and/or non-disclosure and the occurrence of the insured event, the insurer will be entitled to rescind the insurance contract and will consequently be discharged from its obligation to pay the insurance proceeds.

Please note that in the case of life insurance contracts, the remedies available to the insurer in instances of misrepresentation and/or non-disclosure are more limited. For example, an insurer is only able to rescind a life insurance contract within the first five years of the insured term; thereafter the insurer will only be entitled to claim for the insurance premium difference.

3. Effect of breach of warranty and condition precedent

Under Turkish law, insurance contracts are not conditional contracts. Therefore, they cannot be subject to conditions precedent.

Under Turkish law, there is no recognised warranty concept. However, the insurance contract may impose on the policyholder and the insured certain obligations that must be complied with during the insured period. The remedies available to the insurer for breach of such obligations by the policyholder and the insured are the same as those applicable to misrepresentation and/or the non-disclosure.

4. Consequences of late notification

The policyholder is obliged to notify the insurer without undue delay as soon as it becomes aware of a claim.

In cases where the policyholder has, due to its own fault or negligence, failed to notify or delayed the notification of a claim to the insurer, and such failure or delay results in an increase of the insurance proceeds, the insurer will be entitled to reduce the amount of the insurance proceeds. The amount of the reduction is dependent on the extent of the policyholder's fault or negligence.

5. Entitlement to bring a claim against an insurer

Generally, the policyholder has a right to bring a claim against the insurer under an insurance contract. Also, beneficiaries under the life insurance contracts shall have right to bring a claim against the insurer. Moreover, in the case of third-party liability insurance, a prospective third-party claimant who has suffered an insured loss because of the actions and/or omissions of the policyholder has a right to bring a claim directly against the insurer.

6. Entitlement to damages from an insurer for late payment of claim

Under the TCC, insurance proceeds shall become due and payable by the insurer to the policyholder once an insured event has been realised, a claim notified to the insurer by the policyholder and the insurer has completed its investigation of the claim. The insurer is required to complete its investigation within forty five days from the date of notification of the claim by the insured. This period is fifteen days for life insurances.

The late payment of insurance proceeds constitutes a "default" by the insurer under the TCC and consequently default interest will be due in addition to the insurance proceeds. The default interest rate can be determined in the insurance contract freely by the parties, subject to the relevant limitations under the Code of Obligations No. 6098 for non-commercial insurance policies. However, if no default interest rate is specified in the insurance contract or if the rate therein is not applicable to the particular claim, then specific default interest rates would be applied in accordance with the Law on Legal Interest and Default Interest No. 3095.

7. General rules concerning the limitation period for claims

Under the TCC, the statutory limitation period for insurance claims is six years from the date when the insured event occurred; reducing to two years once the policyholder becomes aware that the insured event has occurred.

However, with respect to third-party liability insurance, the statutory limitation period is ten years from the date when the insured event occurred; reducing to two years once the third party becomes aware that the insured event has occurred.

8. Policy triggers with respect to third-party liability insurance

Third-party liability insurance is triggered when the insured third party suffers an insured loss during the insured period.

9. Recoverability of defence costs

The recoverability of defence costs varies depending on the types of insurance contract; however, generally the insurer is liable for the reasonable costs and expenses incurred by the policyholder and insured, including expenses relating to the defence of claims.

10. Insurability of penalties and fines

There is currently no specific legislation in Turkey in relation to the insurability of penalties and fines.

Contacts

Döne Yalçın
E doene.yalcin@cms-rrh.com

Ana Radnev
E ana.radnev@cms-cmno.com

Ukraine

1. Introduction

An insurer has three main options for starting its full scope insurance operations in Ukraine. Those options would be: (i) to establish a 'greenfield' company; (ii) to acquire an existing Ukrainian insurer, or (iii) open a branch of the parent insurance company in Ukraine.

A limited scope of insurance services, subject to certain restrictions and requirements, may be directly (without establishing a legal entity or registering a permanent establishment) provided by foreign insurers in Ukraine. According to Ukrainian insurance law (the 'Insurance Law') foreign insurers are allowed to conduct the following direct and intermediate insurance activities (such as brokerage or agency operations) in the Ukrainian market:

- insurance of the risks related to marine transportation, commercial aviation, launches of space craft (including satellites), and freight, if the object of insurance is a property interest in the goods to be transported and/or in the transport vehicle, and/or a liability arising out of such transportation of goods;
- re-insurance (including insurance mediation); and
- ancillary insurance services, such as advisory services, actuarial risk assessment and claims settlement.

A foreign insurer (i.e. a financial institution established outside the jurisdiction of Ukraine and permitted under the laws of its home state to conduct insurance activities) carrying out insurance activities within the above scope in Ukraine shall be subject to the following requirements (the 'General Requirements'):

- the home state of the foreign insurer must be a member state of the World Trade Organisation that does also take part in the international co-operation in the field of the prevention and counteraction of the legalisation (laundering) of profits and the financing of terrorist activities, and cooperates with the Financial Action Task Force (FATF). The exception is made for non-resident re-insurers, which can be based in non-WTO countries, being however FATF members;
- a memorandum on information exchange has been signed (or a respective agreement has been concluded) between the authorised insurance regulator of the home country of the foreign

insurer, and the National Commission that regulates financial services markets (the 'Commission'). Unfortunately only a few such memorandums, in particular with Armenia, Poland, Latvia and Lithuania (as reported by the Commission on 29 November 2013) have been signed so far by the Commission and Ukraine is also not a member of the International Association of Insurance Supervisors. The Commission expects to sign memorandums with Moldova, Turkey, Macedonia, Belarus, Israel, Australia, Czech Republic and Hungary in the near future;

- the insurance business of the foreign insurer is supervised by the state authorities in accordance with the legislation of the home country of the foreign insurer;
- an international treaty on the prevention of tax evasion and the prevention of double taxation has been concluded between Ukraine and the home country of the foreign insurer;
- the foreign insurer is located in a country or in a specific territory that does not have an off-shore status in accordance with the Ukrainian law; and
- the financial reliability (stability) rating of the foreign insurer is compliant with the requirements set forth by the Commission.

In Ukraine, an insurance company may be established in the form of a joint-stock company, a full partnership, or an additional liability company. Although joint-stock companies are most common, registration of a full partnership or an additional liability company is much more simple and swift.

There are certain specific requirements regarding the composition of shareholders (there must be at least three), the structure of the charter capital (100% in cash or 25% max in state bonds) and the minimum amount of the charter capital of the Ukrainian insurance company (EUR 1m in UAH equivalent is set for non-life insurers).

The minimum amount of the charter capital for life insurers is currently EUR 10m (in UAH equivalent), a substantial increased from EUR 1.5m in May 2013. This increase is mostly relevant for life insurance companies licensed after May 2013, as the already-existing life insurers were not required to make any revisions to their charter capitals. However, insurers required to re-apply for their insurance licence, for example due to a change of the company's legal form, will also be required to increase their charter capital in compliance with the current statutory level.

To be eligible to carry out insurance activities in Ukraine, a company must also complete the following procedures with the Commission: (i) register as a financial institution; (ii) obtain a licence for insurance activity; and (iii) submit its approved insurance product rules.

In order to obtain and maintain its financial institution status, a company must have: a certain number of qualified insurance professionals, office premises, hardware and software and an operational business plan covering at least three years.

Insurers must apply to the Commission for each separate type of insurance activity, provided, however, that a life insurer is not allowed to sell any other insurance products.

A financial institution must adopt and register its insurance product rules (the 'Insurance Rules') for each of its products. The Insurance Rules must be developed and submitted by the insurer to the Commission simultaneously with the submission of the documents for the insurance licence and each time these rules are changed or a new type of insurance activity is added to the insurance licence.

Due to the lengthy, difficult and bureaucratic procedure and fees associated with establishing a greenfield insurance company in Ukraine, international insurance players often choose an easier and quicker option – to acquire a local insurance company in Ukraine.

However, in most cases the acquisition of interest in the local insurer must be authorised by the Commission and the anti-trust authority – the Antimonopoly Committee of Ukraine. The Commission's approval is mandatory if the foreign insurer intends to purchase or increase its stake in the Ukrainian insurer resulting in the foreign insurer obtaining direct or indirect control over 10%, 25%, 50% or 75% of the Ukrainian insurer's charter capital. This means that the approval will not be required if the foreign insurer already holds say 10% of the shares and intends to acquire control over another 14% (up to 24% in total).

The Commission will thoroughly inspect the foreign insurer's financial capabilities and the reputation of its senior management personnel. The preliminary conclusions of the Antimonopoly Committee of Ukraine, also required by the Commission, should be obtained following the general procedure set forth by Ukrainian anti-trust law.

New Options for the Non-Resident Insurers

Alternatively, as of 17 May 2013 (five years after the date Ukraine joined the WTO) foreign insurers have been able to carry out full-scope insurance activities in Ukraine directly via Ukrainian branches, which are treated as resident insurance companies. Such branches of foreign insurers must also be registered with the Commission, hold a respective insurance licence and comply both with the general requirements mentioned above and some additional requirements, including:

- the foreign insurer must issue a written irrevocable commitment note to confirm the unconditional performance of all obligations undertaken by its branch in Ukraine;
- since under Ukrainian law permanent establishments are not separate legal entities and thus do not form a charter capital, foreign insurers must place a guarantee deposit (at least equal to the minimum amount of the charter capital established for resident insurers, as specified above) with a Ukrainian bank;
- the insurance funds of a foreign insurer must be deposited only in the territory of Ukraine.

Ukrainian insurance law includes the reciprocity principle, according to which foreign insurers are allowed to open branches in Ukraine only if the foreign insurer's home country permits the same to Ukrainian insurers.

2. Effect of misrepresentation and/or non-disclosure

The policyholder is obliged to disclose to the insurer all matters that may be relevant for the insurer's assessment of risks and inform the insurer if the risks may have changed. Misrepresenting information about (i) the subject matter of the contract (object); or (ii) the insured event may constitute grounds for the insurer to refuse to provide indemnity under the policy. In case the policyholder did not inform the insurer that the object had been already insured, such new insurance contract is void.

3. Effect of breach of warranty and condition precedent

The concept of warranty as such does not exist in Ukrainian legislation. Under applicable general provisions of the civil law, the affected party may raise a claim requiring compensation of pecuniary and non-pecuniary damages from the other party, as well as payment of the liquidated damages and unilateral termination of the contract (if such consequence is directly provided in the contract). In case of breach of contractual obligations concerning misrepresentation and/or non-disclosure by the policyholder, the consequences arise as described in the Section 2 above.

4. Consequences of late notification

Under the Insurance Law the policyholder has an obligation to notify the insurer about the insured event within a time limit specified by the Insurance Rules. In the case of late notification of the insured event (without any reasonable excuses) the insurer is allowed to refuse to provide indemnity under the policy.

5. Entitlement to bring a claim against an insurer

Under the general rules, only the policyholder has the right to bring a direct claim against the insurer. For third party liability insurance and insurance contracts in favour of third parties, the Ukrainian insurance legislation provides that a third party, being a party which suffered the damages, or beneficiary under the insurance contract which is executed in its favour, is entitled to indemnity under the policy and therefore, may also bring a claim directly against the insurer.

6. Entitlement to damages from an insurer for late payment of claim

In case of late payment by an insurer, the policyholder is entitled to claim payment of the liquidated damages for the whole period of such insurer's delay. The amount of payable liquidated damages is determined by the insurance contract. In case the insurance contract does not contain provisions on the amount of the liquidated damages payable in case of late payment by an insurer, the latter shall bear liability according to general provisions of the civil law, in particular, an insurer shall pay an outstanding inflation-adjusted amount as well as 3% interest per annum from the outstanding amount.

7. General rules concerning the limitation period for claims

The general limitation period in Ukraine is three years from the date when a person becomes aware or might reasonably have been expected to become aware of a breach of his or her right to claim or of the actions of the person responsible for the breach. It is also applicable to the claims of third parties against insurers. There is no limitation period for policy-holder claims against the insurer in Ukraine.

8. Policy triggers with respect to third-partyliability insurance

The occurrence of an insured event is a default policy trigger in third-party liability insurance. However, the insurers are free to set other triggers in the Insurance Rules or agree on them directly in the insurance contract, provided that such triggers comply with Ukrainian legislation.

9. Recoverability of defence costs

Insurance-related disputes are generally resolved by either civil courts (between individuals and legal entities) or commercial courts (between legal entities). Administrative courts consider claims against state authorities or public officers; therefore are not directly involved in insurance disputes on the commercial matters.

In civil cases recovery of the defence costs is allowed only within certain limits established by law. A winning party is entitled to not more than 40% of the subsistence minimum (as of 1st January of the relevant year) per one hour of legal assistance in court hearings, various procedural actions and case studies, provided that the defeated party is not exempt from payment of the defence costs, in the latter case up to 2.5% of the same can be compensated from the state budget.

In turn, there is no upper celling for recovery of the defence costs in commercial proceedings. However, the court may reduce the amounts claimed to the reasonable market level and unlike in civil proceedings will only recover attorney fees, i.e., legal assistance provided not by professional lawyers (certified "advocates") will not be subject to compensation.

Such practice also corresponds to the principles of the on-going court system reform. According to the recent changes to the Constitution of Ukraine from 1 January 2019 only advocates will be allowed to represent clients in all Ukrainian courts.

In all instances defence costs must be documented and proven in court.

10. Insurability of penalties and fines

Ukrainian law does not provide for a specific regulation to this particular type of insurance product. Based on the general principle, insurance may cover financial interests associated with (i) life, health, labour capacity, pension coverage (personal insurance); (ii) ownership, use or disposal of the property (property insurance) and (iii) damages caused to third parties (liability insurance).

Hence, recovery of penalties and fines through insurance may take place if such recovery is related to either of the above insurance types, for instance, coverage of traffic fines resulting from operation of a vehicle (property insurance) or fines and penalties imposed on a legal entity as a result of negligent management – D&O insurance (liability insurance).

The insurance regulator also specifically recognises certain other insurance products, such as insurance of contractual liability (for instance, borrower's liability under credit facility agreements, including payment of fines and penalties), investments, financial risks (business operation losses), etc.

Nevertheless, insurance of penalties and fines is not a common type of insurance on the Ukrainian market, especially taking into account that it might be difficult in certain cases for the insured to prove that an insurance event was not caused deliberately or for the insurance company to properly estimate risks and reasonably price its product.

Contacts

Anna Pogrebna
E anna.pogrebna@cms-rrh.com

Olexander Martinenko
E olexander.martinenko@cms-cmno.com

Contacts

CMS Albania
Rr. Sami Frashëri
Red Building – 1st Floor
1001 Tirana, Albania
T +355 4 430 2123

Mirko Daidone
E mirko.daidone@cms-aacs.com

Edita Poro
E edita.poro@cms-aacs.com

CMS Austria
Rechtsanwälte GmbH
Gauermanngasse 2
1010 Vienna, Austria
T +43 1 40443 0

Daniela Karollus-Bruner
E daniela.karollus-bruner@cms-rrh.com

Thomas Böhm
E thomas.boehm@cms-rrh.com

CMS Belgium
Chaussée de La Hulpe 178
1170 Brussels, Belgium
T +32 2 74369 00

Virginie Frémat
E virginie.fremat@cms-db.com

Carl Leermakers
E carl.leermakers@cms-db.com

CMS Bosnia and Herzegovina
Ul. Fra Anđela Zvizdovića 1
71000 Sarajevo,
Bosnia and Herzegovina
T +387 33 94 4600

Andrea Zubović-Devedžić
E andrea.zubovic-devedzic@cms-rrh.com

Ana Terzić
E ana.terzic@ cms-rrh.com

CMS Brazil
Travessa do Ouvidor 50 – 5 Andar
CEP 20040–040 Centro,
Rio de Janeiro, Brazil
T +55 21 3722 9830

Ted Rhodes
E ted.rhodes@cms-cmno.com

CMS Bulgaria
Landmark Centre
14 Tzar Osvoboditel Blvd.
1000 Sofia, Bulgaria
T +359 2 92199 10

Nevena Radlova
E nevena.radlova@cms-cmno.com

Antonia Kehayova
E antonia.kehayova@cms-rrh.com

CMS Chile
Av. Costanera Sur 2730, piso 10
Parque Titanium, Las Condes
7550000 Santiago de Chile, Chile
T +562 24852 000

Ramón Valdivieso
E ramon.valdivieso@cms-ca.com

Fernando De Carcer
E fernando.decarcer@cms-ca.com

CMS Colombia
Calle 75 No. 3 - 53
Bogotá D.C., Colombia
T +57 1 321 8910

Sergio Rodríguez-Azuero
E sergio.rodriguez@cms-ra.com

CMS Croatia
Ilica 1
10000 Zagreb, Croatia
T +385 1 4825 600

Sandra Lisac
E sandra.lisac@bmslegal.hr

Marija Mušec
E marija.musec@bmslegal.hr

CMS Czech Republic
Palladium, Na Poříčí 1079/3a
110 00 Prague 1, Czech Republic
T +420 2 96798 111

Tomaš Matějovsky
E tomas.matejovsky@cms-cmno.com

Petr Benes
E petr.benes@cms-cmno.com

CMS France
2 rue Ancelle
92522 Neuilly-sur-Seine Cedex,
France
T +33 1 4738 5500

Jean-Fabrice Brun
E jean-fabrice.brun@cms-fl.com

Laurent Mion
E laurent.mion@cms-fl.com

Anne Renard
E anne.renard@cms-fl.com

CMS Germany
Kranhaus 1, Im Zollhafen 18
50678 Cologne, Germany
T +49 221 7716 0

Winfried Schnepp
E winfried.schnepp@cms-hs.com

Tobias Bomsdorf
E tobias.bomsdorf@cms-hs.com

CMS Hungary
YBL Palace
Károlyi utca 12
1053 Budapest, Hungary
T +36 1 48348 00

Gabriella Ormai
E gabriella.ormai@cms-cmno.com

Istvan Pozsgay
E istvan.Pozsgay@cms-cmno.com

CMS Italy
Via Agostino Depretis, 86
00184 Rome, Italy
T +39 06 4781 51

Laura Opilio
E laura.opilio@cms-aacs.com

CMS Luxembourg
3, rue Goethe
1637 Luxembourg, Luxembourg
T +352 26 2753 1

Nicolas Gerique
E nicolas.gerique@cms-dblux.com

Vivian Walry
E vivian.walry@cms-dblux.com

CMS The Netherlands
Newtonlaan 203
3584 BH Utrecht, The Netherlands
T +31 30 2121 111

Bas Baks
E bas.baks@cms-dsb.com

CMS Peru
Av. Santa María 130
Miraflores, L18
Lima, Peru
T +51 1 513 9430

Marco Antonio Ortega
E marcoantonio.ortega@cms-grau.com

Raúl Ferreyra
E raul.ferreyra@cms-grau.com

CMS Poland
Warsaw Financial Centre
ul. Emilii Plater 53
00-113 Warsaw, Poland
T +48 22 520 5555

Małgorzata Surdek
E malgorzata.surdek@cms-cmno.com

Katarzyna Kucharczyk
E katarzyna.kucharczyk@cms-cmno.com

Ewa Świderska
E ewa.swiderska@cms-cmno.com

CMS Portugal
Rua Sousa Martins, 10
1050-218 Lisbon, Portugal
T +351 21 09581 00

Cristina Rogado
E cristina.rogado @cms-rpa.com

Joaquim Shearman de Macedo
E joaquim.macedo@cms-rpa.com

CMS Romania
S-Park,
11–15, Tipografilor Street
B3–B4, 4th Floor
District 1
013714 Bucharest, Romania
T +40 21 4073 800

Gabrial Sidere
E gabriel.sidere@cms-cmno.com

Cristina Popescu
E cristina.popescu@cms-cmno.com

CMS Russia
Naberezhnaya Tower
Block C, Presnenskaya Nab., 10
123112 Moscow, Russia
T +7 495 786 4000

Leonid Zubarev
E leonid.zubarev@cmslegal.ru

CMS Serbia
Cincar Jankova 3
11000 Belgrade, Serbia
T +381 11 3208 900

Milica Popovic
E milica.popovic@cms-rrh.com

CMS Slovakia
UNIQ, Staromestská 3
811 03 Bratislava, Slovakia
T +421 2 3214 1414

Martina Novysedláková
E martina.novysedlakova@cms-cmno.com

Michaela Némethová
E michaela.nemethova@cms-cmno.com

CMS Slovenia
Bleiweisova 30
1000 Ljubljana, Slovenia
T +386 1 62052 10

Aleš Lunder
E ales.lunder@cms-rrh.com

CMS Spain
Paseo de Recoletos 7–9
28004 Madrid, Spain
T +34 91 4519 300

Carlos Peña
E carlos.pena@cms-asl.com

Rafael Sáez
E rafael.saez@cms-asl.com

CMS Switzerland
Dreikönigstrasse 7
P.O. Box
8022 Zurich, Switzerland
T +41 44 285 11 11

Clemens von Zedtwitz
E clemens.vonzedtwitz@cms-vep.com

Jodok Wicki
E jodok.wicki@cms-vep.com

CMS Turkey
Süzer Plaza, Askerocağı Caddesi
No:6 Kat:15 D:1501
34367 Elmadağ/Şişli – Istanbul,
Turkey
T +90 212 401 4260

Döne Yalçın
E doene.yalcin@cms-rrh.com

Ana Radnev
E ana.radnev@cms-cmno.com

CMS Ukraine
6th Floor, 38 Volodymyrska Street
01030 Kyiv, Ukraine
T +380 44 39133 77

Anna Pogrebna
E anna.pogrebna@cms-rrh.com

Olexander Martinenko
E olexander.martinenko@cms-cmno.com

CMS United Kingdom
Cannon Place
78 Cannon Street
EC4N 6AF London
United Kingdom
T +44 20 7367 3000

Alex Denslow
E alex.denslow@cms-cmno.com

Alaina Wadsworth
E alaina.wadsworth@cms-cmno.com

Liliane Fozard
E liliane.fozard@cms-cmno.com

International coverage

Europe

Aberdeen
Amsterdam
Antwerp
Barcelona
Belgrade
Berlin
Bratislava
Bristol
Brussels
Bucharest
Budapest
Cologne
Duesseldorf
Edinburgh
Frankfurt
Funchal
Geneva
Glasgow
Hamburg
Kyiv
Leipzig
Lisbon
Ljubljana
London
Luxembourg
Lyon
Madrid
Manchester
Milan
Monaco
Moscow
Munich
Paris
Podgorica
Poznan
Prague
Reading
Rome
Sarajevo
Seville
Sheffield
Skopje
Sofia
Strasbourg
Stuttgart
Tirana
Utrecht
Vienna
Warsaw
Zagreb
Zurich

Dubai
Istanbul
Muscat
Riyadh
Tehran

Middle East

Beijing
Hong Kong
Shanghai
Singapore

Asia-Pacific

C/M/S/ Law-Now™

Law.Tax

Your free online legal information service.

A subscription service for legal articles on a variety of topics delivered by email.
cms-lawnow.com

C/M/S/ e-guides

Law.Tax

Your expert legal publications online.

In-depth international legal research and insights that can be personalised.
eguides.cmslegal.com

CMS locations:
Aberdeen, Algiers, Amsterdam, Antwerp, Barcelona, Beijing, Belgrade, Berlin, Bogotá, Bratislava, Bristol, Brussels, Bucharest, Budapest, Casablanca, Cologne, Dubai, Duesseldorf, Edinburgh, Frankfurt, Funchal, Geneva, Glasgow, Hamburg, Hong Kong, Istanbul, Kyiv, Leipzig, Lima, Lisbon, Ljubljana, London, Luanda, Luxembourg, Lyon, Madrid, Manchester, Mexico City, Milan, Monaco, Moscow, Munich, Muscat, Paris, Podgorica, Poznan, Prague, Reading, Rio de Janeiro, Riyadh, Rome, Santiago de Chile, Sarajevo, Seville, Shanghai, Sheffield, Singapore, Skopje, Sofia, Strasbourg, Stuttgart, Tehran, Tirana, Utrecht, Vienna, Warsaw, Zagreb and Zurich.

---

cms.law