Ten Things Every Insurer Should Know

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Foreword

The insurance industry is a major component of the global economy, operating internationally, to protect people and businesses against a wide range of risks. Establishing and operating an insurance business is highly regulated, and the complexity of the regulatory landscape is also linked to the great diversity of local requirements. Jurisdictions vary in their approach to commonly occurring insurance issues and their process for bringing insurance claims.

'Ten things that every insurer should know' is a simple but comprehensive guide that compares and contrasts ten key issues across 32 jurisdictions, looking into:

1. Regulation & governing bodies
2. Effect of misrepresentation and/or non-disclosure
3. Effect of breach of warranty and condition precedent
4. Consequence of late notification
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Albania

2. Regulation & governing bodies

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.

3. 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 them.

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 them based on which the insurance contract has been executed, the insurer, within three months after it becomes aware, is entitled to:

— amend the amount of insurance premium, insurance amount or insurance period;

— 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. Recoverability of defence costs

This policy is not envisaged by Albanian law.

11. 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:

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.

Product Liability Insurance.

This insurance covers the activity of manufacturers, indemnifying consumers for damages caused by their products.

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Austria

1. Regulation & governing bodies

Insurers and reinsurers are authorised and regulated by the Austrian Financial Market Authority ("**FMA**"). The regulation of insurers and reinsurers operates under the framework of legislation established by the Austrian Insurance Supervisory Act 2016 (*Versicherungsaufsichtsgesetz* – VAG 2016) and, in addition, is heavily influenced by EU insurance directives and regulations.

Insurers that have their registered seat in Austria need a license issued by the FMA prior to taking-up and pursuing insurance business in Austria. They must adopt one of the following legal forms to operate: a joint-stock company, a European company or a mutual insurance association; the joint-stock company is the most common 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 that have their registered seat in another EEA member state may write insurance in Austria either on a freedom of establishment or on a freedom of services basis. They do not need a licence from the FMA but can passport their home Member State licence into Austria. EEA insurers are subject to the supervision of the regulatory body in their respective home member state. The FMA's supervision over EEA insurers is limited to requiring them to provide all necessary documents required to verify compliance with Austrian provisions concerning insurance contracts and the accepted principles of proper business operation.

Insurers that have their registered seat outside the EEA must not conduct insurance business in Austria, unless they have acquired a licence from the FMA and established a branch in Austria. Special rules apply to insurers that have their registered seat in Switzerland

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

When concluding the insurance contract, the insured is obliged to notify the insurer of all circumstances and information that they know are material for the insurer to write the risk. Any circumstances or information which may possibly influence the insurer's decision to enter into the insurance contract or under the agreed terms are material. In doubt, any circumstance or information the insurer has explicitly and in written form asked for is deemed material. The case law of the Austrian Supreme Court is strict with the insured on this point and also assumes an obligation of the insured to investigate their affairs in order to obtain the information that is requested from the insurer.

A breach of the duty of disclosure is deemed to have occurred both if the notification was omitted and if it was incorrect. In both cases the insurer's remedy is to withdraw from the insurance contract within a month of becoming aware of said violation. The right of withdrawal does not apply if (i) the policyholder is not at fault for omitting the notification or making an incorrect notification, (ii) the insurer knew the true circumstances at the time the contract was concluded or (iii) the insurer expressly waived the notification of material circumstances. In any case, the insurer may not withdraw from the contract after the expiry of the withdrawal period.

The withdrawal of the insurer leads to the cancellation of the insurance contract. The policyholder no longer has any claims against the insurer for the period after the withdrawal. Furthermore, the parties must repay any benefits received. This principle is pierced in two ways: firstly, the insurer is entitled to the insurance premium for the period from the conclusion of the insurance contract until that point in time when the withdrawal became effective. For the current insurance period, the insurer is therefore entitled to the pro rata premium. Furthermore, in the event that the insured event has already occurred at the

time of withdrawal, for example, the insurer becomes aware of the violation of the disclosure obligation during the investigation of the insured event, the following applies: The insurer remains liable to provide coverage for that insured event if the insured can prove that the incorrectly disclosed or concealed circumstance had no influence on the occurrence of the insured event or on the amount of the benefit payable by the insurer under the policy.

Intentional misrepresentation or non-disclosure is considered 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

The insured event is not defined in Austrian insurance contract law but is left to the contractual arrangement by the parties to the insurance contract. In any case, the insured is obliged to notify the insurer of the occurrence of an insured event immediately, i.e. without any undue delay, after becoming aware of it. Special rules in third party liability, livestock, fire and life insurance provide for exact time periods within which the insured must notify the insurer of the occurrence of the insured event.

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 (e.g. that the notification was too late) is on the insurer.

The insured will lose cover 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 the 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)

The entitlement to bring a claim against the insurer depends on the insurance contract in question. In case of an individual insurance contract, the policyholder may bring a claim against the insurer. If the individual insurance contract also (or exclusively) covers the interests of a third person (third party insurance), that third person is entitled to bring a claim against the insurer only provided that (i) the policyholder has agreed to this or (ii) the insured person possesses the policy schedule. In addition, following the case law of the Austrian Supreme Court in third party insurance the insured third person may also assert a claim against the insurer if the policyholder recognisably does not want to pursue the claim further without having reasonable grounds for doing so.

In endowment insurance, the policyholder can designate one or more persons as beneficiaries. This means that the policyholder determines

which person or persons are to receive all or part of the insurance benefits after his/her death. This person or persons have a claim against the insurer after the occurrence of the insured event and can assert this claim themselves.

In compulsory motor third party liability insurance the damaged third party is entitled to directly claim compensation from the insurer.

Claims against the insurer may, under certain circumstances, also be asserted by persons to whom the policyholder has validly assigned or pledged the claim under the insurance.

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

Payment from an insurer is due following the completion of the surveys necessary to determine the insured event and the scope of the performance of the insurer. However, if said surveys have not been completed within two months after the notification of the claim, the policyholder is entitled to request an explanation from the insurer as to why the surveys could not yet be completed. If the insurer does not provide such explanation within a further period of one month, payment becomes due irrespective of whether the surveys of the insurer have been completed.

If the surveys are not finished 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 and it begins with the time when the claim against the insurer becomes due. 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 policyholder 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 and the relevant statutory or contractual provision on which the denial of the claim are based. In any event, there is a long-stop limitation of ten years.

The insurer is released from its obligation 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 their part, to enforce the claim under the insurance contract in a timely manner.

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

There are several ways in which cover under a third-party liability insurance is triggered.

The first is on a ‘loss occurring’ basis. The insurance provides cover for losses of a third party that occur during the policy period.

Secondly, the policy may be on an ‘act-committed’ basis. This requires that the act that gives rise to the loss is committed during the policy period.

Thirdly, the policy may provide cover on a ‘discovery basis’. In these cases, the insured event is the first verifiable determination of an environmental disturbance that may result in a liability of the insured for damages.

Also, the policy may provide cover on a ‘claims made’ basis for claims against the insured that are made during the policy period.

9. Recoverability of defence 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; in essence, this 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 defence 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 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 in violation of *bonos mores*, or which would cover administrative or penal fines, is void.

In 2004, the FMA 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.

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Belgium

1. Regulation & governing bodies

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.

Insurers and insurance intermediaries are subject to the Insurance Distribution Directive. 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 Belgian 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

When concluding the agreement, the policyholder is obliged to accurately communicate all circumstances known to him that he should reasonably regard as information that could influence the insurer's assessment of the risk (see above). The description of the risk sometimes takes the form of specific statements required by the insurer from the policyholder at the conclusion of the contract. These statements concern certain characteristics of the risk and their veracity is a condition for the very existence of the coverage; the so-called warranties. In this way, if the actual situation deviated from the warranties, insurers sought to exclude coverage. The provisions of the Belgian Insurance Act, which imperatively regulate the insurance company's duty of notification (and the related sanctions – see above), ensure that this is no longer possible. 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.

The insurer under life insurance contracts must in principle provide the beneficiary of payment with an overview of the information he needs in order to execute the requested payment, within two months following the request for payment. This period of two months can be extended, if the insurer does not have the information necessary to identify the beneficiaries under the life insurance contract. The insurer must proceed with pay-out within one month following the receipt of the requested information. If the insurer fails to respect these terms, the beneficiary shall be entitled to late payment interests (in accordance with the statutory interest rates) on the amounts due under the insurance contract.

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. The limitation period for a claim arising out of an insurance contract will in any case not be longer than 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.

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Bosnia and Herzegovina

1. Regulation & governing bodies

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 than 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 arose. 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.

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Brazil

1. Regulation & governing bodies

The Brazilian insurance market is regulated by two governmental bodies that report to the Ministry of Finance. These are the Private Insurance National Council (CNSP) and the Superintendence of Private Insurance (SUSEP). CNSP is an inter-ministerial body composed by, *inter alia*, the Ministry of Finance, the Central Bank, the head of SUSEP, among others. The CNSP's role is to provide strategic direction on insurance policy in Brazil. CNSP formulates 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. The role of SUSEP is to manage, supervise and monitor the operation of the insurance market in Brazil by overseeing the activities of insurance and reinsurance companies, as well as insurance and reinsurance brokers. SUSEP further regulates the guidelines enacted by the CNSP.

The contract of insurance 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, CNSP resolutions and SUSEP regulations. All contracts of insurance and reinsurance are regulated, with greater protection given to contracts of insurance with consumers (within the meaning of the CDC).

Brazilian case law typically holds buyers of first party insurance to be consumers under the argument that they are protecting their own goods or assets. Nevertheless, whether or not those purchasing third party insurance will be consumers or not will depend heavily upon whether the contract shall serve the policyholder's business or not. If it does, the CDC will be displaced.

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.

Reinsurance transactions

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 gradually to private enterprise.

Local reinsurers have a right of first refusal on risk transfers by cedants, provided they meet the exact same conditions offered in the international market.

Local reinsurers are prevented from retroceding more than 70% of their gross premium in any given year, except for financial, rural and nuclear risks, which are not subject to such limitation.

Shall direct insurers cede in excess of 90% of gross premiums in any given year, they must present justifications to SUSEP for doing so until March 31 of the subsequent year.

In the event of insolvency, extrajudicial liquidation decreed by SUSEP or bankruptcy by the cedant, the reinsurer will be allowed to pay straight to the insured.

Any risk can only be transferred to a reinsurer not duly licensed by Brazilian authorities in the event of shortage of offering by licensed local or foreign reinsurers. In any event, such a transfer must not be made to reinsurers headquartered in tax havens.

Intragroup reinsurance and retrocession contracts must follow fair competition conditions.

Reinsurance contracts are free to determine what degree of claims' control, if any, the reinsurer will exercise when a loss is to be adjusted.

Direct insurers cannot assume under retrocession contracts more than 2% of the premium they had underwritten in any given year.

Insurance products

Historically, the content of insurance products in Brazil was highly regulated and standardised. In 2021, insurance authorities passed a series or rules eliminating much of SUSEP's intervention in this realm and seeking to foster market innovation and the creation of more tailored products. Insurance products aimed at consumers must be previously approved by SUSEP, although under a much less stringent regime than before. Ever since 2021, insurers have had a great deal of freedom to draft custom contracts for large risk insurance lines, which are not subject to SUSEP's prior approval.

Insurance law in Brazil may be subject to significant change in the coming years if Bill of Law no. 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 Bill of Law no. 3,555 / 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

Under the BCC, insurers and insured parties must conduct dealings in line with the principle of utmost good faith, both before and after agreeing to the contract.

Also pursuant to the BCC, a material misrepresentation or non-disclosure by the part of the policyholder that might reasonably influence the insurer's acceptance of the risk or valuation of the premium shall cause the insured to lose the right to indemnification. However, Brazilian courts have mitigated the harshness of this rule. They have consistently found that only a wilful omission made in bad faith as to the declaration of risk can trigger the insurer's right to refuse payment of cover.

Similarly, the insured shall lose the right to indemnification when they intentionally aggravate the risk.

Ambiguities and imbalances in contracts of insurance should be avoided as judicial interpretation of clauses tends to favour the insured rather than the insurer (*contra proferentem* doctrine).

A contract guaranteeing a risk arising out of a wilful act of the insured shall be null and void.

When seeking to sustain an omission, a material misrepresentation or even the intentional aggravation of risk, the insurer will bear the burden of proof to demonstrate that the insured has failed to act in utmost good faith under the specific circumstances.

3. Effect of breach of warranty and condition precedent

Conditions precedent and warranties are not specifically provided for under Brazilian law as such. Yet, courts interpret them just like any other contractual obligations. Courts will investigate whether they clearly established obligations to either party and their impact for the contract to attain its goal. The principle of utmost good faith will permeate all the analysis.

4. Consequences of late notice

Where an insured suffers loss as a result of an insured event, the insured should make a claim as soon as they become aware of the occurrence of the loss. Failure to do so, if gross, may lead to the insured losing the right to be indemnified for the loss. The law does not 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 covered loss. The loss may be considered amplified where the claims adjuster is no longer able to properly handle it. 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

For non-compulsory third party insurance contracts, third parties who have suffered an injury may bring a direct lawsuit against the insurer, provided that the insured is also a named co-defendant in the dispute.

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 when the insurer justifiably requests further documentation and shall end 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 a separate tort.

7. General rules concerning the limitation period for claims

The general time limit for the insured to file an insurance claim is one year (art. 206, BCC).

For third party non-compulsory insurances, the one-year statute of limitations period starts to run from the date the insured is summoned in connection with a third-party claim, or from the date the insured indemnifies the third-party, duly authorised by the insurance company.

As for first party insurances, the start date from which this limitation period runs 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.

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 Brazilian Superior Court (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 insurance

The general rule in insurance contracts is that occurrence of the loss to the insured is what triggers the claim. Also, the policy in force at the time of the loss occurrence shall be the one implicated.

It turns out that in liability insurance, identifying the trigger (and thus the triggered policy under a series of continuous policies) can be a very complex task.

The time at which the loss occurred and when the insured became aware of it are determinations that may rest on circumstances outside of the parties' reasonable control or knowledge. Equally, it can be hard to correctly predict or quantify the extent of the damage the insured has suffered immediately. Therefore, in practice, most liability policies are written on a claims-made basis with limitation periods, although liability policies on an occurrence basis are also lawful and available for commercialisation.

9. Recoverability of defence costs

Liability insurance in Brazil must always cover the loss of the insured in connection with an award, whether judicial or arbitral, that has held the insured liable towards the third-party claimant, or the settlement made between the latter and the insured, provided that the insurer has previously approved the payment.

The insured can recover defence costs when these are covered by the policy. Typically, they are. When defence costs are covered, the policy must tell whether the insured will be entitled to choose their counsel freely or with reference to a list provided by the insurer. When defence costs coverage is provided, the policy shall provide the insurer with the right to subrogate against the insured, in situations where it is later found that the damages have resulted from a wilful act or when the insured acknowledges their liability for intentional or fraudulent acts.

10. Insurability of penalties and fines

Liability policies may also cover fines or penalties applied against the insured. In most cases, such cover is excluded and can be written back into the policy through a specific endorsement.

In any event, fines and penalties are administrative in nature and are not to be confused with liquidated damages, which remains outside the scope of liability policies written in Brazil.

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Bulgaria

1. Regulation & governing bodies

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 ("**FSC**"). 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 FSC must be completed. The FSC 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 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, Self-insurance cooperative (SE), 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 is 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.

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

In terms of bankruptcy proceedings against an insurer, these can be initiated only upon an application of the FSC to the court. The court will then institute proceedings on the day of receipt of the application and will schedule a hearing no later than fourteen days thereafter.

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 be it the Bulgarian Consumer Protection Commission or the FSC; 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 and expenses related to litigation. The insurer covers the insured’s costs incurred in non-insurance related litigation.

Another case is the third party liability insurance, where the insurer would defend also its own interest in litigation.

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.

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.

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Chile

1. Regulation & governing bodies

Insurance companies in Chile must be incorporated as public corporations or be authorised 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 Commission for the Financial Market (*Comisión para el Mercado Financiero*, or "**CMF**"). Insurance contracts are regulated by articles 512 to 601 and 1158 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 CMF; 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 7,500), 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 sale of insurance in Chile can be made by a general insurance company (first group) or a life insurance company (second group). The former covers the risk of loss or damage of goods or patrimony. Life insurance companies, on the other hand, cover risks of persons or guarantee, within or upon termination of a certain term, capital, a paid-off policy or income of the insured party or its beneficiaries. Exceptionally, personal risk and health can be covered by both types of companies. Risks related to credit can only be insured by general insurance companies having the sole purpose of covering this type of risk, which could also cover surety and fidelity.

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 CMF.

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 CMF.

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 , which includes terms and conditions that are duly registered in the CMF, 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 , with terms and conditions that are freely agreed between the parties, it is quite common in certain types of coverage, such as 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.

Year in view

Law No. 21,210 of 24 February 2020 established that remote remunerated services provided by non-residents not domiciled in Chile, must pay value added tax ("**VAT**") from 1 July 2020. This tax obligation is only for foreign taxpayers without domicile or residence in Chile that provide remote services to be used in Chile's national territory by natural or legal persons who are not VAT taxpayers.

As regards its impact on insurance contracts agreed outside Chile, the general position can be summarised as follows:

— Premiums paid for insurance contracts agreed outside Chile are subject to a 22 per cent withholding tax and exempted from VAT. However, under the new regulations, VAT would apply provided that the premium (1) is related to services rendered or used in Chile and (2) is exempted from the 22 per cent withholding tax because of the application of laws or treaties to avoid double taxation.

— The cases expressly exempted from the 22 per cent withholding tax remain the same, namely those related to premiums paid in connection with (1) hull and machinery ("**H&M**") insurance, protection and indemnity insurance ("**P&I**"), freight and other insurance related to the maritime industry; (2) aircraft, freight, P&I and other insurance related to the air navigation industry; (3) insurance and reinsurance related to export credits; and (4) insurance and reinsurance related to guarantee payments of obligations towards third parties arising from the financing of concessionaires of public ports.

— Reinsurance remains subject to a 2 per cent withholding tax.30

— In addition to those at point (a) above, the cases expressly exempted from VAT remain the same, namely those related to premiums paid in connection with (1) import or export cargo insurance, H&M and risks for assets located abroad; (2) earthquake risks; (3) air navigations risks within Chile; (4) reinsurance; and (5) adjustable life insurance.

Given that the VAT changes are relatively recent and as yet there are no guidelines available, this summary proceeds from a conservative standpoint. In this respect, the IRS may in future issue resolutions or guidelines that help to clarify how these changes actually impact the insurance industry.

Outlook and conclusions

Owing to the October 2019 civil unrest in Chile, policies providing or excluding related risks, such as civil disturbance, civil commotion, looting or terrorism, among others, are being tested by local adjusters and courts. This also includes the testing of aggravation clauses, limits and sub-limits wording and deductibles. In addition, it remains to be seen how local policies will deal with the effects of the covid-19 pandemic, particularly in relation to business interruption.

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Colombia

1. Regulation & governing bodies

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.

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 assess 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

[1] Colombian Commercial Code, Article 1036
[2] Colombian Commercial Code. Article 1045
[3] Colombian Commercial Code. Article 1058
[4] Colombian Commercial Code. Article 1060

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 become 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.

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 defence costs

According to article 1128 of the Colombian Commercial Code, when dealing with liability insurance, the insurer must assume the defence 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;

[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

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 defence 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 defence 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 misdemeanours is invalid under Colombian law. However, fines and penalties of a different nature are considered insurable.

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Croatia

1. Regulation & governing bodies

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 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 they are 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 potential damages caused by such delay.

Any contractual provision that deprives an insured of the right to compensation (or insurance benefit) in the case that insured fails to fulfil any of his obligations after the occurrence of an insured event is null and void.

5. Entitlement to raise a claim against an insurer

The insured (and the beneficiary in 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 by law 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 amount 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 obliged, 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 indisputed 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 insurance amount, bear the proceedings costs and other justifiable costs made in order to determine the insured's responsibility. Whether an insurer bears amount of attorney's cost in line with Attorney's Tariff or freely contracted higher amount for attorney's costs depends on the provisions of the policy.

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.

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Czech Republic

1. Regulation & governing bodies

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 ("**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, although the Civil Code allows that under certain circumstances, insured or beneficiaries may seek payment under a policy even if they intentionally triggered the insured event. However, such type of cover is permissible only when allowed by a distinct law or if specifically agreed between the policyholder and the insurer. We note “insurance against penalties” is reserved for rather rate situations, and it is very likely that any general 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. In 2018, the Supreme Administrative Court ruled that using paid assistance against traffic fines (marketed as “**insurance**”) may be seen as an aggravating circumstance in administrative proceedings.

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.

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France

1. Regulation & governing bodies

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).

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Germany

1. Regulation & governing bodies

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, the branch must also be incorporated in the local commercial register.

In March 2011, last updated in July 2019, 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 'textform'.

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 'textform' (duty of disclosure), the insurer will be entitled to withdraw from the contract only if the insured has acted with gross negligence or intent. In the event of an innocent breach or simple negligence on the part of the insured, the insurer will only be entitled to terminate the contract, subject to a notice period of one month, 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 withdraw or terminate 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 terminate the contract without prior notice.

In each case the insurer must inform the insured in 'textform' of the possible consequences of breach of the duty of disclosure. 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 aggravation 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 intentionally 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 aggravation of the 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 insurance 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 held liable for damages according to the principles of German civil law laid down in the German Civil Code ("**BGB**"). 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, commencing at the end of the year that the claim arose. When a claim under an insurance contract is notified to the insurer, limitation is suspended 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 must 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 must 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 them 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*.

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Hungary

1. Regulation & governing bodies

The operation of the Hungarian insurance industry is basically determined by the Insurance Act (of 2016), the Civil Code (of 2014) and the relevant EU directives and regulations. In addition, the regulatory guidelines, issued by the Hungarian National Bank (HNB) on frequent basis, are of great importance for the local market players. The insurance industry is extensively regulated with strong emphasis and regulatory attention to the consumer protection concerns.

Several different forms of operation are available in Hungary to start the insurance business locally: (i) a private company limited by shares (subsidiary), (ii) a European private company limited by shares (SE), (iii) a cooperative, (iv) an association.

In addition, EU Member State insurers and reinsurers may provide their services through FOE (branch) or FOS (cross border service) protocol. Only branch office is allowed for third-country insurers. While the subsidiaries hold the majority of market shares, the FOS operators are more vital in many respects.

For FOS/FOE players, the prudential regime of their home country applies in many respect, however the HNB also exercises extensive supervision over the activity under the general good (host country) regime with focus on consumer protection. HNB guideline of 2019 gives direction of matters falling within the general good.

HNB, the integrated financial services authority, provides the license for subsidiaries in two phases: (i) in the first phase, the company must submit detailed supporting documentation and an application for a foundation licence, (ii) in the second phase, within 90 days of receiving the foundation licence, the applicant needs to submit a request for an operational licence. 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. The foundation of a composite company, conducting both life and P&C insurance, is not permitted.

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 same duty applies to the insured(s).

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.

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 explained 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 by the policy. From a protection perspective, consumer contracts would have limitations, to the benefit of individual (private) parties.

4. Consequences of late notification

Late claim reporting may trigger the insurer's release from payment or lead to claim 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 (practically for short-term policies like travel insurance), 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

In general, only the policyholder, and/or the insured or the beneficiaries (death claims) may bring a claim against the insurer. Third parties are not entitled to make a direct claim against the insurer, regardless of what relationship the third party holds with the insured.

Liability insurance manifests an exception in this regard: (i) motor third party liability insurance automatically grants, as dictated by the MTPL Act, the right to the injured third party (claimant) to bring such a claim directly against the insurer; and (ii) other liability policies may also provide such entitlement to the claimant if the insurer provides this possibility in its policy conditions.

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

Claim payment becomes due when the claims process is completed. Hungarian law gives liberty to the insurers to define the appropriate period or deadline for claim payment, but the applied deadline must be disclosed in the conditions, along with all type of claim documents which the insurer may require for the specific policy.

Insurers usually set a 15 day period from the date of the receipt of the last materially important document, by the end of which the payment should be made. More complex contracts may determine a longer period for payment.

Since 2021, and for non-life classes only, all insurers must publish on their website a so-called Claim Settlement Notice for all their products. This separate, mandatory document should disclose the possible ways of making a claim, the conditions of arrangements, the relevant time limits, and the possible forms of payment including settlement. Under any circumstances, the insurer must also respond to the claim within 30 days from the submission by providing either a duly substantiated proposal for the service, or a reasoned claim rejection or postponement of decision if not all conditions are clear.

If the insurer fails to meet the predefined deadline and becomes delayed with the payment, the general indemnity consequences apply, including default interest. The consumers may also turn to the Financial Arbitration Body with complaints or may initiate consumer protection proceedings before the HNB. The regulator would initiate disciplinary or corrective actions against the insurer when such delays are significant or happen on recurring basis and may also impose regulatory fines.

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 this period according to the parties' mutual will. But the exclusion of limitation is not permitted. For life, accident and health insurances, a two-year lapse period is generally admitted on the market. Any alteration from basic 5 years should be separately disclosed in the conditions to ensure legal effect.

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:

— if the claimant was unable to exercise his right within the predefined limitation period due to external circumstances, the claimant is provided with an additional one-year period to raise the claim which period starts from the date when such circumstances ceased to hinder the claimant in exercising their respective rights;

— 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

Similarly to other jurisdictions, the local indemnity policies (including PI and D&O policies) are mostly underwritten on occurrence or claims-made basis. Sometimes a combination of these two is available within the same policy.

The occurrence-based policy provides coverage if the loss occurred during the policy period even if the claim is reported later in time, practically up to the end of limitation period. This type of liability is less popular and more expensive.

The claims-made policies dominate the market. Under this liability scheme, the claim notification must be made within the policy period to secure the cover. Additional features are the retroactive period which may extend the cover retroactively prior to the commencement date and the extended reporting period (ERP) which provides the similar effect by extending the notification period even with years after the policy expiration for extra premium.

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.

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 principal claim previously awarded.

Unless otherwise agreed by the parties, the defence costs to be reimbursed in excess of the liability limit. The insurers usually restrict this excess in the conditions by applying the limits to all and any obligations.

The attorney’s fees usually represent the dominant part of such additional expenses and the courts pay particular attention that these are judged in line with the aforementioned principles. The decision on fees is case-sensitive by taking into account the nature, length and complexity of the specific case and 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. The laws do not regulate this in detail. The need for such coverage typically arises under liability insurances and usually limited to civil penalties, not criminal ones. Specific imitations and exclusions may further restrict the applicability of such covers (e.g. intentional wrongdoing or gross 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. Accordingly, the policies need to have carefully worded languages that are in line with other general legal principles and requirements such as fairness, good faith and prohibition of misuse of laws.

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Italy

1. Regulation & governing bodies

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.

In case of business under the right of establishment, within a period of thirty days from the date of receipt of the communication IVASS shall indicate to the home country regulator the general good provisions the insurer must comply with. The EEA insurer may establish the branch and start business in Italy from the moment it receives from its regulator the IVASS' note on general good provision or, in any case, from the expiry of the aforesaid 30-days deadline.

The business under the freedom of services by an EEA insurer is subject to the notification to IVASS, by the home country regulator, of the information and conditions required under UE provisions. The insurer may begin its activity as soon as IVASS acknowledges receipt of this notification.

Companies from non-EEA countries are only entitled to undertake activity in Italy by establishing a local branch (i.e., under the right of establishment).

The procedure is more demanding and requires the prior authorisation of IVASS, which shall assess the fulfilment of a number of requirements.

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

Pursuant to articles 1892 and 1893 the insured is under a duty to disclose all material facts relating to the insurance which he intends to enter into. In case of wilful or grossly negligent non-disclosure the insurer is entitled to request the annulment of the insurance contract and/or claim a total release from its 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 terminate contract and/or reduce the indemnity due in proportion to the difference between the agreed premium and the premium that would have been charged if the true state of affairs had been known.

3. Effect of breach of warranty and condition precedent

The strict concept of guarantee and prior condition is unknown in Italian insurance law. However, the law or the contract often provides for similar schemes.

An example of a condition precedent might be the payment of the premium: under Article 1901 of the Italian Civil Code, if the insured fails to pay the premium, coverage is suspended until payment is made.

The policyholder's declaration of circumstances relevant to the risk could instead be seen as a warranty, the breach of which gives rise to the consequences seen in the previous paragraph.

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)

As a general rule, 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 are some exceptions: e.g., in case of motor vehicle third-party liability insurance and hunting insurance, the third party that has suffered damage can bring a claim directly against the insurer. Moreover, the recent law on medical liability allows the damaged party to bring the claim against the insurer. However, this rule is not yet in force.

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

Under Italian law, 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 is the market standard in the case of PI policies) for the parties to opt for a claims made scheme. This is the case of claims-made policies. The validity of claims-made policies and their compatibility with the Italian legal system has been much debated. However, their legitimacy is now well established, since current judicial interpretation considers the claims-made model to be a legitimate alternative to the loss-occurrence model. However, the validity of the claims made policies may be subject to the assessment of the Court on the adequacy of the insurance product with respect to the interests and needs of the policyholder. If it is not adequate (i.e., because the claims made scheme creates gaps in coverage) the contract could be deemed partially void.

9. Recoverability of defence costs

Pursuant to art. 1917 civil code the Insurer must cover the insured's defence costs up to 25% of the policy limit 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.

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Luxembourg

1. Regulation & governing bodies

Luxembourg's insurance market developed in the 1990s. Since then, Luxembourg authorities have created a prosperous environment that has contributed to the growth of the Luxembourg financial sector. 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 ('*Commissariat aux Assurances*', the "**CAA**").

Authorisation is granted for each specific insurance field provided certain conditions are met, *inter alia*:

— 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 and professional experience;

— Any natural or legal person wishing to directly or indirectly take over a qualifying holding (defined under Luxembourg law as 'a direct or indirect holding in an undertaking which represents 10% or more of the capital or of the voting rights or which makes it possible to exercise a significant influence over the management of the undertaking') or to further increase their qualifying holding in an insurance company will be required to seek the CAA's prior approval. The CAA will in this context assess whether the sound and prudent management of the insurance company is ensured;

— The company must appoint an approved independent auditor ('*réviseur d'entreprises agréé*');

— Insurance companies wishing to operate in Luxembourg must comply with specific rules regarding solvency margins, assets and accounting principles.

Insurance companies based in another EEA Member State may carry out insurance activities in Luxembourg under the freedom of establishment or freedom to provide services principles. 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 for it to be authorised.

It is in principle illegal for a Luxembourg insurance company to carry out both life insurance and non-life insurance activities (certain exemptions do, however, exist for certain insurance classes).

2. Effect 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 the assessment of the risk by the insurer. The policyholder is not required to disclose circumstances already known by the insurer or that the insurer should reasonably be expected to know.

On the other hand, where intentional omission or inaccuracy have misled the insurer in his risk assessment, the insurance contract shall be deemed null and void.

Unintentional omission or inaccuracy does not void the insurance contract. Within one month of becoming aware of such unintentional omission or inaccuracy, the insurer shall propose the amendment of the insurance contract. The amendment will take effect on the date at which the insurer became aware of the omission or inaccuracy.

Alternatively, if the insurer is able to produce evidence that he would not have insured the risk if he had been fully aware of all circumstances

(including any unintentional omissions or inaccuracies), the insurer may terminate the contract within the same period mentioned above, i.e. one month.

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

3. Effect of breach of warranty and condition precedent

Luxembourg insurance law provides that an insurance policy may only provide for the partial or total forfeiture of the right to insurance benefits due to the non-fulfilment of a specific obligation imposed by the policy and provided that such breach is causally linked to the occurrence of the loss.

In addition, when entering into an insurance policy, the policyholder is obliged to disclose accurately all the information that may have a direct impact on the assessment of the risk by the insurer (see section 2). Where intentional omission or inaccuracy can be evidenced and have misled the insurer in his risk assessment, the insurance contract shall be deemed null and void.

Condition precedents are not explicitly foreseen under the Luxembourg insurance law and shall therefore be subject to general contract law.

4. Consequences of late notification

The insured must notify as soon as possible, and in any case within the timeframe provided for under the policy, any damage that occurred and which is covered by the policy. Furthermore, the insured has a general obligation to take reasonable steps to prevent and mitigate the consequences of the damage.

If the policyholder fails to notify the insurer on time or if the policyholder fails to mitigate the damage and this results in damage for the insurer, the insurer will have the right to claim a pro-rata reduction of the coverage to be provided. The insurer could even decline payment if the insured's misconduct was intentional and / or unlawful.

5. Entitlement to bring 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 raise a claim directly against the insurer. In the event of mandatory civil liability insurances, the exceptions, nullities or forfeitures contained either under Luxembourg law or in the insurance contract will not be enforceable against the damaged third party. For non-mandatory civil liability insurance, the exceptions, nullities or forfeitures contained under Luxembourg law or in the insurance contract will be enforceable, provided they arose prior to the claim.

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

Luxembourg insurance law provides that the insurer must pay the agreed benefit as soon as it is in possession of all relevant information concerning the occurrence and circumstances of the claim and, where applicable, the amount of the claim.

The sums due by the insurer shall in any case be paid within thirty (30) days of their being determined. After this period, default interests at the applicable legal rate shall be payable.

7. General rules concerning the limitation period for claims

In principle, any claim resulting from an insurance contract may be raised up until three years, starting on the day of the event that gave rise to the claim. However, where the claimant proves that he/she became aware of the event giving rise to a claim at a later date, this timeframe will start on the date the claimant actually became aware of the event. This timeframe shall in any case 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 its insurance payment.

8. Policy triggers with respect to third party liability insurance

For liability insurance, 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 is 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.

9. Recoverability of defence costs

Under a liability insurance policy, the insurer must 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.

10. Insurability of penalties and fines

Luxembourg insurance law provides that no fine or criminal settlement may be covered by an insurance contract, with the exception of those for which the person liable is responsible.

There are no specific legal provisions related to the insurability of administrative penalties or fines. However, Luxembourg doctrine seems to be against the insurability of administrative sanctions, insofar as they are of a criminal or quasi-criminal nature.

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Montenegro

1. Regulation & governing bodies

Under currently applicable legislation, there is only one way to undertake insurance activity in Montenegro 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.

The Agency for Insurance Supervision is the regulatory authority in charge of supervision over insurance companies, including issuance of licenses for insurance and reinsurance activities.

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.

In third party liability insurance, a direct claim of a third party which sustained loss towards the insurer 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 Montenegrin 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 Montenegro, insurance coverage is not available for fines and penalties.

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The Netherlands

1. Regulation & governing bodies

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.[12]

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.[13]

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 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[14]

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

[12] DSC 23 April 2010, ECLI:NL:HR:2010:BL:6024.
[13] DSC 27 October 2000, ECLI:NL:HR:2000:AA7915.
[14] 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.

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 of 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 defence 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.

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Norway

1. Regulation & governing bodies

According to the Norwegian Financial Institutions Act an Insurer must have a license to conduct insurance activities in Norway. An application for a license is sent to the Norwegian Financial Supervisory Authority, which either gives advice for decision to the Ministry of Finance, or grant a license by delegation.

To be granted a license, the company needs to meet specific requirements on owners' suitability, initial capital and the management of the company. These requirements are based on provisions in EU an EEA directives in the financial field. Whether or not a license is given depends on an assessment of the company's capital and solvency ratio and whether the company has a sound organizational and operational plan. Among other things, the necessary experience is required for board members, the managing director or another person who actually manages the business.

The insurance companies must take part in a guarantee system which is intended to help secure payments of claims. The objective is to prevent or reduce financial loss to consumers or small businesses if the insurance company is not able to meet its obligations. In order to conduct insurance activity in Norway, it is required that the company is a member of this guarantee system. This also applies to an insurance company with headquarters in another EEA country that operates through a branch establishment in Norway.

An insurance company that has permission to conduct insurance business in an EEA country may conduct such business in Norway provided the company has a license to conduct insurance activities in the home country and that a notification is sent to the supervisory authority in the home country.

The Norwegian Insurance Contract Act ("**ICA**") has provisions concerning non-life insurance. For some insurance products these provisions are mandatory in favour of the Insured. The act is non-mandatory for instance for marine insurance and insurance for aircrafts etc.

2. Effect of misrepresentation / or non-disclosure

For insurance agreements regulated by the ICA there is a general obligation on the insured to provide information to the insurance company before and during the policy period.

Before a policy is issued, the insurer can ask for information which is relevant to evaluate the risk. The insured is obligated to provide the insurer with correct and complete answers upon questioning. These questions can be presented as a questionnaire or in other written form, but this is not a requirement.

In principle the duty of disclosure does not include an obligation for the insured to disclose information unsolicited. However, the insured is obliged give unsolicited information about special circumstances which the insurer cannot be expected to ask about, if the insured understands that the information is significant for the Insurance company's risk assessment.

During the policy period there is no general duty of disclosure. The insured is, however, required to rectify any incorrect or incomplete information given at the formation of contract and to inform about new or changed conditions.

If the Insured have breached the duty to disclose information of significance, the insurer can terminate the insurance contract with 14 days' notice. This applies even if the insured cannot be blamed for the misinformation. If the insured has acted dishonest, the insurer is also entitled to terminate other contracts with the insured with immediate effect. If an insurance event has occurred, the misrepresentation or non-disclosure gives the insurer the opportunity to refuse the insured compensation under the insurance agreement. This must however be notified within specific time limits.

Also, when filing a claim, the insured is obligated to provide the insurer with all the available information and documents which is necessary to evaluate the claim. If the insured deliberately gives incorrect or incomplete information with the knowledge that this can lead to receiving

insurance which is not entitled, the insured can lose any claim against the insurer related to the incident. The insurer is then also entitled to terminate the policy with one week's notice.

3. Effect of breach of warranty and condition precedent

The insurer can make reservations in three situations; Firstly, if the insurer is prevented from obtaining information about certain circumstances, reservations about discharge from liability related to these circumstances can be made. Secondly, reservations about discharge from liability can relate to specific conditions relevant to the risk. The reservation is not valid unless the insured either has a positive knowledge of the reservation, or the reservation is stated in the agreement. Thirdly, a reservation about reduction of liability can be made if the premium calculation is explicitly made depending on how the insurance object is used, and there has been a change which grant a higher premium.

4. Consequences of late notification

The insured is obliged to notify the insurer without undue delay when an insurance event has occurred. If the insurer has not been notified of an insurance claim within one year after the insured became aware of the facts which substantiates the claim, the insured loses the right to compensation. There is no requirement that the notification must be given in writing, but the insured has the burden of proof that notification has been given.

5. Entitlement to bring a claim against an insurer

According to ICA an injured third party is entitled to raise a claim directly against the liability insurer given that the insurance covers the insured's liability. When asked, both the insurer and the insured are obliged to inform the injured party of the liability insurance. If an injured third party raises a claim directly against the insurer, the insurer must notify the insured without undue delay, and keep the insured informed about the claim proceedings. Where the ICA is non-mandatory, for example for large commercial companies and marine/aircraft insurance, this right to bring a claim directly against the insurer can be waivered.

When a claim is brought directly, the insurer can invoke the same objections towards the claimant as the insured. The insurer is also entitled to invoke their objections concerning the insured, as long as these relate to circumstances occurring after the damage took place. The claimant has the same position towards the insurance which he would have towards the insured, thus the claimant does not get better terms or more payment when raising a claim directly. The insurance company is entitled to deduct the insured's self-risk when paying damages to the claimant.

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

The insured is entitled to penalty interest for late payment of compensation two months after sending notification of the insurance event to the insurer. If the delay in payment is due to the insured not providing necessary information to consider the claim, the insured is not entitled to penalty interest for the period of which the insurance company is waiting for information/ documentation from the insured which the company needs to handle the claim. This two-month rule is not practical in large, complex claims. In many cases, there is often a considerable amount of information to review, and facts may only begin to emerge later in the claim handling process. It is however possible, to agree on more flexible solutions regarding penalty interest in policies where ICA is not made mandatory.

The Norwegian Delayed Interest Act regulates the calculation of the penalty interest. This act also regulates the situation where a third party raises a claim directly against the insurer. For third party claims the penalty interest starts running when notice requiring payment has been given by the third party. The insurer is obligated to pay penalty interests even if the sum insured is exceeded.

7. General rules concerning the limitation period for claims

The limitation period for claims is three years, normally starting from the end of the year when the insured got the necessary knowledge of the circumstances that substantiates the claim. However, there is an absolute limitation period of ten years from the year the insured event occurred. The limitation period for an injured third-party claiming compensation directly of the insurer, the rules on limitation are the same as the underlying claim between the claimant and the insured.

Furthermore, the insured or an injured third party who have made a claim towards the insurer, must take legal steps within six months after the insurer has refused their claim to avoid limitation. A complaint to The Norwegian Financial Services Complaints Board ("**Finansklagenemnda**") within this six-month period can also prevent the claim from becoming time barred.

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

ICA does not regulate policy triggers. Such triggers are subject to the individual insurance policy. In Norwegian third-party liability insurance, discovery basis is most common trigger. This requires that the damage is discovered during the policy period, either by the insured or the injured party. However, some policies have claims made or other triggers.

9. Recoverability of defence costs

The Norwegian Disputes Act states as a main rule that the losing party shall pay the winning party's defence costs.

In most Norwegian liability policies, the insurer undertakes to investigate whether liability exist and pay the necessary defence costs, but only to the extent that the claim is covered by the insurance. If the claim only partly is covered, be it factual or regarding the amount insured, the defence costs are distributed proportionally between the insurer and the insured.

The insured's own lawyer expenses are only covered by the insurance to the extent this is agreed with the insurer beforehand.

10. Insurability of penalties and fines

The ICA does not contain any explicit rule that the interest to be insured must be legal. There are, however, general provisions which may invalidate clauses insuring penalties and fines. In addition, there is a section in the FUA which prohibits insurance companies from receiving payment for or making offers to customers to insure the risk of criminal sanctions, such as penalties and fines.

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Peru

1. Regulation & governing bodies

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 Nº 29946, the "Insurance Agreement Law", as well as Law Nº 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 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 lapse as 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 it will still be necessary to determine whether the claim requires an adjustment agreement or not. In any case, the insurer can request a term 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 defence 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.

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Poland

1. Regulation & governing bodies

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.

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Portugal

11. Regulation & governing bodies

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, 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 insurance company headquartered in another EU country, provided it meets all the necessary requirements;
- Branches of EU-based insurance companies, provided it meets all the necessary requirements;
- Branches of insurance companies based 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 insurance business activities 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 residing or established in Portugal in order to be able to undertake insurance business on a freedom of services basis. Irrespective of the nature of the risk, 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 supervisory 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 provisions that will apply to the insurance activity carried out.

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

12. Effect of misrepresentation and / or non-disclosure

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

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 the date 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 occurred before the date 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, upon notice of the insured within three months from the date it has become aware of the breach: i) propose a contractual amendment of the policy, setting a deadline of at least 14 days, for the insured to approve or, if allowed by the insurer, provide a counter-offer or ii) terminate the insurance contract, if the insurer is able to demonstrate that it would not have, in any case entered a contract if it were aware of the non-disclosed or misrepresented fact.

The insurance contract is deemed to terminate 30 days after the notice of termination to the insured or within 20 days after the receipt of the contractual amendment proposed by the insurer if the insured fails to respond or rejects it.

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 insurer representative at the time of conclusion of the contract; or v) a breach in connection with circumstances known to the insurer, in particular when they are public and widely known.

The insurer has also duties towards the policyholder to provide information or clarification regarding the conditions of the contract, namely in respect of insurance coverage, limits and exclusions, premium payment conditions, duration and applicable law.

Finally, the insurer is also 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.

13. 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.

14. 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.

15. 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 insurance contract is 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.

Concerning an indemnity insurance, the insurer is only liable to pay the loss suffered/caused up to the amount covered, whereas in life insurance the policy may be written on a contingency basis, where the parties may establish a sum to be paid upon the occurrence of the insured event.

16. 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 accrue, according to the general terms of the Portuguese civil law.

However, there are certain insurance contracts that foresees that in case the insurer fails to comply with the payment of compensation within the specific deadline previewed in the insurance contract or by the court, interest shall accrue of twice the statutory rate applicable to the case. This is the case of compulsory motor insurance.

17. 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 third party.

18. 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 insured is liable during the policy period regarding claims presented after the term of the policy.

Nonetheless, the parties may agree in defining the cover period considering the cause or demonstration of the loss and the claim notification (claims-made policy).

In case of claims-made policy, unless otherwise stated by law or statute and provided that the risk is not cover by a subsequent insurance contract, the insurance contract covers insured events that occurred unnoticed during the policy period, even if the claim is brought in the year that follows the term of the insurance contract.

19. 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 and a certain amount for lawyers' fees based on a percentage of the court fees paid, which is related to the claim value.

20. 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.

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Romania

1. Regulation & governing bodies

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*).

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 and approval of company's management 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, 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.

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.

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 withholding 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).

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Serbia

21. Regulation & governing bodies

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.

22. 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.

23. Effect of breach of warranty and condition precedent

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

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. Insurability of penalties and fines

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

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Singapore

1. Regulation & governing bodies

The Insurance Act 1966 is the governing legislation that regulates insurance activities in Singapore, including as between insurers, insurance intermediaries and related institutions. As a regulated business, all insurers must apply in writing to the Monetary Authority of Singapore ("**MAS**") for a licence. Other statutes governing contracts of insurance in Singapore include the Policies of Assurance Act 1867, the Marine Insurance Act 1906 and the Motor Vehicles (Third Party Risks and Compensation) Act 1960.

Insurance and reinsurance activities are regulated by the MAS in Singapore. The MAS is empowered to enforce the provisions in the Insurance Act and relevant subsidiary legislation (i.e. regulations arising from the Insurance Act). The General Insurance Association and the Life Insurance Association are some of the trade associations that represent the interests of their members in Singapore.

Apart from statute, the common law is another source of law that governs the development of insurance law in Singapore.

2. Effect of misrepresentation and / or non-disclosure

A material misrepresentation and/or non-disclosure can lead to the avoidance of an insurance policy altogether ab initio. An insured has a positive duty to disclose all material facts and information and to avoid any misrepresentations and non-disclosure of material facts when negotiating the insurance contract.

Whether a non-disclosure is determined to be material would depend on (i) whether it relates to circumstances that a prudent insurer would objectively have wished to know; and (ii) whether it would have subjectively induced the insurer to enter into the insurance contract with the insured.

Most insurance policies also contain a general disclosure clause requiring the insured to disclose all material facts and information to the insurer, the failure of which could lead to non-coverage of a claim or the avoidance of the policy altogether.

Under common law, a duty of utmost good faith (*uberrimae fidei*) is implied into all insurance contracts. A failure by the insured to adhere to this duty may lead to the insurer avoiding the insurance contract, and returning all the premiums paid by the insured.

The duty of utmost good faith originated from the English case of *Carter v Boehm* (1766) 3 Burr 1905 and has since been codified in section 17 of the Marine Insurance Act. The duty is imposed upon both the insured and the insurer, and is considered as applicable to all types of insurance contracts and not just marine insurance policies at common law.

There are certain differences between a non-disclosure and a misrepresentation. A non-disclosure is based on the failure to reveal certain material facts or circumstances while a misrepresentation is based on an untruth found in a positive statement. A representation as to a matter of expectation or belief is deemed to be true if it is made in good faith.

3. Effect of breach of warranty and condition precedent

Warranties in a contract of insurance are construed very differently from warranties in a general contract. A warranty under a contract of insurance is characterised by its draconian nature, as it requires strict and exact compliance with a condition.

Warranties are broadly defined as promises that certain statements of fact are accurate and that they will remain accurate for the duration of the insurance cover and may relate to whether a particular thing will or will not be done, or that some condition will be fulfilled. A warranty may be express or implied. The breach of a warranty in an insurance policy entitles the insurer to be wholly discharged from all liabilities under the policy as from the date of the breach of warranty.

On the other hand, the breach of a condition in an insurance contract only entitles the insurer to a claim in damages against the insured.

In general, all procedural requirements stipulated in a policy that are not warranties are construed as conditions precedent. The breach of a condition precedent provides the insurer with a basis for not making payment against an insured's claim under a policy. Consequently, a condition precedent often operates as a pre-condition to liability for an insurer.

4. Consequences of late notification

In general, the time limit for an insured to give notice to an insurer of a claim after a loss has occurred will vary from policy to policy. The late notification of a claim by an insured may result in the insurer refusing to cover the insured in respect of the claim, particularly if such late notification prejudices the insurer's right of recovery under a policy. An insurer may also bring a claim against the insured for any sums rendered unrecoverable from third parties arising from the insured's late notification of its claim against the policy.

5. Entitlement to bring a claim against an insurer

An insured has a general right to bring a claim against an insurer.

A consumer who is dissatisfied with their insurer can file a dispute with the Financial Industry Disputes Resolution Centre ("**FIDReC**"). FIDReC is an independent organisation that provides dispute resolution services to consumers and financial institutions (including insurers) by way of relatively inexpensive alternative dispute resolution methods, such as mediation or adjudication.

Alternatively, an insured may also bring a claim against an insurer directly in the Singapore courts or by way of arbitration or alternative dispute resolution, depending on the dispute resolution mechanism provided for in the contract of insurance.

An insured who wishes to bring a claim against an insurer may also file a complaint with the General Insurance Association or the Life Insurance Association, as applicable.

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

The Insurance Act does not contain any provision specifically dealing with an insured's entitlement to damages from an insurer as a result of late payment of a claim. This is not an issue that has specifically arisen before the Singapore courts and therefore it has not been determined whether an insured will be entitled to damages due to late payment of a claim by an insurer.

The Life Insurance Association ("**LIA**") provides that, a person making a claim pursuant to a life insurance policy must give the insurer a notice in writing of the claim within 30 days of the event or as soon as possible. Within 14 days of receiving the notice of claim, the insurer will let the person making the claim know whether they require any more information. Within 21 days of receiving full information for a claim assessment, the insurer will let the claimant know of its decision to accept or reject the claim. For straightforward cases, the insurer will pay a claim within 14 days of receiving all requisite documents. For more complex cases, more time may be needed and the insured / person making the claim will be kept informed of the progress. For death claims, the insurer will pay interest if they pay a claim more than two months from the date they receive a written notice of the death. The interest will apply from the date notice was given to the date the insurer make the payment, using the interest rates published by the LIA on its website. The interest will be added to the amount to be paid.

7. General rules concerning the limitation period for claims

The limitation period for bringing a claim under a contract of insurance is six years from the date on which the claim accrues, as provided in the Limitation Act 1959. An insured may also find its claim rejected by an insurer on the basis of a late submission of a claim, including but not limited to giving late notice of a claim and/or the late submission of claim documents. Certain policies provide shorter timelines in respect of the commencement of legal proceedings under the policy in the event there is a disagreement between the insured and the insurer regarding the rejection of a claim. Claims for personal injuries must be made within three years from the date of the injury, or the earliest date on which the claimant had knowledge of the injury.

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

Third-party liability insurance is usually triggered by the occurrence of an insured event, typically when an insured is made liable to pay damages to a third party arising from accidental bodily injury and/or property damage to that third party. In the case of Contractors All Risk ("**CAR**") policies,

there would typically need to be a direct connection between the insured event and the contract works happening in or in the immediate vicinity of a contract site.

9. Recoverability of defence costs

In general, an insurer will bear the costs of legal proceedings commenced pursuant to policy coverage. This includes legal fees and costs payable to lawyers and experts appointed with the consent of the insurer. The insurer's right of subrogation means that it steps into the shoes of the insured to pursue any right or cause of action available to the insured. These costs are generally borne by the insurer. In the event the insurer instructs solicitors to defend an insured in respect of a third party claim, such defence costs are usually covered under the policy.

10. Insurability of penalties and fines

In Singapore, insurance policies that provide coverage against penalties and fines are uncommon. Indeed, they may not be recognised by the courts here on the ground of public policy especially if they relate to penalties and fines arising from criminal liability. In cases of civil liability, such as where an employer is found liable for the tortious conduct of its employees or agents, such insurance policies are less likely to be prohibited under the ground of public policy. That said, the award of punitive damages is very rare in Singapore, particularly in the case of contractual disputes. The Singapore courts' general preference is for parties to a contract to be held to their contractual bargain, and a high threshold must be met before the courts would even consider an award of punitive damages.

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Slovakia

1. Regulation & governing bodies

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 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 from the EU as well as from EEA countries 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, such conduct of business should be generally performed as occasional and not as permanent, daily activity in 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 occurrence 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 insurer is not entitled to reduce insurance benefit during the term of the insurance contract due to the fact that the premium was not paid properly and on time.

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. If the insurer refuses to perform (even in part) the insurer is obliged to specify the reason for non-performance or reduction of performance; this reason cannot be changed subsequently. 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 fulfilment 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 general claims against the insurance contract (by the insured or the insurer as applicable). These claims are time-barred

(three years from the date on which they could be applied for the first time). 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 could have been applied for the first time (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.

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Slovenia

1. Regulation & governing bodies

Insurance companies in Slovenia are generally regulated by the Insurance Act (Zakon o zavarovalništvu, "**ZZavar-1**") which stipulates, among other, corporate framework for insurance companies and required authorizations and the Obligations Code (Obligacijski zakonik, "**OZ**") which regulates insurance agreements.

Insurance activity in Slovenia may only be performed by (i) an insurer that has obtained authorisation from the Slovenian Insurance Supervision Agency (Agencija za zavarovalni nadzor, "**AZN**"), (ii) 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) 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 from the AZN to conduct insurance activity.

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 is obliged to disclose to the insurer all circumstances, necessary for the risk assessment that were known or could not have remained unknown to the policyholder.

In case a policyholder deliberately provides false declarations or omits to disclose circumstance that could lead to an insurer to refuse conclusion of the insurance agreement, the insurer has the right to terminate the insurance agreement within three (3) months from when the insurer becomes aware of the false declaration or non-disclosure. If the insurance agreement is terminated for above-mentioned reason, the insurer is entitled to retain already paid premiums and request payment of the premiums for the period up to the termination.

In cases where a policyholder has provided false declaration or has omitted duly disclosure without fault, an insurer may either (i) request termination of the insurance agreement or (ii) request payment of the proportionately higher premiums, both within one (1) month from when an insurer learns about the false declaration or incomplete disclosure. The insurance agreement terminates after the lapse of 14 days from when the insurer notifies the policyholder of termination. If the insurer wants to increase premium, the insurance agreement is automatically terminated in case the policyholder does not accept the proposed increase of premiums within 14 days following notification. In case the insurance agreement is terminated for in this paragraph mentioned reason the insurer must return to the policyholder part of the premiums pertaining to the time remaining up to the end of the insurance period. If the insured event occurs before the declaration was found to be false or incomplete, or later, but before the insurance agreement was terminated or an agreement on increase of the premium was reached, the insurance benefit is proportionately reduced.

The insurer does not have the right to invoke the above-mentioned rights granted to him due to misrepresentation and/or improper disclosure by the policyholder if the insurer was aware or could not be unaware of (true and complete) circumstances relevant for the risk assessment when the insurance agreement was concluded. The same applies in the case when the insurer obtained knowledge of misrepresentation and non-disclosure after conclusion of an insurance agreement, but it failed to timely invoke its rights.

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 of the risk increased if such increase is the result of the policyholder's action, whereas in cases where the risk increases without policyholder involvement, the notification must be made within 14 days of when the policyholders becomes aware of the risk increase.

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

Under Slovenian law, the parties of the insurance agreement may agree on any warranties and conditions precedent as long as they do not breach the mandatory law. The rules regulating insurance agreements are in general mandatory. They can be waived or disregarded only if permitted by law or if this is in an unambiguous interest of the policyholder.

The effect of breach of warranty and condition precedent is dependent on the contractual wording and must be assessed on a case-by-case basis. As a rule, in case the condition precedent is not fulfilled, the agreement does not take effect and if a warranty is breached, damage liability might follow. Other or different consequences might also be agreed upon.

4. Consequences of late notification

A policyholder must (except in cases of health and life insurance) notify an insurer on the occurrence of the insurance event within three (3) days from becoming aware of it. A longer period can be contractually agreed.

In case of late notification, the policyholder must compensate the insurer for any damages. The policyholder, however, does not lose any rights due to late notification. Any contrary contractional provision is null and void.

5. Entitlement to bring a claim against an insurer

Entitlement to bring a claim against an insurer depends on the type of the insurance and the wording of the insurance agreement.

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.

Claims can also be posed by third parties in case they are validly assigned.

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

The insurer must pay the insurance benefits within the agreed deadline, which must not be longer than 14 days from receipt of notification about the occurrence of the insurance event.

In case that a longer period of time is needed to determine the existence of the insurer's obligation or the due amount, the above-mentioned 14 days deadline runs from the day when the insurer's obligation and the due amount were determined.

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

In case the insurer does not perform payment of the due amount, respectively does not perform the payment of the claim in due time, the insurer can be liable under the general rules on contractual damage liability. In any event, the insurer would also be liable for payment of default interest.

7. General rules concerning the limitation period for claims

Claims of policyholders or other beneficiaries form the insurance agreements become time-barred in three (3) years following the first day after the calendar year in which the claim was created. Nevertheless, claims based on life insurance agreements become time-barred in 5 years following the first day after the calendar year in which the claim was created.

If the policyholder or the beneficiary prove that the occurrence of the insurance event was not known to them by the expiry of the limitation periods mentioned above, the limitation period begins to run on the day when they became aware of materialisation of the insurance event. In any case, however, the limitation period expires in 10

years for life insurance and in 5 years for other insurances.

The insurer's claim arising from the insurance agreements becomes time-barred in three years.

If the injured party in third-party liability insurance seeks or obtains compensation from the insured party, the limitation period for the insured party's recourse claim against the insurer begins to run from the date on which the injured party claimed compensation from the insured party in court or on which the insured party compensated the injured party.

A third party's direct claim against the insurer is time-barred at the same time as the third party's claim against the insured who is liable for the damage.

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

Each policy must be reviewed on a case-by-case basis to determine what triggers policy coverage.

Under observation of compulsory provisions of the Slovenian law (e.g. limitation provision, aleatory element) the policy coverage can be triggered on several basis, such as (i) a loss occurring basis (i.e., the loss must occur during the policy period), (ii) on an act committed basis (i.e., the act causing loss must be committed during the policy period), (iii) on a discovery basis (i.e., the insured event must be discovered during the policy period), (iv) on a claim-made basis (i.e., the claim must be made within the policy period), or even by combination of above-mentioned triggers.

With respect to third-party liability insurance the policy coverage will usually be triggered on the loss occurrence basis.

With respect to D&O insurance, the claims-made principle is predominantly used in practice.

9. Recoverability of defence costs

According to the rules governing civil court proceedings, each party bears its own costs. The losing party must then compensate the winning party for duly lodged defence costs that are calculated pursuant to the attorneys' tariff.

Depending on the coverage and the wording of the insurance agreement, the insurer can also be obliged to compensate the policyholder for defence costs under the attorney's tariff or for reasonable defence costs which might, depending on the complexity of the case and other circumstances, be higher that the costs calculated pursuant to the attorneys' tariff.

In event of the liability insurance the insurer bears the costs of a dispute over the insured person's liability, up to the limits of the sum insured.

10. Insurability of penalties and fines

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

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Spain

1. Regulation & governing bodies

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.

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Switzerland

1. Regulation & governing bodies

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. Swiss insurance law is currently being revised. In particular, the Swiss Insurance Contract Act ("**ICA**"; Versicherungsvertragsgesetz), which regulates the relationship between insurance companies and policy holders and insured, has been revised. Various changes have entered into force on 1 January 2022. The following presentation reflects that new situation.

The most important changes concern, among others, (i) the conclusion of the insurance contract (including the introduction of a right of withdrawal), (ii) termination rights, (iii) limitation provisions, and (iv) direct claims rights for third-party liability insurance. The law is also adapted to the requirements of electronic commerce.

The Swiss Parliament is currently also discussing amendments to the Swiss Insurance Supervision Act ("**ISA**"; Versicherungsaufsichtsgesetz). The partial revision concerns in particular the following amendments: (i) introduction of a restructuring regime, (ii) expanded possibilities for insurers to be fully or partially exempted from supervision if adequate customer protection is ensured, (iii) extension of supervision possibilities and (iv) amendments of the provisions on insurance intermediaries.

The Federal Assembly passed the legislative proposal in the final vote on 18 March 2022. The consultation procedure on the implementing provisions ended in September 2022. The revised ISA is expected to enter into force in the 3rd quarter of 2023.

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

— 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 insured may, if the specific circumstances justify, be exempted from supervision by FINMA

2. Effect of misrepresentation and / or non-disclosure

1. Based on questionnaires presented by the insurer, the insured is obliged to disclose to the insurer 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. Both the questioning and the disclosure shall be in writing or in another form that allows proof by text. All facts which the insurer unambiguously asks for are deemed relevant for the assessment of the risk and are, therefore, subject to disclosure.

2. 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 notice in writing or in any other form which provides proof by text. The right to terminate the insurance contract expires four weeks after the insurer has become aware of the non-disclosure of the insured.

3. 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). In the event of termination, the premium already paid has to be refunded by the insurer on a *pro rata temporis* basis.

4. Where the non-disclosure or misrepresentation only relates to a specific risk or person under an insurance contract covering several risks or persons, the insurance remains effective for the remaining part if it is clear from the circumstances that the insurer would have insured this part alone under the same conditions..

5. 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.

In addition, the amendment to the ICA introduced for indemnity insurance policies a right of claim for a damaged party or its legal successor against the insurer. Such direct claims are subject to the existence and limitations of the concerned insurance policies, i.e. the insurer can raise all objections and defences that it would have against the policy holder or the insured also

against the damaged party that is raising the claim.

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

According to the ICA, 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. If the insurer disputes its obligation to pay, the person entitled to claim can demand partial payments up to the undisputed amount after expiry of the same four-weeks' period.

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 in addition.

7. General rules concerning the limitation period for claims

The statutory limitation period for a claim against the insurer under the insurance contract is five years as of 1 January 2022 (an exception applies to claims from the collective daily sickness benefits insurance contract where the limitation period remains two years). The limitation period starts running on the date on which the insured event took place. In practice, the parties can also agree on a longer limitation period 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 ICA 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).

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Turkey

1. Regulation & governing bodies

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.

Association of Insurance, Reinsurance and Pension Companies of Turkey ("**Association**") is a professional organisation and, as per the Insurance Law, all insurance and reinsurance companies established in Turkey must become a member of the Association by paying an entrance fee. This obligation must be fulfilled within one (1) month at the latest upon obtaining the license. However, the President of the Republic of Turkey is authorized to remove the obligation to become a member.

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 and for persons who will travel abroad, personal accident, disease, health and motor vehicle insurances limited to the period of staying abroad. The President of the Republic of Turkey is authorized to expand the scope of insurances that can be taken out abroad.

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

iii. 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. If there is no connection between the bad faith of the policyholder and the occurrence, the insurer pays the insurance indemnity or cost, taking into account the ratio between the premium paid and the premium amount that should have been paid

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 insurance indemnity or insurance amount will become due once the investigation is completed and in 45 days in any case. This period is 15 days for life insurance.

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 insurance claim becomes due.

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.

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Ukraine

1. Regulation & governing bodies

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.

ii. Martial Law and Force Majeure

The President of Ukraine, Volodymyr Zelenskyy, declared martial law across the entire country after Russia attacked Ukraine on 24 February 2022. Ukraine continues to battle against Russia's unprovoked full-scale invasion. Martial law has most recently been prolonged until 19 February 2023 and it will most probably be further extended as the war is on-going.

The war in Ukraine belongs to force majeure, which was separately confirmed by the Ukrainian Chamber of Commerce and Industry.

The parties to an insurance policy may refer to such circumstances as to the ground of exempting them from liability for non-compliance with the insurance policies.

Nevertheless:

— force majeure does not release the party from its obligations, but is only a legitimate reason to postpone the performance of the obligation until the end of the force majeure effect;

— the mere fact of war does not release the party from liability, Instead, the party triggering the force majeure mechanism must demonstrate that the breach was a result of the force majeure event. Namely, an extraordinary and unavoidable circumstance that objectively prevented the fulfilment;

— of its obligations that became due, and there is a causal link between the force majeure event and the breach.

In such circumstances, for example, the insurer may delay the insurance compensation (following the procedure of notification on force majeure and its confirmation), but shall pay it when the force majeure circumstances cease.

iii. New Regulator and New Law

Starting from 1 July 2020 the National Bank of Ukraine (the "**NBU**") has become a regulator of non-banking financial services, including insurance sector.

Recently, the Parliament of Ukraine adopted the new framework law No. 1909-IX dated 18 November 2021 'On Insurance' (the "**Insurance Law**") which restates the previous insurance law dated 1996 (however, being still valid during the transitional period). The Insurance Law will be fully effective starting from 2024 and will change the approach to regulation and supervision of insurance services, which for many years has remained conservative.

The transitional period before the new regulations are not yet in force will allow the market to adapt to the new rules on regulation of the insurance sector as well as the NBU's supervision powers. The Insurance Law strengthens the licensing standards and introduces formation of an effective management system to ensure transparency of the insurance market ownership structure.

iv. Insurance services provided by foreign insurers

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. Foreign insurers (i.e. financial institutions established outside the jurisdiction of Ukraine and permitted under the laws of their home states to conduct insurance activities) are allowed to conduct the following direct and intermediate insurance activities (such as brokerage or agency operations) in the Ukrainian market without obtaining a license of the regulator:

— insurance of the risks under class 5 (aircrafts insurance), class 6 (insurance of water vessels), class 7 (insurance of cargo and luggage), class 11 (insurance of liability arising from the use of an aircraft (including

the liability of the carrier), class 12 (insurance of liability arising from the use of a vessels vessel (including liability of the carrier);

— re-insurance.

A foreign insurer 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. The exception is made for non-resident re-insurers;

— the home state of the foreign insurer has not received any reservations from international bodies regarding its implementation of international standards in prevention and counteraction of the legalisation of criminal proceeds, terrorism financing and the financing of the proliferation of weapons of mass destruction;

— the foreign insurer's home state legislation provides for state regulation and supervision of insurance activities;

— an international treaty on the prevention of tax evasion and the prevention of double taxation has been concluded between Ukraine and the foreign insurer's home country;

— the foreign insurer's home state is not on off-shore list according to the Ukrainian law;

— the foreign insurer's has the relevant permit for (re)insurance in accordance with its home country legislation;

— the financial reliability (stability) rating of the foreign insurer is compliant with the requirements set forth by the regulator; and

— the foreign insurer's home state does not belong to the states carrying out armed aggression against Ukraine.

In Ukraine, an insurance company may be established in the form of a joint-stock company, or an additional liability company. Although joint-stock companies are most common, registration of an additional liability company is much more simple and swift.

Under the Insurance Law, the minimum amount of the charter capital of the Ukrainian non-life insurance company is approx. EUR 809K (UAH 32 million). The minimum amount of the charter capital for life insurers is currently approx. EUR 1.2m (UAH 48 million) in UAH equivalent.

To be eligible to fully carry out insurance activities in Ukraine, a company must also complete the following procedures with the NBU: (i) register as a financial institution or open a branch in Ukraine; and (ii) obtain a licence for insurance activity.

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 NBU for each separate type of insurance activity, provided, however, that a life insurer is not allowed to sell any other insurance products.

Due to the lengthy, difficult and bureaucratic procedure and fees associated with establishing an 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 NBU and the competition authority – the Antimonopoly Committee of Ukraine. The NBU'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 NBU will thoroughly inspect the foreign insurer's financial capabilities and the reputation of its senior management personnel. The merger clearance by the Antimonopoly Committee of Ukraine (if transaction is to be notified under competition laws), also required by the NBU, should be obtained following the general procedure set forth by Ukrainian competition law.

v. Branch Option for the Non-Resident Insurers

Alternatively, foreign insurers may carry out full-scope insurance activities in Ukraine directly via Ukrainian branches, which are treated as resident insurance companies. Under the Insurance Law, such branches of foreign insurers must also be registered with the NBU, hold a respective insurance licence and comply both with the General Requirements mentioned above and some additional requirements, including:

— the legislation of the non-resident insurer's home state, according to the assessment of the NBU, does not contain provisions that may hinder/limit the interaction between it and the regulator of that state or prevent the NBU from exercising its supervisory powers in relation to the branch;

— the amount of the branch's registered capital is not less than the amount of the minimum capital of the resident insurers;

— the foreign insurer must issue a written irrevocable commitment note to confirm the unconditional performance of all obligations undertaken by its branch in Ukraine; and

— the insurance funds of a foreign insurer must be deposited only in the territory of Ukraine.

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, including, disclosure of all the relevant documents and notifying about the existence of an insurable interest. 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, or about the existence of an insurable interest, such new insurance contract is voidable.

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 and in the manner specified by the insurance policy.

The consequence of the delay of such notification should be specified in the insurance 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 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 three per cent 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 (i) a breach of his or her right to claim or (ii) 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-party liability insurance

The occurrence of an insured event is a default policy trigger in third-party liability insurance. However, the insurers can agree with the insured on other triggers 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.

Defence costs shall be distributed according to the results of court proceedings. Defence costs shall be compatible with: (i) the complexity of the case and the services provided by the attorney, (ii) time spent by the attorney for the provision of services, (iii) the volume of services, and (iv) the price of the claim and (or) the significance of the case for the party, including the impact of the court decision on the reputation of the party or the public interest in the case. If the mentioned requirements are not met, the court may reduce the number of costs based on the motion filed by one of the parties. This party shall bear the burden of proving that costs are not reasonable.

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.

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United Arab Emirates

1. Regulation & governing bodies

Insurance in the United Arab Emirates ("**UAE**") is generally regulated:

i. "onshore" (i.e. mainland UAE) on a Federal level, comprising the whole of the UAE with the exclusion of financial free zones; and

ii. "offshore" in the two financial free zones (the "**Financial Free Zones**"), being the Dubai International Financial Centre ("**DIFC**") and the Abu Dhabi Global Market ("**ADGM**").

The onshore UAE insurance market is now regulated by the Central Bank of the UAE ("**CB UAE**") following the merger of the Insurance Authority ("**IA**") into the CB UAE under Decree Federal Law No.25 of 2020. Accordingly, all rules, decisions, circulars, and regulations issued by the former IA under the provisions of the Federal Law no. 6 of 2007 will continue to apply to all licensed institutions and activities until they are replaced by CB UAE.

Separate regulatory frameworks are applicable in the Financial Free Zones. DIFC-registered insurance companies are regulated by the Dubai Financial Services Authority, and ADGM-registered insurance companies are regulated by the Financial Services Regulatory Authority. For the purposes of this note, we will be focusing only on the "onshore" jurisdiction in the UAE, regulated by the CB UAE.

Non-licenced insurers cannot insure risks within the onshore UAE jurisdiction. An insurance agreement that is entered into by a non-licenced insurer is void and the non-licenced insurer may be liable to pay damages and face regulatory sanctions. However, foreign reinsurers may reinsure insurance contracts entered into in the UAE, subject to the foreign reinsurer being regulated in their home jurisdiction and satisfying certain rating requirements.

Insurance and reinsurance companies can only establish a presence in onshore UAE through the following three routes:

(i) the incorporation of a public joint-stock company (a "**PJSC**");

iii. the incorporation of a branch of a foreign company; or

iv. the agreement with an authorised agent in the UAE as an insurance agent.

The minimum capital requirement to exercise insurance activities through an entity in onshore UAE is:

(i) AED 100 million or the equivalent thereof for insurance companies; and

v. AED 250 million or the equivalent thereof for reinsurance companies.

The same capital requirements apply to Takaful operators.

Certain other regulatory steps must be taken before the insurer is fully licensed to carry on its activities, including obtaining a commercial licence from the Emirate in which it is located. Companies offering medical insurance products also require a permit from the relevant authority if they operate within Dubai, Abu Dhabi or Sharjah.

Additionally, at least 51% of the shares in any insurance and reinsurance companies incorporated in the UAE must be owned by UAE or GCC nationals, or a company wholly owned by UAE or GCC nationals. Where a company operates an insurance practice through a branch, a UAE national must be appointed as an agent of the branch. Other ownership requirements apply to certain insurance-related professionals. For example, insurance agents must be 100% owned by UAE nationals/companies.

Although the UAE has recently relaxed foreign ownership restrictions for companies based onshore, we understand that this is unlikely to impact the insurance sector and that such foreign ownership restrictions will continue to apply to companies carrying out insurance activities.

2. Effect of misrepresentation and/or non-disclosure

The insured is obliged to:

vi. at the time of the conclusion of the contract, disclose to the insurer all information known to him in connection with the insured risk in order for the insurer to assess the risks which it shall bear; and

vii. notify the insurer during the term of the contract of any matters arising which may lead to the increase of such risks.

Generally, an insurer's rights in respect of an insured's breach of the policy terms and conditions are provided in the policy itself. If the insured acts in bad faith to conceal any relevant information or by submitting any incorrect information relating to the insured risk, the insurer may claim for the rescission of the contract. In most cases, the insurer can only retain the premiums if it is proven that the insured acted in bad faith. The policy is cancelled from the date of the insured's breach of the contract. For onshore UAE marine insurance, even if bad faith cannot be proven (for example, in cases of negligent or innocent misrepresentation), an insurer may retain half the premium if the insured gave incorrect information. It can also require the policy to be cancelled.

To give a degree of protection to the insured, the insurer is obliged to include all the necessary questions relating to material facts required by the insurer to assess the risk, within the original proposal form. Such form must also set out the consequences on coverage in the event that the insured provides any incorrect or inaccurate information.

3. Effect of breach of warranty and condition precedent

To be valid and enforceable under UAE law, warranties, conditions precedent to liability or exclusion clauses must be:

viii. “prominent” i.e. presented conspicuously such as in bold font and a different colour; and

ix. endorsed by the insured.

Under the UAE Civil Code, any clause that would “cause the contract to be annulled or the insured’s right to be forfeited” is considered void unless that clause is “prominent”.

A number of decisions have been issued by the Dubai Court of Cassation whereby the court has held that where an insurer seeks to rely on a clause that limits or excludes liability, such clause can only be relied upon where if it is found in the body of the policy and is clearly identifiable to the insured.

4. Consequences of late notification

Generally speaking, the insured is obliged to notify the insurer of the occurrence of an insured event as soon as it becomes aware of it. However, customers based in onshore UAE benefit from a number of protections under the general (non-insurance specific) laws, such as the duty of good faith. For example, if an insured has a reasonable excuse for a delay in "notification" to either its insurer or a relevant authority (for instance, the police), a term in their insurance policy providing that late notification will prevent them from having a valid claim is commonly held to be void. In addition, if any policy terms are interpreted by a UAE court to be arbitrary, then such term will typically not be enforceable, which may include a late notification provision.

5. Entitlement to bring a claim against an insurer

Each policyholder has the option to submit a complaint to the CB UAE in the case of an insurance company's breach of any rule or regulation. The CB UAE can issue warnings, impose fines and suspend or revoke an insurance company's licence. In particular, a company can be fined AED 50,000 for failure to pay the compensation stated in the insurance policy to the insured as soon as the accident occurs or as soon as the insured risk takes place and up to AED 250,000 for any persons practicing the operations of insurance or reinsurance inside the UAE without a licence.

Certain insurance disputes must be referred to the CB UAE for resolution by the Insurance Disputes Committee before any specific claims can progress to the onshore UAE courts.

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

The contracting parties are obliged to perform the contract in “good faith”. Therefore, it may be possible for the insured to claim damages for breach of this duty when adjusting and settling

claims (similar to "bad faith" claims). It may be possible for an insured to claim damages for both:

x. breach of the duty of good faith when adjusting and settling claims (including late payment of claims); and

xi. consequential losses flowing from the insurer's breach.

7. General rules concerning the limitation period for claims

The events and requirements triggering coverage under an insurance policy should be defined in the insurance policy. Insurers must set out a clear mechanism for processing claims, including notification requirements and time periods. The insurer must pay when an insured event as set out in the contract occurs. In the onshore UAE, the limitation period for claims under insurance contracts is generally three years from either (a) the date of the occurrence of the insured event; or (b) the date on which the insured became aware of the occurrence of the insured event. Such limitation period will not apply to the extent that there has been any fraud on the part of the insured (for instance, if the insured knowingly conceals any relevant information or submits any erroneous statements).

The limitation period in respect of marine insurance is generally two years from the date of the incident.

8. Policy triggers with respect to third-party liability

In the case of liability insurance, as per UAE laws, the obligations of the insurer only arise when the injured third party makes a claim against the insured. In general, third parties cannot claim under an insurance policy where the policy does not give them the right to do so. However, where the policy specifies that the insurance policy is for the benefit of a third party (defined as a "**beneficiary**"), the insurer must pay the insurance proceeds to them.

Under motor insurance, a third party can bring a direct action against an insurer in certain circumstances.

9. Recoverability of defence costs

Generally speaking, legal fees are not recoverable by a successful party at each stage of any court proceedings, although in certain cases nominal legal costs may be recoverable. However, court filing fees and expert fees are recoverable as part of any final, successful judgment awarded by the court.

10. Insurability of penalties and fines

UAE onshore laws do not contain any definition of an uninsurable interest. However, within the UAE insurance market, many insurers offer coverage for civil fines and penalties, typically including the following:

xii. Products liability insurance: this covers the insured against all sums, which the insured shall become legally liable to pay in respect of: (i) an accidental bodily injury to any person; or (ii) an accidental loss of or accidental damage to property arising due to use of the products sold/supplied by the insured; and

xiii. Professional liability insurance: this covers legal liability arising out of professional negligence of the insured or his employees. Different professions, such as architects, engineers, consultants, lawyers and accountants, can typically be covered under this insurance.

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United Kingdom

1. Regulation & governing bodies

Insurers are dual regulated firms in the UK. They are authorised and regulated from a standards and policies 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"). Insurers are also subject to the rules and guidance set out in the FCA Handbook and PRA Rulebook ("Rules and Guidance"). The Rules and Guidance have been heavily influenced by EU insurance directives, which sought to put in place a harmonised regime of insurance regulation across the EU. Must of this has, to date, been retained following the UK's exit from the EU.

The PRA (or FSA as it was at the time) 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 PRA. 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. The extent to which UK regulation will diverge from Solvency II following Brexit remains to be seen.

Following the end of the Brexit transition period on 31 December 2020, UK insurers no longer have passporting rights into the EU, and EU insurers no longer have passporting rights into the UK. This has meant that insurers have had to reconsider and restructure the manner in which business is written across borders between the UK and the EU. EU insurers that had previously passported into the UK have been permitted to continue their UK activities under the temporary permissions regime ("TPR"), which has granted deemed authorisation to such firms. Such deemed authorisation is, however, temporary in nature and insurers currently operating in the UK under the TPR will need to either apply for full authorisation by a date prescribed by the PRA or withdraw from the UK market. No comparable regime exists within the EU, and so UK insurers that previously relied on passporting to carry out EU business have had to take more immediate steps to alter their structure. Typically this has involved writing EU business to an affiliated insurer that is licensed within the EU.

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 UK prudential regime to the different participants in the Lloyd's market – at the level of the Society of Lloyd's, 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 as part of the Senior Managers and Certification Regime ("SM&CR"). Pursuant to this regime, certain individuals holding senior management functions require approval from and the PRA and/or the FCA and may personally be held to accountable for failures to fulfil their responsibilities. Further, firms must certify, at the outset and on an ongoing basis, the fitness and propriety of employees who pose a risk of significant harm to the insurer or its customers. All certification staff and any other employees who do not fulfil ancillary functions are subject to the PRA and FCA's conduct rules, breach of which may result in disciplinary action. This aspect of insurance regulation is specific to the UK rather than being derived from the EC Directives.

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

— claims by small or medium sized enterprise (SME), i.e. a business that is not a micro-enterprise which has an annual turnover of less than GBP 6.5 million and has either a balance sheet total of less than GBP 5 million, or employs fewer than 50 people

— charities with an annual income of less than GBP 6.5 million at the time of the relevant complaint

— a trustee of a trust which has a net asset value of less than GBP 5 million at the time of the relevant complaint.

The FOS has jurisdiction to make awards of up to GBP 350,000 (excluding interest and costs) for a complaint relating to an act or omission that occurred on or after 1 April 2019, or GBP 160,000 for one that occurred before 1 April 2019. 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, of which version 2.1 was issued in April 2021 on a phased basis. The new version will be the required standard for new and renewal business from 1 August 2021. 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 (1) the date on which the contract is concluded or (2) 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, Scotland and Northern Ireland is substantially the same. Most insurance in the UK is written out of London and is consequently governed by English law.

Insurance 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 2016 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:

— diminished the risk;

— were known by the underwriter;

— were matters of common notoriety;

— were waived by the insurer; or

— 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:

— 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;

— that makes the disclosure in a reasonably clear and accessible manner to a prudent insurer; and

— 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:

— diminish the risk;

— are actually known by the insurer;

— 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.);

— the insurer is presumed to know; or

— 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 a 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 halve 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.

— 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 it is or not). This is for the insurer to prove.

— 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):

— "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

— 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

— 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 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.

COVID-19 and the FCA test case

In June 2020, the High Court was asked to make declarations about the meaning and effect of 21 sample policy wordings. The policies being considered provided cover for Business Interruption Insurance, and the requested interpretation related to (i) disease extensions, (ii) prevention of access/public authority extensions, and (ii) hybrid clauses. The case was brought on behalf of SME policyholders who had claimed for significant losses resulting from the Covid-19 pandemic. Judgment was handed down on 15 September 2020 in which the FCA was largely successful in its claim.

On 15 January 2021 the Supreme Court of England and Wales handed down judgment on the appeal brought by several Insurers affected by the September 2020 judgment. The Supreme Court largely upheld the September 2020 judgment and as a result, many Insurers had to reconsider the interpretation of similar policy wordings and claims they had previously declined. Full details of the test case can be found here: https://www.cms-lawnow.com/ealerts/2021/01/business-interruption-insurance-and-covid19-fcas-expectations-following-supreme-courts-judgment

However, the Supreme Court’s judgment did not resolve a range of complex coverage issues that subsequently arose, relating to the adjustment of Business Interruption losses. In three related actions that concerned the UK’s restaurant and hospitality industries, (*Stonegate, Greggs and Various Eateries*), two key issues were considered: i) whether multiple losses can be aggregated so as to constitute only one loss; and ii) whether insurers are entitled to take into account government support payments in calculating policyholders’ losses. Further details of those claims can be found here: Business Interruption Insurance and Covid-19: aggregation and furlough - further guidance (cms-lawnow.com)

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.

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