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10 things every insurer should know



2016

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The insurance market is constantly evolving and it continues to provide new opportunities for companies seeking to expand, build new partnerships or improve returns on capital. CMS is renowned for its industry know-how, having worked in the insurance and reinsurance market for over half a century. This long-term involvement with risk and insurance professionals across Europe and beyond means we are well-positioned to support you in making the most of these new opportunities.

CMS speaks the insurance industry's language and our cross-regional insurance practice advises many of the sector's major players and representatives.

This document provides a sample of that expertise, compiling and contrasting ten key insurance issues across some of the jurisdictions in which we operate.



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Albania

1. Introduction

The insurance industry in Albania is relatively new. Prior to 1990, there were no specialised insurance companies operating in the country. After the so-called 'liberalisation' of the market in 1999, the insurance market changed significantly in regards to the quality of services and selection of insurance products. To date, many international insurance companies are active in the Albanian market through their acquisition of local insurance companies.

Insurance activity may be performed in two ways. The first way is to duly incorporate a joint-stock company in Albania. Prior to incorporation it is essential that approval is granted by the Insurance Supervisory Authority (ISA), the local regulator. The procedure may take up to six months and usually requires professional assistance since a significant amount of documentation is needed and it must be in Albanian. Certain financial requirements also apply. The insurer cannot be registered in the Trade Registry if it does not comply with all requirements.

The second option is for foreign insurance companies to register branches in Albania. The initial steps are the same as those required for incorporation. However, additional information is required, such as data concerning the financial situation of the parent company, audited financial statements from from the last three years, the future strategy of the parent company, and the development of the insurance market in the country where the parent company is incorporated. The branch can only perform the same activities as its parent company.

Incorporation and registration procedures at the Trade Registry usually take 24 hours. Following incorporation, the insurer must file a written request (along with the necessary documentation) with the ISA to become licensed to carry out insurance activity. The procedure takes up to two months from the date the request is filed. The ISA may extend the term to three months. Insurers licensed to provide motor third-party liability ("MTPL") services become members of the Albanian Insurance Bureau.

Following Albania's application for EU membership, additional legal amendments are expected to occur in the near future, to adapt local law to that of the EU. In fact, a new draft law envisaging the possibility of an EU insurer (with no incorporation requirements) directly providing services in Albania is currently being reviewed by Parliament.

2. Defining insurable interest

Albanian law generally defines an insurable interest as an event envisaged in the insurance agreement. As long as this occurs, the insured has the right to be indemnified by the insurer. However, insurance activity may only be performed in compliance with pre-defined insurance classes provided in the law. As a consequence, insurance agreements cannot provide insurable interests and covered risks other than those permitted by law. The insurance classes cover the common insurable interests provided by other EU jurisdictions.

3. Calculation of premiums

Albanian law does not contain specific rules on the method for calculating premiums. However, it provides that a premium consists of: a calculated premium for the insurance risk (i.e. net premium); a calculated value covering administrative expenses; saving elements in certain classes of life insurance; and a calculated value for the company's profits, including profit generated from risk-free insurance investments and the ones presenting a risk factor.

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

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

4. Consequences of misrepresentation and/or non-disclosure

Prior to executing an insurance agreement, the insurance company must inform the insured or the policyholder regarding the insurance products, the special and general terms and conditions of the agreement, the expenses and profits of the insurance contract, as well as the circumstances that are material for assessing the risk which are known/should have been known to the insured or policyholder.

If the insured deliberately provides inaccurate information or fails to provide the required information, the insurance company has the right to not only be dismissed from the obligation to provide indemnities but also to retain the premiums and terminate the agreement.

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

Albanian law does not outline the procedures for loss adjustment. As a result, parties have discretion to include such provisions in the insurance agreement.

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

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

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

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

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

10. Reinsurance regulations

Albanian law contains specific provisions regarding reinsurance which is defined as a transfer of a part of the risk from the insurer to the reinsurer pursuant to the reinsurance agreement. Provisions similar to those for insurance companies apply to reinsurance companies. Reinsurance companies should be incorporated in Albania and duly licensed. Albanian insurers may execute reinsurance agreements with foreign reinsurance companies only after obtaining prior approval from the ISA. Albanian insurance companies may also perform reinsurance activities after being duly licensed by the ISA. An insurance company must reinsure risks that exceed 10% of the company capital. Reinsurance agreements are similar to insurance agreements.

Contacts

Marco Lacaita

E marco.lacaita@cms-aacs.com

Edita Poro

E edita.poro@cms-aacs.com



Austria

1. Introduction

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

According to the Austrian Insurance Association's Annual Report 2014, the Austrian insurance business has generated a premium income of EUR 16.4 billion in Austria. Insurance business in Austria may only be carried out by legal entities in the form of a joint-stock company, a registered European Company or a mutual insurance association. Insurance activities may not be undertaken by individuals or limited partnerships.

However, insurance mediation activities, which are governed by the Austrian Trade Code (**Gewerbeordnung** - GewO) are permitted for individuals, 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 under its home Member State licence. Such services can either be provided through branch offices established in Austria or on a Freedom of Services basis from outside Austria.

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 insurance; 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 definitions 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 on the calculation of insurance premiums. However, the VAG contains various – very detailed – provisions related to premiums.

For example, Section 91 paragraph 2 of the VAG provides that the gender factor must not lead to different premiums or benefits for women and men.

4. Consequence of misrepresentation and/or non-disclosure

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

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

5. Consequences of late notification

The insured is obliged to notify the insurer of an insured event immediately after the insured became aware of it. The late notification of an insured could release the insurer from its liability to pay any indemnity or otherwise perform under the contract, if such consequence was previously agreed upon in the insurance contract.

This will only apply if the insured has intentionally or with gross negligence failed to timely notify the insurer of an insured event. Insurers remain liable to pay the indemnity if the insured has acted only negligently.

Even when the insured acted with intent or gross negligence, the insurer may still be liable to pay the indemnity, fully or partly, if the insured can prove that the failure to immediately notify the insurer of the insured event does influence the finding of the insured event, or the finding or the scope of the insurer's obligation to perform under the insurance contract.

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

6. Requirements regarding loss-adjusting proceedings

Cash benefits are payable by the insurer after the insurer has finished its necessary enquiries into the insured event and the scope of the insurer's performance. Regardless of any pending loss-adjusting proceedings, payment becomes due if, two months after the claim for payment has been made, the insurer has not terminated the enquiries and the insurer has not responded within one month to a request by the insured to explain why such enquiries could not be finished yet.

7. Entitlement to raise a claim against an insurer

Each insurance contract will determine who is entitled to raise a claim under the insurance contract.

8. General rules concerning the limitation period for claims

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

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

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

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

There is no general rule on 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 outlines specific regulations in relation to reinsurance services. Insurers focusing their business on reinsurance services are not subject to the overall application of the VAG. Reinsurance service providers domiciled in the EEA may passport their home Member State licence into Austria.

Contacts

Daniela Karollus-Bruner

E daniela.karollus-bruner@cms-rrh.com

Thomas Böhm

E thomas.boehm@cms-rrh.com



Belgium

1. Introduction

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

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

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

It is forbidden (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.

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

Belgian insurance contracts are governed by the 2014 Insurance Act, which contains a number of mandatory provisions (e.g. regarding non-

payment of premiums, misrepresentation or non-disclosure of risks and late notification).

2. 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 the 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, if the risk has changed (subject to certain conditions) or as a result of an indexation of the premium. The NBB 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 by the due date, the insurer must send a notice of default stipulating a period of time, which must not be shorter than 15 days, in which the overdue premium (together with any accrued interest) must be paid. If the insured fails to pay, the insurer is entitled to refuse coverage or terminate the policy. However, in the case of 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 policyholder or insured to remedy the default by paying the overdue premium.

4. Consequences of misrepresentation and/or non-disclosure

In addition to the general principles of Belgian law that declare an agreement void due to material error or fraud, insurance law also specifically addresses misrepresentation and non-disclosure of risks.

These rules allow the insurer to amend, terminate or annul the insurance contract if the insured made omissions or errors in the disclosure or representation of the risk. 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 its 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 insurer became aware of the misrepresentation or non-disclosure. 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 with 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 been aware of the non-disclosed or misrepresented circumstance or event, the contract can 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 in 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 maximum period of time within which insurers must pay the claims. Instead, specific laws containing mandatory terms for payment of a claim apply to certain types of insurance, such as fire insurance or motor vehicle insurance. Assuralia (the professional association for insurance companies in Belgium) has issued recommendations regarding payment terms 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 of damages suffered as a result of an insured

event. The claimed amount must be paid directly to the third party with no possibility for creditors of the insured to claim any part of such payment. The type of insurance will determine 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 assert against the insured. 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 a result of an event which 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 that 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 from 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 longstop 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 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 that have occurred during the policy term are also covered.

10. Reinsurance regulations

Reinsurance companies that undertake reinsurance activities without undertaking direct insurance activities in Belgium are subject to specific legal rules introduced in 2009 and last amended in 2014. Every reinsurance company, whether Belgian or foreign, must obtain a licence from the NBB. This 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 NBB. Although the supervision of these companies is based on the home country control principle, the NBB retains a power of supervision over them.

Foreign insurance companies of a non-EEA Member State that 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 NBB and identifies the activities it intends to carry out, and complies with the requirements imposed by Belgian law. The NBB can deny 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.

Contacts

Carl Leermakers

E carl.leermakers@cms-db.com

Benoît Vandervelde

E benoit.vandervelde@cms-db.com

Virginie Frémat

E virginie.fremat@cms-db.com



Bosnia and Herzegovina

1. Introduction

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

Insurance activity in BiH can be undertaken by insurance companies established in the form of joint-stock companies. The minimum share capital requirement ranges from BAM 1 million to BAM 3 million depending on the type of risk insured. There are two types of insurance companies: (i) standard-type joint-stock companies; and (ii) joint insurance companies. A joint insurance company is defined as an insurance company whose members jointly guarantee the financing and compensation for an agreed insured event on the basis of the 'principle of mutuality'.

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

companies established in the territory of RS) (the "Agency" or "Agencies"). An insurance company can be established by a domestic or foreign natural person or legal entity. If the Agency decides that the application for approval fully meets the requirements, it will issue an approval within 60 days from the submission of the application. After the approval is issued, the insurance company is obliged to pay a fee for performing this business activity. The Agencies determine the fee on the basis of the amount of premiums collected in the previous year within the deadlines determined by the Agencies. It is important to note that approval from the Agencies is a pre-condition for entering an insurance company in the Register of Business Entities. This approval becomes effective only upon the

conclusion of the registration procedure for a newly-founded insurance company. Another obstacle that insurance companies face is the obligation imposed on every insurance company to determine a solvency margin in respect of its entire operation corresponding to the total company assets. Moreover, insurance companies have to establish a guarantee fund which constitutes one third of the solvency margin. The minimum amount of the guarantee fund cannot be less than BAM 1 million. However, the amount of the guarantee fund depends on the types of insurance offered by the insurance company. The Agencies also request companies to submit financial reports and other documents necessary to exercise detailed supervision over companies throughout the course of their business dealings and to audit them.

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

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

2. Defining insurable interest

Insurance activities are divided into two categories: life and non-life insurance. The insurable interest is further divided within these two groups in accordance with the type of insurance and the type of risk insured. Legal regulations require separate Agency approvals for

life and non-life insurance activities, except that it is possible to continue combined insurance activities if the insurance company had already been performing both activities at the time when the Law on insurance companies was introduced (in 2005). In such cases it is necessary to have separate administration for the different insurance activities. Both entities' legislation provides for a detailed list of types of insurance and risks against which one can be insured within the two general groups mentioned above.

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

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

3. Calculation of premiums

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

The Supervisory Agency may limit the scope of insurance activities that an insurance company may perform for a certain period if it is necessary to protect the financial stability of the company. Restrictions may apply to the entire activity of the company only to a particular part. The Supervisory Agency can also, after the abolition of the tariff system, order an increase or decrease in tariff premium rates for certain types of insurance, if the Supervisory Agency considered the rates inappropriate.

4. Consequence of misrepresentation and/or non-disclosure

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

5. Consequences of late notification

Except in cases of life insurance, the insured is obliged to notify the insurer of the occurrence of an insured event within a maximum three-day period from the day it found out about the event. If the insured fails to do so, the insured will be obliged to compensate the insurer for its damage incurred as a result.

6. Requirements regarding loss-adjusting proceedings

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

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

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

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

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

10. Reinsurance regulations

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

Contact

Nedžida Salihović-Whalen

E nedzida.salihovic-whalen@cms-rrh.com



Bulgaria

1. Introduction

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

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

Another common option available to foreign (non-EU) insurers is the incorporation of a local branch office. The branch shall obtain a licence in order to provide insurance services in Bulgaria. The branch can provide only those types of insurance which its parent company provides in its jurisdiction and must comply with certain requirements regarding the branch's financial resources and manager(s).

Opening a branch is a more simple procedure than incorporating a new company, with fewer stipulated requirements as to the financial resources and general management. Since a branch is a subsidiary unit of its parent company (not a separate legal entity) it has a simpler organisational and management structure.

In Bulgaria an EU insurer may undertake the activity for which it has been licensed in its home country, either on a Freedom of Services basis or by establishing a local branch. For this purpose, a procedure of exchange of information between the supervising authority in the home Member State and the BFSC must be completed. The BFSC exercises supervision over insurance and reinsurance companies from EU Member States, which operate in Bulgaria, save for supervision over their financial stability, which is performed by the supervising authority in the home country.

European companies (SE), Self-insurance cooperatives, and European Cooperative Societies (SCE) may also conduct insurance business in Bulgaria, subject to obtaining the necessary licence.

2. Defining insurable interest

The insurable interest is defined under the Bulgarian Insurance Code as the legally-recognised necessity for a person to seek coverage against the consequences from a possible occurrence of an insured event. In other words, this is the value that is at risk, should the insured event occur.

The existence of an insurable interest (or a future insurable interest) is a prerequisite for establishing an insurance relationship, the absence of which renders the insurance contract null and void. Where there is no insurable risk an insured person may demand that the whole premium (or a portion of it in case of annuity payments) be reimbursed, unless the insured was aware or should have been aware of the absence of the insurable interest.

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

3. Calculation of premiums

The premium is determined by the assessment of an insurable risk and is usually calculated for an insurance period of one year. During the term of the policy, the amount of the premium can be subsequently amended or either party can seek termination of the policy if there is a significant increase or decrease of the risk, or if the premium amount was not correctly calculated in the first instance.

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

4. Consequences of misrepresentation and/or non-disclosure

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

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

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

5. Consequences of late notification

Generally speaking, the insurer is allowed to refuse to provide indemnity in the event of the insured's failure to notify it of an insured event within the specified term, if (i) this was done with the intention to impede the insurer's verification of the relevant circumstances of the event's occurrence and its consequences; or (ii) this has made it impossible for the insurer to verify the circumstances of the event's occurrence and its consequences. Obligation for notification under property insurance has been explicitly set forth under the Insurance Code in accordance with the cited principles, but similar clauses can be found in other types of insurance policies as well.

6. Requirements regarding loss-adjusting proceedings

An insurer must indemnify the insured, according to the policy, within 15 days from the date of receiving the insured's claim and all necessary evidence under the policy terms, if cover is confirmed. The insurer is obliged to register the date of receipt of the insurance claim, as well as the date of each subsequent filing of documents and to certify these dates before the claimant.

If not all required documents were provided to the insurer, the insurer must render its decision within six months from the filing of the claim in the general case, or within three months of the filing of a claim under motor third-party liability insurance.

The 15-day term does not apply to high-risk insurance, in which case the above terms can be longer.

7. Entitlement to raise a claim against an insurer

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

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

8. General rules concerning the limitation period for claims

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

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

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

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

10. Reinsurance regulations

A reinsurer operating in Bulgaria must be:

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

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

Contact

Nevena Radlova

E nevena.radlova@cms-cmck.com



Croatia

1. Introduction

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

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

According to CFSSA, the authorisation process for a local insurance company to undertake insurance activity may take up to three months. A branch of an EU Member State insurance company may start to perform insurance activity in Croatia three months after CFSSA receives notification from the relevant home country supervisory authority.

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

2. Defining insurable interest

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

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

3. Calculation of premiums

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

Circumstances such as maternity and pregnancy are normally left out for the process of premium calculation.

4. Consequence of misrepresentation and/or non-disclosure

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

In the event of an intentional violation of the disclosure obligations, providing untrue information or concealing important facts, the insurer may rescind the insurance contract. This would happen if the insurer would not have entered into the insurance contract had it been aware of the undisclosed information. The insurer's right to rescind the insurance contract is time-barred (three months starting from the day on which the insurer became aware of misrepresentation and/or violation of disclosure obligation).

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

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

5. Consequences of late notification

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

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

6. Requirements regarding loss-adjusting proceedings

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

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

7. Entitlement to raise a claim against an insurer

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

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

8. General rules concerning the limitation period for claims

The limitation period for claims expires three years after the first day following the calendar year in which the claim originated. The limitation period for claims arising from life insurance is five years. If the insured did not know that the insured event occurred, the limitation period begins on the day on which the insured became aware of it. In any case, the limitation period expires in five years generally, or 10 years in the case of life insurance. The insurer's claim arising from the insurance contract expires in three years.

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

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

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

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

10. Reinsurance regulations

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

Contacts

Gregor Famira

E gregor.famira@cms-rrh.com

Marija Mušec

E marija.musec@bmslegal.hr



Czech Republic

1. Introduction

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

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

Insurers based in EU and EEA Member States can operate in the Czech Republic through a branch established in the Czech Republic. They do not need to obtain a special licence from the CNB to establish a branch. However, they must fulfil information obligations with respect to the Insurance Market Regulator in their home state

before undertaking insurance activities in the Czech Republic. It is less expensive for an insurer from the EU or EEA to establish a branch office in the Czech Republic, compared to obtaining a licence from the CNB. Insurers from countries outside the EU and the EEA can also establish a branch in the Czech Republic but this is usually rather lengthy and costly as it involves obtaining a special licence from the CNB.

Insurers based in EU and EEA countries can also undertake insurance activities in the Czech Republic on a Freedom of Services basis. This is relatively inexpensive and does not require any

complex formal procedures. However, such insurance activities may only be performed in the Czech market on a temporary basis.

2. Defining insurable interest

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

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

3. Calculation of premiums

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

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

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

4. Consequence of misrepresentation and/or non-disclosure

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

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

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

5. Consequences of late notification

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

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

6. Requirements regarding loss-adjusting proceedings

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

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

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

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

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

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

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

10. Reinsurance regulations

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

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

Contacts

Tomáš Matějovský

E tomas.matejovsky@cms-cmck.com



England & Wales

1. Introduction

Insurers are regulated by the Financial Conduct Authority (FCA) under the framework of legislation established by the Financial Services and Markets Act 2000 (FSMA) and, more recently, the Financial Services Act 2012 (FSA 2012).

The FSMA is heavily influenced by the large body of EU insurance directives, which implemented harmonised regime of insurance regulation across the EU. Whereas the Financial Services Authority (the predecessor to the FCA) was a unitary authority responsible for both prudential/financial regulation and for conduct of business, the Prudential Regulation Authority (PRA) was created as part of the Bank of England by the FSA 2012 and is responsible for the prudential regulation and supervision of insurers.

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

The FCA 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 FCA. In many respects the UK regime anticipated many of the techniques in Solvency II but UK insurers still face major challenges in meeting the new EU requirements. The PRA monitors the effects of implementing Solvency II to ensure that gaps in the regulatory framework do not emerge.

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

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

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

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

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

Scotland

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

2. Defining insurable interest

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

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

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

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

3. Calculation of premiums

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

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

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

There are certain standard situations in which the premium may not be fixed at the outset, e.g. where an adjustable premium is payable. In that case, the parties agree an initial payment of premium (called a minimum and deposit premium) to be paid at the outset, with the final amount of premium to be calculated thereafter in accordance with an agreed methodology. If the adjusted premium falls below the deposit, the insurer will keep the minimum. This can happen in

marine insurance policies, where the insurer is able to charge a higher premium in the event of an increase in the risk during the policy period (for example an insured vessel entering a known war zone).

Premiums may be payable in one tranche or in instalments. If 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).

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

4. Consequences of misrepresentation and/or non-disclosure

On 12 August 2016, when the Insurance Act 2015 (the Act) is operative, English law will apply a different legal insurance regime than that which currently exists and this area in particular is subject to law change. As it is possible for the effect of the Act to be excluded by agreement, the law that predates 12 August 2016 may still be relevant. The law predating 12 August 2016 is considered first. For a more comprehensive review of the Act please see the following link: <http://www.cms-lawnow.com/insuranceact2015>.

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

Material means something which would influence a prudent and reasonable underwriter in deciding on the premium or whether to insure the risk. Whether a matter is material to the risk is a broader question than whether it is material to the subject matter of the insurance. Amongst other things, it includes matters material to what is known as the 'moral hazard', matters material to the likelihood of a claim being made but which are not material to the subject matter insured. An example might be previous fraud or criminal convictions of the insured or employees of the

insured. In addition, to rely on a misrepresentation or non-disclosure, the underwriter who underwrote the risk must have been 'induced' by that misrepresentation or non-disclosure. This means that they would have amended the terms or not have written the risk at all, had the correct position been disclosed or represented correctly.

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

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

From 12 August 2016, this area of insurance law will change significantly for business insurance, with consumer insurance being dealt with separately by the Consumer Insurance (Disclosure and Representations) Act 2012.

Insureds will be subject to what is known as the duty of fair presentation and are required by the Act to make a fair presentation of the risk to the insurer. To be a fair presentation insureds must disclose every material circumstances that they know or ought to know, or give disclosure that gives the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries. The Act bans data dumping by stating that disclosure must be made in a manner that would be reasonably clear and accessible to a prudent insurer.

What an insured knows or ought to know is the knowledge of its senior management or of those responsible for the insured's insurance. However, this will not include information acquired by the insured's broker through a business relationship with a person who is not connected with the relevant contract of insurance.

Similar to the law prior to the Act, the insured is not required to disclose matters that: diminish the risk, are known by the insurer, ought to be known by the insurer, the insurer is presumed to know or have been waived by insurers. What an insurer ought to know is defined in the Act and imposes a positive duty on employees of an insurer to pass on knowledge to the relevant underwriters and also includes information that is held by the insurer and readily available.

The insurer has a remedy against the insured for a breach of the duty of presentation only if the insurer shows that, but for the breach, the insurer would not have entered into the contract of insurance at all, or would have done so only on different terms.

Under the Act, an insurer may avoid the policy and keep the premium only where the misrepresentation or non-disclosure is deliberate or reckless. The Act otherwise brings in proportionate remedies. If the risk would have been declined altogether the insurer can avoid the policy and return the premium. If the insurer would have imposed additional terms then those terms are applied to the policy, regardless of whether the insured would have accepted them. Finally, if the insurer would have charged an additional premium, any claim will be paid proportionately, so that if the premium would have doubled the insurer will only pay out on half of any claim.

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. 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 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 has 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.

It had been intended that the Act would include a clause that gave insureds the right to claim damages against insurers for late payment of claims. Whilst this clause never made its way before Parliament, it is seen as an important step forward and, at the time of writing, the Enterprise Bill is making its way through Parliament. In its current form this would add a section to the Act requiring insurers to pay claims in a reasonable time or face a claim for damages. The limitation period for an insured to make a claim of damages for late payment of a claim will expire 1 year after the insurer has paid the claim.

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 six). 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

At common law, contracts of reinsurance are treated much like contracts of insurance. They will fall under the definition of non-consumer contract and be subject to the Act as of 12 August 2016, with the reinsurer being the insurer and the purchaser of the reinsurance being the insured for the purposes of the Act.

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 FCA (or its predecessors). The regime is not identical to that for direct insurers but reinsurers are subject to regulation under FCA's extensive handbook.

The UK regime now reflects the harmonised regime in the EU Reinsurance directive (including the single passport for pure reinsurers). Reinsurers (like insurers) have had to fully prepare for Solvency II which, after numerous delays, came into force at the start of 2016.

Contacts

Alex Denslow

E alexander.denslow@cms-cmck.com

Stephen Netherway

E stephen.netherway@cms-cmck.com



France

1. Introduction

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

- French companies that have been granted an insurance licence by the ACPR. Licensing requirements include the obligation to submit a business plan. The ACPR assesses the adequacy of the technical and financial means of the applying company with the proposed business plan and takes into account the allocation of 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 six months from the moment the application file is completed. Licensed French insurance companies can perform their activities in France either through their French headquarters or through a branch established in another EU Member State.
- EU insurance companies licensed in their home country that have passported their activities licensed under their home country regulations. Such companies can perform their activities in France (subject to the relevant home country authorities notifying the ACPR) either through a French branch (on a Freedom of Establishment basis) or directly through their home country headquarters or through a branch established in another EU Member State (on a Freedom of Services basis). If operating via a French branch, EU insurers must appoint a general representative who must be a French resident (either an individual or a corporate entity having its registered office in France and represented by a French resident individual).

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

2. 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, which can 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 ten year duration of the insurance contract.

With the exception of life and health insurance, the 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 the premium. The insurer is always entitled to terminate the contract where the risk has increased, provided it gives the insured ten days' notice of the termination.

4. Consequences of misrepresentation and/or non-disclosure

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

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

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 provides late notification (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 was not actually prejudicial to the insurer. The time limit for notifying a loss must be clearly stated in the insurance contract and cannot be less than five working days.

6. Requirements regarding loss-adjusting proceedings

The French Insurance Code does not provide any specific rules or mandatory requirements 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 ten 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 have a minimum duration of five years (for some professional liabilities this is increased to ten years). Claims made during the subsequent period are insured only if they relate to insured events that occurred during the policy period. The limit of indemnity during the run-off period must be the same as the limit during the last year of the policy.

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 write reinsurance in their home country can passport their reinsurance activities in France.

The French Insurance Code does not contain specific regulations with regard to reinsurance agreements, which are governed by the general principle of contractual freedom ('liberté contractuelle').

Until now, reinsurance companies have not been subject to specific accounting, prudential or reporting regulations. This will change with the implementation of Solvency II regulations, which will apply to reinsurance undertakings.

Contacts

Laurent Mion

E laurent.mion@cms-bfl.com

Jérôme Sutour

E jerome.sutour@cms-bfl.com



Germany

1. Introduction

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

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

In March 2011 BaFin provided information about the laws and provisions insurers based in EU or EEA countries must comply with for the General Good, if they carry out direct insurance business in

Germany through a branch or cross-border provision of services.

Insurers from countries outside the EU and EEA can also establish a branch in Germany, but need a special licence from BaFin. 'Home-foreign insurance/insurance by correspondence' (insurance written in one country on property or risks located in another country) can be undertaken by insurers from outside the EU and EEA without a branch in the EU and EEA countries, as long as the policy has been taken out on the insured's initiative. Accordingly, insurers from outside the EU and EEA cannot act on a Freedom of Services basis in Germany.

2. Defining insurable interest

Insurance contracts require that the insured has an insurable interest in the subject matter of the insurance. There is no legal definition of insurable interest. 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.

Under case law, business will be insurance if the insurer confers indemnity benefits to the insured in the case of an uncertain event. The assumed risk has to be conferred by concluding contracts with a variety of persons with a similar risk. The premium is calculated by an assessment of risk in consideration of the number of those insured.

3. Calculation of premiums

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

4. Consequence of misrepresentation and/or non-disclosure

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

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

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

questions on their own and provide brokers with their question forms.

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

Unless there has been deliberate misrepresentation and non-disclosure, the insurer cannot avoid or cancel the contract if, being aware of the actual circumstances, it would have written the risk albeit on a different basis. In this situation, upon the insurer's 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 inform the insured in writing of the possible consequences of breach of the duty to notify. Further, if the insurer was independently aware of the misrepresentation or non-disclosure, it cannot rely on the breach.

Under the German Insurance Contract Act, if there is an increase of 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, demand a higher premium, or exclude the increased risk from the cover. These rights are available to the insurer for one month from the time that the insurer becomes aware of the increase in 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 its obligation to provide cover. If there has been gross negligence on the part of the insured, the extent of the insurer's release from 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.

An insurance contract may contain contractual obligations to perform precedent to the insured event. (These are different from the English concept of 'conditions precedent', which refers to an event or state of affairs that is required before

something else will occur and which must occur, unless its non-occurrence is waived, before any contractual duty arises). In German law, the contractual duty of the insurer may arise even if the contractual obligation precedent to the insured event has not been fulfilled. If there is an intentional or grossly negligent breach of the contractual obligation, the insurer may cancel the contract within one month from the time it became aware of the breach.

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

5. Consequences of late notification

The insured is obliged to notify the insurer without undue delay as soon as it 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 it 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 amounts 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 that the insurer may have to pay. With regards to 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 of the

claim being established by judgement, acknowledgement or settlement.

7. Entitlement to raise a claim against an insurer

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

In third-party liability insurance, the third party is not automatically entitled to raise a claim directly against the insurer but must raise a claim against the insured. This does not apply to compulsory motor-liability insurance, 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 three years, beginning with the end of the year that the claim comes into existence. When a claim under an insurance contract is notified to the insurer, limitation is stayed until the insured obtains the insurer's decision in writing.

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 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 are governed by general civil law, not specific reinsurance rules.

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 regulatory law provides specific rules for the latter. According to the Insurance Supervision Act, reinsurance activities within Germany may be undertaken under the following conditions:

- Permission from the BaFin is necessary for reinsurers domiciled 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 through a branch or on a Freedom of Services basis without obtaining separate permission from the BaFin. However, regarding their German activities, they are generally subject to supervision by BaFin. Therefore, such reinsurers are recommended to coordinate

their activities with/consult with the German authorities.

- Reinsurers that have their seat outside the EU and EEA but already have permission to conduct business in another EU or EEA country can apply for privileges considering their solvency capital requirements.
- Reinsurers with their seat outside of the EU/EEA may conduct business in Germany only if permitted by BaFin. However, no permission is required when the foreign reinsurer only conducts so-called 'home-foreign insurance/ insurance by correspondence' business. This is the case if the reinsurance contract is concluded exclusively on the initiative of the reinsured. Another exception occurs when the solvency regime of a reinsurer domiciled in a third country is deemed by the European Commission to be equivalent to the solvency regulations in EU and EEA countries.

Contacts

Winfried Schnepf

E winfried.schnepf@cms-hs.com

Stefan Segger

E stefan.segger@cms-hs.com



Hungary

1. Introduction

As of 1 January 2016 a new Insurance Act entered into force in Hungary. The new Act provides common regulation to both insurance and reinsurance companies. Basically, the aim of the new Insurance Act is twofold: on one hand, it aims to implement Solvency II regulation, and, on the other hand, it aims to modernise certain elements of Hungarian insurance (regulatory) law. The new Act, together with the new rules of insurance contract law stipulated in the new Civil Code (which entered into force in 2014), provides modern regulation of the insurance sector in Hungary.

In Hungary, insurance companies can only operate in the form of: a private company limited by shares, a European private company limited by shares (SE), a cooperative, an association or as a branch office of a third-country insurer.

Reinsurance companies can operate in the form of: a private company limited by shares, a European private company limited by shares (SE), a cooperative or a branch office of a third-country reinsurer. The operation of insurers and reinsurers requires prior authorisation from the Hungarian National Bank (HNB), the competent financial services authority. The authorisation procedure has two phases for both prospective insurers and reinsurers. In the first phase, the company must submit an application to the HNB for a foundation

licence with supporting documentation. In the second phase, within 90 days of receiving its foundation licence, the insurer/reinsurer must submit an additional application for authorisation to undertake insurance/reinsurance. The administrative deadline for the HNB to make a decision in each phase is three months; if necessary, the HNB can extend this deadline once for an additional three months in each phase.

In addition, EU Member State insurers and reinsurers may provide their services through a branch or on a Freedom of Services basis. In both cases, the EU Member State insurer/reinsurer can pursue its insurance activity in Hungary primarily

under the supervision of its home country regulator, but the HNB also exercises supervision over the activity (in particular from the consumer protection's point of view).

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

2. Defining insurable interest

According to the Hungarian Civil Code the only people able to conclude insurance policies are (i) those with an interest in avoiding the occurrence of an insured event on the basis of property or personal relationships (e.g. not only the owner but also the tenant of real estate) or who have an interest in the occurrence of an insured event in respect of life insurance policies which comprise assurance on survival to a stipulated age, birth assurance or marriage assurance; or (ii) those who conclude the insurance contract on behalf of an interested person.

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

3. Calculation of premiums

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

Payment of the insurance premium is governed by specific rules. Most notably, in the case of non-payment of the premium, the insurer shall request the payment in writing within an additional deadline of 30 days. If no payment is made within the additional deadline, then the insurance policy will be terminated as of the original due date of the premium, except if the insurance company makes a claim for the insurance premium in court without delay. Therefore the insurer should request the payment of the premium in order to keep the insurance contract in force.

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

4. Consequence of misrepresentation and/or non-disclosure

When concluding an insurance policy, the policyholder and the insured must disclose any material information, relevant to the insurer in undertaking the risk, which the policyholder and the insured are or should be aware of (these are typically requested by the insurer in the form of a questionnaire). The policyholder and the insured shall also report, in writing, if any material circumstance has changed during the period of the insurance policy.

In the case of non-disclosure, misrepresentation or non-reporting of any material change, the insurance company may be released from its obligations under the insurance contract, except if the policyholder or the insured proves that the insurer was aware of the non-disclosed or non-reported circumstance at the time of concluding the policy or those circumstances did not contribute to the occurrence of the insured event.

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

5. Consequences of late notification

The insurer may reject the claim on the basis of late notification (without demonstrating prejudice) if, (i) the policy stipulates a deadline to notify claims and the policyholder or the insured fails to report the claim within the deadline, fails to provide the necessary information or fails to facilitate the verification of the information provided; and (ii) as a consequence, any facts relevant to the assessment or defense of the claim become unascertainable. In this respect it does not matter whether the policyholder or the insured acted deliberately or negligently in failing to meet the notification requirements.

6. Requirements regarding loss-adjusting proceedings

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

7. Entitlement to raise a claim against an insurer

Under Hungarian law, only the insured or the policyholder are entitled to raise a claim against the insurer. As a consequence, a third party may not make a direct claim against the insurer, even with reference to its contractual relationship with the insured or to non-contractual damage caused by the insured. Therefore, a third party may only enforce its claim directly against the insured party. The only exceptions are: (i) mandatory motor vehicle third-party liability insurance where the injured third party is entitled by law to raise a claim directly against the insurer; and (ii) a third party's possibility to bring an action against a liability insurer for having a declaration that the liability insurance covered the damages occurred at the time when the damages were caused.

8. General rules concerning the limitation period for claims

In Hungary, the general limitation period for claims is five years. The law envisages some specific cases in which the limitation period may be shorter and the parties to the contract may agree on a shorter - or even longer - limitation period. Nevertheless, the exclusion of a limitation period by the parties' mutual agreement is not permitted.

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

However, there are two main rules under which these limitation periods can be extended: (i) if the claimant was not able to exercise their right within the determined limitation period due to circumstances outside their control, then the claimant has an additional one-year period to raise the claim (the additional one-year period starts when such circumstances cease to hinder the claimant in exercising their rights); (ii) some acts have the effect of interrupting the limitation period, for example if an action is brought for the enforcement of the claim and the court has adopted a final and binding decision in conclusion of the proceedings.

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

Indemnity policies (including PI and D&O policies) are mostly written on a mixed occurrence and claims-made basis. This means that the insured is entitled to indemnity under the policy, provided the loss occurred and the claim was made during the policy period, even if the judgment or settlement establishing liability occurs after that period.

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

10. Reinsurance regulations

Establishment procedures, solvency margins and operation of reinsurance companies are regulated by the new Insurance Act, which already provides rules for both prospective insurers and reinsurers. Reinsurance contracts are not regulated by the Hungarian Civil Code specifically, therefore their content is up to the parties' agreement in accordance with general legal rules and reinsurance practices.

Contacts

Gabriella Ormai

E gabriella.ormai@cms-cmck.com

Péter Mitták

E peter.mittak@cms-cmck.com



Italy

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 law and that has been admitted by the Italian Insurance Supervising Authority (IVASS).
- an EEA insurance company that has notified the regulator in its home country that it intends to carry out 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 that has been given permission by IVASS to set up a branch office.

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

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

Insurers can start their activity in Italy (i) as soon as IVASS is notified on a Freedom of Services basis, or (ii) 30 days from the date of notification if

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

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

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

2. 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; if this fails, the insurance contract is null and void.

It is not possible to insure against the effects of administrative penalties, the payment of ransom money in the case of kidnapping or criminal sanctions.

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 except for non-life policies. The premium can be reduced only where the insured risk is also reduced.

4. Consequence of misrepresentation and/or non-disclosure

Before and during the policy period, the insured must disclose all the relevant information to the insurer. Failure to do so, in cases of fraud or gross negligence by the insured, may result in the insurer being able to claim a total or partial release from its obligation to provide cover and remaining 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, an indemnity reduction proportional 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 or pay the claim to the insured, except in motor vehicle third-party liability and in life policies linked to loans or mortgages.

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

7. Entitlement to raise a claim against an insurer

Only the insured has a right to claim against its insurer. However, 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 the limitation period for claims

Any claims deriving from the insurance contract are 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. However, in life policies the limitation period is extended to ten years.

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

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 who 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 IVASS for specific authorisation.

Contact

Laura Opilio

E laura.opilio@cms-aacs.com

Paolo Scarduelli

E paolo.scarduelli@cms-aacs.com



Luxembourg

1. Introduction

Luxembourg's insurance market developed in the 1990s. Since then, Luxembourg authorities have created a prosperous environment that has contributed to growth. Insurances activities in Luxembourg can be carried out by Luxembourg companies as well as by foreign companies, either through a branch office or directly without any establishments in Luxembourg, provided that a certificate has been granted by the Luxembourg Insurance Commission (*Commissariat aux Assurances*, the *Commassu*).

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

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

- The company has to appoint an independent statutory auditor (*'réviseur d'entreprises'*);
- Insurance companies willing to operate in Luxembourg must comply with specific rules regarding solvency margins, assets and accounting principles.

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

In addition, to establish a branch in Luxembourg, foreign companies must justify a similar activity in a third country for a period of less than three years. It is illegal for a Luxembourg insurance company to carry out both life insurance and non-life insurance activities.

2. Defining insurable interest

Insurable interests are defined under Luxembourg law as economic interests in the conservation of the protected good. There is an insurable interest when, as a consequence of future or uncertain events, there could be a potential financial loss upon the destruction of the protected good. The existence of a risk is a fundamental element in the insurance contract. Without it, the contract could not exist.

3. Calculation of premiums

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

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

4. Consequence of misrepresentation and/or non-disclosure

Luxembourg's insurance law provides that the insured has the obligation to disclose accurately all the information that may have a direct impact on the assessment of the risk value. The insurance contract will be null and void if the insured intentionally omits or inaccurately reports some information. If the omission or inaccuracy was not intentionally done the insurance contract will not be null, the insurer will propose a modification of the contract during a period of one month from the date the insurer has known the omission or inaccuracy. If the insured does not accept the modification, the contract could be terminated within the following 15 days. Nevertheless, during the one-month-period delay, the insurer could terminate the contract provided it proves that it has never insured such a risk.

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

The insurer must effect payment of the contractual benefits as soon as it has all the relevant information on the occurrence and circumstances of the claim, and where applicable, the value of the damages. In any case, the amounts due must be paid within 30 days of their assessment. After this period, interest on overdue payments at the current legal interest rate shall be payable.

7. Entitlement to raise a claim against an insurer

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

applicable, provided they occurred prior to the accident. Beneficiaries under life insurance contracts will also have the right to raise claims directly against the insurer.

8. General rules concerning the limitation period for claims

In principle, any claims resulting from an insurance contract may be raised before three years from the day the event that gives rise to the claim occurred. However, this timeframe will start on a later date if the claimant provides evidence that they were not aware of the event. The three year period will start from the date the claimant becomes aware. A claim can never be raised after five years from the date the event occurred, except in cases of fraud.

The insurer could raise a claim against the policyholder within three years, starting from the date the policyholder received payment. The suspension and interruption will not be applicable to minors and incapacitated persons.

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

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

10. Reinsurance regulations

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

Contact

Vivian Walry

E Vivian.walry@cms-dblux.com

Françoise Pfeiffer

E francoise.pfeiffer@cms-dblux.com



Poland

1. Introduction

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

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

Foreign insurers from EU and EEA countries may also undertake activity in Poland through a branch on a Freedom of Establishment basis or directly on a Freedom of Services basis. They are then permitted to carry out those activities in Poland which they are entitled to conduct in their home country on the basis of a relevant permit from the supervising authority of their home country. Such insurers may start operating in Poland after the PFSa has received notification from the relevant home country supervising authority.

Regarding operational aspects, a branch works in the same way as a local company. However, the

costs are much lower – a branch does not require any initial capital and has a simplified organisational structure. The branch is regulated by the parent company's home country regulator.

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

Foreign insurers from countries outside the EU and EEA may undertake insurance activity in Poland either through a 'main branch' subject to a permit issued by the PFSa, or a subsidiary insurance company in Poland. The procedure for establishing a 'main branch' differs significantly from the

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

2. Defining insurable interest

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

3. Calculation of premiums

Premiums are determined on the basis of an assessment of insurable risk and are calculated for the whole policy period. Premiums amounts may not differ on the basis of gender, maternity or pregnancy. If an insurance contract ends before the lapse of the policy period (for example, if one party terminates the contract), the policyholder is entitled to reimbursement of the portion of the premium corresponding to the unused policy period.

4. Consequence of misrepresentation and/or non-disclosure

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

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to complete loss-adjustment proceedings and make a payment or give notice of refusal to pay within 30 days of receiving a

notification of an insured event. If this is not possible due to the complex nature of the claim or any other reasons, the insurer is obliged to inform the claimant. Then the insurer must complete the loss-adjustment proceedings within 14 days of the day the insurer clarified the circumstances necessary to determine its liability or the amount of the indemnity. However, any non-disputed parts of the indemnity should be paid within the original deadline, i.e. 30 days of receiving the notification of the insured event.

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

There are two separate statutes of limitation. The first pertains to the insured's claims against the insurer. These claims are time-barred three years after the day on which they became enforceable. The second pertains to the third party claimant's right to claim against the insurer under the *actio directa* principle (see above). These claims are subject to the same rules as those governing the statute of limitation of the third-party's claims against the insured. As a result, a third-party claimant's claim against the insurer becomes time-barred when it is also time-barred in relation to the insured. For example, if the third party's claim is based on the tort liability of the insured, it becomes time-barred three years after the date that the third party became aware of both the damage and the person responsible for redressing it (i.e. the insured). However, this period cannot be longer than ten years after the occurrence of the event that caused the damage (this long-stop date does not relate to personal injuries).

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

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

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

10. Reinsurance regulations

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

Contacts

Malgorzata Surdek

E malgorzata.surdek@cms-cmck.com

Iain Batty

E iain.batty@cms-cmck.com



Portugal

1. Introduction

The primary statutes applicable to the insurance business in Portugal are Decree-Law 94-B/98, which regulates the activity of insurance companies (and will be gradually replaced by Law 147/2015 starting from January 2016) and Decree-Law n.º 72/2008, which contains the law on insurance contracts.

The '*Autoridade de Supervisão de Seguros e Fundos de Pensões*' (ASF) is the Portuguese regulatory authority that supervises the activities of insurance and reinsurance companies. However, the '*Comissão do Mercado de Valores Mobiliários*' (CMVM) – the Portuguese regulatory authority responsible for the supervision of the stock market – also regulates insurance agreements in connection with mutual funds.

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

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

Foreign EU-based insurance companies conducting activities related to mandatory insurance contracts, such as professional liability or motor-vehicle insurance, must appoint a representative to ASF in order to be able to undertake insurance business on a Freedom of Services basis. Irrespective of the nature of the risk, foreign EU-based insurance companies acting on a Freedom of Services basis must contribute to all insurance funds intended to ensure the payment of claims.

In order to undertake insurance services through a branch established in Portugal, the foreign EU-based insurance company must request its home country's authority to inform ASF of the insurer's intention.

Within two months from receipt of the request, ASF shall inform the relative home country authority of any special provisions that will apply to the branch.

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

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

2. Defining insurable interest

Although Portuguese law does not provide an exhaustive definition of insurable interest, it does require the insured to have an insurable interest, recognised by law, in the risk covered by the insurance agreement. In indemnity insurance the interest must relate to the conservation and integrity of the subject matter insured. In life insurance, it must relate to the life, health and/or physical integrity of the person or persons insured.

In the case of life insurance, the person whose life is being insured must agree to establish an insurable interest if they are not the policyholder.

In addition, there is a variety of uninsurable interest for which insurance is prohibited:

- (i) criminal, administrative or disciplinary liability;
- (ii) kidnapping, hijacking and other crimes against personal freedom;
- (iii) possession or transportation of narcotics or drugs, as their consumption is illegal;
- (iv) death of children under 14 years of age, or of anyone incapable of taking care of themselves due to mental illness or for any other reasons.

The limitations referred to in (ii) and (iv) above do not extend to civil liability and the prohibition regarding 14-year old and younger children mentioned in (iv) does not apply whenever the policyholders are schools, sport institutions or similar entities which are not the beneficiaries of the insurance contracts.

The absence of insurable interest in the insurance agreement will render the contract null.

3. Calculation of premiums

The premium is the monetary consideration paid by the insured in exchange for the insurer's promise of coverage. Premium includes all amounts due by the policyholder/insured under the insurance contract, including any costs related to the coverage of the risk and any costs related to acquisition, management and collection of expenses that arise from issuing the insurance policy.

Unless otherwise stated by law, as in motor insurance and employer's liability insurance, the amount of premium and rules for calculating it are set out in the contract under the parties' freedom to negotiate.

In cases where the insurance agreement does not address the calculation or amount of premium, the premium must be suitable and proportional to the insured risks and calculated in respect of the principles of underwriting techniques, without prejudice to certain insurance categories and the particular circumstances of the insured risks. The premium is due in full when the insurance contract is executed and spans the whole period covered by the policy. However, the parties may agree otherwise.

Cover under the insurance contract does not start until the premium is paid and the insured will be in default if it fails to pay on the due date. The consequences of the failure to pay the premium on the due date depend on the insurance contract.



In order to undertake insurance services through a branch established in Portugal, the foreign EU-based insurance company must request its home country's authority to inform ASF of the insurer's intention.

In the majority of the insurance contracts, the insurer will be automatically discharged from liability from the date of the breach and, in cases where the premium is due upon renewal, the non-payment will stall the extension of the insurance contract.

The non-payment of an additional premium due upon the amendment of the contract will make the amendment ineffective, with the insurance contract remaining in place on the terms previously agreed, unless proceeding with the agreement becomes impossible. In this case, the contract is deemed to be terminated from the date of the breach of duty.

For all remaining insurance contracts, such as life insurance, livestock insurance, mutual insurance and large risk insurance, the remedies for the breach arise out of the terms contracted by the parties. However, in life insurance, the insurer must notify the insured of the premium due date, amount and means of payment within thirty days.

In cases where the insurance contract is terminated, the insured remains liable for any premiums due while the contract was in place.

4. Consequences of misrepresentation and/or non-disclosure.

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

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

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

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

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

On the other hand, where the insured negligently misrepresented or failed to disclose, the insurer

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

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

In general, the insurer cannot rely upon a breach that arises out of: i) a failure to answer to a question in a proposal form; ii) an unclear answer to a very broad question; iii) and apparent contradiction or inconsistency in an answer to a proposal form question; iv) non-disclosure or misrepresentation that is known by the agent of the insurer at the time of the contract; or v) a breach in connection with circumstances known to the insurer, in particular when of common notoriety.

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

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

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



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

5. Consequences of late notification

The insured is required to notify the insurer in accordance with the notification deadline set forth in the insurance contract or, in its absence, within 8 days after acknowledging the insured event.

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

There are no legal or statutory penalties for late notification of a triggering event, but the insurance contract may provide that the insurer may offset the damage caused by late notification from the indemnity, or even avoid the claim, when the breach arises from a deliberate action and results in substantial damage for the insurer.

However, the insurer cannot rely upon the referred terms if it had been made aware of the trigger of cover by any other means within the notification period or where the insured is able to provide evidence that the notification could not have occurred sooner.

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

6. Requirements regarding loss-adjusting proceedings

The insurer is required to award the insured with the benefit set out in the insurance contract following the ascertainment of the occurrence, causes, circumstances and consequences of the insured event. Depending on the particular circumstances of the occurrence, the previous estimation by the insurer of the loss-causing event may be necessary in order to provide the insured with the benefit set forth in the insurance agreement.

The insurer is bound to meet the claim within 30 days after establishing the insured event.

7. Entitlement to raise a claim against an insurer

The general rule under Portuguese Law is that only the insured is entitled to raise a claim against the insurer under the insurance contract, even when the contract is effected on behalf of a third person, in which case a claim by the policyholder can only be sought with the insured's consent. However, for

compulsory third-party liability insurance, the injured third party is allowed to seek relief directly from the insurer. Additionally, in liability insurance contracts, the parties may expressly provide the third party the right to bring a claim against the insurer, solely or jointly with the insured, for the benefit that accrues from the insurance agreement.

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

8. General rules concerning the limitation period for claims

The limitation period for claims that arise from a breach of the insurance contract is five years from the date the claimant becomes aware of the breach. Additionally, claims must be sought within 20 years from the occurrence of the insured event.

In the case of liability insurance, the claim must be brought within three years from the date the claimant became aware of the event but not more than 20 years from the date the event occurred.

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

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

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

Therefore, the cover of a third-party liability insurance contract may alternatively be written in the moment in which the claim is made, unless otherwise stated by law or statute and provided that, in case of no renewal or further insurance agreement, the cover of insured events that occurred unnoticed during the policy period is awarded, even if the claim is brought about in the following year of the term of the insurance contract.

10. Reinsurance regulations

The law applicable to insurance contracts shall apply *mutatis mutandis* to the reinsurance contract, where and if the parties have not agreed otherwise or at all.

Nonetheless, the reinsurance contract must be embodied in a written document that expressly specifies the risks covered by the reinsurance, even though their validity does not depend upon being entered into a specified form.

Unless otherwise provided by law or agreed by the parties, no agreements with the primary insured arise out of the insurance contract. However, the parties may agree on a term that confers rights to the primary insured under the reinsurance agreement, provided that it is not contrary to the law.

Contacts

Bruno Teles Caeiro

E bruno.caeiro@cms-rpa.com

Joaquim Macedo

E joaquim.macedo@cms-rpa.com



Romania

1. Introduction

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

A. Romanian-based insurers

Setting up a Romanian-based insurance company involves the following procedure: (a) prior approval from the FSA; (b) registration of the company with the competent Trade Registry; (c) obtaining an insurance authorisation from the FSA.

An insurer cannot be registered with the Trade Registry before obtaining approval from the FSA. This may take several months and usually involves legal assistance and legal representation of the insurer before the regulator. Incorporation procedures before the Trade Registry may take several days (once the incorporation file is complete) and there are minimum capital requirements for incorporation depending on the type of insurance (life/non-life) to be performed.

Following incorporation, a specific insurance authorisation must be obtained from the FSA before engaging in the provision of insurance on the market. The authorisation procedure is customarily a time-consuming process that may span over the course of several months (the maximum deadline being four months from submission of the complete authorisation file). During this procedure, the applicant is required to produce substantial documentation, including in relation to its shareholders, business plan, feasibility study etc. Filing taxes also apply and, depending on the complexity of the authorisation procedure (for which qualified legal assistance would be recommended) legal fees for representing the insurer before the FSA may also need to be considered.

B. EU/EEA insurers

As a member of the European Union, Romania recognises the right of insurers/reinsurers registered in another EU/EEA state (and authorised by the competent authority in such state) to operate in Romania, on the basis of Freedom of Establishment, through a branch opened in Romania, or directly on the basis of the Freedom of Services, without any other formalised presence. Branches of EU/EEA-based insurers remain subject to the supervision of the regulator in the country of origin but the FSA must be notified about the establishment of the branch to ensure compliance with Romanian insurance legislation.

An EU/EEA-based insurer may also undertake insurance activity in Romania on a Freedom of Services basis by direct selling/managing insurance policies without any corporate presence in Romania. In this case, the FSA must be notified of the insurer's undertakings in Romania, but the EU/EEA insurer itself remains under the supervision and jurisdiction of its state of origin's regulator.

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

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

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

2. Defining insurable interest

Although there is no specific legal definition of an insurable interest in Romanian legislation, the law refers to 'insurable risk' as a mandatory element of the insurance policy and an essential element of the insurance itself. Under the Romanian Civil Code (2011), an insurance policy is terminated by effect of the law if the insured risk has occurred or the occurrence thereof has become impossible prior to the inception of the insurer's obligations under that policy. The same applies when the occurrence of the insured risk has become impossible after the conclusion of the policy.

3. Calculation of premiums

Premiums are generally calculated on an actuarial basis, generally without any interferences from the regulator (market rules of demand-and-supply apply). If the premium is not duly paid, the insurer is entitled to claim termination of the contract, unless the parties have otherwise agreed (at the

same time, the insurer is bound to inform the insured with respect to the consequences of such non-payment or delayed payment). In particular, insurance premium rates for third-party liability insurance for motor vehicle, as established by insurers, must be notified to the FSA before they are applied. Insurers are not permitted to apply different tariffs than those officially notified to the FSA.

4. Consequence of misrepresentation and/or non-disclosure

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

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

If the party in default has not acted in bad faith, and the insured risk has not yet occurred, the insurer is entitled to ask for a premium adjustment or they may choose to terminate the contract unilaterally with 10 days' notice to the insured. In this case, the insurer must reimburse the policyholder for the amount of premium paid for such period which is no longer covered under the policy. In case the misrepresentation/non-disclosure is discovered after the occurrence of the insured event, the indemnification to which the insured is entitled shall be reduced proportionally.

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

Generally, the law provides no requirements for loss adjustment, stating only that the losses shall be paid in accordance with the provisions of the insurance contract concluded between the parties. However, in the case of mandatory third-party liability insurance for motor vehicles, as a general rule, loss evaluation must be concluded through either (i) an indemnification offer issued to the insured; or (ii) a justified notification of refusal of indemnification, issued within three months from the notification of the loss to the insurer.

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

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

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

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

10. Reinsurance regulations

Reinsurance contracts are not expressly regulated by insurance regulatory norms. This means that such contracts are subject to the general rules and provisions of Romanian civil law, and/or international civil or commercial law, as applicable.

Romanian-based reinsurers that intend to undertake reinsurance activity need to obtain a distinct regulatory authorisation from the FSA. Their scope of business must be limited exclusively to reinsurance activities (some ancillary activities are permitted, e.g. actuarial and statistical analysis, risk analysis, research etc.). Other than Romanian-based reinsurers, reinsurance activities may also be carried out in Romania by (ii) reinsurers authorised in other EU/EEA states, carrying out reinsurance activities in Romania on the basis of (a) Freedom of Establishment; or (b) Freedom of Services; (iii) branches of reinsurance companies registered in third-party states, which have been authorised by the FSA; (iv) subsidiaries of reinsurers registered in third-party states, authorised by the FSA; or (v) reinsurers organised as SEs (Societas Europaea).

Contacts

Cristina Popescu

E cristina.popescu@cms-cmck.com

Rodica Manea

E rodica.manea@cms-cmck.com



Russia

1. Introduction

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

Currently, there are no limitations on cross-border supply of insurance of risks connected with international passenger transportation and liability arising therefrom, international transportation of goods, international commercial air transportation and liability arising therefrom as well as liability within the international green card system.

Within four years of Russia's accession to the WTO, there should be no limitation on insuring risks associated with domestic commercial air and maritime transportation, including insurance of goods being transported, the vehicle transporting the goods and any liability arising therefrom, except insurance of the air carrier's liability and life and health insurance of the aircraft crew.

Russian insurance law restricts foreign penetration into the Russian insurance market by setting a market quota. The market quota is calculated by referring to the aggregate charter capital of all insurance companies. The law states that if a share of 'foreign capital' in the aggregate charter capital

of all Russian insurance entities exceeds 50 per cent, the regulator stops licensing insurance companies controlled by non-Russian entities. As of 1 January 2015, this quota amounts to 15.4 per cent. Russian insurance law states that a preliminary consent from the regulator must be obtained for a foreign investor to contribute to the charter capital of a Russian insurance company. This consent may only be denied if that contribution results in the quota being exceeded.

Russian insurance law also imposes the following restrictions:

- until August 2017, foreign-owned companies may not be involved in life insurance, state funded and compulsory motor liability insurance;
- shares in the charter capital of an insurance company should be paid for only in Russian Roubles;

- foreign investors should have at least five years of experience on their domestic market.

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

2. Defining insurable interest

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

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

3. Calculation of premiums

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

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

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

4. Consequence of misrepresentation and/or non-disclosure

Upon conclusion of the contract, the insured shall inform the insurer of the circumstances known to

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

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

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

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

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

7. Entitlement to raise a claim against an insurer

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

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

8. General rules concerning the limitation period for claims

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

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

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

10. Reinsurance regulations

There are limited specific regulations regarding reinsurance in Russia. Reinsurance is regarded by default as an insurer's insurance and the law distinguishes four types of reinsurance contracts (facultative, treaty, facultative-treaty and treaty-facultative reinsurance policies) and two kinds of reinsurance (proportional and non-proportional). Unless the contract of reinsurance provides otherwise, general rules applicable to insurance contracts apply to reinsurance. Reinsurance of the risk of survival under life insurance policies and risks under MTPL policies is strictly prohibited.

Foreign reinsurers can reinsure directly, with certain limitations in respect of ratings, and Russian reinsurance companies must maintain the statutory minimum charter capital, which is twice the statutory minimum charter capital of general insurance companies.

Contacts

Leonid Zubarev

E leonid.zubarev@cmslegal.ru



Serbia

1. Introduction

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

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

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

2. Defining insurable interest

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

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

3. Calculation of premiums

There are no specific legal rules regarding the calculation of premiums. In case of non-payment of the premium, an insurance contract is, by law, terminated one year after the due date of the premium payment without any warning or notice by the insurer. The insurance contract is also terminated due to lack of payment of the premium if the policyholder fails to pay the due premium 30 days after receiving notice from the insurer.

4. Consequence of misrepresentation and/or non-disclosure

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

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

There is no compulsory deadline for completion of loss-adjusting proceedings. The insurer is obliged to indemnify the insured within the period stipulated in the contract, which should not exceed 14 days, from the day the insurer receives notification of the occurrence of the insured event. However, if determining the existence or the amount of the claim requires time, the said period shall run from the day on which the existence and the amount of the claim have been determined.

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

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

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

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

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

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

10. Reinsurance regulations

An insurance company licensed for reinsurance activity cannot undertake other insurance activities. Serbian civil law does not regulate reinsurance contracts, while the application of legal provisions regarding insurance contracts is excluded. This means that the content of a reinsurance contract is determined by the parties. The insurance regulations were amended in 2013 so that insurance companies may directly reinsure abroad against risk arising from natural disasters, floods, etc. This had never happened before, as insurance companies used to have to reinsure with domestic reinsurance companies first.

Contact

Milica Popovic

E milica.popovic@cms-rrh.com



Slovakia

1. Introduction

The basic way of undertaking insurance activity in Slovakia is by establishing a local joint-stock company. It is also necessary to obtain a permit from the National Bank of Slovakia, which is the supervisory body for financial markets and the insurance market in particular. Insurance companies established after 1 April 2000 cannot undertake life and non-life insurance activities simultaneously, except for insurers providing life insurance (such insurers may obtain a special certificate that allows them to offer accident and illness insurance as well).

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

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



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

In terms of market perception and many operational aspects, a branch works in the same way as the establishment of a local company. However, the cost is much lower – a branch does not require any initial capital and has a simplified organisational structure. The branch is regulated by the parent company's domestic regulator. With effect from 1 January 2009, the branch of a foreign insurer based in the EU must always include the phrase '*pobočka poisťovne z iného členského štátu*' ('branch of the insurer from another EU Member State') as part of its business name, in the place of its seat and in written communication.

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

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

The area of insurance is regulated in several acts, regulations and decrees in Slovakia. The main laws in this respect are the Insurance Act, which regulates the insurance companies, and the Civil, which regulates insurance contracts.

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

2. Defining insurable interest

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

3. Calculation of premiums

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

4. Consequence of misrepresentation and/or non-disclosure

Before the execution of an insurance contract, the policyholder and the insured (where different) must disclose all matters indicated in the proposal form (or other insurer-issued document), which are relevant to the insurer's assessment of risk. Misrepresentation and non-disclosure of material circumstances or other relevant conditions may entitle the insurer to reduce the indemnity for the loss suffered where there is a causal connection between the undisclosed circumstances and such a loss.

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

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

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

7. Entitlement to raise a claim against an insurer

In general, only the insured has a right to raise a claim directly against the insurer. However, with respect to third-party liability insurance, if it is stipulated by law (e.g. motor vehicle third-party liability insurance), a prospective third-party claimant who has suffered a loss as a result of the actions or omissions of the insured which are covered by the liability policy, has a right to step into the position of the insured under the insurance contract and to raise a claim directly against the insurer.

8. General rules concerning the limitation period for claims

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

as those governing the statute of limitation of the third party's claim against the insured. As a result, the third party claim against the insurer becomes time-barred when it is also time-barred in relation to the insured. For example, if the third party's claim is based on the tort liability of the insured, it becomes time-barred three years after the date on which the claim became enforceable (in the case of the right to benefit from insurance, the limitation period starts one year after the occurrence of insured event).

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

The occurrence of an insured event is a default policy trigger in third-party liability insurance. However, it is possible for the parties to base insurance entirely on other triggers, such as when the loss occurred or manifested itself or when a claim is made. Nevertheless, there are concerns that a claims-made trigger may not comply with other provisions of Slovak law, particularly in relation to compulsory limitation periods.

10. Reinsurance regulations

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

Contact

Frances Gerrard

E frances.gerrard@cms-cmck.com

Adriana Kováčiková

E Adriana.kovacikova@rc-cms.sk



Slovenia

1. Introduction

In the Republic of Slovenia, the Insurance Act (*Zakon o zavarovalništvu*, 'the ZZavar') provides a legal framework for conducting insurance business.

The Code of Obligations (*Obligacijski zakonik*, 'the OZ') regulates insurance contracts. However, its provisions do not apply to: (i) marine insurance or other types of insurance to which the rules on marine insurance apply; (ii) insurance of claims or (iii) relations deriving from reinsurance.

An Insurance company is a legal entity set up in the form of a joint-stock company, *societas europea* or mutual insurance company. An insurance company shall be a legal entity located in the territory of the Republic of Slovenia, which has been granted an authorisation to perform insurance business by the Insurance Supervision Agency.

Insurance business may only be performed by (i) an insurance company located in the Republic of Slovenia that obtained an authorisation from the Insurance Supervision Agency (*Agencija za zavarovalni nadzor*, 'the AZN') (ii) a branch of a foreign insurance company that obtained an authorisation from the AZN to carry out the insurance business and (iii) a Member State insurance company that, pursuant to the ZZavar, has either established a branch or is authorised to

directly carry out the insurance business in the territory of the Republic of Slovenia. However, entities shall only be permitted to carry out insurance business within classes of insurance for which they were granted an authorisation by the competent.

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

A branch of an EU Member State insurance company may start to perform the insurance business in the Republic of Slovenia two months after the AZN received notification from the competent supervisory authority. Also the Member State insurance company may start to directly perform insurance business upon receiving the notification from its competent supervisory

authority that it has submitted the required documentation to the AZN.

2. Defining insurable interest

ZZavar classifies insurance types with respect to the main risks they cover. Neither ZZavar nor OZ define 'insurable interest'. Therefore the risk is insurable, unless it is explicitly excluded by law or with an insurance contract. According to the OZ, it is not possible to insure in the following cases: insurance against death of a third person who has not yet reached 14 years of age and insurance of a person whose capacity to contract was fully deprived. Further, an insurer is not obliged to pay the insurance benefit if the policyholder, insured person or beneficiary deliberately caused the insurance case. The OZ limits the insurer's obligation in the following cases: (i) when a suicide is committed in the first insurance year, (ii) when the beneficiary murders the policyholder or an insured person, (iii) when the damage arises as consequence of a military operation (iv) when the policyholder or insured person caused the insurance case intentionally.

3. Calculation of premiums

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

If it is stipulated that the premium shall be paid upon the conclusion of a contract, the insurance coverage commences on the day following the day the premium was paid. If stipulated that the premium shall be paid after the conclusion of a contract, the insurance coverage commences on the day when the insurance begins (Art. 937 OZ).

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

If a policyholder pays the premium within one year from it being due, the insurance coverage is restored starting from the following day after

premium and penalty interest were paid (Art. 937/V OZ).

An insurer does not have a right to file a claim for the payment of a due premium regarding the life insurance. If the due premium is not paid within the additional period determined in the registered letter, which shall not be shorter than one month, an insurer can declare (i) to reduce the insurance sum to the redeemable value of the insurance, if at least three annual premiums have been paid, or (ii) to withdraw from the contract, if at least three annual premiums have not been paid yet.

4. Consequence of misrepresentation and/or non-disclosure

When concluding the insurance contract, the policyholder is obliged to inform the insurer of all the significant circumstances for the risk assessment that they are aware of or that could not have remained unknown to them.

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

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

With respect to property insurance, the policyholder is obliged to notify an insurer of every change of circumstances which might be significant for the risk assessment. With respect to personal insurance, the policyholder is obliged to notify an insurer only if the risk increases due to the change of policyholder's work. The policyholder must immediately notify an insurer of the greater risk if the risk has increased due to the policyholder's action or in cases where the risk occurred without its involvement within 14 days of

learning of it. An insurer may, within 30 days after learning of the risk increase, either (i) withdraw from the insurance contract, if the risk increase was such that the insurer would not have concluded insurance contract in the first place or (ii) propose a premium increases if, being aware of such circumstances, it would have concluded the insurance contract only subject to a higher premium. The insurance contract terminates if the policyholder does not accept the proposed premium increase within 14 days.

If the insured event arises before the insurer was notified of the risk increase or after it was notified but before it withdrew from the insurance contract or before an increase in the premium was agreed, the insurance benefit shall be reduced proportionally.

5. Consequences of late notification

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

Contractual provisions that deprive the insured of its right to compensation are null if the insured fails to fulfill any of its obligations after the occurrence of insurance case.

6. Requirements regarding loss-adjusting proceedings

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

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

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

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

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

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

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

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



An insurer is obliged to complete the loss-adjusting proceedings within the agreed period, which shall not exceed 14 days from the receipt of the notification of occurrence of an insurance case.

10. Reinsurance regulations

Reinsurance is not precisely regulated in the ZZavar. Pursuant to ZZavar, a reinsurer can only be organised in the form of a joint-stock company or as a *societas europea*. Reinsurance falls under the insurance business, therefore the same conditions as for conducting insurance business apply. However, a reinsurer may perform reinsurance business in all insurance classes. Slovenian law does not regulate reinsurance contracts, except for provisions of the Maritime Law, regulating maritime reinsurance contract and the Obligations and Real Rights in Air Navigation Act, regulating aviation reinsurance.

Contacts

Aleš Lunder

E ales.lunder@cms-rrh.com

Tomaz Petrovič

E tomaz.petrovic@cms-rrh.com



Spain

1. Introduction

Insurance activity in Spain is regulated under the Act 20/2015, of 14 July on the organisation, supervision and solvency of insurance and reinsurance companies and under the Royal Decree 2486/1998 of 20 November, which approves the Regulation on organisation and supervision of private insurance companies. Additionally, the Act 50/1980 on insurance agreements of 8 October governs the insurance agreements' content, rights and obligations of the parties and related issues.

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

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

Insurance companies based within the EEA already authorised by their home country regulators will be entitled to carry out insurance activity in Spain through the incorporation of a branch in Spain (on a Freedom of Establishment basis) or directly from their home country regulator (on a Freedom of Services basis). In these cases, EEA insurance companies will be allowed to carry out insurance activity in Spain in accordance with the licence granted by their home country regulator, after the notification made by the regulator to the Spanish Treasury Department of the corresponding EEA insurance company communicating its intention to carry out insurance activity in Spain.

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

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

2. Defining insurable interest

Insurable interest is not expressly defined by main Spanish regulations on insurance, nor does the law provide a comprehensive and limited list of coverage or risks that are insurable.

Notwithstanding, it is unanimously agreed that the insurable interest is defined as the relationship between the insured and a thing, right or patrimony (insured object) subject to a monetary valuation, and this relationship suffering damage as a consequence of the occurrence of a certain event.

Without an insurable interest, the insurance agreement would become null for the lack of cause for its execution.

The Spanish Civil Code defines the insurable interest, providing that the parties 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 under the policy and the costs that the insurance company may incur. In addition, premiums may vary for subsequent periods depending on the notification of the circumstances of the risk insured.

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

4. Consequence of misrepresentation and/or non-disclosure

Prior to the execution of the insurance contract, the insured must disclose all circumstances that are material to the risk to be covered by the insurer. This information is commonly submitted by the insurers in the proposal form to be completed by the policyholder. If any information

is not requested by the insurer or is not raised in the proposal form, the policyholder is not obliged to disclose it.

The insurer will have the right to propose a partial amendment of the insurance contract to the policyholder to reflect the new circumstances of the risk, considering the information disclosed. The insurer must make this proposal within the two-month period following the disclosure of information. After receiving the proposal, the policyholder will be entitled to accept or reject the proposal within the following 15 days.

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

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

5. Consequences of late notification

The policyholder is obliged to notify the insurer of the occurrence of an insured event within a maximum of seven days, unless the parties agree a different term in the insurance contract.

In the event of breach, the insurer may claim the damages arising from late notification.

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

6. Requirements regarding loss-adjusting proceedings

The insurer is obliged to pay the insurance compensation 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 compensation within 40 days following notification. This is calculated based on the circumstances that the insurer is aware of at that stage.

7. Entitlement to raise a claim against an insurer

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

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

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

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

8. General rules concerning the limitation period for claims

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

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

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

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

Spanish law allows claims-made policies if they meet certain requirements relating to the limitation periods for covering the damages: (i) if the claims-made clause establishes that the

insurance contract shall cover the events that occurred following the expiration of the insurance policy, the additional coverage period shall be not less than one year from the expiration of the contract; (ii) similarly, if the claims-made clause establishes that the insurance contract will cover any events occurring prior to the enforceability of the policy, the policy must cover any insurance event that occurred within, at least, the one-year period before the enforceability of the policy.

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

10. Reinsurance regulations

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

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

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

Contacts

Carlos Peña

E carlos.pena@cms-asl.com

Rafael Sáez

E rafael.saez@cms-asl.com



Switzerland

1. Introduction

Any companies intending to undertake insurance activity in or outside 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 numerous regulatory requirements. The basic requirements are set out in the Insurance Supervision Act (ISA). Other requirements and provisions are described in greater detail in the Insurance Supervision Ordinance (ISO) and FINMA circulars.

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 activity in or outside Switzerland is either required to establish: (i) a Swiss head office; or (ii) 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. Second, it must meet financial capital requirements, such as a minimum capitalisation and adequate solvency margins. Third, it must present a detailed business plan. Fourth, 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. The insurer and its staff as a whole must provide a sufficient guarantee for sound management.

Regarding 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 insurance 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. For specific groups of professionals, such claims may also relate to pure financial loss.

Insurance policies covering a third party may be taken out without the consent of the third party. The insurance contract must expressly state that the policy is being taken out to provide insurance coverage for a third party. The insurance interest 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 the written consent of the third party prior to the conclusion of the contract.

3. Calculation of premiums

An insurance premium is defined as the amount which the insured person owes to the insurer for covering the risk. In general, Swiss legislation is silent on the calculation of premiums. However, if the premium was calculated taking into account circumstances that may influence the risk, 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 its claim for the outstanding premium, the law presumes that the insurer has waived its right to claim the outstanding premium and choose to withdraw from the insurance contract. If the insurer enforces its claim for the outstanding premium, the insurer is obliged to provide insurance coverage as stipulated in the insurance contract from the moment they receive payment of the premium, interest and any costs relating to the default in

payment. Specific provisions apply to life insurance and motor vehicle liability insurance.

4. Consequence 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 it is or ought to be aware of and 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 non-disclosure of the insured.

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

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

5. Consequences of late notification

Upon occurrence of the insured event, the insured is required to notify the insurer as soon as (i.e. 'immediately after') they become 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, the insurer is entitled to reduce its indemnification 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.

Swiss law also allows defining other consequences for negligent breaches of duties of the insured,

and in particular notification duties. Provided that the policy is clearly worded and that the respective clause is covered by the parties' consensus, late notification may also result in the loss of the insurance coverage.

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 any losses.

However, if 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 the insurer to make a detailed assessment of the accuracy of the claim. In general, an insurer is required to finalise loss-adjusting proceedings and make a claim payment within four weeks from the date it received all the required information.

7. Entitlement to raise a claim against an insurer

The insured has a right to make a claim under the insurance contract directly against the insurer. If a third party is covered by the insurance policy, the policyholder may generally only claim the insurance benefits with the consent of the third party.

Exceptions apply if (i) the policyholder took out the insurance policy with the authorisation of the third party or (ii) there is a statutory obligation to provide insurance cover for the third party or (iii) the third party and the policyholder have agreed that the policyholder should be entitled to claim insurance benefits irrespective of the third party's consent.

8. General rules concerning the limitation period for claims

The statutory limitation period for a claim against the insurer under the insurance contract is two years running from the date on which the insured event took place. Alternatively, the parties may agree on a longer limitation period (up to ten 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 a third-party liability policy. In particular, the parties are free to agree whether the policy trigger is the occurrence of an insured event (occurrence-based) or a claim made against the insured (claims-made).

10. Reinsurance regulations

Reinsurance companies domiciled in Switzerland must be licensed by FINMA to conduct reinsurance activities. The requirements are similar to those for the establishment of an insurance company and include capital requirements and personal requirements for staff members and the executive management.

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

Contacts

Jodok Wicki

E jodok.wicki@cms-vep.com

Clemens von Zedtwitz

E clemens.vonzedtwitz@cms-vep.com



The Netherlands

1. Introduction

Under Dutch law, the persons that have rights under a contract are those that are expressly party to it. These are the policyholder and the parties entitled to coverage in accordance with the terms and conditions of the insurance contract (the insured parties). Although the policyholder pays premiums to the insurer, the insured parties need not necessarily pay. The policyholder and the insured parties are 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 as to whether or when the insured event will happen. Insurance in the Netherlands can be either 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 cannot place the insured in a more advantageous position than it 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 for the insurable interest in the case of life insurance.

3. Calculation 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 in the insurance contract. However, agreement on 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 that 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 reduce any claim payment due to the insured by the amount of: (i) the unpaid

premium; (ii) any losses resulting from 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 obligations to pay the insurer. In turn, the intermediary is entitled to setoff any claim payments against any premiums due from the insured.

It is possible to change the premium after the insurance contract has been executed. If the insurer raises the premium, the insured may terminate the insurance contract with effect from the date on which the increase takes effect or, in any event, within one month of being notified of the increase. 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. Consequence of misrepresentation and/or non-disclosure

Prior to concluding the contract, the insured must disclose to the insurer all information which they are or ought to be aware of 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 that the third party is or ought to be aware of and that will be material to the decision of the insurer.

These disclosure obligations do not apply to: facts that the insurer is or ought to be aware of; facts that would not have a detrimental effect on the policy terms and conditions for the insured; or facts that are confidential under the Medical Examinations Act. The insured only needs to disclose facts concerning their (or a third party's) criminal history if the insurer has expressly and in unambiguous terms asked about the criminal history. Insureds are only obliged to disclose this information for the eight years prior to entry of the policy.

If the insurance is written based on a questionnaire drafted by the insurer (as most policies are), the insurer cannot decline a claim on the basis that questions were not answered; unrequested information was not disclosed; or the answer to a general question was incomplete, unless there was intent to mislead the insurer. A general catch-all question (such as, "Are there any facts or circumstances that may be important to

the insurer that you have not mentioned so far?") does not resolve this lack of information.

On discovery of non-fulfillment of a non-disclosure obligation, the insurer may only invoke its consequences if the insurer has informed the policyholder of the non-fulfillment and its consequences within two months from the discovery of such non-fulfillment. On the insurer's discovery that the policyholder acted with the intent to mislead the insurer, or where the insurer would not have concluded the insurance had it been aware of the non-disclosed information, the insurer may terminate the contract with immediate effect within two months after the discovery.

5. Consequences of late notification

As soon as the insured knows or ought to know of the occurrence of the insured event, it must notify the insurer. The insured must provide the insurer with all the information and relevant documents within a reasonable period to enable the insurer to consider the claim. When the insured fails to notify on time or to 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, if suffered as a result of the late notification. The insurer may only refuse to pay the claim if its 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 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, the insurer may pay the insured and be released from its obligation to provide indemnity only if it first requests the third party to confirm whether the third party will exercise or waive such a right, and the insurer receives no response within four weeks of the request. The insured may not settle the claim with the insurer to the detriment of the third party, if the claim relates to a loss resulting from death or injury.

Dutch law permits a third party to bring a direct claim against the insurer in personal injury claims or claims involving 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, the third party must ensure that the insured is summoned in time to appear in the proceedings.

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

8. General rules concerning the limitation period for claims

A right of action against the insurer for indemnity due under the insurance contract expires three years from the day after the insured became aware of the payment becoming due. The three-year limitation period will be stayed from the date the insured demands payment from the insurer in writing and a new limitation period starts running the day after the insurer either admits or denies the claim in unambiguous terms.

In the case of liability insurance, the limitation period shall be stayed during each negotiation attempt between the insurer and the insured or the third party. A new limitation period of three years will commence the day after the insurer either admits the claim or notifies the other party/insured ending the negotiations in unambiguous terms.

An insurer has five years, from the date of discovering the grounds for the claim, to raise 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.

Contacts

Leonard Bohmer

E leonard.bohmer@cms-dsb.com

Bas Baks

E bas.baks@cms-dsb.com



Ukraine

1. Introduction

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

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

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

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

- the home state of the foreign insurer must be a member of the World Trade Organisation that also takes part in the international co-operation in the field of the prevention and counteraction of the legalisation (laundering) of profits and the financing of terrorist activities, and cooperates with the Financial Action Task Force (FATF). An exception is made for non-resident reinsurers, which can be based in non-WTO countries, but still must be FATF members;

- the Ukrainian National Commission that Regulates Financial Services Markets (the 'Commission') and the authorised insurance regulator of the home country of the foreign insurer have signed a memorandum on information exchange (or concluded a respective agreement). Unfortunately only a few of such memorandums have been signed so far (Armenia, Poland, Latvia and Lithuania, as reported by the Commission on 29 November 2013). The Commission expects to sign memorandums with Moldova, Turkey, Macedonia, Belarus, Israel, Australia, Czech Republic and Hungary in the near future;
- the insurance business of the foreign insurer is supervised by the state authorities in accordance with the legislation of the foreign insurer's home country;
- an international treaty on the prevention of tax evasion and the prevention of double taxation has been concluded between Ukraine and the foreign insurer's home country;
- the foreign insurer is located in a country or in a specific territory that does not have an off-shore status as defined under Ukrainian law; and
- the financial reliability (stability) rating of the foreign insurer is compliant with the requirements established by the Commission.

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

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

The minimum amount of the charter capital for life insurers is currently EUR 10 million (in UAH equivalent), a substantial increase from EUR 1.5 million in May 2013. This increase is mostly relevant for life insurance companies licensed after May 2013, as the already-existing life insurers were not required to make any revisions to their charter capitals. However, insurers required to re-apply for

their insurance licence, for example due to a change of the company's legal form, will also be required to increase their charter capital in compliance with the current statutory level.

To be eligible to carry out insurance activities in Ukraine, a company must also complete the following procedures with the Commission: (i) register as a financial institution; (ii) obtain a licence for insurance activity; and (iii) submit its approved insurance product rules.

In order to obtain and maintain its financial institution status, a company must have: a certain number of qualified insurance professionals, office premises, hardware and software and an operational business plan covering at least three years.

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

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

Due to the lengthy, difficult and bureaucratic procedure and fees associated with establishing a greenfield insurance company in Ukraine, international insurance players often choose an easier and quicker option – to acquire a local insurance company in Ukraine.

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

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

New Options for the Non-Resident Insurers

Alternatively, as of 17 May 2013 (five years after the date Ukraine joined the WTO) foreign insurers have been able to carry out full-scope insurance activities in Ukraine directly via Ukrainian branches, which are treated as resident insurance companies. Such branches of foreign insurers must also be registered with the Commission, hold a respective insurance licence and comply both with the general requirements mentioned above and some additional requirements, including:

- the foreign insurer must issue a written irrevocable commitment note to confirm the unconditional performance of all obligations undertaken by its branch in Ukraine;
- the foreign insurer must deposit a guarantee (at least equal to the minimum amount of the charter capital established for resident insurers, as specified above) with a Ukrainian bank;
- the foreign insurer's insurance funds must be deposited only in the territory of Ukraine.

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

2. Defining insurable interest

There is no specific definition of "insurable interest" in Ukrainian legislation, although the insurance law implies that only the following property interests may be the subject matter of an insurance agreement: (i) life, health, ability to work, and pension (personal insurance); (ii) property possession, use and disposal (property insurance); and (iii) compensation of damage to third parties (liability insurance).

3. Calculation of premiums

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

By default, an insurance contract may be terminated if the policyholder has not paid the premium within 10 business days following the insurer's first written request. The amount of the insurance premium must be agreed by the parties and indicated in the insurance contract. Upon early termination of the insurance contract by the policyholder, the insurer must reimburse the

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

Upon early termination of the contract by the insurer, the insurer shall reimburse the policyholder for all premiums paid by the latter under the contract. If such termination results from the policyholder's breach of its contractual obligations, the insurer shall reimburse only a portion of the insurance premium corresponding to the unused policy period, excluding: (i) statutory operating expenses that were determined during calculations of the insurance premium; and (ii) insurance coverage and compensations that have already been paid under the contract.

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

4. Consequence of misrepresentation and/or non-disclosure

The policyholder is obliged to disclose to the insurer all matters that may be relevant for the insurer's assessment of risks and inform the insurer if the risks may have changed. Misrepresenting information about the subject matter of the contract or the insured event may constitute grounds for the insurer to refuse to provide indemnity under the policy.

5. Consequences of late notification

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

6. Requirements regarding loss-adjusting proceedings

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

7. Entitlement to raise a claim against an insurer

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

8. General rules concerning the limitation period for claims

The general limitation period in Ukraine is three years from the date on which a person is or ought to be aware of a breach of their right to a claim or of the actions of the person responsible for the breach. This three year period also applies to the claims of third parties against insurers. There is no limitation period for policyholder claims against the insurer in Ukraine.

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

The occurrence of an insured event is a default policy trigger in third-party liability insurance. However, insurers are free to set other triggers in the Insurance Rules or agree on them directly in the insurance contract, provided that such triggers comply with Ukrainian legislation.

10. Reinsurance regulations

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

Contacts

Vitaliy Radchenko

E citaliy.radchenko@cms-cmck.com

Olexander Martinenko

E olexander.martinenko@cms-cmck.com

Contacts

Albania

CMS Adonnino Ascoli & Cavasola
Scamoni Sh.p.k.
Rr. Sami Frashëri
Red Building – 1st Floor
1001 Tirana, Albania
T +355 4 430 2123

Marco Lacaita

E marco.lacaita@cms-aacs.com

Edita Poro

E edita.poro@cms-aacs.com

Austria

CMS Reich-Rohrwig Hainz
Rechtsanwälte GmbH
Gauermannngasse 2
1010 Vienna, Austria
T +43 1 40443 0

Daniela Karollus-Bruner

E daniela.karollus-bruner@cms-rrh.com

Thomas Böhm

E thomas.boehm@cms-rrh.com

Belgium

CMS DeBacker
Chaussée de La Hulpe 178
1170 Brussels, Belgium
T +32 2 74369 12

Carl Leermakers

E carl.leermakers@cms-db.com

Benoît Vandervelde

E benoit.vandervelde@cms-db.com

Virginie Frémat

E virginie.fremat@cms-db.com

Bosnia and Herzegovina

CMS Reich-Rohrwig Hainz d.o.o.
Ul. Fra Anđela Zvizdovića 1
71000 Sarajevo, Bosnia and Herzegovina
T +387 33 94 4600

Nedžida Salihović-Whalen

E nedzida.salihovic-whalen@cms-rrh.com

Bulgaria

CMS Cameron McKenna LLP
Landmark Centre
14 Tzar Osoboditel Blvd.
1000 Sofia, Bulgaria
T +359 2 92199 10

Nevena Radlova

E nevena.radlova@cms-cmck.com

Croatia

CMS Zagreb
Ilica 1
10000 Zagreb, Croatia
T +385 1 4825 600

Gregor Famira

E gregor.famira@cms-rrh.com

Marija Mušec

E marija.musec@cbmslegal.hr

Czech Republic

CMS Cameron McKenna v.o.s.
Palladium, Na Poříčí 1079 / 3a
110 00 Prague 1, Czech Republic
T +420 2 96798 111

Tomaš Matějovský

E tomas.matejovsky@cms-cmck.com

England & Wales

CMS
Cannon Place
78 Cannon Street
London EC4N 6AF
United Kingdom
T +44 20 73 67 3000

Alex Denslow

E alex.denslow@cms-cmck.com

Stephen Netherway

E stephen.netherway@cms-cmck.com

France

CMS Bureau Francis Lefebvre
2 Rue Ancelle
92522 Neuilly-sur-Seine Cedex,
France
T +33 1 4738 5500

Laurent Mion

E laurent.mion@cms-bfl.com

Jérôme Sutour

E jerome.sutour@cms-bfl.com

Germany

CMS Hasche Sigle
Kranhaus 1, Im Zollhafen 18
50678 Cologne, Germany
T +49 221 7716 0

Winfried Schnepf

E winfried.schnepf@cms-hs.com

Stefan Segger

E stefan.segger@cms-hs.com

Hungary

Ormai és Társai
CMS Cameron McKenna LLP
YBL Palace
Károlyi Mihály utca 12
1053 Budapest, Hungary
T +36 1 48348 00

Gabriella Ormai

E gabriella.ormai@cms-cmck.com

Péter Mitták

E peter.mittak@cms-cmck.com

Italy

CMS Adonnino Ascoli
& Cavasola Scamoni
Via Agostino Depretis, 86
00184 Rome, Italy
T +39 06 4781 51

Laura Opilio

E laura.opilio@cms-aacs.com

Paolo Scarduelli

E paolo.scarduelli@cms-aacs.com

Luxembourg

CMS DeBacker Luxembourg
3, rue Goethe
1637 Luxembourg, Luxembourg
T +352 26 2753 1

Vivian Walry

E vivian.walry@cms-dblux.com

Françoise Pfeiffer

E francoise.pfeiffer@cms-dblux.com

The Netherlands

CMS Derks Star Busmann
Newtonlaan 203
3584 BH Utrecht,
The Netherlands
PO Box 85250
3508 AG Utrecht,
The Netherlands
T +31 30 2121 111

Leonard Bohmer

E leonard.bohmer@cms-dsb.com

Bas Baks

E bas.baks@cms-dsb.com

Poland

CMS Cameron McKenna
Greszta i Sawicki sp.k.
Warsaw Financial Centre
ul. Emilii Plater 53
00-113 Warsaw, Poland
T +48 22 520 5555

Małgorzata Surdek

E malgorzata.surdek@cms-cmck.com

Iain Batty

E iain.batty@cms-cmck.com

Portugal

CMS Rui Pena & Arnaut
Rua Sousa Martins, 10
1050-218 Lisbon, Portugal
T +(351) 210 958 100

Bruno Teles Caeiro

E bruno.caeiro@cms-rpa.com

Joaquim Macedo

E joaquim.macedo@cms-rpa.com

Romania

CMS Cameron McKenna
SCA S-Park
11 – 15, Tipografi Ior Street
B3 – B4, 4th Floor, District 1
013714 Bucharest, Romania
T +40 21 4073 800

Cristina Popescu

E cristina.popescu@cms-cmck.com

Rodica Manea

E rodica.manea@cms-cmck.com

Russia

CMS Russia
Naberezhnaya Tower, block C
Presnenskaya Naberezhnaya 10
123317 Moscow
Russia
T +7 495 786 4000

Leonid Zubarev

E leonid.zubarev@cmslegal.ru

Serbia

Petrikic & Partneri AOD
in cooperation with
CMS Reich-Rohrwig Hainz
Cincar Jankova 3
11000 Belgrade, Serbia
T +381 11 3208 900

Milica Popovic

E milica.popovic@cms-rrh.com

Slovakia

Ružička Csekes s.r.o.
in association with members of
CMS
Vysoká 2 / B
811 06 Bratislava, Slovakia
T +421 2 3233 3444

Frances Gerrard

E frances.gerrard@cms-cmck.com

Adriana Kováčiková

E adriana.kovacikova@rc-cms.sk

Slovenia

CMS Reich-Rohrwig Hainz d.o.o.
Bleiweisova 30
1000 Ljubljana, Slovenia
T +386 1 62052 10

Aleš Lunder

E ales.lunder@cms-rrh.com

Tomaž Petrovič

E tomaz.petrovic@cms-rrh.com

Spain

CMS Albinana & Suárez de Lezo
Calle Génova, 27
28004 Madrid, Spain
T +34 91 4519 290

Carlos Peña

E carlos.pena@cms-asl.com

Rafael Sáez

E rafael.saez@cms-asl.com

Switzerland

CMS von Erlach Ponchet
Dreikönigstrasse 7
8022 Zurich, Switzerland
T +41 44 285 11 11

Jodok Wicki

E jodok.wicki@cms-vep.com

Clemens von Zedtwitz

E clemens.vonzedtwitz@cms-vep.com

Ukraine

CMS Cameron McKenna LLC
6th Floor, 38 Volodymyrska Street
01034 Kyiv, Ukraine
T +380 44 39133 77

Vitaliy Radchenko

E vitaliy.radchenko@cms-cmck.com

Olexander Martinenko

E olexander.martinenko@cms-cmck.com

CEE Regional Coordinators**Iain Batty**

E iain.batty@cms-cmck.com
CMS Cameron McKenna
Greszta i Sawicki sp.k. Warsaw
Financial Centre
ul. Emilii Plater 53
00-113 Warsaw, Poland
T +48 22 520 5505

Alex Denslow

E alex.denslow@cms-cmck.com
CMS
Cannon Place
78 Cannon Street
London EC4N 6AF
United Kingdom
T +44 20 73 67 3000

Leonid Zubarev

E leonid.zubarev@cmslegal.ru
CMS Russia
Naberezhnaya Tower, block C
Presnenskaya Naberezhnaya 10
123317 Moscow
Russia
T +7 495 786 4000



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