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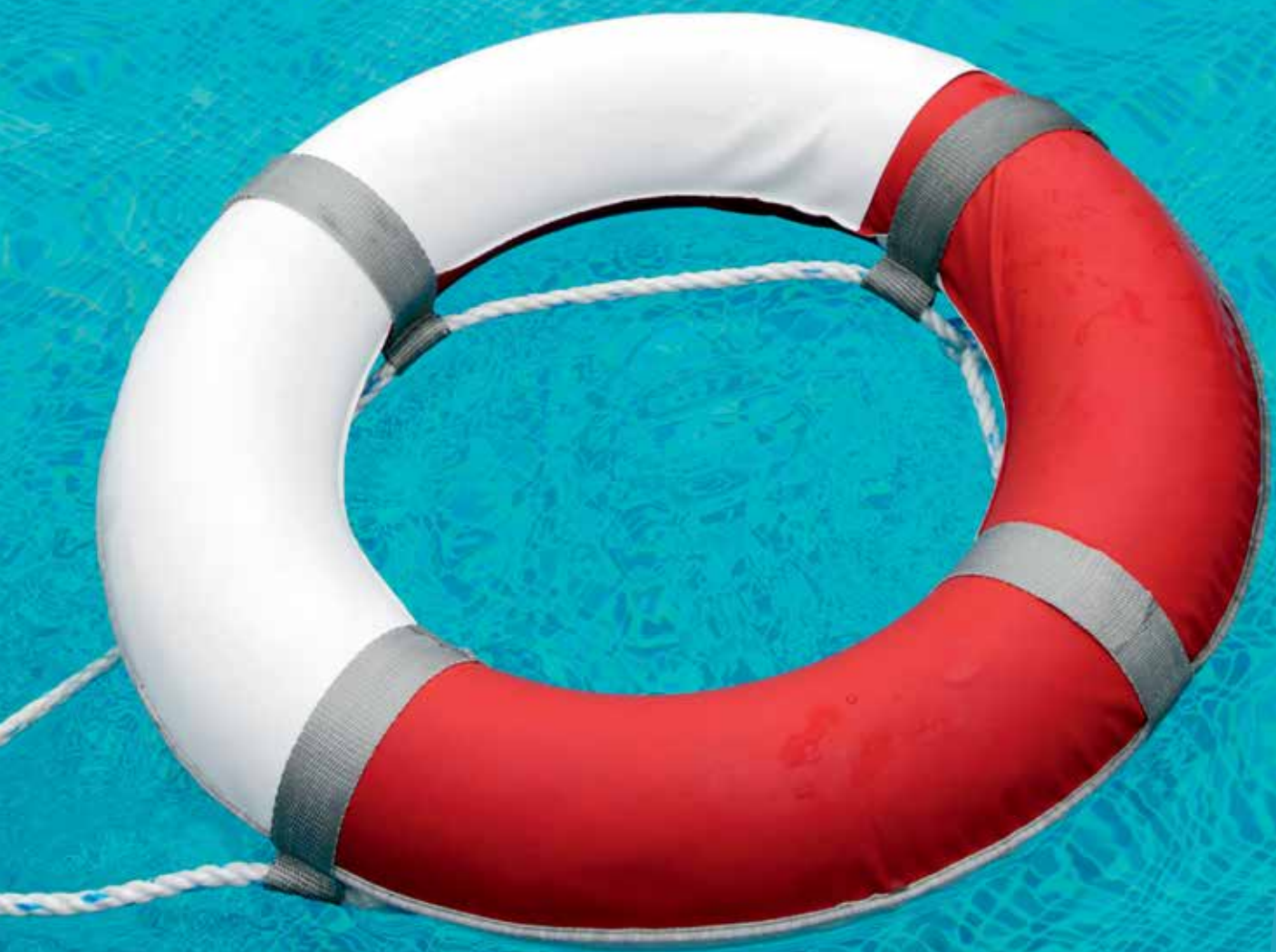
10 things every insurer should know



A guide to 23 jurisdictions in Western and Eastern Europe

CMS is a truly international group of like-minded lawyers across Europe, able to meet the needs of the most demanding international organisations. We combine our expertise across all relevant legal disciplines and jurisdictions to provide top quality advice throughout Europe. We are a recognised market leader in providing legal services to the insurance and reinsurance industry. We have a dedicated insurance team recognised for its general insurance experience. We understand the insurance market and how it operates and have an excellent understanding of the issues you face.

The insurance market is constantly evolving, there continues to be new opportunities for companies who are looking to expand operations. We have gained solid industry know-how working in the insurance and reinsurance market for over half a century now and our long-term involvement in providing insurance expertise across Europe and beyond means that we can support clients to make the most of new opportunities.

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

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 Western Europe. Whilst we do not set out the definitive requirements for an insurer wishing to operate in these countries, this guide serves as a backdrop against which CMS can offer a cohesive and commercially realistic, solutions-based approach to expanding your operations.

All the countries covered in this guide are members of the EU except Switzerland. The topics covered in this guide, other than regulation, have not been subject to EU harmonisation and so vary from jurisdiction to jurisdiction depending on local law. In contrast, the regulatory regime for insurers and reinsurers has been extensively harmonised across the EU (under the extensive body of EU insurance legislation). The EU Directives provide a single market passporting regime. Insurers established and authorised in one Member State are entitled to conduct business in other Member States under the prudential supervision of their "home state" regulator, without requiring separate authorisation in those other States. This passport can be exercised for cross-border business or by establishing a local branch. Since 2007, a similar regime has applied to pure reinsurers under the Reinsurance Directive (2005/68/EC).

The current EU solvency regime for insurers and reinsurers (Solvency I) is very out of date – both in terms of the method for calculating capital requirements and the low level of capital which is generally required under those rules. The EU is in the process of implementing Solvency II, which consolidates much of the insurance legislation and introduces a modern risk based approach to solvency and financial requirements. The new regime takes effect in 2014 and in some countries it will lead to substantial increases in the level of capital that insurers have to hold.

In general, the Western European countries included here have no express legal definition of an insurable interest, instead relying on the general principles of insurance law of that country. It is mostly up to the parties to assess and agree the calculation of premium, although there are certain exceptions where regulations apply in respect of life and health insurance. The consequences of misrepresentation and/or non-disclosure and late notification are usually dealt with through the relevant provisions and obligations in the insurance contract in accordance with usual practice in each country. A distinction is commonly drawn between an intentional act and negligence, with different remedies applying to each situation. Loss adjusting proceedings and policy triggers for third party liability insurance also tend to be governed by the general legal principles of that country and dealt with by provisions in the insurance contract. The rights of the insured and third parties to bring a claim against an insurer under the policy will be governed under each insurance contract and by each country's general contractual laws. Similarly, limitation periods and their specific characteristics are subject to each country's own law.

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.

We get more from CMS as they have aligned themselves with our culture and developed an understanding of how we operate.

Client Feedback

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, few 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 6 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 3 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 2 months of the date when the request has been filed. The ISA may extend the term up to 3 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.

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.

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. It envisages that the limitation period is two years starting from the date when the insured event occurs or when the insured/third party becomes aware of the insured event.

9. Policy triggers with respect to third party liability insurance

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

10. 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.

Austria

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1. Introduction

Austria is a federal democratic republic consisting of nine federal states. Since joining the EU in 1995, Austrian insurance regulations are to a large extent predetermined by EU legislation.

According to the Austrian Insurance Association's Annual Report 2011, the Austrian insurance business has generated a premium income of €16.5bn in Austria. Insurance business in Austria may only be carried out by legal entities in the form of a joint stock company, a registered European Company or a mutual insurance association. Insurance activities may not be undertaken by individuals or limited partnerships.

However, insurance mediation activities are permitted for individuals. These are subject to the provisions of the Austrian Trade Code (Gewebeordnung – "GewO") whereas insurance business activities are subject to the Austrian Insurance Supervision Act (Versicherungsaufsichtsgesetz – "VAG").

The regulatory body for insurers in Austria is the Austrian Financial Market Authority (FMA). Generally, the provision of insurance activities in Austria requires a licence granted by the FMA prior to commencement of these activities. The duration of the licensing procedure depends on the individual facts of the case. However, a licence will usually be granted within a 4 month period.

For insurance companies domiciled in the EEA, it is possible to passport the home Member State licence into Austria. Once passported, the foreign insurance company can provide insurance services in Austria within the scope of its home Member State licence. Such services can either be provided through branch offices established in Austria or on a Freedom of Services basis from outside Austria.

2. Defining insurable interest

Austrian law does not provide an exact definition of insurable interest. According to the VAG and the Austrian Insurance Contract Act (Versicherungsvertragsgesetz – "VersVG"), insurance activities can be divided into various classes: (i) general liability insurance / legal protection insurance, (ii) non-life insurance, (iii) accident and sickness and (iv) life insurance. Annex A to the VAG contains a more detailed description of the various branches in which insurance activities can be carried out.

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

3. Calculation of premiums

Austrian law does not contain any specific provisions as to the calculation of insurance premiums. However, the VAG contains various provisions in connection with premiums, which are very detailed.

For example, Section 9 paragraph 2 of the VAG provides that "unless otherwise provided by law, the gender factor may only lead to different premiums and benefits for women and men if gender is a decisive factor in a risk assessment that is based on relevant and accurate actuarial and statistical data. The insurance undertaking shall update this risk assessment on a regular basis".

4. Consequences of misrepresentation and/or non-disclosure

In Austria, there are various policies for each different insurance business and the Austrian Insurance Association provides sample general terms and conditions as precedents. In general, there is an obligation on the insured to disclose any information known to him in connection with the insured risk in particular information that is relevant to the insurer for writing the insured risk. Relevant are those circumstances suitable to possibly influence the insurer's decision to enter into the insurance contract at all or under the agreed terms. In doubt, circumstances the insurer has explicitly and in writing asked for are deemed relevant. Breach of these disclosure duties may entitle the insurer to withdraw from the insurance contract.

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

5. Consequences of late notification

In general, the late notification of an insured event to the insurer will mean that the insurer is not liable to pay any indemnity due to lapse of time (see section 8).

However, this will only apply if the insured has intentionally or gross negligently omitted to timely notify the insurer of an insured event. Even in case of intention or gross negligence on the part of the insured, the insurer may be liable to pay the indemnity in full or partly if the insured proves that the infringement of his obligation to timely notify the insurer of the insured event does not have any influence on the finding of the insured event or the scope of the insurer's obligation to perform under the insurance contract.

6. Requirements regarding loss-adjusting proceedings

An insurer is obliged to pay claims monies to the insured upon the finalisation of the loss-adjusting proceedings carried out by the insurer. However, irrespective of any pending loss-adjusting proceedings, if two months have passed after the claim has been made without the insurer finalising loss-adjusting procedures, and the insurer, within one month, does not respond to a request for an explanation by the insured, why the loss-adjusting proceedings not been finalised yet, the claim will become due.

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

The limitation period for a claim arising out of an insurance contract is three years. If a third party has a claim under an insurance contract, the limitation period starts as soon as the third party is aware of its right to claim. There is a long stop limitation period of 10 years even if the third party has not been aware of its right to claim.

The law also provides that where a claim has been made by the insured, the limitation period will be stayed until the insurer has issued a written decision setting out at least the facts on which the denial of the claim is based and the respective statutory or contractual provision. In any event, there is a long-stop limitation of ten years.

The insurer is not liable to perform under the insurance contract anymore, if the claim is not enforced within a period of one year starting on the date the insurer has denied the claim in writing as set out above and has informed the insured about the legal consequences of the lapse of time.

9. Policy triggers with respect to third party liability insurance

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

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

10. Reinsurance regulations

The VAG provides for specific regulations in relation to reinsurance services. Insurers focusing their business on reinsurance services are not subject to the overall application of the VAG. However, reinsurance services also require a licence by the FMA if the respective contracts are concluded in Austria or if the reinsurer intends to establish a company or branch in Austria.

The burden of proof is with the insurer to show what it would have done had it been aware of the true state of affairs. If it can show it would not have written the insurance, the insurer can refuse to pay the claim. If the insurer would have written the insurance on amended terms and conditions, the claim shall be dealt with as if the hypothetical amended insurance is in place. If the undisclosed facts are immaterial to the insurer's assessment of the risk, the claim must be paid in full.

Belgium

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1. Introduction

Insurance activities in Belgium can be undertaken by a Belgian company as well as by a foreign company either through a branch office or directly without any establishment in Belgium, provided that a licence has been obtained from the Belgian Banking, Finance and Insurance Commission (BFIC).

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

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

It is forbidden (i) for a Belgian insurance company to undertake both life insurance and non-life insurance activities, and, (ii) for foreign insurance companies which undertake non-life insurance activities in Belgium or abroad, to also undertake life insurance activities in Belgium. This prohibition is subject to certain exceptions: e.g. life insurance activities existing on 27 November 1992 (for Belgian insurance companies) and 15 March 1979 (for foreign insurance companies) can be carried out together with non-life insurance activities, provided that the management and accounting of the life and non-life business are split.

Belgian law insurance contracts are, depending on their subject matter, scope and territorial application, governed (i) either by the 1992 Insurance Law, which contains a number of mandatory provisions (e.g. regarding non-payment of premiums, misrepresentation or non-disclosure of risks and late notification), or, (ii) by the more flexible provisions of the 1874 Insurance Law. Unless indicated otherwise this note will only deal with the 1992 Law (the Law), as this Law governs most insurance contracts.

2. Defining insurable interest

The existence of a personal and legitimate insurable interest is one of the necessary requirements for an insurance contract to be valid. There is an insurable interest where the realisation of an uncertain event leads to a loss suffered by a person or entity.

With regard to non-life insurance (insurance of goods, liability insurance and costs insurance), the insurable interest is the quantifiable interest which the insured has in avoiding the consequences of the risk. With life or personal insurance, a moral interest in the subject matter of the risk may suffice (e.g. the personal relationship between the insured and the beneficiary).

3. Calculation of premiums

The premium can be a fixed or variable amount and can be due on an annual basis or on any other date agreed between parties. In some cases, parties agree on a preliminary premium which is to be adjusted during or after the policy period based on the specific circumstances of the case.

The premium can be amended if there has been a non-disclosure or misrepresentation of the risk, or if the

risk has changed (subject to certain conditions) or, as a result of an indexation of the premium. The BFIC can also oblige an insurance company to increase the premium if the original premium would result in, or threaten to result in, a deficit for the insurance company.

If the insured fails to pay the premium at its due date, the insurer must send a notice of default stipulating a period of time in which the overdue premium must be paid (together with any accrued interest) which must be no shorter than 15 days. If the insured fails to pay, the insurer is entitled to refuse coverage or terminate the policy. However, with regards credit insurance (where the insured credits are funds granted to a Belgian debtor), the insurer is entitled to refuse coverage after a lapse of one month, with no possibility for the policy holder or insured to remedy the default by paying the overdue premium.

Based on the principle of good faith in contractual relationships, Belgian case law has also developed similar principles for non-payment of premiums regarding contracts falling outside the scope of the Law (but within the scope of the 1874 Law - e.g. credit insurance contracts insuring credits on foreign companies).

4. Consequences of misrepresentation and/or non-disclosure

In addition to the general principles of Belgium law that declare an agreement void due to material error or fraud, insurance law has specific rules with regards misrepresentation and non-disclosure of risks. These allow the insurer to amend, terminate or annul the insurance contract if there have been omissions or errors in the disclosure or representation of the risk made by the insured.If the insured deliberately fails to disclose a risk or deliberately misrepresents the risk, the insurer can request the annulment of the insurance contract. In this case the insurer retains the paid premiums and has the right to claim for the premiums due until the misrepresentation was brought to his attention.

If the risk was unintentionally misrepresented or not disclosed, the contract will either be amended or terminated. The insurer is entitled to propose an amendment to the contract within one month after the misrepresentation or the non-disclosure has come to the insurer's knowledge. The amendment will often be an adaptation of the premium. If the insurer does not propose an amendment within the one month period, the contract will continue at the terms and conditions as originally agreed between parties. Under the Law, if the insured refuses the proposed amendment or if the insurer can prove that it would not have entered into the policy if it had known about the non-disclosed or misrepresented circumstance or event, the contract will be legally terminated.

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

The Law does not provide a general principle regarding the maximum period of time within which the insurer should pay the claim. Specific laws are applicable to certain insurances, for example fire insurance or motor vehicles insurance which provide for mandatory delays for payment of the claim. Assuralia (the professional association for insurance companies in Belgium) have issued recommendations regarding payment delays and loss-adjusting proceedings.

7. Entitlement to raise a claim against an insurer

Under liability insurance, a third party can file a direct claim against the insurer for compensation for damages suffered as a result of an insured event. The claims monies have to be paid directly to the third party with no possibility for any creditors of the insured to claim any of the payment.
The type of insurance will govern whether an insurer can rely on the same defences (such as nullity or loss of rights) against the third party under the insurance contract or the Law, that it would have been able to against the insured under the insurance contract or the Law. Under mandatory insurance regarding civil liability (for example public buildings and motor vehicles) the insurer cannot rely on the same defences against the third party. However, the insurer can rely on the annulment or termination of the contract, or suspension of cover for a period of time, as the result of an event which has occurred prior to the loss. The third party has no right of recourse against the insurer if the insurance contract has ended before the occurrence of the loss, or if the loss is not covered by the policy. Under non-mandatory insurance, the insurer can rely on defences regarding nullity or loss of rights in order to refuse coverage if they relate to events occurred prior to the loss.

8. General rules concerning the limitation period of claims

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

In addition to the general limitation period of three years, the Law also provides for other specific limitation periods. For example, a direct claim of a third party against a liability insurer is time-barred after a period of five years (starting from the occurrence of the event or the knowledge of the existing contract). For life and personal insurance, the limitation period may be 30 years in certain circumstances.

9. Policy triggers with respect to third party liability insurance

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

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

10. Reinsurance regulations

Reinsurance companies which undertake reinsurance activities without undertaking direct insurance activities in Belgium, are subject to specific legal rules introduced in 2009. Every reinsurance company, whether Belgian or foreign, must obtain a licence from the BFIC. The licence is subject to compliance with certain conditions regarding solvency margins and organisation.

Insurance companies based in other member states of the EEA can operate with a licence from their home country regulator without notification to the BFIC. Although the supervision of these companies is based on the home country control principle, the BFIC retains a power of supervision over them.

Foreign insurance companies of a non-EEA member state which do not have a branch office in Belgium, can operate with a licence issued by their home country regulator provided that such company, before starting its activities in Belgium, identifies itself to the BFIC and identifies the activities it intends to carry out, and complies with the requirements imposed by Belgian law. The BFIC can refuse to a company the right to offer its services in Belgium if its home country does not offer equal access to its reinsurance market to Belgian companies.

No specific regulations apply to the content of reinsurance contracts, which are governed by general principles of Belgian contract law.

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 part of both entities. 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 where the transaction is being concluded.

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 1 million BAM to 3 million BAM 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 1 million BAM. 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.

Finally, whilst in FBiH the Agency for supervision is not authorised to determine a maximum amount of premiums imposed by insurance companies in FBiH, the Insurance Agency in RS can order an increase or decrease of the premium value for pre-determined types of insurance offered, if these premiums are found to be inadequate by the Agency.

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. If it is impossible to obtain material evidence during this period then payment of the agreed amount for the insurance can be prolonged for an indeterminate period until the necessary evidence is obtained. Once the latter is received, insurance companies will conduct the loss-adjusting procedure if this proves to be necessary as well as arrange for indemnification within 14 days.

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. This right starts from the day of the insured event occurring, so every later change in rights of the insured towards the insurer is without influence to the right of the injured party to compensation. The insurer is responsible for compensation for damage as well as being responsible for the court costs of the dispute between the insured and the third party (limited to the insurance indemnity amount). Similarly, in the case of insurance of liability for motor vehicles, a third party has the right to file a lawsuit with the relevant court against the insurer for the maximum of the insurance indemnity amount. In certain events the insurer will be allowed to claim a refund of the paid compensation for damage to the third party from the insured.

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.

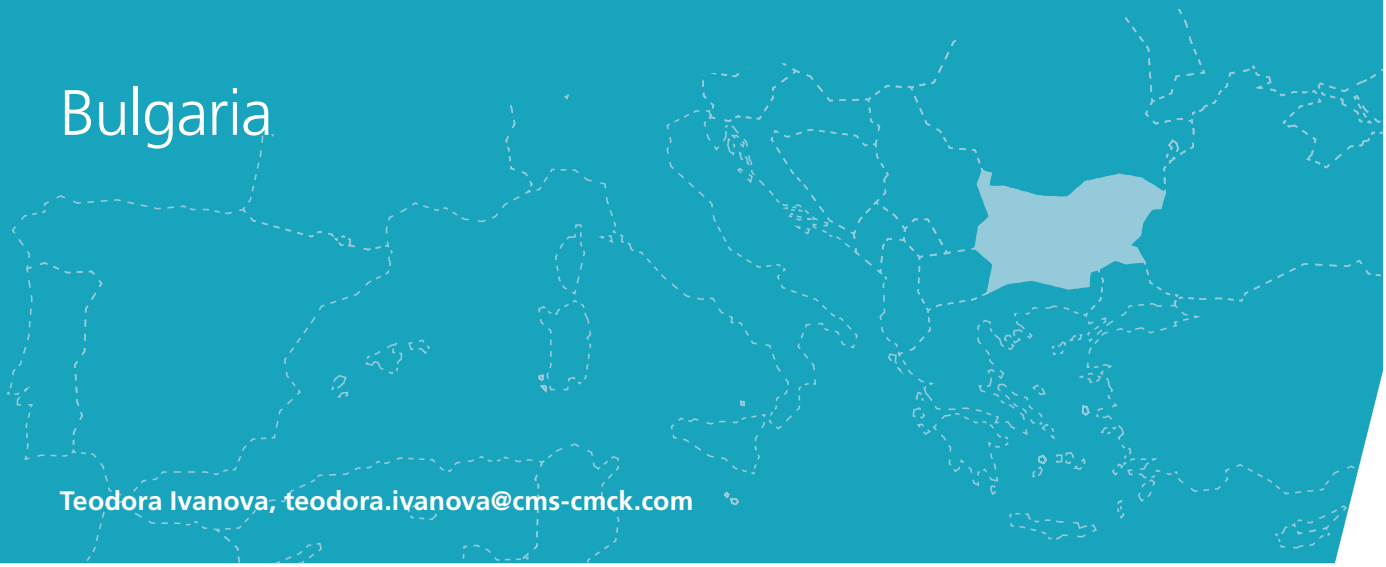
9. Policy triggers with respect to third party liability insurance

Normally, the occurrence of an insured event represents a trigger for third party liability insurance. However, it is possible to structure an "insured event" as a claim made against the insured.

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 have 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 licence from the Bulgarian Financial Supervision Commission (BFSC). An insurer can provide only the types of insurance that are permitted by its license. A single insurer is not allowed to provide both life and non-life insurance. Insurance companies must be joint-stock companies with registered book entry shares and should 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 licence.

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.

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

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 country and in the general case has established an local branch and obtained a licence;
— a European company (SE), which has obtained a reinsurance licence.

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 (3 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 1 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 3 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 3 years after the first day following the calendar year in which the claim originated. The limitation period for claims arising from life insurance is 5 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 5 years or 10 years in the case of life insurance.
The insurer's claim arising from the insurance contract expires in 3 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 3 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 3 years after the injured party became aware of the damage and of the person responsible. In any case the limitation period expires in 5 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; (ii) an insurer based in an EU or EEA country who has established a branch in the Czech Republic; (iii) an insurer based outside an EU or EEA country who has established a branch in the Czech Republic; and (iv) an insurer based in the EU or EEA country who has undertaken insurance business in the Czech Republic on a temporary basis. The Czech National Bank (as the Czech Insurance Market Regulator) can grant a Czech insurance licence either to a joint-stock company or to a cooperative established under Czech law. The process of establishing a Czech joint-stock company/cooperative and obtaining a Czech insurance licence from the Czech National Bank can be costly and may take several months.

Insurers based in EU and EEA countries can operate in the Czech Republic through a branch established in the Czech Republic. They do not need to obtain any special licence from the Czech National Bank to establish a branch, however, they must obtain information concerning the relevant conditions for operating from the Czech National Bank before undertaking insurance activities. It is less expensive for an insurer from an EU or EEA country to establish a branch office, rather than obtaining a direct licence from the Czech National Bank.

Insurers from countries outside the EU and the EEA can also establish a branch in the Czech Republic. This process is lengthy and costly as it involves obtaining a special licence from the Czech National Bank for this purpose. Insurers based in EU and EEA countries can also undertake insurance activities in the Czech Republic on the Freedom of Services basis. This is relatively inexpensive and does not require a complex formal procedure, however, such insurance activities may only be performed on the Czech market on a temporary basis.

2. Defining insurable interest

Under the Czech Act on Insurance Contract, an insurable interest is defined as "a legitimate need for protection against the consequences of a fortuitous event caused by "an insured peril". Under Czech law, life insurance cannot be agreed, for example, to cover the death of a child under three years of age or to cover miscarriage or stillbirth.

3. Calculation of premiums

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

Upon the occurrence of an insured event resulting 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 the premium for the entire period of time for which the insurance was arranged. The above applies unless agreed otherwise by the parties to the insurance contract.
Where an insurance contract terminates before the lapse of the policy period for a different reason other than the occurrence of an insured event (for example, when one of the parties terminates the insurance contract by giving notice of termination, if such termination by notice is allowed by law or under the insurance contract), the insurer is entitled only to the relevant proportionate part of the premium, corresponding to the actual period for which cover was provided.

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 which is to be provided. If the policyholder or the insured provides, during the negotiation of the insurance contract, untrue or incomplete answers either deliberately or due to negligence, the insurer is entitled to withdraw from the insurance contract (if he 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. In addition, the insurer can refuse to pay insurance benefits under an insurance contract if the beneficiary gives deliberately untrue or severely distorted information related to the scope of the insured event when claiming for the insurance benefits, or conceals material facts related to the event.

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 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 insured is obliged to: notify the insurer without undue delay or within a period of time agree in the insurance contract of an insured event; give a truthful explanation of the occurrence and scope of consequences of this event; submit necessary documents; and proceed in the manner agreed in the insurance contract.

If a breach of the obligations mentioned above had 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 may reduce insurance benefits proportionately to reflect the impact of such a breach on the scope of his obligation to provide benefits.

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to finalise loss-adjusting proceedings within three months' notification of an insured event. If the insurer is unable to finalise loss-adjusting proceedings within three months, he shall be obliged to notify the person who is to become or has become entitled to insurance benefits of the reasons why the loss-adjusting proceedings cannot be finalised and to provide this person, on request, with an adequate advance payment. The period of three months may be extended by agreement. This period shall not run if the loss-adjusting proceedings are impossible or impeded through the fault of the beneficiary, the policyholder or the insured.

7. Entitlement to raise a claim against an insurer

In general, it is the beneficiary (i.e. in practice usually the insured) who has the right to raise 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, in the case of life assurance, after 10 years. The limitation period in respect of the right to insurance benefits starts one year after the occurrence of the insured event. This also applies if the injured party became directly entitled to the payment of insurance benefits and 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 mentioned in 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

In the Czech Republic, the Reinsurance Directive (2005/68/EC) has been implemented into national law as of 1 January 2010.

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 an EU or EEA country who has established a branch in the Czech Republic; (iii) a reinsurer based outside an EU or EEA country 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 country 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 country who 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 country 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 a insurance or reinsurance company based outside the EU or EEA). The license can be granted for the provision of life reinsurance, non-life reinsurance or both types of reinsurance together.

France

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1. Introduction

On 21 January 2010 the French regulatory and supervisory authorities in charge of insurance activities were merged with the banking authorities into a single body, the "Autorité de contrôle prudentiel" (ACP). ACP is accordingly the sole remaining authority with competence for supervising insurance companies and insurance intermediaries.

The French regulations that apply to insurance activities are based on the provisions of the Insurance Code.

Insurance activities can be performed in French territory by:

— French companies that have been granted an insurance licence by the ACP. Licensing requirements include the obligation to submit a business plan. The ACP assesses the adequacy of the technical and financial means of the applying company with the proposed business plan and takes into account the allocation of the corporate capital and the shareholders. The granting of the licence can be conditional on specific commitments imposed on the applying company. The duration of the licensing procedure cannot in principle exceed 6 months from the moment the time the application file is completed. Licensed French insurance companies can perform their activities in France either through their French headquarters or through a branch established in another EU Member State.

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

— Insurance companies licensed in an EEA, but non-EU, country. Such companies can establish a branch in France subject to a licence being granted by the ACP (the licensing requirements are lighter than those applying to non-EEA insurers. This includes Swiss insurance companies). Alternatively, they can provide their services directly from their home country headquarters (on a Freedom of Services basis), and do not require a licence for large risks (i.e. risks related to airplanes, trains, ships and vessels, freight, credit insurance to professionals or the activities and assets of large businesses as identified by turnover, number of employees and total balance) or subject to prior licensing by the ACP for mass risks.

— Non-EEA insurers acting through a French branch licensed by the ACP and that have appointed a French resident as their general representative in France, who must be agreed on by the ACP.

Any foreign insurer that wishes to insure motor vehicles in France must appoint a special representative based in France for claims management purposes.

2. Defining insurable interest

According to the general principles that apply to insurance contracts in France, only uncertain events are insurable (with the exception of life insurance where the occurrence of the event is certain). Additionally, risks linked to illegal activities or those that are contrary to public policy are not insurable (for example, it is against French law to provide insurance covering the payment of criminal fines).

3. Calculation of premiums

Premiums are calculated by the insurer on the basis of actuarial assessment of the insured interest and are mutually agreed between the parties. There is a mandatory premium for insurance covering natural disasters in contracts relating to property damage or loss; the premium is calculated as a percentage of the premium payable under the main insurance contract.

In most cases, premium is calculated in advance for that insurance period. However, some contracts (for example, insurance against operating losses or credit insurance) may have a premium based on the annual profits or annual turnover of the insured entity, that can only be determined at the end of the insurance period. For these types of insurances, the insurer requires payment of a provisional premium that is then adjusted in arrears.

Insurance contracts generally have an initial policy period of one year, such initial period to be automatically renewed annually for successive one year periods. The premium is revised annually. There are exceptions such as mandatory builders' liability insurance contracts where the premium is determined and paid in advance for the whole 10 years' duration of the insurance contract.

With the exception of life and health insurance, premium can be reduced or increased during the policy period if an event occurs that reduces or increases the insured risk. However, if the insured does not accept the amended premium, the insurer is not obliged to accept the change to the risk nor is the insurer required to continue the insurance contract where the risk has increased. In such instances, the insurance contract can be subject to early termination with a pro-rata reimbursement of premium. The insurer is always entitled to terminate the contract where the risk has increased, provided it gives the insured 10 days' notice of the termination.

4. Consequences of misrepresentation and/or non-disclosure

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

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

5. Consequences of late notification

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

The time limit for notifying a loss must be clearly stated in the insurance contract and cannot be less than 5 working days.

6. Requirements regarding loss-adjusting proceedings

The French Insurance Code does not provide any specific rule or mandatory requirement relating to loss-adjusting proceedings. Therefore loss-adjusting proceedings should be conducted in accordance with the provisions of the insurance contract.

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

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

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

For life insurance, the limitation period within which the third party beneficiary must bring a claim is 10 years.

9. Policy triggers with respect to third party liability insurance

Under third party liability insurance, where the insured is an individual and the insurance contract is not a professional indemnity policy, the policy trigger will be the occurrence of the insured event.

In other cases, the parties can agree whether the insurance contract will be a claims-made or occurrence based policy.

Claims-made policies must provide for a run-off period starting from the date of termination of the policy and having a minimum duration of five years (for some professional liabilities this is increased to 10 years). Claims made during the subsequent period are insured only if they relate to insured events that occurred during the policy period. The limit of indemnity during the run-off period must be the same as the limit during the last year of the policy.

10. Reinsurance regulations

Any direct insurance company operating in France under a French licence or under an EEA passport can perform reinsurance activities in France.

French companies that are not licensed for direct insurance must obtain a specific licence to perform reinsurance activities. Non-French companies based in another EEA state that practise reinsurance in their home country can passport their reinsurance activities in France.

The French Insurance Code does not provide for specific accounting, prudential or reporting regulations for reinsurance companies.

Germany

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1. Introduction

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

Insurers based in EU and EEA countries can undertake insurance activities in Germany on a Freedom of Services basis. This is relatively inexpensive and does not require a complex formal procedure. Insurers based in EU and EEA countries can also operate through a branch established in Germany. In both cases, the insurers do not need to obtain any spe-cial licence from the BaFin. However, the home country regulator is required to submit in-formation to the BaFin before the insurer commences its activities in Germany, as set out in the Freedom of Services Directive. If the insurer establishes a branch, this branch also has to be incorporated in the local commercial register.

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

Insurers from countries outside the EU and EEA can also establish a branch in Germany, but need a special licence from the BaFin. "Home-foreign insurance" (insurance written in one country on property or risks located in another country) can be undertaken by insurers from outside the EU and EEA, as long as there are no intermediaries or other representa-tives in Germany acting for the insurer. Accordingly, insurers from outside the EU and EEA cannot act on a Freedom of Services basis in Germany.

2. Defining insurable interest

For a contract to be an insurance contract, it is necessary that the insured has an insurable interest in the subject matter of the insurance. There is no legal definition of insurable in-terests. In general, insurance can cover any interest that is not in conflict with the law or in conflict with moral and social principles, and can be given a monetary value.

There is a distinction between indemnity insurance and personal insurance:

— For indemnity insurance contracts, the insurable interest may be a direct relationship with the property insured, for example a right in the property or a right derivable out of the property. Alternatively, it might be a legal liability to make good a loss.
— For personal insurance contracts, the insurable interest depends on whether the cov-er follows the principles of indemnity insurance (e.g. health expenses insurance) or not (e.g. assurance of fixed sums). In the first case, the insurable interest might be a legal liability to balance a loss. In the second, the insurable interest is, put simply, the existence of the person insured and – if the person insured is not the policyhold-er – their consent to be insured.

If the insurable interest does not exist the contract may still be valid. If the insurable interest did not exist at the time of placement, and the insurer was not aware of this, he may not claim a premium but can claim compensation for costs incurred during placement. If the in-surable interest ceases to exist during the policy period, the insurer may claim for premium until the time he became aware that the insurable interest did not exist.

3. Calculation of premiums

There are no legal restrictions on what the parties can agree as premiums, with the exception of life assurance and health insurance, which are subject to regulation. The German Insurance Supervision Act (VAG) stipulates that life assurance and health insurance premi-ums must be calculated by actuarial mechanisms to make sure that the insurer will be able to perform his duties under the insurance contract.

4. Consequences of misrepresentation and/or non-disclosure

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

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

Case law has recently found that it is not sufficient when a broker uses his own form to ask in "textform". In case a broker is involved in the process of seeking cover and uses his own form, it is necessary that the insurer at least adopts the questions as "his own". However, it is advisable for insurers to prepare questions on their own and provide brokers with their question forms as case law has not yet established what would be sufficient for the adoption of a broker form by the insurer.

If the insured is in breach of this obligation, the insurer will be entitled to avoid the contract only if the insured has acted with gross negligence. In the event of an innocent breach or simple negligence on the part of the insured the insurer will only be entitled to cancel the contract and will still be liable for claims arising out of insured events that have already oc-curred and been notified.

Unless there has been deliberate misrepresentation and non-disclosure, the insurer cannot avoid or cancel the contract if he would have written the risk, albeit on a different basis, had he known the actual circumstances. In this situation, if the insurer requests, the cover can be amended retrospectively. However, if the premium increases by more than 10%, the insured may cancel the contract.

In each case the insurer must have informed the insured in writing as to the possible conse-quences of breach of the duty to notify. Further, if the insurer knew independently of the misrepresentation or non-disclosure, he cannot rely on the breach.

The German Insurance Contract Act also contains regulations regarding an increase of the risk under the policy. If there is an increase of the risk, and the insured becomes aware of this, the insured is obliged to notify the insurer without undue delay. If the insured does not comply with this obligation, the insurer may cancel the contract, or demand a higher premi-um, or exclude the increased risk from the cover. These rights are available to the insurer for one month from the time that the insurer is aware of the increase in the risk, and will cease if the risk reverts to its original level.

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

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

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

5. Consequences of late notification

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

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

6. Requirements regarding loss-adjusting proceedings

Under German law, there is no compulsory deadline for loss-adjusting proceedings. Claim monies are due when loss-adjusting proceedings are finalised. If loss-adjusting proceedings are not completed within one month following notification, the insurer is obliged to provide the insured with an interim payment on request. This is based on the minimum amount of what the insurer may have to pay. With regards property insurance the insurer has to pay in-terest (4% per annum) on the claim if loss-adjusting proceedings are not completed within one month after notification. If loss-adjusting proceedings cannot be completed due to a de-fault of the insured, the due date is stayed and no interest is due.

For third party liability insurance the insurer has to indemnify the insured within two weeks from the moment the claim is established by judgement, acknowledgement or settlement.

7. Entitlement to raise a claim against an insurer

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

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

8. General rules concerning the limitation period for claims

Under the German Civil Code, the limitation period is 3 years, beginning with the end of the year that the claim comes into existence. When a claim under an insurance contract is notified to the insurer, limitation is stayed until the insured obtains the insurer's decision in "textform".

9. Policy triggers with respect to third party liability insurance

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

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

10. Reinsurance regulations

The German Insurance Contract Act applies to direct insurance only. Reinsurance is explicitly exempt. Reinsurance contracts governed by German law are not subject to specific reinsurance rules but to the general civil law.

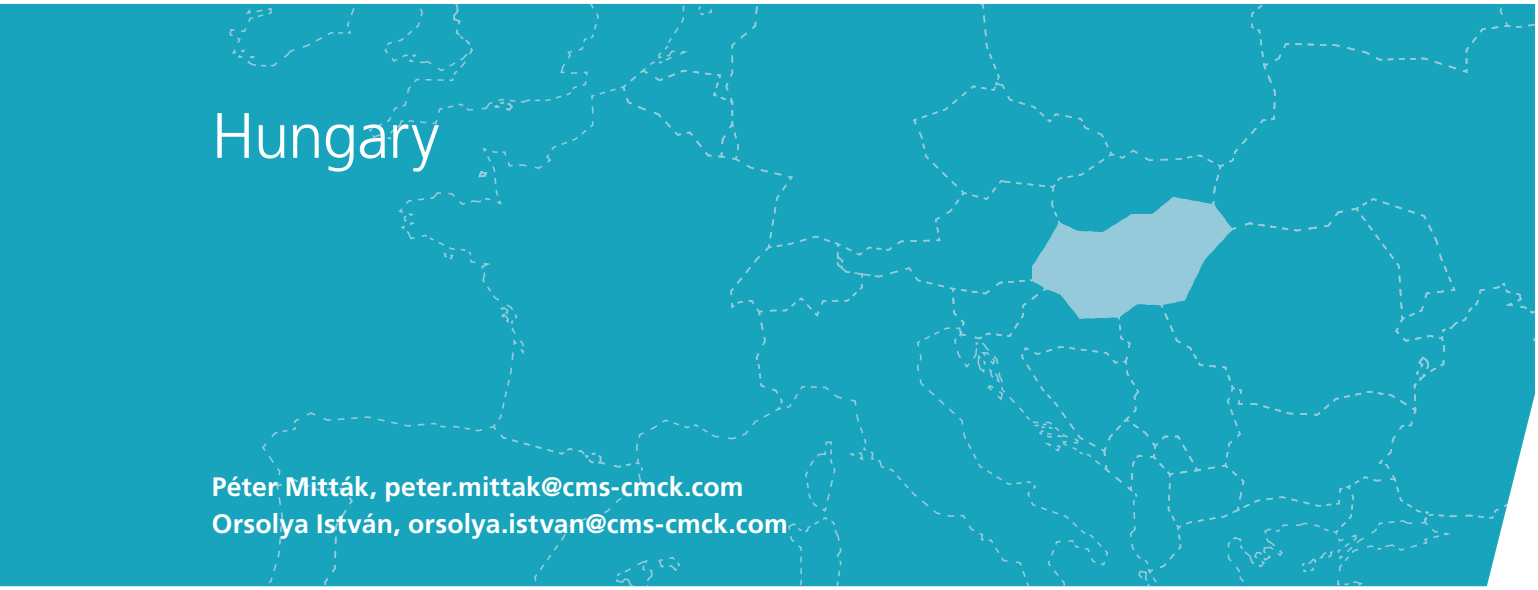
Reinsurance in Germany may be offered either by direct insurers or by reinsurers that pro-vide only reinsurance. The former is exclusively subject to the supervisory law for direct insurers, but for the latter, regulatory law provides specific rules. According to the VAG, reinsurance activity within Germany may be undertaken if one of the following three preconditions is met:

— Permission from the BaFin is necessary for reinsurers with their seat in Germany.
— Reinsurers domiciled in an EU country (other than Germany) or an EEA country that have permission from the regulator in their home country are entitled to act in Germany without separate permission from the BaFin. However, with regards their German activities, they are generally subject to supervision by the BaFin. It is there-fore recommended for such reinsurers to coordinate with the German authorities.
— Reinsurers with their seat neither within the EU nor the EEA may conduct business in Germany only if permitted by the BaFin. However, no permission is required if a reinsurance contract is entered into on the initiative of a German direct insurer or a German reinsurer with no involvement of an intermediary. Also, no permission is required if the reinsurance contract is concluded upon the assistance of an interme-diary with its branch outside Germany if such assistance is exclusively offered out-side Germany (e.g. a Swiss reinsurer offers protection via a London based broker to German direct insurers).

Mixed insurance companies domiciled in a country outside the EU or EEA who have per-mission from the regulator in their home country for both (direct) insurance and reinsurance and who only want to conduct reinsurance business in Germany via intermediaries ("Mittel-spersonen") may do so from their domicile / registered office in Germany, when the follow-ing requirements are met:

— From their registered office in Germany only reinsurance business is to be conduct-ed
— They have permission in their home country to conduct both (direct) insurance and reinsurance business
— They have their head office ["Hauptverwaltung"] in their home country
— They are subject to supervision according internationally in their home country
— A satisfactory cooperation between the responsible authorities in their home country and the BaFin is warranted.

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 reinsures requires prior authorisation from the Hungarian Financial Services Authority (HFSA). 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 HFSA for a foundation licence with supporting documentation. Once in possession of the foundation licence, the insurer must submit a further application within 90 days for authorisation to undertake insurance operation. The HFSA makes a decision on the foundation licence and the operation application within 90 days.

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 under the supervision of its home country regulator.

2. Defining insurable interest

According to the Hungarian Civil Code the only persons who can conclude property insurance policies are those who have an interest in the property or who are insuring the property on behalf of a person with an interest in the property. This rule means that not only the owner can insure the property, but anybody who has a justified interest in insuring the property (e.g. a tenant of a real estate). Any property insurance policy concluded without an insurable interest can be deemed null and void. In the case of personal insurance (life, accident, health) there is no requirement for an insurable interest.

3. Calculation of premiums

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

However, there are certain rules relevant to the payment of the insurance premium. Most notably, in the case of non-payment of the premium, the insurance policy will end by the 30th day following the due date of the payment of the premium without any specific notice or warning issued by the insurance company, except if the insurance company granted a deadline extension for the payment for the policyholder or if the insurance company made a claim for the insurance premium in court. 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 required by the insurance company. In the case of nondisclosure or misrepresentation, the insurance company may be released from its obligations, except if 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.

5. Consequences of late notification

The insurer may reject the claim on the basis of late notification (without demonstrating prejudice) if any facts relevant to the assessment or defence of the claim become unascertainable. In this respect it does not matter whether 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. If this is not possible due to the complex nature of the claim or any other reason, the time period begins to run following receipt of the full documentation justifying the claim.

7. Entitlement to raise a claim against an insurer

Under Hungarian law, only the insured 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 exception is mandatory motor vehicle third party liability insurance where the injured third party (claimant) is entitled by law to raise a claim directly against the insurer.

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 limitation period. On the other hand, the extension of the limitation period by the parties' mutual agreement is generally not permitted.

Concerning insurance contracts, insurers usually shorten the 5-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; (ii) some acts have the effect of interrupting the limitation period, for example if a letter of demand was sent to the insurer, then the limitation period will restart from this point; 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.

Italy

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1. Introduction

Insurance activity can be undertaken in Italy by:

— an Italian insurance company that has met all the conditions set by the applicable Italian laws and regulations and that has been admitted by the Italian Insurances Supervising Authority (ISVAP)
— an EEA insurance company that has notified the regulator in its home country that it intends to carry on business in Italy under either the right of establishment regime (by establishing a branch office) or directly on a Freedom of Services basis
— a non-EEA insurance company having been given permission by ISVAP to set up a branch office

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

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

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

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

2. Defining insurable interest

The insurable interest exists in the relationship between the insured and the subject matter of the insurance, in so far as the insured bears a right over such subject matter (i.e. "de facto" interests are not insurable). The insurable interest may then consist of any interest in properties and rights of credit (property insurance) or in physical and mental health and ability to work (health, disability or accident insurance). For an insurance contract to be valid and enforceable, there must be an insurable interest; failing which, the insurance contract is null and void.

It is not possible to insure against the effects of administrative or criminal sanctions/penalties.

3. Calculation of premiums

Premiums are calculated on a twofold basis: (i) the actual value of the insured risk and (ii) the inclusion of the insurer's costs and expenses for issuing the policy and claims management.

Where the policy is terminated before the end of the policy period, the insured is obliged to pay the premium for the entire policy period. The premium can be reduced only where the insured risk is also reduced.

4. Consequences of misrepresentation and/or non-disclosure

Before and during the policy period, the insured must disclose all the relevant information to the insurer; failure to do so in case of fraud or gross negligence by the insured, the insurer can claim a total or partial release from its obligation to provide cover and remains entitled to the premium for the entire policy period.

5. Consequences of late notification

If no other term is agreed, the insured is required to notify the insurer within three days of either the insured event or of the date the insured has become aware of the insured event. Failure to do so may result in either no cover for the claim in cases of fraud by the insured, or if there has been negligence by the insured, the indemnity reduction proportionally to the subsequent damage suffered by the insurer.

6. Requirements regarding loss-adjusting proceedings

The insured is entitled to a claim payment only if loss occurs. However, there is no specified period within which the insurer must propose and/or pay the claim to the insured, except in motor vehicle third party liability and in life policies linked to loans / mortgages.

The insurer must comply with general legal principles. These principles include requiring the insurer to pay the claim with no delay once the claim payment has become due and payable (e.g. after the insurer's expert assessment) and the insured has made a formal request for payment of the claim.

7. Entitlement to raise a claim against an insurer

Only the insured has a right to claim against its insurer. (Although there is an exception for motor vehicle third party liability insurance, where the third party that has suffered damage can bring a claim directly against the insurer).

8. General rules concerning limitation period for claims

Any claim deriving from the insurance contract is subject to a two year limitation period starting either from the date the loss occurred or, for third-party liability insurance, from the date the third party's claim is notified to the insured. Notification by the insured to the insurer of the third party's claim stays the two year limitation period, until the claim becomes due and payable or the third party's claim against the insured (or the insurer for motor vehicle liability insurance) becomes time barred. In life policies, however, the limitation period is extended to 10 years.

9. Policy triggers with respect to third party liability insurance

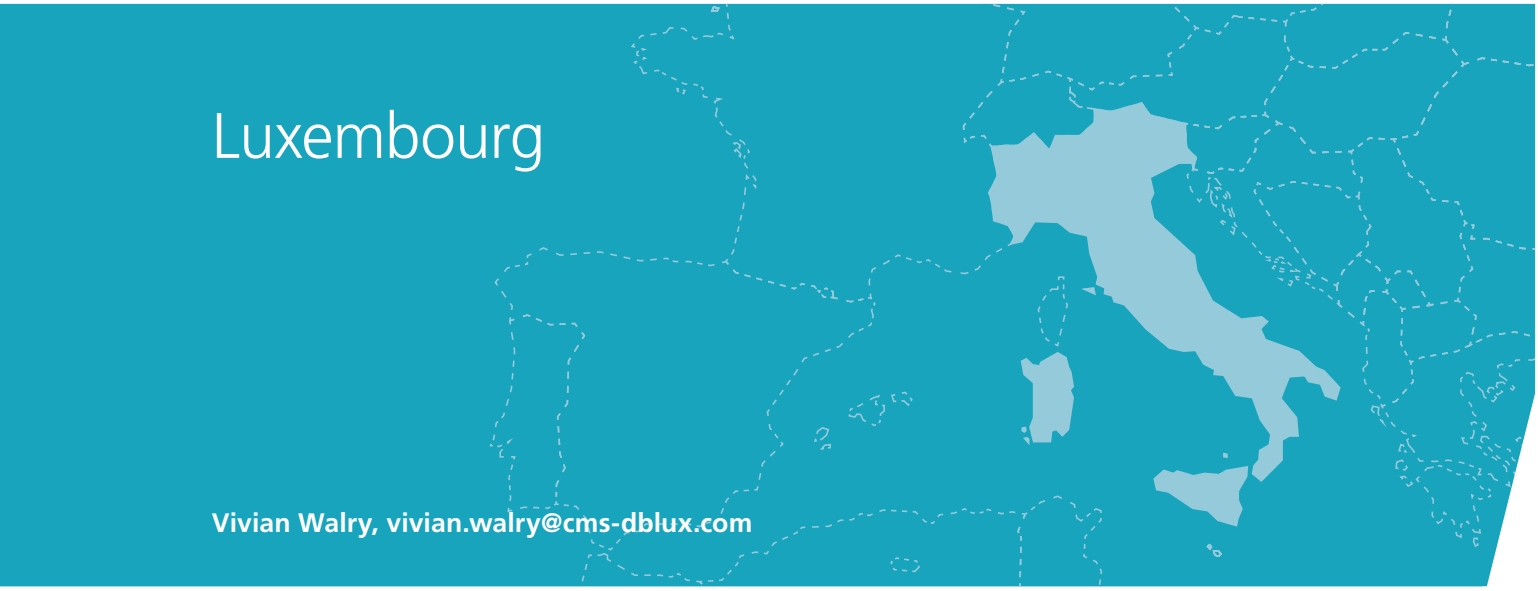
In general, the occurrence of an insured event during the policy period is the default policy trigger in third party liability insurance. However, it is possible, and increasingly common in some insurance contracts, for the parties to agree to other policy triggers (this clause must be specifically signed by the parties). Some old case law, which is slowly being superseded, has held that the claims-made trigger is contrary to Italian legislation even if the relevant clause was specifically signed by the parties.

10. Reinsurance regulations

There has been much debate in Italy as to whether the legal provisions on direct insurance also apply to reinsurance contracts. Although reinsurance is embodied in the same section of the civil code as direct insurance, there is no explicit provision extending the rules on direct insurance to reinsurance contracts. Those that do not consider it applies believe that reinsurance contracts are governed by international custom.

For reinsurance activity to be undertaken in Italy by foreign reinsurance companies (whether EEA or non-EEA) there are regulatory provisions that must be complied with. A non-EEA entity establishing a branch office must apply to ISVAP for specific authorisation.

Luxembourg



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1. Introduction

Luxembourg's Insurance market developed in the nineties, since then Luxembourg authorities have created a prosperous environment that has contributed to the growth. Insurances activities in Luxembourg can be carried out by Luxembourg companies as well as by foreign companies, either through a branch office or directly without any establishment in Luxembourg, provided that a certificate has been granted by the Luxembourg Insurance Commission (The Commassu) "Commissariat aux Assurances". The authorisation is granted for each specific insurance field provided certain conditions are met:

— The company must be effectively managed in and from Luxembourg, this means that the effective management and central administration must be carried in Luxembourg;
— The direct and indirect shareholding of the company structure must be transparent, the shareholders identity must be disclosed to The Commassu;
— The company must be effectively managed by one or more persons meeting the required conditions for integrity, qualifications or professional experience;
— Any natural or legal person determined to directly or indirectly takeover a characterised holding (described by Luxembourg law as "grasping directly or indirectly holding in an insurance company 10% or more of the capital or voting rights, or any other potential for exerting significant influence over the company in which a participating interest is held") in an insurance company must ensure the sound and prudent management of the company;
— The company has to appoint an independent statutory auditor ("réviseur d'entreprises")
— Insurance companies willing to operate their business in Luxembourg must comply with specific rules regarding solvency margins, assets and accounting principles.

Insurance companies based in a non-member state of the EEA that carry on insurance activities in Luxembourg must fulfill particular standards. Although they will mainly be governed and controlled by their home country authorities, The Commassu maintains a certain competence to oversee these companies and must inform the European Commission if certain measures are taken against such companies. They must also comply with Luxembourg legal provisions. Before the insurer commences its activities in Luxembourg, the authorities of the country of origin will have to submit a file to The Commassu and grant authorisation.

In addition, to establish a branch in Luxembourg, foreign companies must justify a similar activity in a third country for a period no less than 3 years. It is illegal for a Luxembourg insurance company to carry on both life insurance and non-life insurance activities.

2. Defining insurable interest

Insurable interests are defined under Luxembourg law as economic interests in the conservation of the protected good.

There is an insurable interest when as a consequence of future and or uncertain events there could be a potential financial loss upon the destruction of the protected good. The existence of a risk is a fundamental element in the insurance contract, without it, the contract could not be

3. Calculation of premiums

Premiums are calculated on the basis of the assessment of the risk. So, if there is a decrease or increase in the risk, premiums can vary. The insured is required to pay the premiums. Failure to pay them will lead to the termination of the policy contract by the insurer.

When premiums are paid within the period of grace the insured risks are covered. On the contrary, if premiums are not paid within the period of grace the insurance policy will be interrupted from the end of the period of grace and the insured goods not covered until payment of the premium. In the event of an additional default payment of the premium, the policy could be lost if thirty (30) days have elapsed after the insured has been required to pay.

4. Consequences of misrepresentation and/or non-disclosure

Luxembourg insurance law provides that the insured has the obligation to disclose precisely all the information that may have a direct impact in the assessment of the risk value. The insurance contract will be null and void if the insured intentionally omit or inaccurately report some information.

If the omission or inaccuracy was not intentionally done the insurance contract will not be null, the insurer will propose a modification of the contract during a period of one month from the date the insurer has known the omission or inaccuracy. If the insured does not accept the modification, the contract could be terminated within the following fifteen (15) days. Nevertheless, during the one (1) month period delay, the insurer could terminate the contract provided he proves that he has never insured such a risk.

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

There is no particular provision under Luxembourg law that deals with the timeframe within which the insurer should pay the claim.

7. Entitlement to raise a claim against an insurer

Third parties are not usually entitled to raise a claim against the insurer resulting from the insurance contract. Nevertheless, under liability insurance contracts, damaged third parties are empowered to claim against the insurer.

In the event of mandatory civil liability insurances the exceptions, annulments or losses contained either in the laws or in the insurance contract will not be applicable against the damaged person. For the rest of the non-mandatory civil liability insurances the exceptions, annulments or losses contained in the laws and in the insurance contract will be applicable provided they were previous to the accident. Beneficiaries under life insurance contracts will also have the right to raise a claim directly against the insurer.

8. General rules concerning limitation period for claims

In principle, any claim resulting from an insurance contract may be raised before three (3) years have elapsed from the day the event that give rise to the claim occurred. However this timeframe will be deemed to be started on a later date if the claimant evidences that he was not aware of the event and will start counting from this latter date. Nevertheless a claim could never be raised five (5) years after the event takes place, except in case of fraud.

In the case of liability insurance, the timeframe for the insured to claim against the insurer will start when the former claims against the latter. The insurer could raise a claim against the policy holder within three (3) years, starting from the policyholder payment day. The suspension and interruption will not be applicable to minors and incapacitated persons.

9. Policy triggers with respect to third party liability insurance

The occurrence of the insured event is the policy trigger in third party liability insurance. Notwithstanding the above, parties can agree on a claims-made policy.

10. Reinsurance regulations

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

The Netherlands

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1. Introduction

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

2. Defining insurable interest

For a contract to be an insurance contract, it is necessary that, at the time the contract is concluded, there is uncertainty either as to whether the insured event will happen, or when it will take place. Insurance in the Netherlands can be either an indemnity insurance or life insurance.

The insurable interest in indemnity insurance is the compensation of loss or damage. The insurable interest is restricted: the compensation can not place the insured in a clearly more advantageous position than he would be in without insurance.

In life insurance the insurable interest relates to the interest of the beneficiary (the person who will receive the claim payment) in the life or health of the person insured. Regulations provide set limits as to life insurance.

3. Calculations of premiums

The premium is the consideration given by the insured in return for the insurer's obligation under the insurance contract to provide an indemnity in case of a loss. The premium will usually be agreed at the placement of the insurance. Agreement as to the precise amount of the premium is not a pre-condition for the policy to take effect. The parties are free to determine the consequences of the insured's failure to pay the first premium. If the insured fails to pay renewal premiums the insurer may terminate the insurance contract or suspend cover provided it has informed the insured, after the premium due date, of the consequences of non-payment and has demanded payment within 14 days.

The insurer may set-off against any claim payment due: (i) the premium due; (ii) any loss on account of the late payment; and (iii) reasonable costs incurred in obtaining payment. This is the case even if the claim payment is due to a person other than the party from whom the premium is due.

When premiums and costs are paid to an intermediary under the insurance contract, the insured no longer has any obligation to pay the insurer. In turn, the intermediary is entitled to set-off any claim payment against any premium due from the insured.

It is possible to change the premium after the insurance contract has been placed. If the insurer raises the premium, the insured may terminate the insurance contract with effect from the date on which the raise takes effect, and in any event within one month of being notified of the raise. The insured also has the right to terminate if the insurer alters any of the terms of the insurance contract to the detriment of the insured parties.

4. Consequences of misrepresentation and/or non-disclosure

Prior to concluding the contract, the insured must disclose to the insurer all information which he knows or ought to know and which may be material to the decision of the insurer to write the insurance or to write it on particular terms.

Where the cover relates to interests of a third party whose identity is known when the insurance is entered into, the insured is also required to disclose facts which the third party knows or ought to know and which will be material to the decision of the insurer.

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

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

On discovery of non-fulfillment of a non-disclosure obligation, the insurer may only invoke its consequences if the insurer has drawn the attention of the policy holder to such non fulfillment within two months from the discovery of such non fulfillment, pointing out its consequences. On the insurer's discovery that the policy holder acted with the intent to mislead the insurer, or where the insurer would not have concluded the insurance had the insurer been aware of the true state of affairs, the insurer may terminate the contract with immediate effect within two months after such discovery.

5. Consequences of late notification

As soon as the insured knows or ought to know of the occurrence of the insured event, he must notify the insurer. The insured must provide to the insurer within a reasonable period all information and relevant documents to enable the insurer to consider the claim. When the insured fails to notify on time or provide adequate information, with the intention of misleading the insurer, the insurer is not obliged to pay the claim (unless this is inequitable). Following innocent or negligent late notification, the insurer may reduce the claim payment by any loss which he suffers as a result of the late notification, and may only refuse to pay the claim if the insurer's interests have been prejudiced.

6. Requirements regarding loss-adjusting proceedings

There are no particular legal requirements relating to the loss adjusting proceedings. Dutch insureds may file any complaints with the Dutch Ombudsman about the insurer's handling of the claim and the loss adjusting.

7. Entitlement to raise a claim against an insurer

For liability insurance involving claims for personal injury and/or death, once the insurer has been notified of the claim and is liable to pay the claim, the third party can request the insurer to pay the claim directly to the third party. If the third party has not exercised this right, payment to the insured will only release the insurer from its obligation to provide indemnity if a request has been made to the third party to confirm within four weeks whether the third party will exercise or waive such a right, and no response has been received from the third party. The insured may not settle the claim with the insurer to the detriment of the third party, if the claim relates to a loss resulting from death or injury.

There is an important exception under Dutch law that in personal injury claims the third party has a direct claim against the insurer. The direct action is open to third parties suffering from a personal injury or the estate of a deceased. The insurer may rely on the terms and conditions of the contract. If the third party commences proceedings against the insurer, he must ensure that the insured is summoned in time to appear in the proceedings.

These rules will not apply where the third party is indemnified independently in respect of its loss, either by a statutory right to compensation or by its own insurance cover.

8. General rules concerning the limitation period for claims

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

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

An insurer has five years from the date of discovery of the grounds for a claim to bring a claim against an insured.

9. Policy triggers with respect to third party liability insurance

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

10. Reinsurance regulations

There are no specific regulations regarding reinsurance contracts in the Netherlands. Reinsurance intermediaries are required to obtain a licence to conduct reinsurance intermediary business.

Poland

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1. Introduction

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

Insurers based in EU and EEA countries can undertake insurance activities in Germany on a Freedom of Services basis. This is relatively inexpensive and does not require a complex formal procedure. Insurers based in EU and EEA countries can also operate through a branch established in Germany. In both cases, the insurers do not need to obtain any spe-cial licence from the BaFin. However, the home country regulator is required to submit in-formation to the BaFin before the insurer commences its activities in Germany, as set out in the Freedom of Services Directive. If the insurer establishes a branch, this branch also has to be incorporated in the local commercial register.

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

http://www.bafin.de/SharedDocs/Veroeffentlichungen/EN/Merkblatt/mb_zulassung_eu_sc_100201_ggrig_en_va.html;jsessionid=D093AE3ABD60A0623D730FF86CD1769D.1_cid241

Insurers from countries outside the EU and EEA can also establish a branch in Germany, but need a special licence from the BaFin. "Home-foreign insurance" (insurance written in one country on property or risks located in another country) can be undertaken by insurers from outside the EU and EEA, as long as there are no intermediaries or other representa-tives in Germany acting for the insurer. Accordingly, insurers from outside the EU and EEA cannot act on a Freedom of Services basis in Germany.

2. Defining insurable interest

For personal insurance (life and accident), insurable interests include the personal interests of individuals such as life, health or ability to work. In respect of property insurance, an insurable interest for this purpose include interest in property that does not conflict with the law and has a monetary value.

3. Calculation of premiums

Premiums are determined on the basis of the assessment of insurable risk and shall be calculated for the whole policy period. 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.

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 proposal form (or other insurer-produced document), 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 the loss suffered where there is a causal connection between the undisclosed circumstances and the loss.

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 the 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.

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to complete the loss-adjusting proceedings within 30 days of receiving the notification of the insured event. If it is not possible due to the complex nature of the claim or any other reason whatsoever, the insurer is obliged to inform the claimant. In these circumstances the insurer is obliged to complete the loss-adjusting proceedings within 14 days from the day when the clarification of circumstances necessary to determine its liability or the amount of the indemnity was possible given that the insurer had acted with due diligence.

7. Entitlement to raise a claim against an insurer

In general, only the insured has a right to raise a claim resulting from an insurance contract directly against the 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 the right to step into the position of the insured under the insurance contract and 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 from the day on which they became enforceable (i.e. from becoming aware of the occurrence of the insured event). 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, the 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 either three years after the date that the third party became aware of both the damage and the person responsible to redress it (i.e. the insured) or ten years after the occurrence of the event that caused the damage (this long-stop does not relate to personal injuries).

The limitation period for a claim for indemnity against the insurer shall cease to run, if that claim or the insured event is reported to the insurer. The limitation period shall re-commence on the day on which 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. There are regulatory provisions regarding the establishment and operation of reinsurance entities in Poland set out in the Act on Insurance Activity.

Romania

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1. Introduction

Undertaking insurance business in Romania usually involves incorporating a Romanian local insurer as a joint-stock company.

The first step is to obtain initial incorporation approval from the local regulator, the Insurance Supervisory Commission (the ISC). Without such approval, the insurer cannot be registered in the Trade Registry. This may take several months and usually involves legal assistance and representation of the insurer before the regulator.

Incorporation procedures at the Trade Registry may take several days. There is also a minimum capital requirement. After official incorporation, the insurer needs to obtain an insurance activity authorisation from the ISC. 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 assistance fees for representing the insurers before the ISC.

Since Romania joined the EU, another way of doing insurance business in Romania is to create and register a branch of an EU or EEA based insurer. The branch can undertake insurance activity based on the right of settlement and is supervised by the regulator from the country of origin of the parent company. The ISC 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/management of insurance policies, without any corporate presence in Romania. In this case, the ISC must be notified of the insurer's undertakings in Romania, but the EU/EEA insurer itself remains under the supervision and jurisdiction of its local regulator.

Insurance activity through a branch, based on the right of settlement 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 of a local company. The relationship with the local regulator is also less demanding.

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 ISC 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 bears on circumstances that influence the insurer's decision to write the insurance or on the terms and conditions of agreeing to do so, 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 misrepresentation or the non-disclosure were discovered.

If the party in default has not acted in bad-faith, and the insured risk has not yet been produced, the insurer must maintain the contract but is entitled to ask for a premium adjustment or choose to terminate the contract unilaterally after 10 days from notifying the insured while returning the premiums for the period for which coverage will not apply further. In case the insured risk has been produced. If 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.

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 become due according to the insurance contract. However, in theory, MTPL claims by the aggrieved party (which technically is not a party of the MTPL insurance contract) are 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 occurence" 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 founded 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 strictly prohibits foreign insurers from carrying out direct and cross-border insurance activities in Russia. Russian insurance law strictly prohibits foreign insurers from carrying out direct and cross-border insurance activities in Russia. Paragraph 5 of Article 4 of the Law on the Organisation of Insurance Business in the Russian Federation states that "in the Russian Federation, insurance of interests of Russian legal and natural persons (except for reinsurance and as otherwise provided for by federal laws) may be pursued only by insurers holding licences obtained as established by the Law". Thus, foreign insurers (except reinsurance) may operate on the Russian insurance market only through their subsidiaries.

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 25 per cent, the regulator stops licensing insurance companies controlled by non-Russian entities. As of 1 January 2012, this quota amounts to 18.1 per cent. Russian insurance law states that a preliminary consent from the regulator must be obtained for a foreign investor to contribute to the charter capital of a Russian insurance company. This consent may only be denied if that contribution results in the quota being exceeded.

Due to the requirements of the Protocol of the Accession of the Russian Federation to the World Trade Organisation (WTO) approved by the WTO in December 2011 and new requirements as to the charter capital of the insurance companies the 25 per cent quota is likely to be increased up to 50 per cent in the nearest future.

Russian insurance law also imposes the following restrictions:

- foreign-owned companies may not be involved in endowment insurance or compulsory insurance
- shares in the charter capital of an insurance company should be paid for only in Russian Roubles
- the General Director (the CEO) and the Chief Accountant (the CFO) of a Russian insurance company should permanently reside in Russia, hold a university degree validated in Russia and have at least two years of professional experience
- foreign investors should have at least 15 years of experience on their domestic market, and at least two years of involvement in the operation of Russian insurance companies.

Investors from the European Union are exempt from these restrictions.

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.

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 may apply insurance rates developed by him taking into consideration the object of the insurance and the nature of insurance risk. The rates are subject to regulatory approval in the case of an initial application for an insurance licence. For some 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.

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).

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 for life, health or property is three years.

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 no specific regulations regarding reinsurance in Russia. Reinsurance is regarded as an insurer's insurance. Unless the contract of reinsurance provides otherwise, general rules applicable to insurance contracts apply to reinsurance. 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

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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 5 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 1 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 3 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 5-year time bar, while under other insurance contracts there is a 3-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 10 years under life insurance contracts and 5 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 3-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.

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 interest 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 policyholder and the insured (where different) must disclose all matters indicated in the proposal form (or other insurer-issued document), which are relevant to the insurer's assessment of risk. Misrepresentation and 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. 109/2006 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. 97/2007, 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.

Insurance company is a legal entity set up in the form of a joint-stock company, societas europea or mutual insurance company.

Insurance business may only be performed by (i) an insurance company with its seat in the Republic of Slovenia which obtained an authorisation 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 authorisation 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 authorised 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 authorisation by the competent authority.

According to the oral information of AZN i) the process of obtaining of an authorisation 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 authorisation 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 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.

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.

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.

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.

An insurer does not have a right to file a claim for the payment of a due premium regarding the life insurance. 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.

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.

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.

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.

5. Consequences of late notification

Pursuant to 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 fulfil any of his obligations after the occurrence of insurance case are null.

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.

7. Entitlement to raise a claim against the insurer

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.

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.

Insurer's claim arising from the insurance contract expires in three years.

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

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. 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.

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

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. 120/2006) 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.

Spain

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1. Introduction

Insurance activities in Spain are regulated under the Legislative Royal Decree 6/2004, of 29 October, which approves the Consolidated Text of the Law on arrangement and supervision of private insurance and the Royal Decree 2486/1998, of 20 November, by virtue of which is the approved Regulation on arrangement and supervision of private insurance where the Law on arrangement and supervision of private insurance is developed.

There are various alternatives available for carrying on insurance activities in Spain, which depend upon the origin of the company undertaking the business.

To carry out insurance activities, Spanish companies must obtain a licence granted by the Treasury Department (Ministerio de Economía y Competitividad). Their activities will be limited to those classes of insurance which are expressly authorised by the licence. Additionally, Spanish companies must adopt a specific legal form (public limited companies, mutual companies, cooperatives, or a social welfare mutual society) in order to obtain the licence.

Insurance companies based in the EEA that are already authorised by their home country regulators will be entitled to carry on insurance activities in Spain through the incorporation of a branch in Spain (on a right of establishment basis) or directly from the home country (on a Freedom of Services basis). They will be permitted to carry on insurance activities in Spain in accordance with the licence granted by the home country regulator, as soon as said regulator notifies the Spanish Treasury Department of the EEA company's intention to develop insurance activities in Spain.

For an EEA insurer, it is more time consuming to obtain a licence from the Spanish Treasury Department than to proceed on a right of establishment or freedom of services basis, where the home country regulator notifies the Spanish Treasury Department about the intention of the company.

Companies based outside of the EEA are required to establish a branch and get a licence from the Treasury Department to carry out insurance activities.

2. Defining insurable interest

Insurable interest is not expressly defined by Spanish law, nor does the law provide a comprehensive and limited list of coverage or risks that are insurable. Spanish Civil Code provides that parties may agree to any clauses or conditions that do not contradict the law, morality or public policy.

3. Calculation of premiums

Premiums are based on (i) technical provisions and (ii) statistical and financial information, depending on the risks to be covered and the costs likely to be incurred.

Where an insurance contract is early terminated (e.g. portfolio transfer, transformation of the insurance company, merger, split up), insureds would be entitled to be reimbursed for the part of the premium corresponding to the unused policy period.

4. Consequences of misrepresentation and/or non-disclosure

Prior to the execution of the insurance contract, insureds must disclose all circumstances that are material to the risk to be covered by insurers. Such information is commonly submitted to insurers in the proposal form completed by insureds. If any information is not requested by insurers or is not raised in the proposal form, insureds are not required to disclose the information.

Insurers will have the right to propose insureds a partial amendment of the insurance contract to reflect the new circumstances of the risk, considering the information disclosed. Such proposal has to be offered by insurers within the two-month period following the disclosure of the information. After receiving the proposal, insureds will be entitled to accept or reject the proposal within the following fifteen days.If an insured event occurs and insureds have not disclosed all the above information, insurers have the right to adjust the claim payment in proportion to the difference between the premium paid and the premium that insureds would have had to pay in the event that the information was disclosed.

During the policy period insureds must disclose all new circumstances that increase the risk that would have affected insurer's decision to underwrite the risk if insurers had been aware of this information during placement of the risk. Likewise insureds are also entitled to disclose circumstances that lower the risk that would have resulted in more beneficial terms and conditions for insureds if insurers had been aware of the circumstance during placement of the risk

5. Consequences of late notification

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

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

6. Requirements regarding loss-adjusting proceedings

Insurers are obliged to pay the insurance claim following the completion of its investigations and any expert investigations required for determining the existence of the insured event and the value of the damages. In any event, insurers are obliged to pay an interim claim payment within 40 days following notification. This is calculated based on the circumstances which the insurer is aware of at that stage.

7. Entitlement to raise a claim against an insurer

The person named in the insurance contract can claim against insurers for compensation for loss arising from the insured event.

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

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

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

8. General rules concerning the limitation period for claims

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

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

9. Policy triggers with respect to third party liability insurance

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

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

On the other hand, "losses occurring" policies should be also considered. Said policies require the third part to evidence that the damage was suffered during the enforceability period of the policy and any damages arisen out of this period are rejected.

10. Reinsurance regulations

Reinsurance activities can be undertaken in Spain by (i) Spanish reinsurance companies authorised by the Treasury Department; (ii) Spanish insurance companies authorised by the Treasury Department, if reinsurance activities are permitted on their insurance licences; (iii) insurance and reinsurance companies based in the EEA, authorised by their home country regulators to carry on reinsurance activities; and (iv) insurance and reinsurance companies based outside of the EEA (through a branch located in Spain), authorised by the Treasury Department.

There are only a few articles regulating reinsurance agreements in the Spanish Act on Insurance Contracts, and they mainly refer to the relationship between the reinsurer and the reinsured.

Within the same limits state for insurance contracts (i.e. law morality and public policy), there are no limits for reinsurance contracts under Spanish regulations.

Switzerland

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1. Introduction

Any company that intends to undertake insurance activities in or out of Switzerland will be required to obtain a licence from, and be subject to supervision by, the Swiss Financial Market Supervisory Authority (FINMA) and will have to meet capital and other requirements. The requirements for obtaining a licence and the regulation of insurance activity differ between life and non-life insurance activities.

Swiss law does not permit in-bound cross-border activities (i.e. selling insurance to Swiss customers from abroad), subject to a few very narrow exceptions. In general, a company aiming to undertake insurance activities in or out of Switzerland is either required to establish (a) a Swiss head office, or (b) a branch office in Switzerland (provided that it is already operating as an insurance company in another country).

An insurance company that plans to establish its head office in Switzerland must meet several requirements before FINMA will issue a licence. First, it is required to establish a company limited by shares and registered in Switzerland. Secondly, it must meet financial capital requirements, such as a minimum capitalisation and adequate solvency margins. Thirdly, it must present a detailed business plan, and fourthly, the staff and the executive management of the Swiss insurance company must provide a sufficient guarantee for sound management.

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

As regards non-life insurance, the licensing procedure for insurers located in an EU member state is generally less onerous than for non-EU insurers, due to the Treaty between Switzerland and the EU regarding Direct Insurances Other than Life Insurances.

2. Defining insurable interest

Swiss law does not provide an exact definition of insurable interest. Under the general principles of Swiss liability law, insurance policies may be concluded to cover liability claims under civil or public law which generally relate to damage caused to persons or things, and for specific groups of professionals, such claims may also relate to pure financial loss.

Insurance policies covering a third party may be taken out without the consent of the third party. The insurance contract must expressly state that the policy is being taken out to provide insurance coverage for a third party. The insurance monies can only be claimed without the consent of the third party if certain requirements are met (see section 7). Life insurance of a third party is only permitted with written consent of the third party prior to the conclusion of the contract.

3. Calculation of premiums

An insurance premium is defined as the price of risk i.e. the price which the insured person owes to the insurer for covering the risk. In general, Swiss legislation remains silent as to calculation of premiums. However, if the premium was calculated taking account of a specific risk circumstance, the amount of premium may be reduced (but not unilaterally increased) if the risk lapses or decreases significantly.

The premium for the first insurance period becomes due on the execution of the insurance contract. The premium payments for the following insurance periods become due at the beginning of each new insurance period. If the premium is not paid at the due date, the insurer is entitled to notify the policyholder and to set an additional time limit of 14 days for payment of the premium. If the premium is not paid within these 14 days, the policyholder is in default and the obligations of the insurer are suspended.

If the policyholder has been in default for more than two months and the insurer has not commenced legal proceedings to enforce the claim, the law presumes that the insurer has waived its right to claim the outstanding premium and choose to withdraw from the insurance contract. If the insurer enforces its claim for the premium payment, the insurer is obliged to provide insurance coverage as stipulated in the insurance contract from the moment it receives payment of the premium, interest and any costs relating to the default in payment. Specific provisions apply to life insurance and motor vehicle liability insurance.

4. Consequences of misrepresentation and/or non-disclosure

Based on questionnaires presented by the insurer, the insured is obliged to disclose to the insurer in writing all facts of which he is aware or ought to be aware that are material to the assessment of the risk to be insured.

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

If the insurer terminates the contract, its obligation to indemnify any loss that has already occurred ceases, provided that the misrepresentation or non-disclosure of a material fact caused or increased the loss. If the insurer has already paid a claim, it is entitled to restitution of the payments made. Specific provisions apply to life insurance.

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

5. Consequences of late notification

Upon occurrence of the insured event, the insured is required to notify the insurer as soon as (i.e. "immediately after") he becomes aware of the event. The policy may also provide that the notification must be in writing.

If the insured negligently breaches the duty to notify, the insurer is entitled to reduce the claim payment to the hypothetical value the loss would have been, had the claim been notified on time and had the insurer had the chance to take steps to limit the loss. As this can be difficult to prove, the law allows the parties to agree in the policy to reverse this burden of proof in the event of a negligent late notification.

If the insured intentionally makes a late notification so as to prevent the insurer from establishing the circumstances of the insured event, the insurer is not bound by the insurance contract and does not have to indemnify the loss.

If however the insured innocently breaches the duty to notify, the insurer remains bound by the insurance contract and is obliged to indemnify the loss.

6. Requirements regarding loss-adjusting proceedings

The insured is obliged to provide the insurer with as much detail as possible about the insured event to enable to the insurer to make a detailed assessment of the accuracy of the claim. An insurer is in general required to finalise loss- adjusting proceedings and make a claim payment within four weeks from the date it received all the required information.

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning limitation period for claims

The statutory limitation period for a claim against the insurer under the insurance contract is two years running from the date on which the insured event took place.

Alternatively, the parties may agree a longer limitation period (up to 10 years) for claims against the insurer under the insurance contract.

9. Policy triggers with respect to third party liability insurance

The parties are generally free to agree upon the nature of the insured event which triggers third party liability insurance. In particular, the parties are free to agree whether the policy trigger is occurrence-based or a claims-made.

10. Reinsurance regulations

Reinsurance companies that transact business from Switzerland are generally required to obtain a licence by FINMA. The requirements are similar to the establishment of an insurance company and include capital requirements and personal requirements for staff members and the executive management.

Foreign reinsurers domiciled abroad that solely undertake reinsurance activities in Switzerland and do not engage in direct insurance business in Switzerland do not need to be licensed by FINMA.

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 (this option will come in effect in 2013). A limited scope of insurance services, subject to certain restrictions and requirements, may be directly 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 (brokerage) insurance activities 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.

Moreover, any foreign insurer carrying out insurance activities within the above scope in Ukraine shall be subject to the following requirements:

- the home state of the foreign insurer must be a member state of the World Trade Organisation and that does 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 State Commission for the Regulation of the Financial Services Markets of Ukraine (the "State Commission");
- 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;
- the foreign insurer has obtained all the appropriate licences to conduct insurance business activities required by the laws of its home state; and
- the financial reliability (stability) rating of the foreign insurer is compliant with the requirements set forth by the State Commission.

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

There are certain specific requirements regarding the composition of shareholders (at least 3), 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 1 million for non-life and EUR 1.5 million for life insurers).

A company will then have to complete the following procedures with the State 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 State Commission for each separate type of insurance activity, provided, however, that a life insurer is not allowed to carry out any risk insurance activities.

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 State 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, i.e., to acquire a local insurance company in Ukraine.

An alternative option to establish an insurer's presence in Ukraine will become available from 16 May 2013 (a lapse of five years from the date when Ukraine joined WTO), when certain provisions of the Insurance Law and other related regulations will come into force and effect. As a result of the anticipated changes, the permanent establishments (branches) of foreign insurers in Ukraine will be treated as resident insurance companies, provided that such branches of foreign insurers are properly registered in the register of the State Commission, have obtained a respective insurance licence with the State Commission, contributed a guarantee deposit in the amount of the minimum charter capital of a Ukrainian insurance company (as mentioned above) and comply with other regulatory requirements applicable to Ukrainian resident insurers and specifically to such branches.

From 16 May 2013, the minimum amount of the charter capital (guarantee deposit – for branches) of life insurers will be increased to EUR 10 million in UAH equivalent. At the same time, this requirement will only be mandatory for the newly registered insurers or insurers that are willing to obtain a new type of insurance licence.

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 10 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 the obligations under the contract, 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 caused by a breach of the obligations under the contract by the policyholder, 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 State Commission together with the Insurance Rules on the basis of the requirements set forth by State 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 speaking 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 resulting 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 regarding foreign insurers 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.

United Kingdom

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1. Introduction

England & Wales
Insurers are regulated by the Financial Services Authority (FSA) under the framework of legislation established by the Financial Services and Markets Act 2000 (FSMA). This regulatory regime has been heavily influenced by the large body of EU insurance directives, which puts in place a harmonised regime of insurance regulation across the EU. FSA is a unitary authority responsible for both prudential/ financial regulation and for conduct of business.

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

The FSA decided some years ago not to wait for the EU Solvency II regime and introduced a modern risk based approach to financial requirements for UK insurers based on individual capital assessment by firms adjusted, where necessary, by capital guidance from the FSA. In many respects the UK regime anticipates many of the techniques in Solvency II but UK insurers still face major challenges in meeting the new EU requirements.

A peculiarity of the UK regime is that insurance regulation comprises not just regulation of an insurer itself but also the personal regulation of certain individuals, such as those exercising significant influence, within the firm. Known as the "approved persons" regime, this aspect of insurance regulation is specific to UK rather than being derived from the EC Directives, and it effectively requires directors and non-executive directors to make an individual promise that their firm will be run compliantly.

Insurers are bound by the decisions which are made by the Financial Ombudsman Service (FOS) established under FSMA and the Consumer Credit Act 2006. FOS has jurisdiction over:

— consumer claims
— claims by micro-enterprises which means businesses employing fewer than 10 people and with a turnover or annual balance sheet that does not exceed €2 million
— charities with an annual income of less than £1 million at the time of the relevant complaint
— a trustee of a trust which has a net asset value of less than £1 million at the time of the relevant complaint.

FOS has jurisdiction to make awards of up to £150,000. It provides a scheme whereby disputes between qualifying insureds and insurers may be resolved quickly and with minimum formality without recourse to UK courts. However, FOS decisions tend to favour complainants and often go beyond what complainants might achieve in court, even though the relevant insurer will be bound by them.

In addition, the London market through the Contract Certainty Steering Committee and Market Reform Group (a cross London market organisation) has implemented a code of practice called the Contract Certainty Code of Practice and agreed a template insurance contract, the Market Reform Contract. The idea is to (a) ensure that contract terms are clear and unambiguous by the time the offer is made to enter into the insurance contract, or the offer

accepted; and (b) to have the contract documentation provided to the insured promptly. This means within seven working days for retail customers and 30 calendar days for all other client classifications, with the timescales measured from the later of the date on which the contract is concluded or the policy incepts (and where there is more than one participating insurer, the date on which the final insurer enters into the contract). The Market Reform Contract sets out certain policy terms which must be separately and clearly labelled.

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

2. Defining insurable interest

For a contract to be an insurance contract, it is necessary that the insured has an insurable interest in the subject matter of the insurance.

Traditionally, the absence of an insurable interest could result in the contract being unenforceable or indeed illegal. The position has been changed somewhat since the implementation of the Gambling Act 2005. The current position would appear to be that:

— for life insurance, accident insurance and marine insurance, it is necessary for the insured to have an insurable interest at the outset for the contract to be enforceable
— for other contracts, if there is no insurable interest they may now be enforceable as contracts by virtue of the Gambling Act 2005, although if they are indemnity policies, then the insured will still need to show that it has suffered a loss as a result of the insured event.

There is no universally accepted definition of insurable interest, although one pre-requisite is that the insured must have a relationship with the subject matter of the insurance. This might be a direct relationship with property insured, for example a right in the property or a right derivable out of the property. Alternatively, it might be a legal liability to make good a loss.

3. Calculation of premiums

The premium is the consideration given by the insured in return for the insurer's obligation to provide coverage under the insurance contract.

The premium will be the amount the insurer considers is sufficient to reflect the risk being underwritten and will be agreed at the conclusion of the contract.

Agreement between the parties on the precise amount of the premium to be paid by the insured is not, however, a pre-requisite for the policy to take effect. The policy will normally provide a formula by which the premium is to be calculated or a defined figure. If insurance is concluded with no agreement on the amount, then a reasonable premium is payable.

There are certain standard situations in which the premium may not be fixed at the outset e.g. where an adjustable premium is payable. In that case, the parties agree an initial payment of premium (called a minimum and deposit premium) be paid at the outset, with the final amount of premium to be calculated thereafter in accordance with an agreed methodology. If the adjusted premium falls below the deposit, the insurer will keep the minimum. This can happen in marine insurance policies, where the insurer is able to charge a higher premium in the event of an increase in the risk during the policy period (for example an insured vessel entering a known war zone).

Premium may be payable in one tranche or in installments. If it is payable in installments, it will be a question of construction whether the contract is divisible (i.e. there is a separate contract reflected by each premium payment) or one contract (which is usually the case).

If the payment of premium within a time period is a warranty or condition precedent, then failure to pay within the time period will mean the insurer is discharged from liability under the policy. In all other circumstances, late payment will not entitle the insurer to refuse cover (generally or for a specific claim). The insurer will also not be able to cancel the contract purely for late payment of premium unless the policy specifically allows it to do so.

4. Consequences of misrepresentation and/or non-disclosure

Under sections 18 and 20 of the Marine Insurance Act 1906, the insured is required not to misrepresent, and must disclose, any material circumstances, prior to the conclusion of the insurance contract. The insured must disclose any matters it knows or ought to know in the ordinary course of its business to know. However if the insured misrepresents a material matter, it does not matter that they did not know or indeed could not know the true position. It is still a misrepresentation.

Material means something which would influence a prudent and reasonable underwriter in deciding on the premium or whether to insure the risk. Whether or not a matter is material to the risk is a broader question than whether or not it is material to the subject matter of the insurance. Amongst other things, it includes matters material to what is known as the "moral hazard", matters material to the likelihood of a claim being made but which are not material to the subject matter insured. An example might be previous fraud or criminal convictions of the insured or employees of the insured. In addition, to rely on a misrepresentation or non-disclosure, the underwriter who underwrote the risk must have been "induced" by that misrepresentation or non-disclosure. This means that they would have amended the terms or not have written the risk at all, had the correct position been disclosed or represented correctly.

The insured is not required to disclose matters which: diminish the risk; are known by the underwriter are matters of common notoriety; are waived by the insurer or are superfluous because of a warranty in the policy.

In the event of an actionable non-disclosure the insurer's only remedy, and the primary remedy in the event of an actionable misrepresentation, is avoidance of the policy "ab initio". This means the policy is treated as never having existed. Amongst other things, this means that the insurer must refund the premium unless the insured has been fraudulent. Otherwise, degree of culpability of the insured in the event of either a misrepresentation or a non-disclosure is irrelevant.

5. Consequences of late notification

Insurance policies will usually contain loss or claim notification obligations imposed on the insured. These may impose specific time limits in which a notification must be made (for example within 30 days of the insured under a professional indemnity policy first becoming aware of a claim against it or a circumstance which may give rise to a claim). Alternatively, it may require notification "immediately" or "within a reasonable time".
The consequences of late notification will depend on whether the clause is designated a condition precedent to liability or not. If it is, then in the event of a breach, no matter how minor, the insurer is automatically discharged from liability for the claim. The insurer does not need to have been prejudiced. If, however, the clause is not a condition precedent, then breach will entitle the insurer to damages only. To claim damages, the insurer must have suffered prejudice.

6. Requirements regarding loss-adjusting proceedings

There are no particular common law legal requirements regarding the loss adjusting procedure. The Insurance Conduct of Business (ICOB) rules do, however, impose some obligations on insurers for certain types of insurance, including for example the requirement that an insurer must handle claims promptly and fairly.

In addition, there are market procedures for claims processing in subscription markets. Lloyd's have implemented a claims scheme, known as the Lloyd's Claim Scheme, which provides a mechanism for the administration and agreement of claims involving more than one Lloyd's insurer. The IUA Claims Agreement Procedures similarly set out claims agreement rules for claims involving IUA Companies.

7. Entitlement to raise a claim against an insurer

A claim under an insurance contract is a claim for damages of breach of contract, even where the insurer admits liability. Damages are categorised as the insurer's promise to indemnify the insured. This means, amongst other things, that the insurer cannot be liable for more than the amount covered under the policy even in the event of a wrongful refusal to pay out a claim. The insurer is not therefore liable for consequential losses to the insured which are caused by a delay in paying out on a policy, or a refusal to do so.

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

8. General rules concerning the limitation period for claims

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

9. Policy triggers with respect to third party liability insurance

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

— The first is on a "claims made" basis, where the claim against the insured is first made during the policy period even if the event giving rise to the claim occurred prior to the policy period. This type of cover is common in professional indemnity and directors and officers insurance policies for example. In addition, the policy may extend cover to include circumstances notified during the policy period which "may" or "are likely to" (or some other causal link) give rise to a claim, even if the claim subsequently materialises after the end of the policy period. This is commonly known as a "deeming provision".
— Secondly, the policy may be a "losses occurring" policy. This requires the third party to have suffered injury during the policy period.
— Thirdly, the policy may provide cover where the event giving rise to the loss occurs during the policy period, even where the loss does not occur until after the policy period. These are "event occurring" policies.

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

10. Reinsurance regulations

Historically, the UK approach has been to require authorisation for reinsurance business on a similar basis to direct insurance; reinsurers in the UK have, for many years, required authorisation from FSA (or its predecessors). The regime is not identical to that for direct insurers but reinsurers are subject to regulation under FSA's extensive handbook.

The UK regime now reflects the harmonised regime in the EU Reinsurance directive (including the single passport for pure reinsurers). The requirements of Solvency II will apply from late 2012.

Reinsurers (like insurers) are now preparing for Solvency II but the new regime is being delayed yet again. The original 2012/13 date was put back to 1 July 2014, but 1 January 2015 now looks to be the earliest date for the new rules to come into effect.

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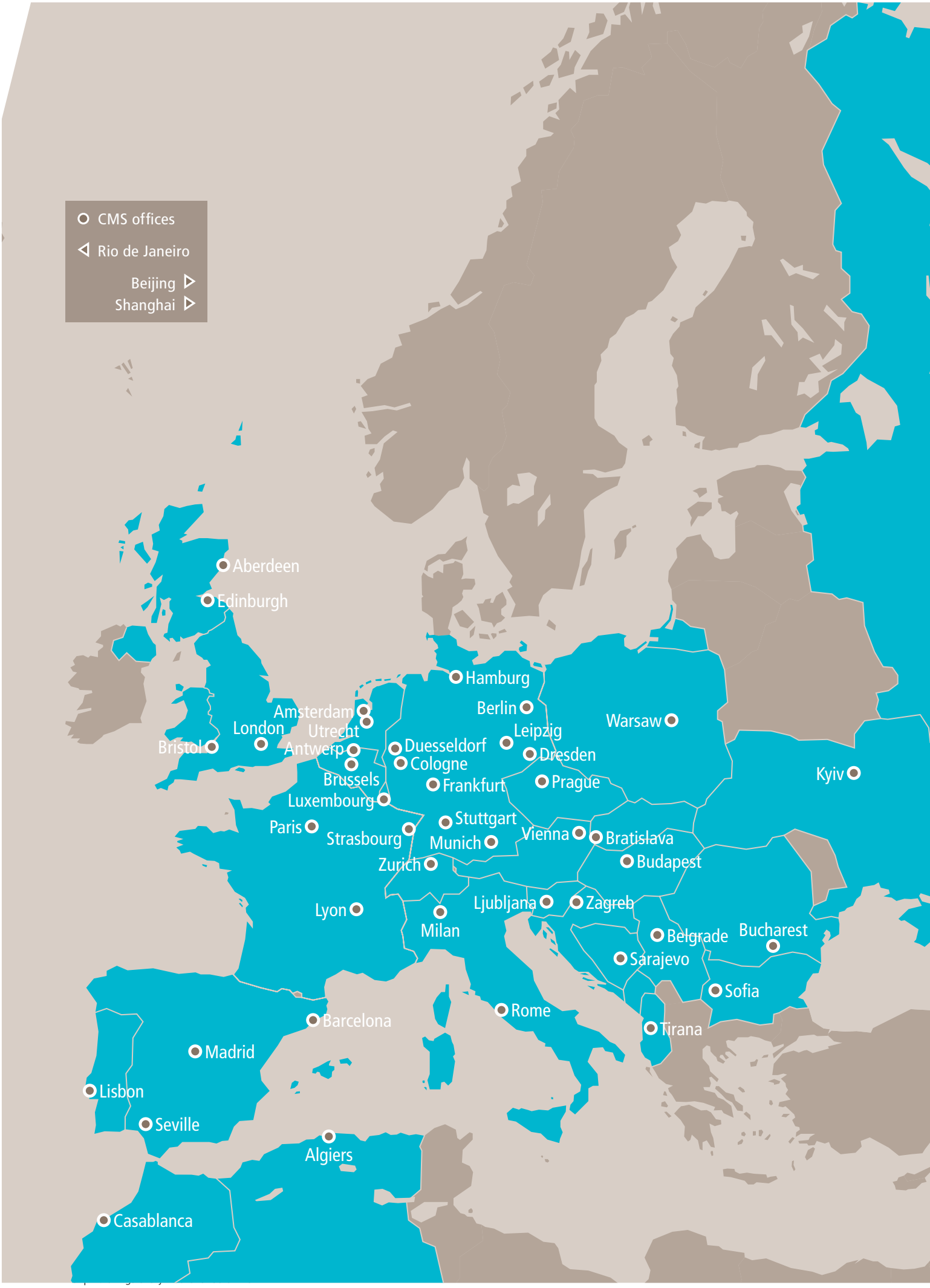
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