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10 things every insurer should know

Central and Eastern Europe

September 2014

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Introduction

The aim of this brochure is to provide an informative introduction to the key areas of concern for an insurer when considering establishing operations in Central and Eastern Europe. Whilst we do not set out the definitive requirements for an insurer wishing to gain a foothold in the region, this guide serves as a backdrop against which CMS can offer a cohesive and commercially realistic, solutions based approach to expanding your operations.

Undertaking insurance activities in most of the countries listed will involve either incorporating a local company, establishing a branch office, or via merger and acquisition of existing local insurance companies. Each route requires some level of regulatory compliance and approval. Many of the countries included in this guide stipulate that an insurance company must be a joint stock entity, meeting certain capital and liquidity requirements. A local branch established by a foreign insurer tends to require a licence from the relevant regulatory authority in the country of operation. By contrast, EU and EEA insurers who undertake insurance activities on a Freedom of Services basis can operate under the supervision of the regulator in their country of origin.

Due to the nature of the legal system throughout Central and Eastern Europe, the civil or relevant commercial "code" is often the key point of reference for both the definition of insurable interests and rules relating to premium calculations. The consequences of misrepresentation and/or non-disclosure, late notification, loss adjusting proceedings and policy triggers for third party liability insurance are usually dealt with through the relevant provisions and clauses in the insurance contract according to country specific norms. In addition, rules concerning the rights of an insured and third parties to bring a claim against an insurer and relevant limitation periods will be subject to the wider overarching contract laws within each country.

Again these laws will usually emanate from a codified body of rules and regulations.

Reinsurance tends to follow the same regulatory framework as general insurance business, with some degree of variance in relation to solvency margins, minimum capital and liquidity ratios and technical reserves.

We hope you find the information both useful and interesting; we welcome your feedback, questions and comments.

For further information about our insurance team and how we can help you, please visit our website *www.cmslegal.com* or contact any of the CMS offices listed at the end of this document.

Albania

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1. Introduction

The insurance practice 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. At date, many international insurance companies are active in the Albanian market mostly by way of acquisition of the existing local insurance companies.

The insurance activity may be performed through two modalities. The first modality is to duly incorporate a joint stock company in Albania. Prior to the incorporation it is essential to be granted the initial incorporation approval by the Insurance Supervisory Authority (ISA), the local regulator. Such 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 the Albanian. Failing to comply with the requirements the insurer cannot be registered in the Trade Registry. Such companies should also meet certain financial requirements.

The alternative modality is the registration of foreign insurance companies' branches in Albania. The above mentioned procedures also apply. Additional information, however, is required such as data concerning the financial situation of the mother company, and its last three year audited financial statements, the future strategy of the parent company and the development of the insurance market in the country where the parent company has been incorporated. The branch can only perform the same activities as that of its parent company.

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

Following Albania's application for EU membership, additional legal amendments are expected to occur in the near future, to adapt local law to the EU ones. As a matter of fact, a new draft-law envisaging the possibility of an EU insurer (no incorporation requirements) to directly provide services in Albania is actually in the process and under assessment of the Parliament.

2. Defining insurable interest

Albanian law provides a general definition of the insurable interest, as an event envisaged in the insurance agreement, which, as long as it occurs, provides the right of the insured to be indemnified by the insurer. However, pursuant to the law, the insurance activity may only be performed in compliance with the pre-defined insurance classes. As a consequence, the agreement may not set-forth different insurable interests and covered risks other than those permitted by the law. The insurance classes cover the common insurable interests provided by other EU jurisdictions.

3. Calculation of premiums

Albanian law does not envisage specific rules with respect to the method of calculating the premiums. However, it provides that the premium consists of:

a) calculated premium for the insurance risk (i.e. net premium);
b) calculated value covering administrative expenses;
c) saving elements in certain classes of life insurance; and
d) calculated value for company's profits, including profit generated from risk-free insurance investments and the ones containing risk factor.

The net premium of the obligatory insurance is determined by the Albanian Ministry of Finance. The voluntary insurance premium may be determined by the insurer. The ISA, is entitled to recommend the insurer data to be used in calculating the fees and premiums for the products of the voluntary insurance.

The insurance company and the insurance intermediaries are obliged to apply compulsory insurance premiums.

4. Consequences of misrepresentation and/or non-disclosure

Prior to executing an insurance agreement, the insurance company shall inform the insured or the policyholder regarding the insurance products, the special and general terms and conditions of the agreement, the expenses and profits of the insurance contract, as well as on the circumstances which are material for assessing the risk and which are known to the insured or policyholder, or under the circumstances could have not remained unknown to him.

Despite the above, should the insured deliberately provide inaccurate or fail to provide the required information the insurance company has the right not only to be dismissed from the obligation to provide indemnities but also to retain the premiums and the agreement termination.

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. Requirements regarding loss-adjusting proceedings

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

However, Law n. 9267 foresees certain mechanisms to cover risks for insurance and reinsurance activity in order to create reserves for any security, capital investments (Art. 95), or provide for a guarantee fund (Art. 93, 95 and 98).

7. Entitlement to raise 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.

8. General rules concerning the limitation period for claims

Albanian law does not make any difference between the types of insurance agreements with respect to the limitation period for claims. Albanian Civil Code envisages that the limitation period for payment of compensation under the insurance contract is two (2) 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. Reinsurance regulations

Albanian law envisages specific provisions regarding reinsurance. It is defined as a transfer of a part of the risk from the insurer to the reinsurer pursuant to the reinsurance agreement. Almost the same provisions regarding insurance companies apply to the reinsurance companies. Such companies should be incorporated in Albania and duly licensed. However, Albanian insurers may execute reinsurance agreement with foreign reinsurance companies, only after obtaining prior approval by ISA. Albanian insurance companies may perform reinsurance activities as well after being duly licensed by ISA in such respect. An insurance company has to reinsure a risk when this latter exceeds 10% of its company capital. The reinsurance agreement is similar to the insurance one.

Bosnia and Herzegovina

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1. Introduction

Bosnia and Herzegovina (BiH) consists of two separate and distinct administrative entities: the Federation of Bosnia and Herzegovina (FBiH) and the Republic of Srpska (RS).Formally, Brčko District is a unique administrative unit of local government under the sovereignty of BiH. The two entities and the Brčko District have their own governmental structures as well as legislation and regulations, which means that insurance, as well as other areas of law, are subject to legal regulations at entity level, 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 ranges from BAM 1m to BAM 3m depending on the type of risk insured. There are two types of insurance companies:

(i) standard-type joint-stock companies; and
(ii) joint insurance companies. A joint insurance company is defined as an insurance company whose members jointly guarantee the financing and compensation for an agreed insured event on the basis of the "principle of mutuality".

The most important pre-requirement imposed on the operation of insurance companies is to obtain 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) ("**Agencies**"). An insurance company can be established by a domestic or foreign natural person or legal entity. The approval is issued in accordance with the types of insurance within a 60-day period, if the Agency decides that the application for approval fully meets the requirements imposed. After the approval is issued, the insurance company is obliged to pay a fee for performing this business activity. The fee is determined by the Agencies on the basis of the amount of premiums collected in the previous year within the deadlines determined by the Agencies. 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 obstacle that insurance companies have to overcome 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 minimum amount of the guarantee fund cannot be less that BAM 1m. However, the amount of the guarantee fund depends on the types of insurance offered by the insurance company. The Agency also requests companies to submit financial reports and other documents necessary for it 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 condition that the Agency

supervising insurance business in one entity forwards 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. As a precondition for issuing the approval the company has to be a joint-stock company, a joint insurance company or has to be established in any other form allowed in EU countries, as well being authorised to perform these activities in its home country. The other conditions for obtaining approval from the Agencies apply to foreign insurance companies in the same manner as they apply to newly-founded domestic insurance joint-stock companies or joint insurance companies. The only exception is that a foreign insurance company seeking to establish a branch office in BiH has to be registered in a country where the reciprocity principle applies in relation to BiH i.e. a country in which a company with its corporate seat in FBiH or RS can also establish a company.

2. Defining insurable interest

Insurance activities are divided into two categories: life and non-life insurance. The insurable interest is further divided within these two groups in accordance with the type of insurance and the type of risk insured. Legal regulations require separate Agency approvals for life and non-life insurance activities, except that it is possible to continue combined insurance activities if the insurance company had already been performing both activities at the time when the Law on insurance companies was introduced (in 2005). In such cases it is necessary to have separate administration for the different insurance activities. Both entities' legislation provides for a detailed list of types of insurance and risks against which one can be insured within the two general groups mentioned above.

Moreover, the Law on insurance companies of RS further provides that insurance companies offering certain types of insurance services (e.g. life insurance connected with investments) will need an additional approval from the Agency for insurance of RS. Motor vehicle liability insurance (and insurance of other similar types of liability) is regulated by a unique Law on motor vehicle liability insurance. There are also other provisions on compulsory liability insurance applicable in FBiH and RS covering civil liability risks and liability involved in the use of motor vehicles in the territory of the entire BiH.

In addition, the Law on obligations also defines types of interest that can be insured against in a standard type of insurance contract which, in conjunction with insurance legislation, covers typical insurable interests and risks as in any other jurisdiction. However, the Law on obligations stipulates that it is not to be applied to insurance of claims as well as relationships of reinsurance.

3. Calculation of premiums

An insurance premium is defined as the price of risk or the price which the insured pays to the insurer for concluding the insurance. The insurance legislation remains silent on the issue of calculation of premium. However, the Law on obligations, which regulates the insurance policy or leaves it open for the parties to the policy to agree on the amount of the premium to be paid, specifies that the payment of premium should be made within contracted time period. If the premium is payable immediately, it should be paid at the conclusion of the contract.

The Supervisory Agency may limit the scope of insurance activities which insurance company may perform, for a certain period if it is necessary to protect the financial stability of the company. Restrictions may apply to the entire activity of the company or to any particular part. Supervision Agency can also, after the abolition of the tariff system, order an increase or decrease in tariff premium rates to certain types of insurance, if the premiums, according to the Agency for supervision, are not considered as appropriate.

4. Consequences of misrepresentation and/or non-disclosure

The insurance-specific provisions covered in the Law on obligations specify that in the case of an intentional, inaccurate or a complete failure to provide notification of an insured event occurring, the insurer has a choice to declare, within one month of the day of finding out about the event, the termination of the contract or propose a premium increase proportionate to the increased risk. Moreover, if the insured has deliberately misrepresented or deliberately failed to disclose a circumstance of such nature that the insurer would not have concluded the contract had he known about it, the insurer can request an annulment of the insurance contract. In this case, the insurer retains the paid premiums as well as having the right to request payment of the premium for the insurance period within which it requested annulment of the contract.

5. 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 this within the given deadline, the insured is obliged to compensate the insurer for the damage which the latter incurred as a result.

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to indemnify the insured within the agreed deadline, which cannot be later than 14 days after the day the insurer receives notification of the insured event occurring. But, if for the setting off the existence of the insurer's obligations, or its amount, is needed some time, this term begins to from the date the existence of its obligations and its amount are established. If the amount of the insurer's obligation is not determined in the above mentioned period, the insurer shall, at the request of authorized persons, pay the undisputable portion of its obligations in respect of the advance.

7. Entitlement to raise 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 FBiH Law on insurance companies in private insurance and the RS Law on insurance companies prescribe to the insured a right of privileged claim 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 for which the insured is responsible, with the maximum amount claimed being the insurer's limit of liability.

8. 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 was created. If the interested party proves that it was not aware of the occurrence of an insured event up to a certain date, the limitation period begins with this day, with the provision that the limitation period will begin in any case ten years (for life insurance) and five years (for other insurance claims) from the day of the standard limitation periods mentioned above. In the case of an injured third party requesting compensation from the insured, the limitation period of the insured's claim against the insurer is initiated on the day the injured party requested compensation from the insured in court or the day of the occurrence of the damage.

9. Policy triggers with respect to third party liability insurance

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

10. Reinsurance regulations

All insurance companies, apart from joint insurance companies can conduct reinsurance activities with the approval of the Agencies. Every shareholding company which exclusively performs reinsurance is subject to a special approval from the Agencies. A company with an approval issued in either of the entities can offer reinsurance services in the territory of the whole of BiH. Newly-founded reinsurance companies are normally established as shareholding companies which usually register reinsurance as their exclusive business activity.

Bulgaria

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1. Introduction

Prior to joining the EU, Bulgaria already had a developed insurance market. Foreign insurers predominantly entered the Bulgarian market by way of merger and acquisition of existing insurance companies. Currently, there are several ways to undertake insurance activity in Bulgaria.

The first option is by incorporating a company in Bulgaria and obtaining the necessary license from the Bulgarian Financial Supervision Commission (BFSC). An insurer can provide only the types of insurance that are permitted by its license. A single insurer is not allowed to provide both life and non-life insurance. 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 insurers is the incorporation of a local branch office. The branch shall obtain a license 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 the home country, either on a Freedom of Services basis or by establishing a local branch. For this purpose, a procedure of exchange of information between the supervising authority in the home member state and the BFSC must be completed. The BFSC exercises supervision over insurance and reinsurance companies from EU member states, which operate in Bulgaria, save for supervision over their financial stability, which is performed by the supervising authority in the home country.

A European company (SE) may also conduct insurance or reinsurance business in Bulgaria, subject to obtaining the necessary license.

2. Defining insurable interest

The rule that any risk that can be quantified can be insured is not applicable in Bulgaria. The Bulgarian Insurance Code contains an explicit list of the types of insurance policies that can be concluded and the risks that can be insured. The list covers most insurable interests and risks, which are common to the international market.

3. Calculation of premiums

The premium is determined on the basis of assessment of insurable risk and is calculated for the entire policy period. During the term of the policy, the amount of the premium can be subsequently amended if there is a significant increase or decrease of the risk, or if the premium amount was not correctly calculated in the first instance.

Where an insurance contract terminates before the expiry of the policy period on the grounds that the insurable interest ceases to exist, the policyholder is entitled to reimbursement for the portion of the premium corresponding to the unused policy period. Such reimbursement is also allowed when the insurance policy is terminated as a result of unintentional misrepresentation or innocent nondisclosure.

4. Consequences of misrepresentation and/or non-disclosure

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

Willful 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 became aware of the mis-representation or the non-disclosure prior to the occurrence of the insured event, the insurer is entitled to terminate or amend 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.

5. Consequences of late notification

Generally speaking, 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 and 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. Obligation for notification under property insurance has been explicitly set forth under the Insurance Code in accordance with the cited principles, but similar clauses can be found in other types of insurance policies as well.

6. Requirements regarding loss-adjusting proceedings

An insurer is obliged to indemnify the insured according to the policy not exceeding a period of 15 days from the date of receiving the insured's notification and all necessary evidence under the policy terms, if cover is confirmed. In the event that there is additional evidence to be collected, the insurer is obliged to complete the loss-adjusting proceedings within 15 days of receiving all evidences of the occurrence of the insured event. This term does not apply to high-risk insurance.

7. Entitlement to raise 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 claim.

8. General rules concerning the limitation period for claims

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

9. Policy triggers with respect to third party liability insurance

Bulgarian law does not explicitly regulate policy triggers. The Insurance Code refers to an "insured event" and it is generally accepted that whether this event is the occurrence 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.

10. Reinsurance regulations

A reinsurer operating in Bulgaria must be:

— a Bulgarian joint-stock company, which has obtained the relevant license for carrying out reinsurance business;
— an existing EU reinsurer, which has obtained a license for carrying out reinsurance business in its home Member State;
— an existing non-EU reinsurer, which has obtained a license for carrying out reinsurance business in its home state and has established a local branch and obtained a license; or through its seat or branch in the home state, subject to the requirements of the Insurance Code;
— a European company (SE), which has obtained a reinsurance license.

In Bulgaria reinsurance companies are not allowed to undertake insurance along with reinsurance activity.

Croatia

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1. Introduction

Insurance activity in Croatia may be undertaken through:
(i) a local insurance company that has obtained the authorisation of the Croatian Financial Services Supervisory Agency (CFSSA),
(ii) a branch of a foreign (non-EU) insurance company that has obtained authorisation from CFSSA to perform insurance activity in Croatia, or
(iii) an EU member state insurance company that has either established a branch in Croatia or is authorised to directly carry out insurance business in the territory of Croatia.

These entities 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.

According to CFSSA, the process of a local insurance company getting authorised to undertake insurance activity may take up to three months. A branch of an EU member state insurance company may start to perform insurance activity in Croatia three months after CFSSA receives notification from the relevant home country supervisory authority. An EU insurance company may start to directly perform insurance activity in Croatia upon receipt of confirmation from its home country supervisory authority that it has submitted the required documentation to CFSSA.

2. Defining insurable interest

Insurable interest is defined in the Croatian Civil Code as a future unpredictable risk which is independent from will of both the policyholder and the insured.

The following types of insurance are not allowed:
(i) insurance against death of a third party who is under 14 years of age, and
(ii) insurance of a person who does not have the capacity to contract.

3. Calculation of premiums

Premiums are calculated dependant on risk selection. An insurer takes into account the insurance industry criteria and personal characteristics and circumstances of the insured: age, medical condition, disability and other personal circumstances that may affect the level of assumed risk.

Such circumstances as maternity and pregnancy are normally left out for the process of premium calculation.

4. Consequences of misrepresentation and/or non-disclosure

Misrepresentation and nondisclosure of material circumstances or other relevant conditions may entitle the insurer to reduce the indemnity for the loss suffered where there is a causal connection between the undisclosed circumstances and such a loss.

In the event of an intentional violation of disclosure obligations, providing untrue information, or concealing important facts, 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'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 disclosure obligation).

In the event of unintentional violation of disclosure obligation, providing untrue information, or concealing important facts, the insurer may within one month starting from the day on which it became aware of misrepresentation and/or violation of disclosure obligation terminate the insurance contract or request increase of the premium.

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

5. Consequences of late notification

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

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

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to complete the loss-adjusting proceedings within timeframe agreed in the insurance contract but not later than of 14 days after receiving notification of the insured event. If unable to complete within 14 days the insurer is obliged to provide the insured with an advance payment of undisputed amount on request.

If it is not possible to complete the loss adjusting proceedings within 14 days after receiving notification of the insured event, due to uncertainty of the insurer's obligation or amount of the claim, the 14-days deadline starts running as of the day on which the insurer's obligation became certain and the amount of the claim has been established.

7. Entitlement to raise a claim against an insurer

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

In third party liability insurance, the third party is 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 and professional liability insurance, where the third party may raise a claim directly against the insurer of the motor vehicle as well as against the insured.

8. 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 did not know that the insured event occurred, the limitation period begins on the day on which the insured person became aware of it. In any case the limitation period expires in 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 years runs from the day the injured person filed a claim against the insured person or when the insured person reimbursed the damages.

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

9. 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.

10. Reinsurance regulations

Reinsurance can only be written by a joint stock company. Reinsurance is classified as insurance business and is governed by the Insurance Act, therefore, conditions applicable to joint stock insurance companies shall apply as well to reinsurance companies. A reinsurer must perform reinsurance business as its sole business.

Czech Republic

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1. Introduction

In general, insurance activity in the Czech Republic can be undertaken by

(i) an insurer with a Czech insurance licence granted by the Czech Insurance Market Regulator, the Czech National Bank (the "**CNB**");
(ii) an insurer based in another EU or EEA member state which has established a branch in the Czech Republic;
(iii) an insurer based outside the EU or EEA which has established a branch in the Czech Republic and has obtained a Czech insurance licence; and
(iv) an insurer based in the EU or EEA that has undertaken insurance business in the Czech Republic on a temporary basis. The CNB (as the Czech Insurance Market Regulator) can grant a Czech insurance licence to a joint-stock company, a cooperative established under Czech law or a Czech branch of the insurance company based outside the EU or EEA. The process of establishing a Czech joint-stock company or cooperative and obtaining a Czech insurance licence from the CNB can be costly rather 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 it is usually rather lengthy and costly as it involves obtaining a special licence from the CNB.

Insurers based in EU and EEA countries can also undertake insurance activities in the Czech Republic on the basis of freedom to provide services. This is relatively inexpensive and does not require any complex formal procedure. However, such insurance activities may only be performed in the Czech market on a temporary basis.

2. Defining insurable interest

Under the Czech Civil Code, which newly regulates insurance contracts as of 1 January 2014, an insurable interest is defined as "a legitimate need for protection against the consequences of an insured event". The existence of an insurable interest is the fundamental pre-condition for the rise and duration of insurance and its existence must be determined objectively (i.e. mutual declaration of insurer and policyholder in the insurance contract will not be sufficient in this respect).

If an insurable interest does not exist at the time of the conclusion of the insurance contract, the contract will be deemed invalid. In the event that the insurable interest terminates after the insurance contract has been concluded, the insurance will cease to exist upon the termination of the insurable interest.

3. Calculation of premiums

Premiums are determined on the basis of an assessment of the insurable risk and, in insurance contracts, can be agreed either as so-called current premiums (i.e. premiums determined for a fixed period of insurance, such as one year), or as lump sum premium (that is, premiums determined for the entire period of time for which the insurance has been arranged).

On the occurrence of an insured event which results in the termination of the insurance, the insurer shall be entitled to the current premium until the end of the period of insurance during which the insured event occurred. In the case of a lump sum premium, the insurer shall be entitled to receive the premium for the entire period of time for which the insurance was arranged. This applies unless agreed otherwise by the parties to the insurance contract.

The insurer cannot change the premium amount without the consent of policyholder unless provided otherwise in the insurance contract. However, the insurer may not change the premium amount due to reasons other than the change of conditions decisive for determination of premium amount. In addition, the insurer may not change the premium amount due to age or health status.

4. Consequences of misrepresentation and/or non-disclosure

The policyholder and the insured are obliged to provide true and complete answers to all 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 the 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.

5. 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 a 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 obligations.

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.

6. Requirements regarding loss-adjusting proceedings

The insurer must finalise loss-adjustments within three months from the notification of an insured event. If the insurer is unable to finalise loss-adjusting proceedings within this period, the person notifying the insurer of the insured event shall be informed of the reasons why the adjustment proceedings cannot be finalized (in writing if the notifying person requests). In addition, the person claiming its right to insurance benefits may, in such a situation, request an adequate advance payment from the insurer. In case the insurer does not fulfil its obligations above, the insurer will be considered to be delaying under the contract and any provision of the insurance contract stating otherwise shall be disregarded.

7. Entitlement to raise a claim against an insurer

In general, it is the beneficiary (in practice usually the insured) who has the right to bring a claim resulting from an insurance contract directly against the insurer.

8. 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.

9. 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.

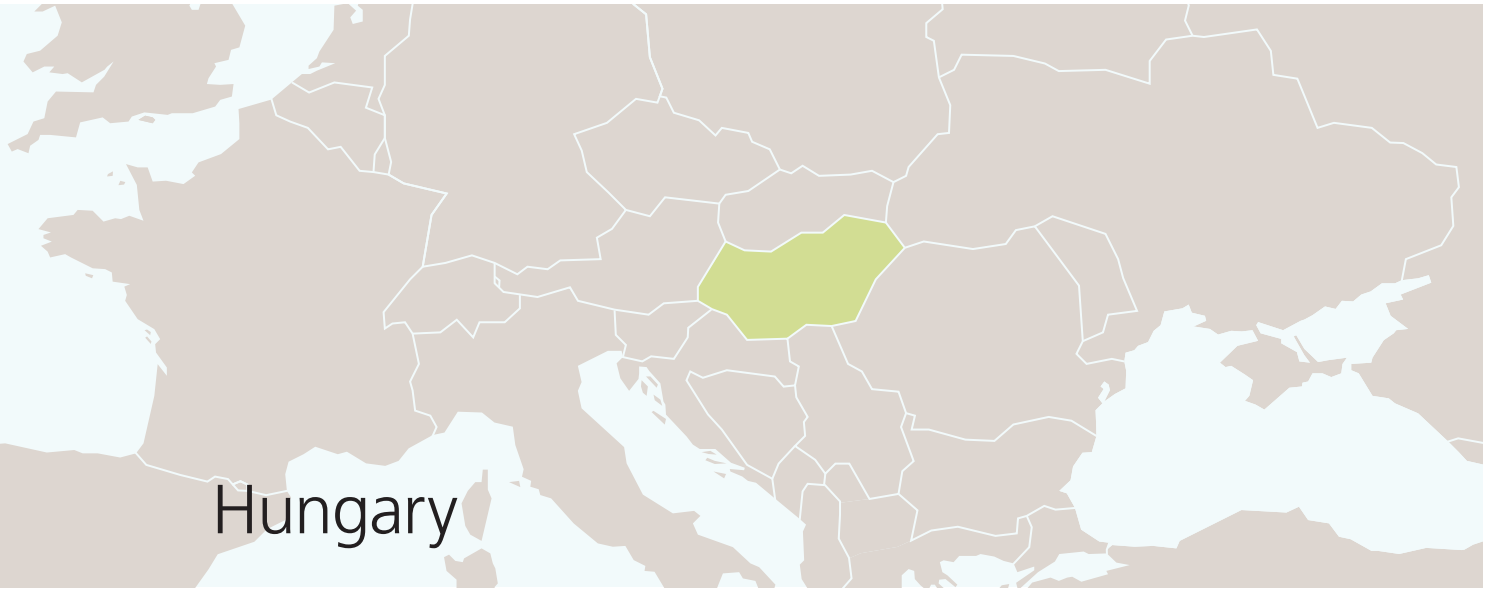
Claims-made coverage is not expressly envisaged by Czech insurance law. However, there are no particular difficulties regarding claims-made coverage. In practice, claims-made policies are a market standard, for example in respect of D&O insurance.

10. Reinsurance regulations

Reinsurance activities in the Czech Republic can be undertaken by

(i) a reinsurer with a Czech reinsurance licence granted by the Czech Insurance Market Regulator;
(ii) a reinsurer based in another EU or EEA member state who have established a branch in the Czech Republic;
(iii) a reinsurer based outside an EU or EEA member state who has established a branch in the Czech Republic and was granted a Czech reinsurance licence;
(iv) a reinsurer based in the EU or EEA member state who has undertaken insurance business in the Czech Republic on a temporary basis;
(v) an insurer with both a Czech insurance licence and reinsurance licence granted by the Czech Insurance Market Regulator;
(vi) an insurance company based in an EU or EEA member state which is entitled to undertake reinsurance business on the basis of its home country licence, and who has either established a branch in the Czech Republic, or has undertaken insurance business in the Czech Republic on a temporary basis;
(vii) an insurance company based outside an EU or EEA member state who has established a branch in the Czech Republic and was granted a Czech reinsurance licence.

The Czech National Bank can only grant a Czech reinsurance licence to a joint-stock company (or to a branch of an insurance or reinsurance company based outside the EU or EEA). The licence can be granted for the provision of life reinsurance, non-life reinsurance or both types of reinsurance together.



Hungary

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1. Introduction

In Hungary, insurance companies can only operate in the form of a private company limited by shares, a cooperative, an association or as a branch office of a third-country insurer, while reinsurance companies can operate in the form of a private company limited by shares, a cooperative or as a branch office of a third-country reinsurer. In any case, the operation of insurers and reinsurers requires prior authorisation from the Hungarian National Bank, being the competent financial services authority (HNB). The authorisation procedure has two phases for both prospective insurers and reinsurers. In the first phase, the company has to submit an application to the HNB for a foundation licence with supporting documentation. Once in possession of the foundation licence, in the second phase the insurer must submit a further application within 90 days for authorisation to undertake insurance operation. The administrative deadline for the HNB to make a decision in each phase is three months respectively; if necessary, the HNB can extend this deadline once with further three months in each phase.

In addition, EU member state insurers and reinsurers may provide their services through a branch or on a Freedom of Services basis. In both cases the EU member state insurer/reinsurer can pursue its insurance activity in Hungary primarily under the supervision of its home country regulator, but the HNB also exercises supervision over the activity (in particular from consumer protection point of view).

2. Defining insurable interest

According to the Hungarian Civil Code the only persons who can conclude insurance policies are

(i) those who have an interest in avoiding the occurrence of an insured event on the basis of any property or personal relationship (e.g. not only the owner but also the tenant of a real estate) or who have an interest in the occurrence of an insured event in respect of life insurance policies which comprises assurance on survival to a stipulated age, birth assurance or marriage assurance; or

(ii) those who conclude the insurance contract on behalf of an interested person. Any indemnity insurance policy (property or liability insurance) or any group fixed-sum insurance policy (life or accident insurance) concluded without an insurable interest can be deemed null and void. In the case of single fixed-sum insurance policies (life or accident insurances) as well as health insurance policies there is no requirement for an insurable interest; however, if the insurance policy was concluded without the consent of the insured then the designation of the beneficiary is deemed null and void.

3. Calculation of premiums

There are no specific legal rules concerning the calculation of premiums, but the amount of the premium as well as the method and occurrence of payment must be determined in the insurance policy or in the general terms & conditions.

There are certain rules relevant to the payment of the insurance premium. Most notably, in the case of non-payment of the premium, the insurer shall request the payment in writing by determining an additional deadline of 30 days. If no payment is made within this additional deadline, then the insurance policy will end with a retroactive effect by the original due date of the payment of the premium, except if the insurance company makes a claim for the insurance premium in court without delay. Therefore the insurer is to request the payment of the premium in order to keep the insurance contract in force.

If an insurance event occurs, and as a consequence the policy terminates, the insurers are entitled to demand the premium for the whole term (typically for the calendar year).

4. Consequences of misrepresentation and/or non-disclosure

When concluding an insurance policy the policyholder and the insured shall disclose any material information relevant from the perspective of undertaking the risk by the insurer, which the policyholder and the insured were aware of or had to be aware of (these are typically asked by the insurance company in the form of a questionnaire). The policyholder and the insured shall also report in writing if any material circumstance has changed during the period of the insurance policy. In the case of non-disclosure or misrepresentation or in the case of non-reporting of any material change, the insurance company may be released from its obligations, except if the policyholder or the insured proves that the insurer was aware of the non-disclosed or non-reported circumstance at the time of concluding the policy or those circumstances did not contribute to the occurrence of the insured event.

In respect of life insurance policies, the insurance company may not be released from its obligation even if the disclosure or change reporting obligation was breached, provided that five years have already passed since the conclusion of the insurance policy (in respect of the breach of disclosure obligation) or since the date when the change should have been reported (in respect of the breach of change reporting obligation).

5. Consequences of late notification

The insurer may reject the claim on the basis of late notification (without demonstrating prejudice) if

(i) the policy stipulated a deadline to notify claims and the policyholder or the insured fails to report to the insurance company the claim within such deadline, fails to provide the information necessary or fails to facilitate the verification of the information provided, and

(ii) as a consequence, any facts relevant to the assessment or defense of the claim become unascertainable. In this respect it does not matter whether the policyholder or the insured acted deliberately or negligently in failing to meet the notification requirements under the policy.

6. Requirements regarding loss-adjusting proceedings

Under Hungarian law, there is no compulsory deadline for loss-adjusting proceedings. However, according to market practice, the insurer is obliged to complete the loss adjustment within 15 days. This time period generally begins to run following the insurer's receipt of the full documentation justifying the claim.

7. Entitlement to raise a claim against an insurer

Under Hungarian law, only the insured or the policyholder is entitled to raise a claim against the insurer. As a consequence, a third party is not allowed to make a direct claim against the insurer even with reference to its contractual relationship with the insured or to non-contractual damage caused by the insured. Therefore, a third party may only enforce its claim directly against the insured party. The only exceptions are

(i) mandatory motor vehicle third party liability insurances where the injured third party (claimant) is entitled by law to raise a claim directly against the insurer; and

(ii) a third party's (claimant's) possibility to bring an action against the liability insurer of the insured for having a declaration that the liability insurance covered the damages occurred at the time when the damages were caused.

8. General rules concerning the limitation period for claims

The general limitation period in Hungary is five years. The law provides some specific cases where the limitation period may be shorter, or the parties to the contract themselves may agree a shorter or even a longer limitation period. Nevertheless, the exclusion of limitation by the parties' mutual agreement is not permitted.

Concerning insurance contracts, insurers usually shorten the five-year limitation period to a one or two year term. The limitation period starts on the date on which the relevant claim becomes due. In respect of claims for compensation the limitation period commences upon the occurrence of the damage/loss.

However, there are two main rules under which these limitation periods can be extended:

(i) if the claimant was not able to exercise his/her right within the determined limitation period due to circumstances outside his/her control, then the claimant has an additional one-year period to raise the claim; this additional period shall be calculated from the date when such circumstances ceased to hinder the claimant in exercising his/her rights;

(ii) some acts have the effect of interrupting the limitation period, for example if an action is brought for the enforcement of the claim and the court has adopted a final and binding decision in conclusion of the proceedings; following the interruption the limitation period restarts.

9. Policy triggers with respect to third party liability insurance

Indemnity policies (including PI and D&O polices) are mostly written on a mixed occurrence and claims-made basis. This means that the insured is entitled to indemnity under the policy, provided the loss occurred and the claim was made during the policy period, even if the judgment or settlement establishing liability takes place outside of that period. Furthermore, there are simple claims-made policies available on the Hungarian market.

Liability polices may contain a "deeming" provision which enables the insured to notify circumstances that are likely to give rise to a claim and to have insurers afford cover in relation to any later claim arising out of the circumstances within the policy period during which they were notified. It is also common practice for the insurer to provide a discovery period provision for an extra premium, which extends the reporting period up to a maximum of 72 months following the expiration of the policy.

10. Reinsurance regulations

The establishment, solvency margins and operation of reinsurance companies are regulated by the Reinsurance Act. Reinsurance contracts are not regulated by the Hungarian Civil Code specifically, therefore their content is up to the parties' agreement in accordance with general legal rules and reinsurance practices.

Montenegro

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1. Introduction

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 organized 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 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 for supervision over insurance companies, including issuance of licenses for insurance and reinsurance activities.

2. Defining insurable interest

With respect to property insurance, the Montenegrin Law on Contracts and Torts provides that any person who would suffer material loss due to the occurrence of an insured event may conclude a property insurance contract. Claims under a property insurance policy may be raised only by a person who, at the moment of loss which resulted in a claim, had material interest that the insured event does not occur.

With respect to personal insurance (life, health, accident etc.), insurable interest is not defined.

3. Calculation of premiums

There are no specific legal rules regarding the calculation of premiums.

In case of non-payment of the premium, an insurance contract is de jure terminated one year following the due date for the payment of the premium without any warning or notice by the insurer. This deadline is not applicable in case of life insurance. The insurance contract is also terminated due to non-payment of the premium if the policyholder fails to pay the due premium 30 days following the day it has received a notice by the insurer.

4. Consequences 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 former 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.

5. Consequences of late notification

A policyholder is obliged to notify the insurer of the occurrence of an insured event within rhree days of the date the policyholder becomes aware of the occurrence of an insured event (life insurance policy holder is exempted from this deadline). If the policyholder fails to notify the insurer of the occurrence within the above period, it is obliged to compensate the insurer for the loss the insurer sustained due to the late notification. However, the insurer may not refuse to provide indemnity under the insurance policy.

6. Requirements regarding loss-adjusting proceedings

There is no compulsory deadline for completion of loss-adjusting proceedings. The insurer is obliged to indemnify the insured within the period stipulated in the contract, which is a period not exceeding 14 days, counting from the day the insurer receives notification on 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 on 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 an advance. If the insurer breaches all legal deadlines, it owes to the policy holder default interest on the amount of proceedings from the day of notification about insured event and the damage compensation for damages suffered by the policy holder due to late payment.

7. Entitlement to raise 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.

8. 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 it was not aware of the occurrence of the insured event, the relevant time starts running from the day it becomes aware of the occurrence. Absolute time limitation is set to ten 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.

9. 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.

10. Reinsurance regulations

An insurance company which is licensed for reinsurance activity cannot undertake other insurance activities. Montenegrin civil law does not regulate reinsurance contracts, while the application of legal provisions regarding insurance contracts is excluded. This means that the content of a reinsurance contract is determined by the parties.

Poland

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1. Introduction

Insurance activity in Poland is undertaken by establishing a local joint-stock company or mutual insurance company and obtaining a permit from the Polish Financial Supervision Authority (PFSA). Although there are certain advantages to establishing a local insurance company (it is perceived by the market as demonstrating a commitment to Poland) it is an expensive course of action. The legal and actuarial fees are relatively high and there is a minimum capital requirement. It is also necessary to go through a lengthy and cumbersome licencing 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. Such insurers may start operating in Poland after the PFSA has received a notification from the relevant home country supervising authority.

In terms of many 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. The branch is regulated by the parent company's home country regulator.

Foreign insurers from EU and EEA countries that conduct activity in Poland on a Freedom of Services basis are also regulated by their home country supervisory body. The local Polish regulator can enforce general "best practice" rules, which are designed to protect insureds. This method of conducting insurance activity in Poland is the cheapest.

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 to the procedure of establishing a branch of a foreign insurer from an EU or EEA country.

2. Defining insurable interest

For personal insurance (life and accident), insurable interest includes life, health, ability to work, etc. In respect of property insurance, an insurable interest is an interest in property that does not conflict with the law and has a monetary value. Insurable interest is a very broad term.

3. Calculation of premiums

Premiums are determined on the basis of an assessment of insurable risk and are calculated for the whole policy period. Amounts of premiums may not be differentiated on the basis of criterion of sex or due to maternity or pregnancy. If an insurance contract ends before the lapse of the policy period (for example, if one party terminates

the contract), the policyholder is entitled to reimbursement of the portion of the premium corresponding to the unused policy period.

4. Consequences 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 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.

5. 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.

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to complete loss-adjustment proceedings and make a payment or give notice of refusal to pay 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 reason, 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 part of the indemnity should be paid out within the original deadline, i.e. within 30 days of receiving the notification of the insured event.

7. Entitlement to raise 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).

8. 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.

9. 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.

10. Reinsurance regulations

There are no specific regulations regarding reinsurance contracts under Polish law. The regulations on insurance contracts do not apply to reinsurance contracts, which are governed by the general rules of Polish contract law. Regulations on the establishment and operation of reinsurance entities in Poland are set out in the Act on Insurance Activity.

Romania

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1. Introduction

Undertaking insurance business in Romania involves incorporating a Romanian local insurer as a joint-stock company, unless insurance business is provided by one of the following alternatives:

(i) based on freedom of establishment or freedom to provide services;
(ii) through branches of entities from third states; or
(iii) through societas europea.

The first step to incorporate an insurer as a joint-stock company is to obtain initial incorporation approval from the local regulator, the Financial Supervisory Authority (the "**FSA**"). Without such approval, the insurer cannot be registered in the Trade Registry. This may take several months and usually involves legal assistance and legal representation of the insurer before the regulator.

Incorporation procedures at the Trade Registry may take several days, and there is a minimum capital requirement for incorporation. After incorporation, the insurer needs to obtain an insurance activity authorisation from the FSA. Obtaining the authorisation is usually a time-consuming process which may take several months. This procedure also incurs certain costs such as regulatory taxes and legal fees for representing the insurers before the FSA.

Since Romania joined the EU, another way of doing insurance business in Romania is to create and register a local branch of an EU or EEA based insurer. The branch can undertake insurance activity based on the freedom of establishment principle and is supervised by the regulator of the country of origin of the insurer's parent company. The FSA must be notified about the establishment of the branch to ensure compliance with Romanian insurance legislation.

An EU or 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.

Insurance activity through a branch, based on freedom of establishment and/or direct insurance activity on a freedom of services basis within the EU involves lower costs in terms of money, human resources and time required to obtain approvals/incorporation compared to insurance business run through a Romanian subsidiary. The relationship with the FSA is also less demanding where no Romanian subsidiary is set up.

The insurance/reinsurance premiums and the commissioning fees related to premium payments are exempted from taxation. Insurance /reinsurance premiums are tax deductible.

2. Defining insurable interest

Although there is no specific legal definition of an insurable interest in Romanian legislation, the law refers to the "insurable risk" as the compulsory content of the insurance policy.

3. Calculation of premiums

Premiums are generally calculated on an actuarial basis. If the premium is not duly paid, the insurer can claim termination of the contract, unless the parties have agreed otherwise. Motor vehicle third party liability insurance (MTPL) premium tariffs as settled by insurers must be notified to the FSA before they are applied. The insurers cannot apply different MTPL tariffs than the officially notified ones.

4. Consequences of misrepresentation and/or non-disclosure

In case of misrepresentation and/or non-disclosure, the consequences depend on whether the declarer (i.e. the insured or the contractor) acted in bad faith or not.

If bad faith is established and the misrepresentation or non-disclosure relates to circumstances that influenced the insurer's decision to write the insurance or relates to the terms and conditions of agreeing to contract, the insurer has the right to avoid the contract, cease risk coverage, keep the premiums that were paid and claim the premiums that are due until the moment the mis-representation or the non-disclosure was discovered.

If the party in default has not acted in bad-faith, and the insured risk has not yet occurred, the insurer must maintain the contract but is entitled to ask for a premium adjustment or choose to terminate the contract unilaterally after ten days from notifying the insured while returning the premiums for the period for which coverage will no further apply. In case the insured risk has occurred and the discovery of the misrepresentation/non-disclosure occurs after the insured event, the indemnification to which the insured is entitled shall be reduced by the proportion between the paid premiums and the premiums that should have been paid in case of a full and correct disclosure.

5. Consequences of late notification

Late notification may lead to the insurer's refusal of indemnification, when such notification effectively removes any reasonable possibility for the insurer to establish the cause of the insured event or the extent of the loss, or leads to an increase in the loss resulting from the insured event.

6. Requirements regarding loss-adjusting proceedings

Generally, the law provides no requirements for loss adjustment, stating only that the losses shall be paid in accordance with the provisions of the insurance contract as settled between the parties. However, in the case of MTPL insurance, as a general rule, loss evaluation must be concluded by either

(i) an indemnification offer issued to the insured or
(ii) a notification of indemnity refusal (which must be justified), within three months from the date of notifying the loss to the insurer.

7. Entitlement to raise a claim against an insurer

Generally, the insured (or beneficiaries) is/are entitled to raise claims based on the insurance contract against the insurer. For third party liability insurance, the third party that suffered the damage covered by such a policy can file a direct claim against the third party liability insurer within the limits and according to the terms of the policy and the law.

8. General rules concerning the limitation period for claims

The Statutes of Limitation applicable under law to insurance/reinsurance contract claims in particular, provide a limitation of two years starting from the dates when payment of premium/indemnification became due according to the insurance contract. However, in theory, MTPL claims by the aggrieved party (who is technically not a party to the MTPL insurance contract) is subject to the general three year limitation.

9. Policy triggers with respect to third party liability insurance

In principle, the law does not contain provisions related to policy triggers in the particular case of third party liability insurance. In practice, the only known exception would be the MTPL policies, which are usually deemed as being triggered according to the "loss occurrence" rule. All other third party liability insurance is usually governed according to the terms and conditions established by the parties within the insurance contract.

10. Reinsurance regulations

Reinsurance contracts are not expressly regulated by insurance regulatory norms. This means that such contracts are subject to the general rules and provisions of Romanian civil or commercial law, and/or international commercial law, as applicable. A Romanian company authorised to undertake insurance activity can also undertake reinsurance business. Companies incorporated in Romania that aim to undertake reinsurance activity only need to obtain a distinct regulatory authorisation.

Russia

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1. Introduction

Russian insurance law is in the transition stage. In accordance with the Protocol of the Accession of the Russian Federation to the World Trade Organisation (WTO), within nine years from 22 August 2012 Russia has to ease most of the restrictions applicable to foreign investors into the insurance sector. Currently, there are no limitations on cross-border supply of insurance of risks connected with international passenger transportation and liability arising therefrom, international transportation of goods, international commercial air transportation and liability arising therefrom as well as liability within the international green card system. Within four years of Russia's accession to the WTO, there should be no limitation on insuring risks associated with domestic commercial air and maritime transportation, including insurance of goods being transported, the vehicle transporting the goods and any liability arising therefrom, except insurance of the air carrier's liability and life and health insurance of the aircraft crew.

Russian insurance law restricts foreign penetration into the Russian insurance market by setting a market quota. The market quota is calculated referring to the aggregate charter capital of all insurance companies. The law states that if a share of "foreign capital" in the aggregate charter capital of all Russian insurance entities exceeds 50%, the regulator stops licensing insurance companies controlled by non-Russian entities. As of 1 January 2014, this quota amounts to 15.88%. Russian insurance law states that a preliminary consent from the regulator must be obtained for a foreign investor to contribute to the charter capital of a Russian insurance company. This consent may only be denied if that contribution results in the quota being exceeded.

Russian insurance law also imposes the following restrictions:

- until August 2017 foreign-owned companies may not be involved in life insurance, state funded and compulsory motor liability insurance
- shares in the charter capital of an insurance company should be paid for only in Russian Roubles
- foreign investors should have at least five years of experience on their domestic market.

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

2. Defining insurable interest

The Russian Civil Code states that a contract of property insurance may only be made subject to a policyholder or a beneficiary having an interest in preserving the property being insured. A contract of insurance made in breach of this requirement is null and void.

It is prohibited to insure illegal interests and losses resulting from participation in games, lotteries and wagers. It is also prohibited to insure expenses that a person might incur in order to free hostages.

3. Calculation of premiums

The amount of the premium and the term for its payment are established by the insurance contract. While calculating the insurance premium an insurer must apply economically justified insurance rates developed by him taking into consideration the object of the insurance, the nature of insurance risk and the loss statistics for three previous years in case of non-life insurance and five years in case of life insurance. The rates are subject to regulatory approval in the case of an initial application for an insurance licence and must be published by the insurers on their websites. For compulsory types of insurance (e.g. mandatory motor vehicle third party liability insurance (MTPL), mandatory liability insurance of owners of hazardous facilities) the insurance rates are regulated by the government.

If the insurance contract provides for payment of the insurance premium in instalments, the contract may specify the consequences of failing to pay the periodic insurance premium instalments within the stipulated time limit. For example, it is possible to provide that in such case the contract is terminated.

If the insured event occurs prior to payment of the periodic insurance premium instalment, and this amount is overdue, the insurer shall have the right to offset the overdue amount against the indemnity payment.

4. Consequences of misrepresentation and/or non-disclosure

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

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

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

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

Russian law does not stipulate that loss adjusting proceedings must be completed within a certain period of time (except for MTPL and mandatory liability insurance of owners of hazardous facilities). However, the insurers have to publish on their websites terms and conditions of insurance including exhaustive lists of documents required for loss adjusting and timeframe for taking coverage decisions.

7. Entitlement to raise a claim against an insurer

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

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

8. General rules concerning the limitation period for claims

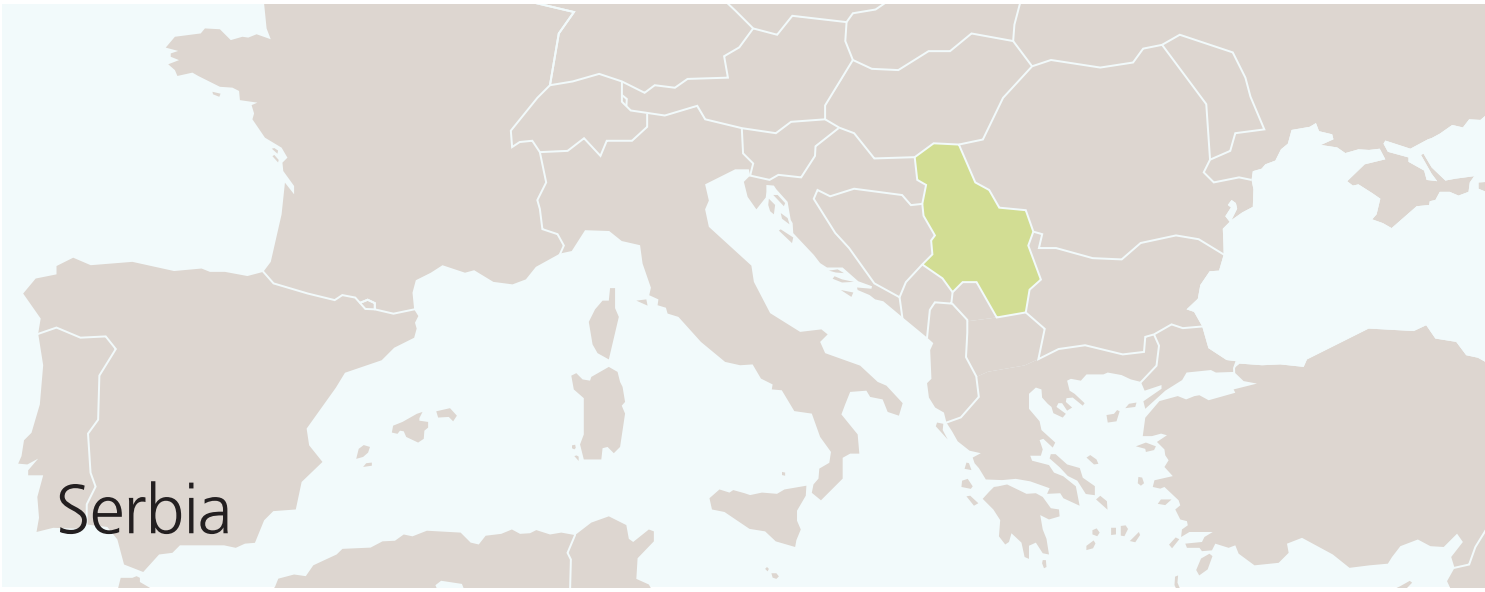
The limitation period for claims arising from a property insurance contract is two years. The limitation period for claims arising from third party liability insurance is three years. The limitation period starts at the date when the insurer declines cover.

9. Policy triggers with respect to third party liability insurance

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

10. Reinsurance regulations

There are limited specific regulations regarding reinsurance in Russia. Reinsurance is regarded by default as an insurer's insurance and the law distinguishes four types of reinsurance contracts (facultative, treaty, facultative-treaty and treaty-facultative reinsurance policies) and two kinds of reinsurance (proportional and non-proportional). Unless the contract of reinsurance provides otherwise, general rules applicable to insurance contracts apply to reinsurance. Reinsurance of the risk of survival under life insurance policies and risks under MTPL policies is prohibited at all. Foreign reinsurers can reinsure directly, with certain limitations in respect of ratings, and Russian reinsurance companies must maintain the statutory minimum charter capital, which is twice the statutory minimum charter capital of general insurance companies.



Serbia

Contact

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1. Introduction

Under currently applicable legislation, there is only one way to undertake insurance activity in Serbia and that is to establish a local insurance company. A local insurance company must be organized 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 it has been licensed for by the regulator. The same insurance company cannot undertake life insurance and non-life insurance activities.

Foreign entities may be shareholders of a domestic insurance company provided that reciprocity with the country of their origin exists. The current legislation contains provisions which will enable foreign insurance companies to undertake insurance activities in Serbia through their registered branches five years after Serbia joins the WTO.

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

2. Defining insurable interest

With respect to property insurance, the Serbian Law on Contracts and Torts provides that any person who would suffer material loss due to the occurrence of an insured event may conclude a property insurance contract.

Claims under a property insurance policy may be raised only by a person who, at the moment of loss which resulted in a claim, had material interest that the insured event does not occur.

With respect to personal insurance (life, health, accident etc.), insurable interest is not defined.

3. Calculation of premiums

There are no specific legal rules regarding the calculation of premiums.

In case of non-payment of the premium, an insurance contract is de jure terminated one year following the due date for the payment of the premium without any warning or notice by the insurer. The insurance contract is also terminated due to non-payment of the premium if the policyholder fails to pay the due premium 30 days following the day it has received a notice by the insurer.

4. Consequences 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 former 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.

5. 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, it is obliged to compensate the insurer for the loss the insurer sustained due to the late notification. However, the insurer may not refuse to provide indemnity under the insurance policy.

6. Requirements regarding loss-adjusting proceedings

There is no compulsory deadline for completion of loss-adjusting proceedings. The insurer is obliged to indemnify the insured within the period stipulated in the contract, which is a period not exceeding 14 days, counting from the day the insurer receives notification on 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 on 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 an advance.

7. Entitlement to raise 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.

8. 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 it was not aware of the occurrence of the insured event, the relevant time starts running from the day it becomes aware of the occurrence. Absolute time limitation is set to ten 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.

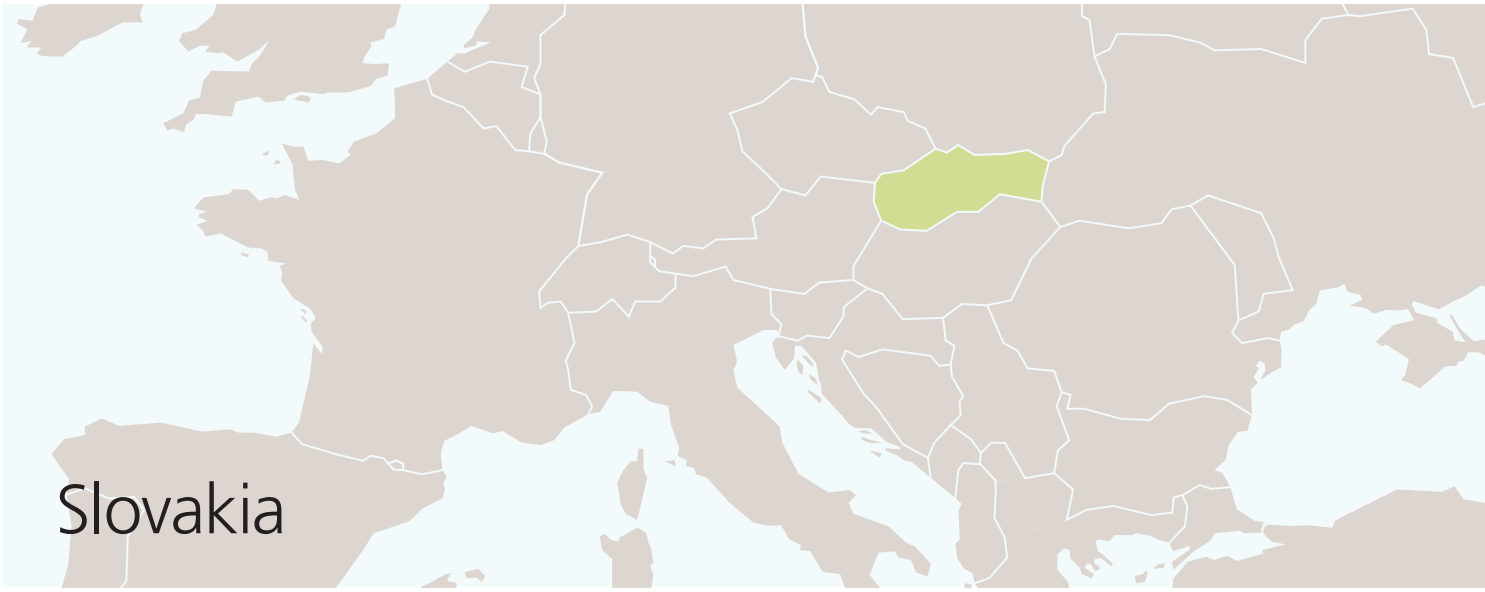
A direct claim of a third party which sustained loss towards the insurer in third party liability insurance is subject to the same statute of limitation rules governing third-party claims against the insured.

9. 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.

10. Reinsurance regulations

An insurance company which is licensed for reinsurance activity cannot undertake other insurance activities. Serbian civil law does not regulate reinsurance contracts, while the application of legal provisions regarding insurance contracts is excluded. This means that the content of a reinsurance contract is determined by the parties. The insurance regulations were amended in 2013 so that the insurance companies may directly reinsure abroad against risk arising from natural disasters, floods, etc, which wasn't the case before when they had first to reinsure with domestic reinsurance companies.



Slovakia

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1. Introduction

The basic way of undertaking insurance activity in Slovakia is 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 insurers which provide life insurance (these insurers may obtain a special certificate that allows them to offer accident and illness insurance as well). Although there are certain advantages in establishing a local insurance company (it is perceived by the market as demonstrating a commitment to Slovakia and 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. Such 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 organizational structure. The branch is regulated by the parent company's domestic regulator. With effect from 1 January 2009 the branch of a foreign insurer based in the EU must always include the phrase "pobočka poisťovne z iného členského štátu" ("**branch of the insurer from another EU member state**") as part of its business name, in the place of its seat and in written communication.

Foreign insurers conducting business in Slovakia on a Freedom of Services basis are also regulated by the home country supervisory body, while the local Slovak regulatory body can enforce general "best practice" rules, which are designed to protect the insured. This method of conducting insurance activity in Slovakia is the cheapest; however it is not perceived by the market as a permanent presence in Slovakia.

Foreign insurers from other states may only undertake insurance activity in Slovakia through a "main branch" authorized by the National Bank of Slovakia.

2. Defining insurable interest

Insurance can cover any intwerest that is not in conflict with the law or in conflict with moral and social principles and can be given a monetary value.

3. Calculation of premiums

The premium is determined on the basis of assessment of the insurable risk. The premium is calculated for the whole policy period. Depending on the contract, the premium is payable in instalments or in a lump sum. Where an insurance contract expires before the lapse of the policy period (for example if the party to the insurance contract terminates the contract), the policyholder is entitled to reimbursement of the portion of the premium corresponding to the unused policy period. The only instance where this does not apply is where the limit of indemnity has been exhausted.

4. Consequences of misrepresentation and/or non-disclosure

Before the execution of an insurance contract, the policy-holder 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 nondisclosure of material circumstances or other relevant conditions may entitle the insurer to reduce the indemnity for the loss suffered where there is a causal connection between the undisclosed circumstances and such a loss.

In the event of an intentional violation of disclosure obligations, providing untrue information, or concealing important facts, 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 awareness of the material non-disclosure. If the insurer fails to rescind by this point, the right to do so will expire.

5. Consequences of late notification

Under the insurance contract or general insurance terms and conditions, the policyholder and the insured (where different) may be obliged to notify the insurer about the insured event within a specified time limit. The insurer is allowed to reduce indemnity in cases of intentional or grossly negligent failure to notify an insured event as required, as long as the failure either increased the loss or made it impossible for the insurer to establish the circumstances of the event's occurrence and its consequences, and the insurer did not receive a notification of the circumstances within the time limit via other sources.

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to complete the loss-adjusting proceedings without delay, and if unable to complete within 30 days after receiving notification regarding the insured event, the insurer is obliged to provide the insured with an adequate advance payment on request. If it is not possible to complete the loss adjusting proceedings within 30 days, due to the complex nature of the claim or for any other reason, the insurer is obliged to inform the claimant. The indemnity must be paid within 15 days after completion of the loss adjusting proceedings.

7. Entitlement to raise a claim against an insurer

In general, only the insured has a right to raise a claim directly against the insurer. However, with respect to third party liability insurance, if it is stipulated by 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 step into the position of the insured under the insurance contract and to raise a claim directly against the insurer.

8. General rules concerning the limitation period for claims

There are two separate statutes of limitation. The first one pertains to the insured's claims against the insurer. These claims are time-barred three years from the date on which they became enforceable. In the case of rights to benefit from insurance the limitation period starts one year after the 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 governing the statute of limitation of the third party's claim against the insured. 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 either three years after the date on which the claim became enforceable (in the case of the right to benefit from insurance, the limitation period starts one year after the occurrence of insured event).

9. 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.

10. Reinsurance regulations

There are no specific regulations regarding reinsurance under Slovak law. The establishment of a reinsurance company and reinsurance activities are governed by the provisions of the same legal act as the one governing insurance activities in general. According to this act, reinsurance activity is defined as taking over of insurance risks by the reinsurance company, evaluation of risks and their management, administration of reinsurance contracts, creation of technical reserves, maintaining the requested rate of solvency and administration of technical reserves, the provision of benefits under reinsurance contracts and providing consultancy services in the area of insurance. Like insurance companies from EU member states, reinsurance companies from EU member states may undertake reinsurance activity in Slovakia either via a branch or directly on the Freedom of Services basis (obviously in both cases the reinsurance company has to possess a valid permit for providing reinsurance activity granted in its home country).

Slovenia

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1. Introduction

In the Republic of Slovenia The Insurance Act (Zakon o zavarovalništvu, Official Gazette of the Republic of Slovenia No. 13/2000 et al, hereinafter referred to as: "**the ZZavar**") determines a legal frame to conduct insurance business. Further the Code of obligations (Obligacijski zakonik, Official Gazette of Republic of Slovenia No. 83/2001 et al, hereinafter referred to as: "**the OZ**") regulates the insurance contract, however its provisions do not apply to

(i) marine insurance or other types of insurance to which the rules on marine insurance apply,
(ii) insurance of claims and
(iii) relations deriving from reinsurance in accordance with Art. 923 of the OZ.

Insurance company is a legal entity set up in the form of a joint-stock company, societas europea or mutual insurance company. An insurance company/undertaking shall be a legal entity with its seat in the territory of the Republic of Slovenia that has been granted an authorization to perform insurance business by the Insurance Supervision Agency (Art. 1 of the ZZavar).

Insurance business may only be performed by

(i) an insurance company with its seat in the Republic of Slovenia which obtained an authorization of the Insurance Supervision Agency (Agencija za zavarovalni nadzor, hereinafter referred to as: "**the AZN**") to carry out the insurance business,
(ii) a branch of a foreign insurance company which obtained an authorization of the AZN to carry out the insurance business and
(iii) a Member State insurance company which pursuant to the ZZavar has either established a branch or is authorized to directly carry out the insurance business in the territory of the Republic of Slovenia. However entities shall only be permitted to carry out insurance business within those classes of insurance for which they were granted an authorization by the competent authority. Art. 3 ZZavar

According to the oral information of AZN

(i) the process of obtaining of an authorization to carry out the insurance business by an insurance company with its seat in the Republic of Slovenia may take up to three months and
(ii) its authorization to establish a branch of a foreign insurance company is granted usually within one month from receipt of a complete application. Further a branch of a foreign insurance company is also required to dispose with sufficient equity.

A branch of a Member State insurance company may start to perform the insurance business in the Republic of Slovenia upon expiry of two months period after the AZN received notification from the competent supervisory authority. Further the Member State insurance company may start to directly perform insurance business upon receiving the notification of its competent supervisory authority that it has submitted the required documentation to the AZN.

2. Defining insurable interest

ZZavar classifies insurances with respect to the main risk they cover. ZZavar nor OZ define the insurable interests. Therefore the risk is insurable, unless it is explicitly excluded by law or with an insurance contract. Pursuant to Art. 973-977 of the OZ the following cases are not insurable: insurance against death of a third person who has not yet attained 14 years and insurance of a person whose capacity to contract was fully deprived. Further, an insurer is not obliged to pay the insurance benefit, if the policyholder, insured person or beneficiary deliberately caused insurance case. OZ limits insurer's obligation in the following cases:

(i) when a suicide is committed in the first insurance year,
(ii) when the beneficiary murders the policyholder or an insured person,
(iii) when the damage arises as consequence of a military operation
(iv) when the policyholder or insured person caused the insurance case intentionally.

3. Calculation of premiums

The insurance contract shall determine the fixing and payment conditions of premiums as well as legal consequences, if a premium is not paid as agreed. Insurer may in the process of risk selection and assessment as well as determination of premiums and payment of insurance benefit apply the insurance industry criteria and consider only the following personal circumstances or characteristics of the insured person: age, medical condition, disability, occupation and other personal circumstances which may justifiably influence the level of the assumed risk, excluding gender, maternity and pregnancy. Art. 83 ZZavar

If stipulated that the premium shall be paid upon the conclusion of a contract the insurance coverage commences on the day following the day the premium was paid. If stipulated that the premium shall be paid after the conclusion of a contract the insurance coverage commences on the day which is stipulated as the day the insurance begins. Art. 937 OZ

If insurance premium falling due after the conclusion of a contract is not paid within 30 days from a registered letter being delivered to the policyholder, the insurance coverage ceases. Upon expiration of aforementioned term, an insurer can terminate the insurance contract without notice period. Art. 937/III OZ

If a policyholder pays the premium within one year from falling due, the insurance coverage is restored starting from the following day after premium and penalty interest were paid. Art. 937/V OZ

An insurer does not have a right to file a claim for the payment of a due premium regarding the life insurance in accordance with Art. 969 of the OZ. If due premium is not paid within the additional period determined in the registered letter, which shall not be shorter than one month, an insurer can declare

(i) that it is reducing the insurance sum to the redeemable value of the insurance, if at least three annual premiums have been paid, or
(ii) that it is withdrawing from the contract, if not even three annual premiums have been paid yet.

4. Consequences of misrepresentation and/or non-disclosure

When concluding the insurance contract the policyholder is obliged to inform an insurer of all the circumstances significant for the risk assessment of which he knows or could not have remained unknown to him.

When policyholder deliberately makes a false declaration or conceals a circumstance of such nature that the insurer would not have concluded insurance contract if it had known true state of affairs, an insurer may demand annulment of the insurer contract. In such case an insurer has the right to demand the payment of the premium for the insurance period in which the annulment of the contract was demanded. Insurer's right to terminate the insurance contract ceases in three months after an insurer learns of the false declaration or concealment. Art. 932 OZ

In case that a false declaration or omission of the notification were not committed deliberately, an insurer may within one month of learning of the falsehood or incompleteness of information either withdraw from the insurance contract or propose the premium increase in proportion to the greater risk. The insurance contract terminates in 14 days after an insurer notified the policyholder of withdrawal or if the policyholder does not accept the proposed premium increase within 14 days from the notification receipt. In such case an insurer must return the part of the premium pertaining to the time remaining to the end of the insurance period. Art. 933 OZ

The policyholder is

(i) with respect to the property insurance obliged to notify an insurer of every change of circumstances which might be significant for the risk assessment and
(ii) with respect to the personal insurance obliged to notify an insurer only if the risk increased due to the change of policyholder's work. He must immediately notify an insurer of the greater risk if the risk has increased due to his action or in the case the risk occurred without his involvement within 14 days of learning of it.

An insurer may within 30 days after learning of the risk increase, either

(i) withdraw from the insurance contract, if the risk increase was such that he would not have concluded insurance contract in the first place or

(ii) propose the premium increase, if knowing such circumstances he would have concluded the insurance contract only subject to higher premium. The insurance contract terminates, if the policyholder does not accept the proposed premium increase within 14 days. Art. 938 OZ.

If insurance case arises before the insurer was notified of the risk increase or after he was notified but before he withdrew from the insurance contract or before an increase in the premium was agreed, the insurance benefit shall be reduced proportionally. Art. 939 OZ

5. Consequences of late notification

According to Art. 941 of the OZ, with exception of health and life insurance, a policyholder shall notify an insurer of insurance case at latest within 3 days after learning of it, unless otherwise stipulated in the general conditions. In case of late notification a policyholder is obliged to reimburse an insurer for any caused damages.

Contractual provisions which deprive insured person of his right to compensation or insurance sum, if he fails to fulfill any of his obligations after the occurrence of insurance case are null. Art. 942 OZ

6. Requirements regarding loss-adjusting proceedings

An insurer is obliged to complete the loss-adjusting process within the agreed period, which shall not exceed 14 days from the receipt of the notification of occurrence of an insurance case. If certain time is necessary to determine the existence of insurer's obligation or of its amount, the term begins on the day when the existence and amount of insurer's obligation have been determined. However, if a policyholder, an insured person or beneficiary cause an insurance case intentionally or with fraud an insurer is not obliged to make any payment. Art. 943 and 944 OZ

7. Entitlement to raise a claim against the insure

Generally, the insured person and the beneficiary in the case of the insurance against death have the right to raise a claim against an insurer resulting from an insurance contract. However, in the 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. Art. 965 OZ

8. General rules concerning the limitation period for claims

Limitation period for claims expires in three years counted from the first day following the calendar year in which the claim originated, except for limitation period for claims arising from life insurance which expire in five years. If the insured person did not know that the insurance case occurred, the limitation period begins with the day the insured person became aware of it. However, in any case the limitation period expires in five years, except for limitation period regarding the life insurance which expires in ten years. Art. 357 OZ

Insurer's claim arising from the insurance contract expires in three years. Art. 357/III

If in a third party liability insurance an injured person claims and obtains compensation from an insured person, the limitation period of three years shall run from the day the injured person filed a claim against the insured person or when the insured person reimbursed the damages. Art. 357/IV OZ

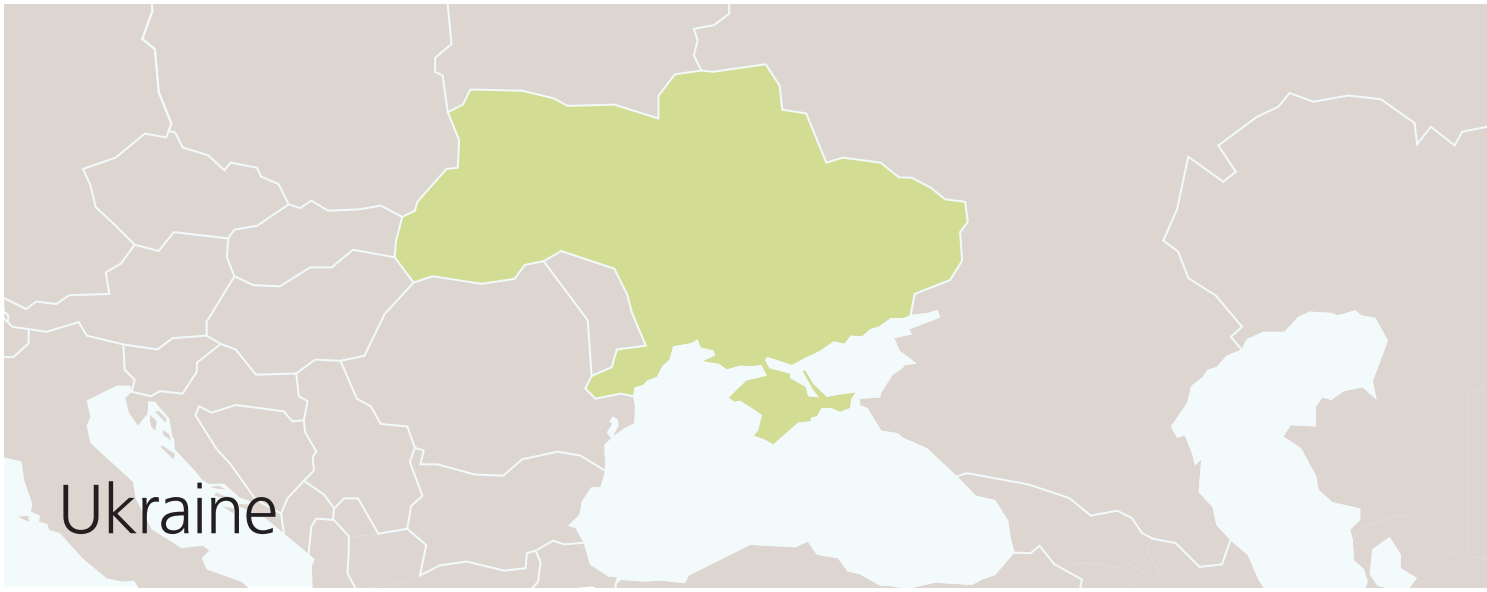
Limitation period for a direct claim for damage of an injured party against an insurer expires in three years after the injured party became aware of the damage and of the responsible person. In any case the claim expires in five years after the damage occurred. Art. 357/V OZ If the damage was caused by a criminal offence for whose prosecution a longer limitation period applies, such longer limitation period shall apply also to damage claims. Art. 353 OZ

9. Policy triggers with respect to third party liability insurance

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

10. Reinsurance regulations

Reinsurance is not precisely regulated in the ZZavar. Pursuant to ZZavar a reinsurer can only be organized in the form of a joint stock company or as a societas europea. Reinsurance falls under the insurance business, therefore the same conditions apply as for the conducting of insurance business (please see under Insurance activity). However a reinsurer may perform reinsurance business in all insurance classes.Slovenian law does not regulate reinsurance contracts, except for provisions of the Maritime Law (Pomorski zakonik, Official Gazette of Republic of Slovenia Nr. 26/2001 et al) regulating the maritime reinsurance contract and the Obligations and Real Rights in Air Navigation Act (Zakon o obligacijskih in stvarnopravnih razmerjih v letalstvu, Official Gazette of Republic of Slovenia Nr. 12/2000 et al) regulating the aviation reinsurance.



Ukraine

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1. Introduction

An insurer has three main options for starting its full scope insurance operations in Ukraine. Those options would be:
(i) to establish a "greenfield" company;
(ii) to acquire an existing Ukrainian insurer, or
(iii) open a branch of the parent insurance company in Ukraine.

A limited scope of insurance services, subject to certain restrictions and requirements, may be directly (without establishing a legal entity or registering a permanent establishment) provided by foreign insurers in Ukraine. According to Ukrainian insurance law (the "**Insurance Law**") foreign insurers are allowed to conduct the following direct and intermediate insurance activities (such as brokerage or agency operations) in the Ukrainian market:

— insurance of the risks related to marine transportation, commercial aviation, launches of space craft (including satellites), and freight, if the object of insurance is a property interest in the goods to be transported and/or in the transport vehicle, and/or a liability arising out of such transportation of goods;
— re-insurance (including insurance mediation); and
— ancillary insurance services, such as advisory services, actuarial risk assessment and claims settlement.

A foreign insurer (i.e. a financial institution established outside the jurisdiction of Ukraine and permitted under the laws of its home state to conduct insurance activities) carrying out insurance activities within the above scope in Ukraine shall be subject to the following requirements (the "**General Requirements**"):

— the home state of the foreign insurer must be a member state of the World Trade Organisation that does also take part in the international co-operation in the field of the prevention and counteraction of the legalisation (laundering) of profits and the financing of terrorist activities, and cooperates with the Financial Action Task Force (FATF). The exception is made for non-resident re-insurers, which can be based in non-WTO countries, being however FATF members;
— a memorandum on information exchange has been signed (or a respective agreement has been concluded) between the authorised insurance regulator of the home country of the foreign insurer, and the National Commission that Regulates Financial Services Markets (the "Commission"). Unfortunately only a few such memorandums, in particular with Armenia, Poland, Latvia and Lithuania (as reported by the Commission on 29 November 2013) have been signed so far by the Commission and Ukraine is also not a member of the International Association of Insurance Supervisors. The Commission expects to sign memorandums with Moldova, Turkey, Macedonia, Belarus, Israel, Australia, Czech Republic and Hungary in the nearest future;
— the insurance business of the foreign insurer is supervised by the state authorities in accordance with the legislation of the home country of the foreign insurer;
— an international treaty on the prevention of tax evasion and the prevention of double taxation has been concluded between Ukraine and the home country of the foreign insurer;

— the foreign insurer is located in a country or in a specific territory that does not have an off-shore status in accordance with the Ukrainian law; and
— the financial reliability (stability) rating of the foreign insurer is compliant with the requirements set forth by the Commission.

In Ukraine, an insurance company may be established in the form of a joint-stock company, a full partnership, or an additional liability company. The majority of Ukrainian companies were established as joint-stock companies, though registration of a full partnership or an additional liability company is much more simple and swift.

There are certain specific requirements regarding the composition of shareholders (at least three), structure of the charter capital (100% in cash or 25% max in state bonds) and minimum amount of the charter capital of the Ukrainian insurance company (EUR 1m in UAH equivalent is set for non-life insurers).

The minimum amount of the charter capital for life insurers is EUR 10m (in UAH equivalent). It was substantially increased from EUR 1.5m in May 2013. The change is mostly relevant for life insurance companies licensed after May 2013, while the already existing life insurers were not required to make any revisions to their charter capitals. However, in certain cases requiring insurers to re-apply for the insurance licence, as for instance, change of the company's legal form, the charter capital of the life insurer must also be brought in compliance with the current statutory level.

A company must also complete the following procedures with the Commission to be eligible to carry out insurance activities:
(i) registration as a financial institution;
(ii) obtaining licence for insurance activity(ies); and
(iii) approval of the insurance product(s) rules.

In order to obtain and maintain its financial institution status a company is required to have a certain number of qualified insurance professionals, office premises, hardware and software etc. and a minimum three year operational business plan.

Insurers must apply to the Commission for each separate type of insurance activity, provided, however, that a life insurer is not allowed to sell any other insurance products.

A financial institution must adopt and register its insurance product rules (the "**Insurance Rules**") for each of its products. The Insurance Rules must be developed and submitted by the insurer to the Commission simultaneously with the submission of the documents for the insurance licence and each time these rules are changed or a new type of insurance activity is added to the insurance licence.

Given the above details and considering
(i) the lengthy, difficult and bureaucratic procedure; and
(ii) associated legal, accounting and actuarial fees, associated with establishing a greenfield insurance company in Ukraine, international insurance players often choose an easier and quicker option – to acquire a local insurance company in Ukraine.

However, in most cases acquisition of interest in the local insurer must be authorised by the Commission and Ukrainian anti-trust authority – the Antimonopoly Committee of Ukraine. Approval of the Commission is mandatory if the foreign insurer intends to purchase or increase its stake in Ukrainian insurer granting the foreign insurer direct or indirect control over 10%, 25%, 50% or 75% of Ukrainian insurer's charter capital. This means that the approval will not be required if the foreign insurer already holds say 10% of the shares and intends to acquire control over another 14% (up to 24% in total).

The Commission will be thoroughly checking the foreign insurer's financial capabilities and reputation of its senior management personnel. The preliminary conclusions of the Antimonopoly Committee of Ukraine, also required by the Commission, are to be obtained following the general procedure set forth by Ukrainian anti-trust law.

New Options for the Non-Resident Insurers

Alternatively, starting from 17 May 2013 (a lapse of five years from the date when Ukraine joined WTO) foreign insurers can carry out full-scope insurance activities in Ukraine directly via their permanent establishments (branches), which are treated as resident insurance companies. Such branches of foreign insurers must also be registered with the Commission, hold a respective insurance licence and comply both with the General Requirements mentioned above and some additional requirements, as for instance:
— the foreign insurer must issue a written irrevocable commitment note to confirm the unconditional performance of all obligations undertaken by its branch in Ukraine;
— since under Ukrainian law permanent establishments are not separate legal entities and thus do not form a charter capital, foreign insurers must place a guarantee deposit (at least equal to the minimum amount of the charter capital established for resident insurers, as specified above) with a Ukrainian bank;
— the insurance funds of a foreign insurer must be deposited only in the territory of Ukraine.

Also, Ukrainian insurance law sets forth the reciprocity principle, according to which foreign insurers are allowed to open branches in Ukraine only if the foreign insurer's home country permits the same to Ukrainian insurers.

2. Defining insurable interest

There is no specific definition of the "insurable interest" in Ukrainian legislation, though the Insurance Law implies that only the following property interests may be the subject matter of an insurance agreement:

(i) life, health, ability to work, and pension (personal insurance);
(ii) property possession, use and disposal (property insurance); or
(iii) compensation of damage to third parties (liability insurance).

3. Calculation of premiums

The premium is calculated by the actuary on the basis of the relevant statistics of risks occurred and also takes into consideration the investment profit, which must be determined in the contract (4% per year is the maximum) in the case of life insurance.

By default, an insurance contract may be terminated if the policyholder has not paid the premium following the first written request of the insurer within ten business days. The amount of the insurance premium must be agreed by the parties and indicated in the insurance contract. Upon early termination of the insurance contract by the policyholder, the insurer must reimburse to the policyholder the portion of the insurance premium corresponding to the unused policy period, excluding:

(i) statutory operating expenses that were determined during calculations of the insurance premium;
(ii) insurance coverage and compensation that has already been paid under the contract. If such termination is caused by the insurer's breach of its contractual obligations, the insurer shall fully refund the insurance premiums paid.

Upon early termination of the contract by the insurer, the insurer shall reimburse to the policyholder all the insurance premiums paid by the latter under the contract. If such termination is results from the policyholder's breach of its contractual obligations, the insurer shall reimburse only a portion of the insurance premium corresponding to the unused policy period, excluding:

(i) statutory operating expenses that were determined during calculations of the insurance premium;
(ii) insurance coverage and compensations that have already been paid under the contract.

The above-mentioned rules, however, do not apply to life insurance contracts. In case of early termination of a life insurance contract, the insurer shall pay a fee to the policyholder, which is calculated based on the methodology developed by the actuary. This fee should be approved by the Commission together with the Insurance Rules on the basis of the requirements set forth by Commission.

4. Consequences of misrepresentation and/or non-disclosure

The policyholder is obliged to disclose to the insurer all matters that may be relevant for the insurer's assessment of risks and inform the insurer if the risks may have changed. Misrepresenting information about

(i) the subject matter of the contract (object); or
(ii) the insured event may constitute grounds for the insurer to refuse to provide indemnity under the policy.

5. Consequences of late notification

Under the Insurance Law the policyholder has an obligation to notify the insurer about the insured event within a time limit specified by the Insurance Rules. In the case of late notification of the insured event (without any reasonable excuses) the insurer is allowed to refuse to provide indemnity under the policy.

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to complete the loss-adjusting proceedings within the time limits specified by the Insurance Rules. The Insurance Law does not stipulate any specific timeframes for loss-adjustment. Generally the timeframes for loss-adjustment are 10–30 days. Compensation under some specific types of insurance, e.g., mandatory motor vehicle third party liability insurance, shall be paid within 15 days after the indemnity amount has been adjusted with the insured, though within 90 days after the respective application accompanied by the evidence has been submitted by the insured. Insurance indemnity shall be paid in the currency provided for in the insurance contract, unless otherwise is provided by Ukrainian legislation.

7. Entitlement to raise a claim against an insurer

Under the general rules, only the policyholder has the right to raise a direct claim against the insurer. For third party liability insurance and insurance contracts in favour of third parties, the Ukrainian insurance legislation provides that a third party, being a party which suffered the damages, or beneficiary under the insurance contract which is executed in its favour, is entitled to indemnity under the policy and therefore, may also raise a claim directly against the insurer.

8. General rules concerning the limitation period for claims

The general limitation period in Ukraine is three years from the date when a person becomes aware or might reasonably have been expected to become aware of a breach of his or her right to claim or of the actions of the person responsible for the breach. It is also applicable to the claims of third parties against insurers. There is no limitation period for policy-holder claims against the insurer in Ukraine.

9. 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 are free to set other triggers in the Insurance Rules or agree on them directly in the insurance contract, provided that such triggers comply with Ukrainian legislation.

10. Reinsurance regulations

The insurance legislation governs to a certain extent only reinsurance with foreign (non-resident) insurers. Reinsurance business conducted by foreign re-insurers must comply with the General Requirements set out above. Reinsurance is mandatory if the insured sum under one of its contracts exceeds 10% of the insurer's paid charter capital, and/or the voluntary and mandatory insurance reserves.

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