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10 things every insurer should know

Western 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.

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Introduction

The aim of this brochure is to provide an informative introduction to the key areas of concern for an insurer when considering establishing operations in 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 2012 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

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 2008, the Austrian insurance business has generated a premium income of €16.2bn in Austria; an increase of 2.1% compared to 2007. 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 certain information in connection with the insured risk. 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).

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 does not respond to a request for an explanation by the insured, 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 the legal reasons for denying the claim, based on the facts. In any event, there is a long-stop limitation of ten years.

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.

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

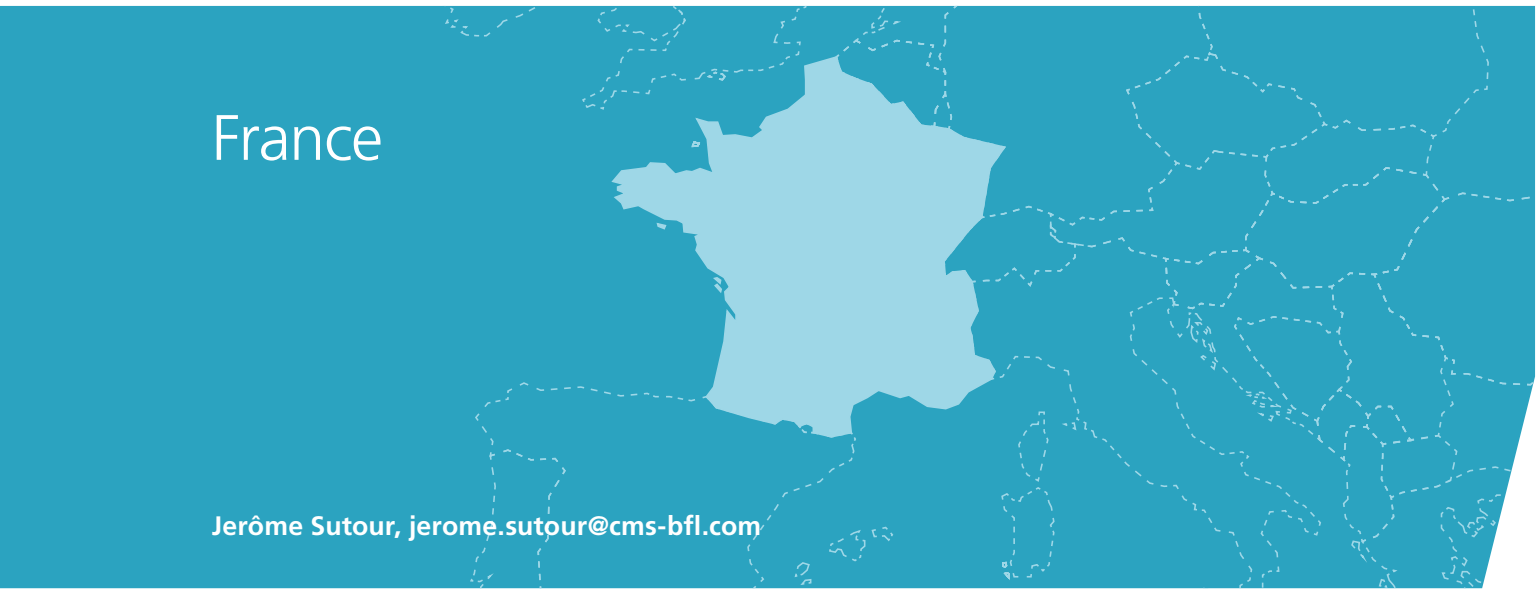
Reinsurance companies which undertake reinsurance activities without undertaking direct insurance activities in Belgium, are subject to specific legal rules introduced in 2009. Every reinsurance company, whether Belgian or foreign, must obtain a licence from the BFIC. The licence is subject to compliance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

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

Insurers based in EU and EEA countries can undertake insurance activities in Germany on a Freedom of Services basis. This is relatively inexpensive and does not require a complex formal procedure. Insurers based in EU and EEA countries can also operate through a branch established in Germany. In both cases, the insurers do not need to obtain any special licence from the BaFin. However, the home country regulator is required to submit information 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.

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 representatives 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 interests. 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 cover 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 policyholder – 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 insurable 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 premiums 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 fulfill these duties, otherwise in specific circumstances, the insurer may be entitled to terminate cover under the insurance contract.

Under the German Insurance Contract Act, 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".

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 occurred 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 consequences 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.

Under the German Insurance Contract Act, there are also 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 premium, or exclude the increased risk from the cover. These rights are available to the insurer for one month from the time that the insurer 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 increase 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 insurer 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 contract within one month.

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

Under the German Insurance Contract Act, 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 obligation of notification. If there is no contractual agreement between the parties, the insurer cannot decline cover. The parties need to agree contractually as to the consequences of late notification but may only stipulate the consequences of the breach of contractual obligations as provided for in the German Insurance Contract Act (see above).

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

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 interest (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 default 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 indemnity insurance.

— "Act-committed basis". This requires that the act that caused the damage is committed during the policy period. This is common in professional indemnity policies.

— "Discovery basis". This requires that the damage is discovered during the policy period. This is common in environmental pollution policies.

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 provide 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 therefore 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 intermediary with its branch outside Germany if such assistance is exclusively offered outside Germany (e.g. a Swiss reinsurer offers protection via a London based broker to German direct insurers).

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 means the insurer can claim a total or partial release from its obligation to provide cover and the insurer 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 insurance.

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.

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.

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.

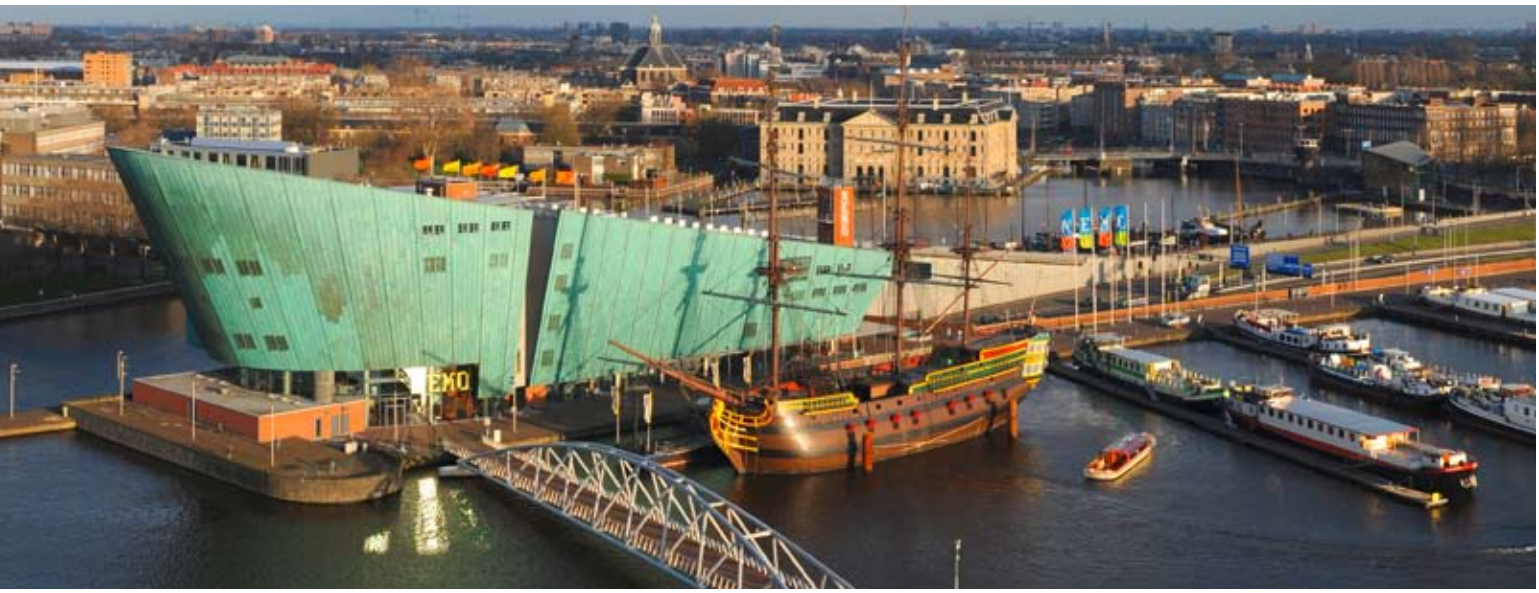
The insurer may set-off against any claim payment due: (i) the premium due; (ii) any loss on account of the late payment; and (iii) reasonable costs incurred in obtaining payment. This is the case even if the claim payment is due to a person other than the party from whom the premium is due.

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.
In the case of intentional non-disclosure by the insured, the insurer may terminate the contract with immediate effect within two months of discovering the non-disclosure. The insurer retains the premium and does not have to pay any claim. In the case of innocent or negligent non-disclosure, the insurer has two months from the discovery of the non-disclosure to terminate the contract, provided it has notified the insured of its awareness of the non-disclosure and of the consequences. 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.

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

These are currently subject to review by the Dutch government, as they are quite unclear.

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 the claim or rejects it in unambiguous terms by registered letter. The rejection letter must state that the insured's right of action expires in six months.

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 rejects it by registered letter 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.

Spain

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1. Introduction

There are various alternatives available for the carrying out of 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 Hacienda). Their activities will be limited to those types 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 out insurance activities in Spain through establishing 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 out insurance activities in Spain in accordance with the licence granted by the home country, as soon as the home country regulator notifies the Spanish Treasury Department of the EEA company's intention to perform 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 freedom of services basis, where the home country regulator notifies the Spanish Treasury Department. Companies based outside of the EEA are required to establish a branch and obtain 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. The 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 terminated early (e.g. through portfolio transfer, transformation of the insurance company, merger, split up), the insured will 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, the insured must disclose all circumstances that are material to the risk to be covered by the insurer. Such information is commonly submitted to the insurer in the proposal form completed by the insured. If any information is not requested by the insurer or is not raised in the proposal form, the insured will not be required to disclose the information.

The insurer will be entitled to withdraw from the insurance contract in the event the insured provides false or incomplete information regarding the circumstances of the risk to be covered. The contract is treated as terminated going forwards: the insurer may retain the premiums paid by the insured and any claim payments already made do not have to be returned.

If an insured event occurs and the insured has not disclosed all the above information, the insurer has the right to reduce the claim payment in proportion to the difference between the premium paid and the premium that the insured would have had to pay in the event that the information was disclosed.

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

5. Consequences of late notification

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

Similarly, the insured must provide the insurer with all the information about the circumstances and the consequences arising from the insured event.

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to pay the 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, the insurer is 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 the insurer for compensation for loss arising from the insured event.

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.

8. General rules concerning the limitation period for claims

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

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

9. Policy triggers with respect to third party liability insurance

For third party liability insurance, coverage is triggered either (i) by the occurrence of an insured event, or (ii) by a third party notifying the insured 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.

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 Spanish 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 perform reinsurance activities; and (iv) insurance and reinsurance companies based outside of the EEA (through a branch located in Spain), authorised by the Spanish 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.

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 third party liability 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 or the price which the insured person owes to the insurer for concluding the contract. 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 its right to terminate 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 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 in any event. 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. Under third party liability insurance policies, 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 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 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.

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 a personal 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. 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 up to £100,000 only. 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. Promptly in this context 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 seems to be 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 under the insurance contract. It is essentially the price paid by the insured for the insurer undertaking to cover the risk insured.

The premium will be the amount the insurer considers is sufficient to reflect the risk being underwritten. The premium will often 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 almost always provide at least a formula by which the premium is to be calculated, or indeed a defined figure. If insurance is concluded with the premium to be arranged, and no arrangement is made, then a reasonable premium is payable.

There are certain standard situations in which the premium may not be fixed at the outset. One of these is 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. Another example occurs in marine insurance policies, where the insurer is able to charge an increased 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 go or in instalments. If it is payable in instalments, 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). It will also be a matter of construction of the contract whether the premium is earned at the outset or as each instalment falls due.

If the payment of premium within a time period is designated a warranty or condition precedent to cover, then failure to pay within the time period will mean the insurer is discharged from liability under the policy. Otherwise, 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 in the ordinary course of its business to know. But 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 the prudent hypothetical underwriter in deciding on the premium or whether to insure the risk. It need not be a decisive influence, but rather simply something which would have an effect on the thought process of the prudent underwriter. 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 actual underwriter who underwrote the risk must have been "induced" by that misrepresentation or non-disclosure. This means that they would not have written the risk at all, or not on the terms that they did, had the correct position been disclosed or represented correctly.

The insured is not required to disclose matters which diminish the risk, which are known by the underwriter, which are matters of common notoriety, which are waived by the insurer or which 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.

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