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Chambers Global Practice Guides

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INTRODUCTION

Contributed by: Simon Cooper, **Ince**

A Year Dominated by COVID-19, Climate Change and Geopolitical Conflict

Although the human cost of the COVID-19 pandemic gradually receded in most parts of the world during 2022, the insurance and legal implications of the pandemic continue to be tested. Inevitably, this has led to extensive litigation in several jurisdictions, with the UK and the USA being just two examples. Consequently, courts around the world are revisiting previously accepted approaches to concepts such as causation and aggregation as well as the proper construction of key policy terms. Clearly, the courts' conclusions on these issues will vary from jurisdiction to jurisdiction, and this guide provides an invaluable overview to the approach adopted in key jurisdictions around the world.

A second major theme of 2022, and one which will continue into 2023, was climate change. The COP27 summit took place in Egypt in November 2022 and its importance for the insurance industry was highlighted by the fact that 2022 was one of the costliest years since 1970 in terms of natural catastrophe losses. Insured losses during the year are estimated at USD115 billion. These losses stem from a series of catastrophes ranging from hurricanes to winter storms, flooding and hailstorms (Swiss Re Sigma Preliminary Results December 2022).This estimate, which was provided before the December 2022 "cyclone bomb" in North America, reflects a continuing 5–6% annual average increase in natural catastrophe losses over the last decade and has only increased the already widespread concern that climate change will see a long-term increase in the number and severity of natural disasters.

In addition, climate change is likely to challenge previous assumptions about the nature of the risk posed by natural disasters; for example, flooding may become more frequent and more widespread. From a legal perspective, these developments will raise issues of policy construction; for instance, in relation to aggregation clauses and the obligation on reinsurers to follow claims decisions of the underlying insurer. From a regulatory perspective, one may also see steps by governments around the world to compel insurers to provide cover for catastrophic risk. An example of this might be Flood Re in the UK.

The major geopolitical issue of 2022 has, of course, been the war in Ukraine. As well the horrendous human suffering caused by the war, the conflict has raised difficult issues for the insurance industry. One of the features of the Western response to Russia's aggression has been the imposition of sanctions on Russia and its allies as well as on individuals and organisations associated with Putin's regime. These sanctions, and the retaliatory sanctions imposed by Russia, create a difficult legal and regulatory environment for insurers which can only be enhanced by the different approach to sanction enforcement in different jurisdictions.

In addition to sanctions, the war has emphasised the role of war risk insurance and the scope of the cover which it provides. Indeed, such has been the pressure on this class of business that the main marine insurers are withdrawing war risk cover in the disputed areas. The hybrid nature of modern warfare, including as it does aspects such as cyber conflict and physical conflict, brings into question many definitions of "war" in insurance covers. Most cyber policies exclude coverage for war and related risk, but defining and proving "war" in the context of a cyber-attack often challenges existing legal

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definitions and it is important for insurers to know how different jurisdictions approach this and related issues.

Modernising the Global Insurance Industry

In 2022 the drive to modernise the world's insurance markets continued apace, and that trend will continue in 2023. The changes being introduced are in many cases fundamental and bring with them a range of legal and regulatory challenges for insurers, brokers and regulators alike.

One aspect of the drive for modernisation is the continuing search by established insurers for new markets and territories in which to expand. The desire for expansion is being assisted by regulatory adjustments in some jurisdictions that are increasingly open to external investment, but it is also challenged by the growing assertiveness of insurers domiciled in emerging markets. It is imperative, therefore, that insurers, related professions and their advisers all understand the different legal and regulatory requirements for operating in different jurisdictions. This guide, written by experts from around the world, seeks to provide a practical overview of these requirements in the key international jurisdictions.

Insurtech

The growth of insurtech and the wider use of artificial intelligence presents both opportunities and challenges to insurers and brokers. Insurers are using insurtech to create more personalised and better-targeted insurance products through the development of sophisticated algorithms to analyse detailed source data and broader market data, to produce a highly specific risk profile and price. Similar initiatives are being developed to speed up the handling of claims while increasing insurers' ability to detect fraud and analyse the cost and benefit of claims disputes. At present, these advances are limited principally to personal lines insurance and SME business, but it is expected that they will be applied to larger commercial risks in the coming years.

The increasing use of insurtech, and AI more generally, brings with it significant legal and regulatory challenges, and the responses are likely to vary from jurisdiction to jurisdiction. For example, insurtech involves managing huge quantities of personal data, which is often of a sensitive nature. The coming into effect of the European Union's General Data Protection Regulation (GDPR) has created a new legal regime within which insurers have to manage this data, with the risk of incurring very significant financial penalties for non-compliance. Importantly, although this is an EU regulation, it applies to insurers anywhere in the world that hold information about EU citizens, so has potential ramifications for insurers and their advisers wherever they may be. Jurisdictions outside Europe, of course, have different approaches to data protection, which this guide seeks to highlight.

One of the key objectives of insurtech is to strengthen the connectivity between insurers and their clients. This is achieved through more personalised underwriting and the adoption of different distribution methods, including social media and internet apps. Many innovative, new products rely on source data gathered through wearable technology and the internet of things (IoT). These communications, and information from things like wearable technology, will be subject to a new EU regulation, the ePrivacy Regulation (ePR). As with the GDPR, the ePR will have a worldwide reach and bring with it the same significant penalties for breach as the GDPR.

All of these technological advances are challenging existing legal assumptions, which are often based on laws developed for an entirely

different commercial world. How the laws of different jurisdictions adjust to these challenges is one of the issues this guide seeks to address.

Artificial intelligence

As well as the regulatory issues associated with the growth of insurtech, the adoption of AI technology by insurance buyers raises new legal challenges for insurers, including the question of where liability will lie if a piece of AI technology, dependent on machine learning, causes injury or breaks the law. Similar issues will arise in relation to the programming of autonomous ships and vehicles and the choices they may have to make when faced with the likelihood of collision. The answer to these questions is likely to differ between jurisdictions, so it will be important for insurers to understand local laws before accepting business that exposes them to risks of this nature.

Political Tensions

There is no sign of a resolution to the war in Ukraine and 2023 is likely to see continuing political instability and tensions between some of the world's leading economies. The insurance industry is not immune to the commercial and regulatory consequences of such conflict. These political tensions have also been expressed in actual or alleged cyber-attacks by one country or its proxy against another. Such attacks can lead to very significant insured losses, both in targeted countries and in other countries that experience "collateral damage".

The Brexit transition period was terminated on 1 January 2021 and no replacement for the previous passporting arrangements has yet been agreed between the United Kingdom and the remaining EU members. This is one of the many regulatory and legal uncertainties that will continue to hinder UK and European insurers through 2023. Until the post-Brexit regulatory framework has been agreed, bilateral arrangements between the UK and individual EU member states are likely to be of an ad hoc nature, and there will inevitably be uncertainty over the ability of UK insurers to write European business (and vice versa) and how that business may be written – for example, with respect to the regulation of underwriting agents.

Emergence of New Risks

At the same time, new risks are emerging, and concern continues about the potential for a "new asbestos" – be that legalised cannabis and medical marijuana, opioids or microplastics and nanotechnology. The legal context for the handling of insurance claims and coverage disputes in different jurisdictions will play a large part in determining the impact of any of these risks, if they do emerge.

Despite the uncertainty and risk development the industry faces over the coming years, there is no shortage of investment, with private equity houses continuing to show an interest. The industry saw continuing consolidation among insurers and brokers in 2022. In addition, money from outside the industry continues to be invested in new insurance vehicles such as insurance-linked securities (ILS), which are said to have "come of age" during the COVID-19 pandemic. Regulators in a number of jurisdictions are opening their markets to the underwriting of these products, but it remains to be seen whether they can be sufficiently flexible to wrest a meaningful share of the market from Bermuda.

Overall, 2023 is expected to see the continuation and speeding up of the modernisation process across the insurance industry together with a slower, but nonetheless significant, shift towards new markets and new ways of doing business.

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Ince is a specialist professional services firm, offering legal, corporate finance, consultancy and technology services to clients in a variety of complex, regulated sectors. It is one of the world's leading specialist insurance and reinsurance firms, with deep roots in the London and international markets. Now in its 150th year, Ince has long been synonymous with the development of insurance law through the courts. The firm is expert in all classes of insurance and reinsurance, including professional indemnity, marine, property and construction, aviation, reinsurance and ART, specialty, and political risk and trade credit. The firm also provides expert advice on corporate and regulatory issues in the insurance sector, and provides advice on insurance and reinsurance from its international offices spanning Europe, Asia and the Middle East. Ince has developed strong partnerships with pioneering technology companies, including the formation of the InceMaritime legal and technology solution for the shipping sector, and the collaboration with Arachnys and Yoti to build an integrated digital KYC solution for client onboarding.

Contributing Editor

Simon Cooper is a consultant at Ince with more than 35 years' legal experience in the insurance sector. His practice has encompassed most classes of business, including professional indemnity, property, cyber and reinsurance of all kinds. Simon is experienced in all forms of dispute resolution and in working with lawyers in many jurisdictions, as well as co-ordinating multi-jurisdictional projects on clients' behalf. He has been involved in a number of landmark cases during his practice and advises widely on the development of new products for insurers; he has also been instructed in relation to a number of recent modernisation projects in the London insurance market and is a recently retired member of the IBA Insurance Committee.

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AUSTRALIA

Trends and Developments

Contributed by:
Michael Polorotoff, Catherine McAdam, Jeremy Peck and Andrew Toogood
Moray & Agnew **see p.17**

Introduction

Australia is a federation of states and territories bound together by the Australian Constitution. It has an overarching federal system of government with its own courts, although each state and territory within the federation has its own system of government and courts.

Like most countries that formed part of the British Empire, Australia's system of government is modelled on the Westminster system and an independent judiciary is a central hallmark. Australia's legal system was also inherited from English common law.

Insurance and reinsurance law are no different, albeit there have been statutory and regulatory modifications, including the enactment of the Insurance Contracts Act 1984 (Cth) (ICA) and the Corporations Act 2001 (Cth). The ICA aims to strike a fair balance between the interests of insureds, insurers and other members of the public, and to ensure that provisions in insurance contracts and the practices of insurers in relation to such contracts operate fairly.

The Australian insurance industry continues to grapple with many evolving challenges and opportunities, such as:

- the impact of the COVID-19 pandemic on business interruption claims, with mixed success for the market in the test case proceedings heard in the New South Wales Court of Appeal and the Federal Court – something that has also attracted attention from the corporate regulator and the Australian Financial Complaints Authority in terms of assessing pandemic-related claims in a fair and efficient manner;
- the change in the federal government in May 2022 and the new Labor government implementing its progressive agenda;
- the devastating floods that have ravaged parts of Australia in 2022, exacerbating supply chain and labour market shortages and increasing costs and delays for claims;
- the testing economic environment, including successive official interest rate increases and rising inflationary pressures – the latter of which is contributing to claims inflation for insurers; and
- the increasing frequency and severity of cyber-related claims, which show no sign of abating and will generate new risk exposures beyond traditional cyber-related losses – the Optus and Medibank cyber-attacks are two recent and notable examples.

This article provides a high-level snapshot of some key issues and the likely trends and developments facing industry participants and various lines of business.

D&O, Professional Indemnity and Financial Institutions

Class actions

Class actions remain an ever-present danger for financial lines insurers when pricing and consid-

ering risks, and managing the subsequent fallout.

Before the new Labor government came to power in mid-2022, some balance was being restored to the D&O market and, in particular, the Side C market. However, following the change in the federal government, the pace of legislative reform has slowed – with some of the former Conservative government's reforms being unwound or jettisoned.

If anything, any further reforms are likely to favour third-party claimants and the litigation funding industry. Specifically, the new Labor government has announced proposed changes for the winding back of the licensing requirements for litigation funders and the registration of funding agreements as managed investment schemes. Such changes are likely to remove safeguards for group members and to lower barriers to entry for litigation funders.

However, it remains to be seen whether the new federal government will proceed with the former government's proposed legislative reforms seeking to cap the returns to plaintiff law firms and litigation funders or, instead, seek to modify or remove the previous reforms aimed at modifying the materiality standard for Side C Claims, which raised the bar for plaintiffs. Otherwise, there has been a steady rate of new filings for such claims, including at least two arising from the COVID-19 pandemic (Virgin and IAG).

Following the introduction of contingency fees in Victoria, more and more class actions are being filed in that jurisdiction. This trend is expected to continue until the other jurisdictions make corresponding legislative changes, thereby encouraging further competition. Western Australia has also introduced a class action regime, which is likely to mean representative proceedings will now be filed in that jurisdiction. New South Wales is likely to remain an unattractive jurisdiction for new class action filings, given that certain authorities prohibit pre-mediation class closure and related orders; however, there is a competing line of authority in the Federal Court jurisdiction to the effect that such class closure is permissible.

D&O

As the Australian economy seeks to navigate the challenging economic environment, this is likely to generate more corporate collapses – especially in the construction industry as it faces significant supply chain and labour market shortages. These economic pressures should lead to more insolvent trading claims, as well as pre-litigation investigations and examinations of D&Os (and, for that matter, professional advisers).

In relation to the latter, in February 2022, the High Court ruled by a majority that shareholders were entitled to summon former directors and officers of failed companies for public examination (pursuant to section 596A of the Corporations Act). That power was previously understood to be limited to external administrators. This ruling, however, increases the likelihood of shareholder plaintiffs using this examination power to marshal evidence before claims are commenced against failed companies or their directors and officers.

Corporate wrongdoing

The corporate regulator (Australian Securities and Investments Commission, or ASIC) continues to prosecute corporate wrongdoing and misconduct in a robust manner. Indeed, ASIC has commenced numerous proceedings seeking pecuniary penalty orders, adverse publicity notices and related orders. Of particular note,

ASIC successfully brought a proceeding against an Australian Financial Services Licensee for breaching its licence obligations to act efficiently and fairly after it failed to demonstrate adequate risk management systems to manage its cyber-security risks.

Cyber-risks and ESG

Cyber-risks and ESG issues have assumed greater prominence in recent times. Specifically, ASIC has become more active in monitoring such matters from a regulatory perspective and is expected to prosecute companies and D&Os for misconduct for misrepresenting their ESG credentials (ie, greenwashing claims).

Professional indemnity

In the professional indemnity space, financial services providers (including financial planners) and their insurers continue to be frustrated with the external dispute resolution process administered by the Australian Financial Complaints Authority. This has also presented capacity challenges for financial planners. Otherwise, it is expected that professional indemnity claims will continue to be filed at the usual rate but with a particular emphasis on advisers of failed companies and insolvency practitioners in the context of the global and national economic headwinds.

Falling property prices, combined with rising interest rates, will generate mortgage stress and potentially expose valuers and lawyers to an increase in claims. Non-compliant cladding claims remain a concern for construction professionals and their insurers, and there have been some legislative reforms that arguably increase the risk profile for insurers.

Life and Personal Insurance

New duty of disclosure

There has been a significant change to the applicant's duty of disclosure with regard to the majority of life insurance contracts.

Previously, the insured had a duty to disclose all matters that they or a reasonable person knew to be relevant to the insurer's decision about whether to accept the risk and, if so, on what terms. From 27 September 2021, applicants for life insurance (and, indeed, all types of "consumer insurance contracts") will no longer be bound by a duty of disclosure.

Instead, customers entering into a consumer insurance contract will have a duty "to take reasonable care not to make a misrepresentation". Whether an insured has complied with this duty must be determined in respect of all the relevant circumstances.

The following matters may be taken into account when determining whether an insured has taken reasonable care not to make a misrepresentation:

- the type of consumer insurance contract in question, and its target market;
- explanatory material or publicity produced or authorised by the insurer;
- how clear – and how specific – any questions asked by the insurer of the insured were;
- how clearly the insurer communicated to the insured the importance of answering those questions and the possible consequences of failing to do so;
- whether or not an agent was acting for the insured; and
- whether the contract was a new contract or was being renewed, extended, varied or reinstated.

Any particular characteristics or circumstances of the insured of which the insurer was aware, or ought reasonably to have been aware, are to be taken into account when determining whether an insured has taken reasonable care not to make a misrepresentation.

Claims handling – a "financial service"
Claims handling services are now subject to the financial services provisions of the Corporations Act. An insurer is now obliged to do all things necessary to ensure that its claims handling services are provided efficiently, honestly and fairly. This means that, to satisfy this obligation, an insurer will generally need to handle and settle insurance claims:

- in a timely way;
- in the least onerous and intrusive way possible;
- fairly and transparently; and
- in a way that supports consumers, particularly ones who are experiencing vulnerability or financial hardship.

Insurance claims managers – defined as those who carry on a business of handling and settling claims for one or more insurers – are required to obtain a financial services licence. There is generally an associated obligation to provide the services efficiently, honestly and fairly.

The new obligations apply to persons providing claims handling and settling services in relation to any insurance claim made on or after 1 January 2021 that is still on foot after the transition period ended on 31 December 2021.

New Life Insurance Code of Practice
A new Life Insurance Code of Practice (LICOP), with enhanced consumer protections, will come into force on 1 July 2023. This is the first major overhaul of the LICOP since it was introduced in 2017.

The changes significantly enhance consumer protections across sales, underwriting, and claims, with a particular focus on better supporting customers suffering mental illness. The major enhancements include:

- reduction in insurers' rights to access a claimant's clinical notes, both at underwriting and claims stage;
- no blanket mental health exclusions on new policies; and
- an insurer can only investigate whether the duty of disclosure has been breached if it has "reasonable grounds" to do so.

Cyber
The past 12 months have seen a significant jump in the number and severity of cyber-attacks and, in particular, ransomware. Australia experienced two historically large attacks on Medibank Private, its largest health insurer, and on Australia's second largest telecommunications company, Optus.

In the case of the Medibank attack, the personal and health data of approximately 10 million customers was accessed – the vast majority of which has now been released by the hackers on the dark web. Medibank has estimated its immediate costs associated with the breach at approximately AUD35 million but has not quantified further potential customer and other remediation, regulatory and litigation related costs.

Of a similar scale, the attack on Optus obtained access to the personal data of 10 million customers, including their home addresses and passport and driver's licence details. Optus has agreed to meet the costs of the replacement of

those identification documents. The company has set aside AUD140 million as an exceptional expense to cover the customer remediation programme following the breach.

These events have sharply focused the attention of insurers, regulators and insureds. Both companies face investigations by the Australian Information Commissioner in order to determine whether they "took reasonable steps to protect the personal information they held from misuse, interference, loss, unauthorised access, modification or disclosure". Numerous other investigations are underway. Both companies are facing imminent class actions by their affected customers and potentially from shareholders.

Following the attacks, the federal government has passed legislation lifting the maximum fines for repeated or serious data breaches from AUD2.2 million for each contravention to AUD50 million.

The growing losses have resulted in changes to the dynamic of the insurance market. There has been a rapid increase in the number of businesses taking up cyber-insurance. At the same time, premiums have increased and there has been a marked decrease in limits. Some capacity has left the market altogether. Further, insurers continuing to write the cover are undertaking much more stringent underwriting analysis, including – at times – the employment of third-party cybersecurity consultants to test the durability of a prospective insured's systems.

Major insurers have publicly discussed the option that payments to ransomware criminals do not form part of the cover offered by them in the future. With this in mind, the Australian government has set out its ransomware action plan, in which it states that it "does not condone paying a ransom to cyber criminals".

The government notes that ransom payments demanded from insured organisations are often tailored to the insured amount under a cyber-insurance policy. The government is currently considering whether to outlaw the payments of a ransomware demand. Major insurers have indicated their support for such a legislative step.

The Federal Court recently handed down its decision in Inchcape Australia Limited v Chubb Insurance Australia Limited (2022) FCA 883. This decision dealt with the scope of cover that might be available for cyber-risks, albeit under a Financial Institutions Electronic and Computer Crime Policy. Inchcape had been the target of a ransomware attack and sought indemnity for AUD2.3 million in costs. It had incurred costs to:

- investigate the ransomware and prevent further attacks;
- replace hardware;
- reproduce destroyed data;
- perform ancillary tasks in reproducing data and the manual processing of orders.

The insurer declined cover and successfully defended its position in the Federal Court. The policy in question was not a standalone cyber-insurance policy. The policy did not include specific cover for the costs of incident response. The court found that the cover was limited to "direct financial loss" – that is, the cost of blank media and the costs of transcribing the lost data onto it. Costs relating to incident response, business interruption or hardware loss were not direct financial loss.

This decision is a salient lesson of the risks of relying on 'silent cyber', where cyber cover is

sought under policies not specifically designed to cover cyber risks. In this case, one would imagine that many of the costs incurred would have been covered under a stand-alone cyber policy. Given the substantial losses suffered by Medibank and Optus discussed above, one would imagine that brokers and insureds will undertake more sophisticated scenario testing when purchasing cyber cover in the future.

Liability Claims

The nature of liability claims changed with the 2017 Royal Commission into Historical Institutional Child Sexual Abuse, which led to a surge in historic abuse claims against state departments and religious bodies. While the National Redress Scheme provides for no-fault compensation, the abolition of limitation periods for such abuse claims and the ability to set aside prior confidential settlement agreements has facilitated these challenging claims being brought.

Further, latent/exposure injury claims have not diminished, despite the use of asbestos products effectively being banned approximately 40 years ago – no doubt owing to the presence of those products from prior use (Australia has the highest use in the world) and the emergence of fibrotic silicosis claims for workers in the artificial stone industry.

The complexity and uncertainty surrounding liability for work-related accidents continues, with diminishing no-fault workers compensation benefits and limitations on recovering damages from employers encouraging injured workers to pursue non-employers and attempts to maximise their potential compensation. This is further exacerbated by the increasing use of contractors or labour-hire workforces (eg, on mining and infrastructure projects), which effectively shifts liability to entities not directly involved in the work system or site – including by means of contractual assumption of risk. The permutations of potential outcome for these claims add to the uncertainty for insurers.

The prospect of claims for sports-related concussion and chronic traumatic encephalopathy loom for liability insurers. Sports organisations are taking steps to minimise the risk of this condition, in light of the suggestion of potential class actions.

Property

Australian property insurers continue to be affected by volatile and increasing natural risks, with bushfire, storm and flood damage claims a prominent feature of the past few years. 2022 was characterised by floods again affecting many areas of the East Coast and the industry was hit with increased construction costs and delays.

Prior uncertainty and inconsistency surrounding flood cover has mostly been resolved through the use of a standard definition of the exclusion. Against the background of climate change concerns, the insurance industry continues to call for improved regulation and action to avoid or mitigate the impact of these natural risks as a more economic approach than increased premiums.

The industry's exposure to COVID-19 business interruption claims appears to have largely receded following the dismissal of the policyholders' appeals to the High Court in the "second test case". The first test case in late 2020 was unfavourable for the industry after it was unanimously held (including on appeal) that standard pandemic exclusions in business and industrial special risk policies that referenced the

repealed Quarantine Act – rather than the current Biosecurity Act – were ineffective.

The second COVID-19 test case addressed more specific coverage issues concerning ten particular claims, including whether business interruption cover was triggered for disease outbreaks or by government mandates preventing access. Broadly speaking, it was held that:

- cover was not triggered without a local outbreak within the vicinity of the premises (which could not be proven);
- the mandates were issued to protect public health more broadly, rather than specifically from a disease (contrary to UK findings); and
- causally, the closure of premises and consequent losses were not suffered as a result of an outbreak.

Recent and current concerns

Combustible cladding claims have been emerging for the past four years, as building owners and the construction and insurance sectors grapple with the unexpected cost of replacing cladding. Recent judgments, including at appeal level, have so far dismissed technical arguments that cladding was potentially compliant with applicable building codes and that consultants who specified such cladding have "peer professional opinion" defences based upon most industry participants specifying the same products.

Continuing concerns pertaining to the performance of engineers and builders, and challenges with legal recourse against them for defects, led to the introduction in New South Wales of legislation to impose (if not confirm) a duty of care on builders and designers with a ten-year retrospective limitation period. The object is to improve building standards or otherwise hold participants responsible, but an incidental effect is increased exposure of insurers to building defect claims. Further reform to building law is now proposed to increase owner protection and likely to result in increased liability to professional indemnity insurers.

The past year also saw a revival of claims based upon policy rectification, estoppel and alleged breaches of the duty of utmost good faith (with a significant matter currently reserved by the High Court) – possibly indicating a more aggressive attitude to pursuing claims against insurers.

Marine Law

"Supply chain issues" is a phrase that became extremely common for everyone in everyday life in 2022.

COVID-19 has continued to have a huge effect on all aspects of the marine industry globally, including destabilising the global container freight supply chain, delaying air transport, delaying shipments and causing air and freight rates to continue to rise. This has been particularly the case recently, with goods being shipped from China as a result of lockdown orders.

Supply chain issues have been further exacerbated by the Russian invasion of Ukraine, which has reduced shipping and air pathways and also the accessibility of materials and products – in particular, all goods that are being shipped to and from Europe.

Locally, border restrictions have limited and delayed road transport of goods around the country. All these factors have put intense pressure on Australian exporters and importers.

Although there has been a number of new scenarios facing the Australian marine market,

marine law in Australia remains relatively settled. The majority of claims are governed by the Marine Insurance Act 1909 (Cth) (MIA); however, the other relevant legislative acts in relation to marine claims in Australia are:

- the Admiralty Act 1988, which extended the admiralty jurisdiction from the Federal Courts to the State and Territory Supreme Courts; and
- the Carriage of Goods By Sea Act 1991 (COGSA), which gives effect to a modified version of the Hague-Visby Rules - a set of international rules adopted by countries in relation to:
  (a) the governance of the bill of lading/waybill for cargo being shipped; and
  (b) the liabilities that may be imposed on the party agreeing to the shipment.

Two recent cases that have looked at COGSA are Carmichael Rail Network Pty Ltd v BBC Chartering Carriers GmbH & Co. KG (The BBC Nile) (2022) FCAFC 171 and Poralu Marine Australia Pty Ltd v MV Dijksgracht (2022) FCA 1038.

In Carmichael, the Full Court of the Federal Court determined that parties to a contract for the interstate carriage of goods by sea cannot be prevented from arbitrating a dispute overseas where they have agreed to do so. In making this decision, the Full Court held that Section 11 of COGSA, which precludes foreign jurisdiction clauses in sea carriage documents, does not apply to interstate carriage of goods – meaning it is possible to exclude the jurisdiction of an Australian Court for disputes arising out of bills of lading for interstate carriage.

In Poralu, the Federal Court held that the incorporation of only part of a convention (here Articles I-VIII, but not Article IX of the Hague Rules) is not sufficient to overcome the applicability of COGSA and the Hague-Visby Rules. It also held that COGSA does not apply to the carriage of goods by sea under a charterparty unless a "negotiable" sea carriage document is issued for the carriage. In this case, the operators were able to rely on their limitation of liability clause to limit their liability to GBP100 per package. The owners of the vessel were also able to rely on this limitation as a result of the Himalaya clause contained in the Booking Note, which had been validly incorporated.

Finally, it does not appear that any of the supply chain issues will resolve any time soon. Further, Australian ports may be closed or significantly slowed down if companies such as Svitzer decide to proceed with the lockouts they were contemplating in late 2022.

Moray & Agnew is a leading national law firm of more than 650 people, including more than 105 partners. The firm serves domestic and international clients from offices in Sydney, Melbourne, Brisbane, Canberra, Newcastle, Perth and Cairns. The insurance practice is highly regarded and a pre-eminent market leader. It includes 85 partners and 198 other lawyers working exclusively in insurance law and related areas. Moray & Agnew represents all the major Australian and international insurance participants, including local carriers, Lloyd's of London syndicates, brokers, reinsurers, claims managers, all tiers of Australian government, and insureds. The firm's specialty focus is acting in defence of third-party claims, pursuing recoveries and advising on complex coverage issues in a cost-effective and pragmatic manner. Built on a solid history in insurance law, client demand has guided the firm's growth into commercial litigation and dispute resolution, construction and projects, corporate and commercial, property and development, and workplace legal services.

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The key source of private insurance law is the Austrian Insurance Contract Act (VersVG), which is based on general civil law provisions, in particular the General Civil Code Book (ABGB), and supplements these, but in some cases also supersedes them. The Austrian Insurance Contracts Act mainly focuses on the insurance contract itself and defines obligations for the insurer and the policyholder. Nevertheless, certain insurance contracts are excluded from the scope of application of the VersVG. This particularly applies to reinsurance contracts to which – in the absence of special statutory provisions – only general civil law applies.

The provisions of the VersVG are in turn supplemented – depending on the type of contract – by further regulations. For example, the provisions of the UGB (Commercial Code) apply to insurance contracts concluded by commercial enterprises. The provisions of the KSchG (Consumer Protection Act) apply to contracts with consumers.

In addition to contractual provisions, Austrian Insurance law is significantly influenced by the Insurance Supervision Act 2016 (VAG 2016). The VAG primarily defines (re)insurance companies as well as their organisational and regulatory framework, governance as well as capital and liquidity requirements. In addition, European Union legal acts such as the Solvency II Directive (Directive 2009/138/EC on the taking-up and pursuit of the business of Insurance and Reinsurance) or the IDD Directive (Directive EU 2016/97 on Insurance Distribution) have recently played a significant role in Austrian insurance law.

Although precedents are legally not binding, Austria's Supreme Court decisions have an essential purpose in giving specific content to the law and determining the meaning of provisions. Decisions of lower courts are regularly also set aside by the Supreme Court if they are not in accordance with its jurisdiction.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

The Austrian Insurance regulatory framework is essentially determined by the Insurance Supervision Act 2016 (VAG 2016), which implements the Solvency II Directive of the European Union.

The provisions of the VAG are supervised by the Austrian Financial Market Authority (FMA) and primarily aim to protect the insured person. Operation of an insurance company requires a licence from the FMA. Furthermore, the insurer is also obliged to disclose certain data. In this regard, IDD stipulates most disclosing and information obligations EU-wide. Nevertheless, insurance companies are only subject to formal monitoring, which means the supervisory authority cannot intervene in actual business activity. According to the Austrian Industrial Code, insurance and reinsurance intermediaries need a special business licence from the competent district administrative authority.

Worth mentioning in this context is the European Insurance and Occupational Pensions Authority (EIOPA), which ensures a common supervisory practice and uniform application of European rules. Although EIOPA has no direct legislative competence, it has a considerable influence

on European standards as it draws up drafts of technical standards to which the European Commission subsequently gives binding legal effect in the form of resolutions or regulations.

2.2 The Writing of Insurance and Reinsurance

The operation of an (re)insurance company requires licensing or authorisation by the FMA in the form of a concession. If an Austrian company is granted a licence to operate an insurance company, this licence in principle applies to all EU member states.

A separate concession must be applied for each class of insurance, whereby the operation of certain forms of insurance excludes other classes of insurance. Therefore, the parallel operation of a life insurance policy and a property insurance policy is excluded (under the principle of separation of lines of business).

In order to obtain a concession, the company applying for a concession must meet certain requirements. For example, the insurance company has to establish an effective risk management system, whereas capital and liquidity requirements follow the Solvency II Directive and Regulation EUR 2015/35. Furthermore, headquarters of the insurance company must be located in Austria. Foreign providers of intermediary insurance or reinsurance services need a domicile or branch in Austria unless bilateral treaties define otherwise. Apart from that, the insurance company needs at least two board members who are able to comply with governance regulations and sufficiency of own funds. Moreover, the purchase of a qualified share (any share which corresponds to at least 10% of the capital or the voting rights) has to be notified to the FMA.

Domestic insurance companies may only operate in the legal form of a stock company, *societas Europaea* or a mutual company. There are no differences between writing consumer insurances or corporate insurances regarding these requirements.

2.3 The Taxation of Premium

The insurance premiums paid by the policyholder are generally subject to the Insurance Tax Act (VersStG), which provides different tax rates for different lines of business.

For example, a motor-related insurance tax is charged on motor vehicles registered in Austria, which is calculated on the basis of the engine's displacement or power. For motor vehicles that are not subject to motor-related insurance tax, the motor vehicle tax law applies. Another example is insurance premiums paid for fire insurance, which are subject to the Fire Protection Act; the Fire Protection Act levies a tax of 8%. Health insurance premiums are taxed at 1%, while life insurance premiums are taxed at either 4%, 11% or 18%. For legal entities as well as for (re) insurance companies, a tax rate of 25% applies.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Generally, every (re)insurance company needs an Austrian concession to offer insurance and reinsurance services in Austria. With regard to (re)insurance companies that do not have their headquarters in Austria, the Insurance Supervision Act does differentiate between (re)insurers domiciled in other signatory countries of the European Economic Area (EEA insurers) and (re) insurers based in other jurisdictions (referred to

as "third-country insurance and third-country reinsurance companies").

EEA insurers may carry out their business either by establishing a branch office in Austria or according to their freedom to provide services within the European Economic Area. Thus, EEA insurers do not require an additional licence to do businesses in Austria. However, there is a duty to notify their intention to conduct insurance business in Austria to their competent home country supervisory authority. Other than EEA insurers, third-country (re)insurance companies require a licence in order to be able to conduct insurance business in Austria. Such licence may be obtained from the competent Austrian regulator, FMA. In addition, third-country (re)insurers need to establish a branch office in Austria before doing business there.

Due to Brexit, the UK is no longer member of the EU. In terms of the EEA Agreement, the UK now is a third country, which makes it harder for British companies to access the Austrian (re) insurance market.

Additionally, Section IV of the Insurance Supervision Act does provide specific licensing requirements for third-country (re)insurers. However, where the European Commission has determined the solvency regime of a third country to be equivalent in accordance with Article 172 (2) or (4) of Directive 2009/138/EC, the provisions of this Section shall not be applied to third-country reinsurance companies having their head office in that third country. Reinsurance contracts concluded with such companies shall therefore be treated in the same manner as reinsurance contracts concluded with EEA reinsurance undertakings. Section 4, paragraph 19a VAG provides further facilitation for companies with their seat in the USA, as the operation of reinsurance in Austria undertaken by a company with its headquarters in the USA does not need a concession. However, this only applies if the conditions of a bilateral agreement with the EU are met and the reinsurance business is not conducted through a domestic Austrian branch.

3.2 Fronting

According to the Austrian regulator FMA, fronting is only partly permitted. A complete transfer of risk from an insurance company signing business in Austria to one or more reinsurers ("fronting") is prohibited as it contradicts the nature of insurance business. However, the complete passing of risk with respect to a part of the cedent's insurance portfolio may be allowed for certain reasons, provided that such a fronting arrangement is limited in time.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Due to the existing market structure, major merger and acquisition activities in Austria were rather scarce in the last few years. In general, Austrian law does not provide for a specific legal regime when it comes to merger and acquisition activities relating to insurance companies. Therefore, acquisition of an interest in insurance companies may, in principle, be conducted on the basis of a regular share purchase agreement.

Permit for Intended Acquisition

Austrian supervisory law defines a number of preconditions that a buyer of an insurance company has to meet in order to gain a permit for the intended acquisition by the FMA. Any acquisition of a qualifying holding (eg, a direct or indirect holding in an undertaking that represents 10% or more of the voting right or capital, or any

other possibility of exercising a significant influence over the management of that undertaking) in an insurance or reinsurance company has to be notified to the FMA in advance. The same applies for acquisitions of shares by persons already being shareholders in the event they intend to increase their participation to 20%, 30% or 50%.

Prohibition of Intended Acquisition

The FMA may prohibit the intended acquisition if, following the assessment of the acquiring party, there are justified reasons to do so. The assessment criteria are set out in Section 26 of the VAG and include:

- the reputation of the proposed acquirer;
- the reputation and experience of the officers and directors responsible for the management of the insurance company;
- the financial soundness of the proposed acquirer, in particular in relation to the type of business pursued and envisaged in the insurance or reinsurance undertaking in which the acquisition is proposed;
- whether the insurance or reinsurance undertaking will be able to comply and continue to comply with the requirements pertaining to contractual insurance activities and with the provisions of the Financial Conglomerates Act and, in particular, whether the group of which the insurance or reinsurance undertaking will become part has a structure that makes it possible to exercise effective supervision, effectively exchange information among the competent supervisory authorities and determine the allocation of responsibilities among the competent supervisory authorities; and
- whether there are reasonable grounds to suspect that, in connection with the proposed acquisition, money laundering or terrorist financing is being or has been committed or attempted, or that the proposed acquisition could increase the risk thereof.

Corresponding notification duties exist in the case that a shareholder intends to sell their shares, or to decrease their shares below 20%, 30% or 50%. In case the whole insurance business is merged, the concession automatically transfers and no approval of the FMA is needed. The acquisition or sale is generally considered as approved if the FMA does not prohibit such within 60 days following the notification.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The Austrian legal system knows three forms of insurance intermediation, which differ in very important aspects – especially with regard to the accountability of the intermediary. All distribution channels have to comply with the applicable regulations with regard to insurance distribution – these are (i) the Industrial Code (GewO), applicable to insurance agents and brokers, and (ii) the Insurance Supervision Act 2016 (VAG 2016), applicable to insurance companies. All intermediaries need a business licence for their intermediary services. To obtain such licence the intermediary has to file a business registration with the competent administrative authority.

Insurance companies are able to sell insurance contracts by employees (direct sales). In this scenario, employees act directly on behalf of the insurance company and can be attributed to it in all mediation activities. Co-operation is based on labour law regulations and is characterised above all by factual and (in contrast to other forms of mediation) personal binding instructions on the employee.

Insurance Agents

An insurance agent can either act exclusively for just one insurance company or as a multiple agent for several. The insurance agent as independent entrepreneur is responsible for compliance with corporate, company and, above all, trade law regulations. Despite this much broader relationship between insurance agents and insurance companies, co-operation is characterised by a tight connection. Thus, the insurance agent is often contractually obligated to follow objective (but not personal) instructions. For example, the insurance agent is usually required to use the corporate identity of the insurance company to comply with internal insurance guidelines and business processes that are intended to ensure successful economic co-operation. For these reasons, the insurance agent is equally attributable regarding contract mediation to its insurance company, like an employed insurance staff member when direct selling.

Insurance Broker

An insurance broker – just like an insurance agent – is an independent entrepreneur and must therefore be strictly separated from the insurance company. In contrast to the insurance agent, the insurance broker is not attributable to the insurance company. They are considered a confederate of the policyholder, to whom they are liable in the event of improper advice. Actions that the insurance broker undertakes vis-à-vis the insurance company on behalf of the policyholder are thus basically attributable to the latter, as are actions undertaken by the policyholder themself.

Due to their practical relevance in Austria, distribution by credit institutions (banks) should also be mentioned here. In principle, they are not subject to any particular restrictions; all forms of insurance intermediation are at their disposal. However, a separate approval of the Austrian Financial Market Authority (FMA) is required, as this authority assumes the function of a trade authority in the case of insurance brokerage by a credit institution.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

When concluding the insurance contract, the policyholder must disclose all circumstances to the insurer, which are known to them and could be significant for the insured risk. Circumstances, which are capable of influencing the insurer's decision to conclude the contract or to agree to the agreed terms, are considered as significant. Circumstances, which the insurer asked for explicitly and in written form, are – in case of doubt – also considered to be significant. This duty of disclosure is a statutory obligation.

Insurers do not have to proactively seek information from the policyholder, but generally use clauses in their terms and conditions stipulating certain disclosable information and circumstances. The circumstances relevant for the assessment of the risk to be insured are in practice usually requested in the application form. If the applicant answers these questions truthfully and completely, it can usually be assumed that the applicant has fulfilled their obligation to disclose. According to the judicature of the Austrian Supreme Court (OGH), however, circumstances that are not expressly requested must be communicated additionally if an application question conclusively refers to them overall, or if their communication appears to be self-evident. After the contract has been concluded, the insured person has to inform the insurer about any increases of the risk.

The insurer is also obliged to inform the policyholder about their right to withdraw from the contract within 14 days. In case of a life insurance, the policyholder may withdraw within 30 days.

6.2 Failure to Comply With Obligations of an Insurance Contract

If the policyholder culpably fails to report a significant circumstance, the insurer may withdraw from the contract. A withdrawal is only possible within one month from the date the insurer became aware of the violation of the disclosure obligation.

A withdrawal is nevertheless not possible if the policyholder is not to blame for the lack of notification or for the inaccuracy of their information (eg, if the policyholder answers an application question incorrectly or incompletely, because the insurer formulates it in an unclear way, or if the policyholder's notification is lost by post). The withdrawal of the insurer leads to the cancellation of the contract from the outset – in other words, the contract is cancelled retrospectively from the beginning of the contractual relationship. Any claims that have already arisen shall be voided and both contracting parties must defer the benefits drawn from the contract.

Regarding the premium, despite the withdrawal, the insurer is entitled to that part of the premium that falls between the conclusion of the contract and the effectiveness of the withdrawal. In exchange, those events are covered that occur before the withdrawal becomes effective and do not fall within the hidden risk area. If a withdrawal from the contract is not possible (eg, due to lack of culpability), the insurer can adjust the premium to the increased risk or, under certain circumstances, terminate the contract.

In addition to these notification obligations of the policyholder, there are also certain information obligations of the insurer towards the policyholder that have to be provided for the most part prior to the conclusion of the contractual declaration of the policyholder. In the event of a breach of these pre-contractual information obligations, the law grants the policyholder the right to withdraw from the contract under certain circumstances.

6.3 Intermediary Involvement in an Insurance Contract

Please refer to **5.1 Distribution of Insurance and Reinsurance Products**.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

The Austrian Insurance Contract Act does not stipulate a special form for the conclusion of an insurance contract. Therefore, according to general civil law, only a concordant declaration of intent of the contracting parties is required, which can be made not only in writing but also, for example, conclusively or even verbally. Only in a few cases is a written form required (eg, withdrawal from the contract).

According to civil law rules, an insurance contract must (only) stipulate the essentialia negotii of a contract, meaning the insured risk, the insurance fee and the nature of the insurance. Insurance companies often use general terms and conditions for multiple contracts, which have to comply with the Austrian Civil Code. Thus, surprise clauses or clauses grossly disadvantageous are prohibited. Regarding the content of an insurance contract, there are no further limits set.

6.5 Multiple Insured or Potential Beneficiaries

Insurances can also be concluded for third parties. In D&O policies, the company concludes an insurance contract for the company whereas people in management functions are covered by the policies. The insured persons do not have to be named in the policies by name. It is sufficient if those people can be determined by their function. The knowledge of such persons is attributed to the insured company. Therefore, coverage can be denied in case the management violated an obligation.

6.6 Consumer Contracts or Reinsurance Contracts

Since insurance contract law is strongly influenced by the principles of general civil law, most of the relevant provisions in insurance law equally apply to entrepreneurs and consumers. In case the policyholder is a consumer, the Consumer Protection Act, which provides for special protection requirements, applies to the insurance contract. According to the Consumer Protection Act, general conditions must be clear and unambiguous otherwise they are void.

Moreover, the Austrian Insurance Contract Act, for example, makes an explicit differentiation in connection with the period of engagement of the policyholder. If an insured person is a consumer, they are allowed to terminate the contract annually if at least three years have elapsed since the commencement of the insurance. The Austrian legislator obviously assumes that an entrepreneur can assess the consequences of their decision with regard to commitment period better than an average consumer can.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Austrian law distinguishes between classical forms of reinsurance and concepts of alternative risk transfer. Austrian supervisory law explicitly addresses finite reinsurance activities as well as activities by special purpose vehicles pursuant to Directive 2005/68/EC.

Finite reinsurance is defined as reinsurance under which the maximum economic risk transferred, arising both from a significant underwriting risk and timing risk transfer, exceeds the premium over the lifetime of the contract by a limited but significant amount. Further, a finite reinsurance contract must provide for either combined consideration of the time value of money or contractual provisions to moderate the balance of economic experience between the parties over time to achieve the target risk transfer.

According to Austrian supervisory law, insurance and reinsurance companies that pursue finite reinsurance activities shall ensure that they are able to properly identify, measure, monitor, manage, control and report the risks arising from those contracts or activities. Whereas finite reinsurance contracts are widely considered as genuine (re)insurance contracts, business conducted by special purpose vehicles when signing alternative risk transfer transactions is usually not classified as insurance business.

Special purpose vehicles are defined as companies other than an existing insurance or reinsurance company, which assume risks from an insurance or reinsurance company and which fully fund their exposure to such risks through the proceeds of a debt issuance or any other financing mechanism where the repayment rights of the providers of such debt or financing

mechanism are subordinated to the reinsurance obligations of such a company.

Special purpose vehicles with head offices in Austria require a licence pursuant to Section 105 of the VAG 2016 granted by the FMA in accordance with the provisions set forth in the implementing regulation 2015/462/EC. Special purpose vehicles pursuant to Section 105 of the VAG 2016 signing alternative risk transfer transactions do not as yet play a major role in the Austrian insurance market.

7.2 Foreign ART Transactions

As outlined in **7.1 ART Transactions**, alternative risk transfer transactions are generally not treated as insurance or reinsurance contracts under Austrian law. Therefore, also foreign ART transactions are not considered as reinsurance contracts. However, Austrian supervisory law does provide for the possibility to consider both recoverable from reinsurance contracts and special purpose vehicles pursuant to Directive 2005/68/EC when calculating the total amounts recoverable. Detailed provisions may be found in the EIOPA guidelines on the valuation of technical provisions (EIOPA-BoS-14/166).

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are generally – besides a few special exceptions in the Insurance Contract Act – interpreted like any other civil contract. Therefore, it is the will of the contracting parties, which shall be decisive for interpretation. Of course, the peculiarities of insurance law imply a number of other circumstances relevant in the context of interpretation. For example, the insurance intermediary has to evaluate the customer's wishes and needs on the basis of information provided by the customer. Intermediaries also have to draw up a consultation protocol for the entire consultation process. Furthermore, the will of the contracting parties can often be identified on the basis of the advertising materials used in the advisory process.

If it is not possible to ascertain a concurring will of the parties, the contractual declarations are to be interpreted – in accordance with the provisions of general civil law – on the basis of the bona fide exercise of traffic law. In this case, it depends on how a bona fide recipient of the declaration would have understood the contractual declaration in doubt. If there are still unclear issues after the interpretation of a contract, the contract has to be interpreted to the detriment of the person who made use of the unclear declaration. This is especially relevant in the context of the interpretation of insurance contracts, as it is generally not possible to clearly determine a party's will regarding individual terms on the basis of the interpretation possibilities described above. Insurance contracts are therefore usually interpreted at the insurer's expense if they are unclear.

8.2 Warranties

Warranties are basically already stipulated by the Insurance Contract Act as well as the Austrian Civil Code. However, insurance contracts also often include a corresponding clause. If such clauses are specifically stated in the insurance contract, they are usually described as notification obligations.

If a policyholder culpably fails to report a significant circumstance as pointed out in **6.2 Failure to Comply with Obligations of an Insurance Contract**, the insurer may withdraw from

the contract. After the insurance contract has been concluded, the policyholder has to inform the insurer about any increases of the risk. The increase of such risk is afterwards only included in the insurance contract if the insurer agrees.

If the policyholder, after conclusion of the contract, does not disclose any increase of the risk, the insurer has the right to withdraw the contract without observing a notice period. In the event of a breach of the agreed contractual obligations, the insurance conditions usually stipulate the insurer's discharge from liability. In this respect, it is essential for the policyholder to be aware of the obligations that apply to them and to fulfil such obligations in the event of a claim. However, the insurer's discharge from liability does not apply if the policyholder is not at fault for the breach of the obligation.

8.3 Conditions Precedent

Austrian Insurance Law knows conditions precedent as well as conditions subsequent.

Conditions precedent do not have to be explicitly named as such, but should be described as clearly as possible, as contracts containing conditions precedent only become effective if the stated condition is fulfilled. If the condition subsequently occurs, that event will cease one party's obligation to the other.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurance contract disputes are subject to general civil jurisdiction unless they are social insurance claims. Since insurance companies are operating in the form of a joint-stock company or a European joint-stock company, the civil courts, as district or regional courts in commercial matters, usually have jurisdiction in the event of an action filed by the policyholder against the insurer for the contractually owed insurance coverage. Disputes under EUR15,000 fall under the jurisdiction of the district courts, whereas regional courts are competent for disputes above the amount of EUR15,000. Alternatively, special arbitration courts can be consulted. This applies for disputes over coverages to consumer contracts and reinsurance contracts.

The limitation period starting after the insured risk occurred is three years. Every insured person applying for coverage has to submit a declaration of damage including documents of the case to the insurer. After such declaration of damage has been filed, the limitation period gets suspended until the insurer sends a written decision about coverage. Any possible claims become time-barred, if not claimed by the policyholder within ten years. If the insurer denies coverage, the insured person has to assert its claims in court within one year.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Generally, uncertainties as to the (international, subject matter and local) jurisdiction of a court must already be examined by the court without the application of a party (ie, ex officio). However, in most cases, potential lack of jurisdiction is only examined in detail following a respective motion by the defendant party. Parties may also agree on the jurisdiction of a certain court within the limits set by law. In the absence of a valid agreement, statutory provisions stipulate which court has jurisdiction.

If the court seized decides to have jurisdiction, the following procedural step is to examine which law is applicable. In this context, the applicable law may result from the agreement

of the parties and, in the absence thereof, from statutory provisions. Of course, an agreement on jurisdiction as well as on the applicable law is not conceivable in the case of tortious claims.

For claims with foreign references – eg, when the (re)insurer has its seat in a foreign country – the jurisdiction follows the rules of Regulation EU 1215/2012 on Jurisdiction and the Recognition and Enforcement of Judgments in Civil and Commercial matters (EuGVVO). The applicable law follows the Regulation EG 593/2008 on the Law applicable to Contractual Obligations in Insurance Contracts. As reinsurance contracts are explicitly excluded from the scope of the Regulation EG 593/2008, Austrian Law on International Private Law is applicable.

9.3 Litigation Process

In general, there are several ways in which a court action can be initiated in Austria, whereby under certain circumstances the plaintiff has the choice, but in other cases a certain procedure is mandatory. The litigation process is governed by the Code of Civil Procedure, which states the principle of orality for litigation processes.

Most legal actions against insurers are filed using the national order for payment form. The court issues a so-called conditional order for payment on the basis of the plaintiff's alleged facts, in which the insurer is ordered to pay the sum of money claimed or to raise an objection within a certain period of time, after which ordinary court proceedings are initiated. This procedure must be carried out nationally up to EUR75,000; internationally there is no obligation to carry out an order for payment procedure, and also no value limit. In the case of amounts exceeding EUR75,000, or if the claim is not merely in the form of money, the regular court proceedings shall be instituted immediately, in which the parties submit their substantive and legal arguments, on which the court shall decide.

If the order for payment is not objected or a judgment is not appealed to the next higher court, the order for payment or judgment becomes effective. The prevailing party can then file an application for execution, which initiates the execution proceedings.

9.4 The Enforcement of Judgments

According to the EuGVVO, all judicial decisions of the civil and commercial courts of the EU member states are recognised ipso jure without a separate legal act and are enforceable in Austria. However, recognition can be refused for certain reasons listed in the EuGVVO.

In the case of an application for enforcement of a foreign judgment, the actual enforcement is preceded by a so-called exequatur procedure – ie, the procedure for declaring enforceability. Special conditions have to be considered in case of a European Enforcement Order according to EuVTVO.

9.5 The Enforcement of Arbitration Clauses

In addition to decision on insurance contracts disputes by state courts, there is the possibility to declare non-state courts (arbitral tribunals) competent for disputes arising out of a predetermined legal relationship in the form of an arbitration clause. This is usually achieved by an additional written agreement in the insurance contract and results in the decision authority and jurisdiction of the particular arbitral tribunal. Apart from family and tenancy law claims, arbitration clauses are enforceable.

9.6 The Enforcement of Awards

A domestic arbitral award usually has the effect of a legally binding court decision and is enforceable after the expiry of the payment period stated in the arbitral award.

Austria is party to the New York Convention since 1961. The Convention requires courts of contracting states to give effect to private agreements to arbitrate and to recognise and enforce arbitration awards made in other contracting states. Conversely, Austrian arbitral awards are enforceable in states that have ratified the New York Convention. However, the enforcement of a foreign arbitral award may be refused in certain cases.

9.7 Alternative Dispute Resolution

Generally, alternative dispute resolution (eg, mediation) does not play a big role in the resolution of insurance disputes in Austria. Nevertheless, the Alternative Dispute Resolution Act (AStG) provides a further possibility for consumers to resolve insurance disputes. According to this Act, a consumer can initiate an alternative dispute resolution procedure instead of a regular court procedure in advance in order to achieve a cost-effective, quick and simple settlement of the dispute. However, such a procedure requires the consent of the insurance company. For this reason, the parties are free to terminate the procedure at any stage.

9.8 Penalties for Late Payment of Claims

Provisions of penalties are generally uncommon in insurance provisions. Claims for damages which arose due to late payments can be raised if the insurer improperly delayed settling the claims and the policyholder has faced losses on this ground. Furthermore, the policyholder can withdraw from the contract, and as the insured, can reclaim paid premiums and default interest.

9.9 Insurers' Rights of Subrogation

According to the Austrian Insurance Contract Act, compensation claims of the policyholder against third parties are subrogated to the insurer if the insurer compensates the policyholder. The subrogation is not applicable if the compensation claim would be directed against a family member of the policyholder living in the same household. However, compensation claims, even in this case, are subrogated if the family member caused the damage intentionally. If the policyholder waives its compensation claims against a third party, the insurer is relieved from its obligations to compensate if the insurer could have claimed compensation out of such subrogated claim.

10. Insurtech

10.1 Insurtech Developments

In general, quite a lot of insurtech business activity can be observed in the Austrian insurance market recently. Besides co-operating with insurtech start-ups, a number of Austrian insurance undertakings have established their own online direct distribution channels, some of which use their established company brands, whilst others create their own brands for future online business. Most of these online distribution channels provide for the possibility of signing retail insurance contracts without consulting an insurance distributor in person.

As for the legal framework for the business conducted by insurtechs, it has to be noted that insurtechs have to comply with the same legal standards applicable to "conventional" market participants. As a matter of fact, the amount of regulation of insurance law can be seen as a major challenge for insurtechs in Austria.

10.2 Regulatory Response

Insurtechs can be non-concessioned and concessioned companies. Therefore, the FMA not only supervises licensed companies in fintech, but also clarifies the licence obligation. The FMA has established a fintech point of contact ("FinTechNavigator") on its website, which fintech companies may contact regarding licensing requirements or other legal frameworks. However, it has to be noted that, with respect to insurtechs conducting business as an insurance intermediary rather than as an insurance company, the FMA is not the competent supervisory body.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Following international trends, insurance contracts relating to cyber-risks (such as data theft and phishing mails) have recently become increasingly popular in Austria. Whereas cyber-risks have tended not to receive the same attention in Austria as in other countries, the COVID-19 pandemic seems to have changed that. A recent survey shows that 38% of companies in Austria have noticed an increase in cyber-attacks during the pandemic. In this regard, the FMA requires high data security standards from insurers.

Other emerging risks which affect the insurance market are the consequences of global warming and associated natural disasters. The demand for insurances covering these risks is high, although some risks face extreme difficulties to be insured in the future.

11.2 New Products or Alternative Solutions

With regard to the introduction of new insurance products relating to cyber-risks, a top-down development can be observed. Whereas cyber-insurance was initially subscribed mainly by large-scale enterprises, insurance undertakings in Austria have also begun to explicitly target small and medium-sized enterprises as potential customers. Furthermore, the Austrian insurance market has recently seen the introduction of retail cyber-insurance products explicitly tailored for the needs of private persons, including coverage for damages suffered through the use of online shopping tools.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

The COVID-19 pandemic had and still has an effect on the Austrian insurance and reinsurance market, whereas some market areas are more affected than others. Effects were particularly noticeable in the field of business interruption insurances. In this regard, there have been extensive discussions as to whether or not the COVID-19 pandemic is an insured event under existing business interruption policies.

In February 2021, the Austrian Supreme Court ruled that business interruption caused by general measures imposed by the authorities to prevent the spread of COVID-19 does not fall within the scope of typical business interruption policies in Austria. The Supreme Court upheld that ruling in a similar case in March 2021.The court's main reasoning was – at least regarding the wording in the underlying cases – that business interruption is qualitatively a different risk

than a ban on entering the premises. One must differentiate whether the business premises of a company are closed by means of an individual order by the authorities or whether customers are no longer able to enter certain business premises due to a generally applicable curfew or measures to avoid the gathering of people in larger numbers. The risk of a mere de facto closure of the business as a side-effect due to the ordered ban on entering was eventually not qualified as an insured event under the policy.

Another insurance area widely affected by COVID-19 is directors' and officers' insurance. This is because the economic effects of the pandemic also led to an increased need for action by the executive staff of companies, as they had to apply for COVID-19 state aid in due time, establish an effective risk management or implement sufficient safety and health precautions for employees and customers. As a result a larger number of liability claims in relation to directors' and officers' insurances has been observed in the past months and is expected in future.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Both internationally and nationally, there has been a significant increase in cybercrime in recent years. While in 2017 around 16,800 cybercrime offenses were reported in Austria, this figure had already risen to over 46,000 by 2021. With increasing digitisation, not only is entrepreneurial activity shifting to the "digital world", but criminal organisations are also adapting their actions to the changed circumstances.

In this context, the COVID-19 pandemic has not only contributed to a noticeable push in the area of digitalisation, but also to another significant increase in "cybercrime". The Austrian cyber market was affected by, and had to deal with, a large number of cyber-attacks because the rise of companies having their staff work at home. According to the Cybercrime Report of the Austrian Federal Ministry of the Interior 2021, the rate of solved crimes in the cybercrime area has remained relatively constant at slightly more than one-third over the past five years (about 36.9% in 2021). Conversely, around two-thirds of these crimes remain unsolved, so that it is in fact not possible for victims to assert claims for damages in these cases.

The steady increase in cyber incidents has made the need for comprehensive insurance protection more and more apparent in recent years. In many cases, it is only when specific incidents occur that entrepreneurs realise that "classic" insurance products often offer a certain level of protection, but that there are – sometimes very serious – gaps in coverage.

The insurance industry has responded to the increased need for protection against cyber incidents by launching a wide variety of products. In some cases, these have been based on standard insurance products and corresponding extensions or "additional modules" have been formulated to provide supplementary protection against "cybercrime". On the other hand, there are concepts that are primarily "tailored" to cyber incidents.

BLS Rechtsanwälte GmbH is one of the leading medium-sized law firms in Austria, with almost 50 years of experience and approximately 60 employees located in the heart of Vienna. It provides legal advice to companies of all sizes and to private individuals, especially in connection with insurance matters. These include major claims settlement for national and international insurance companies and defence against liability and cover claims. In addition, BLS is regularly mandated with the support of complex mandates, in particular D&O and fidelity insurance, both as coverage and monitoring counsel and as direct representatives of insured persons in civil and criminal cases. The independent certification body TÜV Austria certified the business law firm's quality management system, attesting to its practice and client orientation. BLS was the first Austrian law firm to undergo this examination. As the only Austrian member of the Avrio Advocati European Law Firms Association, BLS has access to a wide network of international attorneys at law, tax advisers and notaries, enabling it to handle cross-border matters swiftly and efficiently.

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BELGIUM

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Insurance and reinsurance law is governed by a comprehensive body of law.

Firstly, the authorisation and supervision of (re) insurance undertakings is governed by the Law of 13 March 2016 on the statute and supervision of insurance and reinsurance undertakings (Solvency II Law), which implemented Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of insurance and reinsurance (Solvency II Directive).

Other implementing Royal Decrees and regulatory guidance by the national competent authority for prudential supervision, the National Bank of Belgium (NBB), supplement the Solvency II Law.

Secondly, the Law of 4 April 2014 on insurance (the "Insurance Law") governs, among others, the activity of (re)insurance distribution. The Insurance Law implements Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (recast) – the Insurance Distribution Directive (IDD).

Laws governing specific aspects of insurance law, implementing Royal Decrees and regulatory guidance by the national competent authority for supervision on (re)insurance distribution, the Financial Services and Markets Authority (FSMA) supplement the Insurance Law.

Finally, the Insurance Law and related texts set out general Belgian rules relating to insurance contracts including, among others, mandatory formalities for the conclusion and performance of insurance contracts, rules of conduct and minimum content for various types of insurance contracts.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Insurance and reinsurance business is regulated by the Solvency II Law, which is supplemented by implementing Royal Decrees and regulatory guidance by the national competent authority for prudential supervision, the NBB.

The activity of (re)insurance distribution is governed by the Insurance Law. Among others, this law implements the IDD. The FSMA is the national competent authority for supervision on (re)insurance distribution.

2.2 The Writing of Insurance and Reinsurance

Insurance and reinsurance undertakings are not allowed to carry out any activity of insurance in Belgium unless they have obtained a licence.

The Solvency II Law has implemented the European rules with regard to passporting rights for insurance and reinsurance undertakings established in other EEA member states.

Additional requirements are imposed on insurance undertakings established and licensed in third-country jurisdictions. They must establish a local Belgian branch before carrying out activities in Belgium.

Reinsurance undertakings established and licensed in third countries have a choice: they can establish a branch in Belgium or carry out their activities by way of the freedom to provide services with regard to the same activity for which they have obtained authorisation in their home state.

The requirements for carrying out insurance or reinsurance activities do not differ depending on whether those activities relate to consumers or to SMEs and corporations. Furthermore, no different rules apply to the underwriting of excess layers.

The requirements for authorisations are described in the Solvency II Law and the Royal Decree of 22 February 1991 on the general regulation on the supervision of insurance undertakings. In its 2017 memorandum on the application for authorisation by an insurance or reinsurance company under Belgian law and related communications, the NBB issued further practical guidance.

The key criteria for authorisation relate to quantitative requirements (such as minimum capital requirements), qualitative requirements (such as governance) and transparency requirements (such as reporting to the NBB and disclosures to the general public).

Reinsurance undertakings are equally subject to a comprehensive body of insurance regulation. However, both the Solvency II Law and the Insurance Law take into account the specific nature of reinsurance business. Often, this results in less stringent regulatory conditions, such as the requirements for market access for third-country reinsurance undertakings or the (non-)imperative nature of the provisions governing reinsurance contracts.

2.3 The Taxation of Premium

An insurance premium tax is due when the insured risk is located in Belgium. The normal rate is 9.25%, but there are also reduced rates, depending on the nature of the insurance products. Additional contributions may apply to specific insurance coverages (excluding third-party motor liability insurance coverage).

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Insurance and reinsurance undertakings established in other EEA member states may exercise passporting rights through a branch or by way of the freedom to provide services in accordance with European rules.

Insurance undertakings established in third-country jurisdictions can only carry out activities in Belgium after establishing a local branch.

This procedure is governed by the Solvency II Law and regulatory guidance by the NBB, notably the NBB's 2017 Communication on the procedures for the performance of insurance or reinsurance activities in Belgium by insurance or reinsurance companies governed by foreign law.

The branch of an insurance company from a third country may only perform insurance activities in Belgium if, among others:

- the insurance company is governed by the law of a third country that is considered "equivalent";
- the NBB has entered into a co-operation agreement with the supervisory authorities of the third country of origin;

- the insurance company has been granted authorisation in the third country of origin for performing the insurance activities it intends to carry out through its Belgian branch; and
- the branch has been granted prior authorisation by the NBB.

To obtain NBB approval, the branch of the insurance undertaking must submit a dossier to the NBB, containing, among others, information on its organisation, solvency and prudential information, proof that it has the necessary eligible own funds to attain half of the absolute floor of the minimum capital requirement and sufficient collateral in Belgium and the contact details of the authorised representative in Belgium.

The UK became a third party since 1 February 2020 but benefited from the EU's passporting arrangements until 31 December 2020. In the context of Brexit, the Belgian legislature has provided for a transitional regime for which it requires insurance undertakings governed by UK law that have lost their passporting rights and intend to run off (that is, decrease assets of) an existing portfolio to notify the NBB of their intention. This notification must contain the following information.

- A pledge not to conclude any new insurance contracts in Belgium.
- Evidence that the insurer is duly licensed to carry out activities of insurance in the UK.
- Evidence that the insurer complies with UK legal and regulatory requirements, that it is not subject to a recovery plan, a plan of short-term financing or a comparable measure of the UK supervisors and that no reorganisation measure is imposed in the UK.
- A run-off plan.
- A commitment to support the Belgian activities financially and operationally in order to pay insurance benefits in the interest of policyholders and beneficiaries.
- The provision of any information allowing the NBB to assess the insurer's commitments in Belgium.
- The appointment in Belgium of a representative who meets the requirements of Article 593 of the Solvency II Law. In particular, the representative must:
  (a) be domiciled or have their usual residence in Belgium;
  (b) have sufficient authority to bind the company towards third parties and represent it before Belgian authorities and courts; and
  (c) meet the same fit and proper requirements as a board member or a member of the management committee.

Furthermore, the insurer in run-off must comply with the following requirements:

- it must update this information at least once a year and on the occasion of every important change; and
- it must inform the policyholders and beneficiaries as soon as possible that the continuity of the insurance benefits is guaranteed and provide all useful information in this regard.

Reinsurance undertakings established and licensed in third countries may establish a branch in Belgium or carry out their activities by way of the freedom to provide services with regard to the same activity for which they have obtained authorisation in their home state.

3.2 Fronting

Fronting (that is, a risk-management mechanism in which an insurer underwrites a policy to cover a specific risk or a set of risks, then cedes the risk(s) to a reinsurer) is permitted in Belgium but

it cannot be excluded that the NBB will consider that the reinsurer should exercise insurance activities. Depending on the concrete circumstances, the amount of risk ceded will probably be relevant. The NBB could rely on the European Insurance and Occupational Pensions Authority (EIOPA) recommendation, according to which a minimum retention of 10% of the business written could be envisaged.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Pursuant to Article 102 of the Solvency II Law, the prior approval of the NBB is required for mergers involving an insurance or reinsurance undertaking, as well as for demergers. The same applies to the transfer of all or part of the business, including the complete or partial transfer of a portfolio, resulting in the transfer of the rights and obligations arising from the insurance or reinsurance contracts. The NBB can only refuse its approval for reasons relating to the undertaking's ability to comply with the provisions of the Solvency II Law or other measures implementing the Solvency II Directive, or for reasons relating to a sound and prudent policy of the undertaking or if the decisions could seriously affect the stability of the financial system. The NBB has published a circular concerning the procedure to be followed in the case of transfer of a portfolio of insurance or reinsurance contracts and in the case of mergers or demergers (NBB_2021_006).

The NBB shall publish in the Belgian Official Gazette an extract from any decision approving a merger or a transfer of rights and obligations arising from insurance or reinsurance contracts.

Portfolio transfers involving the transfer of rights and obligations of insurance contracts for which the member state of the commitment or of the risk is Belgium, carried out by an insurance undertaking governed by the law of another member state and approved by the supervisory authorities of its home member state, are published in Belgium as well.

The Insurance Law provides that transfers of insurance contracts relating to risks or commitments situated in Belgium are opposable to the policyholders, the insureds, the beneficiaries and any third party that has an interest in the performance of the insurance contract when they are authorised by the NBB or by the competent authorities of another member state. This opposability takes effect as soon as the NBB's approval is published in the Belgian Official Gazette.

However, the Insurance Law provides a right of cancellation for the policyholder which must be exercised within three months from the date of publication. Moreover, this right of cancellation does not apply to mergers and demergers of insurance companies or to transfers carried out within the framework of a contribution of assets in general or of a branch of activity, or to other transfers between insurance companies that are part of the same consolidated whole.

Several insurers specialised in run-off are active on the Belgian market. It is expected that this run-off business will only grow in the future.

According to a study of the NBB, inward direct investments exceeded outward investments until 2015. More was invested in Belgium than what Belgium invested abroad, mainly because of the central location of Belgium within the EU and its well-educated labour market. However,

there has been a shift towards more outward investments since 2015. Note that this study does not focus on insurance and reinsurance undertakings alone but provides an overall insight to inward and outward investments in Belgium. Furthermore, there have been no mergers or demergers of (re)insurance undertakings in 2022 according to the website of the NBB. There have only been transfers of portfolios (18 to be exact).

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

In the Insurance Law, insurance distribution is defined as:

"... the activities of advising on, proposing, or carrying out other work preparatory to the conclusion of contracts of insurance, of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim, including the provision of information concerning one or more insurance contracts in accordance with criteria selected by customers through a website or other media and the compilation of an insurance product ranking list, including price and product comparison, or a discount on the price of an insurance contract, when the customer is able to directly or indirectly conclude an insurance contract using a website or other media."

The following activities are considered as insurance distribution:

- presenting insurance contracts;
- proposing insurance contracts;
- carrying out other work for the conclusion of insurance contracts;
- concluding insurance contracts;
- contributing in the administration of insurance contracts; and
- contributing in the execution of insurance contracts.

Among others, the following are not considered as insurance distribution activities:

- the occasional provision of information to a customer in the context of another professional activity (other than insurance distribution), insofar as the information provider does not take any further steps to assist in the conclusion or execution of an insurance contract;
- professional claims handling for an insurance undertaking and claims settlement and expert assessment;
- the mere provision of data and information on potential policyholders to insurance intermediaries or insurance undertakings, provided that the information provider does not take any further steps to assist in the conclusion of an insurance contract; and
- the mere provision of information on insurance products or on an insurance intermediary or insurance undertaking to potential policyholders, provided that the information provider does not take any further steps to assist in the conclusion of an insurance contract.

The last two activities mentioned are the typical activities of a client contributor. The FSMA provides more guidance on the qualification as client contributor.

The activity of (re)insurance distribution is governed by Part 6 of the Insurance Law, as well as its implementation of Royal Decrees and FSMA regulatory guidance.

(Re)insurance intermediaries must register with the FSMA before carrying out (re)insurance distribution activities in Belgium or, alternatively, exercise passporting rights when registered in another EEA member state.

The FSMA register of insurance intermediaries consists of the following categories:

- insurance brokers;
- insurance agents;
- insurance sub-agents;
- mandated underwriters; and
- ancillary insurance intermediaries.

In addition to these categories of insurance intermediaries, insurers may also act as (direct) insurance distributors without the intervention of an insurance intermediary. In that case, the insurers have to comply with the provisions of Part 6 of the Insurance Law as insurance distributors. Sometimes, these provisions are less stringent than the provisions applicable to insurance intermediaries. Bancassurance (a strategy where a bank cross-sells by selling insurance products through its own bank distribution channels) is also a common practice in Belgium. The FSMA has drawn attention to the EIOPA warning with regard to bancassurance to ensure that credit protection insurance (CPI) products offer fair value to consumers by:

- taking action to address issues with high remuneration paid by insurance manufacturers to insurance distributors for the sale of CPI products; and
- preventing detrimental conflicts of interest in the context of bancassurance business models.

Reinsurance distribution is equally regulated by the Insurance Law. The FSMA register of reinsurance intermediaries consists of the following categories:

- reinsurance brokers;
- reinsurance agents; and
- reinsurance sub-agents.

The FSMA regularly emphasises that the whole chain of (re)insurance distribution is regulated and that any (re)insurance undertakings must verify whether all intermediaries in the distribution chain are duly authorised. For example, the FSMA reminded insurance distributors on 9 June 2022 of the prohibition on relying on insurance intermediaries and ancillary insurance intermediaries who are not registered, referring to the applicable criminal sanctions and administrative fines.

The Insurance Law sets out detailed registration conditions (eg, professional knowledge and experience requirements for regulated positions), as well as rules of conduct (eg, precontractual disclosures, conflict of interest management). These rules are further supplemented by Implementing Royal Decrees, such as the Royal Decree of 18 June 2019 on the implementation of Articles 5, 19°/1, 264, 266, 268 and 273 of the Insurance Law, and FSMA guidance (eg, Handbook on IDD rules of conduct of 25 January 2022, newsletters, FAQs).

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Under Belgian law, the (prospective) policyholder is the most suitable person to inform the insurer of the risk to be insured. For this reason, the (prospective) policyholder has been assigned a spontaneous obligation to inform, which also

forms the essence of the insurance agreement. This obligation stems both from the principle of good faith and from the concern to correct the imbalance of information between the insurer and the policyholder. As soon as possible and before the insurance contract is concluded, the (prospective) policyholder must inform the insurer of "all circumstances known to him, which he must reasonably consider to be information that may influence the insurer's assessment of the risk".

The fulfilment of the duty of disclosure by the policyholder is a crucial element in the insurer's risk assessment. Article 58 of the Insurance Law requires the policyholder to disclose all circumstances known to them, which they ought reasonably to consider as constituting a basis for the assessment of the risk by the insurer. The policyholder does not have to disclose those circumstances that are already known or should be known to the insurer. By "should be known" is meant that the insurer is deemed to know facts of common knowledge, of what it was able to deduce from the policyholder's statements and knowledge that, as an insurance specialist, it cannot be unaware of. Furthermore, genetic data may not be communicated.

From the fact that the Insurance Law assumes a spontaneous duty of disclosure, it follows that the insurer has no duty of investigation and verification. In principle, the insurer is not obliged to ask questions about any element of the risk to be assessed. Even though the policyholder is in principle required to disclose all essential circumstances, the use of a questionnaire can sometimes lead to discussions on whether elements that were not mentioned in the questionnaire needed to be disclosed by the policyholder, or can lead to issues regarding the proof of a breach of the duty of disclosure. However, as a general rule the insurer needs to maintain a professional attitude. According to case law, the insurer can be obliged to ask questions about the risk if it is plausible that the (prospective) policyholder cannot assess their relevance. If the (prospective) policyholder does not answer the questions posed by the insurer and the insurer nevertheless concludes the policy, it may be assumed that the unanswered question was not relevant to the assessment of the risk (except in cases of fraud).

Article 58 of the Insurance Law applies to consumers in the same way as it does to enterprises.

6.2 Failure to Comply With Obligations of an Insurance Contract

Articles 59 and 60 of the Insurance Law contain a strict and mandatory penalty mechanism in the event of a breach of the policyholder's duty of disclosure.

In the case of intentional omission or intentional misstatement of information about the risk, which misleads the insurer in the assessment of that risk, the insurance contract is null and void. The premiums that have matured up to the moment the insurer became aware of the intentional omission or intentional misstatement of information shall accrue to the insurer.

If the omission or misstatement of information is not intentional, the contract shall not be null and void. Within a period of one month from the day on which the insurer became aware of the omission or misstatement, it shall propose that the contract be amended with effect from the day on which it became aware of the omission or misstatement. If the insurer provides evidence that it would never have insured the risk, it may cancel the contract within the same period. If the proposal to amend the contract is refused by the

policyholder or if, after the expiry of a period of one month from the receipt of such a proposal, it is not accepted, the insurer may cancel the contract within 15 days. An insurer who has not cancelled the contract or proposed an amendment within the periods previously stipulated may not subsequently refer to facts of which it was aware.

If the unintentional omission or misstatement of information cannot be attributed to the policyholder and if a claim occurs before the amendment or cancellation has taken effect, the insurer shall be bound to pay out the benefit.

If the unintentional omission or misstatement of information can be attributed to the policyholder and if a claim occurs before the amendment or cancellation took effect, the insurer shall only be obliged to pay out the benefit based on the ratio of the premium paid to the premium that the policyholder would have had to pay if they had properly disclosed the risk. However, if, in the event of a claim, the insurer provides proof that it would not under any circumstances have insured the risk, the true nature of which is revealed by that claim, its payment shall be limited to the payment of an amount equal to all premiums paid.

6.3 Intermediary Involvement in an Insurance Contract

The Insurance Law does not regulate the legal relationship between the insurance intermediary and the policyholder on the one hand and between the insurance intermediary and the insurer on the other.

The sector has, however, introduced certain customs, such as the brokerage customs, which include some of the obligations of insurers in relation to insurance brokers. Consequently, the parties themselves largely determine the content of their co-operation. It must be noted that the Insurance Law does impose an obligation to regulate the relationship between the insurer and the insurance intermediary in a written agreement. For whom the insurance intermediary acts will depend in practice on the status of the insurance intermediary and the specific mandates which may or may not be given to the insurance intermediary, such as collecting premiums, settling claims and paying out the insurance benefits.

An insurance broker undertakes towards a prospective policyholder to seek out an insurer who can insure the risk offered on optimum terms. This creates a contracting relationship between the prospective policyholder and the broker. When the broker can perform legal acts, however, it concerns a mandate.

If the intermediary is an insurance agent, it acts for the insurer in view of its dependence on a particular insurer and the fact that it looks for customers exclusively for that insurer. In that case, the rules on commercial agency in accordance with the Code of Economic Law apply to the relationship between an insurer and an insurance agent.

The Insurance Law provides that the payment of a premium by the policyholder to a party other than the insurer may be a liberating act if that party demands payment and apparently acts as an agent for the collection of the premium.

From Belgian case law, a duty to inform, a duty to advise, a duty to warn, a duty to investigate and a duty to assist can be derived on the part of the insurance intermediary.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

Article 5, 14° of the Insurance Law defines an insurance contract as follows:

"… an agreement under which one party, the insurer, undertakes towards another party, the policyholder, and in return for payment of a fixed or variable premium, to provide a service stipulated in the agreement in the event of an uncertain event occurring in which, depending on the case, the insured or beneficiary has an interest that it does not occur."

Subject to admission and oath and regardless of the amount of the commitments, the insurance contract and its amendments have to be proved by writing. No evidence provided by witnesses or presumptions over and above the contents of the writing is admissible. However, if a beginning of proof is made in writing, proof by witnesses or presumptions is admissible.

The insurance contract must at least contain:

- the date on which the insurance contract was concluded and the date on which it commences;
- the duration of the contract;
- the identity of the policyholder and, where appropriate, of the insured and the beneficiary;
- the name and address of the insurer or co-insurers;
- where appropriate, the name and address of the insurance intermediary;
- the risks covered; and
- the amount of the premium or the way in which the premium may be determined.

In its communication of 2015 on the essential elements of the insurance agreement, the FSMA clarified that five essential conditions must be met in order to conclude that a contract qualifies as an insurance contract/product (position of the FSMA_2015_13 dated 26 August 2015 on the essential elements of an insurance policy), as follows:

- an uncertain event;
- an insurable interest;
- a premium;
- an insurance service; and
- an operation of an independent nature.

An Uncertain Event

This condition concerns a possible future event of which the actual occurrence or timing is uncertain. The occurrence of this event cannot depend on the will of the parties. The insurer's intervention depends on the occurrence of this uncertain event. If the intervention of the insurer is not dependent on a specific event that is future and uncertain at the time of the conclusion of the contract, there is no insurance contract.

An Insurable Interest

The second condition is the insurable interest, meaning the interest that the uncertain event does not occur. This characteristic distinguishes the insurance contract from a bet. It should be noted that prior to the conclusion of the insurance policy, the insurable interest exists exclusively on the part of the insured person (or, where applicable, the beneficiary) and not on the part of the insurer.

A Premium

This condition concerns the obligation of the policyholder to pay a premium. The premium is legally defined as "any form of compensation requested by the insurer as counterpart for its

obligations". The compensation as counterpart is sufficient, regardless of how this is (technically) obtained.

An Insurance Service

This condition concerns the service provided by the insurer: the payment by the insurer of a certain amount or the provision of a service due upon the occurrence of the uncertain event. This may be the payment of a sum or the provision of breakdown assistance, repatriation or any other form of assistance.

An Operation of an Independent Nature

This final condition is met when the obligation that is the subject of an insurance contract, and that seeks to offer coverage if a specific, negative, uncertain event occurs, has an independent character. It is not independent (and as a consequence not an insurance contract) if it is:

- ancillary to a principal operation which is not uncertain (eg, a sales contract); and
- limited to indemnification or compensation for a (direct) loss arising from an event whose cause is intrinsic to the main operation or to its subject (eg, a defect due to a material or manufacturing defect inherent in the purchased device).

6.5 Multiple Insured or Potential Beneficiaries

Article 77 of the Insurance Law provides that the parties may agree at any time that a third party, under the conditions they determine, can claim the benefits provided by the insurance.

This third party does not have to be designated or even conceived at the time of the stipulation, but they must be identifiable on the day that the insurance benefits are due and payable.

The possibility of a claim by beneficiaries not named in the insurance contract may affect the duty of disclosure by the policyholder at the time of the conclusion of the insurance contract, if it concerns a circumstance which the policyholder is aware of at the time of the conclusion of the policy and which they may reasonably know may affect the insurer's risk assessment. This is a factual matter.

6.6 Consumer Contracts or Reinsurance Contracts

Although consumer protection was one of the main goals of the Belgian legislature when it drafted Part 4 of the Insurance Law, it should be noted that the legislature did not make a distinction in the application of the provisions between a policyholder-consumer or a policyholder-enterprise.

The rules of Part 4 on insurance contract law do not apply to reinsurance contracts.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Alternative Risk Transfer (ART) transactions such as insurance-linked securities (ILS) can be subscribed in Belgium, depending on the concrete circumstances.

ILS typically involve the intervention of investment banks to create special purpose vehicles, through which (re)insurers cede premiums and risks associated with a portfolio of (re)insurance business to investors.

Special purpose vehicles are defined in the Solvency II Law as any undertaking, which has legal personality or not, other than an existing insurance or reinsurance undertaking, which assumes

risks transferred from insurance or reinsurance undertakings and which fully funds its exposure to such risks through the issuance of debt or any other funding mechanism, where the repayment rights of those who have made a payment under that debt or other funding mechanism are subordinated to the reinsurance obligations of such an undertaking.

7.2 Foreign ART Transactions

In principle, ART transactions subscribed in other jurisdictions will be treated in accordance with the rules applicable in these other jurisdictions. Special purpose vehicles wishing to establish themselves on Belgian territory must obtain prior authorisation from the NBB.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The Insurance Law contains a specific interpretation rule. This provision states that, in the case of doubt about the meaning of a clause, the interpretation most favourable to the policyholder shall prevail in all cases. If the policyholder and the insured are not one and the same person, the interpretation most favourable to the insured shall prevail. This interpretation rule goes beyond the general civil law interpretation rule. It is a kind of civil sanction against terms whose meaning is unclear. The scope of application also includes, besides insurance contracts concluded with consumers, insurance contracts concluded with companies and professionals. Only in the case of large risks does this interpretation rule not apply.

This interpretation rule takes precedence over the general interpretation rules, in accordance with general civil law. However, it should be noted that, in addition to this interpretation rule in favour of the policyholder, other interpretation rules are also taken into account in Belgian case law. Therefore, the common intention of the parties is often verified and the actual meaning and scope of the policy is sought. In this regard, there is considerable scope for the court to take into account the underwriting process between the parties, the circumstances in which the policy was entered into, as well as common practice or understanding of a particular type of insurance contract or clause.

8.2 Warranties

Warranties and breach of warranty (meaning a clause which goes to the root of the insurance contract, whose breach cannot be remedied and automatically discharges the insurer from any further liability from the date of the breach) are not explicitly provided for under Belgian insurance law.

From an insurance law perspective, it is likely that a breach of warranty will be construed as a misrepresentation of the risk (see also **6.2 Failure to Comply with Obligations of an Insurance Contract**).

8.3 Conditions Precedent

Conditions precedent are not explicitly provided for under Belgian insurance law. In the absence of any specific insurance law rules, general Belgian contractual law principles have to apply. In accordance with these standard principles, conditions precedent are authorised in a contract.

A similar principle can be found in the partial or total forfeiture of right to the insurance benefits. The Insurance Law provides that the insurance contract can impose a specific obligation on the policyholder and/or insured and provide for the

partial or total forfeiture of the right to the insurance benefits, due to the non-respect of this specific obligation (imposed by the contract), provided that the non-respect of the obligation is causally related to the occurrence of the loss.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurance disputes in Belgium are resolved in accordance with the provisions of the Belgian Judicial Code. Belgium is a civil law jurisdiction. Therefore, the rule of precedent does not apply.

The general rules on limitation are laid down in the Civil Code and vary between five years to 20 years before a claim is time-barred, depending on whether the claim is based on contractual or non-contractual liability. In the case of criminal prosecution, shorter limitation periods apply, which vary depending on the type of crime that was committed.

For insurance disputes, specific limitation periods are prescribed imperatively in Article 88 (and following) of the Insurance Law, for example as follows.

- In principle, the limitation period in the case of coverage disputes is three years starting from the day of the event giving rise to the right to bring legal proceedings. If the person to whom the right to bring legal proceedings belongs proves that they only became aware of the event at a later time, the limitation period starts to run from that time, but in any event it expires five years after the event, barring fraud.
- In the case of liability insurance, that limitation period of three years only starts to run on the date on which the injured party or victim has filed a legal claim against the insured.
- In life insurance, the time limit is 30 years for the right of legal action relating to the reserve formed on the date of termination or on the expiry date by the premiums paid, minus the sums used.
- The direct action of the injured party against the liability insurer is time-barred five years after the damage-causing act, or after a crime, if one has been committed, took place. However, if the injured party can prove they became aware of their right of direct action against the liability insurer on a later date, the limitation period will start to run from that later date, but in any event it expires ten years after the damage-causing act or crime.

Coverage disputes relating to consumer contracts are normally brought before the competent courts, whereas reinsurance contracts are more often resolved through arbitration (see **9.5 The Enforcement of Arbitration Clauses**).

As a general rule, a third party can only rely on the existence of an insurance contract.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Jurisdiction disputes between Belgian policyholders/insurers and policyholders/insurers situated in another EU member state are governed by the Brussels I bis Regulation, which contains specific provisions on insurance disputes, in essence leaving a broad choice for policyholders and insureds to sue insurers before the courts of their own country (Article 11(1b) of the Brussels 1 bis Regulation) or in the courts of the place where the harmful event occurred (in the case of liability or immovable property insurance) (Article 12 of the Brussels I bis Regulation). However, these protective provisions do not apply in the

case of so-called large insurance risks or other risks described in Article 16, for which forum clauses can be concluded between the parties (Article 15(5) and Article 16 of the Brussels 1 bis Regulation).

As to the applicable law, the provisions of the Rome I Regulation on the law applicable to international contracts will apply. This Regulation also has particular provisions to protect the interests of policyholders laid down in its Article 7. These protective provisions in favour of the policyholder, however, again do not apply in the case of "large risks insurance contracts", in which case the contractual freedom prevails (Article 7.2 of the Rome 1 Regulation). This Article 7 also does not apply to reinsurance contracts.

In the case of disputes with non-EU insurers, it must first be established whether an international treaty on this subject is in place. This is very seldom the case. If there is no relevant international treaty in place, the rules of the Belgian International Private Law Code will apply. In principle, Belgian courts have jurisdiction to hear contractual claims if the contractual obligation arose in Belgium or is performed or has to be performed in Belgium. With regard to the applicable law, the Code makes a full circle and refers to the Rome I Regulation.

9.3 Litigation Process

The litigation process is a contradictory process in which the rights of the defendant are fully observed. The defendant must be summoned in court by way of a writ of summons and has the right to file defence by way of written pleadings and to be heard during oral pleadings. Examination and cross-examination of witnesses is very rare, but sometimes parties produce written witness statements in order to substantiate their (factual) arguments. Judges mostly take their decisions in insurance disputes on the basis of contemporaneous paper trails (including the insurance policy) and the final reports of court-appointed experts after a contradictory investigation involving all parties and their experts which in complex cases may easily take more than one year (as in France). The evidence value of reports drafted by party-appointed experts and adjusters is very limited.

Finally, court proceedings in Belgium will always be conducted in either French, Dutch or German. Depending on the court that rules on the matter, it may even be the case that evidence drafted in another language (including English, which is often the case for industrial risk or financial lines insurance contracts) must be translated by the parties into the language of the court proceedings (either French, Dutch or German). Sometimes, the court will oblige the parties to have that translation carried out by a "sworn" translator. This obviously increases the cost of litigation in Belgium.

9.4 The Enforcement of Judgments

If a judgment is rendered by a foreign court of a country that is a member of the EU, the issue of enforcement is again regulated by the Brussels I bis Regulation and is rather straightforward. If it is rendered by another court and there is no international treaty that applies (which is usually the case), enforcement will have to be conducted on the basis of the provisions of the Belgian Judicial Code and the Belgian International Private Law Code (exequatur requested from the court of first instance) and will be far less straightforward to obtain.

Particular attention will then be given by the Belgian court to the observance of the rights of defence of all parties by the foreign court whose judgment is sought to be enforced in Belgium.

9.5 The Enforcement of Arbitration Clauses

The arbitration provisions in commercial contracts of insurance and reinsurance are enforced by the courts because arbitration is a dispute resolution mechanism that is recognised and regulated by the Belgian Judicial Code, including the issue of enforcement of arbitral awards. Courts must declare themselves without jurisdiction if a valid arbitration clause is invoked by one of the parties before any substantive argument on the merits is raised (Article 1679, Section 1 of the Judicial Code).

Arbitration is not allowed in the case of private insurance disputes on the basis of Article 90 Section 1 of the Insurance Law, unless agreed after the dispute arose (which, in practice, never happens). It is allowed and often used in the case of industrial risk insurance, financial lines, professional indemnity, casualty and reinsurance disputes. Both ad hoc arbitration and institutional arbitration (mostly Cepani, the Belgian arbitration and mediation centre) are chosen by the parties in their policy conditions. In reinsurance contracts, Bermuda arbitration or that of the London Court of International Arbitration (LCIA) are often applied, usually in combination with Bermudan or UK law. These clauses are valid and enforceable in the context of a reinsurance agreement.

9.6 The Enforcement of Awards

Belgium is a party to the New York Convention. Parties must file an enforcement request with the court of first instance of the place where the arbitration proceedings were conducted, and the test applied by the court will be fairly limited. In essence, the court will check whether:

- the parties agreed to arbitration;
- the rights of defence of any of the parties were not violated; and
- the arbitration award does not violate any provisions of public order in Belgium (Article 1721 of the Judicial Code).

The party that was convicted may also apply to the same court to obtain a ruling setting aside or annulling the arbitral award (Article 1717 of the Judicial Code).

9.7 Alternative Dispute Resolution

Alternative dispute resolution (ADR) in Belgium basically comes down to mediation and arbitration (see **9.5 The Enforcement of Arbitration Clauses**). Belgian law does not (yet) recognise the concept of court-ordered or imposed mediation in insurance law. It largely depends on the judge sitting on the bench whether they will promote mediation to the parties at dispute. Overall, mediation is not (yet) very popular or used in insurance disputes, probably because many disputes are settled without the assistance of a mediator.

9.8 Penalties for Late Payment of Claims

As a general rule, insurers will only have to pay statutory interest on the principal amount. Only if an insured can prove that an insurer deliberately postponed payment in order to inflict specific damages on the insured will the insured be able to obtain additional damages from the insurer.

There are some exceptions to this general rule. Third party motor liability insurance and fire insurance against ordinary risks may lead to increased interest if the insurer does not comply with the time limits imposed by law.

Belgian law is not familiar with the concept of punitive damages. However, late payment in third-party motor liability insurance can also

be penalised by a compensation of EUR250 in addition to the increased interest.

9.9 Insurers' Rights of Subrogation

Article 95 of the Insurance Law confers statutory subrogation claims to insurers. The insurer who has paid the compensation shall, to the extent of the amount of that compensation, subrogate the rights and actions of the insured or the beneficiary against the liable third parties.

If, through the fault of the insured or the beneficiary, the subrogation cannot take effect to the benefit of the insurer, the latter may claim from the insured or the beneficiary the reimbursement of the compensation paid, to the extent of the loss suffered.

The subrogation may not prejudice the insured or the beneficiary who has been only partially compensated. In that case they may exercise their rights for what is still due to them in priority to the insurer.

The insurer shall have no recourse against the relatives in the direct ascending or descending line, the spouse and the relatives in the direct line of the insured, nor against the persons residing with them, their guests and their household staff, except in the case of malicious intent. However, the insurer may exercise recourse against these persons in so far as their liability is actually covered by an insurance contract.

10. Insurtech

10.1 Insurtech Developments

Digital innovation is growing rapidly. Insurers innovate by:

- applying digital techniques for the distribution of their insurance policies (eg, smart phone apps);
- co-operating with (ancillary) insurance intermediaries having innovative distribution models;
- implementing advanced internal processes (eg, cloud computing); and
- developing new insurance products (eg, cyber cover).

There has been a rise in the number of banks acting as insurance distributors for insurance products offered through their websites or apps, with no physical contact with the policyholders. Finally, in the last few years a number of specialised companies have entered the Belgian market as a Lloyd's broker or cover-holder (or its Belgian equivalents – respectively, the insurance broker and the mandated underwriter) who underwrite insurance only via the internet.

10.2 Regulatory Response

The regulator prioritises its supervision on new technologies. While there is no overall approach to insurtech or digitisation, the regulator regularly issues specific guidance. For example, the NBB has published guidance on the outsourcing to cloud service providers and cloud computing. Detailed rules on cybersecurity exist, such as the FSMA's communication on basic principles for the management of cyber risks and the NBB's prudential expectations on the management of cyber risks.

The NBB and FSMA offer a fintech contact point that explains specific supervisory rules, policies and authorisation procedures, assists in navigating the supervisory landscape and provides information on potential supervisory issues, for example when developing an innovative financial concept.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

The NBB continues to monitor closely the impact of COVID-19 and low interest rates on the insurance industry.

Furthermore, the insurance sector has an increased interest in catastrophe risks, following the floods of July 2021. Together with the Belgian government, the insurance sector aims to help victims of natural disasters, resulting in a dialogue about affordable risk allocation. An interpretative law broadened the scope of natural disasters to subsidence of a significant mass of the soil layer, causing destruction or damage to property, resulting in whole or in part from a prolonged period of drought.

Finally, there has been an increased focus on sustainability on all policy levels. These developments should be monitored closely, as the new regulatory initiatives may have a large impact on various aspects of insurance business (capital requirements, disclosures, investments, risk management, reporting, internal trainings, etc). On 29 April 2022, the FSMA published a communication with key guidelines on sustainable financing by insurance undertakings.

For the regulator's response to new technologies, refer to **10.1 Insurtech Developments** and **10.2 Regulatory Response**.

11.2 New Products or Alternative Solutions

Insurance policies related to new technologies (such as cyber-insurance policies) have developed significantly and are becoming more and more common on the market. In the future, insurance products for drones, robotics, and automated guided vehicles may enter the market.

Insurers have tried to amend their existing products in order to take possible new pandemics into consideration.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Litigation and Coverage Issues

The pandemic does not appear to have had any impact on the type or amount of litigation and insurance-related litigation; neither has there been an important portion of COVID-19 coverage disputes in Belgium, mainly because there were not many business interruption policies entered into which provided cover for business interruption losses without any evidence of physical loss being required. Also, the Belgian legislature has not obliged insurers to pay pandemic losses, which normally under the policy conditions were not insured.

A limited number of coverage disputes on COVID-19 losses are currently pending before various Belgian courts, but have not yet led to any (published) case law. Because most, if not all, business interruption policies only provide cover in the case of a physical damage, there has not been a great number of cases before Belgian courts. As far as is known, there has been only one case in relation to an event cancellation policy and one case in relation to a limited property and business interruption cover in an environmental liability insurance policy. No definitive judgments, however, have yet been rendered in these cases.

In certain policies (for instance, event-cancellation or property), insurers are careful to stipulate an exclusion for pandemic losses in general and COVID-19 losses in particular. Particular orders by the regulator prohibit such clauses in healthcare insurance policies.

Regulators' Response

As the FSMA anticipated that insurance companies would offer more distance insurance services in the context of the pandemic, it formulated a series of recommendations in this regard. The FSMA points out the additional legal obligations that apply when insurance contracts are concluded remotely. The FSMA also expects the internal supervisory bodies of the company to actively oversee the adaptation of the usual procedures or alternative procedures in order to verify whether – by means of these procedures – compliance with the rules of conduct can be guaranteed. The FSMA further stipulates that insurance companies must examine how they can ensure that the interests of the client remain a priority during and in the aftermath of the COVID-19 crisis.

The FSMA has also made adjustments to the training requirements and examination system for insurance intermediaries. For instance, certain deadlines for following the required continuing training courses were extended.

Moreover, the FSMA has sent a questionnaire to various Belgian insurance undertakings to evaluate the impact of COVID-19 on the implementation of the product oversight and governance (POG) rules, and in particular on the changes of risk profiles of products as a result of changes in the habits and behaviours of policyholders after the heath crisis and the impact on the exclusions in insurance contracts (coverage of pandemics, clarity of clauses, etc). The FSMA will publish the results of its study in the near future.

The NBB took several measures related to COVID-19, such as the creation of the Economic Risk Management Group (ERMG). The NBB continues to monitor closely the impact of COVID-19 and low interest rates on the insurance industry.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

The Belgian legislature is currently rewriting the Civil Code. On 1 January 2023, Book 5 regarding the law of obligations/contract law enters into force. Some of these provisions will have a (limited) impact on insurance and reinsurance law.

To date, no other significant legislative or regulatory developments that may affect insurance coverage, insurance litigation or claims have been identified. However, it is not impossible that they will be enacted in the near future, in particular in relation to climate change and perhaps also in relation to certain pandemic coverages.

Lydian is a full-service Belgian business law firm with an Anglo-Saxon approach to practising law. The firm's approach is client-focused, acting fast and delivering straight-to-the-point solutions that add true value. Lydian's insurance team of 18 lawyers makes it the largest and most reputed team in insurance of any full-service Belgian business law firm. Clients come to Lydian when their challenges in the insurance industry are of a strategic nature, complex or require a high-quality level of service. The firm's insurance and reinsurance team has in-depth expertise and experience in all areas of insurance, including claims and disputes, distribution of insurance products (domestic and cross-border), regulatory (including assistance in post-Brexit operations), life and non-life insurance, policy wording, compliance, the Insurance Distribution Directive (IDD), insurance-premium taxes, corporate insurance, reinsurance and captives. Lydian services the majority of the insurance companies active in Belgium, as well as many of the larger intermediaries, insurance brokers, loss adjusters and insurance pools.
The firm would like to thank Merel van Dongen for her contribution to the chapter.

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Trends and Developments

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Insurance Distribution Through Third-Party Providers

The activity of insurance distribution in Belgium is regulated by Part 6 of the Insurance Act of 4 April 2014 (the Insurance Act). The most common form of insurance distribution concerns the offering of insurance contracts through insurance distribution by insurance intermediaries. The insurance broker and the insurance agent are the most well-known examples of Belgian insurance intermediaries. Insurance undertakings may also offer insurance contracts directly to prospective policyholders without the intervention of an insurance intermediary. However, insurance contracts are increasingly no longer concluded exclusively through these traditional channels. More and more companies whose main activity is something other than insurance distribution (such as travel agencies, tour operators, car dealers, leasing companies, supermarkets, sports shops, funeral undertakings, opticians, banks and health insurance funds), are offering insurance products on the Belgian market.

In this article, an overview is presented of the Belgian legislature's and regulator's response to these types of insurance distribution, the different types of statutes of these undertakings that can be distinguished and the points of attention that should be noted.

Insurance Distribution Activities

Third-party providers of insurance contracts who perform insurance distribution activities in Belgium must in principle be duly registered in the register of insurance and ancillary insurance intermediaries maintained by the Financial Services and Market Authority (FSMA) and must comply with all the applicable conditions and obligations. Whether or not insurance distribution activities are carried out will therefore be important in determining the appropriate status of the third-party provider.

The following activities are considered as insurance distribution:

- presenting insurance contracts;
- proposing insurance contracts;
- carrying out other work for the conclusion of insurance contracts;
- concluding insurance contracts;
- contributing in the administration of insurance contracts; and
- contributing in the execution of insurance contracts.

Among others, the following are not considered as insurance distribution activities:

- the occasional provision of information to a customer in the context of another professional activity (other than insurance distribution), insofar as the information provider does not take any further steps to assist in the conclusion or execution of an insurance contract;
- professional claims handling for an insurance undertaking and claims settlement and expert assessment;
- the mere provision of data and information on potential policyholders to insurance interme-

diaries or insurance undertakings, provided that the information provider does not take any further steps to assist in the conclusion of an insurance contract; and
- the mere provision of information on insurance products or on an insurance intermediary or insurance undertaking to potential policyholders, provided that the information provider does not take any further steps to assist in the conclusion of an insurance contract.

Ancillary Insurance Intermediary

Third-party providers of insurance products carrying out insurance distribution activities frequently act as ancillary insurance intermediaries. The status of ancillary insurance intermediary was introduced in the Belgian Insurance Act following the implementation of the European Insurance Distribution Directive (2016/97/EU) (IDD), though similar conditions existed in Belgium before the implementation of the IDD for bypassing the provisions on insurance distribution.

One qualifies as an ancillary insurance intermediary if one carries on, or has access to, insurance distribution activities against remuneration as ancillary to one's principal professional activity and, in this context, offers insurance products that are complementary to a good or service.

Ancillary nature of the insurance product

With regard to the ancillary nature of the insurance product, the FSMA clarifies that this may involve any type of insurance product closely related to a good or service. The provider may distribute insurance products, with the exception of life insurance products or civil liability products, which are complementary to goods or services supplied by the provider themselves, but also those supplied by a third party. For example, a self-employed seller of an energy contract who also sells a related insurance product will qualify as an ancillary insurance intermediary, even though they are not the energy supplier themselves.

However, in order to qualify as an ancillary insurance intermediary, the person distributing life insurance or civil liability insurance must themselves supply the good or service to which that insurance is ancillary.

Exempted Ancillary Insurance Intermediary

If the retailer is found to meet the definition of an ancillary insurance intermediary, they must register as an ancillary insurance intermediary in the register of the FSMA and comply with the corresponding conditions and obligations. However, under certain conditions, an intermediary can be exempted from this registration obligation and other distribution requirements.

The insurance is complementary to the good or service of the provider and covers specific risks

The insurance must be complementary to the good or service supplied by a provider, where such insurance covers:

- the risk of breakdown or loss of, or damage to, the good or the non-use of the service supplied by that provider; or
- damage to, or loss of, baggage and other risks linked to travel booked with that provider.

Examples include a car dealer who, when selling a car, also offers vehicle casco (casualty and collision) insurance, or an optician who, when selling spectacles, also offers loss insurance in case of damage to the spectacles purchased. For the non-use of a service within the meaning of this

condition, the following examples are given in the IDD: a train journey, a gym membership or a season ticket for a theatre.

The Belgian regulator clarifies that the cause of the occurrence of a risk is not relevant for the assessment of the exemption condition. In order to fall within the exemption condition, the ancillary insurance intermediary may not distribute insurance products that also cover the consequences when these risks occur with other goods or services. However, in the case of travel insurance, the risks covered are both the non-use of the service (the trip) and the other risks linked to the service. Furthermore, the Belgian regulator interprets this exemption condition strictly, which means that the insurance must be taken out by the provider of the good or service to which it relates. Thus, the ancillary insurance intermediary will only benefit from the exemption if it is both the provider of the insurance and of the good or service to which the insurance relates.

Insurance premium must remain below a certain threshold

The amount of the premium paid for the insurance product cannot exceed EUR200 calculated on a pro rata annual basis. Where the insurance is complementary to a service and the duration of that service is equal to, or less than, three months, the amount of the premium paid per person cannot exceed EUR200. It is remarkable that the Belgian legislature has opted for a lower threshold than the one provided for in the IDD of EUR600. It is even more remarkable that a legislative proposal has been introduced on 8 July 2022 to lower that threshold from EUR200 to EUR50. The legislative process is time-consuming and the question remains whether this proposal will ever become law.

Client Contributor

The status of (exempted) ancillary insurance intermediary shall apply only to the natural person or undertaking carrying out insurance distribution activities. However, if one does not carry out insurance distribution activities, one is not required to register as an ancillary insurance intermediary and does not have to fulfil the associated conditions and obligations. If, in the course of another professional activity, one does not offer insurance contracts to prospective policyholders but only directs prospective customers to insurance undertakings and insurance intermediaries, one may qualify as a client contributor.

Client contributors are described by the FSMA as persons who, within the context of another professional activity, direct (potential) clients to insurance companies or insurance intermediaries, or introduce them to those clients (for example, car dealers, funeral organisers and real estate agents) without acting as an insurance intermediary.

Limitation of activities

Client contributors cannot exercise insurance distribution activities.

Persons who limit themselves to communicating to insurance intermediaries or insurance companies the identity of potential clients, or who direct potential clients to insurance intermediaries or insurance companies by giving them the relevant address and contact details, do not practise insurance distribution activities.

Client contributors may, without being registered as insurance intermediaries, provide potential clients with documentation on insurance products, communicated by an insurance company or an insurance intermediary, provided that the

communicated documentation only contains general and non-personalised information, and/or may refer them to an insurance intermediary or an insurance company.

Drafting of personalised offers, drafting of insurance conditions, treatment and settlement of insurance proposals, insurance applications and pre-signed policies do not fulfil this requirement. Finally, the clients' contributor is not authorised to collect premiums or pay the insured or the policyholder. Therefore, it should be realised that, within the status of a client contributor, the possible actions of the person concerned are limited.

Collective Policyholder

Third-party providers whose principal professional activity is something other than offering insurance contracts could also act as collective policyholders, and their customers will be considered to be insured persons under the insurance contract entered into by the third-party provider as a collective policyholder.

Collective insurance policies under the Insurance Act

Belgian law does not prohibit collective insurances. However, there are no specific legal provisions that are (only) applicable to collective insurances under Belgian law. Insurance law is based on the common (individual) policy structure with one policyholder, who in most cases is also the insured, and one insurer, through the intervention of an insurance intermediary. Since the implementation of the IDD, only Article 279 Section 2 of the Insurance Act contains a reference to collective insurance contracts:

"In the case of group insurance, 'customer' must be understood to mean the representative of a group of members who enter into an insurance contract and where the individual members cannot take an individual decision to join. The representative of the group must, without delay after the member joins the group insurance, provide this member with all the information required under this act and the decrees and regulations implementing it."

Thus, the law imposes on the collective policyholder of a collective insurance contract with compulsory affiliation an explicit information obligation with respect to affiliated members. No similar statutory rule is provided for collective contracts with optional affiliation. However, in such contracts, an obligation of this kind can always be contractually imposed on the collective policyholder. Furthermore, the same obligation can be derived from case law of the European Court of Justice (see f.ex. C-143/20 and C-213/20 of 24 February 2022 on unit-linked insurance).

Well-known examples of collective insurances on the Belgian market are professional liability policies concluded by professional associations (eg, lawyers and insurance brokers), and car insurance policies concluded by automobile clubs for the benefit of their individual members. Collective insurance is widespread in sectors such as mobile telephony, credit cards, travel and energy.

As for mobile telephony and multimedia devices in general, the FSMA has issued a general regulation which entered into force on 13 November 2022 and which prohibits various multimedia insurance contracts with variable premiums sold together with multimedia devices. Any person is prohibited from marketing multimedia insurance policies to consumers in Belgium or proposing to them the subscription of such multimedia insurance policies for which the premium is paid

in instalments and not, in a manner determined by agreement at the outset, split in equal parts whose payment is regularly spread over the full term of the contract. This regulation should be read in the light of the FSMA's strict approach to the distribution by ancillary insurance intermediaries of multimedia insurances.

The collective policyholder acts as a client contributor or an insurance intermediary

In principle, it is usually not the intention that the collective policyholder act as an insurance intermediary. However, the FSMA further considers that a person can have the capacity of policyholder and (ancillary) intermediary at the same time. This has also been confirmed at the European level by the European Court of Justice (see f.ex. C-633/20 of 29 September 2022).

There is therefore a risk that a regulator, an authority or a court would re-qualify the collective insurance contract as an individual insurance contract and regard the collective policyholder as an insurance intermediary. Once someone is considered to be an insurance intermediary, they are subject to the legal requirements set out in Part 6 of the Insurance Act (obligation to register, rules of conduct, etc) and fall under the control of the FSMA, unless they can rely on the exemption as an ancillary insurance intermediary (as previously mentioned).

With regard to this last point, the FSMA has published a newsletter in which it sets out criteria on which it assesses whether the collective policyholder should be considered an insurance intermediary, confirmed in its Handbook on IDD rules of conduct of January 2022. The FSMA refers to the following elements.

- Voluntary or mandatory adherence to the collective policy:
  - (a) if the customers have a choice on whether to adhere or not, a choice between different types of cover or a choice between the offer with adherence to the insurance policy and the same offer without that adherence, it is "likely" that the collective policyholder is carrying out regulated activities; or
  - (b) if the customer must adhere to the policy without further options, it is "unlikely" that the collective policyholder is carrying out regulated activities.
- Insurable interest:
  - (a) if the collective policyholder does not have any interest in the occurrence of the insured risk or the customers' principal aim is to insure their own interests, it is "likely" that it is carrying out regulated activities of insurance distribution; or
  - (b) if the collective policyholder does have an interest in the occurrence of the insured risks (and not in that of the insured customers), it is "unlikely" that it is carrying out regulated activities of insurance distribution.
- Other relevant elements:
  - (a) the FSMA notes that its assessment depends on the factual circumstances at hand and that it is important to consider all relevant elements, such as the identity of the beneficiary, the marketing of the insurance policy as an essential part of the offering, and the role of the collective policyholder in the management and performance of insurance contracts; and
  - (b) if the insurance component is not promoted in the commercial offer as an essential component, it is less "likely" that the collective policyholder is carrying out regulated activities of insurance distribution.

The qualification therefore must be verified on a case-by-case basis.

Conclusion

Increasingly, insurance products are no longer sold solely through traditional channels. More and more companies whose main professional activity is something other than selling insurance products are offering their customers the possibility of concluding an insurance contract through them, or are directing their customers towards an insurer or insurance intermediary with a view to concluding an insurance contract. The legislature anticipated this by introducing the new status of ancillary insurance intermediary. Similarly to other insurance intermediaries, ancillary insurance intermediaries are subject to a registration requirement. Most of the applicable obligations that rest on other insurance intermediaries also apply to ancillary insurance intermediaries. The main criterion for determining whether or not the third party qualifies as an (ancillary) insurance intermediary relates to the performance of insurance distribution activities.

Insurers and insurance intermediaries co-operating with third-party providers should, therefore, pay attention to a clear delineation of their activities. On 9 June 2022, the FSMA reminded insurance distributors of the prohibition on relying on insurance intermediaries and ancillary insurance intermediaries who are not registered, referring to the applicable criminal sanctions and administrative fines. This clearly shows that the Belgian regulator keeps a close watch on such activities, which will prompt increased caution on the Belgian insurance market.

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The firm would like to thank Merel van Dongen for her contribution to the chapter.

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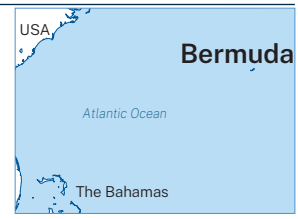

Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The principal legislation governing companies in Bermuda is the Companies Act 1981, as amended (the "Companies Act"), under which the majority of companies in Bermuda are incorporated by registration.

In addition to the Companies Act, (re)insurance companies and (re)insurance intermediaries in Bermuda are also governed by the provisions of the Insurance Act 1978 and related regulations, rules and guidance notes, each as amended from time to time (the "Insurance Act"), which applies to any person carrying on insurance business in or from within Bermuda. "Insurance business", which includes that of reinsurance, is the business of effecting and carrying out contracts to:

- protect persons against loss or liability to loss in respect of risks to which they may be exposed; or
- pay a sum of money or render money's worth on the occurrence of a loss event.

Insurers in Bermuda should also be aware of the provisions of the Life Insurance Act 1978 (the "Life Act"), the Segregated Accounts Companies Act 2000 (the "SAC Act"), the Incorporated Segregated Accounts Companies Act 2019 (the "ISAC Act") and the Non-Resident Insurance Undertakings Act 1967 (each as amended), as applicable.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Bermuda's Regulator

The Bermuda Monetary Authority (BMA) has a legal authorisation and compliance division, which vets the ownership of all entities incorporating or forming in Bermuda and liaises with the various divisions within the BMA to ensure compliance. The BMA carefully scrutinises the ownership of these entities, requiring information on the direct, intermediate and ultimate owners. The BMA must be satisfied that the persons who wish to own/control such entities are persons of integrity and good standing.

In applying a risk-based regulatory approach, the BMA first employs a framework that assesses the nature, scale and complexity of entities seeking to conduct business in Bermuda, their related risk and the level of sophistication of the clients involved. It then supervises them accordingly.

For commercial (re)insurers, the BMA established a risk-based capital model as a tool to assist the BMA both in measuring risk and in determining appropriate levels of capitalisation. This is termed the Bermuda Solvency Capital Requirement (BSCR) or an in-house (re)insurer solvency capital model approved by the BMA. The BSCR model is a risk-based capital model that provides a method for determining an insurer's capital requirements (statutory capital and surplus) by taking into account the risk characteristics of different aspects of the insurer's business.

The BMA introduced prudential standards in relation to all commercial (re)insurers' enhanced capital requirement (ECR). The ECR is equal to the higher capital and surplus requirement of the BSCR or that company's approved internal model. To enable the BMA to better assess the quality of the commercial (re)insurer's capital resources, applicable (re)insurers are required to disclose the makeup of their capital in accordance with the "three-tiered capital system". In order to minimise the risk of a shortfall in capital arising from an unexpected adverse deviation, the BMA expects that such insurers operate at or above a threshold capital level, which exceeds an insurer's ECR.

Under this system, all of the (re)insurer's capital instruments will be classified as either basic or ancillary capital, which in turn will be classified into one of three tiers based on their "loss absorbency" characteristics.

Highest quality capital will be classified as Tier 1 capital and lesser quality capital will be classified as either Tier 2 capital or Tier 3 capital. Under this regime, up to certain specified percentages of Tier 1, Tier 2 and Tier 3 capital may be used to support the insurer's solvency margins and ECR.

While not specifically referred to in the Insurance Act, the BMA has also established a target capital level (TCL) equal to 120% of its ECR. While an insurer is not currently required to maintain its statutory capital and surplus at this level, the TCL serves as an early warning tool for the BMA. Failure to maintain statutory capital at least equal to the TCL will likely result in increased regulatory oversight.

Any (re)insurer that fails to comply with its ECR must, at the point that the directors become aware of such failure or have reason to believe that such failure has occurred, immediately notify the BMA and then within 14 days file a written report containing the particular circumstances that lead to the failure and outlining their plan (including actions to be taken and indicative timeline) on how they intend to rectify the failure.

Additionally, and subject to any legislation to the contrary, any insurer that fails to comply with their ECR is prohibited from declaring and paying dividends until the failure has been rectified with the BMA.

Categories and Classes of Insurers

The Insurance Act distinguishes between insurers carrying on the following activities.

- Long-term business, which consists of insurance contracts covering life, annuity, accident and disability risks and certain other types of contract. This does not include "excepted long-term business" (as defined in the Insurance Act).
- Insurers carrying on general business – ie, any insurance business that is not long-term or special purpose. General business includes accident and disability policies and having been in effect for less than five years.
- Insurers carrying on special-purpose business, including that under which an insurer fully funds its liabilities to its insureds through the proceeds of a debt issuance, cash, time deposits or other financing mechanism. Long-term business consists of insurance contracts covering life, annuity, accident and disability risks and certain other types of contracts.

There are eight general business classifications (Classes 1, 2, 3, 3A, 3B, 4, IGB and IIGB), six long-term business classifications (Classes A, B, C, D, E and ILT) and three classifications of restricted special-purpose insurer, unrestricted

special-purpose insurer and the collateralised insurer (SPIs), which can be classified as either general business or long-term business.

Insurers are sub-divided into three categories:

- captive insurers (Classes 1, 2, 3, A and B) ("Captive Insurers");
- commercial insurers (Classes 3A, 3B, 4, C, D and E) ("Commercial Insurers"); and
- special-purpose and collateralised insurers.

The IGB, IIGB and ILT categories can be either captive or commercial insurers.

In general, insurers proposing to carry on general business will be registered as follows.

Class requirements
A Class 1 insurer is:

- wholly owned by one person and intends to carry on insurance business consisting only of insuring the risks of that person; or
- an affiliate of a group and intends to carry on insurance business consisting only of insuring the risks of any other affiliates of that group or of its own shareholders.

A Class 2 insurer is wholly owned by two or more unrelated persons and intends to carry on insurance business in respect of which not less than 80% of the net premiums written will be written for the purpose of either of the following.

- Insuring the risks of any of those persons or of any affiliates of any of those persons.
- Insuring the risks which, in the BMA's opinion, arise out of the business or operations of those persons or any affiliates of any of those persons, or are registrable as a Class 1 insurer, but for the fact that:
  - (a) not all of the business which it intends to carry on, but at least 80% of the net premiums written, will consist of the business described under the requirements for a Class 1 insurer; or
  - (b) it intends to carry on insurance business in respect of which not less than 80% of the net premiums written will, in the BMA's opinion, arise out of the business or operations of the person by whom it is owned or any of the affiliates of that person.

A Class 3 insurer is not registrable as a Class 1, Class 2, Class 3A, Class 3B, Class 4 insurer or special-purpose insurer.

A Class 3A insurer intends to carry on insurance business in circumstances where:

- 50% or more of the net premiums written, or 50% or more of the loss and loss expense provisions, represent unrelated business; and
- total net premiums written from unrelated business are less than BMD50 million.

A Class 3B insurer intends to carry on insurance business in circumstances where:

- 50% or more of the net premiums written, or 50% or more of the loss and loss expense provisions, represent unrelated business; and
- total net premiums written from unrelated business are BMD50 million or more.

A Class 4 insurer:

- has total statutory capital and surplus of not less than BMD100 million; and
- intends to carry on insurance business including excess liability business or property catastrophe reinsurance business.

A Class IGB insurer intends, at the time of its registration, to carry on general business in an innovative and experimental manner whereas a Class IIGB insurer intends to carry on business in an innovative manner.

Long-Term Business
In general, insurers proposing to carry on long-term business will be registered as follows.

Class requirements
A Class A insurer is:

- wholly owned by one person and intends to carry on long-term business consisting only of insuring the risks of that person; or
- an affiliate of a group and intends to carry on long-term business consisting only of insuring the risks of any other affiliates of that group or of its own shareholders.

A Class B insurer is wholly owned by two or more unrelated persons and intends to carry on long-term business in respect of which not less than 80% of the premiums and other consideration will be written for the purpose of one of the following.

- Insuring the risks of any of those persons or of any affiliates of any of those persons.
- Insuring risks which, in the BMA's opinion, arise out of the business or operations of those persons or any affiliates of any of those persons.
- Registrable as a Class A insurer, but for the fact that:
  (a) not all of the business which it intends to carry on, but at least 80% of the premiums and other considerations written, will consist of the long-term business described under the requirements for a Class A insurer; or
  (b) it intends to carry on long-term business in respect of which not less than 80% of the premiums and other considerations written will, in the BMA's opinion, arise out of the business or operations of the person by whom it is owned or any of the affiliates of that person.

A Class C insurer has total assets of less than BMD250 million and is not registrable as a Class A or Class B insurer.

A Class D insurer has total assets of BMD250 million or more, but less than BMD500 million, and is not registrable as a Class A, Class B or Class C insurer.

A Class E insurer has total assets of more than BMD500 million and is not registrable as a Class A or Class B insurer.

A Class ILT insurer intends at the time of its application for registration to carry on long-term business in an innovative and experimental manner.

Special-Purpose Insurers
A special-purpose insurer is an insurer that carries on special-purpose business. "Special-purpose business" means insurance business under which an insurer fully collateralises its liabilities to the persons insured through the proceeds of any one or more of the following:

- a debt issuance where the repayment rights of the providers of such debt are subordinated to the rights of the person insured;
- some other financing mechanism approved by the BMA;
- cash; and
- time deposits.

Restricted special-purpose business means special-purpose business conducted between a special-purpose insurer and specific insureds approved by the BMA.

A collateralised insurer is an insurer that carries on special-purpose business but is not a special-purpose insurer.

Registration Process

There are two key steps involved in registering an insurance company in Bermuda.

Step 1 – Application approval

An application is made to the BMA's Insurance Licensing Advisory Committee (ILAC) for approval of the insurance programme. This application must be submitted to the BMA by close of business on the Monday of the week of the ILAC's meeting on the ensuing Friday. The application will include (but is not limited to) the following:

- business plan;
- Form 1B;
- five-year pro-forma financial projections;
- draft policy/policies;
- actuary/loss-reserve specialist analysis, if required;
- BSCR calculation, if required;
- resumés and personal declaration forms for directors and officers;
- acceptance letters and CVs of the service providers (ie, principal representative, insurance managers, auditors and loss reserve specialists, as applicable); and
- other supportive information specific to the application.

Step 2 – Registration

Once the BMA has approved the application, an application is then made to the BMA for the company to be registered as an insurance company. This application will include the following:

- business plan (as revised and if applicable);
- Form 1B, signed by two directors and the principal representative;
- acceptance letters and CVs of service providers (if not already provided);
- proof of capital being paid into the company; and
- registration fee.

Generally, the insurance company can be approved for registration and registered within 14 days of submission of the application. It is worth noting, however, that the application process may take longer if the BMA requires additional information or defers or declines the application. As the ILAC meets once a week (every Friday), each deferral by the BMA for further information will postpone registration by at least a week.

Insurers must also meet the "minimum criteria" for registration as follows:

- officers and controllers meeting a fitness and propriety test;
- suitable corporate governance policies and processes established according to the nature, risk profile, size and complexity of the insurer;
- a minimum of two individuals effectively directing the business of the insurer;
- a suitable number of non-executive directors on the board of directors of the insurer;
- business being conducted in a prudent manner;
- the position of the insurer within the structure of any group to which it belongs must not obstruct effective consolidated supervision; and

- the business of the insurer must be carried on with integrity and the professional skills appropriate to the nature and scale of the insurer's activities.

The minimum margin of solvency for general insurers is calculated by reference to the greater of net premiums and discounted loss reserves and other insurance reserves. A minimum floor of BMD120,000 applies for single- parent captives and BMD100 million for Class 4 reinsurers. The minimum margin of solvency for long-term insurers is a proportion of assets reported on the insurer's statutory balance sheet, subject to a minimum floor of BMD120,000 for single-parent captives and BMD8 million for Class E insurers (or 2% of the first BMD500 million of assets plus 1.5% of assets above USD500 million, whichever is greater; here BMD=USD).

An approved loss-reserve specialist is to be appointed by all multi-parent captives and commercial insurers carrying on general business and a qualified actuary approved by the BMA must be appointed by all insurers carrying on long-term business.

Captive insurers' reporting requirements include annual financial statements, and an annual statutory financial return comprised of:

- auditor's report;
- solvency certificate;
- loss reserve opinion (general business multi-parent captives);
- actuary's opinion (long-term business multi-parent captives);
- declaration of compliance;
- underwriting analysis; and
- own risk assessment.

Commercial insurers' reporting requirements include:

- annual financial statements (GAAP);
- annual capital and solvency return (comprising a version of the insurer's BSCR model); and
- quarterly financial returns.

In addition to this, commercial insurers must offer proof that they:

- maintain assets sufficient to capitalise an enhanced capital requirement (based on the insurer's BSCR model);
- satisfy a minimum portion of their enhanced capital requirement with qualifying tiers of eligible capital;
- maintain a head office in Bermuda;
- have conducted the commercial insurer's solvency self-assessment;
- have prepared and published a financial condition report and declaration executed by the CEO of the insurer and any senior executive responsible for actuarial risk, risk management, internal audit, or compliance function (to be made available on the insurer's website, if applicable, or in hard copy to members of the public on request); and
- maintain a target capital level of 120% of enhanced capital requirement.

Registration of Special-Purpose Insurers (SPIs)

The BMA has put in place a new expedited one-step process for registration of SPIs which are permitted to carry on restricted special-purpose business.

Under the new process, the BMA offers a turnaround time of three business days. Other benefits of the procedure are that the process may

be initiated on any business day by submitting an application prior to 5pm (Bermuda time) and the required information is provided through a new SPI checklist with no need to submit a business plan.

The Insurance Code of Conduct

All insurers must comply with the BMA's Insurance Code of Conduct (the "Code"), setting out the duties, requirements and standards with which insurers are to comply when conducting business.

The Code requires insurers to establish and maintain a sound corporate governance framework, providing for appropriate oversight of the insurer's business and adequately protecting policyholder interests. The Code further requires the board of directors of an insurer that employs an insurance manager to ensure that such insurance manager meets the fitness and propriety tests. Moreover, the board of directors and chief and senior executives are required to adopt an effective risk management strategy and an internal controls framework that has regard for international best practice on risk management and internal controls.

As there are varying risk profiles of insurers, the BMA interprets the Code based on the nature, scale and complexity of the business of each insurer. The BMA updates/revises the Code from time to time, with the most recent being in August 2022. The Code became operative on 1 September 2022 and the revisions relate mainly to corporate governance outsourcing, business continuity, disaster recovery and risk management. The BMA will allow for a transition period for compliance with the new provisions of the Code, from the operative date, as follows:

- a period of six months for compliance with Section 8; and
- a period of 12 months for compliance with the other new sections of the Code.

The revised Code also provides further details on the BMA's expectation regarding climate risk for commercial insurers. The BMA acknowledges that climate risk measurement and management methods are still evolving, and that insurers will therefore need to continuously update their approach during the implementation phase and beyond.

Cyber-Risk Code of Conduct

In response to a consultation paper published in December 2019, the BMA published the Insurance Sector Operational Cyber-Risk Management Code of Conduct (the "Cyber Code"). The Cyber Code applies to all insurers, insurance managers and insurance intermediaries (agents, brokers and insurance marketplace providers – "Registrants"). The Cyber Code establishes duties, requirements, standards, procedures, and principles to be complied with in relation to operational cyber-risk management. The BMA expects that cyber-risk controls will be proportional to the nature, scale and complexity of the organisation.

The BMA also recently required that insurers appoint a Chief Information Security Officer (CISO). The role of the CISO must be allocated appropriately to a qualified member of staff or to an outsourced resource. The role of the CISO is to implement and monitor the operational cyber-risk management programme. The CISO role is expected to be of sufficient seniority to facilitate the effective delivery of the operational cyber-risk management programme.

Insurance Intermediaries

Insurance intermediaries, including insurance managers, brokers, agents or insurance marketplace providers, or their innovative counterparts – IA, IB, IM or IMPs (collectively, "insurance intermediaries") – must comply with the respective BMA code of conduct. Insurance intermediaries can be either a natural person or a body corporate. The insurance intermediary must also meet minimum criteria for registration. This includes the fitness and propriety of controllers, which is assessed by reference to the competence, capability, honesty, integrity and reputation of the officer controllers.

Insurance intermediaries must maintain adequate professional indemnity insurance but are not otherwise subject to any prudential requirements.

Principal Representative

Every insurance company registered in Bermuda, even those with no physical presence on the island, must appoint a principal representative. A principal representative can take the form of a natural person or body corporate, but is more often a body corporate. The insurance manager of an insurer commonly also acts as the insurer's principal representative, but it is possible for both roles to be fulfilled by two separate entities. The BMA must approve the appointment of a principal representative by an insurer.

The principal representative exists so that the BMA can have some identified individual or company present in Bermuda to whom it can look in respect of an insurer's affairs. The principal representative has specific statutory obligations including the requirement to report certain events to the BMA, breach of which constitutes an offence under the Insurance Act. In particular, the principal representative must report the insolvency or likely insolvency of the insurer, the breach by the insurer of any law or the insurer's licence, the breach of any condition or solvency margin of the insurer or the failure by the insurer to adhere to certain other directions of the BMA.

Auditor

Subject to any directions given by the BMA to the contrary, every insurer must appoint and maintain an auditor approved by the BMA. Insurers must have their statutory financial returns audited annually by an approved auditor. Under prevailing policy, the BMA will only appoint individuals or firms resident in Bermuda as approved auditors.

Loss-Reserve Specialist

The Insurance Act stipulates that in certain instances a loss-reserve specialist (LRS), approved by the BMA, must opine on the insurer's loss reserves. The LRS is usually an actuary but must be independent from the actuary who sets the reserve levels. This opinion gives the BMA additional assurance concerning the level of reserves carried by the insurer.

Actuary

Insurers registered as long-term insurers must appoint an actuary in accordance with the Act, and have this appointment approved by the BMA. The primary role of the approved actuary is to opine on the adequacy of the total long-term business insurance reserves, reflected in insurers' statutory financial statements and statutory financial returns, and any other matters specified by the BMA.

2.2 The Writing of Insurance and Reinsurance

See **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**.

2.3 The Taxation of Premium

This does not apply in this jurisdiction.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Establishing a Physical Presence in Bermuda

In Bermuda, it is possible to establish a fully operational office in a few weeks.

Head Office Requirements

The Insurance Act was amended in 2016 to require commercial insurers to establish and maintain their head office in Bermuda. In determining whether commercial insurers have complied with the head office requirements, the BMA considers the following six factors:

- where the underwriting, risk management and operational decision making of the insurer occurs;
- whether the presence of senior executives responsible for and involved in the decision-making related to the insurer's insurance business is located in Bermuda;
- where meetings of the board of directors of the insurer occur;
- the location where management of the insurer meets to effect policy decisions of the insurer;
- the residence of the officers, insurance managers or employees of the insurer; and
- the residence of one or more directors of the insurer in Bermuda.

The BMA will apply the proportionality principle when it considers the above factors in determining whether the insurer, based on the nature, scale and complexity of its business, has met the head office requirements.

The head office requirement does not apply to a commercial insurer that has a permit under the Non-Resident Insurance Undertakings Act 1967 or a permit under Section 134 of the Companies Act. These provisions cover branch operations in Bermuda for foreign insurers.

Non-resident Insurance Undertakings

There are a few representatives of overseas carriers in Bermuda, commonly referred to as non-resident insurance undertakings (NRIUs). Most NRIUs have engaged agents in Bermuda who receive commissions on premiums written. Most of these premiums arise out of the sale of life insurance policies.

Economic Substance Requirements

The Council of the EU adopted a resolution on a code of conduct for business taxation, the aim of which is to counteract the effects of zero tax and preferential tax regimes around the world. In 2017 the Code of Conduct Group (the "Code Group") investigated the tax policies both of EU member states and of third countries, assessing tax transparency, fair taxation and implementation of anti–BEPS measures. Following assessment by the Code Group, Bermuda was included in a list of jurisdictions required to address the Code Group's concerns about "economic substance". Like their counterparts in the British Virgin Islands, the Cayman Islands, Guernsey, Jersey and Isle of Man, the government of Bermuda has been working closely with the Code Group to ensure that those concerns are adequately addressed. As a result of this engagement, the Economic Substance Act 2018, as amended (the "Substance Act"), and the Economic Substance Regulations 2018 (the "Substance Regulations") became operative on 31 December 2018.

Which Entities Are Subject to the Substance Act?

The Substance Act applies to "registered entities", which means:

- companies incorporated under the Companies Act;
- companies formed under the Limited Liability Company Act 2016; and
- partnerships (exempted, exempted limited or overseas).

A registered entity will be in scope of the Substance Act if it conducts a relevant activity. The relevant activities are:

- banking;
- insurance;
- fund management;
- financing and leasing;
- headquarters;
- shipping;
- being distribution and service centres;
- being a holding entity; and
- intellectual property.

Economic Substance Requirements

A registered entity conducting a relevant activity will satisfy the economic substance requirements if:

- it is managed and directed in Bermuda;
- core income generating activities (CIGA) are undertaken in Bermuda in relation to the relevant activity;
- it maintains adequate physical premises in Bermuda;
- there are adequate full-time employees in Bermuda with suitable qualifications; and
- there is adequate operating expenditure incurred in Bermuda in relation to the relevant activity.

How Will a Company Be Assessed on Compliance?

The Registrar of Companies (the "Registrar") will determine whether a company is compliant with the economic substance requirements based on the information provided in the annual filing. Registered entities in scope of the Substance Act will be required to file, on an annual basis, an economic substance e-declaration ("Declaration") with the Registrar through the online economic substance Declaration portal. The Declaration will include the following information:

- the nature and extent of the relevant activity including the CIGA undertaken by the relevant entity;
- the nature and extent of the entity's presence in Bermuda;
- whether the entity is managed and directed in or from Bermuda; and
- the nature and extent of outsourcing arrangements to affiliates or service providers.

How Is "Adequate" To Be Assessed?

The Substance Act does not impose a minimum annual expenditure nor a minimum number of employees in order to satisfy the economic substance requirements. Rather, "adequacy" will be assessed based on the particular circumstances of the entity.

Compliance and Enforcement

The Registrar will have monitoring and enforcement powers under the Registrar of Companies (Compliance Measures) Act 2017 and will have the power to fine an entity for non-compliance.

Implementation Period

The commencement date for the Substance Act was 1 January 2019 and the new regime became immediately applicable to new registered entities incorporated or registered after this date.

The transitional period for existing entities has ended. The first reporting commenced in 2020.

Relevant Activity of Insurance
The Substance Regulations set out the CIGA applicable to insurance as including the following:

- predicting and calculating risk;
- insuring or re-insuring against risk;
- providing client services; and
- preparing regulatory reports.

Brexit
The aforementioned responses are unaffected by Brexit.

3.2 Fronting
This does not apply in this jurisdiction.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies
Some of the M&A insurance deals Appleby worked on in 2021 and 2022 include:

- counsel to AUB Group which entered into an agreement with Odyssey Investment Partners to acquire 100% of Tysers for AUD880 million;
- counsel to Etelequote Limited in connection with the sale of its operating subsidiaries to Primerica, Inc (NYSE:PRI), a well-established provider of financial services to middle-income families throughout the United States and Canada;
- counsel to Global Atlantic Financial Group Limited (Global Atlantic) in connection with the sale of Global Atlantic to a subsidiary of KKR & Co Inc (KKR); and
- counsel to Argo Group International Holdings, Ltd, an underwriter of specialty insurance and reinsurance products in the property and casualty market, in an agreement to sell its reinsurance business, Ariel Re.

Other notable insurance deals Appleby worked on in 2021 include:

- counsel to the Vantage Group in connection with its formation of Vantage Risk Ltd as a Bermuda-exempted company and registration as a Class 4 insurer under the Insurance Act 1978 (Insurance Act) – one of the largest new insurance platforms in Bermuda;
- having acted for the UK's largest special motor insurer and Lloyds's underwriter ERS Insurance (now rebranded IQUW) in developing a significant presence in Bermuda including the establishment of a Class 3B reinsurer; and
- having acted as Bermuda counsel for Chaucer, the international specialty (re)insurance group, in the formation and licensing of its Bermuda Class 4 insurer and insurance agent.

Two companies registered in Bermuda may amalgamate and continue as one company or merge and continue as one of the merging companies (hereinafter referred to as a "business combination"). A business combination requires each company to enter into an amalgamation or merger agreement, as the case may be, which sets out the terms and means of effecting the business combination.

The directors of each company involved in a business combination must submit the amalgamation or merger agreement, as the case may be, before the shareholders of their respective companies. They must then gain shareholder

approval before the amalgamation or merger agreement can be effected and the amalgamated or surviving company can be registered by the Registrar. Special attention should be paid to the provisions of the by-laws of the respective companies that apply to meetings. Appropriate notice must therefore be given to the shareholders, and they should also be sent a summary of the amalgamation or merger agreement and a statement of the fair value of their shares.

At the meeting, each share of an amalgamating or merging company is entitled to the right to vote, irrespective of whether it carries that right and, if the amalgamation or merger agreement contains a provision that would constitute a variation of the rights attaching to any class of shares, then the holders of such shares are entitled to vote separately as a class. Unless the provisions of the by-laws provide otherwise, the resolution of the shareholders or class must be approved by a majority of 75% of those voting at the meeting, where the quorum is two people holding (or representing by proxy) more than one third of the issued shares of the company (or the class).

Should the amalgamation or merger agreement receive approval, then the dissenting shareholders are entitled to receive the merger consideration and, if they are not satisfied that they have been offered fair value, they may apply to the court within one month of the notice of the meeting to assess the fair value of their shares.

BMA Approval

The regulatory authority responsible for registering mergers and amalgamations pursuant to the Companies Act is the Registrar. For insurance companies, a BMA "no objection" or some form of notification will also be required as the BMA must remain informed of all the controllers of all registered insurers in Bermuda and any material changes to them. A "controller" for this purpose means:

- the managing director of the registered insurer or its parent company;
- the chief executive of the registered insurer or of its parent company;
- a 10%, 20%, 33% or 50% "shareholder controller"; or
- any person in accordance with whose directions or instructions the directors of the registered insurer or of its parent company are accustomed to act.

The definition of shareholder controller is set out in the Insurance Act, but generally refers to:

- a person who holds 10% or more of the shares carrying rights to vote at a shareholders' meeting of the registered insurer or its parent company;
- a person who is entitled to exercise 10% or more of the voting power at any shareholders' meeting of such registered insurer or its parent company; or
- a person who is able to exercise significant influence over the management of the registered insurer or its parent company by virtue of its shareholding or its entitlement to exercise, or control the exercise of, the voting power at any shareholders' meeting.

The BMA will also want to assess the financial strength of the amalgamated company and will expect the management accounts for each of the amalgamating companies and pro forma financials for the amalgamated company to be provided as part of their assessment.

Changes to the direct or ultimate beneficial ownership may also give rise to filing requirements

under the Exchange Control Act 1972 and related regulations, which are made via the BMA's filing portal.

Notification of Material Change

Pursuant to various sections of the Insurance Act, (re)insurers are required to notify the BMA before effecting a material change to the business of the respective insurer or that of an insurance group of which it is a member.

For the purposes of this section, a material change includes:

- acquisition or transfer of insurance business being part of a scheme falling within, or any transaction relating to a scheme of arrangement under, Section 25 of the Insurance Act or Section 99 of the Companies Act;
- an amalgamation with or acquisition of another firm;
- engaging in unrelated business that is retail business;
- the acquisition of a controlling interest in an undertaking that is engaged in non-insurance business which offers services and products to persons who are not affiliates of the insurer;
- outsourcing all or substantially all of an insurer's actuarial, risk management, compliance or internal audit functions;
- outsourcing all or a material part of an insurer's underwriting activity;
- the transfer other than by way of reinsurance of all or substantially all of a line of business;
- the expansion into a material new line of business;
- the sale of an insurer; and
- outsourcing of an officer role.

In order to effect a material change, the (re)insurer must have served on the BMA, in writing, a notice stating that the (re)insurer intends to effect such change. Once the notice is served, the BMA has 30 days beginning with the date on which the notice was served to notify the (re)insurer, in writing, that there is no objection to the (re)insurer effecting the material change. If, after the 30-day period has elapsed, the (re)insurer has not received a response from the BMA, it is free to effect the desirous material change. In practice, parties often prefer to have some form of acknowledgement or no-objection from the BMA before proceeding.

The BMA is required by the Insurance Act to serve a notice of objection unless it is satisfied:

- that the interests of the policyholders of the (re)insurer would not in any manner be threatened by the material change; and
- without prejudice to the preceding paragraph, that, having regard to the material change the requirements of the Insurance Act would continue to be complied with or, if any of those requirements are not complied with, that the (re)insurer concerned is likely to undertake adequate remedial action.

Before issuing a notice of objection, the BMA is required to serve upon the (re)insurer concerned a preliminary written notice stating the BMA's intention to issue a formal notice of objection. Upon receipt of the preliminary written notice, the (re)insurer served may, within 28 days, file written representations with the BMA which shall be taken into account by the BMA in making its final determination.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

This does not apply in this jurisdiction.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

This does not apply in this jurisdiction.

6.2 Failure to Comply With Obligations of an Insurance Contract

This does not apply in this jurisdiction.

6.3 Intermediary Involvement in an Insurance Contract

This does not apply in this jurisdiction.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

This does not apply in this jurisdiction.

6.5 Multiple Insured or Potential Beneficiaries

This does not apply in this jurisdiction.

6.6 Consumer Contracts or Reinsurance Contracts

This does not apply in this jurisdiction.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Bermuda is the world's leading domicile for insurance-linked securities (ILS) transactions. With a highly regarded regulatory framework, sophisticated legal system, developed infrastructure and global companies with a physical presence, Bermuda maintains a reputation as a quality jurisdiction that has demonstrated its ability to respond to changes in market conditions while meeting its clients' commercial needs.

The BMD100 billion ILS market has proven to be both relevant and reliable after the heavy catastrophe losses around the world in 2017 and 2018. As of December 2022, the BMA revealed that there have been 63 new insurer registrations, including two intermediaries. Bermuda's (re)insurance market is comprised of over 1,200 (re)insurers holding total assets in excess of USD980 billion and writing gross premium of approximately USD240 billion.

As of 31 December 2020, Bermuda maintained its position as the premier jurisdiction for captives, with a total of 680 captives writing gross premiums of approximately BMD25 billion. According to the Bermuda Stock Exchange (BSX), Bermuda has listed over 100 more ILS and catastrophe bonds in 2020 than it did in the previous year. At the end of 2020, the total number of ILS-listed securities stood at 590, with a combined nominal value of USD43.01 billion. Issuance for the first nine months of 2022 reached USD8.9 billion, which is above average relative to previous years. Forecasts predict a substantial growth in deals by year-end 2022.

Bermuda has been in the ILS market for more than 20 years and was involved in some of the first deals in the mid-1990s. The influx of capital has been the main catalyst for the growth of the ILS market. Many investors are now developing their own modelling and due diligence capabilities, and cedants are now sponsoring deals as a way of securing more competitive prices.

Some of the more common ILS structures in today's market are as follows.

- Catastrophe bonds – the capital market alternative to traditional catastrophe reinsurance that uses fully collateralised SPI to transfer a defined set of risks from an insurer to capital market investors. Initially, catastrophe bonds were structured to offer high yields for investors with high-risk appetites and only covered a single peril. Nowadays, catastrophe bonds tend to cover a multitude of perils and are structured as low risk/investment grade by offering over-collateralisation or guarantees from third-party insurers.
- Reinsurance sidecars – fully collaterised special-purpose insurers created to purchase some, or all, of an insurance policy in order to share in the profits and risks. The ceding insurer or reinsurer, who cedes risk to the reinsurance sidecar, normally pays its premiums for the coverage upfront, allowing investors to profit from the premium return with their collateral exposed for the duration of the underlying reinsurance contracts. Reinsurance sidecars used to be formed as joint ventures between existing insurance or reinsurance companies, but increasingly have been used as a convenient deployment vehicle for third-party capital in the reinsurance underwriting business.
- Contingent capital structures – these offer insurers the option to raise capital during a defined commitment period based upon the occurrence of a qualifying event. Should the qualifying event occur, investors provide the insurer with capital determined by the amount of catastrophic loss, and if no catastrophic event occurs, there is no exchange of funds. Because low-probability, high-severity event insurance tends to be scarce or uneconomic, contingent capital can be a cost-effective solution for a company needing liquidity relief.
- Extreme mortality bonds – these enable the issuer to protect itself from large deviations in longevity or mortality due to deaths from disease, pandemics, war, terrorism or natural catastrophes. These bonds are structured similarly to other asset-backed securities, with deviations in mortality serving as the trigger.
- Longevity swaps – these transfer the risk of pension scheme members living longer than expected from pension schemes to an insurer or bank provider.
- Industry loss warranties – these are reinsurance contracts whose payouts are linked to a predetermined trigger of estimated insurance industry losses rather than their own losses from a specified event. They are essentially swap contracts.

7.2 Foreign ART Transactions

This does not apply in this jurisdiction.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

This does not apply in this jurisdiction.

8.2 Warranties

This does not apply in this jurisdiction.

8.3 Conditions Precedent

This does not apply in this jurisdiction.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage
This does not apply in this jurisdiction.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law
This does not apply in this jurisdiction.

9.3 Litigation Process
This does not apply in this jurisdiction.

9.4 The Enforcement of Judgments
This does not apply in this jurisdiction.

9.5 The Enforcement of Arbitration Clauses
This does not apply in this jurisdiction.

9.6 The Enforcement of Awards
This does not apply in this jurisdiction.

9.7 Alternative Dispute Resolution
This does not apply in this jurisdiction.

9.8 Penalties for Late Payment of Claims
This does not apply in this jurisdiction.

9.9 Insurers' Rights of Subrogation
This does not apply in this jurisdiction.

10. Insurtech

10.1 Insurtech Developments
Insurtech is the insurance industry's next evolution and, given that Bermuda has been at the forefront of providing innovative solutions in the insurance industry for decades, it is a natural progression for the jurisdiction.

The BMA has taken a proactive response to the growing insurtech market, anticipating the needs of current and future players. Leveraging Bermuda's reputation as a centre of excellence for innovation in a sound regulatory environment, the BMA has launched two parallel innovation tracks initially targeted at the insurtech market:

- the insurance regulatory sandbox (the "Sandbox"); and
- an innovation hub (the "Innovation Hub").

The BMA has endeavoured to provide innovative solutions in the insurance industry to maintain Bermuda's dominance in the global ILS and captive sectors.

The Insurance Regulatory Sandbox
The Sandbox is a space where companies can test new technologies and offer innovative products and services to a limited number of customers in a controlled environment and for a limited period of time.

The Sandbox is available for entities registered, or proposing to become registered, under Section 4 (insurer) or Section 10 (insurance intermediaries) of the Insurance Act. The BMA encourages the use of a separately incorporated company (subsidiary or joint venture) to carry out activities within the Sandbox.

The licences available are ILT, IGB, IM, IA and IB for long-term insurers, general business insurers, insurance managers, agents and brokers, respectively. On successful graduation from the Sandbox, the company will be relicensed under an existing class of insurer or insurance intermediary, as follows:

- Class 1, 2, 3, 3A, 3B or 4 (if a general business insurer);

- Class A, B, C, D or E (if a long-term insurer);
- special-purpose insurer;
- collateralised insurer;
- insurance manager;
- broker;
- agent; or
- salesman.

Innovation Hub

The Innovation Hub is a platform for exchanging ideas and information and for facilitating dialogue between the BMA and market participants. The space is designed for activities not directly regulated by the BMA and is ideal for a company still developing its thoughts and ideas, not yet prepared for proof of concept, and therefore not ready to apply for entry into the Sandbox. There is a dedicated working group for the insurance sector called the BMA Insurance Innovation Working Group.

The Innovation Hub is initially aimed at companies seeking to create innovative insurance solutions. However, it will be expanded to include other financial technology start-ups more broadly in the future.

10.2 Regulatory Response

This does not apply in this jurisdiction.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

This does not apply in this jurisdiction.

11.2 New Products or Alternative Solutions

This does not apply in this jurisdiction.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

This does not apply in this jurisdiction.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

This does not apply in this jurisdiction.

Appleby is one of the world's leading international law firms. Its global teams of legal specialists advise public and private companies, financial institutions and private individuals. It is a full-service law firm providing comprehensive, expert advice and services across corporate, dispute resolution, property, regulatory, and private client and trusts practice areas. The firm works with clients to achieve practical solutions, whether from a single location or across multiple jurisdictions. Appleby has offices in ten highly regarded, well-regulated global locations, operating in nine of them and practising the laws of eight jurisdictions. Its office locations include the key international jurisdictions of Bermuda, the British Virgin Islands, the Cayman Islands, Guernsey, Isle of Man, Jersey, Mauritius, and the Seychelles, as well as the international financial centres of Hong Kong and Shanghai.

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APPLEBY

BRAZIL

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Brazil's main sources of insurance and reinsurance law are as follows.

- The Brazilian Civil Code (Law No 10.406/2002) Articles 757–802 establishes key rules pertaining to insurance contracts in general, non-life insurance and life insurance.
- The Brazilian Commercial Code (Law No 556/1850) Articles 666–731 establishes specific rules applicable to maritime insurance.
- The Brazilian Aeronautical Code (Law No 7.565/1986) Articles 281–286 governs some aspects of aviation insurance.
- Decree-Law No 73/1966 establishes Brazil's National System of Private Insurance (*Sistema Nacional de Seguros Privados*), whose executive agencies, the National Council of Private Insurance (*Conselho Nacional de Seguros Privados* – CNSP) and the Superintendency of Private Insurance (*Superintendência de Seguros Privados* – SUSEP) are tasked with regulating the insurance and reinsurance market for the benefit of policyholders. It also provides some rules on insurance contracts.
- Complementary Law No 126/2007, which abolished the federal government's monopoly on reinsurance (formerly exercised through the *Instituto de Resseguros do Brasil* – IRB), establishes the rules on reinsurance and retrocession contracts.
- As Brazil's legal system on insurance is incomplete and outdated, the executive agencies (the CNSP and especially the SUSEP) supplement the law with extensive regulation on insurance and reinsurance. The most relevant rules on prudential supervision and specific insurance branches (property insurance, life insurance, etc) are found in the CNSP's *resoluções* (resolutions) and the SUSEP's *circulares* (circular letters).
- For policies taken by consumers (ie, those who do not take insurance for business activities), Brazil's Consumer Protection Code (Law No 8.079/1990) provides important rules on business practices (eg, tie-in sale is forbidden) and policy content (eg, policy provisions that excessively restrict consumers' expected rights related to the insurance contract are null and void).
- Where health insurance is considered a type of insurance, Law No 9.656/1998 establishes detailed rules on health insurance contracts, and Law No 9.961/2000 enacts and defines the legal powers of Brazil's National Health Agency (*Agência Nacional de Saúde* – ANS), an independent regulatory agency.
- Where complementary welfare is considered a type of insurance, Complementary Law No 109/2001 regulates open and closed pension funds. Law No 12.154/2009 establishes two executive agencies responsible for pension funds supervision: the National Council of Complementary Welfare (*Conselho Nacional de Previdência Complementar* – CNPC) and the Superintendency of Complementary Welfare (*Superintendência Nacional de Previdencia Complementar* – PREVIC).

In the last decade, Brazil has made significant efforts to increase the relevance of precedent in legal practice. Despite these measures, such as the promulgation of a new Civil Procedure Code (Law No 13.105/2015), the courts, especially Brazil's highest court on federal law (the Superior Court of Justice or *Superior Tribunal de Justiça* – STJ), have not adopted a stable body of precedent.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Oversight of the insurance and reinsurance sector falls to many different independent and executive regulatory agencies.

- Decree-Law No 73/1966 – the CNSP and the SUSEP are responsible mainly for supervising insurance and reinsurance companies and open pension funds. The CNSP, mostly through resolutions, is supposed to establish general guidelines and rules on solvency, insurance policy, reinsurance in general, co-insurance and insurance, and reinsurance brokerage. The SUSEP is tasked with complementing and executing CNSP guidelines, which, in practice, results in extensive supervisory activities, due to the vast powers directly attributed to the SUSEP (eg, the agency is charged with setting guidelines for all insurance policies) and to the usually open-ended regulation produced by the CNSP.
- Law No 9.961/2000 – the ANS, as the only independent agency between all regulatory bodies, is responsible for health insurance regulation. It establishes limits for yearly premium adjustments, defines which procedures must be covered, authorises health insurance writing, and conducts prudential oversight of health insurers.
- Law No 12.154/2009 – the CNPC and the PREVIC, which mirror the CNSP and the SUSEP (all four of which are likely to be merged to reduce redundancy), supervise closed pension funds in all capacities, focusing mainly on authorisation for new funds.

2.2 The Writing of Insurance and Reinsurance

Only legally authorised entities (which in any case must be corporations) are allowed to write insurance and reinsurance. Insurance and reinsurance companies must comply with legal and regulatory requirements established in Decree-Law No 73/1966 and CNSP Resolution 422/2021.

Legal authorisation for insurers and reinsurers is given in two steps. First, a legal representative of the future shareholders must request formal authorisation to constitute a (re)insurance company from the SUSEP. The request must be accompanied by:

- a sound business plan;
- a full description of the corporate group and the shareholders;
- proof of financial and economic capabilities suitable for the (re)insurance branch(es) in which the corporation intends to operate, especially the minimum partnership capital requirement, set by CNSP Resolution 432/2021;
- a description of the financial resources to be used in the (re)insurance company; and
- any other document demanded by the SUSEP to prove the reputation and good character of the future relevant shareholders.

After authorisation is granted, the (re)insurance company must be constituted within 90 days and prove the origin of the resources used. Then, the SUSEP grants authorisation to underwrite (re) insurance in the requested branches. There is no regulatory distinction between excess lawyers and reinsurance and other insurance branches, but there are more flexible rules pertaining to SME insurance and business insurance. Both branches are subject to less regulation, either by

having lighter authorisation requirements (SME insurance – SUSEP Circular Letter 439/2012) or less stringent supervision on policy content (a type of business insurance, in particular large or jumbo risks – CNSP Resolution 407/2021).

Regulatory authorities have recently loosened authorisation requirements for certain types of insurance companies, aiming to promote innovation through CSNP Resolutions 381/2020 and 417/2021 and SUSEP Circular Letters 598/2020 and 636/2021. This so-called regulatory sandbox grants a temporary authorisation to operate, which must be converted into permanent authorisation, with all the requirements mentioned above, within three years of active insurance writing.

International reinsurers follow a different procedure, as they are already constituted in their home jurisdiction. They must only be registered with the SUSEP to be allowed to write in Brazil. According to Complementary Law No 126/2007, the reinsurer must:

- appoint a representative residing in Brazil;
- present its latest financial statements;
- prove itself to be regularly constituted in its original jurisdiction;
- demonstrate to have been writing reinsurance for more than five years in the branch in which it intends to operate;
- prove to not have any solvency issues;
- possess more than USD150 million in assets; and
- have its individual solvency rated at least BBB or equivalent by selected risk-rating agencies.

Where the international reinsurer aspires to be an admitted reinsurer (ie, not just an eventual one), it must also establish a representation office in Brazil and deposit USD5 million (non-life insurance) or USD1 million (life only) in an authorised bank account.

2.3 The Taxation of Premium

Payment of insurance premiums is considered a financial transaction and is subject to a federal tax on financial transactions (IOF). According to Decree No 6.306/2007, the federal government is allowed to tax most insurance transactions (rural insurance is exempt from taxation) up to a rate of 25% of the premium paid, but the effective rate is very diverse – reinsurance, obligatory insurance, credit insurance, performance bonds and other types of insurance currently have a taxation rate of 0%. Life and health insurance is currently subject to a 2.38% rate, while other insurance branches not specified in the decree are subject to a 7.38% rate.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Brazilian law relating to overseas-based insurers is different from the rules on international reinsurers.

Overseas Insurance

Under Complementary Law No 126/2007, all policies related to risks located *in Brazil* must be taken in Brazil. Only if local insurance companies are not willing to write that risk, or if the specific insurance branch is not operated in Brazil, can the insured search for coverage in other jurisdictions. Proof that insurance coverage is not locally available is regulated by Circular Letter No 603/2020: the insured must present the formal refusal to underwrite from at least five

insurance companies operating in the Brazilian market.

Nonetheless, global insurance programmes are not forbidden by Complementary Law No 126/2007. Only risks located exclusively in Brazil cannot be insured by international insurers through policies taken by Brazilian residents or companies. International groups often use this restrictive wording to bring their usually more protective policies to their local operation.

Another entirely different matter is applicable law. Recently, the STJ has ruled that international insurance contracts (ie, with international insurers), although concluded in Brazil, can stipulate which law governs the contract. This is a liberal interpretation of Brazilian law (Decree-Law No 4.657/1942) adopted in some STJ rulings which is yet to be confirmed by the Constitutional Court (STF). Mainstream consensus is that Brazil has not yet clearly adopted full party autonomy on this choice-of-law matter.

Overseas Reinsurance

Brazilian law related to reinsurance fully allows international reinsurance contracts and reinsurance companies. Complementary Law No 126/2007 separates authorised reinsurers into three groups:

- local reinsurers – reinsurance companies incorporated in Brazil (albeit usually as part of an international group) that have the right to preferentially write 40% of the global reinsurance cession from all insurers operating in Brazil and are the only type of reinsurer allowed to cover specific life insurance policies and pension funds;
- admitted reinsurers – international companies that establish an office in Brazil and deposit a given amount of capital in an authorised financial institution, in addition to fulfilling all registration requirements discussed in **2.2 The Writing of Insurance and Reinsurance**;
- eventual reinsurers – international companies that only fulfil the registration requirements discussed in **2.2 The Writing of Insurance and Reinsurance** and are not incorporated in a tax haven (defined by CNSP Resolution 422 as a jurisdiction that does not tax income, has an income tax rate lower than 20% or does not require the company to publicise its shareholder structure).

According to Complementary Law No 126/2007, the federal government can set specific cession limits to eventual and admitted reinsurers to maintain reinsurance contracts tied to Brazil. However, following Decree No 10.167/2019, insurers are allowed to cede 95% of all premiums to eventual and admitted reinsurers, making both types of reinsurers equivalent for the purpose of cession.

Mirroring the insurance system, CNSP Resolution 168/2007 provides that if there is not any authorised reinsurer (local, admitted or eventual) willing to write the risk, the insurer is allowed to cede to non-authorised reinsurance companies after formally consulting all reinsurers.

According to CNSP Resolution 168/2007, any reinsurance contract related to risks in Brazil must be governed by Brazilian law unless the parties elect arbitration as their preferred dispute resolution method. In the prospective regulation on the subject, set to be enacted in 2023, this rule will likely not be changed.

3.2 Fronting

Fronting is allowed in Brazil. Insurers are required to retain 50% of all premiums received in a particular year pursuant to CNSP Resolution

168/2007. However, the mandatory retention is determined globally. It is, therefore, possible for insurance companies to cede all or almost all risk to reinsurers in specific reinsurance treaties or facultative contracts. In large or jumbo risks, and with policies issued by insurers that are part of large reinsurance groups, this is a recurrent practice frequently tied with claims control or co-operation clauses. As the cedant is the only liable party before the insured under Complementary Law No 126/2007, some retention (even if negligible) is typical.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Consulted market agents report no overarching trend in insurance M&A. There were relevant mergers in health insurance, which has seen phenomenal consolidation over the past few years. In large risks and sophisticated insurance, the increasing presence of international reinsurance groups continues to blur the line between insurance and reinsurance.

By contrast, in retail insurance, a market dominated by large Brazilian companies and bancassurances, technological improvements are streamlining internal processes and facilitating insurance distribution. Insurtechs, the expected target of M&A in insurance, are usually grown inside or in close relation to big insurance. They are not currently focused on displacing traditional insurers – most insurtechs in Brazil threaten the insurance brokerage and traditional insurance agency business, such as with the recent growth of manager general agents (MGAs) and the creation of insurance service initiation companies (SISS).

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Insurance and reinsurance contracts are distributed in different ways in Brazil.

Reinsurance Distribution

According to Complementary Law No 126/2007, facultative and treaty reinsurance contracts are supposed to be directly concluded between the cedent and reinsurer or by way of a legally authorised intermediary (the reinsurance broker).

The reinsurance broker must be authorised to operate in Brazil by the SUSEP. Under CNSP Resolution 422/2021, reinsurance brokers must comply with regulatory requirements different from those applicable to insurance brokers. The most relevant distinction is that reinsurance brokers are required to have professional liability insurance (E&O) with a minimum BRL10 million global limit.

Insurance Distribution

Insurance is distributed by a myriad of channels, and recently authorities have created new ones through so-called open insurance (CNSP Resolution No 415/2021). Direct sale, insurance brokerage, insurance agents and distribution deals with large financial companies are the most-used venues.

- Insurance companies are allowed to receive and accept insurance proposals directly from the proponent, waiving any insurance intermediation. In this case, the insurance company must still pay the usual brokerage commission to a fund administered by the National Insurance School Foundation (FUNENSEG) pursuant to Law No 4.594/1964.

- Insurance brokers are the legally preferred channel for insurance distribution. Insurance brokerage is governed by three main laws:
  (a) The Brazilian Civil Code (Law No 10.406/2002) enacts general rules relating to brokerage in Articles 722–729;
  (b) Law No 4.594/1964 establishes specific rights and duties for insurance brokers and requires operating authorisation for insurance brokerage. In Brazil, brokers are responsible for counselling the policyholder on which is the best insurance product in the market for its purposes; and
  (c) Decree-Law No 73/1966 provides that brokers are part of the National System of Private Insurance and empowers the SUSEP to grant operating authorisation to brokers. The most prominent requirement is a specific professional qualification for working in an insurance branch group (mostly life and non-life insurance).
- Insurance agencies are generally limited to retail insurance, mainly distributing travel, life and certain types of casualty insurance (eg, extended warranty insurance). Large retailers are typically considered the biggest insurance agents. Agents are subject to the following regulations:
  (a) The Brazilian Civil Code (Law No 10.406/2002) enacts general rules relating to agency in Articles 710–721;
  (b) Law No 4.886/1965 provides basic rules on commercial agency, focusing mainly on protecting the agent as the economically weaker contractual party; and
  (c) CNSP Resolution 431/2021 establishes specific rules on insurance agents (eg, it forbids an agent from underwriting on the insurer's behalf).

Since most retail insurance is operated by bancassurance conglomerates, banks are frequent venues for taking policies. They are not typical insurance agents – thus, the aforementioned rules do not directly apply – as they are usually beneficiaries of the policy taken by the client (eg, in payment protection insurance) or are the policyholder in group insurance. Authorities have tried to curb the latter through CNSP Resolution No 439/2022, which forbids group insurance administration only for financial gain.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

According to Article 766 of the Brazilian Civil Code (Law No 10.406/2021), the insured must disclose all relevant information to the insurer when the contract is being negotiated.

Case law and jurisprudence have recently highlighted that the insurance company must at least refer to which kind of information may be relevant to write the risk. Where a questionnaire is provided, the courts have mostly referred to the questions in determining whether the information allegedly omitted was material or not. This is frequently discussed in life or health insurance litigation (therefore, in consumer insurance contracts). Any documents not demanded or questions not asked, unless obviously relevant, cannot be levied against the policyholder or beneficiary to deny coverage.

6.2 Failure to Comply With Obligations of an Insurance Contract

If any misrepresentation is made, the insurance company may demand additional premium from the insured, who may lose coverage only if the insurance company can prove wilful misconduct

or gross negligence in omitting information. Contrary to expectations, case law shows that the gross negligence threshold is easily achieved. Especially in business insurance, courts are rarely impressed with allegations that a misrepresentation was made by mistake, without any intention to hurt insurers.

6.3 Intermediary Involvement in an Insurance Contract

Insurance intermediaries can act on behalf of both insurers and policyholders, although in a legal sense none represent either insurance companies or insureds. Brokers, in general, are perceived to be acting on behalf of policyholders, and are thus legally required to aid policyholders in choosing, negotiating, and administering the insurance contract according to Law No 4.594/1964 and longstanding practice. For instance, in large-risks insurance, claims made by the insured to any insurer are frequently handled by brokers, who typically mediate loss-adjusting communications.

Conversely, in retail insurance (such as policies issued by bancassurance conglomerates) brokers are frequently part of the same economic group as the insurers and are incorporated for the sole purpose of raising commissions. "Contingent commissions" agreements with insurance companies are unfortunately common in Brazil, making brokers financially interested in quashing or reducing claims brought by policyholders. Therefore, on whose behalf an intermediary is acting must be determined on a case-by-case basis.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

The Brazilian Civil Code (Law No 10.406/2021) Article 757 establishes the five distinguishing features of any insurance contract:

- guarantee or coverage;
- insurable interest;
- risk;
- premium; and
- enterprise.

By legal definition, insurers guarantee the legitimate interests of insureds and receive a premium. The insured must, then, have a qualified interest – that is, an economic or otherwise relevant relation to a thing or a person worthy of protection – to be able to insure it. The legitimacy of the interest is typically only called into question to prohibit speculation through insurance. In life insurance, for instance, the Civil Code requires the policyholder to expressly declare its interest in the life of the insured person, and a kinship or likewise worthy link between insured person and policyholder is required for the contract to be valid.

Insurance contracts are consensual, although the Brazilian Civil Code demands that the insured submit an insurance proposal in writing to the insurance company. Policies are seen as having only probatory value of the agreement and it is longstanding practice that insurance contracts can be formed by simple silence of the insured after receiving a proposal.

Recently, and in contravention to the Brazilian Civil Code, the SUSEP has tried to change this through Circular Letter No 642/2021. Under this illegal but still-in-force regulation, proposals must be signed by the insured and acceptances

must be given in writing or in other specific way by insurers.

According to the Brazilian Civil Code (which is supplemented by SUSEP Circular Letters No 621/2021 and No 667/2021, and CNSP Resolution No 407/2021), the insurance policy should at least contain, in a clear and direct way:

- the name of the insured or beneficiary, if applicable;
- protected interests;
- covered risks;
- liability limits;
- premium owed by the insured; and
- contract duration.

6.5 Multiple Insured or Potential Beneficiaries

Parties not named as insureds can be beneficiaries of an insurance contract. This is the rule and not the exception in some branches (eg, Construction All Risks (CAR) insurance). The insured must of course have a legitimate interest threatened by insurable risks in that specific insurance branch to be able to benefit from coverage.

Disclosure obligations fall only on the insured taking the policy if they are the only party involved in negotiations. In certain insurance branches, such as bonds, insurance companies may question policyholders and beneficiaries alike before writing the risk. In that case, both are obliged to disclose what was asked and what is obliviously relevant to risk assessment must be informed to insurers.

6.6 Consumer Contracts or Reinsurance Contracts

The rights and duties of the parties are not inherently different regarding reinsurance and consumer contracts. As with any rules related to good faith and fair dealing, case law adopts a more defensive stance when dealing with consumers and other vulnerable parties, while weakening the influence of many protective statutes on commercial contracts negotiated by experts.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Alternative risk transfer (ART) transactions are not at all common in Brazil, although a recent federal law (Law No 14.430) created an insurance-linked security (the *Letra de Risco de Seguro* – LRS) and a specific type of insurance company (the *Seguradora de Proposito Específico* – SSPE) focused on ART. As far as is known, the market has not engaged much with these new tools and there is no regulation classing them as insurance or reinsurance contracts.

7.2 Foreign ART Transactions

International ART transactions are even rarer in Brazil. Local insurance and reinsurance companies do not frequently use them and there is no specific regulation on ART transactions. Considering the broad and economically focused language of CNSP Resolution No 422/2022, which establishes general rules on solvency, ART transactions could be treated as reinsurance for solvency purposes.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Where the insurance policy is drafted only by the insurance company (or by reinsurers), as is the case in almost all situations, the Brazilian Civil Code (Law No 10.406/2002) imposes the so-

called contra proferentem interpretation – ie, an ambiguous contract term should be construed against the drafter. Despite clear wording in the law, case law has been somewhat reluctant to broadly interpret insurance policies and frequently defers to the actuarial stability argument. As policies in Brazil are notoriously badly written, resorting frequently to mistranslations from international sources, the contra proferentem rule should not be used sparingly.

In addition to this specific and overstated rule in insurance, Brazil's rules on interpretation are very similar to those found in other civil law jurisdictions. The aim of any contractual interpretation is to reveal common intent registered in a party's declarations. To that end, circumstances, "usual practice", reasonableness and good faith are all tools used in relevelling or reconstructing the common will manifested in the declarations – there are few binding rules on interpretation, such as the above-mentioned contra profentem rule. Four corners clauses, although frequent in commercial contracts, hold little sway.

8.2 Warranties

Although not referred to as such, as a "warranty" is a foreign concept for civil law jurisdictions, most policies impose duties on the insured whose breach entails loss of coverage, or which must be observed to ensure coverage in the case of loss. It is not clear how far insurers can impose these duties on policyholders, as Decree-Law No 73/1966 prohibits any clause that affects coverage not linked to a legally established cause of coverage loss, such as risk aggravation or late-claim notice. Case law typically combines both the policy clauses and the closest legal provision in most rulings, and requires that the warranty breach be directly related to the loss discussed.

8.3 Conditions Precedent

As with warranties, "conditions precedent" are a foreign concept for civil law jurisdictions, and are by contrast rare in insurance contracts in Brazil. Insurers usually do not tie the existence of the insurance contract to any specific event. A noteworthy exception are the "open policies" in transport insurance, which require the insured to disclose to the insurer certain facts before coverage is granted to each trip.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Disputes over coverage are usually addressed by ordinary litigation. Arbitration is rare in insurance, even though policies frequently allow arbitration as a dispute resolution method. In consumer contracts, under the Brazilian Consumer Protection Code, compulsory arbitration clauses are forbidden. By contrast, arbitration is commonplace in reinsurance contracts.

Under the Brazilian Civil Code (Law No 10.406/2002), the limitation period for an insurance claim in Brazil is one year. The date on which this period starts is a very disputed subject. The dominant view in case law was that the period starts from the loss discovery and is suspended during loss-adjusting procedures. More recently, the courts have been adopting a different starting point for the limitation period: the moment in which the insurer refuses coverage to the policyholder or beneficiary.

Any beneficiary can enforce an insurance contract, be they named in the policy or not. Injured third parties can also directly enforce an insurance contract against the insurer in civil liability insurance, despite breached warranties by the insured.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

According to Decree-Law No 4.657/1942, the law applicable to insurance contracts is the law of the proponent's residing county, and Brazilian courts have jurisdiction over disputes where the respondent resides in Brazil, or where Brazil is the place in which performance should be rendered.

As discussed in **3.1 Overseas-Based Insurers or Reinsurers**, Brazil is one of the last jurisdictions in which party autonomy on choice of law is not clearly established, despite some rulings to this effect by the country's highest federal court.

9.3 Litigation Process

According to Brazil's Civil Procedure Code (Law No 13.105/2015), litigation in Brazil starts with a complaint filed either in a state or federal court. After preliminary analysis, the judge orders the respondent to be served.

Against the claimant's complaint, the respondent may either recognise the claimant's enforced right or respond to the complaint, which can lead to a counterclaim.

The judge then enquires of the parties regarding evidence. After all relevant evidence is procured, parties may present final arguments summarising all that has been presented thus far.

The judge subsequently renders their final judgment on the case. The losing party may appeal to the state or regional federal court, which reviews the ruling made by the singular judge in collegiate bodies. After the regional or state court reviews the decision, the losing party can appeal either to the Superior Court of Justice (*Superior Tribunal de Justiça* – STJ) on grounds of federal law violation by the lower court, or to the Supreme Federal Court (Supremo Tribunal Federal – STF) on grounds of a constitutional violation by the lower court or the STJ.

9.4 The Enforcement of Judgments

Pursuant to Brazil's Civil Procedure Code (Law No 13.105/2015) and Arbitration Law (Law No 9.307/1996), national provisional and definite rulings or arbitration awards can be enforced in Brazil, requiring either a simple request or a specific petition. By contrast, under the Brazilian Constitution, foreign judgments must be previously approved by the STJ, which assesses whether or not the judgment violates Brazil's public policy or res judicata rule.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses can be enforced both in commercial insurance and reinsurance contracts under the Brazilian Arbitration Law (Law No 9.307/1996). As insurance contracts are frequently formed by adhesion to already drafted polices, the adhering party must consent either by specifically signing the arbitration clause or by enforcing the arbitration clause themselves.

9.6 The Enforcement of Awards

The Brazilian Arbitration Law (Law No 9.307/1996) treats an arbitration award as having the same legal effect as a court ruling. As such, the same restrictions mentioned in **9.4 The Enforcement of Judgments** apply to foreign arbitration awards, but the approval procedure is governed by the Arbitration Law (Law No 9.307/1996), which mirrors the New York Convention (incorporated by Decree No 4.311/2002).

9.7 Alternative Dispute Resolution

Alternative dispute resolution methods such as mediation play a small role in insurance and

reinsurance disputes in general, despite being a growing field in other matters.

9.8 Penalties for Late Payment of Claims

Under the Brazilian Civil Code (Law No 10.406/2002), insurers are liable for all damages caused by late payment of claims if the loss-adjustment process is not regularly conducted. According to SUSEP Circular Letter No 621/2021, insurers also have 30 days after receiving all requested documents to settle the claims. If the deadline is not observed, interest must be paid to the insured.

9.9 Insurers' Rights of Subrogation

According to the Brazilian Civil Code (Law No 10.406/2002), insurers have a right of subrogation following the payment of a claim – any act of the insured that diminishes or extinguishes this right is considered void.

In general, case law pertaining to subrogation has been overprotective of insurance companies. Even though they supersede the insured as creditor before the responsible party, insurers are subject to new limitation periods, extending claims almost indefinitely, and some case law frees them even from arbitration clauses that bind the insured.

10. Insurtech

10.1 Insurtech Developments

Insurtechs are generally seen as the latest big change in the Brazilian insurance market and are expected to be as relevant as fintechs have been to the financial services sector. Having such big shoes to fill means that it is very difficult to accurately measure real developments taking in place in the Brazilian insurance market due to insurtechs.

Insurtechs have had an impact on insurance distribution. Most successful Brazilian insurtech enterprises tackle how insurance is processed internally (eg, premiums and claims), promoted to the consumer, and sold to the policyholder – not insurance contracts or economics. In that capacity, there is healthy co-operation between traditional innovation-focused business models and insurance businesses, who feel the impulse to improve provided services. The biggest insurers in Brazil have dedicated teams and investment lines for improving internal processes.

Nevertheless, insurance is a more conservative business than financial services in general (especially banking). It is difficult to affect the core product without financial backing of a large financial conglomerate or international reinsurers. Underwriting, insurance policies wording, loss adjusting and claims settling are, by their nature, very similar between all insurance and reinsurance companies. There is no insurance without a certain degree of standardisation. Hence, in core insurance, insurtechs are yet to have any meaningful impact, particularly on insurance branches that rely heavily on reinsurance (eg, large or jumbo risks), although some marginal change can be seen (eg, in bike insurance).

10.2 Regulatory Response

In the last few years, Brazilian regulatory authorities have been playing a very active role in fostering innovation in the insurance sector. The biggest action taken is the creation of the so-called regulatory sandbox (CSNP Resolutions 381/2020 and 417/2021), in which new insurtechs can be incorporated with less stringent regulatory requirements and oversight for a maximum period of three years. The aim is to allow new ideas to be tested in a friendlier – albeit controlled – environment.

Despite these efforts, it is too early to tell how successful they have been. Insurtechs, although providing new and interesting solutions, are currently very distant from true competitors to the established insurance companies in Brazil, who are mainly branches of the biggest financial conglomerates in the country.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

The regulatory authorities have been quick to introduce regulation on new insurance policy types such as cyber-risks insurance (a special liability policy governed by SUSEP Circular Letter 638/2021). The market has not, in return, been so eager to face emerging risks. High deductibles and restrictive underwriting have been the usual answer, as new insurance products are seen as too uncertain or volatile.

This is not an isolated trend in the Brazilian insurance sector. Despite relevant general growth in the last few years, anything other than small retail insurance is facing persistent crises and being left to international groups and reinsurers who are willing to write.

11.2 New Products or Alternative Solutions

Brazil is not a leading market in developing alternative solutions to address emerging risks. Almost all innovation on insurance comes from more established markets – ie, Europe (in particular the UK) and the United States.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

COVID-19 obviously provoked significant change in the insurance sector. Even though infectious diseases or pandemics were an excluded risk in almost all life insurance policies, most life insurers stood ready to cover the deaths caused by COVID-19. This branch of insurance also experienced unprecedented growth in 2022: an almost 18% increase in premiums paid since 2021. In non-life branches, loss ratios plummeted, as most insurance policies (adopting common law countries' standards) tie coverage to physical damage. As economic activity picked back up at the tail end of the COVID-19 pandemic, loss ratios started to normalise both in life and in non-life insurance.

In terms of legal development, Brazil has experienced unprecedented change in the (re)insurance legal framework. Almost all relevant insurance regulation was either revised or revoked in the past four years. It is not clear yet how the administration will deal with this – ie, whether it will uphold most created rules, revoking only those which the current president's party have challenged in the Constitutional Court, or whether it will promote another general revision of insurance regulation.

The three final areas for which regulation was drafted but not approved were reinsurance, transport insurance and complementary welfare. It would not be surprising to see these rules enacted even though the new administration favours a substantially different economic policy to that pursued in the last four years by the Ministry of Economy, to which insurance regulators are subordinate.

It remains to be seen whether the Insurance Contract Law Bill will gather steam in Congress (PLC 29/2017) in the following months. If the bill does become law (it only needs to be voted for by the Senate), all rules on insurance policy will be changed to become clearer and more aligned with the practice in other jurisdictions, such as Portugal, Spain, France, Belgium, Switzerland and Germany.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Among the last groups of CNSP resolutions proposed by the former federal government insurance regulators was a broad revision of all rules related to reinsurance contracts (cession limits, formation, etc). One of the most relevant provisions in the drafted resolutions is the increase to global cession limits imposed on all insurance companies from 50% (CNSP Resolution 168/2007) up to 90%, favouring fronting operations in Brazil and reaffirming the consistent trend towards reinsurer empowerment in the country.

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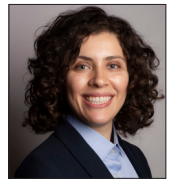

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Trends and Developments

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Brazil – Recent Developments of a Regulatory Nature

The year 2022 has been an eventful year in terms of new norms being passed by regulatory bodies in Brazil, such as by the Superintendency of Private Insurance (SUSEP) and the National Council of Private Insurance (CNSP). In this article, the authors refer with emphasis to SUSEP Circular No 666 of 27 June 2022, as well as CNSP Resolution No 451 of 19 December 2022.

SUSEP Circular No 666/2022

SUSEP Circular No 666/2022 deals with the sustainability requirements to be complied with by insurance companies, open complementary pension fund entities (EAPCs), savings bonds companies, and local reinsurers.

There is a growing number of insurers and reinsurers that are decarbonising their portfolios and incorporating weather events and regulatory transitions into their business decisions. According to this Circular, companies must create processes and controls to identify, evaluate, measure, treat, monitor and report the risks to which they are exposed.

For this, three specific instruments should be adopted: a policy for managing sustainability risks, a sustainability policy and a sustainability report.

Sustainability risk management

The management of sustainability risks policy must be compatible with the size of the supervised company, the nature and complexity of its operations and the materiality of the sustainability risks to which it is exposed.

The supervised company must prepare a materiality study in order to identify, evaluate and classify, by materiality levels, the sustainability risks to which it is exposed, taking into consideration the characteristics of its activities, operations, products, services, clients, suppliers and service providers.

The classification of sustainability risks by levels of materiality must be based on the value resulting from the combination of its estimated probability and impact, and a risk must be considered immaterial only if this value is below the minimum parameter of relevance defined by the supervised company.

Sustainability policy

The sustainability policy (which will not be considered as a complementary policy to the risk management policy) must establish principles and guidelines aimed at ensuring that sustainability aspects, including risks and opportunities, are considered in the conduct of its business and in its relationship with stakeholders.

Sustainability report

The supervised company must elaborate and disclose, by 30 April of each fiscal year, a sustainability report, describing at minimum the actions regarding its effectiveness and explaining the results (if any) obtained in the previous year and those expected for the current year. It must also disclose the most relevant aspects

related to the management of the sustainability risks to which it is exposed.

The SUSEP Circular also defined the types of risks that may affect the insurance sector, which is an evolution of the norms in this area since it seeks to define complex concepts such as climatic risks (referring to losses associated with climate change, and transitions to be promoted by supervening regulations and the adoption of new technologies and litigation losses), environmental risks (related to environmental degradation) and social risks (referring to losses due to human rights violations). These are discussed in more detail here.

- Climatic risks concern the following:
  (a) physical climatic risks – the possibility of losses caused by events associated with frequent and severe inclement weather or long-term environmental changes, which can be related to changes in weather patterns;
  (b) transition climate risks – the possibility of losses caused by events associated with the process of transition to a low carbon economy, in which the emission of greenhouse gases is reduced or offset and the natural mechanisms for capturing these gases are preserved; and
  (c) litigation climate risks – the possibility of losses caused by claims in liability insurance or direct actions against the supervised company, both due to failures in the management of physical or transition climate risks.
- Environmental risks – the possibility of losses caused by events associated with environmental degradation, including the excessive use of natural resources.
- Social risks – the possibility of occurrence of losses caused by events associated with the violation of fundamental rights and guarantees, or by acts that are harmful to the common interest.

Thus, the issuance of SUSEP Circular No 666/2022 represents a regulatory benchmark for the insurance sector in Brazil, being in line with the global trend of incorporating climate risks in the financial analyses of companies' portfolios.

CNSP Resolution No 451/2022

CNSP Resolution No 451/2022 provides specifically for the following operations:

- cession and acceptance of reinsurance and retrocession operations and their intermediation;
- co-insurance operations;
- foreign currency operations; and
- contracting of insurance abroad.

One of the main provisions of the Resolution deals with preferential offers, which should ensure equal treatment to all reinsurers, and consists of the right of preference that local reinsurers have in relation to other reinsurers, for the purposes of acceptance of reinsurance contracts – whether automatic or facultative – provided that the local reinsurer accepts the respective reinsurance offer under the conditions identical to those offered and/or accepted by the international market.

If unfair practices are identified in the performance of the preferential offer – including, but not limited to, unequal treatment of the reinsurers consulted or any changes to the contractual terms and conditions offered, with the issue of endorsements that distort the final contractual terms and conditions of the placement – the reinsurance contract will be disregarded for

prudential purposes, without prejudice to other applicable penalties.

Another main provision is the requirement that a risk transfer policy be developed and implemented by insurance companies and that local reinsurers properly manage their reinsurance and retrocession operations.

The risk transfer policy, unlike the sustainability policy, should complement the risk management policy, under the terms of the specific regulations governing the internal controls system, the risk management system and the internal audit activity, and should be aligned with its underwriting policy.

For the purposes of developing this risk transfer policy, insurance companies and local reinsurers should establish, without prejudice to the requirements determined in the specific regulation that provides for the internal controls systems, the risk management system and the internal audit activity. This should comprise at least the following:

- the objectives of the risk transfer policy adopted;
- the technical criteria used in the preparation of reinsurance and/or retrocession programmes, with due grounds for the protection structures adopted;
- the acceptable risk exposure limits;
- mechanisms aimed at guaranteeing the compatibility of the limits of exposure to risks with the business strategy of the insurance company or local reinsurer, as the case may be;
- the criteria for selecting and monitoring counterparties and intermediaries, including the management of credit and liquidity risks;
- the procedures for the monitoring, analysis and treatment of high levels of concentration with counterparties and intermediaries;
- the procedures for the monitoring, analysis and treatment of the transfer of risks with linked companies, under the terms of the regulations in force;
- the management of the accumulation of risks in relation to a determined product, line of business or group of lines of business, geographical region and/or a single insured party;
- the management of the accumulation of individual losses that may result from catastrophic events and spiralling risks;
- forms of control and monitoring aimed at mitigating risks inherent to the mismatch of terms and conditions of reinsurance and/or retrocession contracts and the underlying contracts; and
- the operating procedures and systems aimed at the internal control of operations and risk management, ensuring compliance with the risk transfer policy.

The Resolution also provides for some restrictions, including the fact that local reinsurers may not cede in retrocession more than 70% of the premiums written for the risks they have underwritten, considering the totality of their operations, in each calendar year, except for the following groups of lines of business:

- financial risks;
- rural; and
- nuclear.

If, however, this percentage is higher than 90%, considering the totality of their operations, per calendar year, the insurance companies should submit to SUSEP a technical justification for this percentage of reinsurance cession, which SUSEP may authorise depending on this justi-

fication. If the justification is not deemed sufficient by SUSEP, the cedent will be subject to penalties.

Another important restriction is the fact that reinsurance operations concerning life insurance with survival benefit, and complementary pensions, are exclusive to local reinsurers. However, reinsurance operations relating to risk coverages marketed in life insurance plans with survival benefit, or to complementary pension plans – separately or together with survival coverages – are not subject to the restriction provided for in this Resolution.

With regard to reinsurance contracts, the following provisions need to be followed or stipulated:

- the beginning and end of the rights and obligations of each party, also foreseeing how these responsibilities will cease in cases of cancellation;
- the criteria for cancellation;
- the risks covered and the risks excluded;
- the coverage period, identifying the beginning of the reinsurer's liability and the exact moment in which the losses are covered by the contract;
- reinsurance contracts aimed at protecting risks located in Brazil should include a clause determining the submission of any disputes to Brazilian legislation and jurisdiction, except in the case of an arbitration clause, which should comply with the legislation in force;
- the participation of the reinsurer in the adjustment of claims may be provided for, as well as the provision in reinsurance contracts of a claims control clause, without prejudice to the liability of the insurer towards the insured; and
- the contractual formalisation of reinsurance operations will take place within 180 days from the beginning of the validity period of the cover, under penalty of it being null and void, for all prudential purposes and effects, from its inception.

Furthermore, an important clause was included in Resolution No 451/2022 which clearly states that risk transfer in reinsurance and retrocession operations, with reinsurers not authorised to operate in Brazil, will be permitted exclusively when the insufficiency of capacity by local and foreign reinsurers is proven, regardless of the prices and conditions offered by all such reinsurers.

For this, the situation of insufficiency of capacity should be proven by means of consultation carried out with all reinsurers authorised to operate in Brazil, in accordance with the criteria established by SUSEP.

With regard to risk transfers in reinsurance by insurance companies and in retrocession by local reinsurers, exclusively related to nuclear risk operations, the insufficiency of capacity referred to in this article is characterised by the lack of registration in Brazil of foreign reinsurers specialised in nuclear risks under the terms of the regulation in force. That is, in the event of partial acceptance of risk by any reinsurers authorised to operate in Brazil, only the remaining portion of the risk not covered may be ceded to reinsurers not authorised to operate in Brazil.

However, the Resolution makes a caveat that SUSEP may, in exceptional circumstances, authorise the transfer of risks with reinsurers not authorised to operate in Brazil (which do not comply with the requirements provided for in the legislation in force nor with the provisions of the Resolution) for technically justifiable reasons which aim to safeguard national interest or secu-

rity, and may establish additional requirements to those provided for in specific regulations.

Acceptance of reinsurance or retrocession of a cedent abroad by a local reinsurer may be made through direct negotiation with the cedent abroad, through a reinsurance broker headquartered in Brazil, or an intermediary abroad. The acceptance of retrocession by insurance companies is permitted, including that arising from reinsurers headquartered abroad not registered in Brazil, though it is forbidden for insurance companies to accept reinsurance from insurers, whether registered in Brazil or not and headquartered abroad.

It is important to note that local reinsurers may only accept reinsurance or retrocession contracts, and insurance companies may only accept retrocession contracts from foreign cedents related to the groups of lines of business in which they are authorised to operate in Brazil, without prejudice to the observance of the current rules regarding retention limits. Local reinsurers may accept reinsurance or retrocession from cedents abroad in lines of business, or groups of lines of business, with which there is no direct correlation in Brazil, provided that the risks covered have technical characteristics similar to the risks of groups of lines of business in which they are authorised to operate in Brazil.

With regard to foreign currency operations, the contracting of insurance in foreign currency in Brazil – characterised by the establishment of amounts of insured capital/maximum limit of indemnity in foreign currency – may be effected through agreement between the insurance company and the insured, unless otherwise specifically regulated. Reinsurance and retrocession may also be contracted in foreign currency in Brazil.

When the insured capital/maximum limit of indemnity is established in foreign currency, the following is applicable.

- The corresponding premium may be paid in foreign currency or in Brazilian currency, and converted on the contracting date, as established in the contractual conditions.
- The payment of indemnification may be made, as established in the contractual conditions, in foreign currency or in Brazilian currency, with the value converted and monetarily restated, under the terms of the specific legislation, based on:
  - (a) the date of the effective payment made by the insured, in the case of coverage that provides for reimbursement of expenses; or
  - (b) the date of the occurrence of the event, for the purposes of determining the insured capital/maximum limit of indemnity, in the case of coverage that provides for the payment of indemnification in cash.
- The insurance contractual documents must stipulate the insured capital/maximum limit of indemnity defined in foreign currency.

Finally, regarding insurance abroad, the contracting by individuals resident in Brazil or by corporate entities domiciled in Brazil is restricted to the following situations:

- coverage of risks for which there is no insurance offer in Brazil, provided that the contracting thereof does not represent an infringement of the legislation in force;
- coverage of risks abroad in which the insured is an individual resident in Brazil, for which the validity of the contracted insurance is limited, exclusively, to the period in which the insured is abroad;

- insurance that is the object of international agreements endorsed by the Brazilian National Congress; or
- hull, machinery and liability insurance by Brazilian shipping companies for their own or chartered vessels, under the terms set out in Section 2, Article 11 of Law 9.432, 8 January 1997.

In view of this, it can be seen that SUSEP and the CNSP have been working towards defining what can and cannot be done in Brazil to better provide a scope of performance of services for the Brazilian market.

RPZ Advogados has a wide range of experience dealing with matters related to geological episodes, dam ruptures, fires, explosions, machine breakdowns, business interruptions, plane crashes, navigation accidents, cyber-attacks, engineering risks, class actions, judicial and sanctioning administrative proceedings, criminal investigations and inquiries, professional errors, default of contracts in the public and private sectors, and environmental damages, among others. Over the past few years, the firm has worked on some of the most complex claims that have occurred in Brazil and abroad, always acting in the interest of national and foreign insurers and reinsurers. The firm has offices in the cities of Rio de Janeiro and São Paulo and works in accordance with the best market practices in data processing, in compliance with Brazilian and European legislation. Its team comprises 12 lawyers with extensive expertise developed over years of (re)insurance practice at national and international levels.

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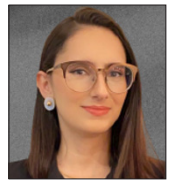

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CAYMAN ISLANDS

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The sources of insurance and reinsurance law in the Cayman Islands primarily comprise the Insurance Act 2010 (the "Insurance Act") and the regulations made thereunder. The Insurance Act came into force on 1 November 2012, enhancing the previous legislation and reflecting developments in international standards and global industry, as well as facilitating the development of insurance and reinsurance-linked securities business. The regulations made under the Insurance Act relate primarily to licensing applications and fees, capital and solvency, portfolio insurance companies and reporting. The Cayman Islands has a combined common law and statute-based legal system. Although the Cayman Islands has its own body of case law, English case law is also of persuasive authority and may often be cited in court.

The Cayman Islands market includes insurers and reinsurers of domestic and non-domestic risk. The Cayman Islands is the leading jurisdiction for healthcare captives, representing almost a third of all captives. As of 30 September 2022, medical malpractice liability continues to be the largest primary line of business, with workers' compensation the second largest. In the past two years, captives and reinsurers are increasingly licensing to offer long-term insurance, including life, life annuity and pension risk transfer. In addition, the ratio of commercial insurers being licensed in the Cayman Islands has been increasing in the past three years compared to the licensing of traditional captives.

Around 90% of the risks insured by the Cayman Islands international insurance industry are in North America. The next most important geographical source is the Caribbean and Latin America, collectively. Perhaps unsurprisingly, therefore, the Cayman Islands has not sought equivalency with the EU Solvency II framework to date, and the US National Association of Insurance Commissioners model continues to be regarded as more favourable. Moreover, Cayman Islands legislation does provide (re)insurers with flexibility to implement their own internal capital model.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

The Insurance Act strengthened the supervisory powers of the Cayman Islands Monetary Authority (CIMA). CIMA regulates the insurance sector in accordance with the Insurance Act and regulations, together with the rules, statements of guidance, policies and procedures issued by CIMA. When issuing rules, guidance, policies and procedures, CIMA seeks to adopt standards recommended by the Insurance Core Principles issued by the International Association of Insurance Supervisors (IAIS). The policies and procedures to be followed by CIMA itself, when performing its regulatory functions, are set out in its regulatory handbook.

Insurers, insurance managers, insurance agents and insurance brokers are subject to the Cayman Islands AML Regulations (2020 Revision). Along with all other key financial sector jurisdictions, the Cayman Islands has implemented the US Foreign Account Tax Compliance Act (FATCA) and the OECD's Common Reporting Standard (CRS) – pursuant to which, certain insurers writ-

ing cash value insurance or annuity contracts are regarded as financial institutions and therefore face resulting reporting and other obligations.

Although not specifically insurance or reinsurance-related, there are legal obligations that may have an impact on the insurance and reinsurance sector (among others).

The Cayman Islands is a member of the OECD's Inclusive Framework on Base Erosion and Profit Shifting (BEPS), which brings together more than 100 jurisdictions to collaborate on the implementation of the OECD BEPS package.

The Tax Information Authority (International Tax Compliance) (Country-by-Country Reporting) Regulations 2017 were gazetted on 15 December 2017 to implement BEPS Action 13, namely Country-by-Country Reporting, in the Cayman Islands. These regulations only apply to multinational enterprise (MNE) groups with consolidated group revenue of USD850 million or more during the previous fiscal year. Groups with consolidated group revenue of less than USD850 million are excluded. However, Cayman Islands resident entities that are constituent entities of MNE groups are required to take certain steps to comply.

As part of its BEPS compliance, the Cayman Islands has introduced the International Tax Co-operation (Economic Substance) Act (2021 Revision) (the "ES Act") in response to requirements for geographically mobile activities to have economic substance. Under the ES Act, a "relevant entity" that is carrying on "insurance business" is required to maintain economic substance in the Cayman Islands and file annual notifications and reports. Such entities have been required to comply with the ES Act since 1 July 2019.

The Cayman Islands Data Protection Act (2021 Revision) (DPA) came into force in September 2019. International financial sector businesses will find many similarities between the DPA and the data protection laws of other jurisdictions where they are active. The DPA requires a data controller to comply with eight data protection principles when processing personal data and to ensure that those principles are complied with in relation to personal data processed on the data controller's behalf pursuant to a written contract. The DPA also deals with data security, data breaches and the rights of individual data subjects, including providing a privacy notice.

Types of Insurance and Reinsurance Licences in the Cayman Islands

Any person carrying on insurance business, reinsurance business or business as an insurance agent, insurance broker or insurance manager (collectively, "Regulated Business") in or from the Cayman Islands is required to hold a valid licence issued for that purpose under the Insurance Act. As set out in further detail later, domestic insurers offer insurance to Cayman Islands residents and businesses under a class A licence. The non-domestic market comprises both insurers that insure non-domestic risks under a class B licence and insurance-linked securities structures under a class C licence. Reinsurers offer reinsurance products for domestic or foreign risks under a class D licence.

The Cayman Islands is an established jurisdiction for licensing insurance and reinsurance business. There were a total of 765 insurance licensees under the supervision of CIMA in 2021, 686 of which related to the international insurance market. There were 25 insurers licensed to offer their products in the domestic market, supported by 79 insurance intermediaries.

There were a total of 668 class B, C and D insurers and reinsurers as of 30 September 2022. Pure captives and segregated portfolios represented the two main categories, with 278 (42%) and 149 (22%) companies respectively.

The Cayman Islands is gaining traction as the jurisdiction of choice for class D reinsurers specialising in the longevity risk and pension risk transfer sector. The number of class D reinsurance licences has doubled in recent times, taking the total of class D licensees to six. With the investment management search for permanent capital and the private equity houses seeking to allocate capital, and Cayman Islands being a customary choice of domicile for these sectors, more of these legal entities and transactions are being established and transacted in the Cayman Islands.

2.2 The Writing of Insurance and Reinsurance

Any person carrying on regulated business in or from the Cayman Islands is required to hold a valid licence issued for that purpose under the Insurance Act. A person or entity who contravenes this requirement commits an offence and is liable on summary conviction to a fine of KYD100,000 or imprisonment for a term of five years, or to both.

In addition, pursuant to the Monetary Authority Act (2020 Revision) and the Monetary Authority (Administrative Fines) Regulations (2019 Revision) (as amended by the Monetary Authority (Administrative Fines) (Amendment) Regulations 2020), CIMA has the power to impose additional fines for breaches of a number of regulatory laws, including the Insurance Act. A person carrying on regulated business without holding a valid licence under the Insurance Act, in particular, would be categorised as a "very serious" breach (in relation to which, CIMA has the discretion to impose a fine of up to KYD100,000 on an individual in breach and up to KYD1 million on a body corporate in breach).

A person wishing to carry on regulated business in or from within the Cayman Islands shall make an application in writing to CIMA for a licence under one or more of the following categories.

- Class A insurer licence -for carrying on domestic insurance business by a local insurer or external insurer, or limited reinsurance business as approved by CIMA.
- A class B insurer licence, -for the carrying on of insurance business other than domestic business in respect of which:
  - (a) at least 95% of the net premiums written will originate from the insurer's related business;
  - (b) more than 50% of the net premiums written will originate from the insurer's related business; or
  - (c) 50% or less of the net premiums written will originate from the insurer's related business.
- Class C insurer licence – for the carrying on of insurance business involving the provision of reinsurance arrangements in which the insurance obligations of the class C insurer are limited in recourse to and collateralised by the class C insurer's funding sources or the proceeds of such funding sources, which include the issuance of bonds or other instruments, contracts for differences, and such other funding mechanisms approved by CIMA.
- Class D insurer licence – for the carrying on of reinsurance business and such other business as may be approved in respect of any individual licence by CIMA.

- Insurance agent licence – for the soliciting of domestic business on behalf of not more than one general insurer and one long-term insurer.
- Insurance broker licence – for arranging or procuring, directly or through representatives, insurance or reinsurance contracts (or the continuance of such contracts) on behalf of existing or prospective policyholders.
- Insurance manager licence – for providing insurance expertise to, or for, class B insurers or class C insurers.

Requirements for Licence Applications

An application for a licence under the Insurance Act must contain prescribed information and be accompanied by a business plan and an application fee, which is dependent on the licence applied for. CIMA may approve an application for a licence subject to such conditions as CIMA determines for the proper operation and supervision of the licensee. A licensee must carry on business only in accordance with the information provided in its licence application and business plan. The business plan should contain details of the reasons for the business to establish an operation in the Cayman Islands, as well as the short and long-term objectives and how these will be achieved. The applicant must be able to demonstrate that it has adequate resources – in terms of manpower, systems and expertise – to meet its objectives. Further detailed guidance on the contents of business plans is available and depends on the type of licence required.

To satisfy CIMA's licensing requirements, an applicant is required to ensure that:

- the persons carrying on the business to which the application relates are fit and proper to be directors, managers or officers in their respective positions;
- it is able to comply with the Insurance Act and the AML Regulations (2020 Revision), as applicable;
- the grant of a licence will not be against the public interest of the Cayman Islands;
- it has personnel with the necessary skills, knowledge and experience, and such facilities, books and records as CIMA considers appropriate for the nature and scale of the business;
- the structure of its insurance group, if any, will not hinder effective supervision; and
- its capital complies with the prescribed level.

In terms of ownership, the names, addresses, nationalities and percentages of shareholdings of all shareholders must be provided to CIMA at the time of licensing. If the shares are held by a body corporate, details of ultimate beneficial ownership and the chain of connection must be provided. CIMA will request additional information in respect of any shareholder, whether a body corporate or an individual, holding more than 10% of the company's issued capital or total voting rights. For an individual shareholder, the additional information will include a completed personal questionnaire and supporting documents.

CIMA will also require details of an applicant's management, including a completed personal questionnaire and supporting documents for each person who is to be – or is currently performing the function of – a director, officer or manager. CIMA will use the evidence provided to assess whether such persons are fit and proper to perform the relevant function based on this information.

In terms of capital and solvency requirements, every applicant is required to comply with the prescribed level of capital requirements under

the Insurance Act. The prescribed capital and solvency requirements for each category of licence are set out in the relevant regulations made thereunder. CIMA reserves the power to prescribe a higher level of capital based on risk factors specific to the applicant and can exclude from the calculations assets that it deems inappropriate.

Annual and Ongoing Requirements

Every licensee is required to comply with annual and ongoing requirements. Every licensee is required to pay the prescribed annual fee on or before January 15th every year after the first grant of its licence. The annual licence fee varies depending on the class of licence and is currently equal to the application fee for each class of licence. A licensee that fails to pay the prescribed annual fee on time may be subject to penalty fees.

Subject to any waiver, an annual audit must be carried out in accordance with internationally recognised accounting standards by an independent auditor approved by CIMA. It is normally required that local auditors be appointed.

The annual reporting requirements of a licensee vary depending on the type of licence that it holds. Each licensee will be required to complete and submit to CIMA a prescribed form together with a number of documents, including audited financial statements.

Licensees are subject to ongoing conduct of business requirements, including in relation to outsourcing, corporate governance, internal controls, record-keeping, cybersecurity, market conduct, reinsurance arrangements and business continuity. Ongoing prudential requirements include capital adequacy, and investment and risk management. All licensees must have in place compliance and procedural manuals and internal controls to ensure effective management and compliance. Any changes to a licensee's business plan must be notified to CIMA.

Generally, licensees are Cayman Islands incorporated companies or exempted companies, as discussed further in **3.1 Overseas-Based Insurers or Reinsurers**. However, two forms of company are particularly relevant and useful for certain types of insurance and reinsurance business. A segregated portfolio company (SPC) is a single legal entity divided into an unlimited number of portfolios – the assets and liabilities of which are legally segregated from each other. The Insurance Act permits SPCs to register subsidiary companies as portfolio insurance companies (PICs) with CIMA. A PIC of a licensed SPC may write insurance business without the need for a separate insurance licence. PICs have the express power to contract with the parent SPC, any segregated portfolio of the parent SPC and any other PIC related to the parent SPC. Each PIC is a separate legal entity from the SPC and any other PIC. This facilitates the drafting of legal documentation, as each entity is a distinct legal person.

2.3 The Taxation of Premium

No income, capital gains, corporation or insurance premium taxes as such are payable in the Cayman Islands. However, government fees in the form of stamp duties are payable under the Stamp Duty Act (2019 Revision) on:

- each new or renewed domestic general (not life) insurance policy in the amount of KYD12; and
- each new or renewed property insurance policy in the amount of 2% of the premium of such a policy.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

The requirement to obtain a licence under the Insurance Act to conduct regulated business applies only in so far as the business is being conducted in or from within the Cayman Islands.

Only a person incorporated under the Companies Act (2021 Revision) (the "Companies Act") may be an insurance broker, insurance manager, a "local" class A insurer or a class D insurer. However, it is also possible to be licensed as an "external" class A insurer, meaning an insurer that is not a local class A insurer and whose principal or registered office is in a jurisdiction outside the Cayman Islands where the legislation for the regulation and supervision of insurers is acceptable to CIMA. A licensee that is an insurance broker, an insurance manager, a class A insurer or a class D insurer must have a place of business in the Cayman Islands.

Only a person incorporated as an exempted company under the Companies Act with at least two directors may be licensed as a class B insurer or a class C insurer. An exempted company is one whose founding shareholder has signed a declaration that it will carry on business mainly outside the Cayman Islands. Unless it permanently maintains a place of business in the Cayman Islands approved by CIMA, a class B or class C insurer must appoint an insurance manager and maintain full and proper records of the class B or class C insurer at the insurance manager's place of business or at another location approved by CIMA.

3.2 Fronting

Fronting is permitted in the Cayman Islands.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

M&A do occur regularly but such activity is not high, as existing owners are often established businesses or families with little reason to sell.

The issuance or transfer of shares of more than 10% of an insurer or reinsurer requires the prior approval of CIMA. In assessing the application, CIMA will evaluate factors including:

- the fitness and propriety of the proposed shareholder(s) and relevant directors, senior officers and managers;
- the proposed shareholder's sources of funds;
- CIMA's ability to supervise the proposed group structure; and
- the ability of the foreign regulator to conduct consolidated supervision of the group that will include the Cayman Islands insurer or reinsurer if the acquiring entity is regulated as a financial services provider in a foreign jurisdiction.

CIMA will also consider whether any proposed business plan changes are sound and feasible, and whether the interests of policyholders, investors, clients, creditors or the public would be negatively impacted by the proposed acquisition or merger.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Insurers within the domestic market offer their products directly as well as through intermediaries, namely insurance brokers and insurance agents (see **6.3 Intermediary Involvement in an**

Insurance Contract). Intermediaries range from individuals to large international firms. Intermediaries can operate as enterprises, or divisions of insurers or other financial institutions (including banks), or as part of non-financial organisations.

CIMA expects all licensees to demonstrate a high level of responsibility in the marketing of all their services.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Contracts of insurance are based upon the principle of utmost good faith. The general principles of English insurance common law regarding non-disclosure and misrepresentation have been followed in the Cayman Islands. Thus, each contracting party is obliged to disclose all circumstances material to the risk to the other contracting party.

An insured will therefore generally be under a positive duty to disclose to the insurer all circumstances material to the risk that is to be insured, regardless of whether the insurer has specifically asked about those matters. Circumstances are material for these purposes if they would influence the judgement of a prudent insurer in determining the premium or whether to insure the risk at all. Any failure to make such disclosure could provide grounds for the insurer to void the contract.

6.2 Failure to Comply With Obligations of an Insurance Contract

When an insurer has entered into a contract of insurance that relied on a misrepresentation by the insured, or where the insured has failed to disclose a material fact that – if disclosed – would have led the insurer to enter into the contract upon different terms or not enter into the contract at all, the insurer may have the right to rescind the contract. The insurer may also have a claim for damages against the insured where it has suffered loss due to misrepresentation or non-disclosure by the insured.

6.3 Intermediary Involvement in an Insurance Contract

Intermediaries fall into two categories in the Cayman Islands. An insurance broker means a holder of a valid insurance broker licence for arranging or procuring – directly or through representatives – insurance or reinsurance contracts (or the continuance of such contracts) on behalf of existing or prospective policyholders. An insurance agent means a holder of a valid insurance agent licence for the soliciting of domestic business on behalf of not more than one general insurer and one long-term insurer.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

Consistent with English common law, contracts under Cayman Islands law do not need to be in writing. In practice, policies are issued in writing and – for the purposes of regulatory policy – documentation must be available for inspection by CIMA and meet certain requirements. There is no statutory requirement for insurable interest in Cayman Islands law, although English common law may be taken to imply a requirement for insurance interest in all types of indemnity insurance. Before or at the time of signing the contract, the customer must be provided with a range of prescribed written information, including in relation to the insurer, any intermediaries, the product, and claim and complaints procedures. In addition, certain commissions and any conflicts of interest must be disclosed.

6.5 Multiple Insured or Potential Beneficiaries

The position is no different where there are multiple insureds.

Pursuant to the Contracts (Rights for Third Parties) Act 2014 (the "Third Parties Act"), a third party may enforce a term of an insurance or reinsurance contract governed by Cayman Islands law in its own right if:

- the third party is expressly identified in the contract by name, as a member of a class or as answering a particular description, which includes a person nominated or otherwise identified pursuant to the terms of the contract (however, the third party need not be in existence when the contract is entered into); and
- the contract expressly provides in writing that it may.

If a third party is to be granted rights under a contract, the parties to that contract should remember to consider such third-party rights if they wish to rescind or amend the contract (unless there is an express term in the contract that provides that the contract may be rescinded or varied without the consent of the third party).

Any third party granted rights under a contract pursuant to the Third Parties Act will be subject to any remedy that would have been available to that third party for breach of contract if the third party had been a party to the contract. If a contractual term excludes or limits liability in relation to any matter, the relevant exclusion or limitation of liability will also apply to the third party.

6.6 Consumer Contracts or Reinsurance Contracts

The position is no different with regard to consumer contracts or reinsurance contracts.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

There has been an increase in ART products such as insurance-linked securities. As mentioned in **2.2 The Writing of Insurance and Reinsurance**, the class C licence was introduced for the provision of reinsurance arrangements in which the insurance obligations of the class C insurer are limited in recourse to – and collateralised by – the class C insurer's funding sources or the proceeds of such funding sources. This includes the issuance of bonds or other instruments, contracts for difference, and such other funding mechanisms approved by CIMA that facilitate ART. In recognition of their particular model, class C insurers are subject to a different level of regulatory oversight and may be able to obtain audit waivers in certain circumstances.

The Cayman Islands is experiencing an increased interest in the establishment of class C vehicles that facilitate the transacting of derivative swaps for pension risk transfer arrangements.

7.2 Foreign ART Transactions

See **7.1 ART Transactions**.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are subject to the same approach to construction and interpretation as

other contracts, apart from where a term already has a settled, judicially accepted meaning. Additionally, the Insurance Act outlines certain requirements and considerations that need to be observed when approaching the entry into, enforcement of and interpretation of insurance contracts, including:

- the invalidity of terms within insurance contracts relating to domestic insurance business that attempt to oust the jurisdiction of the courts of the Cayman Islands;
- the validity of contracts involving parties that fail to operate with the requisite insurance licences;
- the requirement to arbitrate differences or disputes relating to an insurance contract that relates to domestic insurance business; and
- the regulation of agreements between insurance brokers and insurers.

The courts of the Cayman Islands have also given specific guidance on the following matters relating to insurance contracts:

- factors to be considered in ascertaining the jurisdiction with which a contract of insurance has closest connection;
- the law with which a contract of insurance has closest connection;
- the degree of probability required for insurers to prove claims are fraudulent;
- how ambiguities in insurance policies are to be construed;
- the duty of parties to an insurance contract to disclose any material information voluntarily before entry into an insurance contract, the standard of the duty, and how the materiality of the information is assessed; and
- the importance of complying with widely recognised insurance industry standards and the consequences of non-compliance.

When interpreting the terms of an insurance contract or determining evidential matters in relation to bona fide legal relations between the parties (such as the parties' subjective intentions, explanations and subsequent conduct), the Grand Court of the Cayman Islands (the "Grand Court") – which is a superior court of record – is entitled to analyse the transaction and is not restricted to merely considering the transaction itself. This may include the examination of external evidence, including the parties' explanations and circumstantial evidence (such as evidence of the subsequent conduct of the parties). Although there is no dedicated consumer protection regime in the Cayman Islands, the Grand Court has held that ambiguities arising from the interpretation of insurance policies are to be construed in favour of the policyholder.

8.2 Warranties

As mentioned in **6.1 Obligations of the Insured and** Insurer, insurance contracts are based on utmost good faith. Warranties in an insurance contract may be expressly made or implied, but are materially of greater importance than in other forms of contracts. Warranties in insurance contracts must be complied with. If not observed, a breach of warranty in an insurance contract – regardless of triviality or absence of any loss suffered – may discharge an insurer from all liability under the policy or may entitle the policyholder to avoid the contract.

8.3 Conditions Precedent

A condition precedent in an insurance contract need not be titled as such, but will be so construed if expressly made (unless the term is used indiscriminately). Depending on the seriousness of the breach, breach of a condition precedent may, for example, entitle an insurer to refuse payment under the policy without treating the policy as discharged.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

The mechanism for dispute resolution will be determined by the applicable terms of the insurance or reinsurance contract and whether the contract relates to foreign or domestic insurance business.

However, where a dispute arises in connection with a contract of domestic insurance business and there is no valid arbitration agreement in place between the parties, they are required to agree to the appointment of one arbitrator for the adjudication of the dispute. Where the parties are unable to agree on a choice of arbitrator, CIMA will appoint an arbitrator on the parties' behalf, who will conduct the arbitration pursuant to the Arbitration Act 2012 (the "Arbitration Act"). The position is no different in relation to consumer contracts or reinsurance contracts.

Limitation periods in the Cayman Islands are imposed by statute, particularly the Limitation Act (1996 Revision) (the "Limitation Act"), which generally prescribes the relevant time limits within which a claimant may bring proceedings for various types of claims. In an insurance context, if the claimant wishes to bring a claim against the other party on the basis that they breached a term of the insurance policy or on the basis that the insurer unreasonably denied an insurance claim brought under the insurance policy, these claims would be subject to a limitation period of:

- six years from the date on which the claim accrued if the insurance contract was executed as a simple contract; and
- 12 years if the contract was executed under seal or as a deed.

Separately, if there are findings that a party has paid premiums to an insurer with the intent to defraud a creditor, the creditor may commence proceedings subject to the six-year limitation period provided for in the Fraudulent Dispositions Act (1996 Revision). However, the enforcement of any judgment resulting from that claim shall be permitted against the proceeds outside of any limitation period.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

The Insurance Act provides that every contract of domestic business shall be subject to the jurisdiction of the courts of the Cayman Islands, notwithstanding any provision to the contrary contained in the contract or in any agreement related to the contract.

Disputes concerning choice of law and those relating to insurance business conducted outside the Cayman Islands are addressed pursuant to Cayman Islands jurisprudence and English conflict of law principles that have been adopted in the Cayman Islands. There are no applicable international conventions in this respect.

9.3 Litigation Process

Civil proceedings in the Cayman Islands are commenced before the Grand Court. The Grand Court possesses and exercises a similar jurisdiction as that exercised in England by His Majesty's High Court of Justice and its divisional courts. Additionally, the Grand Court has the power to make binding declarations of right in any matter, whether or not any consequential relief is - or could be - claimed.

Civil Procedure in the Grand Court is governed by the Grand Court Rules 1995 (as amended) (GCR), which closely follow the former Rules of the Supreme Court of England and Wales as

they were prior to the introduction of the Civil Procedure Rules in 1999. The GCR lays down procedural requirements that have to be complied with at each stage of civil litigation, such as:

- the method of commencing civil proceedings ("originating process");
- the issuance, service and acknowledgment of service of the originating process;
- formal requirements of pleadings;
- applications for interlocutory relief in advance of the determination of substantive issues;
- disclosure obligations;
- trial; and
- costs of the parties.

Any proceeding commenced in relation to an exempted insurer – such as an action by or against its directors, insurance manager or auditor, or any action for breach of a contract of insurance (including an application for a declaration) where the amount claimed exceeds KYD1 million – is deemed a "financial services proceeding" and is allocated to the specialist Financial Services Division (FSD) of the Grand Court (one of the five divisions of the Grand Court). FSD proceedings attract fixed fees of KYD5,000 for the commencement of proceedings, are assigned to specific commercial judges, and have specific procedural guidelines. As a result, hearings in the FSD are generally fast-tracked and thus heard within six to eight weeks of the closing of pleadings in the ordinary course of business.

Civil actions that do not fall within the aforementioned scope of financial services proceedings are allocated to the Civil Division of the Grand Court, which typically deals with civil cases on a more general basis. No specific judges are immediately assigned to cases in the Civil Division, although judges retain the discretion to direct that they be "seized" of any particular case. In addition to attracting certain fixed fees, proceedings commenced in the Civil Division endorsed with a claim for a debt or liquidated demand attract ad valorem fees of:

- 1% of the principal sum claimed in excess of KYD10,000;
- 0.5% of the principal sum claimed in excess of KYD100,000; and
- 0.25% of the principal sum claimed in excess of KYD1 million.

9.4 The Enforcement of Judgments

Foreign judgments have no direct operation in the Cayman Islands, so they cannot directly be enforced by execution. However, certain foreign judgments may be enforced pursuant to Cayman Islands statutory or common law rules.

There is a specific procedure for registering judgments by the superior courts of Australia and its external territories for the purposes of their enforcement under the Foreign Judgments Reciprocal Enforcement Act (1996 Revision). Otherwise, foreign judgments outside Australia and its external territories can only be enforced pursuant to common law.

A party seeking to enforce a foreign judgment pursuant to common law must commence an action in the Cayman Islands on the foreign judgment. The action must be brought in the FSD. Subject to certain exceptions, a foreign judgment may be enforced pursuant to Cayman Islands common law if all of the following conditions apply:

- the judgment is a determination of the existence of rights against a person (in personam) rather than over property (in rem);

- the foreign court had jurisdiction over the party against whom the plaintiff is attempting to enforce the judgment;
- the judgment is not impeachable under the relevant common law rules; and
- the judgment is final and conclusive (notwithstanding that it may be subject to an appeal in the foreign courts).

In most cases, it is then possible to apply for summary or default judgment on the grounds that the defendant has no defence to the claim. Provided the aforementioned conditions are met, the judgment procedure will be quicker and more straightforward than the procedure for a claim that must be brought on its merits.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses contained in commercial insurance and reinsurance contracts are readily enforced. Furthermore, unless otherwise agreed by the parties, the Grand Court may – on the application of a party to the arbitration proceedings who has given notice to the other parties – determine any question of law arising during the proceedings that the Grand Court is satisfied substantially affects the rights of one or more of the parties. Any application made to the Grand Court pursuant to the Arbitration Act will be heard in the FSD.

9.6 The Enforcement of Awards

An award made by an arbitral tribunal may, with leave of the Grand Court, be enforced in the same manner as a judgment or order of the Grand Court to the same effect and, where leave is so given, judgment may be entered in terms of the award.

Foreign arbitral awards have no direct operation in the Cayman Islands and so, for example, they cannot directly be enforced by execution. However, previously, awards made in states that are party to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the "New York Convention") could be enforced within the Cayman Islands (as the Cayman Islands is a party to the New York Convention). Following the enactment of the Arbitration Act in July 2012, that jurisdiction was significantly extended so that arbitral awards from any foreign state may be enforced pursuant to Cayman Islands statute – irrespective of whether or not the New York Convention is engaged.

9.7 Alternative Dispute Resolution

See the previous sections.

9.8 Penalties for Late Payment of Claims

Pursuant to the Insurance Act, where CIMA is of the opinion that an insurance licensee (i) is committing, or about to commit, an act that is an unsafe or unsound practice when conducting the business of the licensee, or (ii) is pursuing, or about to pursue, a course of conduct that is an unsafe or unsound practice in conducting the business of the licensee, CIMA may direct the licensee – in relation to a policy, a line of business or the entire business of the licensee – to cease or refrain from committing the act or pursuing the course of conduct and to perform such acts that (in the opinion of CIMA) are necessary to remedy or ameliorate the situation.

A person who, without reasonable cause, fails to comply with such direction given by CIMA commits an offence and is liable to:

- a fine of KYD100,000 or to imprisonment for a term of five years (or both) on summary conviction; and

- a fine of KYD500,000 or to imprisonment for a term of ten years (or both) if on conviction on indictment.

Furthermore, if the offence of which the person is convicted continues after conviction, they commit a further offence and are liable to a fine of KYD10,000 for every day on which the offence is so continued.

Additionally, CIMA has broad powers to take regulatory enforcement action, which it may exercise without notice on an urgent basis, where appropriate. Such actions include:

- suspension of the licence of a licensee;
- revocation of the licence of a licensee;
- the imposition or amendment of conditions or further conditions on a licence or registration;
- requiring the substitution of a director, operator, senior officer, general partner, promoter, insurance manager or shareholder of a licensee or registrant (as applicable);
- appointing a person to assume control of the affairs of a licensee or registrant;
- appointing a person to advise a licensee or registrant on the proper conduct of its affairs; and
- in serious cases, applying to the Grand Court for an order directing that the company be wound up.

9.9 Insurers' Rights of Subrogation

The English common law on subrogation is of persuasive authority and would likely be cited in, and applied by, the courts of the Cayman Islands.

10. Insurtech

10.1 Insurtech Developments

Although the game-changing qualities of insurtech have been recognised as an important part of the discussion on the development of the insurance industry in the Cayman Islands, the authors are not aware of any specific and material insurtech initiatives or developments by local regulators.

However, in order to facilitate the emergence of insurtech initiatives and the development of insurtech products and other fintech-related ventures, the Cayman Islands government has previously announced an intention to introduce an adaptable, technology-neutral, regulatory sandbox-type framework that will facilitate and promote innovative applications of technology.

10.2 Regulatory Response

Please see **10.1 Insurtech Developments**.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Emerging risks that affect the Cayman Islands are similar to those in other key financial sector jurisdictions as described earlier. In addition, CIMA has stated in a Supervisory Information Circular issued in July 2022 that climate risk and ESG risks are material risks for the insurance sector, owing to the direct impact on insurability of policyholders' assets as well as insurer's operations, investment objectives and reputation. As such, CIMA urges insurers to better understand the impact of these risks in their risk management and corporate governance frameworks in

order to manage and mitigate these risks more effectively.

11.2 New Products or Alternative Solutions

As discussed **7. Alternative Risk Transfer (ART)**, the class C licence regulatory regime has facilitated an increase in ART products such as insurance-linked securities. There is an increasing focus on transactions that provide innovative solutions to the transfer of longevity risk. The Cayman Islands is also the natural domicile for insurers and reinsurers affiliated with investment funds, given its status as the leading private equity and hedge funds domicile.

As an international insurance centre, the Cayman Islands has experienced significant growth. Stability, a sophisticated legal system and regulatory regime, and appropriate implementation of international standards are all factors in making the Cayman Islands even more popular.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

In February 2022, CIMA introduced a new "Rule and Statement of Guidance on the Investment Activities of Insurers" following industry consultation. These new regulatory measures provide minimum requirements and guidance for insurers with regard to their investment strategies and activities. They aim to ensure assets are managed in a sound and prudent manner consistent with the risk profile and liquidity needs of the insurer. Among other things, insurers will be required to submit an investment policy for CIMA's approval and have an adequate system of internal controls to ensure insurers appropriately supervise their investment activities and manage their assets in accordance with the investment policy. Insurers have until 28 February 2023 to implement these new requirements.

The Insurance Act was amended with effect on 28 June 2022 to introduce capital redemption contracts (also known as funding agreements). Capital redemption contracts are issued by insurers under which they may:

- receive and accumulate sums of money;
- pay a sum or sums of money; or
- render money's worth on dates and in amounts not contingent on human life or against risks of the insured person.

These contracts will be regulated by CIMA and included in the definitions of "contract of insurance", "contract of reinsurance" and "long-term business".

In 2022, CIMA consulted on the following proposed measures:

- expanding its current Rule on Corporate Governance for Insurers to all regulated entities and updating the related statement of guidance;
- consolidating requirements in the current 2007 Rule on Internal Controls and sector-specific guidance for internal controls into one combined rule and statement of guidance for all regulated entities; and
- introducing new obligations to remain consistent with revised international frameworks.

In addition, on 16 December 2022, CIMA issued a consultation for comments by 1 February 2023 on its proposed Rules and Statement of Guidance on Reinsurance Arrangements. This is a re-consultation in response to the magnitude of

revisions and following industry feedback on the November 2021 consultation.

These consultations have not been completed.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

CIMA plans to hold forthcoming consultations in the first half of 2023 with regard to:

- updating its procedure for approvals and notifications; and
- changes to take into account more complex transactions and provide more flexibility.

Walkers is a leading international law firm with ten offices, located in Bermuda, the British Virgin Islands, the Cayman Islands, Dubai, Guernsey, Hong Kong, Ireland, Jersey, London and Singapore. Walkers' Cayman Islands (re)insurance team has six partners and seven other qualified lawyers. Of the Cayman Islands law firms, only Walkers has sizeable offices in the three principal (re)insurance jurisdictions: the Cayman Islands, Ireland and Bermuda. The (re) insurance team regularly works with the finance and corporate, insolvency and dispute resolution, and regulatory and risk practices to offer a full suite of legal services for the (re)insurance market. Key practice areas are alternative capital solutions, captives and direct insurers, distressed insurance, finance, general corporate, longevity/mortality, pension risk transfer, M&A, regulatory risk advisory, outsourcing, reinsurance, secured lending, tax and alternative exchange of information.

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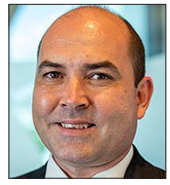

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CHILE

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The insurance and reinsurance legal framework is constructed from various regulations and laws, as follows.

- Title VIII of Book II of the Code of Commerce, *About Insurance in General and in Particular about Non-marine Insurance* (Article 512 et seq).
- Title VII of Book III of the Code of Commerce, *About Marine Insurance* (Article 1158 et seq).
- The Insurance Companies Act (DFL 251), which regulates insurance companies.
- Supreme Decree 1055-2013, which establishes regulation of auxiliaries to the trading of insurance and procedures for loss adjustment.
- Resolutions issued by the Chilean regulator, the Commission for the Financial Market (CMF). This also includes the previous resolutions issued by its predecessor, the Securities and Insurance Superintendency (SVS).
- General provisions relating to the interpretation of contracts found in the Civil Code (Articles 1560 et seq).

Since Chilean law and practice follows a civil law system, precedent and court rulings are generally not mandatory. Strictly speaking, each ruling or award only relates to the subject matter of the case. Nonetheless, the criteria established by Chilean higher courts (the Courts of Appeal and the Supreme Court) and their judgments are usually followed.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

In Chile, insurance and reinsurance companies, local insurance and reinsurance brokers, and loss adjusters are mainly regulated by the CMF.

2.2 The Writing of Insurance and Reinsurance

Who is Entitled to Write Insurance and Reinsurance Business?

Insurance and reinsurance companies can be stock corporations incorporated in Chile, as long as they provide only these services and complementary activities as authorised by the CMF through rules of general application, and comply with the special regulations established in Title XIII of the Chilean Corporations Act (companies subject to special regulations).

The selling of insurance in Chile can be undertaken by a general insurance company (first group) or a life insurance company (second group). The former covers the risk of loss or damage of goods, or patrimony. Life insurance companies, on the other hand, cover risks of persons or guarantee them within or on termination of a certain term, capital, paid-off policy or rent for the insured party or its beneficiaries. Exceptionally, personal risk and health may be covered by both types of company. Risks related to credit can be insured only by general insurance companies having the sole purpose of covering this type of risk, which could also cover surety and fidelity.

Notwithstanding this, foreign insurers that are incorporated abroad may commercialise and sell direct insurance cover in Chile relating to international marine transportation, international

commercial aviation and cargo in international transit and satellites.

In addition, companies incorporated abroad are allowed to establish branch offices in Chile. These branch offices are subject to the general procedure provided by the Chilean Corporations Act for the incorporation of agencies of foreign companies and must obtain authorisation from the CMF (as per Titles XI and XIII of the Chilean Corporations Act). In addition, the branch offices must prove to the CMF that they comply with all requirements established for the authorisation of insurance companies, and must follow further publication and registration formalities.

Reinsurance of contracts subscribed to in Chile is contracted by insurance and reinsurance companies with the following entities:

- national corporations whose exclusive scope of business is reinsurance;
- national insurance companies that can only reinsure risks from the group they are authorised to operate in; and
- foreign reinsurance entities that are classified by two different risk classification agencies approved by the CMF, and ranked at least within the BBB risk category or its equivalent.

Reinsurance can be provided by the aforementioned foreign reinsurance entities either directly or through reinsurance brokers registered in the Registry of Foreign Reinsurance Brokers, which is managed by the CMF.

No different rules apply to the underwriting of excess layers or to reinsurance contracts.

Product Regulation

Insurance and reinsurance companies must word their contracts using the models of policies and clauses contained in the Register of Policies of the CMF. Exceptionally, they may use non-registered models where they relate to general insurance, where the insured or the beneficiary are legal entities, and where the annual premium is higher than 200 Chilean UF (an indexed unit of account) (eg, in case of large risks). In addition, non-registered models can also be used for cargo, transport, marine or aircraft hulls, or related insurance.

Areas of compulsory insurance cover in Chile include:

- motor liability;
- employers' liability for occupational accidents and diseases; and
- brokers' errors and omissions.

In addition, Decree-Law 3500 of 1980, which regulates the Chilean pension system, also establishes a compulsory insurance in connection with, inter alia, disability and social security life annuities to be contracted jointly by all companies authorised to manage the covering pension funds.

Standards That an Insurer Must Satisfy

The minimum capital of a Chilean insurance company must be 90,000 Chilean UF. In the case of Chilean reinsurance companies, this is 120,000 Chilean UF for any of the authorised groups in which they may operate.

To meet the obligations of underwriting insurance and reinsurance business, Chilean-regulated insurers and reinsurers must establish technical reserves in accordance with the current principles, procedures, mortality charts, interest rates and other technical parameters within the time limit and in the format established by the CMF through general rules.

2.3 The Taxation of Premium

Generally, if the insurance is contracted in Chile, its premium is subject to a 19% value-added tax (VAT). If the insurance is contracted abroad (due to the insured's decision), then the premium is subject to a 22% withholding tax and exempted from VAT. Reinsurance is subject to a 2% withholding tax.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Anyone is free to take out insurance in Chile. Except for compulsory insurance, taking out insurance abroad is not forbidden, but insured parties are subject to the legislation governing international charges and taxation.

3.2 Fronting

Foreign insurers cannot sell insurance directly in Chile (exceptionally, they can do so in connection with international marine transportation, international commercial aviation and cargo in international transit).

Fronting is not expressly defined under Chilean law; however, the foregoing is an accepted practice, notwithstanding the fact that the cedant company will always remain as the responsible party to pay the indemnity to the insured under the local policy. Direct actions of the insured against the reinsurer are not valid unless otherwise agreed in the reinsurance contract or as per an assignment of rights after the loss from the reinsured to the insured. In this respect, under Chilean regulations the insurer cannot postpone the payment of the indemnity to the insured due to the existence of a reinsurance contract.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

The transfer of business or portfolios and mergers or divisions of insurance entities requires special authorisation from the CMF, and must be carried out in conformity with the general rules established by it for this purpose. In any case, the insureds must be informed, and the conditions of the transfer may not encumber their rights or modify their guarantees.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Insurance products must be sold mainly in accordance with the CMF regulations and the Consumer Protection Act.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Under Chilean law, the main obligation of the insurer is to pay the indemnity, provided that there is coverage. The insured is subject to the following obligations:

- sincerely stating all circumstances required by the insurer to identify the insured object and risks;
- reporting about other insurances covering the same object, if required by the insurer;
- paying the premium in the agreed manner and term;
- acting as the diligent head of family for preventing a loss (in the case of an imminent loss, the insurer must reimburse the expenses

reasonably incurred by the insured to comply with this obligation);
- not aggravating the risk, and informing the insurer in a timely manner about circumstances that may constitute an aggravation;
- adopting all measures to save the insured object or keep its remains (the insurer must reimburse the expenses reasonably incurred by the insured to comply with this obligation);
- notifying a loss to the insurer as soon as feasible upon knowledge of the occurrence of any circumstance that may constitute a loss; and
- establishing the occurrence of the loss and sincerely stating, with no reticence, its circumstances and consequences.

As regards the insurer's obligation to reimburse per the fourth and sixth point above, such reimbursement cannot exceed the insured amount.

Chilean law recognises the concept of utmost good faith, and the insured must respond to an insurer's request for information about a risk by honestly disclosing the information requested, to allow insurers to identify the object of the insurance and assess the nature of the risk. For these purposes, it suffices that the insured reports exclusively as per the insurer's request.

6.2 Failure to Comply With Obligations of an Insurance Contract

As regards the insurer's obligation to sincerely state all circumstances required by the insurer to identify the insured object and risks, if the insured incurs errors, reticence or inaccuracies before a loss in connection with information requested by the insurer and which are determinant for the insured risk, the insurer can rescind the contract.

In addition, if the insured provides information that is false, the insurer can avoid the policy and return the premium. The insured must also disclose circumstances that increase the risk during the policy period.

That said, if the insurer fails to request information at the placement stage, the insurer may not then allege any errors, reticence or inaccuracies by the insured, as well as those facts or circumstances that are not included in the request for information.

6.3 Intermediary Involvement in an Insurance Contract

Intermediaries and the Role of the Broker

Among others, Chilean law regulates the activities of insurance and reinsurance brokers, and loss adjusters. Their main licensing requirements can be summarised as follows.

Insurance brokers

Insurance brokers are defined as natural persons or legal entities who have been registered as such with the CMF and who act as independent intermediaries in the contracting of insurance policies with any insurer.

Reinsurance brokers

Reinsurance brokers are subject to specific rules contained in SVS General Rule No 139/2002. In general, they must be registered in the Registry of Reinsurance Brokers kept by the CMF and comply with the following requirements.

- They cannot be registered as insurance brokers.
- They must establish a liability insurance policy for no less than 20,000 Chilean UF or one third of the premium intermediated in the immediately preceding year, whichever is

higher (the policy must not be subject to any deductibles).
- Foreign reinsurance brokers must be legal entities, and must certify that they have been legally incorporated abroad and are entitled to intermediate risks ceded from abroad. In addition, foreign reinsurance brokers must designate an attorney with a broad range of faculties to act on their behalf in Chile, including the power to serve and be served with court proceedings.

Loss adjusters

Unlike in many jurisdictions, in Chile the loss adjuster is appointed to act as an impartial claims specialist and must be licensed and supervised by the CMF. The loss adjuster's role is to investigate and review the circumstances of the loss or damage, and to report on the validity of the policy coverage in respect of the claim. The loss adjuster's report is released to both the insured and to the insurer.

Agencies and contracting

As regards agency issues, brokers are also subject to the general agency provisions of both the Civil Code and the Commercial Code.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

Under Chilean insurance law, an insurance contract is defined as an agreement whereby one or more risks are transferred to an insurer, in exchange for a premium, who becomes obliged to indemnify the damage suffered by the insured or to satisfy capital, income or other agreed provisions.

The essential ingredients of an insurance contract are thus:

- the insured risk;
- the insurance premium; and
- the insurer's conditional obligation to indemnify.

The absence of any of these ingredients renders the contract void.

Insurance policies must contain the following basic provisions and information:

- the identity of the insurer, insured and beneficiary (if applicable);
- the insured subject matter;
- the insurable interests;
- the risks taken by the insurer;
- the policy period;
- the insured amount;
- the value of the insured subject matter;
- the premium;
- the policy date and the insurer's signature; and
- the insured's signature when mandatory by law.

In addition, Chilean law defines reinsurance as an agreement whereby the reinsurer undertakes to indemnify the reinsured within the limits and modalities set forth in the agreement, for liability affecting its patrimony as a consequence of the obligations it has undertaken in one or more insurance or reinsurance contracts. When construing the will of the parties, Chilean law considers international reinsurance practice.

Reinsurance is subject to the principle of freedom of contract with a few mandatory restrictions, such as the fact that it cannot alter the terms of the insurance contract and that the insurer cannot delay payment of the indemnity due to the reinsurance.

Direct actions of the insured against the reinsurer are not valid unless otherwise agreed in the reinsurance contract or as per an assignment of rights after the loss from the reinsured to the insured.

6.5 Multiple Insured or Potential Beneficiaries

Under Chilean law, beneficiaries are defined as those parties who are not the insured but who have the right to indemnity in the case of a loss. Where the insurance policy includes a beneficiary, it must specify their identity or how their identity may be determined.

6.6 Consumer Contracts or Reinsurance Contracts

As stated in **2.2 The Writing of Insurance and Reinsurance**, insurance companies must word their contracts using the models of policies and clauses in the CMF's Register of Policies. The Register of Policies is meant to be a publicly available deposit which concentrates the contents of the insurance policies, forms and clauses available in the market as approved by the CMF.

Exceptionally, insurers may use non-registered models where these relate to general insurance, where the insured or the beneficiary are a legal entity, and where the annual premium is higher than 200 Chilean UF (for larger risks). In addition, non-registered models may also be used for cargo, transport, marine or aircraft hulls, or related insurances.

As previously stated, reinsurance is subject to the principle of freedom of contract, with a few mandatory restrictions.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

ART transactions are not regulated in Chile.

7.2 Foreign ART Transactions

See **7.1 ART Transactions**.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

As discussed in **1.1 Sources of Insurance and Reinsurance Law**, insurance and reinsurance contracts are subject not only to the Code of Commerce, but also to the general provisions relating to the interpretation of contracts in the Civil Code (Article 1560 et seq) and certain provisions contained in DFL 251.

The Chilean position on insurance and reinsurance contracts can be broadly summarised as follows.

- The provisions of Chilean insurance law are in general mandatory, unless stated to the contrary. However, if a clause is deemed to provide an insured with a greater benefit than is provided under the law generally, the specific terms of a policy will prevail over the Code of Commerce.
- Chilean law considers it of paramount importance to determine the intentions of the parties at the time of contracting and to give effect to those intentions even if they are not reflected in the literal words of the contract.
- A Chilean tribunal will strive to facilitate clauses in contracts with the goal of ensuring that the parties' intentions are fulfilled. Actions can

include amending the contract if no provision is made for a given state of affairs.
- Under Chilean law, it is permissible for a tribunal to ascertain the parties' intention by looking outside the contract at, for example, the negotiations between the parties and market practice at the date of contracting.
- In construing the intention of the parties to a reinsurance contract, Chilean law will consider international reinsurance practice.

Under Chilean regulations, insurers must ensure that the contracted policies are drafted in a clear and understandable fashion. Where there is doubt regarding the meaning of a provision when using model policies or clauses registered with the CMF (see **2.2 The Writing of Insurance and Reinsurance**), the interpretation that is more favourable to the insured prevails.

8.2 Warranties

Under Chilean law, insurance warranties are defined as "the requirements aiming to confine or decrease the risk, which are stipulated in the insurance contract as conditions that must be met to allow payment of an indemnity after a loss."

8.3 Conditions Precedent

In Chile, conditions precedent are not regulated. However, the insurer or reinsurer can achieve similar effects if they are treated as essential conditions of the contract, which are defined by the Chilean Civil Code as those without which the contract does not produce effects at all or degenerates into a different contract.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Under Chilean law, there is no strict need for dispute resolution clauses as insurance disputes are subject by default to arbitration. Nevertheless, an insured has the right to make a claim in the local courts where the sum in dispute is less than 10,000 Chilean UF. In this respect, the arbitrator must be appointed when the dispute arises.

As regards limitation periods for starting proceedings in respect of (re)insurance claims, under Chilean law the general principle is that any action relating to non-marine (re)insurance is time-barred after four years. Marine (re)insurance disputes are time-barred after two years.

As stated in **6.5 Multiple Insured or Potential Beneficiaires**, the insurance policy must identity beneficiaries or contain the mechanism to determine them. Other third parties may enforce an insurance through assignment of rights, as per Chilean regulations.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

According to Article 29 of the Insurance Companies Act (DFL 251), any dispute arising from insurance and reinsurance contracts governed by the law shall come under the jurisdiction of the Chilean courts. This rule is mandatory and cannot be repealed by agreement of the parties. Therefore, although there is contractual freedom to agree on the applicable law, any dispute must be settled in principle in the Chilean courts.

Nevertheless, once a reinsurance dispute effectively arises, the parties to the reinsurance policy are entitled to resolve disputes under Chile's international commercial arbitration rules (Law

19971, which is based on the UNCITRAL Model Law on International Commercial Arbitration).

9.3 Litigation Process

Stages of Litigation

Generally, in Chile, civil and commercial disputes at first instance comprise three main phases:

- discussion (exchange of pleadings);
- evidence; and
- judgment.

Unless remedies are waived, the right of appeal arises when the decision of the inferior tribunal causes grievance to one or more parties (there are no specific causes). The appeal remedy is available for most first-instance court rulings and is usually heard by a court of appeal. The appeal remedy must comply with basic form requirements. The regular term for appealing is five days but, in the case of final decisions, the period is ten days counted as of the service of the decision. Depending on the subject of the trial and the type of decision appealed, the processing of an appeal can take up to two years.

There is only one appeal stage, and the second-instance tribunal is allowed to review both factual and legal issues. Nonetheless, it is possible to challenge the decision of a second-instance tribunal through exceptional remedies such as cassation (these remedies are heard by the Supreme Court).

Evidence

There are no discovery obligations in Chile, but the parties are free to submit evidence based on documents, witnesses, parties' confessions, inspections ordered by the court, expert reports and presumptions.

In insurance and reinsurance disputes, ordinary and arbitration courts are entitled to the following specific faculties relating to evidence issues:

- at the request of a party, to accept additional means of proof to those pointed out above;
- to decree evidentiary measures ex officio at any stage of the trial;
- to request recognition of documents and deal with objections; and
- to assess evidence under the "sane critic" doctrine.

Costs

Except for minor expenses associated with service, paperwork and auxiliary officers, there are no court fees payable in Chile. Lawyer fees can be recoverable, but only if the judge rules that there was no reasonable basis to litigate. Arbitrators fix their fees in accordance with the parties.

9.4 The Enforcement of Judgments

Enforcement of Foreign Judgments and Arbitral Awards

Foreign judgments and arbitral awards are enforced through a process called exequatur. This process is contemplated in the Civil Procedure Code under which judgments issued in a foreign country shall be given force in Chile by existing treaties. For their enforcement, the procedures set out in Chilean law shall be followed unless they have been modified by such treaties. If there are no treaties related to the matter, Chile shall grant to the judgment the same force granted to Chilean judgments by the jurisdiction in which the judgment was made. Where the judgment comes from a jurisdiction that does not enforce Chilean judgments, it shall not be enforced in Chile.

If none of the previous rules may be applied, foreign judgments shall be enforced in Chile provided that:

- they contain nothing contrary to the laws of the Republic of Chile, though procedural rules to which the case would have been subject to in Chile shall not be considered;
- they are not contrary to national jurisdiction;
- the party against whom enforcement is sought was duly served with process, though such party may still be able to allege that for other reasons it was prevented from making a defence; and
- they are not subject to appeals or further review in the country of origin.

A duly legalised copy of the judgment – officially translated into Spanish, if necessary – must be presented to the Chilean Supreme Court to begin the exequatur process. In the case of an arbitral award, its authenticity must also be certified by attestation of a high court of the originating jurisdiction.

Notice of the enforcement request must be served on the party against whom it is sought. Such party shall have 15 days (which may be extended depending on where the party is domiciled) to respond. An opinion from an independent court official is also requested by the Supreme Court.

The Supreme Court entertains the matter in a hearing at which the parties may make oral statements.

After enforcement is allowed, the judgment must be presented to the competent civil court to commence an executive proceeding (by which the defendant's assets can be foreclosed, if applicable).

For arbitral awards, a law on international commercial arbitration – based on the UNCITRAL Model Law – was passed in 2004. Its Article 35 regulates the recognition and enforcement of foreign arbitral awards. Article 36 lists the defences that can be asserted against enforcement, and regulates orders of stay. Chile is also a party to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards. In this respect, Chilean courts have enforced all foreign arbitral awards that comply with the rules set out in the law regarding enforcement.

9.5 The Enforcement of Arbitration Clauses

As stated in **9.1 Insurance Disputes over Coverage**, insurance disputes are generally subject to arbitration. Also, as stated in **9.2 Insurance Disputes over Jurisdiction and Choice of Law**, any dispute arising from insurance and reinsurance contracts governed by the Insurance Companies Act (DFL 251) must come under the jurisdiction of the Chilean courts. However, once a reinsurance dispute effectively arises, the parties to the reinsurance policy are entitled to resolve disputes under Chile's international commercial arbitration rules.

9.6 The Enforcement of Awards

As described in **9.4 The Enforcement of Judgments**, arbitral awards are enforced in the same way as court judgments.

9.7 Alternative Dispute Resolution

Apart from arbitration, there are no other industry-specific settlement mechanisms in Chile, and ADR is not much used in the context of insurance disputes.

Mediation is not compulsory. However, prior to entering the evidence stage, Chilean courts are obliged to call for a conciliation hearing whose

main aim is to help the parties achieve settlement. Courts and arbitrators may be more active in their approach to searching for amicable settlement, depending on the circumstances.

9.8 Penalties for Late Payment of Claims

Generally speaking, punitive damages are not contemplated under Chilean law.

However, as regards settlement of losses, Supreme Decree 1055-2013 (which establishes regulations for local insurance brokers and loss adjusters) states that upon receipt of the final adjustment report on both liability and quantum for the loss, the insured and insurer have ten days to object, failing which the parties are taken to have accepted the adjustment.

If objections are made to the final loss-adjustment report, the adjuster thereafter has six days to respond, and the response is sent to both insured and insurer simultaneously.

In the case of insurance referred to under the second paragraph of Article 542 of the Chilean Code of Commerce (concerning damage insurance), the time limits for responding are increased to 20 days (objection to the final report) and 12 days (response from the adjuster), respectively.

The insurer is required to notify the insured within five days of the completion of the adjustment process on its final decision on the claim. The loss or undisputed sum must be paid within six days for registered contracts (ie, those contracts registered with the CMF and that are normally standard form). However, this period can be extended where the insurance is a non-registered contract.

9.9 Insurers' Rights of Subrogation

Article 534 of the Chilean Code of Commerce states that upon payment (whether partial or total) of the indemnity under the insurance contract, the insurer automatically subrogates all the insured's rights and actions against third parties responsible for the loss. Strictly speaking, no assignment of rights is required, provided evidence of the payment is submitted.

10. Insurtech

10.1 Insurtech Developments

Chile recently enacted a law providing the first regulatory framework for fintechs. Among others, the so-called Fintech Law modified the Chilean Insurance Act (DFL 251) to expressly allow parametric insurance, which implies that on the occurrence of a risk or adverse event stipulated in the insurance contract, indemnity can be paid without the insured having to justify the existence or amount of the damages, even if they are not finally materialised. Under this modality, the factors and risks must be demonstrable and clearly measurable through objective procedures, and the risk must be insured according to the general insurance rules.

10.2 Regulatory Response

The CMF has yet to issue further guidelines on parametric insurance.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Supreme Decree 1055-2013 includes two provisions specifically aimed at catastrophe losses, as follows:

- the CMF can extend the adjustment period up to 180 days; and
- where there is more than one loss notified at a condominium each insurer shall appoint only one adjuster.

In addition, the CMF has adopted a strategy to address climate change in financial markets, advanced to the global forefront of disclosure, and is working to develop comprehensive supervision of issuers, with a view to financial materiality. In this respect, the CMF issued NCG No 461-2021, which implies disclosure of sustainability and corporate governance aspects (ESG) for issuers of publicly offered securities and other audited companies – ie, banks, insurance companies, AGFs, stock exchanges, among others.

11.2 New Products or Alternative Solutions

See **11.1 Emerging Risks Affecting the Insurance Market**.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Given the magnitude of the economic and human shock resulting from the spread of COVID-19 in the country, the CMF was constantly monitoring its effects on the financial market and the entities under its supervision, working in close co-ordination with the Ministry of Finance, the Central Bank and other international regulators.

During the pandemic, the CMF analysed the best alternatives to mitigate the impact of the economic shock to the financial system.

The CMF reinforced its commitment to safeguard the stability of the Chilean financial system and to continue protecting investors, policyholders, and depositors, exercising its regulatory and supervisory roles in order to safeguard the solvency and liquidity of the audited institutions.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

In June 2021, a Bill on Compulsory Individual Health Insurance, COVID-19 (Law 21,342) was enacted. This is an insurance that employers must provide to those workers in the private sector who are carrying out face-to-face functions, in whole or in part, while the COVID-19 health alert is in force.

This system allows, in a centralised way, for verification of the contracting and validity of COVID-19 insurance. Information contained in the consulted database is provided by (and is the responsibility of) the insurance companies.

In addition, there is a bill under discussion to reform the Chilean Reorganisation Act (Law 20,720), which seeks to modify and modernise bankruptcy processes.

JJR Abogados y Corresponsales Ltda (JJR) is a Chilean law firm based in Santiago city and connected to the global world. JJR provides a complete range of legal services with particular focus on complex matters and cases, and in practice areas that require a high degree of specialisation, such as international transactions, international trade, maritime law, insurance and reinsurance, telecommunications, media and technology, litigation and dispute resolution. JJR's insurance and reinsurance practice incorporates vast experience on complex cases and in-depth knowledge on these issues. The firm aims at providing sound legal and practical advice with a clear commercial approach, and JJR has earned a significant reputation for its work on behalf of the London and worldwide reinsurance markets. Among others, the firm specialises in mining, energy and construction, political risks, earthquakes, liability, general reinsurance, insurance and reinsurance brokers' liability, drafting of insurance terms and conditions, advice in connection to Chilean compulsory adjustment procedures and regulatory work. JJR's experience includes resolving major litigation and arbitration cases.

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CHINA

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Sources of insurance and reinsurance law include the Insurance Law, the judicial explanations issued by the Supreme People's Court, and rules and guidelines issued by the China Banking and Insurance Regulatory Commission (CBIRC).

Although China is not a common law country, the guiding judicial cases of the people's courts, especially the Supreme People's Court, could be taken as reference in other cases held before the courts.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Insurance and reinsurance companies in China are subject to the regulatory supervision of the CBIRC as of 2018, after the combination and reorganisation of the former China Banking Regulatory Commission and China Insurance Regulatory Commission. Main legislation includes the Insurance Law and other rules as indicated in **1.1 Sources of Insurance and Reinsurance Law**.

2.2 The Writing of Insurance and Reinsurance

Both qualified Chinese domestic insurance companies and foreign-invested insurance companies may write insurance and reinsurance business.

Chinese domestic insurance companies, where the shareholdings of all foreign investors are no more than 25% (according to the Insurance Law, amended in 2015), must have registered capital of no less than CNY200 million. For foreign-invested insurance companies, according to the newly revised Administrative Regulations of the People's Republic of China on Foreign-funded Insurance Companies (Amended in 2019), their foreign shareholders must have a total capital of no less than USD5 billion.

Different types of insurers, such as life insurers, property and casualty insurers, reinsurers, foreign-funded insurers and domestic insurers, are subject to different detailed rules under the Insurance Law.

For instance, life insurance companies must comply with the rules and regulations promulgated by the CBIRC, including:

- the Administrative Measures for the Disclosure of Information on Personal Insurance Products;
- the Provisions on Basic Services for Life Insurance Business;
- the Administrative Measures for the Telemarketing Business of Personal Insurance Products;
- the Administrative Provisions on Authenticity Management of Personal Insurance Customer Information; and
- the Administrative Provisions on Insurance Terms and Insurance Rates of Life Insurance Companies.

A property and casualty insurance company must comply with rules and regulations including:

- the Measures for Graded Disposal of Property Insurance Disasters and Accidents;
- the Administrative Measures for the Insurance Clauses and Insurance Rates of Property Insurance Companies; and
- the Guidelines on Development of Insurance Products by Property Insurance Companies.

Reinsurers should comply with rules and regulations that include:

- the Administrative Provisions on Reinsurance Business; and
- the Provisions on the Establishment of Reinsurance Companies.

Foreign investment insurance companies are subject to, inter alia:

- the Administrative Regulations on Foreign-funded Insurance Companies; and
- the Implementation Rules for the Regulations of the People's Republic of China on Foreign-funded Insurance Companies (Amended in 2021).

The writing of insurance contracts is regulated by the Insurance Law of the People's Republic of China (PRC) and related rules. Article 18 of the Insurance Law specifies the required items of an insurance contract, including:

- the insurer;
- the policyholder;
- the insured party;
- the beneficiary of a life insurance;
- the subject matter of insurance;
- insurance liabilities; and
- exclusion of liability.

Article 19 of the Insurance Law provides certain circumstances under which the clauses in an insurance contract may be deemed invalid.

Certain insurance clauses and premium rates of insurance policies which relate to social and public interests, mandatory insurance, newly developed insurance policies of life insurance, etc, should be subject to the approval of the CBIRC. Other types of insurance policies should be filed with the insurance regulatory authorities, for their records. Detailed rules include:

- the "Negative List" for Life Insurance Products (2021 edition);
- the Notice of the CBIRC General Office on Launching the Special Campaign to Regulate the Chaos in the Personal Insurance Market;
- the Guidelines on Development of Insurance Products by Property Insurance Companies (2016); and
- the Administrative Methods on Insurance Contract Terms and Insurance Rates of Life Insurance Companies (Amended in 2015).

2.3 The Taxation of Premium

Premium will be subject to value-added tax (VAT) with the applicable rate of 6% and other related ancillary taxes, including urban maintenance and construction tax, and education surcharges. Stamp duty may also apply for property and casualty insurance contracts. Insurance and reinsurance companies will also generally be subject to enterprise income tax of 25% in respect of their profits.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

An overseas-based insurer or reinsurer that has not completed the registration process within China cannot directly write business in China. However, such a foreign insurance company could write reinsurance of a Chinese domestic insurer.

3.2 Fronting

Fronting is not expressly permitted. According to Articles 19 and 21 of the Administrative Provisions on the Reinsurance Business (2021), except for aviation and spaceflight insurance, nuclear insurance, oil insurance and credit insurance, where a direct insurance company cedes out a direct insurance business for property insurance by means of proportional reinsurance, for each risk unit the total proportion ceded by it to the same reinsurer must not exceed 80% of the insured amount or the limit of liability under the direct insurance contract undertaken by the cedant.

Additionally, an insurer that carries out an overseas ceding business must establish a monitoring system for such business, analyse the credit risks and liquidity risks of the reinsurance business ceded overseas every half-year, and propose countermeasures in a timely manner so as to ensure the safety of reinsurance transactions. The analysis report must be reviewed and confirmed by the general manager of the company and must be properly kept.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

China has been, and continues to be, a fundamental driving force of mergers and acquisitions (M&A) activity in the insurance sector in Asia. This is both from the perspective of inbound foreign investment looking to buy into a share of the ever-growing premiums in China, and from outbound investment as Chinese insurers look to acquire regional businesses.

For Chinese domestic insurance companies, pursuant to the Administrative Measures on Equity of Insurance Companies (2018), shareholders of Chinese domestic insurance companies are classified into four categories, as follows:

- financial Type I shareholders;
- financial Type II shareholders;
- strategic shareholders; and
- controlling shareholders.

Each are subject to further specific requirements. For instance, controlling shareholders (holding one third or more of the shares or having a controlling impact) must have total assets of not less than CNY10 billion, net assets of the most recent year of not less than 30% of the total assets, and satisfy certain other requirements. The Administrative Measures on Equity of Insurance Companies also provide that the shareholding of a single shareholder must not exceed one third of the registered capital of the insurance company.

As regards foreign-funded insurance companies, China is actively encouraging foreign investment into the Chinese insurance sector, evidenced by a series of relaxation legislation and policies

issued by the authorities. Foreign investments into any life/non-life insurance sectors, insurance asset management sectors and insurance intermediary sectors are no longer subject to any foreign ownership restrictions, though regulatory approvals/filings and qualifications are still required. The foreign ownership restriction for life insurance companies in China was officially lifted by the CBIRC with effect from 1 January 2020 (having been brought forward from 2021).

Qualification requirements imposed on foreign investors have also largely been removed or amended to speed up foreign investment in the Chinese insurance sector. Highlights include removing the qualification requirements on foreign investors, which required a track record of having engaged in the insurance business for at least 30 years and having established an insurance representative office for at least two years.

Further, qualified foreign financial institutions and insurance groups, not limited to foreign insurance companies, are now permitted to invest in insurance companies in China.

In addition, specific requirements imposed on branches set up by a foreign-invested insurance company (insurance FIE) have been removed. Insurance FIEs are now subject to the same treatment as domestic insurance companies for branch opening.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The main distributors of insurance and reinsurance, and their products, include agents, brokers, bancassurance, direct sales, and internet sales.

Insurance agents, including professional insurance agencies, concurrent-business agencies and individual agents, are regulated by the Regulatory Provisions on Insurance Agency Persons promulgated by the CBIRC, effective from 12 November 2020. National professional insurance agencies should have a paid-in registered capital of at least CNY50 million and provincial capital of at least CNY20 million, subject to the approval of the CBIRC.

Insurance brokers are regulated by the Regulatory Provisions on Insurance Brokerages (2018). National professional insurance brokers should have a paid-in registered capital of at least CNY50 million and provincial capital of at least CNY10 million, subject to the approval of the CBIRC.

Bancassurance is regulated by the Administrative Measures on Insurance Agency Business of Commercial Banks (2019).

In addition, there are specific rules regarding distance selling or online sales of insurance, such as the Administrative Measures for the Telemarketing Business of Personal Insurance Products, and the Interim Measures for the Regulation of Internet Insurance Businesses (2015).

In the case of online insurance sales, the head office of an insurance company must establish a uniform and centralised business platform and process flow, to conduct a centralised operation and uniform management of its internet insurance business. No employees of an insurance company may develop an internet insurance business in their own name.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

When concluding an insurance contract, the insurance applicant must make an honest disclosure when the insurer enquires about the subject matter insured or relevant circumstances concerning the insured. The insurer shall have the right to rescind the insurance contract if the applicant fails, intentionally or through gross negligence, to perform their obligation to make an honest disclosure, thereby materially affecting the decision of the insurer about whether to provide the insurance or whether to increase the premium rate.

The insurer should take the initiative to seek information relevant to the conclusion of the insurance contract as the insured is obliged to disclose information only when inquired of by the insurer. For those clauses in the insurance contract that exempt the insurer from liability, the insurer must provide sufficient warning and explanations to the insurance applicant regarding those clauses in the insurance contract.

These rules are generally the same for consumer contracts and commercial contracts.

6.2 Failure to Comply With Obligations of an Insurance Contract

If an insurance applicant intentionally fails to perform their obligation to make an honest disclosure, the insurer shall bear no insurance liability in respect of the insured incident occurring prior to the rescission of the contract, and the paid premiums are not refundable.

If an applicant fails to perform their obligation to make an honest disclosure out of gross negligence, which has a material effect on the occurrence of an incident covered by the insurance, the insurer shall, with respect to the incidents occurring prior to the rescission of the contract, bear no insurance liability, but must return the paid premiums.

If an insurer enters into an insurance contract with an applicant knowing that the applicant has failed to disclose a material fact, the insurer may not rescind the contract. If an insured incident occurs, the insurer shall bear the insurance liability.

6.3 Intermediary Involvement in an Insurance Contract

Insurance intermediaries include insurance brokerage companies, insurance agencies and insurance assessment institutions.

Insurance brokers provide intermediary services to insurance applicants and insurance companies to execute insurance contracts based on the interests of insurance applicants. An insurance agency is authorised by an insurance company to conduct insurance business on its behalf.

An insurance assessment institution refers to an institution that accepts entrustment and specialises in such business as assessment, inspection, appraisal and loss adjustment of the subject matter insured, and insured accidents. Such institution receives remuneration as agreed.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

The insurance contract is generally in writing and the insurer must issue an insurance policy, an insurance contract or any other insurance certificate to the insurance applicant in a timely manner.

The insured should have an insurable interest. A life insurance policyholder shall, at the conclusion of the insurance contract, have insurance interests in the insured party.

The subject matter of insurance for a life insurance policy is the life expectancy and physical body of a human being.

An insured party in a property insurance policy shall, at the time of occurrence of an insured event, have insurance interests in the subject matter of insurance. The subject matter of insurance of a property insurance policy is the property and its relevant interests.

Pursuant to Article 18 of the Insurance Law, an insurance contract must contain the following content:

- the name and address of the insurer;
- the names and addresses of the insurance applicant and the insured, and the name and address of the beneficiary in the case of life insurance;
- the scope of insured matters;
- insurance liability and liability exemption;
- the period of insurance and commencement date of insurance liability;
- the amount insured;
- the premium and payment method;
- the method for paying indemnity or insurance benefits;
- liabilities for breaches of contract and the dispute resolution method; and
- the date of the conclusion of the contract.

The insurance applicant and the insurer may agree upon other particulars related to insurance in the insurance contract.

6.5 Multiple Insured or Potential Beneficiaries

In a life insurance contract, a beneficiary is generally designated by the insured party or the policyholder to have the right to make insurance claims, and may sometimes also be referred to in property and casualty contracts. The policyholder or the insured party may be the beneficiary.

The beneficiary of a life insurance policy must be designated by the insured party or the policyholder. The appointment of a beneficiary by a policyholder shall be subject to consent of the insured party. A policyholder who enters into a life insurance contract for their employees may not designate any person other than the insured party and their immediate relatives as the beneficiary. Where an insured is a person without capacity or with limited capacity for civil conduct, their guardian may designate the beneficiary.

6.6 Consumer Contracts or Reinsurance Contracts

There are policyholder protection schemes in China as regards consumer contracts. The explanation of standard clauses in an insurance contract shall be preferential to the policyholder or the insured in the case of any differing understanding of such clauses.

For reinsurance contracts, according to Article 29 of the Insurance Law, the insured party or the beneficiary of the original insurance policy may not directly make a claim for compensation or payment of insurance monies from the reinsurer.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

China promulgated the Administrative Measures on Insurance Protection Funds in 2008 (recently amended in 2022), and established the China Insurance Security Fund Company in 2008 for providing relief to policyholders and companies, and for disposing of insurance industry risks.

The former China Insurance Regulatory Commission promulgated the Mutual Insurance Organisation Regulatory Interim Methods in 2015 to govern and regulate the development of mutual insurance organisations. In 2020, the China Belt and Road Reinsurance Pool was established.

No regulations on industry loss warranty contracts and insurance-linked securities are applicable.

7.2 Foreign ART Transactions

No related information has been provided.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Generally speaking, consumers and the insured party are more favoured, and particular rules are applied in respect of the interpretation of an insurance contract. Article 30 of the Insurance Law stipulates that where there is a dispute over a contract clause between an insurer and the policyholder, where the insured party or beneficiary of an insurance contract concluded by adopting the standard clauses provided by the insurer and there are two or more interpretations of a contract clause, the court or arbitration agency shall adopt the interpretation which is in the interest of the insured party and the beneficiary.

Extraneous evidence may be permitted by the courts, such as evidence regarding the negotiations, the circumstances in which the contract took place, or the "usual practice" or understanding in relation to such contracts or particular terms therein.

8.2 Warranties

From an enquiry perspective, information disclosed by an insured may be identified as warranties of the insured. According to Article 16 of the Insurance Law, where an insurer enquires about the subject matter of insurance or the relevant information of the insured party for the purpose of conclusion of an insurance contract, the policyholder must provide truthful information.

Breach of warranties of the insured, intentionally or due to gross negligence, may lead to the cancellation of the insurance contract by the insurer and refusal to make compensation or payments. However, if the insured can prove that the breach of warranties has no causation with the occurrence of the loss, the insurer may still be obliged to make compensation or payments.

8.3 Conditions Precedent

Normally, no conditions precedent would be expressly described as such in an insurance contract. However, there may be claim procedure clauses, which require an applicant, an insured or a beneficiary to notify the insurer of the occurrence of an insured accident in a timely manner.

Where an insured accident is not notified of in a timely manner, intentionally or due to gross negligence, with the result that it is difficult for the insurer to determine the nature, cause and

extent of the loss, etc, of the accident, the insurer shall not bear the obligation of indemnity or payment of insurance benefits for the part unable to be determined – except for those insured accidents whose occurrence the insurer knows of through other channels, or should know of in a timely manner.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Disputes over coverage under an insurance contract are typically addressed based on the insurance contract and related facts. For consumer contracts, the interpretation rules in cases of disputes would generally be favourable to the consumers, as indicated in **8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence**. The insured or policyholder may not claim directly against the reinsurer.

The limitation period is three years for non-life insurance claims under the Civil Code and five years for life insurance claims under the Insurance Law.

A third party that is not a contractual party to an insurance agreement is generally not entitled to bring a direct action against an insurer. However, for liability insurance, Article 65 of the Insurance Law provides that an insurer must, at the request of an insured party, make direct compensation of insurance monies to a third party for damages caused by the insured party of a liability insurance policy to the third party, where the compensation liability of the insured party towards the third party is determined. Where the insured party does not make such request, the third party shall have the right to directly request the insurer to make compensation of insurance monies in respect of the portion of the compensation it should receive.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

In China, disputes are mainly resolved by mediation, arbitration or the courts. For a foreign-related contract, the parties may choose a foreign law as the governing law pursuant to the Law on the Application of Laws to Foreign-related Civil Relations, or choose foreign courts or international arbitrations to resolve disputes.

9.3 Litigation Process

The litigation process is as follows.

- First-instance court proceedings – these may be conducted in either a so-called common proceeding or a summary proceeding:
  - (a) a common proceeding should be completed within six months following the registration, and this duration may be prolonged for another six months where the case is complicated; and
  - (b) a summary proceeding should be completed within three months, or otherwise should be converted into a common proceeding.
- Appellate proceedings – the time limit for filing an appeal is 15 days for a domestic party and 30 days for a party from a foreign country. An appellate review should generally be completed and a final judgment made within three months after the appeal. This period may be prolonged for complicated appeals.

9.4 The Enforcement of Judgments

Judgments can normally be enforced in China. The time limit for an application to enforce a judgment is two years. Where a party fails to perform the judgment within the designated period,

the judicial enforcement officials may take compulsory measures to enforce it.

The recognition and enforcement of a foreign judgment in Chinese courts is conducted in accordance with applicable international treaties or conventions, or in accordance with the principle of reciprocity. A party can submit an application directly to an intermediate people's court, which has jurisdiction for recognition and enforcement. Cases of recognition and enforcement of foreign judgments made in foreign countries such as Singapore and the USA have occurred in China.

9.5 The Enforcement of Arbitration Clauses

Where there is a valid arbitration clause in a commercial insurance or reinsurance contract, it is enforceable. An arbitration agreement must include the following content:

- the expression of an application for arbitration;
- issues for arbitration; and
- the chosen arbitration commission.

9.6 The Enforcement of Awards

An arbitral award may generally be enforced. However, within six months of the date of receipt of the award, any party to the arbitration may petition the intermediate people's court where the arbitration commission is located to vacate the award upon the following circumstances:

- there was no arbitration agreement between the parties;
- the matters in question fall outside the arbitration agreement or beyond the power of the arbitration commission;
- the composition of the members of the arbitral tribunal or the procedure of the arbitration violated required legal procedure;
- the evidence on which the award was based had been forged;
- the counterparty concealed evidence that could materially affect fair arbitration; or
- the arbitrators solicited or accepted bribes, committed illegalities for personal gain or perverted the law.

China is a signatory to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards of 1958. An award by a non-Chinese arbitral tribunal could be submitted to the intermediate people's court with territorial jurisdiction over the target party, or where the party's property is located, to be enforced.

9.7 Alternative Dispute Resolution

There are generally two types of alternative dispute resolution under the Civil Procedure Law (as amended in 2021), including mediation and arbitration.

In 2016, the Supreme People's Court and the CIRC (the former CBIRC) co-issued the Opinion on Fully Promoting to Establish the Connection Scheme between Litigation and Mediation for Insurance Disputes, to establish the multiple dispute resolution mechanisms for insurance disputes within the whole of China.

In 2021, the CBIRC and the Supreme People's Court launched an online litigation and mediation connection system to promote using mediation to resolve insurance disputes based on the previous offline litigation and mediation connection system.

No different rules apply to consumer contracts or reinsurance contracts in this regard.

9.8 Penalties for Late Payment of Claims

In accordance with Article 23 of the Insurance Law, the insurer must pay the insured party or the beneficiary for losses due to delay of settling claims.

Where an insurer refuses to perform its obligation to make compensation or pay insurance benefits as agreed upon in an insurance contract, it may be ordered by the insurance regulatory authorities to make correction, and be subject to a fine ranging from CNY50,000 to CNY300,000.

Where the case is serious, then the scope of business of the insurance company may be restricted, the insurance company may be ordered to stop accepting new business, or the business permit of the insurance company may be revoked.

9.9 Insurers' Rights of Subrogation

There is an automatic right of subrogation of the insurer upon payment of an indemnity by the insurer. According to Articles 60 and 62 of the Insurance Law, where the occurrence of an insured event is due to damage to the subject matter of insurance made by a third party, the insurer may, with effect from the date of making compensation of insurance monies to the insured party, exercise subrogation rights within the scope of the compensation amount to claim for compensation from the third party.

However, an insurer may not exercise subrogation rights to claim for compensation from the family member of the insured party or its member, except for an insured event which is caused intentionally by a family member of the insured party or its member.

10. Insurtech

10.1 Insurtech Developments

Insurtech in China has recently entered a state of rapid development. By the end of May 2021, there were 238 insurtech companies in China, and insurance companies are investing more and more in this technology.

The scope of insurtech in China includes:

- cloud computing;
- big data;
- the internet of things;
- artificial intelligence;
- the internet of cars;
- wearable devices; and
- genetic diagnostics.

Huize, Waterdrop, and Yuanxin Technology represent the leading insurtech companies in China.

10.2 Regulatory Response

The CBIRC supports and encourages the development of insurtech, and indicates that insurtech – as an important means to reduce the operational risks of scientific and technological startups and optimise the allocation of financial resources – is efficient for the transformation of major scientific and technological achievements and for surmounting the threshold for large-scale production and application. The CBIRC also indicated intensifying the support of relevant policies and continuing to promote the relevant work of technological innovation in the financial industry and the capital market.

In addition, to further strengthen the risk supervision of information technology outsourcing of banking and insurance institutions, the CBIRC issued the Regulation Measures for the Risk Supervision of Information Technology Out-

sourcing of Banking and Insurance Institutions in January 2022, which put forward specific regulatory requirements and regulatory measures on information technology outsourcing of insurance institutions.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Cybersecurity has been a major issue – particularly regarding, for instance, blackmail software. The CBIRC, together with the Ministry of Industry and Information Technology (MIIT), have encouraged and promoted cybersecurity insurance.

The risk of personal information disclosure is also interwoven with cybersecurity and national security. As processors of personal information, insurance companies should disclose their personal information processing rules in line with the principles of openness and transparency, while managing and using customer information in accordance with the principles of legality, reasonableness, security, and confidentiality, and preventing leakage of customer information.

The in-depth application of innovative technologies in the insurance industry has also led to corresponding technical risks. For example, in the areas of cloud computing and big data, traditional customer information security problems may be even more prominent. In the future, the insurance industry will also be challenged by the risk of equipment hijacking and remote control when autonomous driving is implemented.

11.2 New Products or Alternative Solutions

Certain new products and solutions are being developed to solve emerging risks, such as cybersecurity insurance and data security insurance. The Shanghai Municipal Financial Regulatory Bureau released the first Cybersecurity Insurance Service Standard in China in September 2022.

At present, the insurance industry in China is forming a relatively complete big data ecosystem that covers insurance companies, third-party insurance platforms, brokers, agents, business partners, related data and technical support parties. In implementing the requirements of the Personal Information Protection Law, privacy computing may become an important tool.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Following the COVID-19 epidemic, and under the guidance of the CBIRC, Chinese insurers helped Chinese enterprises through difficulties with practices including premium reduction, delay of payment of premium, extension of insurance periods and prompt compensation. The Ministry of Commerce and China Export and Credit Insurance Corporation promulgated a policy to support foreign trade companies in coping with the impact of COVID-19 by means of short-term export credit insurance.

However, recent significant changes can be seen with the COVID-19 epidemic prevention policy in China, and despite the number of infected patients it is expected that China will embrace a full opening-up in 2023. Whether these chang-

es will have a specific impact on the insurance industry remains to be seen.

In July 2021, the CBIRC promulgated the Measures for Regulatory Evaluation of Protection of Consumer Rights and Interests by Banking or Insurance Institutions. In May 2022, the CBIRC drafted the Administrative Measures for the Protection of Consumer Rights and Interests of Banking and Insurance Institutions (Draft for Comments) and sought public comments. In the future, Chinese regulatory authorities will likely continue to strengthen the supervision of the protection of consumer rights and interests in the insurance industry.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

In October 2022, the CBIRC revised the Measures for the Administration of Insurance Protection Funds which changed the fixed rate system of insurance protection funds into a risk-oriented rate system, and clarified the relevant financial requirements for insurance protection funds.

DeHeng Law Offices was formerly known as China Law Office (CLO) until 1995, and was founded in Beijing in January 1993 with the approval of the Ministry of Justice of the People's Republic of China. It has grown into one of the largest full-service law firms in China. Having a stable and experienced team is the treasure of the finance and insurance department of DeHeng Law Offices. With a good reputation and outstanding performance in the area of legal services for financial and insurance clients, DeHeng has acted as a permanent legal adviser for a major bank in its project evaluations and for a number of large-scale banks, funds, stock exchanges, and securities companies. Dr Jia's team focuses on providing professional and high-quality legal services for banks, securities investment funds, industrial funds, enterprise annuity, insurance, social security funds, foreign-related financing, and private equity investment and financing.

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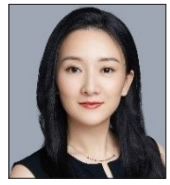

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Trends and Developments

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Insurance and Reinsurance in China

In 2022, the Chinese insurance industry maintained its status of opening up to the global market while continuing its development of reliance on the domestic market – which is all the more remarkable considering the impact of the COVID-19 pandemic. In assessment of the development of the Chinese insurance industry, this article conducts an overall review of the milestone policies and events that have shaped the industry's development in the last two years, and forecasts where the Chinese insurance industry may be heading.

Further Expansion of Market Access for Foreign Investors

Insurance companies

In 2021, the China Banking and Insurance Regulatory Commission (CBIRC) released its *Decision on Amending the Implementing Rules of the Regulations of the People's Republic of China on Foreign-Invested Insurance Companies* (CBIRC Decree (2021) No 2) («关于修改<中华人民共和国外资保险公司管理条例实施细则>的决定»(中国银行保险监督管理委员会令2021年第2号)). The amendment provides for:

- implementing rules on the expansion of "foreign shareholders" of Chinese foreign-invested insurance companies to include foreign insurance group companies and other overseas financial institutions according to the *Regulations of the People's Republic of China on Foreign-Invested Insurance Companies (amended in 2019)* («中华人民共和国外资保险公司管理条例(2019)»); and
- specific qualifications for the two types of shareholders.

After the amendment became effective, foreign investors have been seen scaling up investment in the industry. For instance, Allianz China Life Insurance Co, Ltd became the first Chinese joint-venture life insurance company to be converted into a life insurance company wholly owned by a foreign investor (Allianz China Holding).

After 20 years of establishing its footprint in China, Chubb Limited was approved to increase its stake in Huatai Insurance Group to 83.22%. Prudential Financial also entered the Chinese reinsurance segment by acquiring a 10% stake in Qianhai Reinsurance. Tian Yuan Law Firm has assisted both Huatai Insurance Group and Prudential Financial in closing these investments.

Insurance asset management companies

The *Administrative Provisions on Insurance Asset Management Companies* (CBIRC Decree (2022) No 2) («保险资产管理公司管理规定»(中国银行保险监督管理委员会令2022年第2号)) that went into effect on 1 September 2022 removes the 25% cap on foreign ownership percentage, expands the scope of qualified shareholders for this, and sets unitary qualification standards for domestic and foreign shareholders alike.

On 27 July 2021, Allianz Insurance Asset Management Company Limited obtained approval from the CBIRC to become the first wholly foreign-owned insurance asset management company. Meanwhile, more foreign-invested

insurance asset management companies are awaiting approval for establishment.

Insurance brokerage companies

China's commitments to the World Trade Organization (WTO) involved imposing a series of restrictions on foreign investors in setting up insurance brokerage companies in China. Namely, a foreign investor must:

- have more than 30 years of market presence in any WTO member country;
- have established a representative office in China for two consecutive years; and
- have total assets of not less than USD200 million in the fiscal year previous to filing the setup application.

On 3 December 2021, the CBIRC published the *Notice of the CBIRC General Office on Clarifying Relevant Measures for the Opening-up of the Insurance Intermediary Market* (Yin Bao Jian Ban Fa (2021) No 128) (银保监会办公厅«关于明确保险中介市场对外开放有关措施的通知»)(银保监办发 (2021) 128号) that significantly lowered the restrictions on foreign investors' market access to this market segment, revoking requirements on foreign shareholders' market presence experience and total asset value, and allowing foreign insurance groups and domestic foreign-invested insurance groups to operate in this segment through firms they establish.

Domestic Insurance Companies

Domestic insurance licences scaled back

Since 2018, the CBIRC has tightened up on granting licenses for domestic insurance companies. Between 2018 and 2022, insurance licences have been issued only to:

- Guomin Pension & Insurance, China Rong Tong Property & Casualty Insurance, and China Agriculture Reinsurance Corporation, which were set up to address key national policy problems;
- Dajia Insurance Group, a newly created insurance company succeeding the restructured Anbang Insurance Group; and
- several insurance companies invested by foreign-invested insurers.

Slow equity trading market of domestic insurance companies

Facing market downturn and tight cash flow, increasingly more shareholders of insurance companies have opted to sell their equity interest, or have been forced to sell their shares through judicial auctioning. Compared with the past few years, however, the appeal of insurance company equities has remarkably declined, with the market showing little interest in the equities of most insurance companies.

Chinese insurance companies going overseas

Despite the challenge from market slowdown, Chinese insurance companies have not ceased going overseas. In 2021, Taikang Life Insurance established a subsidiary in Hong Kong, China Taiping Insurance Group launched a subsidiary in Luxembourg and China Reinsurance Group increased capital investment in its subsidiary in the UK. In 2020, China Life Reinsurance Company also established a subsidiary in Hong Kong and closed capital injection in 2021.

These overseas subsidiaries are set up by Chinese insurance companies to better serve the increasing number of Chinese companies "going abroad" and, in co-ordination with China's national strategy, to provide insurance services to meet the needs of the state, enterprises and key projects of the Belt and Road Initiative.

In addition to setting up foreign subsidiaries, Chinese insurers have also been proactive in exploiting the international capital market to spread out insurance risks. On 1 October 2021, China Property & Casualty Reinsurance, a subsidiary of China Reinsurance Group, successfully issued the first catastrophe bond in Hong Kong, in response to the release of the *Circular of the General Office of the China Banking and Insurance Regulatory Commission on Relevant Matters Concerning the Issuance of Catastrophe Bonds by Domestic Insurance Companies in the Hong Kong Market* (Yin Bao Jian Ban Fa (2021) No 102) («关于境内保险公司在香港市场发行巨灾债券有关事项的通知») (银保监办发 (2021) 102号) that permits Chinese insurance companies to shift risks of catastrophe caused by natural disasters (such as earthquakes, typhoons or floods) or public health emergencies by offering catastrophe bonds in Hong Kong through SPVs.

Strengthening the Compliance Management Capability of Insurance Companies, and Regulating Shareholders

Between 2021 and 2022, the CBIRC issued a series of regulations that aim to streamline the corporate governance system of insurance companies – for instance:

- the *Corporate Governance Guidelines for Banking and Insurance Institutions* (Yin Bao Jian Fa (2021) No 14) («银行保险机构公司治理准则»(银保监发 (2021) 14号));
- the *Measures for the Supervision and Administration of Insurance Group Companies* (CBIRC Decree (2021) No 13) («保险集团公司监督管理办法»(中国银行保险监督管理委员会令2021年第13号));
- the *Interim Measures on Regulation of Conduct of Major Shareholders of Banking and Insurance Organisations (For Trial Implementation)* (Yin Bao Jian Fa (2021) No 43) («银行保险机构大股东行为监管办法»(试行)(银保监发 (2021) 43号));
- the *Interim Measures on Performance Evaluation of Directors and Supervisors of Banking and Insurance Institutions (For Trial Implementation)* (CBIRC Decree (2021) No 5) («银行保险机构董事监事履职评价办法»(试行)(中国银行保险监督管理委员会令2021年第5号)); and
- the *Administrative Measures on Related-party Transactions of Banking and Insurance Institutions* (CBIRC Decree (2022) No 1) («银行保险机构关联交易管理办法»(中国银行保险监督管理委员会令(2022) 1号)).

Compared with the general company law of China, the CBIRC imposes even stricter rules on shareholders – especially major shareholders of insurance companies – and closely monitors their directors and supervisors in the administration of their duties, with a view to providing better protection of minority shareholders and insurance companies.

In the near future, corporate governance of insurance companies will remain an issue of key concern for the CBIRC, with the conduct of insurance company shareholders, affiliated transaction management and independent directors administering their duties under continuous supervision of the regulator.

Solvency Supervision Strengthened

On 15 January 2021, the CBIRC revised the *Administrative Provisions on the Solvency of Insurance Companies (2021)* (CBIRC Decree (2021) No 1) «保险公司偿付能力管理规定(2021)»(中国银行保险监督管理委员会令2021年第1号)(the "Administrative Provisions"). The revision elaborates on the framework of solvency regulation to cover three interlinked ratios:

- the core solvency adequacy ratio;

- the comprehensive solvency adequacy ratio; and
- the comprehensive risk rating.

On the whole, the implementation of China's second-generation solvency regulatory system would raise higher requirements on asset allocation and debt structure adjustment of insurance companies. Leveraging solvency regulation, the CBIRC is in a better position to guide the insurance industry in focusing on service of the Chinese real economy and capital market development.

Insurance Business

Pension schemes

With increased aging in the Chinese population, pension schemes have become one of the most promising insurance product categories in China.

Policy-wise, on 8 April 2022 the State Council released its opinion encouraging development of private pension plans, built on the principles of voluntary participation and market-oriented management, in dovetail with the existing basic pension insurance, enterprise annuity and occupational pensions to create a comprehensive Chinese pension system.

To implement the State Council's policy on private pension plans, on 21 November 2022 the CBIRC issued the *Notice regarding the Launch of Private Pension Plans of Insurance Companies* (Yin Bao Jian Gui (2022) No 17) «中国银保监会关于保险公司开展个人养老金业务有关事项的通知»(银保监规 (2022) 17号) permitting qualified insurance companies to operate a private pension plan business and to provide insurance products such as annuity insurance, endowment insurance and other insurances that are recognised by the CBIRC as private pension plan insurance products. The notice heralds an era where a qualified insurer is permitted to provide certain insurance products as the subject of investment from a private pension plan account.

As regards institutional setups, in 2021 HASL Pension Limited Company was approved by the CBIRC to become the first pension company invested by a joint-venture life insurance company. On 21 March 2022, Guomin Pension Co, Ltd was approved by the CBIRC to become a new giant in the pension market segment.

As stated repeatedly by the CBIRC, foreign investors and capital are encouraged to establish pension institutions in China, and foreign-invested life insurance companies are encouraged to operate pension businesses in China as well. With the further development of private pension plans and their liberalisation, it is believed that the Chinese pension market will continue to attract market entry of qualified and experienced foreign life and pension institutions.

Agriculture insurance

The Rural Revitalisation Strategy is a key national strategy in China. Under its guidance, agriculture insurance ("agri-insurance") has been the focus of development of the Chinese property insurance segment in recent years, and has achieved some remarkable progress.

In June 2021, the CBIRC, in conjunction with several other ministries, promulgated a new regulation that aims to further improve the full coverage of input cost insurance and harvest income insurance for three major staple crops. In April 2022, the CBIRC issued a new notice, reiterating the need to encourage development of agri-insurance in better service to the Rural Revitalisation Strategy.

The Rural Revitalisation Strategy offers broad growth opportunities to the agri-insurance sector, driving the growth of property insurance. Although the CBIRC maintains an encouraging stance towards experienced foreign insurers offering agri-insurance services in China, most foreign investors choose to tap into the market segment through reinsurance, given the policy-driven nature and high risks of such type of insurance. With the development of Chinese agri-insurance, new needs for reinsurance and opportunities for co-operation between Chinese insurance companies and foreign reinsurers are expected to emerge.

Progress in Risk Disposal of Insurance Companies

On 17 July 2020, the CBIRC issued an announcement on the receivership of six institutions. Accordingly, Tian'an Property Insurance, Hunxia Life Insurance, Tian'an Life Insurance and Yi'an Property Insurance will stay in receivership for two years.

On 29 June 2022, the CBIRC approved a bankruptcy and reorganisation plan involving Yi'an Property Insurance, marking the first Chinese insurance company entering bankruptcy proceedings. In July 2022, the insurance asset package of Tian'an Property Insurance was publicly listed and traded at the Shanghai United Assets and Equity Exchange.

At present, the disposals of Huaxia Life Insurance and Tian'an Life Insurance are still in progress.

Since the receivership of Anbang Insurance Group in 2018, China's insurance regulatory authorities have relied on receivership to mitigate financial systematic risks. Since 2022, the risks related to AnBang Insurance Group, Mr Xiao Jianhua and their affiliates have basically been dissipated. Tian Yuan has been deeply involved in the related receivership and risk disposals.

Evolving Green Insurance

ESG is a new idea for investment and financing in international currency. This concept evaluates the sustainability of enterprise operations and the impact of investment and financing on social values from three dimensions: environment, social responsibility and corporate governance. Implementation of ESG by the Chinese insurance industry has highlighted the concept of green insurance as a key factor in green financial management.

Ever since publication of the financial regulator's opinion on buildup of a green system of finance, Chinese insurers have proactively pursued the idea of green insurance. From a policy perspective, on 1 June 2022 the CBIRC issued the *Guidelines for Green Finance in Banking and Insurance Sectors* (Yin Bao Jian Fa (2022) No 15) («银行业保险业绿色金融指引»(银保监发 (2022) 15号)) for Chinese insurers to follow, covering such issues as organisational management, policy and capacity buildup, investment and financing process management, internal control and disclosure.

With a deepening understanding of green insurance and ESG, Chinese insurance companies have begun to develop more green insurance products, including:

- compulsory liability insurance for environmental pollution;
- environmental protection technology and equipment insurance;

- product quality and safety liability insurance for low-carbon and environment-friendly consumer goods;
- liability insurance for ship pollution damage;
- forest insurance;
- agri-insurance;
- animal husbandry insurance; and
- disaster insurance.

More insurance companies are also expected to direct insurance funds to the fields of green and low-carbon development. According to the Insurance Asset Management Association of China, insurance fund investment directed towards green projects had reached CNY1071.6 billion by the end of August 2021.

Green finance, peak CO2 emissions, carbon neutrality and ESG are vital concepts gaining currency in the international financial market. The Chinese insurance industry will also follow this trend by proactively putting these ideas into practice. For instance, in terms of liability, the industry is expected to develop more green insurance products; and in terms of assets, green projects will become a new focal point of insurance funds.

Tian Yuan Law Firm is a general-service Chinese law firm. Founded in 1992, it was one of the earliest partnership law firms in China. Tian Yuan has headquarters in Beijing and branch offices in Shanghai, Shenzhen, Chengdu, Hangzhou, Xi'an, Haikou, Suzhou, Guangzhou, Hefei, Kunming, Nanjing and Hong Kong. Tian Yuan is one of several law firms in China with a standalone insurance team, and offers comprehensive legal services tailored to the needs of clients. Its insurance team is comprised of many lawyers who specialise in the insurance industry. The firm's team is led by partner Wei XU, and the team's lawyers all have extensive experience in the insurance sector and the capital market. The team's clients include major types of insurance institutions and supervisory authorities in China. A recent highlight of the team's work includes having assisted Huatai Insurance Group and Prudential Financial in closing their respective investments.

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Mr Wei Xu is the leading partner of the insurance sector of Tian Yuan Law Firm, and has extensive first-hand experience of advising insurance institutions and other financial institutions on contentious and non-contentious matters. He has supported clients across the full range of their legal needs in the insurance sector and capital market, including with establishment of insurance institutions, M&A and investment, takeover and risk disposal, insurance capital usage, and disputes and subrogation.

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Denmark is primarily a civil law country and the major piece of legislation for insurance in Denmark is the Danish Insurance Contracts Act, which mainly governs the relationship between the insurer and the insured. However, the Insurance Contracts Act is heavily supplemented by case law and Danish insurance law today is a combination of statutory regulation, case law, and general contracts and tort law.

The Danish insurance market is widely regulated; however, no explicit statutory rules apply to reinsurance. With regard to reinsurance, an analogy of the Insurance Contracts Act is applied alongside general contract law.

The Danish Financial Business Act is the main piece of legislation regarding the rules for establishing and carrying out insurance business, along with a number of other acts governing financial business in Denmark (eg, the Danish AML Act, the Danish Companies' Act and the Danish Marketing Practices Act).

The Danish Insurance Mediation Act, which implements the EU Directive 2006/97 on Insurance Distribution, regulates insurance brokers and other intermediaries that distributes insurance commercially.

Moreover, the Brussels I Regulation's rules on jurisdiction for insurance contracts also apply in Denmark.

In addition to case law and the above-mentioned statutes, insurance and reinsurance will also rely on administrative practice (especially from the Insurance Complaints Board) and preparatory legislative works.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Insurance and reinsurance companies are part of the financial market in Denmark, which is supervised by the Danish Financial Supervisory Authority (the FSA).

The FSA supervises and monitors the financial market in Denmark and has the authority to issue orders and report issues if an insurance or reinsurance company does not comply with the Danish Financial Business Act. Moreover, the FSA may report companies to the police if they do not comply with the Financial Business Act. The FSA further monitors compliance with AML regulation. Violation may result in fines or up to four months' imprisonment.

Insurance and reinsurance contracts activities can only be carried out after an authorisation given by the FSA. Companies and persons that carry out insurance and/or reinsurance contracts activities are required to register in a publicly available register controlled by the FSA.

2.2 The Writing of Insurance and Reinsurance

Generally, the requirements for establishing an insurance company in Denmark are the same for all types of insurance products. Special additional requirements apply to life insurance companies and to motor insurance companies.

Similarly, the requirements for writing insurance are the same for all types of insurances. Special information duties and limitations apply when entering into consumer insurance contracts, which are subject to certain consumer protection laws. In the case of life insurance, limitations apply to insurance contracts for third parties.

As mentioned in **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**, it requires an authorisation from the FSA to write insurance and reinsurance business in Denmark. Authorisation is given upon an application to the FSA, which must set out a plan of business and operation for the insurance company. The FSA has the authority to establish the rules for the application and the application process. The requirement to obtain an authorisation applies to all insurers.

Furthermore, the Danish Financial Business Act stipulates certain requirements to the insurer's and reinsurer's capital, organisation and solvency. The requirements depend on which group the insurer or reinsurer belongs to. Group 1 consists of companies that meet the listed requirements on, among other things, their gross annual income. Group 2 consists of all companies not included in group 1.

Generally, the minimum capital requirement must not be less than 25% or more than 45% of the insurer's or reinsurer's solvency capital requirement.

The board of directors and the executive board of group 1 companies have a responsibility to make sure that the company has sufficient capital to cover the minimum capital requirement.

The solvency requirements for group 2 companies depend on which activity they carry out. The board of directors and the executive board of group 2 companies have a responsibility to make sure that there are sufficient capital to cover all the company's insurance obligations at all times.

2.3 The Taxation of Premium

The insurance company must pay tax on non-life insurances in certain circumstances.

However, some insurance products are exempt from taxation. Workers' compensation insurance and reinsurance are examples of exemptions.

The insurance premium is not subject to VAT.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

The requirements described in **2.2 The Writing of Insurance and Reinsurance** also apply to foreign insurance and reinsurance companies.

Companies outside the EU and European Economic Area (EEA) need to establish a branch or a company in Denmark and obtain an authorisation from the FSA to undertake insurance and reinsurance business in Denmark. As a result of Brexit, UK-based insurance and reinsurance companies are subject to these rules as well.

Companies in the EU may carry out insurance and reinsurance business in Denmark without an authorisation from the FSA, if the company already has been granted an authorisation from its home country. The companies will have to notify the FSA who, in turn, will obtain proof of solvency, proof of authorisation, etc, from the home country. The foreign insurer will be subject

to the same rules as Danish insurers regarding good business practices, consumer protection regulation, the Insurance Contracts Act, etc.

3.2 Fronting

Fronting is permitted in Denmark and the cedant takes no risk. Fronting normally comes with a fronting fee, which is individually agreed between the parties.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

The M&A market in Denmark has been quiet in relation to insurance companies for a long period of time. However, in recent years there have been a couple of M&A activities relating to insurance companies.

In 2018 the largest Danish insurance company, Tryg Insurance, acquired Alka Insurance. Up until May 2022, there had not been any mergers or acquisitions since 2018. In May 2022 Alm. Brand Insurance acquired Codan Insurance for DKK12.6 billion (approximately GBP1.5 billion) and thereby became the second-largest insurance company in Denmark, just behind Tryg. Whether there will be further consolidation on the Danish insurance market is difficult to predict.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Both insurance brokers, agents and bancassurance brokers are active in the Danish insurance market. All insurance intermediaries must obtain a licence from the FSA in order to sell or convey commercial insurance products. The Danish Insurance Distribution Act, which governs insurance distribution in Denmark, is – to a large extent – an implementation of the Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (the "EU Insurance Distribution Directive").

The FSA issues a licence for insurance distribution when, inter alia, the following basic conditions are met:

- the company is registered in Denmark;
- members of management comply with the "fit-and-proper" rules, which include requirements concerning knowledge, reliability, responsibility and integrity;
- the company has a liability insurance or another equivalent guarantee against claims for damages; and
- the company has taken measures to protect customers against the company's inability to pay.

Ancillary insurance products are widely used in Denmark as a supplement to services or goods, such as insurance for electronic products or luggage. Intermediaries who distribute such insurance products are exempt from the licence requirement, but must still be registered with the FSA.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The general rules of the parties' obligations when entering into an insurance contract are set out in the Insurance Contracts Act. In respect of consumer insurance, the Danish consumer

protection laws supplement the Insurance Contracts Act.

An insurance contract is usually initiated by an insurance application or through an insurance broker. The insured usually completes a questionnaire issued by the insurer containing information about the insured and the risk the insurer would be undertaking. The insurer then makes an offer of insurance or denies the application based on the information provided. Except for mandatory insurances (eg, third-party liability motor insurances), the insurance companies are not obligated to write insurances.

The Duties of the Insured

The insured is obliged to loyally provide correct and complete information to the insurer. However, when the contract is initiated by an insurance application, the insured's obligation does not expand further than to loyally provide correct and complete answers to the insurer's questions and the insured only has a duty to reply. There is no obligation to provide further information beyond that requested by the insurer.

If the insured fraudulently provides false information, fraudulently fails to disclose information, or in any other way misrepresents during the contract negotiation the insurance contract will be deemed null and void.

The Duties of the Insurer

Insurers do not have an obligation to actively seek verification of the accuracy of the information provided by the insured. However, insurers cannot assert that the information given is incorrect, if they – at the time the contract is issued – knew or ought to have known that the information was incorrect. This implies an obligation for the insurer to actively seek clarification on the correct information when it is suspected that incorrect or incomplete information has been given.

It is not uncommon that bigger companies are represented by an insurance broker who designs the insurance package (or even writes the terms) and issues them for tender between insurers. In such cases, the insurance contract will – to a large extent – be based on the tender provided by the broker and and thus, in turn, the insured.

The insurer is obliged to provide a wide range of information to the consumer before a consumer insurance contract is concluded. This includes information on the insurer's right of withdrawal, as well as extensive information about the company and the price and conditions of the insurance.

Generally, insurers in Denmark have become more and more aware of collecting extensive risk information from the insured. This might entail a greater responsibility for the insured to provide accurate risk information.

6.2 Failure to Comply With Obligations of an Insurance Contract

Consequences of the Insured's Fraudulence

If the insured fraudulently provides incorrect information or fails to disclose facts of importance during the negotiation of the insurance contract, the contract is not binding upon the insurance company and will be deemed null and void.

Consequences of the Insured's Negligence

If the insured provides incorrect information or fails to disclose facts of importance by negligence, the insurance company will only be liable on a pro rata basis calculated based on the premium. The insurer must document what premium they would have claimed had the cor-

rect facts been known and the insurance claim is calculated on this basis.

Would the insurer presumably not have offered insurance to the insured had the correct information been disclosed, the insurer is exempt from liability.

If the insured did not know or could not have been expected to know that information provided by them was incorrect, the insurer is liable to the same extent as they would be had no incorrect information been given.

6.3 Intermediary Involvement in an Insurance Contract

It is not uncommon for intermediaries to be involved in the negotiation of insurance contracts. The most common intermediary is the insurance broker, who acts on behalf of the insured. The Danish Insurance Distribution Act specifically states that insurance brokers act on behalf of their customers and may not receive remuneration from insurers.

The Danish Insurance Distribution Act, which – to a large extent – implements the EU Insurance Distribution Directive, regulates insurance intermediaries and insurance distribution. The FSA is responsible for monitoring insurance brokers and intermediaries and issues licences for same.

The Insurance Distribution Act sets out several requirements for intermediaries. They must have sufficient professional liability insurance, they must be registered with the FSA, they must adhere to the fit-and-proper requirements and must comply with various disclosure duties vis-à-vis the FSA. Finally, the intermediary must have general knowledge of insurance mediation and distribution and must ensure that its employees have proper training in insurance distribution on a general level and sufficient training in the specific products that the company distributes.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

There are no formal requirements in the Insurance Contracts Act for the format of the insurance contract in general, nor a requirement for it to be concluded in writing. However, the insurer will typically issue a policy confirming the insurance contract containing the terms of the insurance. There is no legal obligation to do so, but an obligation to issue a policy may arise from custom in certain industries.

For some types of insurance products however, certain requirements do exist.

Consumer Insurance Contracts

The Insurance Contracts Act sets out certain mandatory rules that apply to consumer insurance contracts.

The provisions herein state that consumers must receive clear written information on the right of withdrawal. This information must be received before or together with the other insurance terms. For consumer contracts initiated through a remote sale, the required information by the insurer mentioned in **6.2 Failure to Comply with Obligations of an Insurance Contract** must be provided to the consumer "on paper or on other durable medium" before the contract is concluded and the consumer can at any point require the insurance terms on paper.

Non-Life Insurance (Property Insurance)

Any legitimate interest that can be valued in money can be subject to non-life insurance, according to the Insurance Contracts Act. The insurable interest must be present at the time of

the occurrence of the insurance event. It is thus not a requirement that the interest is present when the insurance contract is concluded. The line between a legitimate interest and an illegitimate interest is not perfectly clear; however, as a general rule, it is not possible to ensure the interest to avoid criminal liability.

The fact that the interest must be measurable in money entails non-economic interests, such as the sentimental value of an object, cannot be insured under a non-life insurances. The interest must be measurable according to an objective monetary measure.

Insurance of Fixed Sums (Life and Personal Injury Insurance Primarily)

The legitimate insurable interest requirement only applies to non-life insurances. It is therefore possible to conclude a life or personal injury insurance contract or insurance for accidents or sickness without an insurable interest. In order to avoid speculation in the death of a third party, the Financial Business Act prohibits insurers from signing insurance contracts in which it undertakes a duty to pay an amount exceeding the paid premiums for the death of a third party without said third party's consent. Such a requirement does not exist for insurance of a third party's personal injury insurance.

6.5 Multiple Insured or Potential Beneficiaries

Multiple parties can be beneficiaries under an insurance contract without being named. The requirements for such insurance contracts are the same as listed earlier. For property insurance, the general statutory rule is that – unless there is a named beneficiary – the insurance is written for the benefit for anyone who either owns the piece of the property, a mortgagee or other with a property right to it.

Among others, D&O insurances may cover the "board of executives" or "the management" without naming each individual. Professional liability insurances also cover unnamed insureds and, in car insurances, the insurance also normally covers unnamed sub-contractors.

Each insured/covered under such insurance will be identified with the individual negotiating the contract, however. This entails that any wrongful information provided, or any misrepresentation, will affect all insured notwithstanding their own good faith.

6.6 Consumer Contracts or Reinsurance Contracts

For consumer contracts, reference is generally made to **6.1 Obligations of the Insured and Insurer** and **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract** on the insurer's duty to provide the consumer with certain information.

In addition, consumer contracts are subject to the general Danish consumer protection laws (eg, the Marketing Practises Act).

Consumers can complain to the Insurance Complaints Board if they have a dispute with their insurer concerning payment of insurance claims.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Alternative risk transfers (ARTs) have not reached the Danish insurance market as of yet. For this reason, there is no legislation regulating this type of insurance for the time being.

7.2 Foreign ART Transactions

To the best of the authors' knowledge, this issue has not been raised and therefore no position has been taken at this time.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are interpreted in the same way as any other contracts.

The provisions of an insurance contract are subject to a strict interpretation of the wording. If the wording is unclear, the interpretation will be based on a natural understanding of the language in the provision together with the other provisions and the circumstances under which the insurance contract was conducted.

When interpreting unclear wording in standard insurance contracts drafted by the insurer the interpretation that is most unfavourable to the insurer will generally be chosen. However, the purpose of the agreement must still be taken into consideration. As mentioned in **6.1 Obligations of the Insured and Insurer**, it is not uncommon that larger insurance schemes are drafted by an insurance broker and sent to insurers on a tender basis. In such cases any unclear terms will – to a larger extent – be interpreted against the broker (and thus the insured).

As regards consumer contracts, the rules of interpretation are more favourable to the consumer. A clear example is that events occurred after the conclusion of the contract cannot be used to the detriment of the consumer.

The parties are free to determine which evidence should be considered when interpreting an insurance contract. However, the court may preclude evidence with no significance to the case. Generally, notes from meetings, minutes of meetings, and emails from the negotiation phase are all admissible evidence when interpreting an insurance contract. Moreover, market practices, case law and standard insurance products are also used when interpreting insurance contracts.

8.2 Warranties

Warranties are treated and interpreted no differently than other contractual terms.

8.3 Conditions Precedent

Condition precedents are treated as other contractual terms. Condition precedents will normally be singled out and stated as such, but it is not a firm requirement that they be. There is a distinction in the Insurance Contracts Act between condition precedents for cover and safety measures that need to be in place in order to grant insurance cover. Whereas condition precedents for cover need to be in place at the time of occurrence for cover to activate, condition precedents for certain safety measures would need to have prevented the occurrence had they been adhered to (causation). In practice this means that, even if the insured needs to undertake certain safety measures (eg, keep a fully functioning fire prevention system), the insurer will still be liable for cover if the occurrence could not have been prevented despite the safety measure being in place – for example, where a truck hit the house and there was no fire.

The Insurance Contracts Act contains a number of statutory condition precedents that primarily require the insured to notify the insurer of an occurrence without undue delay.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

There is no specialised insurance court in Denmark and insurance disputes are largely handled by the general courts. However, some insurance contracts contain an arbitration clause requiring specific insurance disputes to be settled by arbitration. A consumer is not bound by an arbitration agreement unless it was agreed to after the dispute arose. Arbitration clauses regarding insurance disputes are relatively common in Denmark, especially in matters within reinsurance, and are widely used in warranty and indemnity insurance and other corporate insurances.

Disputes concerning insurance coverage between a consumer and an insurer are dealt with both by the courts and by the Insurance Complaints Board. The latter is often preferred, owing to shorter case handling time and lower litigation costs.

The Insurance Complaints Board

A complaint with the board has to be initiated by the consumer.

Decisions from the Insurance Complaints Board are not binding on the consumer and do not preclude subsequent court proceedings, nor is a complaint to the board a prerequisite for subsequent court proceedings.

In addition to disputes between consumers and insurers, the board is also competent to handle all complaints relating to motor insurance and to rule in insurance disputes between professional parties, provided that the matter is not essentially different from private insurance matters.

The Limitation Period

The general limitation period is three years under the Danish Limitation Act. The limitation period will commence at the earliest point in time at which the claimant could demand satisfaction of the claim.

The Limitation Act is supplemented by special limitation provisions in the Insurance Contracts Act, according to which the limitation period for personal injury claims is extended to ten years. Upon filing of an insurance claim, the limitation will be suspended until at least one year after the insurer's full or partial rejection of the claim. Negotiations between the insurer and the insured similarly suspend the limitation period until one year after the negotiations have ended.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

The court will then either proceed with the case, refer it to the right forum or dismiss the case entirely.

If the court has assumed jurisdiction, then the defendant will have to challenge jurisdiction either in their defence or during the first case management conference at the latest. Failure to challenge jurisdiction in the defence or at the case management conference will preclude the defendant from challenging jurisdiction at a later stage. If jurisdiction is challenged, the court will normally schedule an interim hearing on jurisdiction before proceeding with the case on the merits.

The Danish Administration of Justice Act governs the rules of jurisdiction together with the Brussels I Regulation. Denmark is not party to the Rome I and II Regulations and thus the Rome Convention applies in Denmark with regard to choice of law for contractual obligations.

If the parties have opted for arbitration, the choice of law will be determined in accordance with the applicable rules for arbitration – unless the parties have opted for a specific choice of law.

9.3 Litigation Process

Denmark is generally a favourable jurisdiction for litigation. The courts are efficient and fast, and the court process is transparent.

The litigation process consists of an oral hearing that ranges from half a day up to several weeks – although most oral hearings are conducted in a single full court day – and a pre-hearing phase.

The litigation proceedings are commenced by filing a writ of summons with the relevant city court (or, in some cases, the Maritime and Commercial Court) through an online joint court portal. There is a fixed fee of DKK1,500 for filing a writ of summons. The courts will ensure that the writ is properly served on the defendant(s) and will set a deadline for the defendant to submit a statement of defence.

Following the submittance of the statement of defence, the court will call for a case management conference. The case management conference is normally done by telephone and will set out how the proceedings will move forward, the date of the hearing, the need for expert evidence, etc. Depending on the subject matter and complexity of the case, the court and parties may have several case management conferences.

During the pre-hearing phase the parties are generally free to submit evidence and pleadings as they deem necessary up until a cut-off date by which the pre-hearing phase ends (normally four weeks before the hearing). It is generally not possible to submit new evidence or new arguments after the cut-off date.

During the pre-hearing phase the court may rule on procedural questions and may even schedule part-hearings (on jurisdiction, statute of limitation, choice of law, etc). Depending on the decision in question, the decision may either be directly appealed or leave to appeal will have to be granted through the special Appeal Permission Board.

Before the oral hearing, the court will normally ask the parties to provide skeleton arguments outlining the arguments they wish to rely on during the oral hearing. Moreover, the claimant will be asked to provide a bundle of evidence that has been agreed to by the defendants. The parties are furthermore free to submit bundles of the evidence they expect to rely on during the oral hearing.

Prior to the oral hearing, a listing fee becomes due. The listing fee is calculated on the basis of the monetary claim in question and ranges from DKK3,000 to a maximum of DKK160,000. Court fees and listing fees are recoverable should the claimant prevail in their claim.

The courts generally have up to four weeks to render a judgment.

All cases commence in the city courts or with the Maritime and Commercial Court. During the pre-hearing phase, parties may request the court to refer the case to the High Courts. The High Courts will decide whether to admit the case in first instance.

All judgments rendered by the courts in first instance are appealable to a higher court. Third-instance appeals to the Supreme Courts require

the permission from the Appeals Permission Board.

9.4 The Enforcement of Judgments

Judgments are enforceable 14 days after being rendered. The losing party may suspend their duty to pay by appealing within the 14-day enforcement deadline.

Domestic judgments can be enforced through the bailiff's court. The bailiff's court is a subdivision under each of the city courts. An enforcement application can be submitted once the time limit for execution has lapsed, and the bailiff's court will assist in enforcing the claim.

The bailiff's court has various measures available when assisting in enforcing a judgment, including levying of attachment or execution, forced sale, and arrest.

The general rule under the Danish Administration of Justice Act is that foreign judgments are not enforceable in Denmark. However, in practice there are several important exceptions to this rule. Denmark is party to the Brussels I Regulation, the Lugano Convention and the Hague Choice of Court Convention, which are all implemented in Danish law by the Danish Act on Recognition and Enforcement of certain foreign judgments (the "Enforcement Act"). This entails that judgments from EU member states, Norway, Iceland and Switzerland are generally recognised and enforceable in Denmark. Please note that, following Brexit, the UK is no longer party to the Brussels I Regulation and the UK is not yet a party to the Lugano Convention. The UK became a party to the Hague Choice of Court Convention in 2021 and, consequently, judgments rendered by a UK court that are covered by the HCCC are enforceable in Denmark – but, otherwise, they are not.

The procedure for enforcing foreign judgments is generally the same as for domestic judgments. However, judgments covered by the HCCC and the Lugano Convention must be declared enforceable by the bailiff's court before they can be enforced (the exequatur procedure).

Judgments not covered by the Enforcement Act (in practice, the conventions mentioned in the Act) are neither recognised nor enforceable in Denmark. Consequently, a party wishing to enforce a foreign judgment in Denmark must obtain a Danish judgment on recognition of the foreign judgment. Such a judgment of recognition may potentially require a full Danish court hearing on the merits of the case, including witness testimonies, submission of evidence and an oral hearing.

9.5 The Enforcement of Arbitration Clauses

Denmark is party to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the "New York Convention") and thus the Danish courts generally recognise and enforce arbitration clauses by dismissing the case should it be governed by an arbitration clause.

However, if a case has been commenced before the courts and one party alleges that the matter is subject to an arbitration clause, the courts will rule on jurisdiction before referring the matter to arbitration (albeit only prior to commencement of arbitration). The court may also order interim measures or assist in enforcement.

9.6 The Enforcement of Awards

As mentioned in **9.5 The Enforcement of Arbitration Clauses**, Denmark is party to the New York Convention and awards rendered in countries party to the convention are immediately enforce-

able in Denmark. In addition, arbitration in Denmark is governed by the Danish Arbitration Act (which, to a great, extent follows the 1985 UNCITRAL Model Law), according to which foreign awards are recognised irrespective of whether the award was rendered in a contracting state to the New York Convention.

Enforcement of an arbitral award may be refused owing to the reasons listed in Section 39 of the Danish Arbitration Act. The grounds for refusal are equivalent to the grounds listed in the Article V of the New York Convention and the UNCITRAL Model Law's Section 36.

Enforcement of arbitral awards otherwise follows the rules for enforcement of foreign judgments.

9.7 Alternative Dispute Resolution

Litigation and arbitration are the overriding means of dispute resolution involving insurance claims in Denmark. Arbitration is more used for reinsurance claims than for ordinary claims.

Mediation and negotiation do not – at least, as yet do not – play any notable role when it comes to resolving insurance disputes in Denmark. Although the courts may offer mediation, they cannot force the parties to mediate or negotiate.

9.8 Penalties for Late Payment of Claims

Pursuant to the Danish Insurance Contracts Act, the insurer must pay out the claim 14 days after it was possible to obtain the information and evidence necessary in order to assess the claim and calculate the claim.

The insured is entitled to interest on the insurance claim from the point that the insurer was obligated to pay out the claim. Interests are calculated on the basis of the Danish Interest Act. The interest rate on claims due to late payments is the official lending rate of the Danish National Bank plus 8%.

Theoretically, the insured may claim additional damages for the insurers delay of payment under the general rules on liability in damages. However, the Danish "shortage of funds" doctrine – by which the injured party's lack of funds or access to funds does not in itself create liability for the tortfeasor – limits the access significantly.

Punitive damages are not available in Denmark.

9.9 Insurers' Rights of Subrogation

The insurer generally subrogates in the insured's claim against the tortfeasor upon payment of the claim, with a few limitations. The subrogation right is statutory and no letter of subrogation or other documentation for the subrogation is required.

For claims that are covered by a property insurance or loss of profit insurance, the insurer does not subrogate in the claim against the tortfeasor if the tortfeasor is a private individual.

Further, the insurer subrogates in the rights of the insured with the limitations of the insured's rights as well. A tortfeasor may invoke any defences against the subrogated insurer that the tortfeasor could invoke against the insured, notwithstanding any insurance payout.

Finally, the insurer does not subrogate in claims paid out under a life insurance, personal injury insurance or other personal insurance, or if the parties have entered into non-recourse terms in the insurance contract.

10. Insurtech

10.1 Insurtech Developments

App-based insurance products continue to make their way into the Danish insurance market.

One example is the Swedish insurance company Hedvig Försäkring AB, which established a Danish branch in 2021. The company offers home, travel, accident and housing insurance, as well as a separate insurance package for students. Insurance claims are primarily processed through the Hedvig mobile app, which by their own admission has an average claims processing time of six minutes – the fastest recorded processing time was only 195 seconds. The insurance product appeals mostly to a younger demographic, owing to the digital solutions.

A similar app-based insurance company, Undo, has been established in the Danish market for some years now. Older and well-established insurers like IF Insurance have also started to move in a more digital direction by introducing app-based solutions. This could indicate that a generational shift is underway in the Danish insurance industry, as it moves away from traditional ways of doing insurance business towards more digital solutions.

10.2 Regulatory Response

There are as of now no specific regulations applying to insurtech issues. App-based insurances and other insurtech products are subject to the same rules as conventional insurance.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Cyber-risk continues to be a risk that both insureds and insurers have focus on. Insurers who underwrite cyber-risk insurance are requiring insureds to undertake heavier measures to prevent phishing, hacking, ransomware attacks, etc. Most insurers will require an insured to document what countermeasures they take in order to prevent cyber-attacks and will make countermeasures a conditions precedent for cover.

Cyber-risks and other emerging/new risks are often excluded from the standard insurance products and will often need to be covered by specific insurance products covering these risks.

Moreover, more insurers are offering “cyber forensic teams” and training to insureds as part of the cyber cover.

11.2 New Products or Alternative Solutions

New products are constantly being developed to counter cyber-risk. As mentioned in **11.1 Emerging Risks Affecting the Insurance Market**, insurers are now also offering additional services to high-risk insureds in order to counter cyber-attacks.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

There have been some cases regarding insurance cover arising from COVID-19. The cases have, among other things, concerned the extent

to which there is cover for interruptions caused by COVID-19 under normal business interruption clauses (eg, traffic congestion or supply chain breakdowns). Moreover, the cases have concerned the question of "occurrences" in the context of COVID-19 (both with regard to deductibles as well as payment of claims subject to a limit).

There has been no legislative response in relation to insurance cover of COVID-19; however, most insurers have either excluded or limited the pandemic cover to certain amounts.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

There have not been any significant legislative or regulatory developments within the insurance and reinsurance industry in 2022.

Hafnia Law Firm LLP is a specialised law firm focusing on insurance, dispute resolution and the shipping industry. Hafnia Law Firm consists of six partners, five lawyers and five junior associates, all located in Copenhagen, Denmark. The firm advises both insurers and insureds on insurance matters and works regularly with the largest insurance companies in Denmark. Hafnia Law Firm primarily advises domestic and foreign companies in the private commercial sector; however, it has also handled litigation both for and against the public sector on several occasions. The firm currently handles several insurance disputes involving insurance cover, defence matters, and recourse against third parties for subrogated claims. The lawyers at the firm all have right of audience at the High Courts and half of the qualified lawyers have right of audience before the Supreme Court, underlining the firm's focus on litigation and dispute resolution.

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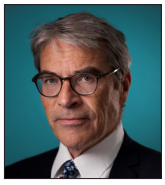
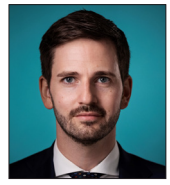


Henrik Thal Jantzen joined Hafnia Law Firm as a partner in 2018. He was a part of Kromann Reumert's insurance and dispute resolution practice for more than 20 years, after becoming a partner at that firm in 1993. Henrik has substantial experience in general commercial insurance matters, including disputes in relation to construction and operational all-risk policies and property risk. He is a highly experienced commercial litigator and has conducted several landmark financial, insurance and maritime cases before the Danish Supreme Court. Henrik has been a member of the Supreme Court Bar Association since 1991 and has acted as counsel and arbitrator in several arbitration proceedings.



Andreas Oxholm joined Hafnia Law Firm in 2016 as assistant attorney and became an attorney-at-law in 2019 with right of audience before the High Courts. In 2021 Andreas obtained an LLM degree from New York University in International Business Regulation, Litigation and Arbitration, which added to his experience in cross-border commercial dispute resolution. He has extensive litigation experience, particularly with insurance claims. Andreas regularly takes instructions from Danish insurers on cover and recourse matters and has been teaching at the Danish Insurance Academy. He has represented both municipalities and international commercial clients in various liability cases before the Danish courts and in LMAA arbitrations.

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FRANCE

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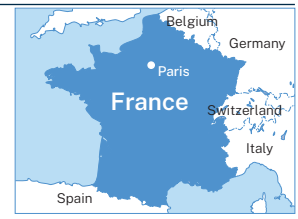

Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Insurance law in France is mainly governed by the Insurance Code (IC), the Social Security Code, the Mutual Code, and the Monetary and Financial Code (MFC). Other codes, such as the Civil Code, may also apply to a lesser extent.

EU legislation also has a significant impact on French insurance regulation - for example, Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (the "Solvency II Directive") or Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (the "Insurance Distribution Directive").

Finally, case law emanating from French courts is particularly important, in that it interprets and applies French insurance law and, so doing, clarifies insurers' and policyholders' respective rights and obligations.

Reinsurance, for its part, is governed by the Civil Code rather than the IC. As such, reinsurance practice benefits from greater contractual freedom than insurance practice. Moreover, French reinsurance practice is influenced by English reinsurance practice to a significant extent – whether it be in terms of product design or dispute resolution.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

In France, insurance and reinsurance activities are regulated by an independent administrative authority known as the French Prudential Supervision and Resolution Authority (*Autorité de Contrôle Prudentiel et de Résolution*, or ACPR). It licenses and controls insurance and reinsurance, as well as banking activities. The ACPR has three functions:

- a regulatory function – the creation of soft law, through issuing general rules and guidelines (by way of circulars, decrees, etc) for banking, insurance and reinsurance activities;
- an oversight function – via continuous and ad hoc controls of insurance companies and intermediaries; and
- a disciplinary function – with a range of possible sanctions.

The ACPR is a member of the European Insurance and Occupational Pensions Authority (EIOPA), which was created on 1 January 2011 and is one of the three supervisory authorities of the European System of Financial Supervision. It is independent, but reports to the European Parliament, the Council of the European Union, and the EC.

2.2 The Writing of Insurance and Reinsurance

To be authorised to write insurance or reinsurance, any new insurance or reinsurance company must respect the licensing procedure as set out in Articles L321-1 to L321-3 and R321-1 to R321-5 of the IC. These articles were amended on 8 October 2021 in order to impose a duty to

inform the EIOPA before granting authorisation (under the Freedom of Establishment) to a (re) insurance undertaking in another EU member state if the proposed scheme of operations suggests that the (re)insurer's activities will have a significant impact on the French market.

The ACPR can grant licences either conditionally or unconditionally or, alternatively, refuse to grant them altogether. Its decision is based on the following criteria:

- the integrity, expertise and experience of the applicant's managers;
- the extent and suitability of the technical and financial means that the applicant plans to implement; and
- the applicant's shareholding structure and shareholder status.

Moreover, insurance undertakings operating in France must respect the Solvency II Directive and, as such, must:

- have a governance system that ensures sound and prudent management;
- comply with minimum capital requirements;
- have an adequate risk management system; and
- organise regular internal reviews.

The ACPR grants licences to insurance undertakings for specific categories of business. Applicants must choose between 26 categories listed in Article R321-1 of the IC. Unlike reinsurance companies, insurance companies cannot be listed for both life and non-life insurance business.

2.3 The Taxation of Premium

Article 991 et seq of the General Tax Code regulates the French insurance premium tax (IPT), which applies to all insurance policies covering risks situated in France.

Insurance undertakings that are not established in France must be registered with the French tax authorities and assign a representative who is responsible for paying the IPT.

The rate of the IPT depends on the insured risk, and can vary from 7% to 33%.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

The approach of French jurisdiction to overseas-based insurers or reinsurers doing business in France (or with counterparties in France) varies depending on where the insurer or reinsurer is registered.

Insurance and Reinsurance Companies Registered in an EU Member State or in an EEA State

Insurance companies

Pursuant to Articles 147 to 149 of the Solvency II Directive and Article L310-2 of the IC, the Freedom to Provide Services and the Freedom of Establishment allow any insurance company authorised in a member state to carry on its insurance activities throughout the EU.

A non-French insurance undertaking wishing to exercise its freedom to provide services must have received authorisation for its activities from the supervisory authorities of its home state. The Solvency II Directive provides that the authorisation granted by a member state is valid throughout the EU.

Reinsurance companies
Directive 2005/68/EC of the European Parliament and of the Council of 16 November 2005 on reinsurance and amending Council Directives 73/239/EEC, 92/49/EEC as well as Directives 98/78/EC and 2002/83/EC (the "EU Reinsurance Directive") facilitated the conduct of reinsurance business within the European Economic Area (EEA) by extending the European passport system to reinsurers. Thus, the approval issued by the authorities of the EU member state in which the reinsurer's head office is located will be valid throughout the EEA. The reinsurer can then act outside said EU member state under the Freedom to Provide Services or the Freedom of Establishment (Article L310-1-1-1 of the IC).

Other Foreign Insurance and Reinsurance Companies Operating in France

Insurance companies
Foreign insurance companies located outside the EU and the EEA may only operate in France after obtaining an administrative licence and a special licence for the benefit of a general representative (Articles L310-2, I, 4° and L329-1 of the IC). Following Brexit, from 1 January 2021 this regime now applies to insurance companies located in the UK. However, it should be noted that, pursuant to a 16 December 2020 Ordinance and Article A310-1 of the IC, UK-based insurers were allowed – and, indeed, obligated – to keep on performing their obligations under policies that were still in force on 1 January 2021, albeit on a purely run-off basis (see **13.1 Additional Market Developments**).

Reinsurance companies
Reinsurers whose head office is not located in the EEA may also reinsure insurance companies established in France.

Foreign reinsurers, in principle, must not be treated more favourably than European reinsurers (Article L310-1-1 of the IC). However, these reinsurers may benefit from the same rules as European reinsurers if the regulations of their head office country are deemed to be "equivalent" to the EU regulations. This equivalence system was necessary to comply with the WTO agreements aimed at liberalising international trade in services – in particular, the General Agreement on Trade in Services.

In practice, equivalence allows foreign reinsurers to reinsure European companies under the same conditions as European reinsurers. These "equivalence" decisions are taken by the EC. On 5 June 2015, the EC granted equivalence for a period of ten years to six such countries: Australia, Bermuda, Brazil, Canada, Mexico and the USA. Switzerland was granted unlimited equivalence.

3.2 Fronting

There are no limitations in France on the introduction of fronting arrangements by reinsurance companies. Moreover, there is no obligation for the cedant to retain any share of the risk.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

After a marked decrease in M&A transactions during 2020, 2021 saw a significant uptick in transactions, with 17 M&A transactions taking place during the first three quarters of 2021. This pace continued and, indeed, accelerated in 2022 – a total of 23 M&A transactions occurred during the first three quarters of the year.

Major insurers are redistributing their development efforts on corporate risks and reconsidering their presence in mature global markets.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

In France, most insurance products are distributed by traditional actors (eg, brokers and general agents) and, directly, by employees of the insurance company. However, new ways of distributing insurance are emerging, such as:

- online insurance comparators websites;
- insurtech; and
- high street banks that increasingly offer insurance products.

The Insurance Distribution Directive, which came into force in France on 1 October 2019, changed the EU's legal framework for insurance distribution.

Firstly, it modified Article L112-2 of the IC, as a consequence of which insurance distributors must now provide their clients with a standardised document that summarises the key characteristics of the envisaged insurance contract.

Secondly, the scope of the applicable regulation has been broadened. Indeed, Article L511-1 et seq and Articles R511-1 et seq of the IC – which regulate the activity of distributing insurance products – now also apply to the distribution of insurance products online and over the telephone. Moreover, Article L511-1 - which used to apply only to intermediaries who undertook distribution as a principal activity – now also applies to insurance companies and includes most distributors who undertake this activity on a secondary basis.

Finally, pursuant to Articles A512-6 and A513-7 of the IC, insurance company employees, general agents and brokers must hold a master's or bachelor's degree or professional certificate in finance, banking or insurance.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Article L113-2 of the IC governs the policyholder's disclosure obligations, which mainly consist of completing a questionnaire drawn up by the insurer, as well as answering any questions clearly phrased and submitted by the insurer by other means (eg, letter, fax or email).

As a matter of French insurance law, the insured is under no obligation to spontaneously disclose information that might be relevant to the policy and the scope of their disclosure obligations is exclusively determined by the insurer's questions. However, if the insured does elect to spontaneously disclose information, then the statements must be accurate and truthful or else the contract could be avoided for fraudulent misrepresentation.

During the life of the policy, the policyholder also has a continuous duty to disclose all changes relating to the information that was disclosed in the insurance questionnaire or in response to the insurer's questions at inception.

Pursuant to Article L112-3 of the IC, if the insurer's questions are not sufficiently clear and precise, the insurer may not then rely on the fact that the insured's answers are vague or unreliable to

try to limit or deny coverage. It is therefore key that insurers draft their subscription questionnaires with this principle in mind and draft individual questions in a sufficiently precise fashion.

The French legislature has recently amended the regime that governs borrowers' insurance in to residential mortgages. As of 1 June 2022, the requirement to complete a medical questionnaire has been removed for mortgages below EUR200,000 that will mature before the policyholders' 60th birthday - with a view to enabling a wider group of people to have access to mortgages. Therefore, for these products, insurers will no longer be able to rely on policyholders' medical information to calculate premiums or to decide whether they underwrite the risk. Moreover, as of 1 September 2022, these borrowers' insurance contracts can be terminated at will by policyholders without paying any fee.

6.2 Failure to Comply With Obligations of an Insurance Contract

Policyholders' Failure to Comply with Their Obligation to Provide Information

The IC provides sanctions in the event that policyholders fail to comply with their legal obligation to disclose relevant information either at the beginning of the insurance contract or during its lifespan. These sanctions vary, depending on whether or not the policyholder was acting in good faith when they failed to disclose any information or provide accurate answers.

The insurer can avoid the policy, which will be deemed to be null and void, if the inaccurate information or the lack of disclosure:

- was deliberate and in bad faith; and
- influenced the insurer when deciding to provide cover or setting the amount of the premium.

However, if the insured was acting in good faith when they provided or failed to disclose the information at issue, the IC provides a more forgiving sanction: the policy will not be deemed null and void, but the indemnity owed by the insurer will be reduced, according to a rule of average (based on the premium the insurer would have requested, had the risk been accurately disclosed).

Notably, in decisions handed down in 2019 and 2021, the French Supreme Court held that – pursuant to European Law – auto insurers could not invoke policyholders' misrepresentations in order to limit or deny coverage to third-party victims.

Insurers' Failure to Comply with Their Obligation to Provide Information

Insurers' obligation to provide information is set out in Article L112-2 of the IC, which provides that – prior to entering into the insurance contract – the insurer must provide the potential insured with:

- a copy of the proposed insurance contract; and
- information sheets concerning:
  - (a) the amount of the premium and the cover provided by the policy; and
  - (b) the law that applies to the contract (if not French law).

The IC does not provide for any sanctions should the insurer fail to deliver the information sheets or a copy of the proposed insurance contract. Established case law, however, holds that the insurer will not able to invoke certain clauses (eg, exclusion and forfeiture clauses) against the insured if the insurer failed to bring their contents to the insured's attention and such clauses will be deemed unenforceable as a result.

Furthermore, as Article L112-2 requires the information to be provided before entering into or amending the insurance contract, insurers cannot remedy the situation by providing the information in question at a later date.

6.3 Intermediary Involvement in an Insurance Contract

When an intermediary is involved in the negotiation of an insurance contract, it can act on behalf of the policyholder or the insurer, depending on the nature of the contractual relationship.

The insurance broker's role is to source the policies that are best-suited to the profile of its policyholders in terms of protection, guarantees or rates. They then take care of the administrative set-up of the contract and negotiate its terms. Brokers provide clients with pre-contractual advice on premiums and coverage; therefore, they fall under the category of insurance distributors. As such, they have legal obligations in relation to the pre-contractual information and advice they provide.

Insurance brokers also be involved in claims handling. They assist the policyholder or insured in case of a loss, including during the investigation and the adjustment of the loss, and may also advise insurers when choosing the party-appointed adjusters. The broker's involvement regarding the handling of the claim depends on the extent and complexity of the loss and the sophistication of the insured.

Brokers can, however, act on behalf of the insurers – for instance, by collecting premiums owed under the policy.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

In principle, the insurance contract comprises an offer and an acceptance by which the parties demonstrate their will to be bound. It is a consensual contract but the consent given does not have to take a specific form; rather, it may be express or implied.

However, pursuant to Article L112-4 of the IC, policy clauses that stipulate nullities, forfeitures or exclusions shall be valid only if they are printed very clearly – for example, underlined or in bold (or both) – so that the design of the contract itself immediately brings the insured's attention to such clauses. Moreover, to be valid, the scope of exclusion clauses must not be so wide as to deprive the policy of its initial purpose. Finally, in a recent decision, the Supreme Court ruled that amendments to an existing policy are only valid if made in writing.

Moreover, to be valid, the insurance contract must be based on an insurable interest. It is indeed required that the interest exists on the day of subscription in order for the insurer to be liable for the coverage. The notion of the insurable interest is expressly referred to in Article L121-6, paragraph 1, of the IC, which provides that any person with an interest in the preservation of an object may have it insured.

According to Article L112-4 of the IC, the insurance policy is dated the day it is issued and it must indicate:

- the names and domiciles of the contracting parties;
- the insured object or person;
- the nature of the risks covered;

- the time from which the risk is guaranteed and the duration of this guarantee;
- the amount of this guarantee; and
- the insurance premium or contribution.

The policy should also indicate:

- the law applicable to the contract where French law does not apply;
- the address of the insurer's registered office and, where applicable, the branch granting coverage; and
- the names and addresses of the authorities responsible for supervising the insurance undertaking granting cover.

Finally, insurance contracts' legal requirements vary according to the nature of the risk. Indeed, insurance against "large risks" (as defined by the IC) allows for more flexibility than where there are standard risks against which consumers will take out insurance. As such, "large risks" insurance contracts – unlike consumer or standard insurance contracts – are not subject to the following:

- Article L112-2 of IC, which requires the insurer to provide the insured with an information sheet on the price and guarantees, as well as a copy of the draft contract;
- the first paragraph of Article R126-2, which prohibits the stipulation of deductibles or ceilings specific to damage resulting from acts of terrorism; or
- the obligation that the policy be drafted in French or, indeed, governed by French law.

6.5 Multiple Insured or Potential Beneficiaries

In the context of a group insurance, the policyholder is bound to provide the members with a notice prepared by the insurer defining the coverages and their terms and conditions of entry into force, as well as the formalities to be completed in the event of a claim. They must inform participants in writing of any changes to their rights and obligations at least three months before their expected effective date.

Moreover, credit institutions that engage in insurance operations of any kind are subject to the ordinary rules applicable to all insurance intermediaries. The loan insurance operation must comply with the rules that apply to the distribution of non-life insurance, especially the following:

- the obligations relating to the medium of information (dematerialisation) – ie, certification on paper or on another durable medium – as codified in Article L521-6 of the IC; and
- the provision of a standardised insurance product information document (IPID), referred to in Article L112-2 of the IC.

The credit institution satisfies the membership formalities by issuing borrowers with an insurance application form, also known as a membership application or individual membership application form. In practice, this document is not necessarily separate from the loan contract, as the application for membership may be included on the same form. In this case, however, it is required that the borrower's membership be evidenced by a signature separate from that showing their acceptance of the offer of credit.

Finally, under French insurance law, the beneficiary of the loss payee clause can act directly against the insurer for payment of the benefit provided for in the contract.

6.6 Consumer Contracts or Reinsurance Contracts

Reinsurance leaves the field open to contractual freedom. Built on a practice that is not inclined to strict drafting, certain clauses can radically change the economics of the contract.

As mentioned in **1.1 Sources of Insurance and Reinsurance Law,** reinsurance practice is not governed by the IC in France. Instead, it is governed by the principles of the Civil Code – meaning that the practice of reinsurance enjoys somewhat more contractual freedom than that of insurance. When it comes to dispute resolution and product design, French reinsurance is influenced by the English practice.

"Large risks" insurance contracts are more regulated than reinsurance contracts, although though their regime still allows a certain degree of flexibility (see **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract**). "Standard" or consumer insurance contracts, however, are heavily regulated and must abide by numerous and detailed requirements – all of which are aimed at protecting the insured (as a consumer and the less sophisticated of the two parties in the insurer-insured relationship).

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

All risks (property damage, personal injury, liability, life) corresponding to classes 1 to 26 of Article R321-1 of the IC may be transferred to a securitisation undertaking in an Alternative Risk Transfer (ART), either:

- directly by the insurance or reinsurance undertakings, under French or foreign law; or
- indirectly by another insurance risk securitisation vehicle, under French or foreign law, approved in accordance with Article 46 of the EU Reinsurance Directive.

Indeed, Order No 2008-556 of 13 June 2008 introduced the option for securitisation undertakings to bear insurance risks and defined the regime applicable to securitisation transactions carried out by French insurance and reinsurance companies.

In accordance with Article L214-189 of the MFC, a securitisation undertaking must be approved by the ACPR to bear insurance risks. The ACPR verifies that:

- the statutes or regulations of the securitisation undertaking actually authorise it to bear insurance risks;
- the persons responsible for the management of the securitisation undertaking are of good repute and have appropriate professional qualifications; and
- the securitisation undertaking has put in place administrative and accounting procedures to identify and assess the insurance risks objectively – as well as internal control and management mechanisms that enable it to monitor the evolution of these risks.

The ACPR also verifies that the asset composition and risk coverage strategy of the securitisation undertaking are compatible with the rule limiting the total amount of commitments to the value of its assets, as required by Article D214-237, 5° of the MFC.

Securitisation undertakings underwriting insurance risks are, in fact, subject to dual supervision:

- first, the approval of the securitisation undertaking by the ACPR; and
- second, the supervision of the securitisation undertaking's management company by the French Financial Market Authority (*Autorité de Marches Financiers*, or AMF).

However, according to Article L310-1-2 of the IC, contracts through which a securitisation vehicle assumes an insurance risk do not constitute insurance contracts.

7.2 Foreign ART Transactions

Whether written in other jurisdictions or under French law, ART transactions do not constitute insurance contracts under Article L310-1-2 of the IC.

An ART written in another jurisdiction may be transferred:

- directly by the insurance or reinsurance undertakings; or
- indirectly by another insurance risk securitisation vehicle, approved in accordance with Article 46 of the EU Reinsurance Directive.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The main priority when interpreting an insurance contract is to respect the will of the contracting parties. Hence, where the policy is clear, the courts must simply apply and enforce it. However, if the policy is ambiguous and needs to be interpreted, the courts and parties can use extraneous evidence about the negotiations, the circumstances in which the contract was placed, or the "usual practice". They can also refer to the (non-mandatory) contractual interpretation guidelines provided in the Civil Code (Articles 1188 et seq), which are as follows:

- one must look for the common intention of the contracting parties, rather than focus on the literal meaning of the words;
- where this intention cannot be inferred, the contract must be interpreted according to the meaning that a reasonable person in the same situation would ascribe to it;
- the contract is to be interpreted in its entirety;
- contracts that concern the same operation should be interpreted together, rather than independently from one another;
- specific provisions take precedence over more general provisions; and
- a non-negotiated contract is interpreted against the drafter.

French insurance law tends to be pro-consumer and consequently pro-insured. Ambiguous policy provisions are therefore often interpreted in the manner that is most favourable to the insured (which may, in turn, lead to their being set aside). The following additional rules regulate the interpretation of an ambiguous policy.

- Firstly, according to the French Consumer Code, if the insured is a consumer then the ambiguities must be interpreted in its favour.
- Secondly, in case of ambiguities, the non-negotiable standard terms of the contract shall be interpreted in whichever way is least favourable to the insurer.
- Thirdly, the IC adds that certain key clauses, such as exclusion clauses, must have a clear scope and be readily understandable by the insured upon first inspection. The aim is to prevent any doubt regarding what is covered and what is excluded from coverage. As a consequence, exclusion clauses that require

interpretation will be set aside, as will exclusion clauses that rely upon open-ended lists and use such phrases as "including" or "such as" (note that, in a recent decision, the French Supreme Court held that this was the case even in instances where the risk that effectively occurred was one of the risks that were explicitly identified in the open-ended list).

8.2 Warranties

An insurance contract contains an implied warranty – that is, a promise by the insured that statements affecting the validity of the contract are true. Moreover, Article L113-2 of the IC provides that the insured must answer the questions asked by the insurer in a truthful fashion.

8.3 Conditions Precedent

Under French law, policies can include condition precedents – one example of such would be a stipulation that the insurance contract will not be considered entered into or binding until the first premium has been paid.

Policies can also include coverage conditions, which are distinct from condition precedents. Indeed, if a condition precedent is not met, the insurance contract will be deemed to have never existed. In contrast, failure to satisfy coverage conditions for a certain time will merely suspend the insurer's obligation to provide insurance cover during the relevant period before resuming as soon as the condition is met again. Such conditions are feature frequently in insurance cover for breaking and entering or theft, where the insurer's cover obligation is conditional upon certain security measures always being maintained (eg, the presence of a functioning alarm system protecting the risk).

It should be borne in mind that coverage conditions are distinct from exclusion clauses, as a consequence of which their validity is not dependent on:

- appearing in bold print in the contract; or
- being drafted in a readily understandable fashion and with a narrow scope.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurers can add a mediation and conciliation clause in their policies in order to address any disputes over coverage under an insurance contract.

The requirements regarding these clauses vary depending on the identity of the insured – for instance, "large risks" insurance contracts can stipulate mediation and conciliation clauses, with no obligation to specify the exact means of initiating mediation. However, if the insured is a consumer, the insurance contract must indicate how to initiate the mediation, pursuant to Article L112-2 of the IC. Moreover, when the insured is a consumer, arbitration clauses contained in the insurance contract are automatically deemed null and void.

In accordance with the applicable case law, if an insurance contract contains a conciliation clause or a mediation clause, the parties must go through these steps before they can take legal action.

The limitation period that applies to claims relating to the performance of insurance contracts lasts two years, pursuant to IC Article L114-1. This time limitation period only starts to run from the moment the insured becomes aware of the loss. It can be interrupted by the insured sending a letter to the insurer to that effect via registered

mail with confirmation of receipt. On 21 December 2021, an exception was introduced for cases where damage resulting from land movements due to drought and soil dehydration is recognised as a natural disaster; the limitation period has been extended to five years in such cases.

The time limitation period can only be successfully invoked by the insurer if the policy in question reinforce the articles of the IC that govern the time limitation period and indicate how it can be interrupted.

The two-year time limitation that applies to insurance contracts has recently been challenged before the French Constitutional Court on the grounds that it is excessively short and unfair if the insured is merely a consumer. However, on 17 December 2021, the Constitutional Court ruled that the two-year time limitation applicable to insurance contracts was constitutional and would be upheld.

In a recent decision, the French Supreme Court held that the two-year limitation period only applied to actions relating to the insurance contract itself. Consequently, it does not apply to civil liability claims against the insurer, which are subject to a five-year limitation period.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Choice of Jurisdiction

In the absence of a clause conferring jurisdiction, the jurisdiction is determined according to the rules of private international law. For French courts, these rules derive from four texts:

- European Regulation EC 44/2001 of 22 December 2000;
- the Brussels Convention of 27 September 1968;
- the Lugano Convention of 16 September 1988; and
- the common French law of jurisdiction.

The criterion for the application of these texts is the domicile of the defendant.

Choice of jurisdiction for defendants domiciled outside the EU or the European Free Trade Association

For defendants domiciled outside the EU or the European Free Trade Association, the international jurisdiction of French courts is determined by extending the rules of internal territorial jurisdiction.

Among these rules of internal territorial jurisdiction several articles apply:

- Articles 14 and 15 of the Civil Code; and
- Article R114-1 of the IC for insurance matters.

These articles establish a jurisdictional privilege in favour of litigants of French nationality. Article 14 provides that a foreigner, even if not residing in France, may be cited before French courts for the performance of obligations contracted by them in any country with a French person. Article 15 adds a privilege of exclusive jurisdiction and provides that a French person must be brought before a French court for obligations contracted by them in a foreign country, even with a foreigner.

Nonetheless, Article R114-1 of the IC derogates from the ordinary rule of jurisdiction (ie, the jurisdiction of the court of the defendant's domicile). Indeed, in the event of a dispute, this rule would oblige the insured to cite their insurer before the court of the domicile in which the company's registered office is located.

Consequently, French law has established that the defendant is brought before the court of the insured's domicile in all proceedings relating to the determination and payment of an insurance indemnity. However, there is an exception to this rule if the dispute relates to buildings - in which case, the defendant is then cited before the court of the location of the insured objects. Moreover, in the case of insurance against accidents of any kind, the insured may cite the insurer in the court local to the place where the event occurred.

Defendants domiciled in an EU member state, Switzerland, Norway or Iceland

If the defendant in the action is domiciled in an EU member state, Switzerland, Norway or Iceland, the standards that apply will be the Brussels I bis Regulation and the revised Lugano Convention.

This regulation tends to protect the weaker party. Thus, an insured beneficiary or policyholder can decide to claim against an insurer either in the courts of the EU member state where the claimant is domiciled or the EU member state where the insurer is domiciled. The insurer, however, has no choice and must claim in the courts of the EU member state where the defendant is domiciled.

Choice of Law

In insurance matters, conflicts of law are governed by two distinct sets of rules:

- the Rome Convention of 19 June 1980; and
- the laws transposing the European directives of 22 June 1988 and of 8 November 1990 – that is, Articles L181-1 and seq of the IC in France.

To determine which sets of rules apply, it is necessary to locate the risk situation. Indeed, when the risk is located outside the EEA, then the Rome Convention will determine the applicable law.

For risks located in the EEA, the law is based on the rules laid down by the national transposition of the following European directives:

- Council Directive 90/619/EEC of 8 November 1990 on the coordination of laws, regulations and administrative provisions relating to direct life assurance, laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 79/267/EEC, amended by Council Directive 92/96/EEC of 10 November 1992, for life insurance; and
- Second Council Directive of 22 June 1988 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 73/239/EEC, amended by Directive 92/49/EEC of 18 June 1992, for non-life insurance.

On one hand, the main rule regarding life insurance contracts is expressed by Article L183-1 of the IC, which indicates that the contract shall be governed by French law – to the exclusion of any other law – if the agreement is made in France. However, if the policyholder is an individual and national of another member state of the EEA, the parties to the insurance contract may choose to apply either French law or the law of the EU member state of which the policyholder is a citizen.

On the other hand, in the case of non-life insurance contracts, Article L181-2 of the IC says the contract shall be governed by the law of the state

with which it has the closest links. The contract is presumed to have the closest links with the EEA member state in which the risk is located.

The parties may derogate from this connection principle by choosing the applicable law, as offered to them in Articles L181-1 and L181-2 of the IC. But said choice must be express or result with certainty from the clauses of the contract or the circumstances of the cause. Finally, according to the Article 13 of the Brussels I bis Regulation and Article 11 of the Lugano Convention, the injured party may bring a direct action; however, only if it is possible to do so according to the applicable law.

The victim will be able to bring the civil liability insurer before the court of the member state or contracting state in which which they have sued the liable insured. However, the latter has other options when it comes to jurisdiction.

As direct actions against the liability insurer of the alleged liable party are allowed under French law, it is therefore possible for the injured party to bring a direct action in front of French courts.

9.3 Litigation Process

Insurance disputes in France are litigated in the following tribunals:

- first instance commercial courts;
- first instance civil courts (formerly County Court and High Court);
- courts of appeal; and
- the French Supreme Court (the Cour de Cassation).

The first instance commercial court or the first instance civil court have jurisdiction subject to the identity of the parties (ie, whether the parties are civil or commercial entities).

Decree No 2019.912, which has come into force on 1 January 2020 merges the County Court and the High Court, which now constitute a single court (*Tribunal Judiciaire*).

Once the first instance decision has been handed down, the parties that wish to do so can bring an appeal, without seeking prior permission. The distinction between civil and commercial entities disappears upon appeal, as the courts of appeal hear both types of cases alike.

Once the court of appeal has rendered its decision, it is possible to bring a second and final appeal before the French Supreme Court only if it relates to a point of law, as the French Supreme Court only hears appeals on points of law.

9.4 The Enforcement of Judgments

In France, to force the counterparty (defendant or debtor) to comply with the judgment against them, the party will have to go to the enforcement authorities. They alone have the power to force the debtor to pay, calling on law enforcement if necessary.

Under the Brussels I bis Regulation, which governs the recognition and enforcement of judgments in cross-border cases, if the party has an enforceable judgment issued in an EU member state then it can go to the enforcement authorities in any other member state (eg, where the debtor has assets) without any intermediary procedure being required. The Brussels I bis Regulation abolishes the “exequatur” procedure. The debtor against whom the party seeks the enforcement may apply to the court requesting refusal of enforcement.

The purpose of enforcement is generally to recover sums of money, although it may also be to have some other kind of duty performed – for

example, a duty to do something (such as deliver goods or finish work) or refrain from doing something (such as trespassing).

In practice, the party needs to have an enforceable document (a court judgment or a deed) if it wishes to apply for enforcement. The enforcement procedures and the authorities who handle them (courts, debt collection agencies, and bailiffs) are governed by the national law of the member state where enforcement is sought.

Foreign decisions taken in third countries (ie, outside the EU) can be enforced via the exequatur proceeding.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses in commercial insurance and reinsurance contracts can be enforced as per any arbitration clause in other kinds of contracts. To be valid and enforceable, the arbitration clause must have been accepted by the party to whom it is opposed. Moreover, arbitration clauses are not enforceable against non-professionals (ie, persons who did not enter the contract in the course of their professional activity).

A standard arbitration clause for insurers and reinsurers to use has been prepared by The French Centre for Reinsurance and Insurance Arbitration (*Centre Français d'Arbitrage de Réassurance et d'Assurance*, or CEFAREA-ARIAS), which is an association created to promote arbitration and mediation in the field of insurance and reinsurance.

9.6 The Enforcement of Awards

According to Article 1487 of the French Code of Civil Procedure, if amicable enforcement is impossible, the award can be enforced via an exequatur order. An enforcement or exequatur order is the act by which the exequatur judge orders that an arbitral judgment be executed.

Excluded from the scope of the Brussels Convention, international arbitration is governed by international conventions, the most important being the Convention on the Recognition and Enforcement of Foreign Arbitral Awards of 10 June 1958 (the "New York Convention"). However, the New York Convention is not often applied for exequatur proceedings in France. Indeed, it specifies that rules of the state of origin may apply where they are more favourable to the recognition of awards. As French law is liberal on this point, it is essentially the rules of the Code of Civil Procedure that are to be applied.

9.7 Alternative Dispute Resolution

In order to comply with the new requirements of the Directive 2013/11/EU of the European Parliament and of the Council of 21 May 2013 on alternative dispute resolution for consumer disputes and amending Regulation (EC) No 2006/2004 and Directive 2009/22/EC (the "EU Consumer ADR Directive"), insurers have set up – within the framework of the *Fédération Française de L'Assurance* – a unique mediation system managed by an association called *La Médiation de l'Assurance.*

Insurance companies that are members of the *Fédération Française de l'Assurance* – ie, most companies operating in France – have undertaken to join *La Médiation de l'Assurance* and to respect the terms of its mediation charter. The association receives around 20,000 claims per year.

The mediator is appointed for three years and the charter of *La Mediation de l'Assurance* defines its powers, as well as the rules applicable to mediation in assurance. The mediator is

authorised to deal with disputes that may arise between individuals and insurance companies in order to seek amicable solutions.

In addition, mediation may be extended by agreement to other disputes, such as those with a third-party beneficiary or disputes relating to professional insurance (excluding large risks).

According to the mediation charter, the mediation process is a written one – the insurance companies and intermediaries having a maximum period of five weeks to respond to requests for information or documents from the insurance ombudsman. As it is a mediation, however, the opinion that is finally handed down is not binding upon the parties.

9.8 Penalties for Late Payment of Claims

In France, in the event of a delay in compensation, the insurer may be required to pay damages to the insured. If the insurer is late in complying with its obligations, the insured must send a summons to perform its obligation to pay the insurance indemnity in the form of a registered letter with acknowledgement of receipt. Interest starts to accrue from the time the registered letter is received by the insurer.

Regardless of the type of insurance, the interest is based on the indemnity owed by the insurer and is calculated based on the statutory rate of interest in force at the time.

The IC indicates specific rules for delays and interests regarding:

- traffic accidents (regulated by Articles L211-8 and seq of the IC);
- life insurance (governed by Article L132-23-1 of the IC); and
- compulsory construction insurance (ruled by Article L242-1 and seq of the IC).

9.9 Insurers' Rights of Subrogation

Pursuant to IC Article L121-12, the insurer automatically benefits from subrogation rights (up to the amount of the indemnity paid out) from the moment it has indemnified its insured – provided the loss fell within the policy's scope of coverage. Otherwise, the payment is deemed ex gratia and automatic subrogation does not apply; however, in such cases, the parties can nevertheless agree to bestow subrogation rights upon the insurer by way of a subrogation agreement.

Article L121-12 of the IC also provides that the insurer is exonerated from its obligation to indemnify the insured if the latter's conduct constitutes a waiver of its right of action against the liable third party, such that the insurer would be prevented from exercising its subrogation rights in the event it paid an indemnity.

Once it is subrogated into the insured's rights, the insurer has an exclusive right of action against the liable third party. The insured cannot, therefore, initiate proceedings regarding the part of its loss that has been indemnified (unless it produces a joint prosecution agreement entered into with the insurer). The subrogated insurer benefits from all the transferred rights previously held by the insured, including access to rights such as arbitration agreements. Conversely, all defences that could validly be invoked against the insured (including time limitation) can now be raised against the subrogated insurer.

10. Insurtech

10.1 Insurtech Developments

In France, insurance companies tend to enter into partnership strategies with insurtech companies, as they often perceive them as means of accelerating innovation and digitalisation. Insurance companies are generally trying to make the most of insurtech's strengths (agility, technology) without being exposed to some of its perceived weaknesses (financial fragility, operational risks).

Naturally, there is no one single way to proceed and insurers' approaches are quite varied. Some are staking on significant partnership opportunities, through different funds and structures, whereas others are adopting a more selective strategy and focusing mainly on technological partnerships with more limited scopes.

Some of the criteria that are commonly relied upon to select insurtech partners are:

- their ability to provide, or help provide, improved customer service in an automated fashion;
- their expertise in relation to data and security; and
- the quality of their managers with regard to projects.

The following four channels of co-operation are (often jointly) used by the various insurers.

- Commercial partnerships – in this case, insurers want to benefit from the agility and flexibility of insurtech companies offering new customer services or making a commercial difference, which could fit within their strategic target, but which they themselves do not have the capacity to offer quickly at this stage.
- Technological partnerships – these partnerships do not directly concern the commercial sphere but rather fraud prevention and expertise. This configuration can also be adopted when the insurer wishes to remain in control of the customer relationship. They then use a white-label technology provider in order to benefit from the technology while securing their customer relationship.
- Minority shareholdings – these shareholdings are generally aimed at influencing the governance and development of insurtech companies without, however, affecting the partner's start-up spirit.
- Takeovers – this may originate from a desire to invest in a "gem" that the insurance company believes in enough to provide with all the (financial) means necessary to grow. Another motivation may be to secure key technological know-how by controlling the insurtech company entirely. Both cases raise the question of how to integrate these start-ups into large insurance companies without stifling their agility.

At the end of 2020, several French insurtechs created an association for French insurtech companies, which now boasts more than 100 members.

10.2 Regulatory Response

In France, most insurtechs identified in the market operate as insurance brokers. As such, they generally need to register at the *Organisme pour le Registre des Intermédiaires en Assurance* (ORIAS) and respect the regulations that apply to insurance intermediaries.

However, since 2019, some insurtech companies have obtained authorisations from the ACPR to carry out insurance business in France. They will, therefore, bear the financial risks asso-

ciated with their insurance business instead of relying on a partnership with existing insurance companies, as is usually the case.

At the same time, the EIOPA implemented an insurtech task force (ITF) to work on issues arising from insurtech and, in particular, analyse the use of big data by (re)insurance undertakings and intermediaries (both incumbents and start-ups). Furthermore, the ITF maps the supervisory initiatives undertaken by different jurisdictions in the field of insurtech, with a view to establishing efficient and effective supervisory practices. At a later stage, the ITF will also focus on the convergence of supervised algorithms and explore the benefits and risks arising from the use of blockchain and smart contracts for (re)insurance and consumers.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Cyber-risk

According to the 2021 *Fédération Française de l'Assurance* report on emerging risks, cyber-risk remains the main preoccupation for insurance and reinsurance companies. Insurers operating in France are still developing new insurance products to best meet the needs of the market and respond to this emerging type of risk.

To address these risks, a legislative framework has been established at the French level by the Military Programming Law 2019–2025 (*Loi de Programmation Militaire*, or LPM) and at the European level by the Network and Information Security (NIS) Directive in order to strengthen the security of sensitive information systems.

Moreover, the ACPR warned insurers that in view of the increasing exposure of companies and individuals to cyber-risk, cyber-insurance is one of its control and oversight priorities. In this context, it has identified the following areas for improvement:

- comprehensively assessing portfolios' exposure to cyber-risk (including as a result of so-called silent cyber cover) and, if relevant, integrating the assessment into the ORSA (Own Risk and Solvency Assessment) report;
- clarifying definitions and terminology relating to risks in order to enable an unambiguous offering to policyholders;
- gradually building the statistical bases that will make it possible to better delimit the guarantees and to price them in a relevant way; and
- raising awareness and training stakeholders in cyber-risk, both on the part of policyholders and sales forces (promotion/prevention co-ordination).

In May 2021, several insurers have announced that they would cease to cover payments made to ransomware operators. This announcement was part of a more general debate – notably before the French Parliament – on whether such ransom payments should be prohibited, as they may contribute to money laundering, financing terrorism and the development of cybercrime. However, on 1 December 2022, the French Parliament agreed on draft legislation intended to introduce a provision in the IC requiring professional policyholders who suffer ransomware attacks to lodge a criminal complaint within 72 hours of discovering the attack in order to be indemnified by their insurer. If this provision is finally adopted, it would constitute an implicit confirmation of the fact that it is lawful for an

insurer to make a payment in connection with a ransomware attack.

Environmental Risks

According to the 2021 *Fédération Française de l'Assurance* report on emerging risks, climate change is the third main preoccupation for insurance and reinsurance companies today. In France, climate change is generating more frequent and more damaging natural disasters, including the floods in the Aude, hailstorms in the Charente and especially hurricanes Irma and Maria in the French West Indies.

In France, the monitoring of climate risk for the financial sector was introduced by the Energy Transition Green Growth Act (*Loi relative à la Transition Énergétique pour la Croissance Verte*, or LTECV) adopted in August 2015. Article 173 of this law requires all institutional investors to publish information on:

- how their investment policy takes into account criteria relating to compliance with ESG objectives; and
- the measures implemented in order to contribute to the ecological and energy transition.

As part of its supervisory tasks, the ACPR is responsible for verifying that all insurance undertakings apply the contents of Article 173 of the LTECV.

Furthermore, the EIOPA has provided the EC with an opinion recommending a further review of environmental risks by the EU Insurance Distribution Directive and the Solvency II Directive. This opinion suggests that, in order to better integrate sustainability risks into Pillar 2 of the Solvency II Directive, the EC should amend several articles of the delegated Solvency II Directive and EU Insurance Distribution Directive - in particular, those that relate to:

- the principle of the prudent person;
- the management function of risks;
- the actuarial function; and
- the compensation policy.

11.2 New Products or Alternative Solutions

Cyber-risk

In France, new products and alternatives are being developed to address the cyber-risk. As of October 2019, the Ministry of Economy and Finance provides French companies with a cybersecurity self-diagnosis toolbox that is easy to access, practical and free of charge. The company must go to a website to find out its level of computer security in four key areas: passwords, data back-ups, messaging and browsers.

Furthermore, insurance companies have launched new insurance products to best meet the needs of the market. Some of these products target individual consumers with regard to possible risks concerning internet use, such as:

- identity theft;
- cyberharassment of family members;
- disputes relating to the purchase of goods or services;
- disputes on social media platforms; and
- fraud.

These products may also provide other services, such as identifying fraudulent websites and suspicious emails or abnormal credit card activity.

More established insurance companies have, for their part, widened their range of insurance products to help SMEs face cyber-attacks. The new range of cyber-risk insurance includes several

customised offers, depending on the turnover and risk typology of the companies. These insurance contracts provide cover in relation to the prejudice suffered as a result of cyber-attacks and may also provide specialised assistance to the insured.

Following a survey carried out by the ACPR among French insurers in 2021, the ACPR has noted that cyber coverage is mostly available to businesses as part of policies that provide coverage for a multiplicity of risks – rather than as a standalone insurance product. In this respect, the ACPR notes that energy companies and mobile carriers/internet providers are starting to offer cyber coverage to their customers as an add-on to their contracts.

Climate Change

Based on a survey carried out by the ACPR among all French insurers in 2018, and information published by insurers pursuant to Article 173 of the LTECV, the ACPR has noted that most insurers implemented the following steps in connection with this emerging type of risk:

- an internal definition of climate change risk and a process for analysing this risk on all or part of their assets and/or liabilities;
- processes to know the carbon footprint of all or part of their asset portfolio (companies, sovereigns, French regions, etc) to identify the companies and sectors with the highest emissions;
- specific monitoring and a sector policy aimed at limiting investment in sectors qualified as "non-green"; and
- a policy to raise awareness of climate issues in the operational teams in charge of investments, as well as specific policies to encourage companies to take part in the energy transition, and reduce their carbon footprint; and
- tools to improve the consideration and effective integration of climate change risks into their risk management system, such as:
  (a) implementing internal reporting for monitoring exposure to these risks;
  (b) internal risk measurement models; and
  (c) assessments of these risks in their ORSA reports.

In a 2022 monitoring report on the climate commitments of banks and insurers, the ACPR and the AMF noted that:

- banks and insurers are generally committed, even though transparency is uneven regarding their voluntary commitments and the way they address regulatory requirements;
- banks and insurers should track their processes and results in order to assess outcome and identify possible improvements to better achieve their aims; and
- only a minority of companies have set specific targets that define a pathway out of coal financing by 2030 or 2040.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Coverage for business interruption losses related to COVID-19 has remained a key issue, although the volume of disputes before French courts has started to decrease as the two-year limitation period begins to lapse. There has been a marked lack of consistency from one court to another in these matters (including in instances where various courts are ruling on the same policy wording). Nonetheless, a slight majority

of judgments have ruled in favour of the insured – usually because the relevant exclusion clauses were set aside as they were deemed not to have been drafted clearly enough.

Recently, however, the French Supreme Court has handed down a decision in favour of the insurer that related to a widespread policy wording. In its decision, the court ruled that the exclusion clause was valid because – contrary to the insured's contention – it did not nearly deprive the policy of its initial scope of coverage. It will be interesting to see whether this decision initiates a trend or whether it will turn out to be an isolated decision (bearing in mind that COVID-related case law is usually very wording-specific).

13. Other Developments in Insurance Law

13.1 Additional Market Developments

As mentioned in **3.1 Overseas-Based Insurers or Reinsurers**, following Brexit on 31 December 2020, insurers based in the United Kingdom lost the "passporting rights" provided by EU legislation enabling them to sell insurance in France. Therefore, from this date onwards, they could no longer sell insurance on the French market without setting up entities in other EU member states or seeking the required accreditations from the French regulator. Changes were made to the IC, however, to enable them to keep on performing their obligations under policies that were still in force 1 January 2021 – albeit on a purely run-off basis.

The French government is considering a major overhaul of the social security regime, which reimburses members of the general public's general expenses. To this end, it has tasked the High Council for the Future of Health Insurance (HCFHI) with considering several possible options – one of which involves significantly expanding the current scope of the social security regime. If this comes to fruition, the eventual cost to the state is estimated at around EUR22 billion. It would also have a significant impact on insurers that currently insure these risks (potentially reducing their profits by more than 50%, according to the HCFI's estimates). However, this project is still on the drawing board and may not be implemented for some time (if ever).

On 14 January 2022, the HCFI handed down a report containing a number of suggestions aimed at extending social security and reducing inequalities, such as:

- introducing a compulsory, universal and mutualised additional insurance scheme; or
- altering the way social security and private health insurance dovetail by allowing greater freedom to define the levels and content of coverage offered by private insurance companies.

However, none of these suggestions has been decided upon or implemented, and discussions regarding possible reform of the social security regime are still ongoing.

On 9 May 2022, the ACPR announced that it would be simplifying the process for policyholders to initiate mediation proceedings in the event that there is a disagreement with an insurer regarding the coverage of a claim. In the past, a policyholder could only initiate a mediation once it had written to both the insurer's claims management department and its complaints department. However, as of 31 December 2022, policyholders will be able to introduce mediation

proceedings within two months of their first written claim to their insurer.

Finally, on 28 November 2022, the Digital Operational Resilience Act (DORA) was adopted by the Council of the European Union. Its requirements, which operators will have 24 months to implement, aim to render financial institutions less exposed and more resilient when it comes to cyberthreats. As such, the regime that stems from DORA will have an impact on insurers, as well as a significant proportion of their clients.

Kennedys is a global law firm with expertise in dispute resolution and advisory services, staffed by more than 2,300 people across the UK and Europe, Asia–Pacific, the Americas and the Middle East. It delivers straightforward advice, even in complex issues, but it is often the firm's insights and support beyond the law that make a difference to its clients. Each member of the team's expert knowledge in their chosen industry means that the firm has the best people to help clients navigate current and future challenges. Kennedys' lawyers handle both contentious and non-contentious matters, in addition to providing a range of specialist legal services for many industry sectors, including insurance and reinsurance, product liability, banking and finance, construction, healthcare, life sciences, aviation, marine, rail, shipping and international trade, cyber and data privacy, and travel and tourism. The firm has particular expertise in litigation and dispute resolution, especially in defending (re)insurance and liability claims.

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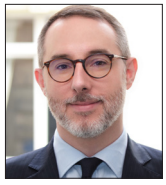

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The Insurance Ordinance (Cap 41 of the Laws of Hong Kong) is the principal source of law governing insurance and reinsurance in Hong Kong. It is supplemented by subordinate legislation covering matters such as the determination of capital requirements and the payment of fees and levies. While the codes and guidelines issued by the Hong Kong Insurance Authority (IA) are not legally binding as such, they contain many of the key regulatory obligations applicable to insurers and insurance intermediaries and are therefore of great importance in practice.

Hong Kong is a common law jurisdiction, so precedent judicial decisions are relevant to insurance law, in particular in relation to insurance contract law and claims. The law in relation to portfolio transfers is also to a large extent determined by judicial precedent.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

(Re)insurers and (re)insurance intermediaries in Hong Kong are regulated by the IA, which has issued detailed guidelines and codes governing the key aspects of regulation not exhaustively dealt with by the Insurance Ordinance and subordinate legislation. The guidelines are supplemented by interpretation notes, explanatory notes and other regulatory circulars.

The writing of unit-linked business, known locally as "investment-linked assurance schemes", is to some extent also regulated by the Hong Kong Securities and Futures Commission (SFC), which has issued a code governing key aspects of such schemes.

While there is currently no cross-border legislation, there is a level of mutual recognition of prudential supervision of insurers between Hong Kong and Mainland China, and the scope of possible cross-border schemes permitting the sale of insurance products across the Greater Bay Area (an area including Hong Kong, Macau, Shenzhen and a number of other cities in Guangdong province) is currently under discussion.

2.2 The Writing of Insurance and Reinsurance

Subject to narrow exemptions, anyone carrying on insurance or reinsurance business in Hong Kong must be authorised by the IA under the Insurance Ordinance. Such business can be carried on either through a Hong Kong-incorporated company or through a branch of an overseas (re)insurer subject to regulation in its home jurisdiction. The exemption applicable to offshore reinsurers conducting reinsurance on a non-admitted basis is considered in **3.1 Overseas-Based Insurers or Reinsurers**.

In order to become authorised, a company must meet certain key criteria, including having sufficient regulatory capital, "fit and proper" directors, controllers and other key persons, adequate reinsurance (or retrocession) arrangements and a local office with a CEO and other relevant staff.

In terms of shareholder controllers, the IA will focus on their financial resources and ability to finance the insurer's business operations and

future capital needs, as well as their industry experience and reputation.

2.3 The Taxation of Premium

An insurance levy payable by policyholders has been applied to premium payments for new and in-force policies since 1 January 2018, subject to certain exceptions. The levy is collected by the relevant insurers and ultimately paid to the IA. The levy rate starts at 0.04% of the insurance premium per policy year and increases gradually to 0.1%. The amount of the levy imposed on each policy is subject to a cap.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Overseas-based direct insurers are not permitted to conduct insurance business in Hong Kong without authorisation.

Overseas insurers may accept business from Hong Kong on a "reverse solicitation" basis so long as they do not conduct insurance or solicitation activities in Hong Kong and do not hold themselves out as insurers in Hong Kong. In practice, the scope of such activity is very limited and typically relates to specialist policies written at the initiative of Hong Kong-based policyholders or their brokers.

Reinsurers are permitted to conduct reinsurance business in Hong Kong without authorisation if they do not have a local presence, do not act through an agent in Hong Kong and do not carry out any regulated intermediary activities.

There is currently no passporting or equivalence regime that would allow overseas insurers or reinsurers to operate in Hong Kong without going through the usual authorisation process.

3.2 Fronting

Fronting is not permitted in Hong Kong and the general expectation is that each insurer retains a minimum share of the business it writes.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Hong Kong has been an active M&A market with regard to insurance companies in recent years. This has largely been driven on the one hand by the desire of Chinese and overseas players to enter what is viewed as a lucrative market with potential for future growth into Mainland China, and on the other hand by owners of small and medium-sized insurers seeking to exit a highly competitive and increasingly regulated market in which it is difficult to remain profitable without scale, especially where Hong Kong is not core to their strategy. The impending introduction of a risk-based capital regime, the reduced premium growth in life insurance due to COVID-19 and political uncertainty in Hong Kong has accelerated this trend.

Hong Kong-based insurance groups continue to invest in Mainland China as well as the other growth markets in the region, in particular South-East Asia. Acquisitions linked to bancassurance or other distribution arrangements have been particularly popular.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Insurance products are most commonly distributed through:

- individual insurance agents engaged by insurers;
- insurance agencies such as banks and other corporates;
- insurance brokers; and
- directly by insurers, including through the internet.

Bancassurance typically falls within the second bullet point since banks act as insurance agencies, although some banks act as insurance brokers. The staff acting for corporate agencies or brokers in the sale of policies are referred to as technical representatives.

Reinsurance contracts are typically written through reinsurance brokers or based on existing relationships between cedants and reinsurers.

Insurance intermediaries that carry on regulated activities in Hong Kong must be licensed by the IA, subject to narrow exemptions. "Regulated activities" is broadly defined and includes a wide range of solicitation and intermediary activities.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The insured must avoid making misrepresentations and must disclose all material facts which are or ought to be known to them and which are material to the formation of the contract. "Material" in this context means that the fact would influence the judgement of a prudent insurer in determining whether to accept the risk and in fixing the premium where the risk is accepted.

The law in Hong Kong reflects the traditional common law position and does not incorporate the reforms that have been undertaken in this area in other jurisdictions, including England and Wales.

While the common law does not impose obligations on insurers to seek information proactively, the Code of Conduct for Insurers issued by the Hong Kong Federation of Insurers, which is not legally binding, provides that insurers should ask clear and specific questions in relation to matters which insurers generally consider to be material to the type of insurance in question. A serious failure to ask pertinent questions could also constitute misconduct under the Insurance Ordinance and have other regulatory implications.

The rules are not generally different as between consumer and commercial contracts, but the courts and regulator are likely to impose higher standards on insurers with regard to questions asked of consumers.

6.2 Failure to Comply With Obligations of an Insurance Contract

The insurer is entitled to avoid the policy (ie, to treat it as if it had never existed) if the insured fails to comply with its obligation to disclose material facts.

The non-binding Code of Conduct for Insurers issued by the Hong Kong Federation of Insurers provides that an insurer should not refuse a claim by a policyholder on the grounds of non-disclosure of a material fact which the policy-

holder could not reasonably have been expected to disclose. The exact scope of that proviso is unclear and does not, in any event, change the legal position that an insured must disclose all material facts.

6.3 Intermediary Involvement in an Insurance Contract

Insurance brokers act for insureds and owe them contractual and fiduciary duties. In addition, they are subject to statutory duties which at least partly overlap with the contractual and fiduciary duties owed to the insured. The key obligations are:

- to act honestly, fairly and in the best interest of the (prospective) insured;
- to exercise an appropriate level of care, skill and diligence;
- to have regard to the circumstances of the (prospective) insured to ensure that the insurance cover sought is suitable;
- to disclose sufficient information to the (prospective) insured;
- to avoid conflicts of interest; and
- to handle the monies of the insured in an appropriate manner.

Insurance agents (whether corporates or individuals) act for an appointing insurer and owe fiduciary and contractual obligations to such insurer. They are also subject to the same statutory duties vis-à-vis insureds as apply to brokers, including an obligation to act in the best interest of the insureds. Some of these obligations are hard to reconcile with their role as agents of the insurers, which has been subject to extensive criticism during the legislative process that applied the statutory duties to insurance agents.

Detailed regulatory obligations applicable to insurance brokers and agents are set out in the respective codes of conduct issued by the IA.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

Features of Insurance Contracts

The distinguishing features of an insurance contract are determined by reference to English case law, namely as an arrangement under which consideration is paid for the provision of benefits upon the happening of an uncertain event that is adverse to the insured. The common law does not require insurance contracts to be in writing, but there are legal and regulatory requirements in relation to the issuance of policy documents and it is universal practice for insurance contracts to be issued in written form.

Generally speaking, there are no specific minimum terms for an insurance contract to be legally valid, but the key terms must be agreed with reasonable certainty or there must be a mechanism for unresolved terms to be agreed at a later stage. In practice, premiums and cover will usually be clearly set out in the insurance policy (or the reinsurance treaty in the case of reinsurance). There are also numerous regulatory requirements in relation to the structure and terms of certain types of policies.

Insurable Interest

For life insurance contracts, the insured must at the outset have an insurable interest in the person whose life is being insured. Certain persons are legally regarded as having an unlimited interest in the life assured (ie, the person whose life is being insured under the policy), such as the life assured themselves and their spouse. Parents are also deemed to have an insurable interest in the lives of their children under Hong

Kong law. For other relationships, the insured will usually need to have an economic interest in the relevant life in order for the policy to be valid.

While an insurable interest is not strictly speaking required for most types of general insurance contracts, they must not amount to gambling or wagering, and the insured must typically prove loss after the insured event occurs.

6.5 Multiple Insured or Potential Beneficiaries

Beneficiaries and Unnamed Insureds

It is common for persons other than the insured/policyholder to be beneficiaries of a life insurance policy. Where certain close family members are named as beneficiaries, this creates a statutory trust in their favour.

It is also possible for certain unnamed persons to obtain rights against the insurer, for instance on the basis of the Contracts (Rights of Third Parties) Ordinance. The ordinance enables third-party enforcement if the contract expressly provides that the third party may enforce the insurance contract or the contract purports to confer a benefit on the third party. However, the operation of the ordinance is typically excluded by policy wording in Hong Kong.

Unnamed persons may also receive the benefit of group insurance policies, such as insurance taken out by employers for the benefit of all their employees. Beneficiaries may also be described generically by reference to certain characteristics.

There are other cases where unnamed persons can become insureds on the basis of agency considerations, but those cases are rare and will not be considered further here.

Impact on Disclosure Obligations

The impact of a wider group of insureds on disclosure obligations is that material facts in relation to the risk arising from those insureds must be disclosed. Where the cover extends to unnamed persons (rather than the unnamed persons just being beneficiaries/payees of the insurance proceeds), the disclosure obligation is therefore also correspondingly extended.

6.6 Consumer Contracts or Reinsurance Contracts

From a legal perspective, the position is generally the same for consumer contracts and reinsurance contracts. However, detailed regulatory obligations apply to direct insurers with regard to the issuance of policies to their policyholders, such as processes in relation to application forms, suitability assessments, disclosure of information and issuance of policies. Most of those regulatory obligations do not apply to reinsurance contracts.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

New ILS Regime

Hong Kong introduced a specific regime in relation to insurance-linked securities (ILS) in 2021 and two ILS have been issued under this regime to date. The protection provided by the issuer of the ILS is treated as insurance for the purpose of Hong Kong insurance law, but is subject to specific rules.

Requirements for Issuance

In order to issue ILS under the Hong Kong regime, the issuing entity must be authorised by the IA for "special purpose business", which is a separate class of insurance. In order to be authorised, the entity must normally appoint two

or more directors and an administrator, all of whom must be "fit and proper" for the purposes of Hong Kong regulation (including by virtue of the administrator having the relevant experience with regard to ILS).

Another key criterion is that the special purpose insurer must be fully funded – ie, its assets (which are typically held in a trust account) must be sufficient to meet the liabilities of the insurer in all reasonably foreseeable circumstances.

ILS can only be sold to certain types of institutional investors specified by Hong Kong legislation.

Challenges

The current challenge with regard to ILS in Hong Kong is that it is a nascent product and the issuance of ILS in the local market therefore takes longer and is procedurally more challenging than in established ILS markets.

7.2 Foreign ART Transactions

There is no specific regime for the recognition of overseas ART transactions. Whether such transactions will be treated as reinsurance for the purposes of the Hong Kong regulatory regime would therefore depend on whether they meet the common law definition of insurance (see **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract**).

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are generally interpreted in the same way as other contracts. The ordinary meaning of words is typically the starting point for interpretation, but circumstances may be taken into account as part of the process. While evidence in relation to market understanding and customs in the market are admissible in evidence, previous negotiations between the parties and their subjective intent are generally not admissible.

The contra proferentem rule generally applies for the benefit of the insured where there is ambiguity in the policy wording, in particular with regard to exclusions from policy coverage. In those cases, the interpretation that is more favourable to the policyholder will generally be adopted.

The rules are generally the same for consumer and business contracts. However, the courts are more likely to strictly follow the wording of the contract in a business context. In the interpretation of reinsurance contracts, custom and market understanding play a greater role than in consumer insurance policies given the technical and industry nature of reinsurance.

8.2 Warranties

Contractual terms can become warranties on the basis of express identification as warranties or by implication, commonly by virtue of "basis of the contract" clauses, which are provisions set out in the proposal form or in the insurance contract to the effect that all answers to the questions in the proposal will form the basis of the contract.

Warranties are different from other contractual terms in that they require strict compliance and any breach permits the insurer to disclaim liability, whether or not the breach was material to the insured risk.

Hong Kong is still subject to the common law approach to insurance warranties and has not

implemented reforms that have been undertaken in other jurisdictions, including England and Wales.

8.3 Conditions Precedent

Contractual terms need not be expressly described as conditions precedent in order to be treated as such. While express designation as a condition precedent is a common approach, the classification may also be derived from the contractual wording – eg, a provision that the insurers have the right to refuse a claim if a particular condition is not complied with.

The consequences of a breach of a condition precedent depend on the contractual wording and the nature of the condition. Failure to comply with a condition will typically preclude the insured from bringing a claim; it may also, if sufficiently fundamental, entitle the insurer to terminate the policy.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Coverage Disputes

Disputes over coverage under an insurance contract are typically settled through the Insurance Complaints Bureau (in the case of consumer contracts) or through litigation or arbitration (see **9.7 Alternative Dispute Resolution** for further details).

Limitation Period

Pursuant to the Limitation Ordinance (Cap 347), the insured generally has six years from the date on which the cause of action accrued to issue proceedings against the insurer. However, the insurance policy will typically specify periods during which claims must be brought following the occurrence of the insured event or the insured's awareness of such event (as applicable).

Enforcement of Insurance Contracts by Third Parties

See **6.5 Multiple Insured or Potential Beneficiaries** regarding the enforcement of insurance contracts by third parties.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

In practice, insurance contracts typically include jurisdiction and governing law provisions. Hong Kong courts will generally recognise and enforce these provisions provided that they are bona fide (ie, made in good faith), legal and are not against public policy. Disputes over jurisdiction and choice of law in insurance contracts are rare.

Where the contract does not contain a jurisdiction or governing law clause, the court will apply the usual common law principles and examine a variety of factors to determine these issues. In considering choice of law, the court will consider the place of intended performance and the insurer's head office location to determine which law has the closest and most real connection with the insurance contract.

9.3 Litigation Process

Depending on the nature of the claim and the amount involved, insurance claims are generally heard in the District Court or the Court of First Instance in Hong Kong.

The main stages in civil proceedings include:

- issuing and service of originating process by way of writ of summons, originating summons, or petition;
- filing pleadings such as the statement of claim, defence and reply;

- discovery and inspection of documents;
- exchange of factual witness statements;
- filing of expert reports (if required); and
- trial.

9.4 The Enforcement of Judgments

Domestic Judgments

The most common ways to enforce domestic judgments in Hong Kong include the following.

- Garnishee proceedings – where a third party (the garnishee) owes money to the judgment debtor, the judgment can be enforced directly against the garnishee. The garnishee will then pay its debts to the judgment creditor instead of the judgment debtor. This option is commonly used against the judgment debtor's bank.
- Charging order/order for sale of assets – judgment creditors can obtain security over the assets of the judgment debtor.
- Writ of fieri facias – also known as a fifa order, this allows an officer of the court to seize and sell the judgment debtor's goods and chattels.
- Bankruptcy or insolvency proceedings may also be considered.

Foreign Judgments – Statutory Registration Scheme

A foreign judgment can be enforced in Hong Kong either through the statutory registration scheme based on reciprocity under the Foreign Judgments (Reciprocal Enforcement) Ordinance (Cap 319) (FJREO) or at common law.

Under the FJREO, judgments from "superior courts" of 15 countries (namely, Australia, Austria, Belgium, Bermuda, Brunei, France, Germany, India, Israel, Italy, Malaysia, the Netherlands, New Zealand, Singapore and Sri Lanka) are enforceable by the simple procedure of registration through an application to the Court of First Instance provided that the application is made within six years of the original judgment.

Once leave is granted, the foreign judgment can be enforced in the same way as a Hong Kong judgment.

Foreign Judgments – Common Law

If the foreign judgment is not from a country listed under the FJREO, it can only be enforced at common law. In this case, the foreign judgment will form the basis of a cause of action and the judgment will be treated as a debt between the parties. To be enforceable at common law, the following requirements must be met:

- the foreign judgment must be for a debt or a definite sum of money, and the defendant must have submitted to the jurisdiction of the foreign court;
- the foreign judgment was final and conclusive;
- the foreign judgment was not obtained by fraud, and was obtained against the same defendant;
- the foreign judgment was not contrary to Hong Kong rules of public policy or notions of natural justice;
- the foreign court had jurisdiction over the defendant according to Hong Kong rules; and
- an action in Hong Kong based on a foreign judgment must be brought within 12 years from the date on which the foreign judgment became enforceable.

Mainland Judgments

Enforcement of People's Republic of China (PRC) judgments is governed by the "Arrangement on Reciprocal Enforcement of Judgments in Civil and Commercial Matters" and the Mainland Judgments (Reciprocal Enforcement) Ordinance

(Cap 597) in Hong Kong (MJREO). The MJREO makes provision for mutual enforcement of Hong Kong and PRC judgments in civil or commercial matters. It also applies to the enforcement of money judgments on disputes arising out of commercial contracts.

In order to register a PRC judgment in Hong Kong:

- the judgment must be from a court which is a designated court under the MJREO (ie, courts at the Intermediate People's Court level or above and specified Basic People's Courts);
- the judgment must be final and conclusive and enforceable in the PRC;
- the judgment must order the payment of a sum of money (not being a sum payable in respect of taxes, fines or penalties); and
- the application to the Court of First Instance must be made within two years from the date of the judgment.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses in commercial insurance and reinsurance contracts can be enforced, so long as they comply with the formal requirements under Section 19 of the Arbitration Ordinance (Cap 609). These include that an arbitration agreement must be in writing, and there must be a reference of the dispute to arbitration. An arbitration agreement may be in the form of an arbitration clause in a contract or in the form of a separate agreement.

9.6 The Enforcement of Awards

Under the Hong Kong Arbitration Ordinance (Cap 609), there are four main categories of arbitral awards:

- convention awards (which are awards issued in states or territories that are party to the New York Convention, other than the PRC);
- Mainland awards (which are awards issued in Mainland China);
- Macao awards (which are awards issued in Macao); and
- awards issued in Hong Kong and Taiwan, and any awards not captured by the first three categories.

Hong Kong is not a contracting state to the New York Convention. In 1997, following the PRC's resumption of the exercise of sovereignty over Hong Kong, the PRC extended the application of the New York Convention to Hong Kong. The PRC's reciprocity and commercial reservations made under Article I(3) of the New York Convention are binding on Hong Kong. As a result, Hong Kong recognises awards issued in the territory of another contracting state to the New York Convention, and arising out of commercial disputes. Enforcement may only be refused pursuant to the limited grounds set out in the New York Convention.

Arrangements in place allow for the enforcement of arbitral awards between Mainland China and Hong Kong (namely the 1999 and 2020 Arrangements Concerning Mutual Enforcement of Arbitral Awards between the Mainland and the Hong Kong Special Administrative Region). All arbitral awards issued pursuant to the Hong Kong Arbitration Ordinance can be enforced in Mainland China. All arbitral awards issued pursuant to the PRC Arbitration Law can be enforced in Hong Kong. Simultaneous enforcement applications may be commenced in the courts of Hong Kong and Mainland China.

There is also an arrangement resulting in mutual recognition of arbitral awards between Hong Kong and Macao.

There are separate provisions in the Hong Kong Arbitration Ordinance concerning the enforcement of awards under these categories. With the leave of the court, arbitral awards (including interim awards), whether domestic or foreign, are enforceable in the same manner as a Hong Kong court judgment.

9.7 Alternative Dispute Resolution

Alternative dispute resolution (ADR), including arbitration, mediation and adjudication, is commonly used in insurance disputes in Hong Kong. Since the introduction of the Civil Justice Reform in Hong Kong in April 2009 and Practice Direction 31 in January 2010, parties to litigation are required to attempt settlement by mediation. Adverse costs orders may be made against a party which unreasonably fails to engage in mediation, regardless of the outcome of the litigation.

Consumer Contracts

For consumer insurance disputes, the Insurance Complaints Bureau (ICB) provides a mechanism to assist in the resolution of insurance disputes arising from personal insurance policies. These disputes must be monetary in nature, including complaints regarding claim decisions of insurers and maladministration on the part of the insurer.

The ICB handles claim-related complaints by way of adjudication under the Insurance Claims Complaints Panel, and non-claim-related complaints by way of mediation provided by the ICB List of Mediators.

- Adjudication involves an independent adjudicator (usually an expert) who considers the claims of both parties and issues a binding decision.
- Mediation is a voluntary procedure whereby a professionally trained and impartial mediator helps the parties settle their dispute. A mediator will not make a decision for the parties, but will assist the parties in exploring the merits of their own cases, as well as in identifying possible solutions in order to facilitate settlement.

Policyholders are not bound to refer their disputes to the ICB. If they choose to litigate or arbitrate their case instead, the ICB does not have jurisdiction unless and until those proceedings are resolved. However, since consumer insurance policies typically do not contain arbitration provisions, ADR outside the ICB would be uncommon for consumer insurance disputes. The ICB has no jurisdiction to handle disputes arising from industrial, commercial or third-party insurance.

Reinsurance Contracts

Reinsurance contracts often contain arbitration clauses, and it is common to arbitrate reinsurance-related disputes (see **9.5 The Enforcement of Arbitration Clauses**).

9.8 Penalties for Late Payment of Claims

Subject to general contractual obligations between the insurer and the insured under an insurance policy, and unlike in the United Kingdom, there is currently no provision in Hong Kong which confers a statutory right of damages if insurers delay payment of claims.

9.9 Insurers' Rights of Subrogation

Subrogation, in the context of insurance, is the right of the insurer to pursue third parties for claims in which the insurer may be liable to the insured. Where the insurer pays for a claim under

an insurance contract, the insurer becomes entitled to "step into the shoes" of the insured and is subrogated to all of the insured's rights and remedies in respect of that subject matter. The insurer is only entitled to the rights and remedies which are available to the insured and the insurer has no greater right than that of the insured.

10. Insurtech

10.1 Insurtech Developments

Insurtech developments in Hong Kong are similar to those in other jurisdictions. For example, online sales and online claims portals, digitally customisable products, online brokers (such as comparison websites), blockchain-based products and products involving connected devices are all seen in the market. There is great interest in insurtech solutions, including those developed in nearby markets with strong insurtech ecosystems, such as Mainland China and Singapore.

A number of purely digital life and general insurers have been authorised by the IA.

10.2 Regulatory Response

The IA has two primary initiatives in relation to insurtech.

Fast Track

One initiative is a "fast track" authorisation process for purely digital insurers, which has been used by a number of new entrants to the life and general insurance markets. Such "fast track" insurers are generally limited to distributing their products through their digital platform and are not permitted to sell them through traditional agent or broker channels.

Sandbox

The other initiative is a "sandbox" which allows insurers to work on insurtech applications and products with the IA before they are launched to the market. Since the launch of the sandbox, this has included online sales platforms and non-face-to-face sale models involving videoconferencing tools. Certain requirements apply to participation in the sandbox, including a reasonably mature insurtech application, solid testing, exit and customer protection measures and the compliance of the application with law and regulation.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Catastrophe risk (including more severe typhoons as a result of climate change) is regarded as one of the key emerging risks in Hong Kong. The newly established regime for ILS (see **7.1 ART Transactions**) is a key response of the regulator to such risk, which affects not only Hong Kong, but Mainland China and the wider region as well and may give rise to an increased demand for risk transfer to the capital markets.

The other regulatory initiatives in Hong Kong have been primarily focused on the emerging protection gaps for an aging population. Many Hong Kong residents have no or limited private health insurance and only limited pensions or other retirement protection. This has resulted in the design and promotion of new products with the assistance of the IA and the Hong Kong government – see **11.2 New Products or Alternative Solutions**.

11.2 New Products or Alternative Solutions

The new ILS regime has been described in **7.1 ART Transactions**.

In the last few years, the Hong Kong insurance industry, supported by the Hong Kong government, has developed a number of products that are designed to address existing protection gaps.

This includes voluntary health insurance scheme (VHIS) products that provide indemnity coverage for hospital treatments in accordance with standards set by the Food and Health Bureau.

The newly developed products also include qualified deferred annuity plans, which are deferred annuity plans meeting certain requirements set by the IA and permit taxpayers to claim a tax deduction for their premiums up to a defined maximum limit.

In November and December 2021, the IA and the Securities and Futures Commission (SFC) provided updated guidance on unit-linked products, which are locally known as "investment-linked assurance scheme" (ILAS) products. The guidance sets out new requirements that such products must meet in relation to various aspects (such as cost of insurance charges, fees and surrender charges) in order to benefit from a swifter approval process involving both regulators.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Relaxation of Rules Relating to the Sale Process

In response to COVID-19, the IA relaxed the requirements relating to the sale of certain types of insurance products. Those relaxations continue to apply while the pandemic continues and are intended to facilitate non-face-to-face sales of products that are not regarded as complex.

As insurers sought to sell a wider range of policies through videoconferences between agents and customers, the IA adopted new rules on the conduct of such sales and required insurers to have the process for such sales approved by it through the insurtech sandbox.

Policy Coverage

A number of insurers have adapted their policies to cover specific COVID-19-related risks, such as under travel or health insurance policies.

The cases conducted in other jurisdictions such as England and Wales in relation to the scope of coverage for business interruption caused by COVID-19 have been closely followed in Hong Kong, since similar coverage issues arise under local insurance policies and reinsurance contracts.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Cross-Border Regimes and ILS

The proposed cross-border insurance regimes for the Greater Bay Area referred to in **2.1 Insur-**

ance and Reinsurance Regulatory Bodies and Legislative Guidance and the new ILS regime set out in 7.1 ART Transactions are key recent market developments.

Risk-Based Capital Regime

The IA is working on the final rules for a new risk-based capital regime that is expected to replace the current formula-based "Solvency I" style regime in 2024. This follows years of extensive quantitative testing and consultation with the industry. The new risk-based regime follows a three-pillar approach similar to Solvency II and other risk-based frameworks. It is complemented by a new group-wide solvency regime for Hong Kong-regulated insurance groups, which was implemented in 2021.

Policyholders' Protection Fund

Following a 2012 consultation regarding the establishment of a Policyholders' Protection Fund (PPF), the Hong Kong government is preparing the legislation needed for such a PPF. The fund will consist of two schemes, one for life and one for general insurance, and will be available to pay claims in the event of an insurer's insolvency. There are existing compensation funds in relation to motor and employees' compensation insurance, which will be carved out from the new PPF.

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Trends and Developments

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Key Commercial and Regulatory Trends in the Hong Kong Insurance Industry

Insurtech

Insurers in Hong Kong continue to focus heavily on the incorporation of technology in key parts of their operations. Insurance sales and distribution, data analytics and underwriting, and policy servicing and administration are all areas in which technology plays an ever-increasing role.

In terms of customer-facing applications, non-face-to-face onboarding and insurance sales (such as through videoconference tools) have been implemented by many insurers in light of the COVID-19 pandemic. Virtual onboarding and sales are generally subject to approval of the insurer's processes and governance by the Hong Kong Insurance Authority (the Insurance Authority) through its insurtech sandbox.

Insurers have also enhanced their digital policy administration and claims platforms. A number of insurers (particularly in the area of general insurance) have developed platforms for online submission of claims, thereby reducing the effort and time expended by policyholders in the claims process.

A number of leading insurers have established specific internal governance and issued guidelines for the use of sales and AI algorithms, although Hong Kong does not yet have specific regulation on such matters that is applicable to insurers.

A handful of digital-only insurers have been authorised in recent years under a "fast track" regime put in place by the Insurance Authority. While virtual insurers continue to grow their product offerings and businesses, their growth is currently limited by restrictions on their licences under which they are generally limited to distributing products through their own digital platforms.

A further constraint on digital sales is that the Insurance Authority continues to take the view that more complex life insurance products should not be sold through online platforms.

Distribution

Technology also plays a key role in distribution channels of traditional insurers. Many traditional insurers have strengthened their digital sales channels, and although their overall contribution to insurance sales is modest in the life sector, their importance is growing, particularly among younger customers.

While insurance agents and bancassurance remain the key distribution channels for life insurance, insurers have also continued to enter into partnerships with digital partners, such as digital platforms and online service providers. Often, those digital partners have to be licensed as intermediaries, but the Insurance Authority has issued guidelines indicating that such a licence may not be required if the sale is conducted in a particular technological form.

Products

While the overall potential for premium growth in the dominant life sector has been limited by the COVID-19 pandemic and the closure of the

border with Mainland China, products championed by the government and subject to favourable tax treatment, in particular voluntary health insurance schemes (VHIS) and qualified deferred annuity products (QDAP), have remained popular.

Most recently, the Insurance Authority and the Securities and Futures Commission have revised the approval process for linked products, locally known as investment-linked assurance schemes (ILAS). Linked products with a specified minimum mortality protection element and simple features (also known as protection-linked plans) are subject to an expedited approval process. However, despite the streamlined process, some insurers continue to regard the approval conditions and process for ILAS as onerous.

Reinsurance and alternative risk transfer

In recent years, there has been a trend towards Hong Kong life insurers reinsuring large blocks of legacy business to internal and external offshore reinsurers, often based on regulatory capital considerations. This trend is expected to continue as insurers prepare for the new risk-based capital regime (see the **Risk-Based Capital** section).

In terms of alternative risk transfer, a new legal and regulatory regime for insurance-linked securities (ILS) came into effect in 2021. Following the example of Singapore, Hong Kong put in place a grant scheme to support initial ILS issuances from Hong Kong. To date, there have been two catastrophe bond issuances under the new regime. While the length of the approval process and the relative lack of local expertise with regard to such issuances continue to raise concerns, Hong Kong's preferential status with Mainland China is likely to result in further risk transfer of Chinese risks to the capital markets through Hong Kong-based ILS.

Development roadmap

The Financial Services and the Treasury Bureau published a roadmap for Hong Kong's insurance industry in December 2022. A number of key points are set out in the roadmap:

- Hong Kong will continue to pursue and strengthen its role as a global risk management centre;
- Hong Kong's insurance industry plays an important part in national initiatives, such as the Greater Bay Area, China's "Belt and Road" initiative and the "dual circulation" economy (meaning a focus on both domestic and international markets);
- there will be an increased focus on talent acquisition, technology and data, including devising mortality tables for the Greater Bay Area that may assist with the development of cross-border life and health products.

A number of these points are considered in more detail below.

Insurance Connect and the Greater Bay Area

The Insurance Authority and relevant government departments continue to liaise with Mainland Chinese regulators on the finalisation of arrangements for Hong Kong insurers to open service centres in designated Mainland locations, such as Qianhai and Nansha. The service centres will allow Hong Kong insurers to service policies issued to Mainland Chinese customers, including with regard to claims and complaints handling.

Discussions are also ongoing regarding the design of an eagerly awaited "Insurance Connect" regime under which Hong Kong-author-

ised insurers would be permitted to sell certain products in the Greater Bay Area (an area comprising Hong Kong, Macau and a number of cities in Guangdong province). The features of such a regime remain challenging, particularly given the strict exchange control regulations in the Mainland, which cannot be addressed in the same way as for existing "Connect" schemes for stocks and bonds.

Another aspect of the integration of the Greater Bay Area is the design of cross-border products, such as motor insurance covering Hong Kong-registered vehicles for travel into other parts of the Greater Bay Area and medical products covering policyholders across the Greater Bay Area. Due to the complex legal and regulatory issues raised by cross-border insurance products, such products currently remain under development.

Group-wide supervision

The Insurance Authority has recently implemented the supervisory regime for Hong Kong-based insurance groups. The regime is built on the principles issued by the International Association of Insurance Supervisors (IAIS). Three insurance groups are currently subject to group supervision, namely AIA, FWD and (the formerly UK-based) Prudential.

The group supervision regime imposes group-wide capital requirements, generally based on an aggregation of capital requirements and eligible capital resources of local operations in the relevant jurisdictions. It also includes requirements for capital instruments that need to be met for such instruments to be recognised as Tier 1 or Tier 2 capital on a group basis. The requirements are generally aligned with corresponding IAIS recommendations.

In addition, the group-wide regime imposes extensive group-wide governance requirements. Among other changes, major acquisitions made by an insurance group have to be assessed through a framework specific to the insurance group and, if assessed to be material, approved by the Insurance Authority. Key persons of the "designated holding company" of the group are subject to fit and proper requirements and approval of the Insurance Authority. Implementation of the group-wide supervision regime has been a focus for the three insurance groups in question.

Risk-based capital

Another regulatory focus has been the risk-based capital (RBC) regime that is expected to apply to all insurers from 2024. Rules have been fine-tuned in consultation with the industry and are in the process of being finalised. In line with other RBC regimes, the Hong Kong rules will be based on three pillars, namely:

- quantitative requirements for the determination of a "prescribed capital requirement" reflecting the risks to which the insurer is exposed;
- qualitative assessment of risks, including through an own risk and solvency assessment (ORSA); and
- disclosure of solvency-related information to the regulator and the public.

There has been an early implementation of the second pillar, so the requirement to prepare ORSAs is already in force.

The change is significant for insurers since Hong Kong has been one of the last jurisdictions in Asia operating under a formula-based capital regime. Several leading insurers have obtained approval for early adoption of the quantitative

regime, allowing them to calculate their capital requirements under the new risk-based capital regime.

While the Hong Kong RBC regime is similar to Europe's Solvency II and other risk-based regimes, it is generally regarded as simpler and more pragmatic than some of the existing regimes, in particular Solvency II.

ESG

Many Hong Kong insurers, in particular the large international insurance groups, increasingly take into account ESG issues as part of their operations. The trend manifests itself in amended investment policies and mandates (which may no longer permit investments in certain "blacklisted" sectors or entities and may require a certain level of investments in "green" securities). In addition, many insurers and reinsurers reflect ESG issues in their underwriting process – eg, by rejecting coverage of objects or companies that are problematic from an ESG perspective.

Some insurers have adopted nuanced approaches to underwriting. Rather than rejecting coverage altogether, they may set underwriting conditions in relation to ESG standards that policyholders must meet, or engage with corporate customers to bring environmental or social standards to an acceptable level before coverage is provided. Such an approach enables insurers to bring about positive change, while reducing ESG risks for both the insurer and the policyholder. However, the approach requires significant ESG expertise on the part of the insurer to be successful.

Many insurers have issued internal ESG guidelines and incorporated ESG issues into their risk and governance regimes. While there is currently no mandatory ESG disclosure regime for insurers in Hong Kong, the Insurance Authority and a task force of the Hong Kong Federation of Insurers are working on "green insurance" and disclosure matters. It is expected that a recommended disclosure standard – potentially aligned with the recommendations of the Task Force on Climate-Related Financial Disclosures – will be issued at some point.

Policyholders' protection scheme

A policyholders' protection scheme with regard to the insolvency of Hong Kong insurers has long been under consideration and the Insurance Authority has very recently announced that it will launch a further consultation on the proposal in December 2022. There is currently no industry-wide scheme (although a few sectoral schemes exist). This is a further measure designed to align the level of policyholder protection in Hong Kong with the standards in other advanced jurisdictions.

Enforcement

There has been a clear trend towards more proactive investigation and enforcement by the Insurance Authority in the last few years. An early focus was on compliance with anti-money laundering requirements, and the first-ever fine was recently imposed by the Insurance Authority on two insurers in this area.

The Insurance Authority has recently focused on insurers' complaints handling and compliance with their filing and notification requirements under the Insurance Ordinance and undertakings given by them. Detailed investigations of perceived regulatory or compliance failures, including investigations involving reports written by law or accountancy firms, are more common now, and it can be expected that the trend towards proactive enforcement will continue.

Sales practices of insurers remain another focus area, in particular where products are sold through insurance agents. Insurers invest heavily in agency training and compliance programmes to mitigate the mis-selling risk.

Talent

Talent remains a concern for Hong Kong insurers, particularly in the actuarial and technology areas, and the industry (with support from the Insurance Authority) is actively trying to attract additional insurance talent to Hong Kong while also enhancing local education and training in these areas.

M&A

Although the level of insurance M&A in Hong Kong has declined due to current economic circumstances, significant activity persists, particularly in the "middle tier" of insurance companies. There is a trend towards consolidation, the key drivers of which include the difficulty of achieving profitability without scale, the incoming risk-based capital regime and an increasing regulatory burden. Buyers typically include existing Hong Kong insurers and other market participants with existing insurance holdings in Hong Kong or other leading jurisdictions.

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The Insurance Business Act is the basis for the regulation of insurance businesses in Japan, providing a contractual relationship surrounding insurance products. Although Japan is not a common law country, the judicial precedent, especially that established by the Supreme Court, should be referred to when interpreting insurance contracts.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

The Financial Services Agency (FSA) is the regulatory authority for insurance and reinsurance businesses in Japan. Life and non-life insurers are regulated by the Insurance Business Act. Reinsurers are regulated in the same way as non-life insurers. Based on the Insurance Business Act, the regulatory authorities have the power to issue administrative dispositions to insurance companies, including orders for business improvement, orders for suspension of business, and/or orders for cancellation of licences.

In fact, broad discretion is given to the regulatory authorities, and those administrative dispositions against insurance companies invoked by the regulatory authorities are not necessarily based on the assumption that violations of law by insurance companies have taken place.

Against this background, entities targeted for supervision not only have to make sure that laws and regulations are being observed but must also follow the guidelines officially promulgated by the regulatory authorities (Comprehensive Guidelines for the Supervision of Insurers).

Underwriting Life and Non-life Insurance

Underwriting life insurance and non-life insurance entails obtaining the necessary business licences from the regulatory authorities. Such licences for life insurance and non-life insurance business cannot be acquired by the same company, and companies are prohibited from running both businesses concurrently. However, both life insurers and non-life insurers are at liberty to offer insurance such as medical care insurance, accident insurance, or overseas travel accident insurance, ie, insurance from the so-called "third sector" insurance market.

Nevertheless, life insurance companies – whether operating in the form of a *kabushiki kaisha* or mutual company – must have board of directors' meetings, auditors' meetings, audit and other committee meetings, and meetings such as nominating committee meetings, and accounting auditors. Foreign companies intending to enter into the Japanese market through their subsidiaries are required to acquire the licences mentioned above. Foreign companies planning to enter through their branch offices must obtain foreign insurer's licences.

During the licence application procedure, the "basic documents" (articles of incorporation, business plan, standard policy provisions and documents showing the method to calculate insurance premiums and policy reserves) must be submitted to the regulatory authorities. Furthermore, insurance companies cannot operate their businesses while being in violation of

the basic documents, and, in order to develop and offer new insurance products, must procure approval for corresponding changes to the basic documents from the regulatory authorities ("Insurance Product Approval" – regular processing takes 90 days, standardised 45 days). However, regarding certain types of insurance, such as fire insurance where there is little concern of insufficient policyholder protection, a notification system to the regulatory authorities has been adopted; nevertheless, notification may not be required in cases where insurance companies state in the statement of business procedures that special provisions related to business insurance are to be established or modified without notifications ("Flexible Provision System").

Other Business and Subsidiaries

Insurance companies are not permitted to conduct any business other than the insurance business (underwriting insurance) and business incidental thereto (restriction on other business). Furthermore, insurance companies are not allowed to own subsidiaries that perform businesses other than as legally stipulated, or obtain voting rights in domestic companies in excess of 10% of their total voting rights. However, with the approval of the regulatory authorities, insurance holding companies may have companies as their subsidiaries that insurers themselves may not own.

With respect to prescribed matters (which are quite extensive), such as customer explanations, or information control, insurance companies are obligated to have a system in place to secure soundness of operations and appropriate management. The minimum amount of capital of an insurance company is JPY1 billion.

Policy Reserves

Insurance companies are required to accumulate policy reserves and appoint an insurance administrator with a predetermined actuary's licence to be involved in work related to actuarial science. In 1996, regulations on the solvency margin ratio were introduced. The solvency margin index has become an assessment standard for the supervisory authorities to execute early corrective actions with broad supervisory reach against targeted companies, including orders to submit an improvement plan.

At present, the solvency margin ratio on a consolidated basis has been introduced. In March 2016, the European Union announced the adoption of the equivalence recognition between Solvency II with temporary equivalence and the Japanese reinsurance supervision and group solvency. In June 2020, the Advisory Council on the Economic Value-Based Solvency Framework, which was established at the Financial Services Agency, published a report in light of which the FSA is currently deliberating the Economic Value-Based Solvency Regulation ahead of its implementation in 2025. On 30 June 2022, the FSA published a report on "The Tentative Decisions on the Fundamental Elements of the Economic Value-Based Solvency Regulation" to help prepare for the implementation of the insurers' organisational restructuring.

2.2 The Writing of Insurance and Reinsurance

See **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**.

2.3 The Taxation of Premium

This is not applicable in Japan.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Under the Insurance Business Act, the regulations that apply to Japanese insurance companies also apply to local subsidiaries of overseas-based insurers. Nevertheless, the Act allows foreign insurance companies to conduct insurance business without establishing such local subsidiaries.

Foreign insurance companies may conduct insurance business in Japan only if they have opened a branch in Japan and obtained the applicable licence from the FSA, the body overseeing insurance companies (Article 185-1 of the Insurance Business Act). This requirement allows the FSA to effectively execute administrative power over such foreign insurers. With some exceptions, Article 185-6 of the Insurance Business Act requires such licensed foreign insurers to conclude insurance contracts with persons having an address or residence in Japan, property located in Japan, or vessels or aircrafts with Japanese nationality inside Japan. The procedure to apply for the licence is mostly the same as that for Japanese insurance companies. Since foreign insurance companies do not have capital inside Japan, they are required to deposit a minimum of JPY200 million to the deposit office to protect policyholders.

Restrictions on Unlicensed Foreign Insurance Companies

Unlicensed foreign insurance companies may not conclude insurance contracts with persons having an address or residence in Japan, property located in Japan, or vessels or aircrafts with Japanese nationality (Restriction on Foreign Direct Insurance; Article 186-1 of the Insurance Business Act) other than the insurance contracts listed below:

- reinsurance contracts;
- marine insurance contracts pertaining to objects such as vessels with Japanese nationality used for international maritime transportation;
- aviation insurance contracts pertaining to aircrafts with Japanese nationality used for commercial aviation;
- insurance contracts pertaining to launching into outer space;
- certain insurance contracts covering cargo located within Japan which is in the process of being shipped overseas; and
- overseas travel insurance.

Exceptions and permissions

The restriction does not apply when an applicant wishing to purchase insurance from unlicensed insurance companies has obtained a permission from the FSA in advance of their applications for insurance as set forth in Article 186-2 of the Insurance Business Act. This exception is provided for to enable policyholders to purchase insurance products that are most beneficial to them. That permission may not be provided in the following cases:

- the insurance product in question violates laws or is unfair;
- it is easy to conclude insurance contracts with licensed Japanese or foreign insurers for comparable insurance products on equal or more advantageous conditions;
- the terms and conditions of the insurance product in question are significantly unbalanced compared to the typical terms and conditions of the same type of insurance products with licensed Japanese or foreign insurers;

- concluding such insurance contracts would unjustly deprive the insured and other related persons of their benefits; and
- concluding such insurance contracts would likely negatively impact the development of the Japanese insurance business or be harmful to the public interest.

In a recent trend, the government of Tokyo is pursuing a policy to attract overseas financial business providers to the Japanese market by providing assistance to cope with complicated financial regulations in Japan, such as opening a one-stop service centre for financial start-ups. It is expected that such a move will attract more overseas insurance companies and revitalise the Tokyo financial markets.

3.2 Fronting

Fronting is not expressly prohibited nor permitted in Japan and there are no explicit expectations with regard to the cedent's retention.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Existing insurance businesses may be acquired in several ways, such as through obtaining shares of Japanese insurance companies, a merger of insurance companies, or sale and purchase of insurance business. The Insurance Business Act provides a regulatory framework for these M&A activities of insurance businesses.

Obtaining Shares

Under the Japanese regulatory framework, shareholders who own a certain percentage of voting rights in insurance companies are subject to oversight of the regulator.

- A shareholder with more than 50% voting rights in an insurance company is required to obtain an approval from the Financial Services Agency (FSA) in advance of acquisition of such voting rights (Insurance Holding Company; Article 271-18-1 of the Insurance Business Act). Insurance holding companies are subject to strict regulations including those regulating the scope of business and imposing subsidiary restrictions, and, in certain instances, reporting obligations. As of 1 August 2022, 15 insurance holding companies have been approved by the FSA.
- Except for insurance holding companies, a shareholder with 20% or more voting rights in an insurance company needs approval from the FSA in advance of acquisition of such voting rights (Major Shareholder of Insurance Companies; Article 271-10-1). Such approval is required even if the investor resides overseas. The FSA oversees major shareholders of insurance companies by imposing reporting obligations and taking administrative dispositions.
- A shareholder with more than 5% voting rights in an insurance company is required to report such acquisition of voting rights within five days (in case of foreign investors, one month) to the FSA (Shareholders with Large Voting Rights in Insurance Company; Article 271-3-1 of the Insurance Business Act). The shareholder has to submit a report if the shareholder's percentage of voting rights changes by 1% or more (either as an increase or decrease). The FSA may take administrative dispositions against shareholders with large voting rights in an insurance company if the FSA finds the report submitted includes false information or lacks important or necessary information, thus causing potential misunderstanding.

Mergers

A merger with an insurance company requires approval by the FSA. Article 167-2 of the Insurance Business Act provides the following standards/checkpoints that the FSA could use in determining whether to give an approval:

- the merger is appropriate in light of the protection of policyholders;
- the merger will not hinder fair competition among insurance companies; and
- it is certain that the surviving insurance company after the merger will be capable of operating the insurance business appropriately, fairly and effectively.

Sale and Purchase

A sale and purchase of insurance business also requires approval from the FSA, pursuant to Article 142 of the Insurance Business Act. Purchasers of insurance businesses must be licensed insurance companies. Such sale and purchase also requires a separate approval to transfer insurance contracts from the FSA, pursuant to Article 139 of the Insurance Business Act. Petitions for approval to transfer insurance contracts are reviewed according to the following standards/checkpoints:

- the transfer of insurance contracts is appropriate in light of the protection of policyholders;
- it is certain that the transferee will be capable of operating the insurance business precisely, fairly and effectively; and
- the transfer does not unjustly affect the benefit of the creditors of the transferor.

The Insurance Business Act does not require policyholders' approvals for transfers of insurance contracts to another insurance company. Instead, the transferor must make a public notice and notify each policyholder, and provide policyholders a chance to file objections to the transfer.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Unless otherwise allowed by any other law, the Insurance Business Act prohibits any person from acting as an agent or intermediary to conclude insurance contracts, an activity that falls within the definition of "insurance solicitation" under the Act.

In the case of a life insurance company, only registered life insurance agents (officers and employees of a life insurer; life insurance agencies (agents) as well as their officers, employees and other personnel) may conduct "insurance solicitation." A characteristic feature of Japanese selling channels is for life insurance companies to utilise a large number of salespeople who have long belonged to those companies (mostly female employees known as "Sei-ho ladies") among their overall salespersons. Put simply, every person selling insurance contracts has to be registered to do so. In principle, in the current legal system, life insurance agents may deal with insurance products of only one insurance company. In other words, they operate within the so-called one-company exclusive system. However, by fulfilling the prescribed legal requirements (such as enrolling two or more life insurance agents) it is possible to deal with insurance products of multiple insurance companies – in fact, quite a number of independent agencies currently do this.

Non-life Insurance Companies

The situation involving non-life insurance companies (including a reinsurance company) is as follows.

- It is recognised that officers (other than auditors) and employees of a non-life insurer may engage in "insurance solicitation," not only without being registered but also, similarly to officers and employees of below-mentioned non-life insurance agencies, without any obligation to give notice thereof. In many cases, employees of a non-life insurance company engage in "non-face-to-face" offerings of their products (by such means as telephone, mail or internet) and tend to transfer business opportunities with large-scale companies to their head office for handling.
- Registered non-life insurance agencies, their officers (with the exception of auditors) and their employees may engage in "insurance solicitation". No officers or employees of non-life insurance agencies are required to be registered, however, they are required to give notice of such a fact.

The majority of non-life insurance sales are made by agencies, which account for 90.7% of total sales on a direct-net-premiums-written basis, while sales by officers and employees of insurance companies (through their direct sales) and insurance brokers account for only around 8.6% and 0.7% respectively.

Dedicated insurance agencies account for 18% (based on the number of entities involved) of all non-life insurance agencies. Around 55% of non-life insurance agencies which are involved in another business are automobile dealers and repair shops, and around 10% of them are entities within the real estate industry – with both figures standing at high percentage rates.

Insurance Brokers

Registered insurance brokers may also engage in "insurance solicitation" (limited to mediating conclusions of insurance contracts). The Insurance Business Act has assigned special duties to such insurance brokers, including:

- the duty to deposit a security guarantee (JPY20 million at the time of commencement of their business, which can be exchanged for an insurance broker's liability insurance policy);
- the duty to disclose fees and commissions;
- the duty to prepare bought and sold notes;
- the duty of loyalty (the duty of "best advice"); and
- other special duties that have not been imposed on insurance agents.

There are only 54 insurance brokers in Japan, which is comparatively low. While most of them focus on large-scale businesses, handling products for individual consumers is extremely rare.

Sales Through Banking Channels

Insurance sales through banking channels in Japan commenced in 2001 but the number of products they could sell was severely restricted. The range of insurance products available for sale by banks has since expanded multiple times, and the restrictions were totally removed in 2007.

Banks function as insurance agents in the selling process. In this respect, it is worth mentioning that additional special regulations have been applied to banks in order to avoid circumstances of insufficient consumer protection, which could result from improper use of the banks' information-gathering ability in relation to customers' funds or their improper influence over customers.

Strict regulations have been imposed on banks, including measures/regulations for the protection of non-public information (pursuant to which customer information obtained through their banking business cannot be used in connection with insurance solicitation without customers' consent) or the regulations concerning soliciting of borrowers (where certain types of insurance products cannot be sold to customers who are granted business loans). While these additional regulations have been imposed for the protection of consumers, they essentially function to protect the traditional channels of insurance distribution.

Recently, "open-for-visitor" agencies have strengthened their presence. Out of the insurance products of multiple insurance companies, these agencies make – on their own initiative – proposals of insurance products that conform to customers' actual needs, which open-for-visitor agencies call consultative selling.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The Insurance Business Act imposes on a policyholder or the insured a duty to disclose material matters regarding risks requested to be disclosed by the insurer (the duty of answering the question).

This is a unilaterally mandatory provision (a provision that makes void those agreements that, contrary to this provision, adversely affect policyholders); however, in the field of non-life insurance – for example, maritime insurance contracts, aviation insurance contracts, nuclear energy insurance contracts and non-life insurance contracts – the coverage of damages arising from business activities conducted by a juridical person or some other organisation or an individual who operates a business is excluded from the scope of the application of the foregoing provision.

6.2 Failure to Comply With Obligations of an Insurance Contract

If a policyholder or the insured violates the aforementioned duty, the insurance company may cancel the insurance contract and, except for damages not arising from violation of the duty of disclosure, will be discharged from liability for making insurance payments. An insurance company's right of cancellation will be extinguished one month after it learns the cause of the cancellation, or five years after the conclusion of the contract.

6.3 Intermediary Involvement in an Insurance Contract

While insurance agents act on behalf of insurance companies, insurance brokers act on behalf of customers independent from insurance companies (buyer's agents).

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

Insurance contracts may be concluded verbally but, in practice, it is commonly done in writing so that the conditions of the contracts are clarified. The existence of insured benefits (economic benefits that may be disadvantaged by the occurrence of insured events) is required as a condition to effectuate a non-life insurance contract. The insured is the person to whom the insured benefit belongs.

The reason for the existence of insured benefits is to prohibit gambling and prevent moral hazards. However, this requirement for the existence

of insured benefits tends to be applied fairly moderately and flexibly.

6.5 Multiple Insured or Potential Beneficiaries

In non-life insurance, only the insureds may be the beneficiaries of an insurance contract. Insurance benefits are paid to the insureds and/or parties authorised by the insureds to receive the benefits.

6.6 Consumer Contracts or Reinsurance Contracts

This is not applicable in Japan.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Based on the content of the product, it should be determined whether such product is subject to Japanese regulation. Certain products may be subject to regulation as reinsurance products.

7.2 Foreign ART Transactions

This is not applicable in Japan.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

There are no laws or regulations on how to interpret contracts specific to insurance contracts.

In general, the courts interpret insurance contracts objectively, taking into account their comprehensibility by average, reasonable customers. Nonetheless, the courts tend to recognise agreements between insurance companies and customers that differ from explicit policy conditions, taking into consideration the way in which insurance companies and customers negotiated and concluded their insurance contracts, and seek reasonable solutions while ordering compensation for damages.

At the time of solicitation of an insurance contract, the Insurance Business Act requires insurance companies to deliver documents (contract outline) containing the following items to fulfil their obligation to provide information:

- the structure of the insurance policy/coverage;
- matters concerning insurance benefits (including giving typical examples of payment conditions of insurance benefits and explaining cases where insurance benefits are not paid);
- duration of the insurance policy;
- the amount of insurance and other conditions for underwriting of insurance contracts;
- the payment of insurance premiums;
- cancellation of insurance contracts and refunds thereof;
- cooling-off procedures;
- matters concerning the notification to be made by the policyholder or the insured;
- the timing of commencement of insurance liability;
- the grace period for payment of insurance premiums; and
- the invalidation and reinstatement of insurance contracts after their expiration.

8.2 Warranties

This is not applicable in Japan.

8.3 Conditions Precedent

This is not applicable in Japan.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurance disputes are generally resolved in district courts or summary courts, depending on the value of the dispute. There are no special courts for resolving commercial insurance disputes and, therefore, the same procedure is applicable to both consumer contracts and reinsurance contracts. In practice, a jurisdiction clause in an insurance policy determines which court will hear disputes in relation to the insurance policy.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

See **9.1 Insurance Disputes over Coverage**.

9.3 Litigation Process

Generally, a first hearing date is scheduled around one month after the filing of a lawsuit. It usually takes six months to one year to reach a judgment.

The losing party may appeal to the upper court based on any grounds if it is not satisfied with the decisions of the court of first instance. There are two stages of appeal.

9.4 The Enforcement of Judgments

A foreign judgment is required to be recognised in Japanese courts. To be capable of recognition and enforcement, a foreign judgment must satisfy the requirements of Article 118 of the Code of Civil Procedure. Whether these requirements are satisfied will be determined by the court in an action for "execution judgment" under Article 24 of the Civil Execution Act.

9.5 The Enforcement of Arbitration Clauses

This is not applicable in Japan.

9.6 The Enforcement of Awards

The Arbitration Act provides that an arbitration agreement must be in writing but does not require any specific wording. Parties to the arbitration may not appeal to the courts regarding the decision of the arbitral tribunal. However, the Arbitration Act provides that the parties may file a petition to set aside the arbitral award to the court in some situations, such as invalidity of the arbitration award due to the limited capacity of a party.

Japan is party to the New York Convention, and arbitration awards received in the member countries can be enforced in Japan.

9.7 Alternative Dispute Resolution

Insurance alternative dispute resolution (ADR) is common, especially in the field of consumer contracts. An increasing number of insurance-related disputes are resolved through ADR.

9.8 Penalties for Late Payment of Claims

Japan has not introduced the concept of punitive damages. Late payment interest is recoverable in respect of claims. Before 31 March 2020, the rates for late payment interest were 5% per annum for non-commercial claims and 6% per annum for commercial claims. As of 1 April 2020, the amendment of the Civil Code became effective and a new structure for late payment interest was introduced, ie, 3% per annum with subsequent reviews every three years to reflect market interest rates.

9.9 Insurers' Rights of Subrogation

For non-life insurance, Article 24 of the Insurance Act provides that, where insured property is totally lost or destroyed, an insurer that has paid an insurance proceeds payment shall be subrogated to ownership and any other real right that the insured holds over the insured property,

in accordance with the ratio of the amount of the insurance proceeds payment thus paid to the insured value (or the agreed insured value if there is any such amount).

Article 25 of the Act provides that, when an insurer has made an insurance proceeds payment, the insurer shall be subrogated with regard to any claim acquired by the insured due to the occurrence of any damages arising from an insured event up to the smaller of:

- the amount of the insurance proceeds payment made by the insurer; or
- the amount of the insured's claim.

10. Insurtech

10.1 Insurtech Developments

In Japan, the emergence of fintech was, at first, most pronounced in the banking sector. Indeed, the Japanese government first responded to fintech by amending the Banking Act so that banks could own technology companies as their subsidiaries, which was previously restricted to some extent (the "Amended Banking Act"). The Amended Banking Act came into force on 1 April 2017. In 2021, the Insurance Business Act was amended in the same way for insurance companies to own subsidiaries that provide IT and other technology to enhance insurance activities and benefit the insurance companies' customers.

Adoption of New Technologies

Japanese insurance companies are gradually adopting new technologies such as IoT (Internet of Things), big data and artificial intelligence to their services. For example, Tokio Marine & Nichido Anshin Life Insurance Co Ltd has introduced a medical insurance policy where an insured might obtain cash back of insurance fees if they walked certain average number of steps, daily. The insured would be required to use wearable technology to monitor their activities and record their health data.

Another example is Sony Assurance Inc's automobile insurance, where an insured has a "driving counter" installed in their car to monitor the insured's driving. If it shows safe driving on the part of the insured, the insurer will provide cash back towards the insurance fees.

Alliance with Tech Companies

Insurance companies alone may not be able to create new insurtech products because they do not have enough resources/knowledge to develop new technology. An alliance with tech companies or telecoms companies is therefore necessary. Another question has been whether insurance companies are allowed to own tech companies or telecoms companies as their subsidiaries to take full control of the new technologies.

The Fintech Support Desk

The FSA regards the fintech trend quite positively. One example of the positive attitude of the FSA is the Fintech Support Desk, which was established to provide a streamlined process for fintech businesses. Indeed, the FSA appears to be watching developments regarding insurtech with a high degree of interest.

10.2 Regulatory Response

See **10.1 Insurtech Developments**.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Cyber-attacks have come to pose a severe and present risk, which Japanese companies have to cope with. Even though countermeasures are being introduced, they can easily be rendered ineffective. The Ministry of Economy, Trade and Industry of Japan (the METI) issued the Cybersecurity Management Guideline, which establishes that cybersecurity is a business challenge and that Japanese companies have to take appropriate protective actions.

To respond to such situations, insurance companies have developed insurance products to cover the costs of information leakage or damages caused by a cyber-attack. However, considering the survey conducted by the General Insurance Association of Japan in 2020 showing that only 6.7% of SMEs respondents have purchased cyber-insurance, the cyber-insurance market in Japan still has significant room to grow.

11.2 New Products or Alternative Solutions

With advancements in autonomous car technology, the question of who should bear legal responsibility in the case of accidents involving self-driving cars is being debated. The Study Group on Liability for Damages in Autonomous Driving that was established by the Ministry of Land, Infrastructure, Transport and Tourism (the MLIT) published its report in March 2018. In the report, the Study Group concluded that, in the transition period where autonomous technology from level 0 to level 4 exist intermixedly, while drivers should basically bear legal responsibility for the damage arising from car accidents, it is appropriate to establish a framework for insurance companies to recover from automobile manufacturers effectively.

Tokio Marine & Nichido Fire Insurance Co Ltd has added protection to cover accidents arising from malfunctions in autonomous driving systems in order to provide prompt relief to victims of such accidents.

Increased longevity may affect the strategy of insurance companies. Recently, the Institute of Actuaries of Japan published the Standard Longevity Table 2018 (previously amended in 2007), indicating significant decreases of projected death rates. With this trend, it is reported that insurance companies will lower fees for life insurance by 5%-10% for newly entered insurance contracts. It is also reported that demand is gradually shifting away from life insurance to products covering living costs when the insureds become unable to work, reflecting increased longevity.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

COVID-19

On 10 April 2020, as the impact of COVID-19 continued to expand, the FSA requested that the insurance industry consider, from the viewpoint of protecting policyholders, a more flexible interpretation and application of policy conditions regardless of any precedents.

Since then and until recently, the insurance companies' policy was to pay insurance benefits by taking that request into consideration. For example, insurance companies paid hospitalisation benefits to COVID-19 patients with mild or no symptoms who were given treatment at various

lodging facilities or at home in order to secure the availability of the hospital system to severely ill patients.

However, on 1 September 2022, the FSA took steps toward facing the new reality of living with COVID-19 by announcing a policy to limit the scope of hospitalisation payments to persons at a high risk of becoming severely affected by COVID-19, including:

- persons aged 65 or older;
- persons in need of hospitalisation;
- persons with COVID-19 who are likely to suffer severely from it and thus are in need of receiving a therapeutic agent or oxygen; and
- pregnant women.

For the most part, all insurance companies have been applying this limitation to persons diagnosed with COVID-19 from 26 September 2022 onwards.

On 5 June 2020, the "Act on Sales, etc, of Financial Instruments" was amended and renamed the "Act on the Provision of Financial Services;" this Act came into effect on 1 November 2021, as a part of the legislation on cross-sectional financial services intermediaries.

New Intermediary Business Category

The new law introduces a new category of "Financial Services Intermediary Businesses," a category which entails a registration system that allows for a one-stop mediation service in all financial areas for a single registration, covering banking, securities, insurance, and loans (ie, cross-sectional legislation for the provision of financial services).

Today, while the employment and the household arrangements have diversified, the progress of information and communications technology has enabled the provision of various financial services online. In this context, the new law puts emphasis on allowing users of financial services more freedom of choice in obtaining financial services that satisfy their individual needs.

Belonging to Financial Institutions

Belonging to a specific financial institution is not required to start a financial services intermediary business. However, a security deposit is mandatory to secure financial resources to pay potential compensation in the future. Furthermore, a financial services intermediary is not allowed to accept users' assets, handle certain types of services, or concurrently run an insurance agency or a brokerage business.

Scope of Insurance Products

The scope of insurance products that can be handled by financial services intermediaries is stipulated by a government decree, but financial service intermediaries are not allowed to handle insurance policies with strong investment potential, fire insurance, reinsurance, business-oriented insurance, group insurance, and non-life insurance with insurance amounts exceeding JPY20 million.

Insurance Brokers

Each individual insurer has to decide how to deal with financial services intermediaries and what attitude to adopt towards this new sales channel. The insurance sector already has a long-standing market player in the form of an insurance broker which is independent from insurers. To determine what stance to take towards financial services intermediaries, insurers are advised to analyse their own relationships with brokers, bearing in mind the different functions served by brokers and intermediaries.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

General Principles of Customer-Centric Business Operation (Comparable Common KPIs for Foreign-Currency-Denominated Insurance)

On 30 March 2017, the FSA published the "General Principles of Customer-Centric Business Operation." If financial undertakers running a financial company attempt to adopt these general principles (while it is up to financial undertakers whether they adopt them, in practice, it is difficult for insurers to choose not to), they are required, for example, to develop and make public clear guidelines to achieve the customer-centric business operation and regularly make public announcements on how their efforts in relation to such guidelines are progressing.

The FSA's strategic priorities for the fiscal year 2022 are as follows.

- Based on the reports on the policy for initiatives, etc, the list of financial business operators is to be updated and disclosed on a regular basis. Also, with regard to the reports on common KPIs at investment trusts, the figures should be compiled and analysed, and the results thereof disclosed.
- With regard to common KPIs for foreign currency-denominated insurance policies, the analytics must also be disclosed in the same manner as in the case of investment trusts. Furthermore, the dissemination and penetration of common KPIs for foreign currency-denominated insurance policies should be promoted, and financial institutions should be encouraged to disclose such KPIs.
- Financial institutions' policies for initiatives that are considered to be well-designed should be collated and used as case studies.
- Financial institutions' specific initiatives on customer-centric business operations should be monitored to verify that they are clearly stated in the policies for initiatives and firmly adopted by front-line sales staff.
- Financial institutions' organisational structures should be monitored to ensure that they are positioned to create, sell and manage products that contribute to the formation of customers' assets. In particular, with regard to financial institutions that handle specially structured bonds, their structures should be monitored to see if the management considers the continuation of such business from the above-mentioned viewpoint and, if the management chooses to continue, whether it has considered the target customers and the content of the explanation for the target customers from the viewpoint of realising sales that would meet true customer needs.
- With regard to sales of foreign currency-denominated insurance, the status of penetration and establishment with respect to the initiatives of insurance companies and other financial institutions selling insurance products on their behalf (eg, solicitation management and after-sales follow-up) must be followed up through dialogue with such companies and agents and questionnaires.
- The idea of the "visualisation" measures should be widely disseminated to those keen on asset building, through magazine articles or lectures.
- Discussions with the insurance industry should continue with the aim of enabling the provision of easy-to-understand information by way of the Important Information Sheet. The JSA must also continue monitoring the status of the introduction and use of the

Important Information Sheet among major financial companies.

Policy for Insurance Supervision

On 31 August 2022, the FSA announced the "The JFSA Strategic Priorities July 2022-June 2023–Overcoming Challenges Confronting the Financial System and Building Foundation for Sustainable Growth." Based on these JFSA Strategic Priorities, the policy of insurance supervision administration for fiscal year 2022 was formulated as follows.

- In view of the change in medium- and long-term business climate, such as the aging society, intensifying natural disasters, and the shrinking automobile insurance market, insurance companies are required to:
  (a) conduct efficient business operations through digitalisation;
  (b) build sustainable business models; and
  (c) develop products catering to the changing customer needs.
- As the insurance companies continue to expand their business overseas, it is important that they clarify their strategies to incorporate the growth from overseas expansion and enhance the sophistication of their group governance.
- The FSA will facilitate the steady progress of these initiatives through dialogue, in co-operation with overseas authorities.
- The frequent occurrence of natural disasters over recent years has resulted in increased payments of insurance claims, causing a rise in the fire insurance premium rates. In particular, in view of the growing interest in the risks associated with surging floods, the FSA will hold dialogues with the parties concerned regarding risk-based segmentation of the water disaster insurance premium rates, as well as collaborate with them in disseminating risk information to promote water disaster insurances and in combating fraudulent business capitalising on disasters.
- In response to the environmental changes referred to above, the FSA will examine the details of the economic value-based solvency regulations while monitoring the progress of organisational development within insurance companies, with a view to achieving seamless transition to a new policy of soundness based on the regulations mentioned above.
- In order to prevent product development and solicitation activities that deviate from the original intent of insurance, such as the sale of insurance products with the primary objective of tax saving (tax avoidance), the FSA will conduct workable product screening and monitoring of insurance solicitation through closer co-operation with the National Tax Agency (NTA).
- In light of the recurrent misconduct by in-house sales representatives, the JSA will encourage insurance companies to build a workable system for managing sales representatives.
- In co-operation with the local finance bureaus, the JSA will hold dialogues with the parties concerned regarding the promotion of insurance solicitation by taking the public insurance system into consideration or sophistication of the insurance agency management system, so that insurance services catering to the diverse needs of customers are readily available.
- With regard to small-amount and short-term insurance providers, the JSA will work with local finance bureaux to review their monitoring methods, identify problems related to their financial strength and appropriateness of their business operations, and take measures in respect thereof at an early stage.

Chuo Sogo Law Office P.C. specialises in the following insurance matters: legal advice and opinions relating to insurance laws and regulations; incorporations, mergers and acquisitions, company restructurings and liquidations for insurance companies; and litigation, mediation, ADR and other dispute resolution remedies related to insurance claims and insurance products. Since 2005, the firm has been loaning its attorneys to work at the Financial Services Agency (FSA) – an agency overseeing the insurance sector in Japan. This experience has given Chuo Sogo insights into and a better understanding of the workings of this complex governmental agency, allowing it to better deal with complex insurance-related regulations to the benefit of its clients.

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Trends and Developments

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Insurance Solicitation by Providing Information About Public Insurance

On 28 December 2021, in light of the purpose of private insurance as a complement to public insurance, the Financial Services Agency (FSA) amended the Comprehensive Supervisory Guidelines for Insurance Companies (the "Supervisory Guidelines") to ensure that insurance solicitors understand public insurance programmes and provide appropriate information about the relevant ones to customers so that they understand their risks and the need for corresponding coverage when concluding insurance contracts.

This amendment does not impose any uniform obligation to provide information about public insurance programmes or regulation of conduct that must be followed for all customers. Therefore, insurers and insurance solicitors are not obliged to include information about public insurance programmes, such as an explanation of important matters, in statutory documents, and thus flexible responses are permissible according to the characteristics of the products being handled and the forms of insurance solicitation.

Following some comments in the public comment procedure that the government should be responsible for publicising public insurance programmes, the FSA launched a site containing this information on 11 March 2022. The site provides an overview of public insurance programmes, indicating the corresponding relationships of private insurance for each risk, and printable materials to be used as leaflets. In practice, by using such leaflets or other materials, insurers and insurance solicitors have started efforts to provide information to customers about public insurance programmes related to the insurance policies being sold.

Actions Against Tax-Saving Insurance

The FSA has issued a series of alerts on insurance products sold primarily for the purpose of tax-saving. In response to the problem of tax-saving by purchasing products with high surrender rates, on 21 October 2019, the FSA amended the Supervisory Guidelines to prevent "insurance products designed to lead to solicitation activities that deviate from the original purpose of insurance, such as contracts whose main purpose is fund management of corporations or contracts that assume cancellation within a short period before maturity from the outset" (Part IV-1-11 of the Supervisory Guidelines), and has encouraged the establishment of an appropriate product management system as well as an appropriate insurance solicitation management system. However, recently, some insurers, which were found to have developed and solicited products that deviate from the original purpose of insurance, such as a name change plan for the purpose of tax-saving by changing the name of a corporation to that of an individual, have been subject to administrative orders by the FSA.

In response to this, in July 2022, the FSA published a scheme for collaboration with the National Tax Agency at each stage of product examination and monitoring in order to deal with the development and solicitation activities

for products whose main purpose is tax-saving, which deviates from the original purpose of insurance.

In addition, the FSA has announced its recognition of the following issues as a result of its monitoring of insurers:

- inadequate systems for early detection and handling of cases in which their insurance solicitors attempt to create or use their own supplementary solicitation materials in order to conduct solicitation primarily for the purpose of tax-saving; and
- insufficient efforts by management to continuously communicate messages to staff and provide training to prevent a corporate culture that prioritises sales and disregards compliance.

Comparable Common KPIs for Foreign Currency-Denominated Insurance Distributors

In January 2022, the FSA published the comparable common KPIs for foreign currency-denominated insurance distributors, based on the common KPIs already introduced for mutual funds, in order to help customers select financial institutions that offer high-quality, customer-oriented financial products and services, and to enable them to easily compare products across industries. Although such KPIs are typically expected to be announced by financial institution agents that sell mutual funds and foreign currency-denominated insurance, insurers that provide such insurance products should also pay attention to these industry movements. Each KPI is composed of (i) the customer ratio by investment evaluation and (ii) the cost/return by product.

Customer ratio by investment evaluation

This provides the distribution of customers by returns, after calculating returns after purchases. Return after purchase is the cancellation refund on the reference date + payment made on the reference date – lump-sum insurance premium upon contract execution (all converted to yen) divided by the lump-sum insurance premium upon contract execution (converted to yen).

Cost/return by product

This is plotted for each issuance of foreign currency-denominated insurance (up to 20 products). Average cost is calculated by annualising the sum of the new contract and renewal fee rates (accumulated payments) for contracts held for five years or more on the reference date by the contract period (number of months elapsed), which becomes a weighted average using the lump-sum insurance premium for each contract. Average return is calculated by annualising the rate of increase in the cancellation refund as of the reference date plus payments made up to the reference date versus the lump-sum insurance premium upon contract execution for each contract held for five years or more on the reference date by the contract period (number of months elapsed), which also becomes a weighted average using the lump-sum insurance premium for each contract.

FSA's Analysis of KPI Figures

On 9 September 2022, the FSA published an analysis of the KPI figures as of the end of March 2022 as the base date. In this analysis, for the customer ratio by investment evaluation, the percentage of customers with a positive investment evaluation rate (simple average of 132 financial service providers) was approximately 70%; no clear relationship between the costs and returns was found for the cost/return by product.

Enhancement of Sales Staff Management Systems

As in the previous fiscal year, there continue to be inappropriate incidents, including money fraud, by sales staff of life insurers so the challenge to develop and establish an effective management system remains. The FSA has issued the following reminders on multiple occasions, urging insurers to develop a corporate risk culture to realise a strong sales staff management system:

- top management should continuously communicate its stance by emphasising compliance and risk management to the sales front lines;
- important compliance training and checks such as unannounced inspections should be conducted with no exceptions;
- principles such as prohibiting sales staff from handling cash should be thoroughly communicated both inside and outside the company;
- sales staff should be thoroughly supervised and guided, especially in cases where customers seek their advice on financial products for their life plans;
- there should be efforts to make risk-based predictive management more sophisticated, with a focus on contracts with a high risk of fraud, such as multiple contracts and large-amount or multiple policyholder loans; and
- based on internal and external cases and environmental changes such as the introduction of remote working, there should be continuous promotion of reviews of functions that serve as a check on the sales front lines and allocation of sufficient resources for necessary internal management.

Upgrading Insurance Agent Management Systems

In recent years, life insurance agents have grown to become a major sales channel along with that of the sales staff; non-life insurance agents have also continued to be a major channel accounting for the majority of sales by non-life insurers. As such, insurance agents play an important role as a link between customers and insurers in both life and non-life insurance, and thus the FSA considers the promotion of more sophisticated supervision of insurance agents to be necessary.

In particular, insurers are expected to be able to reasonably explain the appropriateness of commissions paid to independent agents who act for more than one insurer, reflecting not only the volume of sales but also the quality of the agent's services (business quality), so that the process for making comparative recommendations is not distorted.

In the life insurance sector, as life insurers have been promoting efforts to reflect the business quality of life insurance agents in agent commissions, the Life Insurance Association of Japan (LIAJ) launched its "business quality assessment operation" in April 2022 under which the LIAJ will take the lead in supporting the improvement of agents' business quality based on certain "business quality assessment standards." Agents can check the status of their own business quality initiatives based on those standards, and if they are considered to be doing "well enough" as a result of the self-check, they are eligible to take the "business quality survey" conducted by the LIAJ. The results of the survey will be published for consumers.

The FSA encourages life insurers to expand their efforts to evaluate their agents' business quality by using the "business quality assessment

standards." In fact, some insurers are replacing self-inspection, which insurers have traditionally required agents to perform as part of their education, management and guidance of agents, with the "business quality survey."

Handling of Benefits Pertaining to "Deemed Hospitalisation" for COVID-19

Since the spread of COVID-19, insurers have made special payments of hospitalisation benefits to those who have been confirmed positive, including those who are asymptomatic, by deeming such treatment as hospitalisation under the terms of the policy ("deemed hospitalisation"), even when the insured person has been under medical observation at home or in a setting other than a hospital. With the spread of COVID-19, insurers have faced a significant increase in benefit payments this year.

Meanwhile, as part of the transition to a new phase towards "living with COVID-19," the Japanese government has decided to limit the scope of notification of COVID-19 cases to only those at high risk (eg, elderly persons aged 65 years or older and pregnant women), effective 26 September 2022. In accordance with this change, insurers started from the same date to limit the payment eligibility for special treatment of hospitalisation benefits based on "deemed hospitalisation" to those people at high risk.

Handling of Genetic Information

The FSA considers it important to ensure that insurers do not use genetic information for unfair or discriminatory treatment, and that insurance underwriting and payment practices do not act as a disincentive to promote the use and spread of genomic medicine. In Japan, there is no law prohibiting insurers from selecting risk based on genetic information, as has already been established in the United States and some European countries.

In April 2022, the Japanese Association of Medical Sciences and the Japan Medical Association issued a joint statement calling for the government, regulatory authorities, and related organisations including insurers to take necessary measures to promote genomic medicine. In response, in May 2022, the LIAJ and the General Insurance Association of Japan (GIAJ) released a document titled "Handling of Genetic Information in Life Insurance (Non-Life Insurance) Underwriting and Payment Practices" to clarify the handling of genetic information, including genetic test results and genome analysis information, in insurance underwriting and payment practices. Specifically, the document states that (i) no insurers currently collect or use genetic test results, but that (ii) in the event that new issues are recognised in response to changes in the environment and other circumstances, such as advances in medical care and maturity of social debate, especially in conjunction with genomic medicine becoming more widespread and consumers gaining a more accurate understanding of genetic information in the future, insurers will respond in a timely and appropriate manner, including conducting reviews with reference to the guidance of the supervisory authorities and the opinions of medical professionals.

Mori Hamada & Matsumoto is one of the largest full-service Tokyo-headquartered international law firms. The firm has also established a strong international presence; it now has a presence across East Asia, having offices in Beijing, Shanghai, Singapore, Bangkok, Yangon and Vietnam. The firm's insurance expertise encompasses insurance litigation, regulatory affairs, compliance, reinsurance, captive insurers, group restructurings, mergers and acquisitions, and financings. The firm provides solutions to clients engaged in global insurance markets.

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INDIA

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The primary legislation regulating the Indian insurance sector is the Insurance Act, 1938 (the "Insurance Act") and the Insurance Regulatory and Development Authority Act, 1999 (the "IRDA Act").

Recently, the Ministry of Finance proposed significant amendments to the Insurance Act and the IRDA Act through the Insurance Laws (Amendment) Bill, 2022 which, if brought into force in its current form, will result in various significant changes to registration requirements and operational matters.

The Marine Insurance Act, 1963 has its basis in the UK Marine Insurance Act 1906. Though the Marine Insurance Act primarily regulates marine insurance, the Indian courts (in a manner akin to the courts in the UK) have extended some of the principles of the Marine Insurance Act to non-marine insurance contracts.

Indian courts are constitutionally mandated to follow the precedent system, which is based on the doctrine of stare decisis as far as questions of law are concerned. The lower courts are bound to follow the decisions of the courts above them in the hierarchy. Therefore, the decisions of the Supreme Court of India are binding on all lower courts. However, it is not uncommon to see conflicting decisions.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Insurance and reinsurance companies and insurance intermediaries in India are governed by the Insurance Regulatory and Development Authority of India (IRDAI). Insurance entities set up in the International Financial Services Centre (IFSC) in India are additionally governed by the International Financial Services Centres Authority (IFSCA).

Pursuant to the powers granted to the IRDAI under the IRDA Act, the IRDAI has issued various regulations governing the licensing and functioning of insurers, reinsurers and insurance intermediaries. The regulations issued by the IRDAI govern a wide range of aspects, including:

- registration of Indian insurers;
- registration of the IFSC Insurance Office (IIO);
- registration of the IFSC Insurance Intermediary Office;
- establishment and closure of liaison offices in India by an insurance company registered outside India;
- the assets and solvency margins required to be maintained by insurers;
- issuance of capital;
- manner of preparation of financial statements;
- commission/remuneration and reward structures;
- outsourcing arrangements; and
- registration requirements and corporate governance norms for companies operating in the insurance sector.

The regulations issued by the IRDAI govern all insurers, that is:

- life insurers;
- general insurers;
- standalone health insurers; and
- reinsurers.

In addition, the IRDAI regulations govern all insurance intermediaries, that is:

- insurance brokers;
- corporate agents;
- web aggregators;
- third-party administrators;
- surveyors and loss assessors; and
- insurance marketing firms.

Further, the Foreign Exchange Management (Insurance) Regulations 2015 (the "FEMA Insurance Regulations") regulate the manner in which a person resident in India (that is, a person who has been residing in India for more than 182 days in the preceding financial year) can take or continue to hold a general insurance or a life insurance policy issued by an insurer outside India.

The Reserve Bank of India (RBI) has also issued *Master Direction – Insurance* of 1 January 2016 (as amended), which, read with the FEMA Insurance Regulations, provides guidance on various issues including issuing policies, collecting premiums and settling claims with respect to general, life and health insurance policies.

2.2 The Writing of Insurance and Reinsurance

Under the Insurance Act, an Indian insurance company is permitted to carry on insurance business in India. An Indian insurance company is a public limited company formed under the Companies Act, 2013, which exclusively carries on life insurance business, general insurance business, health insurance business or reinsurance business.

An entity that seeks to carry on insurance business is required to apply for a certificate of registration from the IRDAI in accordance with a three-stage process set out under the IRDAI (Registration of Indian Insurance Companies) Regulations, 2022, as amended (the "Registration Regulations"). The Registration Regulations repeal the IRDA (Registration of Indian Insurance Companies) Regulations, 2000. Some notable changes brought about by the Registration Regulations include that the investment in the insurance company could be made in the capacity of a private equity fund, investor, or promoter, subject to certain specific conditions.

A certificate for registration is required for each category of insurance business (ie, life, general, standalone health and reinsurance). In addition, the Registration Regulations also set out the essential requirements that an applicant applying for registration is required to fulfil, including, but not limited to:

- permissible foreign investment limits;
- minimum capitalisation requirements;
- minimum qualifications of the directors and principal officers;
- planned infrastructure; and
- general track record of conduct and performance of each of the Indian promoters and foreign investors in the business or profession they are engaged in.

The applicant must also provide adequate documentation in support of their application as prescribed under the Registration Regulations.

Foreign Reinsurers

The Insurance Act also permits the establishment of foreign reinsurer branches as well as the setting up of service companies under the Lloyd's India framework. Foreign insurers may apply for registration of a foreign reinsurer branch in accordance with the IRDAI (Registration and Operations of Branch Offices of Foreign Reinsurers Other than Lloyd's) Regulations, 2015 (the "Branch Office Regulations"), and syndicates of Lloyd's may participate under the Lloyd's India framework ("Syndicates of Lloyd's India") through a service company set up in India in accordance with the IRDAI (Lloyd's India) Regulations, 2016.

The Branch Office Regulations specify the eligibility criteria of a foreign reinsurer, such as:

- credit rating;
- infusion of minimum assigned capital into the foreign reinsurer branch;
- in-principle clearance from home country regulator; and
- commitment to meeting all liabilities of the foreign reinsurer branch.

Further, foreign reinsurers can also be registered with the IRDAI as a cross-border reinsurer (CBR) in accordance with the IRDAI's *Guidelines on Cross-Border Reinsurers* of 22 January 2021 (the "CBR Guidelines"). This is a single-stage application for allotment of a filing reference number made through cedants who wish to conduct business with that CBR. The CBR Guidelines specify eligibility criteria for CBRs, such as authorisation from the home country regulator, credit rating, solvency margin and claims settlement experience.

A foreign reinsurer may also apply to the IFSCA in order to set up a branch within the IFSC and obtain registration as an IIO for carrying on reinsurance business. For setting up an IIO, a foreign reinsurer is required to comply with the IFSCA (Registration of Insurance Business) Regulations, 2021 (the "IIO Regulations") and the IFSCA (Operation of International Financial Services Centres Insurance Office) Guidelines, 2021 (the "IIO Guidelines") which govern the registration requirements for an entity seeking to conduct the reinsurance business in the IFSC.

2.3 The Taxation of Premium

Premiums received on account of insurance and reinsurance business attract applicable taxes, including goods and services tax. Income tax laws provide deductions to the policyholder on life and health insurance premiums paid.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Overseas, non-admitted insurers cannot write direct insurance business in India. As a general rule, the purchasing of insurance from overseas insurers by Indian residents is prohibited in India, unless the purchase falls within the general or specific approval of the RBI.

Non-admitted insurers who have registered with the IRDAI as CBRs can write reinsurance of Indian risks from overseas in accordance with the IRDAI's regulations on the reinsurance of life and general insurance business.

In addition to this, the IRDAI has issued *Guidelines on the Establishment and Closure of Liaison Office in India by an Insurance Company registered outside India* of 17 October 2022 which

lay down the framework for overseas insurers to open liaison offices in India.

Indian residents are permitted to purchase health insurance policies from overseas insurers provided the aggregate remittance (including premium) does not exceed the limits prescribed by the RBI under the LRS. Indian residents are also permitted to purchase insurance policies in respect of any property in India or any ship, vessel or aircraft registered in India with an insurer whose principal place of business is outside India – though only with the IRDAI's prior permission.

3.2 Fronting

The overarching regulatory framework for the reinsurance of risks is laid down by the IRDAI (Re-insurance) Regulations, 2018 (the "Reinsurance Regulations"). The guiding principle is maximising retention within India, so each insurer must maintain the maximum possible retention commensurate with its financial strength and volume of business, and ensure that it is not merely "fronting" for a reinsurer or retrocessionaire.

In this regard, fronting is defined as a process of transferring risk in which an Indian insurer cedes or retrocedes most of or all of the assumed risk to a reinsurer or retrocessionaire.

Recently, the IRDAI circulated an exposure draft on the IRDAI (Re-insurance) (Amendment) Regulations, 2022 which proposes to modify the existing Reinsurance Regulations.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Acquiring Stakes

The insurance sector has, in recent years, been abuzz with the news of new players looking to acquire stakes in insurance companies and insurance intermediaries. While such restructuring is a complicated process in itself, the approval requirements stipulated by the IRDAI additionally extend the process. Sections 35, 36 and 37 of the Insurance Act prescribe the procedure for obtaining the approval of the IRDAI for amalgamation and transfer of insurance business of insurers. The IRDAI has also notified the scheme rules which prescribe the procedure required to be complied with by insurers for the purpose of amalgamations and transfer of business.

The parties are required to prepare a scheme which sets out the agreement under which the transfer or amalgamation is proposed to be effected, and containing such further provisions as may be necessary for giving effect to the scheme. Two months prior to making an application to the IRDAI for the approval of such scheme, a notice of intention to make such application is required to be sent to the IRDAI, along with a statement of the nature of the transaction and the reasons thereof, and four certified copies of the following documents:

- a draft of the agreement or deed under which it is proposed to effect the amalgamation or transfer;
- balance sheets in respect of the insurance business of each of the insurers concerned in such amalgamation or transfer;
- a report on the proposed amalgamation or transfer, prepared by an independent actuary

who has never been professionally connected with any of the parties concerned in the amalgamation or transfer in the preceding five years;
- actuarial reports and abstracts in respect of the insurance business of each of the insurers; and
- any other reports on which the scheme of amalgamation or transfer was founded.

The statutory and regulatory framework lays down the manner in which approval of the IRDAI may be sought, the documents required, as well as the pre- and post-approval actions required to be complied with by the parties.

Amalgamations

In addition to the foregoing, pursuant to the powers conferred under Section 37A of the Insurance Act, the IRDAI also has the power to prepare a scheme of amalgamation of an insurer with another insurer, where the IRDAI is satisfied that such an amalgamation is necessary in the public interest, in the interest of policyholders, in order to secure the proper management of an insurer, or in the interest of the insurance business of the country as a whole.

Transferring amalgamation of business of an insurer without the approval of the IRDAI is also grounds for suspension of the insurer's certificate as issued by the IRDAI. Through a circular titled *Transfer of Shares of the Insurance Companies* of 23 July 2020, the IRDAI clarified that provisions with respect to transfer of shares will apply mutatis mutandis to the creation of a pledge or any other kind of encumbrance over shares of an insurer by its promoters.

Recently, Exide Life Insurance Company Limited merged with HDFC Life Insurance Company Limited, and Bharti AXA General Insurance Company Limited was acquired by ICICI Lombard General Insurance Company Limited. Further, the IRDAI has given the final approval to GoDigit General Insurance Limited and in-principle approval to IndiaFirst Life Insurance Company Limited for listing on the stock exchange.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The IRDAI has issued regulations setting out the licensing or registration requirements and procedures for all recognised intermediaries, including insurance agents, corporate agents, brokers, surveyors, third-party administrators, web aggregators, insurance repositories and insurance marketing firms.

The IRDAI has issued the IRDAI (Insurance Intermediaries) (Amendment) Regulations, 2022 which amend the maximum number of arrangements that a corporate agent is permitted to enter into with life, general and health insurers under the IRDAI (Registration of Corporate Agents) Regulations, 2015, as well as amend the maximum limit of tie-ups permitted to insurance marketing firms with life, general and health insurers and increase their area of operation under the IRDAI (Registration of Insurance Marketing Firm) Regulations, 2015.

Individual Insurance Agents

An application for a licence as an individual insurance agent is required to comply with the conditions provided under the Insurance Act and regulations issued by the IRDAI in this regard. Individual agents are required to have completed practical training and possess the requisite knowledge for soliciting insurance business before applying for a licence. Individual agents

are expected to only engage in insurance distribution services and are permitted to solicit business for only one insurance company engaged in each class of insurance business.

Corporate Agents

Entities eligible to operate as corporate agents include firms, banks, non-banking financial companies, co-operative societies, NGOs and companies. Corporate agents are permitted to engage in any business as their main business, other than insurance distribution. However, if a corporate agent has a main business other than insurance distribution, the corporate agent is not permitted to make the sale of its products contingent on the sale of an insurance product, or vice versa. Corporate agents are allowed to have arrangements with a maximum of nine insurers in each class of insurance business.

Insurance Brokers

Insurance brokers are required to exclusively carry out the distribution of insurance products. Any company, limited liability partnership or co-operative society may apply to the IRDAI for grant of an insurance broker certificate of registration. Applicants can register as direct brokers, reinsurance brokers, or composite brokers (involved in both direct and reinsurance broking). The minimum capital is INR7.5 million for direct brokers, INR40 million for reinsurance brokers and INR50 million for composite brokers. All insurance brokers are required to be part of the Insurance Brokers Association of India.

Insurance Marketing Firms

Entities that are licensed as insurance marketing firms are permitted to distribute insurance products along with mutual funds, pension products and certain other financial products, provided that permissions are in place to distribute those financial products from the respective regulator. IMFs are required to have a minimum net worth of INR1 million. They are also permitted to undertake survey functions through licensed surveyors on their rolls, policy servicing activities, and other activities which are permitted to be outsourced by insurers under the applicable regulatory framework. IMFs are allowed to have tie-ups with a maximum of six insurers in each class of insurance business.

Web Aggregators

An entity such as a company or a limited liability partnership that is registered as a web aggregator is permitted to display on its website information on insurance products of those insurers with whom the web aggregator has entered into an agreement. The web aggregator is also permitted to display product comparisons on its website, carry out activities for lead generation and share leads with insurers. A web aggregator is required to have a minimum capital of INR2.5 million.

POSP

The IRDAI has issued guidance for the appointment of a point-of-sales person (POSP) for solicitation and servicing of point-of-sale products on behalf of life, general and health insurers. A POSP may be appointed by either an insurer or an insurance intermediary. The entity engaging the POSP is required to train the POSP and conduct an in-house examination of such POSP, in accordance with the norms issued by the IRDAI.

MISP

The IRDAI has issued the *Guidelines on Motor Insurance Service Providers* (the "MISP Guidelines") to regulate the role of automobile dealers in the distribution and servicing of motor insurance products. A duly registered MISP is permitted to solicit, procure and service motor insurance policies for insurers or insurance inter-

mediaries, as the case may be, in accordance with the provisions of the MISP Guidelines.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

All insurance policies in India contain insuring clauses, general conditions, exclusions and definition sections. The insuring clause, exclusion and definition wording depends on the type of policy being issued and cover requested, though the conditions are fairly standard in that they will include notification, co-operation, consent, changes in material risk and other insurance clauses. These clauses can be deleted or modified by way of endorsements.

Wording of insurance contracts is highly regulated in India. In relation to various forms of general insurance, it is noted that the erstwhile Tariff Advisory Committee (TAC) – a statutory body that was established under the Insurance Act – issued a standard form of policy terms and conditions relating to fire, marine (hull), motoring, engineering, industrial risks and workmen compensation, which cannot be deviated from by insurers and to date are still required to be followed for most businesses.

However, the tariff general regulations, terms, conditions, clauses, warranties, policy, add-ons, endorsement wording and proposal form applicable to specific coverage under fire and allied perils insurance business governed by the erstwhile All India Fire Tariff 2001 have been de-notified with effect from 1 April 2021. In this context, the IRDAI has also issued the *Guidelines for Standard Products for Fire and Allied Perils for Dwellings, Small and Micro Businesses*, in accordance with which insurers are now required to replace the policy wording of the identified categories with the standard terms and conditions issued thereunder.

In addition, the IRDAI's circular on *Filing of fire insurance products for Dwellings, Micro and Small Businesses* of 12 May 2022 permits general insurers to design and file "alternative products" covering fire and allied perils for dwellings, micro and small businesses. Further, the IRDAI has issued an exposure draft on *Long-Term Fire Insurance products* of 7 December 2022 covering fire and allied perils in variation to the "standard products" and "alternative products".

In addition, for health insurance policies, the IRDAI has specified a standard set of definitions, general conditions, exclusions, standard nomenclature for critical illness, and a standard list of generally excluded expenses. The IRDAI has also specified a number of regulatory requirements and conditions vis-à-vis coverage and presentation of health insurance policies, making these policies highly regulated.

Policy Terms

There are also extraneous rules that have an impact on policy terms. For example, the Insurance Act gives the policyholder a right to override contrary policy terms in favour of Indian law. The IRDAI (Protection of Policyholders' Interests Regulations), 2017 (the "Policyholders Regulations") prescribe certain matters to be mandatorily incorporated in life insurance, general insurance and health insurance policies. Some of the key requirements are as follows:

- the name and unique identification number (UIN) allotted by the IRDAI for the product, its terms and conditions, and details of the sales person;

- benefits payable and the contingencies upon which these are payable, and the other terms and conditions of the insurance contract, including any riders/endorsements;
- details of the nominee(s);
- the premiums payable, frequency of payment, grace period allowed, and implication of discontinuing the payment of an instalment of the premium;
- any special clauses, exclusions or conditions imposed on the policy;
- the address and email of the insurer to which all communications in respect of the policy must be sent;
- details of the insurer's internal grievance redressal mechanism, along with the right of the insured to approach the insurance ombudsman with requisite territorial jurisdiction;
- the list of documents that are normally required to be submitted in the case of a claim.

Where exclusions are to be stipulated in the policy, the Policyholders Regulations require that, wherever possible, insurers must endeavour to classify the exclusions into the following:

- standard exclusions applicable in all policies;
- exclusions specific to the policy which cannot be waived; and
- exclusions specific to the policy which can be waived on payment of an additional premium.

Similarly, to provide clarity and understanding of the conditions to the policyholder, insurers are also required to try to broadly categorise policy conditions into the following:

- conditions precedent to the contract;
- conditions applicable during the contract;
- conditions when a claim arises; and
- conditions for the renewal of the contract.

While a broad product classification based on the target customer base exists under general insurance and health insurance policies in India, the above requirements apply uniformly to consumer contracts as well as commercial contracts.

In the year 2020–21, the IRDAI also standardised various general, health, and life insurance policy wordings for insurers across the board to adhere to.

Good Faith and Other Obligations

It is a fundamental principle of insurance law that utmost good faith (uberrimae fide) must be observed by the contracting parties. The duty of utmost good faith places an obligation on the insured to voluntarily disclose all material facts which are relevant to the risk being insured. If there has been a misrepresentation or non-disclosure of a material fact, an insurer can avoid the policy from the beginning. Even though a policy may not expressly say so, all insurance policies are based on this principle.

Further, the Indian Marine Insurance Act, 1963 and the Policyholders Regulations mandate that an insured is under an obligation to disclose all material information sought by the insurer in the proposal before the inception of the policy. An insurer is therefore entitled to receive full and fair disclosure of the material information that would influence the judgement of the insurer in determining whether to accept or reject the risk. The Supreme Court has stated this is to be done through the proposal form.

The Policyholders Regulations also impose an obligation on the insured to disclose all material information. This forbids the insured from con-

cealing what they privately know, with a view to drawing the insurer into a bargain based on their ignorance of that fact. The insured's duty to disclose is not confined to the facts which are within his knowledge, but extends to all material information which the insured ought to have known. The duty of good faith is of a continuing nature.

6.2 Failure to Comply With Obligations of an Insurance Contract

An insurer is entitled to receive fair presentation of the risk. If there is a misrepresentation or non-disclosure of a material fact, the insurer has the right to void the policy ab initio. Unless the misrepresentation or non-disclosure was fraudulent, the premium must be returned to the policyholder. In the case of life insurance policies, the policy cannot be called into question on any grounds (including fraud) after the completion of three years from the date of the issuance or the revival of the policy.

6.3 Intermediary Involvement in an Insurance Contract

An insurance intermediary involved in the negotiation of contract is required to recommend insurance to a prospect taking into consideration the needs of the prospect. Intermediaries are expected to act in the interest of policyholders.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

Insurance is a contract of indemnity. Though insurance is a contract, in order to be a valid insurance contract it should have something more than what in general is required under a normal contract as per the Indian Contract Act, 1872. It is not sufficient for an insurance contract that the contracting parties should have capacity to contract – a person entering into a contract of insurance must also have insurable interest in the subject matter of the contract. The element of insurable interest must be present in all types of insurance, failing which it would simply be a wagering contract that would be void.

An insurance contract is required to contain certain mandatory clauses as enumerated in **6.1 Obligations of the Insured and Insurer**.

6.5 Multiple Insured or Potential Beneficiaries

The present regulatory framework does not set out express norms on the payment of claims to unnamed insureds, so, typically, coverage of such parties largely depends on the terms and conditions of the underlying insurance policy.

6.6 Consumer Contracts or Reinsurance Contracts

The Reinsurance Regulations issued by the IRDAI define a contract of reinsurance as a legally binding document on all the parties that provides a complete, accurate and definitive record of all the terms and conditions and other provisions of the reinsurance contract. Reinsurance arrangements do not need to be pre-approved by the IRDAI, but they need to be documented and filed with the IRDAI within the stipulated time period.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

ART was expressly recognised in India by way of the Reinsurance Regulations in 2018. The Reinsurance Regulations stipulate that an Indian insurer intending to adopt ART solutions must submit such proposals to the IRDAI. The IRDAI may, after necessary examination and on being

satisfied with the type of ART solution, allow the ART proposal on a case-by-case basis. The Reinsurance Regulations do not expressly set out the benchmarks on which the IRDAI shall examine these proposals.

7.2 Foreign ART Transactions

Per the directions of the IRDAI issued in 2004, any ART arrangement has to be accounted for based on the principle of "substance over form". If the agreement is in the nature of reinsurance coupled with a financing arrangement, and the components are capable of separation, each element should be accounted for as per the Generally Accepted Accounting Principles (GAAP).

However, in cases where the aforementioned components are not separable, the entire arrangement should be treated as a financial transaction and should be accounted for accordingly. All non-life insurers are required to account for the ART arrangements by looking into the "substance over form", and account for this as per the GAAP.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

When interpreting insurance contracts, Indian courts have held that while construing the terms of a contract of insurance, the words used therein must be given paramount importance, and it is not permitted for the court to add, delete or substitute any words. It has also been observed that, because upon issuance of an insurance policy the insurer undertakes to indemnify the loss suffered by the insured on account of risks covered by the policy, its terms have to be strictly construed in order to determine the extent of the liability of the insurer.

The general rule is that, where the contract is expressed in writing, oral evidence is inadmissible to explain or vary the terms of a written contract. Although a contract must always be construed according to the intention of the parties, that intention can only be ascertained from the instrument itself. All other evidence of intention is excluded because, when an agreement is reduced to writing, the parties thereto are bound by the terms and conditions of that agreement.

In the event that any policy provision is ambiguous or there is uncertainty as to the meaning or intention of the provision, then this is to be construed contra proferentem – that is, against the maker of the document.

8.2 Warranties

Warranties are the clauses which form the basis of the contract of insurance. Usually, clauses which are meant to operate as warranties are expressly stated to be as such in the insurance policies. All warranties under an insurance policy must be strictly complied with, whether material to the risk or not. If a warranty is breached, an insurer is discharged from all liability under the policy.

8.3 Conditions Precedent

Usually, an insurance policy will expressly state the provisions which are conditions precedent to liability. If any condition precedent has been breached, the insurer has the right to repudiate the claim. However, where it is not expressly stated, the Indian courts will make efforts to decide whether a particular clause is merely a condition or a condition precedent to the insurer's liability.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurance policies are structured to incorporate comprehensive mechanisms for dispute resolution both in respect of coverage and quantum disputes. Insurance policies typically include details of the insurance ombudsman, who is appointed to address complaints by the insured, inter alia in relation to the settlement of claims.

The IRDAI requires insurers to formulate a grievance redressal policy and file it with the IRDAI. An insurer is also required to provide the details of the grievance redressal mechanism within the policy. Policyholders who have complaints against insurers are first required to approach the grievance or customer complaints department of the insurer.

Insurers are required to form a part of the Integrated Grievance Management System (IGMS) put in place by the IRDAI to facilitate the registering/tracking of complaints online by the policyholders. In cases of delay or no response relating to policies and claims, the IRDAI can take up matters with the insurers to ensure speedy resolution. While policyholders, claimants or the insured can approach the IRDAI for assistance, advocates, agents and other third parties are not allowed to approach the IRDAI.

Insureds

Insureds have no exclusive judicial venues available to them for resolution of insurance or reinsurance disputes. Insureds are however treated in law as consumers of insurance services and can therefore approach the consumer courts for relief. Insureds can also approach commercial courts or civil courts, depending upon the value of the claim, or invoke arbitration for recovering monies under an insurance policy, provided the insurance policy does not contain an arbitration clause. However, the right to approach a consumer forum exists even where there is an arbitration clause.

The consumer courts follow a three-tier hierarchy which, in ascending order, is as follows:

- the District Consumer Disputes Redressal Commission (the "District Commission");
- the State Consumer Disputes Redressal Commission (the "State Commission"); and
- the National Consumer Dispute Redressal Commission (the "National Commission").

District Commissions have the jurisdiction to deal with complaints arising out of a contract, for services or goods involving allegations of "deficiency in service", where the consideration does not exceed INR5 million. For the State Commission, the threshold is above INR5 million up to INR20 million, whereas the National Commission can take up original complaints where the consideration is above INR20 million. The District Commission and the State Commission must also possess the necessary territorial jurisdiction. Appeals against the decisions of the State Commission are heard by the National Commission. An appeal from the decision of the National Commission lies before the Supreme Court of India. The consumer courts follow a summary procedure to ensure quick adjudication of disputes.

Insureds can also approach the insurance ombudsman for disputes relating to or deficiency of performance arising out of the policy, or any other violation of the Insurance Act against the insurer, its agents and intermediaries, provided their claim value is under INR3 million.

Insureds can also file a commercial suit against an insurer for enforcing their claims. The Commercial Courts Act, 2015 recognises insurance disputes as commercial disputes over a value of approximately INR300,000 and provides for a fast-track procedure for adjudicating disputes.

Coverage, Limitation Periods and Beneficiaries

Disputes pertaining to coverage are rarely arbitrated. Insurance policies generally provide for arbitration in the case of quantum disputes only and coverage disputes are usually excluded. The exception to such exclusions may, in certain cases, be liability policies.

The limitation period for making an insurance claim before a consumer court is two years. For commercial suits and arbitration, the limitation period is three years from the date of rejection of the claim by an insurer or from the date on which the claim arose, as may be applicable.

Unnamed beneficiaries or third parties cannot enforce rights under a general insurance contract. Typically, general insurance contracts have clauses which prohibit assignment of rights under an insurance contract to a third party without the consent of the insurer.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Indian courts are increasingly enforcing the choice of law and jurisdiction made by parties in a contract. Party autonomy is respected save where public interest/policy issues are involved. Where an express choice of law and jurisdiction has not been specified in a contract, Indian courts will usually apply conflict-of-law principles to determine the forum and law which is closest to the dispute. Even in the case of arbitration, a similar approach has been followed. India is a signatory to the New York Convention and the Geneva Convention for enforcement of foreign awards.

9.3 Litigation Process

An insured may, depending on the facts of the case, approach a civil/commercial court, or a consumer court. Proceedings before the consumer courts are summary in nature. This means that typically no cross-examination of witnesses takes place and the dispute is adjudicated based on the documents filed and arguments led by the parties.

The broad ascending hierarchy of the civil courts is similar to the consumer courts. It comprises approximately 600 District Courts, 25 High Courts and the Supreme Court (the highest court in India). Among the 25 High Courts, five High Courts of Calcutta, Madras, Bombay, Delhi and Himachal Pradesh have original jurisdiction, which means that matters above particular pecuniary thresholds will be heard by the High Court in the first instance. For some of these five High Courts, there are territorial limits within which the cause of action must arise for it to be heard by the High Court at the first instance.

Trials before the civil courts follow the usual process of pleadings, evidence and arguments as in other common law jurisdictions and can take an unusually long time to conclude.

Special Benches

The Commercial Courts Act, 2015 carves out special benches in all existing civil courts which adjudicate commercial matters exclusively. Since the Commercial Courts Act, 2015 recognises insurance disputes as commercial disputes, all insurance disputes valued above INR300,000 are now required to be filed before a commercial court with appropriate territorial

jurisdiction at the district level, and are no longer filed before civil courts. There are fixed timelines that all commercial courts need to follow, and the legislation is meant to speed up the adjudication process. The statute also provides for compulsory mediation for parties before filing of a commercial suit, except where a party seeks urgent interim relief.

Appeals against the orders of the commercial courts of first instance lie before the Commercial Appellate Court or the Commercial Appellate Division of the concerned High Court (as the case may be), and the Commercial Courts Act, 2015 does not allow for any further appeals from the orders of either the Commercial Appellate Court or the Commercial Appellate Division of a High Court.

Indian litigation can often be time-consuming and potentially expensive. The number of reported pending cases is close to 49 million. Attempts to clear the backlog have not yielded the desired results, even though the inception of commercial courts has somewhat expedited the trial process. Overall, no consistent improvement has been noticed and the process is still slow and, as mentioned, potentially expensive.

The pendency statistics may however not provide an accurate picture, since some of these matters may not even be in a position to be heard on account of various non-compliance by the parties.

9.4 The Enforcement of Judgments

The Indian Code of Civil Procedure, 1908 (CPC) lays down the procedure for enforcement of Indian and foreign judgments. The basic principle which is followed while enforcing a foreign judgment or decree in India is to examine whether the foreign judgment or decree is a conclusive one, based on the merits of the case and by a superior court having competent jurisdiction. Furthermore, a foreign judgment can be enforced in India by filing an execution petition under Section 44-A of the CPC, if the judgment is passed by a court in a reciprocating territory.

In the case of a judgment passed by a court in a non-reciprocating territory, a suit may be filed upon the foreign judgment or decree. In such situations, the foreign judgment is considered of evidentiary value only. The process of enforcement of judgments can also prove to be slow in such cases.

9.5 The Enforcement of Arbitration Clauses

Domestic Arbitration

Typically, Indian courts strictly enforce arbitration clauses. This position holds true for insurance and reinsurance contracts as well.

The courts generally refer a dispute to arbitration after checking for the existence of an arbitration agreement and the arbitrability of the dispute (ergo omens effects), and let the arbitral tribunal decide jurisdictional issues such as novation, settlement and limitation. However, in extremely rare cases where the dispute is ex facie time-barred or there are no subsisting disputes, the court has the discretion to refuse a reference.

The courts have recognised a few additional, but not exhaustive, categories of subject matter, such as those involving disputes relating to criminal offences, matrimonial disputes, guardianship disputes, insolvency, disputes under the Trusts Act, 1882 and winding-up and testamentary disputes, which ought not to be arbitrated. Additionally, the courts have also held that a party who has approached a consumer commission cannot be forced to arbitrate the dispute

(where such an agreement exists) since the Consumer Protection Act is a beneficial legislation and provides an independent right of action to a consumer.

An arbitration agreement, as per the Arbitration and Conciliation Act, 1996 (the "Arbitration Act"), must be in writing and signed by the parties. The agreement should reflect the intention of the parties to submit their dispute(s) to arbitration. The arbitral tribunal to be constituted should be empowered to adjudicate the dispute(s) in an impartial manner. The parties should have also agreed that the decisions of the arbitral tribunal shall be binding on them.

However, there is no prescribed form required for the purpose of an arbitration agreement. While it is advisable to have an arbitration clause in the contract itself, it may not be mandatory. An arbitration agreement may also come into existence if it is contained in a subsequent exchange of letters, telex, telegrams or other means of telecommunications (including by electronic means) which provide a record of the intent to arbitrate.

The reference in a contract to another document which contains an arbitration clause would have the effect of incorporation if the contract is in writing and the reference is such that it captures the intention of incorporating the arbitration clause as part of the contract.

Foreign Arbitration

Even for foreign-seated arbitrations, the position remains broadly the same. Courts are typically inclined to refer disputes with an arbitration clause to arbitration.

Section 45 of the Arbitration Act requires an Indian court seized of any dispute to refer the parties to arbitration at the request of any one of the parties "unless it prima facie finds that said agreement is null and void, inoperative and incapable of being performed".

9.6 The Enforcement of Awards

The enforcement of domestic awards is governed by Part I of the ACA, while enforcement of foreign arbitration awards rendered in a recognised jurisdiction is governed by Part II of the ACA. Both domestic and foreign awards are enforced as a decree of the civil court.

A domestic award may be enforced only after the expiry of three months from the date on which the arbitral award was received. Three months is significant here as this is the time period within which a party has a right to challenge the award. After three months, the decree holder can initiate proceedings to enforce the award, and such proceedings are to continue unless the court deciding the challenge to the award has stayed the enforcement of the award in question on such terms as reasoned by the court. The condition for staying the enforcement of an award is generally the deposit of 100% of the awarded sums with the court.

The ACA was amended in 2020, whereby a court can grant an unconditional stay on enforcement if it prima facie finds that the award was obtained by fraud or corruption.

Conventions

India is a party to the New York Convention and the Geneva Convention, and therefore if the seat of arbitration is a country which is signatory to the New York Convention or the Geneva Convention dealing with recognition and enforcement of foreign awards, Indian courts would be in a position to enforce convention awards.

The party applying for enforcement of a foreign award is required to produce the following, as evidence:

- the original award or a duly authenticated copy of the award;
- the original arbitration agreement or a duly certified copy thereof; and
- such other evidence necessary to prove that it is a foreign award.

The grounds for refusing enforcement of a foreign award in India are the same as those laid down in the New York Convention. These include:

- incapacity of parties or invalidity of the arbitration agreement;
- violation of principles of natural justice;
- the award being beyond the scope of the arbitration agreement;
- the composition of the tribunal not being in accordance with the agreement between the parties or the law of the country where the arbitration took place;
- the award having not yet become binding between the parties or having been set aside or suspended at the seat of the arbitration;
- the subject matter of the arbitration not being arbitrable; and
- the award being contrary to public policy.

In the context of a foreign arbitration, the scope of public policy has been watered down to reduce the scope of court intervention.

9.7 Alternative Dispute Resolution

Where a court is of the view that there are elements of settlement that may be acceptable to parties before it, it may formulate the possible terms of settlement, take the view of the parties and refer the parties to:

- arbitration;
- conciliation;
- judicial settlement, including settlement through Lok Adalat; or
- mediation.

This power is derived from Section 89 of the CPC.

Such reference will require the consent/agreement of the parties where such consent/agreement is otherwise required under law, for instance in the case of arbitration.

Mediation proceedings and settlement discussions are typically confidential, though in certain circumstances the mediator may be required to file a report before the court if so directed.

The Consumer Protection Act, 2019 gives the discretion to the Commission to refer the dispute to mediation with the consent of the parties if there exist elements of settlement which may be acceptable to the parties (except in matters relating to criminal and non-compoundable offences, fraud, medical negligence, et al). Following this, the government has also issued the Consumer Protection Mediation Rules, 2020.

In practice, courts in India are now progressively encouraging parties to explore the possibilities of an out-of-court settlement with a view to end litigation between them. The courts usually have in-house mediation centres where experienced senior lawyers are appointed to act as mediators to try and resolve long-pending disputes.

Pre-institution Mediation

Section 12A of the Commercial Courts Act, 2015 requires a plaintiff (to a suit) to mandatorily exhaust the remedy of "pre-institution mediation" before it can institute the suit. This

otherwise mandatory requirement need not be exhausted in the event urgent interim measures are sought by the plaintiff.

9.8 Penalties for Late Payment of Claims

The Policyholders Regulations prescribe the claims procedure that is required to be followed by insurers to ensure expeditious processing of claims. These regulations work towards ensuring that insurers settle claims on time. Insurers are required to pay interest at the rate of 2% above the prevalent bank rate in cases where there is delayed payment of the claim amount.

9.9 Insurers' Rights of Subrogation

There is statutory and judicial recognition to the right of subrogation. For statutes, the Marine Insurance Act, 1963, specifically Section 79, provides for the insurer's right to subrogation.

Equally, Indian courts have recognised subrogation as an equitable corollary of the principle of indemnity, under which the rights and remedies of the insured against the wrongdoer are transferred to and vested in the insurer.

No separate contractual clause is required to trigger this; however, in practice, policies do also contain subrogation clauses and insurers will frequently obtain "subrogation letters" and an "assignment" of the third-party claim from the insured. The Policyholders Regulations also obligate an insured to assist its insurer in recovery proceedings, if the insurer so requires.

10. Insurtech

10.1 Insurtech Developments

Applications, artificial intelligence, telematics and the internet of things (IoT) are examples of insurtech which are being utilised by insurers in India for transforming the way insurers do business in India. Some examples of the use of insurtech are detailed below.

Websites and Apps

Indian insurers and intermediaries are partnering with tech companies to develop websites and mobile applications to facilitate the sale and servicing of insurance policies online. Insurers are also collaborating with various tech companies to digitise customer verification, underwriting, premium payment and claims-processing functions, and to automate the policy-issuance and claims-settlement processes.

Health Insurance

Health insurers are collaborating with fitness technology firms to track users' behaviours and offer insurance discounts to those who have a healthier lifestyle. General insurers are collaborating with tech companies to explore IoT solutions to track, inter alia, cargo, theft, hijack attempts and wastage.

10.2 Regulatory Response

The IRDAI has issued various norms to address technological advancements and to regulate insurtech developments. The key regulatory changes are summarised as follows.

- With the significant increase in e-commerce transactions over recent years, the IRDAI has recognised the sale and servicing of insurance products online as well as the issuance of e-insurance policies. The *Guidelines on Insurance e-commerce* of 9 March 2017 lay down provisions for setting up insurance self-network platforms by insurers and insurance intermediaries, for undertaking the sale and servicing of insurance activities in India.
- To counteract issues of data privacy and data breach, the IRDAI issued the *Guidelines on*

Information and Cyber Security for Insurers of 7 April 2017 (the "Cybersecurity Guidelines") to stipulate the norms on, inter alia, information asset management, data security, application security, endpoint security, cloud security and incident management, which are required to be complied with by insurers and reinsurers. Further, through its circular *Re: Guidelines on Information and Cyber Security* of 2 September 2022, the IRDAI extended the applicability of the Cybersecurity Guidelines to insurance intermediaries.

- The *Master Guidelines on Anti-Money Laundering/Counter-Financing of Terrorism (AML/CFT) 2022* provides for a "Video-Based Identification Process" (VBIP) as one of the methods for insurers to perform mandatory KYC processes of their customers.
- The IRDAI has also issued its circular *Product Structure for Insurance of Remotely Piloted Aircraft System (RAPS)/Drones* of 11 February 2021, which provides model policy wordings. General insurers have the flexibility to design and develop their own product, keeping in view the minimum coverage specified in the guidelines.
- The IRDAI has recently issued an exposure draft on *Issuance of e-Policies Regulations 2022* of 29 September 2022, wherein the IRDAI proposed a mandatory electronic insurance account which would consist of all the policies of the policyholder and that, subject to prescribed exemptions, every insurer is required to issue policies in electronic form.
- The IRDAI issued its circular *Participation in Account Aggregator Framework* of 14 November 2022 to provide guidance on the participation of Indian insurance companies and insurance repositories (ie, NSDL, CDSL, Karvy and CAMS) in the RBI's account aggregator framework.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

There has been a growing number of cyber-insurance covers being issued, and claims being made under them. This has also led to an increased requirement for forensic expert analysis for the purposes of assessment of coverage under such policies. This trend is likely to continue in view of the growing cyber-risks. However, since cybercovers are comparatively recent in this jurisdiction, there is yet to be any litigation involving cyberpolicies.

11.2 New Products or Alternative Solutions

Recently, the Indian insurance industry has seen a wave of new insurance products, partly due to regulatory and/or statutory changes and partly to new risks emerging through innovations in other industries. While the industry has been typically slow to adapt and embrace new trends in terms of product offerings, new products have been filed in terms of:

- long-term insurance covers;
- health insurance covers for mental illness;
- standard life insurance products;
- standard COVID-19 health insurance products;
- telematics-based riders;
- specific endorsements for data protection and impersonation frauds (which even cover the resultant fund transfers) in both cyber and crime insurance; and
- a new range of fitness and wellness-focused products in the health sector.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Products

The IRDAI (Unit-Linked Insurance Products) Regulations, 2019 and the IRDAI (Non-Linked Insurance Products) Regulations, 2019 define revised norms vis-à-vis the design and issuance of linked and non-linked life insurance policies by life insurers in India. Further, administration of group life insurance products is now governed by the *Circular on Group Life Insurance Products and other operational matters* of 26 September 2019. For health insurance business, the IRDAI has issued an exposure draft on *Group Insurance Products under Health Insurance Business and other operational matters* of 28 April 2022.

Product Filing Procedures

Recently, the IRDAI introduced many changes in the procedure for product filing for all lines of insurance products, as follows.

- General insurance products – the IRDAI, through a series of circulars issued in June, July and October 2022, extended the applicability of the "use and file" procedure for product filing to all general insurance products.
- Health insurance products – the IRDAI's *Circular on Use and file procedure for all categories of products under health insurance business – reg* of 1 June 2022 provides that all categories of health insurance products and add-ons or riders offered (introduced or modified/revised) by general and health insurers are now permitted to be launched through the "use and file" procedure for product filing.
- Life insurance products – the IRDAI's *Circular on filing of Products/Riders for Life Insurance Business* of 4 October 2022 consolidates and updates all the earlier circulars/guidelines pertaining to filing of products/riders for life insurance business, including the *Circular on Use and file procedure for life insurance products and riders* of 10 June 2022. It specifies that the "use and file" procedure for product filing is applicable to certain life insurance products/riders such as individual and group non-linked term products, group non-linked savings products and unit-linked insurance products offered with existing approved funds.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Recent years have been significant for the insurance sector as they have seen the issuance of several regulations and guidelines issued by the IRDAI, including the following.

- The IRDAI (Appointed Actuary) Regulations, 2022 have been issued, which repeal the earlier IRDAI (Appointed Actuary) Regulations, 2017. The new regulations revise norms on the appointment of actuaries.
- The IRDAI (Regulatory Sandbox) (Amendment) Regulations, 2022 have been issued to amend various provisions of the IRDAI (Regulatory Sandbox) Regulations, 2019, including removal of the limited validity period of the Sandbox Regulations.
- The IRDAI (Assets, Liabilities and Solvency Margin of General Insurance Business) (Amendment) Regulations, 2022 have been issued to amend the IRDAI (Assets, Liabilities and Solvency Margin of General Insurance Business) Regulations, 2016.
- The IRDAI (Actuarial Report and Abstract for Life Insurance Business) (Amendment) Regu-

lations, 2022 have been issued to amend the IRDAI (Actuarial Report and Abstract for Life Insurance Business) Regulations, 2016.

- The IRDAI has issued the *Master Guidelines on Anti Money Laundering/Counter-Financing of Terrorism (AML/CFT)* of 1 August 2022 which consolidate and update the *Anti-Money Laundering/Counter-Financing of Terrorism (AML/CFT) – Guidelines for General Insurers* of 7 February 2013 and the *Master Circular on Anti-Money Laundering/Counter-Financing of Terrorism for (AML/CFT) – Guidelines for Life Insurers* of 28 September 2015.
- The IRDAI (Other Forms of Capital) Regulations, 2022 have been issued to repeal the IRDAI (Other Forms of Capital) Regulations, 2015. The guidelines would be applicable to all classes of life, general and health insurance but do not apply to reinsurance business.
- Pursuant to comments from stakeholders on the exposure draft on the *IRDAI (Surety Insurance Contracts) Guidelines 2021 of 8 September 2021*, the IRDAI issued the *IRDAI (Surety Insurance Contracts) Guidelines 2022* on 3 January 2022, which came into effect on 1 April 2022.
- The IRDAI has issued the *Guidelines in respect of Conflict of Interest and Common Directorship among Intermediary or Insurance intermediary* of 10 October 2022 to specify the norms related to appointment of common directors per the Companies Act, 2013.
- By way of its circular on *Appointment or Continuation of Common Director(s) u/s 48A of the Insurance Act 1938* of 2 September 2022, the IRDAI superseded its earlier circular on *Appointment of Common/Nominee Director(s) on the Board of Insurance Company* of 30 August 2018. The circular provides the framework for appointment or continuation of common director(s) representing insurance agents, intermediaries and insurance intermediaries on the board of insurance companies per the second proviso of Section 48A of the Insurance Act.
- The IRDAI issued a circular on *Revision of Health Insurance Regulatory Returns* of 13 September 2022, which reduces the health insurance returns required to be filed by insurers with the IRDAI. The circular also specifies the timelines for filing health insurance returns.
- By way of its circular on *Immediate Annuity Products* of 13 September 2022, the IRDAI specified that the exit forms submitted by NPS retirees to the Pension Fund Regulatory and Development Authority (PFRDA) shall be treated as proposal forms for offering immediate annuity products by life insurers.
- The IRDAI has issued the Motor Vehicles (Third Party Insurance Base Premium and Liability) Rules, 2022 to revise the base premium and liability for third-party insurance for the various classes of vehicles.
- The IRDAI has recently clarified, through a circular, that the accounting of premiums, claims and related expenses of the General Insurance Corporation of India (GIC) and FRBs will be on an estimation basis.
- The IRDAI has also issued several exposure drafts, including:
  - (a) IRDAI (Expenses of Management of Insurers Transacting General or Health Insurance Business) Regulations, 2022;
  - (b) IRDAI (Expenses of Management of Insurers Transacting Life Insurance Business) Regulations, 2022;
  - (c) IRDAI (Payment of Commission) Regulations, 2022;
  - (d) Long-Term Motor Products covering both Motor Third Party Insurance and Own Damage Insurance;
  - (e) Guidelines on Group Insurance Products

under Health Insurance Business and other operational matters;
(f) IRDAI (Third Party Administrators – Health Services) Regulations, 2016;
(g) Guidelines on Remuneration of Non-Executive Directors and Managing Director/Chief Executive Officer/Whole-time Directors of Insurance companies;
(h) IRDAI (Obligations of an Insurer in respect of Motor Third Party Insurance Business) Regulations, 2022; and
(i) IRDAI (Health Insurance) (Amendment) Regulations, 2022.

While the foregoing exposure drafts are at the deliberation stage and stakeholder comments have been invited, it is anticipated that new regulations and guidelines will be issued on these and other matters in 2023.

As regards claims, while the focus used to be on more traditional lines of insurance (such as catastrophe, life, health and motor insurance), over the past decade or so the Indian insurance market has evolved and liability products such as PI, D&O, cyber policies and EPL have come to the forefront. There is familiarity and demand for these products and consequently significant claims activity. Among liability products, the past five years show there has been a steady upward trend in claims made under PI policies, and this remains the busiest claims area, followed closely by D&O.

As well as an upsurge in the frequency of claims, there has also been a sharp increase in the quantum being claimed by the insured, which means that claims severity is also on the rise. Additionally, a growing number of cyber-insurance covers are being issued, with claims being made under them. This has led to an increased requirement for forensic expert analysis for the purposes of assessment of coverage under such policies.

Tuli & Co was established in 2000 to service the Indian and international insurance and reinsurance industry. It is an insurance-driven commercial litigation and regulatory practice, which has working associations with firms in other Indian cities as well as globally via its association with Kennedys. The firm has a principal office in Noida and another office in Mumbai, and has a pan-Indian presence with insurance/reinsurance and complex commercial disputes before high courts and tribunals across the country. Currently, 49 lawyers are working for the firm.

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Trends and Developments

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Introduction and Key Focus Areas

The Indian insurance industry has grown significantly in the past few years, fueled by the far-reaching regulatory changes of the last two years. Foreign direct investment (FDI) limits were increased from 49% to 100% for insurance intermediaries in 2020, and from 49% to 74% for insurance companies in 2021. Despite this increase in FDI limits, stakeholders continued to seek reforms in the regulatory landscape to keep pace with the changing demands of the insurance sector. These demands have been heeded by the Insurance Regulatory and Development Authority of India (IRDAI), the insurance sector regulator, after the appointment of a new chairperson in March 2022.

In the last few months, the IRDAI has proposed and effected extensive statutory changes for increasing ease of doing business, insurance penetration, product innovation and distribution efficiencies. It would not be an overstatement to say that as and when these changes become effective (presumably in 2023), they will transform the basic structure of the Indian insurance sector.

This article discusses the following key trends and developments in the Indian insurance sector, which are relevant for those operating in or proposing to enter this sector:

- proposed changes to the basic legal framework governing the sector;
- the shifting landscape for registration of and investment in insurance companies;
- greater flexibility to insurers vis-à-vis product development; and
- significant changes to the insurance distribution framework.

Proposed Changes to the Basic Legal Framework

Background

The Insurance Act, 1938 (the "Act") and the Insurance Regulatory and Development Authority Act, 1999 (the "IRDAI Act") are the primary legislation governing the insurance sector. The government of India, in consultation with the IRDAI and industry stakeholders, has recently proposed a spate of radical reforms to the Act under the Insurance Laws (Amendment) Act, 2022 (the "Amendment Act") which, if implemented in their current form, are set to change the basic structure of insurance companies and how they do business. The proposed changes will facilitate the entry of new and varied players in the industry, encourage niche insurance businesses, give greater rulemaking powers to the IRDAI and ensure ease of doing business for insurers.

Welcoming new and varied players into the market

One of the key entry barriers to new players in the insurance market is the minimum paid-up equity capital requirement of INR1 billion for undertaking life insurance, general insurance and health insurance business, and of INR2 billion for undertaking reinsurance business (both prescribed under the Act). The Amendment Act proposes to remove these limits from the Act

and to empower the IRDAI to prescribe appropriate limits under its regulations. This change is significant since any amendment of the Act requires the approval of the Indian Parliament, which is a long-winded process, while the IRDAI can amend its own regulations without parliamentary approval. The greater authority given to the IRDAI will make it a nimble regulator which can dynamically respond to the needs of the market.

The Amendment Act has now demarcated classes and subclasses of insurance business. A "class of insurance business" could be a life insurance business, general insurance business, health insurance business or reinsurance business. A "subclass" of insurance business would be a smaller part of the relevant "class" – eg, fire, marine and miscellaneous subclasses of general insurance business, and personal accident and travel subclasses of health insurance business. These demarcations, coupled with powers granted to the IRDAI to specify any part or segment of a class of insurance business as its subclass, and to regulate registration, minimum paid-up capital and solvency margin requirements for such subclasses, indicates that the IRDAI may ease requirements to facilitate the entry of specialised players focusing on specific segments such as micro-insurance or agriculture insurance, which could boost insurance penetration in India.

Allowing the entry of captive insurers

The Amendment Act proposes to introduce the concept of "captive insurers" to the Act. A captive insurer would undertake general insurance business or any of its subclasses exclusively for its holding company, subsidiaries or associate companies. While present in many other jurisdictions, the concept of a captive insurer was missing in India. Captive insurance companies are essentially a form of self-insurance for corporate groups and are established to meet the unique insurance requirements of a corporate group by themselves. Large Indian conglomerates, who have been demanding the ability to establish captive insurers, will welcome this move since it allows them to tailor coverage according to their needs, maintain pricing stability and retain greater control over the claims process. These captive insurers are expected to be subject to less stringent regulations than other insurers since the protection of policyholders will be a matter of internal management for them.

Changing the basic structure of insurance companies

One significant change proposed under the Amendment Act is the introduction of a composite insurance registration. Presently, a business can seek registration only for one class of insurance business. The Amendment Act allows an applicant to seek registration for one or more classes or subclasses of insurance business (except those applying to exclusively undertake reinsurance business).

This move could disrupt the insurance market as we know it today since most business houses currently operate through two insurance companies – one undertaking life insurance business and the other undertaking general insurance business (or standalone health insurance business). The amendment will open doors to mammoth insurers who can offer products across the spectrum, without incorporating and maintaining two companies. Apart from a tectonic shift in the industry landscape, this change will also require a complete overhaul of the regulatory framework. Presently, different regulations are applicable to life insurers and general insurers, which will need to be altered significantly to cater to a

single insurer undertaking more than one class of insurance business.

Distribution of financial products

Currently, an Indian insurance company can only exclusively undertake insurance business. The Amendment Act proposes allowing insurers to also provide services related or incidental to insurance business and to distribute financial products. The terms "related or incidental to insurance business" and "financial products" have not been defined, and it remains to be seen how the regulator will ring-fence insurance assets from risks associated with non-core businesses. That said, the move will allow insurance companies to offer comprehensive solutions to customers and enable opportunities for insurers with strong distribution channels to add additional revenue streams.

Increased ease of doing business

The Amendment Act has introduced various proposals for ensuring ease of doing business in the insurance sector, including the following.

- Presently, an insurance company is required to receive prior IRDAI approval for transfer of shares exceeding 1% of the paid-up equity capital of the insurance company. The Amendment Act proposes to increase this threshold to 5%, paving the way for more small-ticket investments in the sector in a quick and time-efficient manner.
- The Amendment Act has replaced the requirement of hard-copy filings with electronic submission of returns/filings.
- The net-owned fund requirement of foreign reinsurers' branches including Lloyd's India is proposed to be drastically decreased from INR50 billion to INR5 billion. This move alone should aid the growth of the reinsurance market in India as it will attract smaller reinsurers.
- The Amendment Act proposes to remove the requirement of renewal of registration every three years for insurance intermediaries (such as corporate agents and insurance brokers). The Amendment Act provides that the registration of an insurance intermediary shall remain in force on payment of an annual fee specified by the IRDAI, until suspended or cancelled.

While the Amendment Act signals that India is ready for more flexible and dynamic insurance companies, it also pushes for entities to design and implement robust compliance frameworks, since it proposes to increase present penalty limits.

Shifting Landscape for Registration of and Investment in Insurance Companies

The Registration Regulations

Alongside the proposed changes to the fundamental structure of insurance companies, the IRDAI also issued the IRDAI (Registration of Indian Insurance Companies) Regulations, 2022 (the "Registration Regulations") to supersede the IRDAI (Registration of Indian Insurance Companies) Regulations, 2000 and the IRDAI (Transfer of Equity Shares of Insurance Companies) Regulations, 2015, with effect from 10 December 2022. The Registration Regulations have thus changed the existing framework for the registration of Indian insurance companies as well as for the transfer of shares of an insurance company, and will significantly alter the way investors structure investments in insurance companies. Some of the key changes introduced by the IRDAI are as follows.

- Promoter category – a shareholder holding more than 25% of the share capital of the insurer would qualify as a "promoter" of the insurance company. Previously, any share-

holder holding more than 10% of the insurer's share capital was recognised as a promoter. The promoter of an Indian insurer can be foreign or Indian or both. A person cannot be the promoter of more than one life insurer, one general insurer, one health insurer and one reinsurer. Regulatory clarity is required on limits on multiple holdings as a promoter where such person is the promoter of a "composite insurer" as envisaged under the Amendment Act.

- Minimum promoter stake – the minimum shareholding of promoters must be 50% of the paid-up equity share capital of the insurer. This holding may fall below 50%, but not below 26%, if the insurer's shares are listed on the Indian stock exchange and the insurer has a track record of solvency ratio above the control level of solvency for the last five years.
- Investor category – a person will be classified as an "investor" if such person invests less than 25% of the share capital of the insurer. Previously, any person holding 10% or less of the equity share capital of an insurance company was typically classified as an "investor". All investors collectively may hold not more than 50% of the capital of an insurer, except listed insurers, where such limit would not apply. An investor may invest in any number of insurers if their investment does not exceed 10% of the paid-up capital of the respective insurers. In the case of investment of more than 10% but less than 25%, the investor may invest in up to two insurers in each class of insurance business. The Registration Regulations also provide that an investor may nominate a director on the board of the insurer if its investment exceeds 10% of the paid-up capital of the insurer.
- Future capital commitments from investors – in the case of a one-time investment by an investor in an unlisted insurer, the promoter(s) shall submit an undertaking to infuse capital to meet its solvency and/or business requirement. In the earlier regime, a shareholder holding more than 10% would have qualified as a promoter and would have been asked to give an undertaking to infuse capital to meet solvency requirements.
- Subsidiary company permitted to be an insurer's "promoter" – the earlier regime did not permit a subsidiary company to be the Indian promoter of an insurer. Under the Registration Regulations, subsidiary companies can be promoters of insurers if they satisfy certain conditions, including being listed on the Indian stock exchange(s), having an own source of funds, a net worth of INR5 billion, and the holding company of the subsidiary not itself being a subsidiary.
- NOFHCs as Indian promoter – the Reserve Bank of India (RBI) regulations require non-operative financial holding companies (NOFHCs) to hold investments in all financial services entities of the group regulated by financial sector regulators. The Registration Regulations specifically recognise NOFHCs registered with the RBI as a category of eligible "Indian promoter".
- Lock-in conditions – previously, the IRDAI used to prescribe a minimum lock-in of five years for promoters, and no transfer of shares of the promoters was permitted within this period without specific IRDAI approval. The Registration Regulations now prescribe clear lock-in restrictions for all categories of promoters, whether Indian or foreign, and for investors, depending on the age of the insurer, which could in certain instances also be less than five years. For instance, where an investor subscribes to shares of a company ten years after it has been registered as an insurance company, the investor's shares

would be locked in for one year from the date of investment.
- Classes of insurance business – in addition to the existing classes of insurance business, the Registration Regulations allow the IRDAI to specify other classes for which a registration could be obtained. This supports the provisions of the Amendment Act in enabling the entry of new subclasses of insurers. However, the Registration Regulations allow application for registration for only one class of insurance business which conflicts with the composite insurance registration proposed under the Amendment Act. If the Amendment Act is implemented, the Registration Regulations will have to be amended before the liberalisation can become effective in practice.

Private equity investments

With the increase in the foreign investment limit for insurance companies from 49% to 74% and removal of the requirement that an Indian insurance company must be "Indian-owned and controlled", increased investment activity in the Indian insurance sector has been seen, led by global private equity funds (PE funds). In recent years, a number of global PE funds have made investments in Indian insurance and insurtech companies.

Due to this increased interest by PE funds and the capital-intensive nature of the business, the IRDAI has, under the Registration Regulations, specified that a PE fund can invest in the capacity of a "promoter" only if, among other requirements:

- managers of the PE fund or its parent fund have completed ten years of operation;
- the funds raised by the PE fund including its group entities are not less than USD500 million;
- the PE fund has at least USD100 million of available investible funds; and
- the manager of the PE fund has invested in the financial sector in India or in other jurisdictions.

This move sets out certain eligibility criteria for PE funds who want to invest in insurance companies in the capacity of promoters.

Raising other forms of capital

Easing access to capital, the IRDAI has also recently amended regulations governing forms of capital that could be raised by insurers. Until recently, raising other forms of capital required the approval of the IRDAI – this requirement has now been removed. Additionally, the regulations now prescribe that the other forms of capital being issued must be non-convertible.

These changes will ease the process for insurers to raise capital through non-equity instruments, therefore enhancing sources of capital for insurers.

Increased interest in acquisition through the corporate insolvency resolution process

The Insolvency and Bankruptcy Code, 2016 (IBC) drives the resolution of insolvent and bankrupt companies and provides for a time-bound corporate insolvency resolution process (CIRP). The resolution of companies under the IBC provides a unique opportunity for investors to acquire debt-ridden companies at an attractive value. Under the CIRP, bids are invited for acquiring an insolvent company and its assets, including subsidiaries, with reduced risks vis-à-vis its liabilities.

In 2022, India witnessed the trend of indirect acquisitions of insurance companies through the acquisition of their insolvent holding companies

through CIRP. By way of example, Piramal Enterprises Limited indirectly acquired a 50% shareholding in Pramerica Life Insurance Limited in the CIRP of Dewan Housing Finance Corporation Limited. Similarly, bids have been invited for Reliance General Insurance Company Limited and Reliance Nippon Life Insurance Company Limited, as part of the CIRP of Reliance Capital Limited, where several bidders are participating primarily on account of their interest in the insurance assets of the group.

Greater Flexibility to Insurers vis-à-vis Product Development

Background

Insurance products in India have traditionally been subject to two regimes: the IRDAI's File and Use Procedure ("F&U Procedure") and the Use and File Procedure ("U&F Procedure"). Under the F&U Procedure, insurers must apply to the IRDAI with the proposed product documentation/parameters and obtain approval, before introducing the product on the market. Life insurance products were subject to the F&U Procedure, as were certain general insurance products.

Introduced in 2016, the U&F Procedure for all other general insurance products allowed insurers to introduce new products on the market without obtaining IRDAI approval, subject to internal approvals and filing requirements.

Recent shift in insurance product regulation

During 2022, the IRDAI made significant reforms and relaxations to its requirements on product filing and approval procedures. In June 2022, the IRDAI allowed the U&F Procedure for all health insurance products, and almost all general insurance products (including retail products for agriculture and allied activities). This was considered a stepping stone towards ease of doing business in the insurance sector and greater operational flexibility to insurers in product innovation. The regulator expects this to be used for introduction of customised and novel products, and expansion of the choices available to the policyholders to address dynamic needs of the market.

The IRDAI has similarly issued a circular extending the U&F Procedure for most types of life insurance products – except for individual savings, individual pensions and annuities, such that only these three product classes now require prior IRDAI approval before launch. Owing to this move, life insurers are expected to launch most of their products according to the dynamic needs of the market, expanding customer choice.

Stakeholders believe that such reforms will boost the sector and encourage many first-time buyers of health and life insurance, as they allow Indian insurers to quickly take products to market and modify them as per customer needs.

Proposed Regulatory Changes Having an Impact on the Insurance Distribution Landscape

Expansion of distribution channels

An entity that distributes or markets insurance products in India must be registered as an "insurance intermediary". Among the different classes of insurance intermediary, corporate agents are especially significant for new customer acquisition, since they carry out a different primary business such as banking, finance, retail or other allied activities. Similarly, "insurance marketing firms" (IMFs) can distribute other financial products such as pension plans, mutual funds and loans. Until very recently, corporate agents were permitted to sell the products of only three insurers (in each line of business) and IMFs were restricted to only two tie-ups.

In a significant move to expand existing insurance distribution channels, the IRDAI (Insurance Intermediaries) (Amendment) Regulations, 2022 have been issued, with effect from 7 December 2022. These regulations increase the maximum number of tie-ups of corporate agents from three to nine, and insurance marketing firms from two to six, for each line of business of life, general and health insurance. This is expected to provide a significant boost to the bancassurance channel, which in recent years has proved to be one of the major distribution channels for insurers (along with the agency channel). India is likely to witness an immense increase in bancassurance partnerships and an overhaul of existing arrangements.

Limits on payment of commission and EOM

The limits on commission payable to insurance intermediaries and agents for procuring sales of insurance policies have been much debated, with repeated demands on removing per-policy commission limits and allowing insurers to manage their expenses within the IRDAI framework.

The IRDAI frequently penalises insurers and insurance intermediaries for breaching limits on commissions, as well as for implementing structures to circumvent limits, such as implementing arrangements with group entities, etc. In October 2022, the IRDAI imposed a penalty of INR20 million on a corporate agent, as well as a penalty of INR30 million on a life insurer, for violating the regulator's directions and circumventing the commission limits through elaborate and long-standing arrangements involving purchase of the insurer's shares by the corporate agent at a very low price, to be eventually sold to the insurer's promoter for a high margin.

However, in its recent exposure draft on the IRDAI (Payment of Commission) Regulations, 2022 (released on 23 November 2022), the regulator proposes a major overhaul of the existing regime. Presently, the IRDAI prescribes limits (as a percentage of premium on each policy) up to which commission can be paid to agents or insurance intermediaries. It is now proposed to remove such limits and allow insurers to pay commission solely in accordance with their own board-approved policy. While insurers will continue to file their policies on commission with the regulator, under the proposed regime they would only need to ensure that commission expenses in a financial year are within the limits of expenses of management (EOM) applicable for the insurer (as per norms laid down by the IRDAI).

The proposed changes to commission norms will allow immense flexibility to insurers in deciding the amounts of commission and incentives for their distribution partners, which is likely to result in new innovative products being launched by insurers. Such reforms are also likely to help insurers in improving persistency rates.

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Shardul Amarchand Mangaldas & Co is one of India's leading full-service law firms, known globally for its integrated approach. The firm's 769 lawyers, including 158 partners, provide exceptional services across practice areas including general corporate, M&A, private equity, venture capital, insurance, banking and finance, insolvency and bankruptcy, competition law, dispute resolution, projects and project finance, capital markets, tax, and intellectual property. The firm is an exclusive member of Lex Mundi in India, which helps clients access the firm's partner network across more than 125 countries. The firm's India offices are spread across New Delhi, Mumbai, Gurgaon, Bengaluru, Chennai, Ahmedabad and Kolkata. It has a dedicated team of lawyers who specialise in insurance law, and has been at the forefront of advising clients on all aspects of insurance law ranging from M&A transactions, corporate restructurings, investments, compliance with laws pertaining to foreign investment, and insurance distribution arrangements in India.

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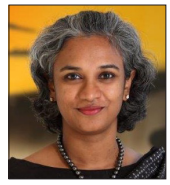

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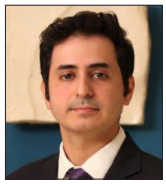

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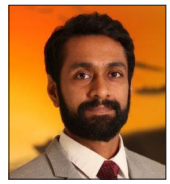

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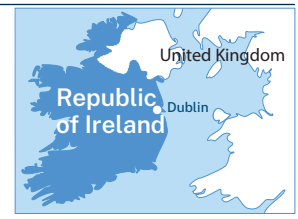

Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Ireland has a common law legal system. The law in relation to insurance contracts is primarily governed by common law principles, the origins of which can be found in case law.

Following the enactment of the Consumer Insurance Contracts Act 2019 (CICA), the Marine Insurance Act 1906 (MIA) only applies to non-consumer contracts. There are some forms of insurance that are compulsory under statute in Ireland – for example, third-party motor insurance and professional indemnity cover for certain professionals.

There is no Irish equivalent to the UK Insurance Act 2015. However, CICA was signed into law in 2019, reforming the area of consumer insurance law. It commenced in two stages (on 1 September 2020 and 1 September 2021), following industry pressure to allow sufficient time for the insurance industry to account for the far-reaching changes imposed. In the case of consumer insurance contracts, CICA has replaced the duty of utmost good faith and the consumer's duty of disclosure with a duty to provide responses to questions asked by the insurer honestly and with reasonable care.

Consumers

There are some restrictions on insurers' freedom of contract – largely for the protection of consumers, as they are subject to the enactment of Irish legislation to comply with EU law. Consumer protection law, in particular, has undergone a number of changes as a result of the Unfair Terms in Consumer Contracts Directive 1993/13/EC and the Distance Marketing of Financial Services Directive 2002/65/EC.

When dealing with a "consumer", the insurer must also comply with the Central Bank of Ireland (CBI)'s Consumer Protection Code 2012 (CPC), the Consumer Protection Act 2007 and Consumer Rights Act 2022 (CRA). Under the CPC, "consumer" is quite broadly defined and includes individuals and small businesses with a turnover of less than EUR3 million. The same definition is applied for the purposes of the CICA. "Consumer" under the CRA is defined as "an individual acting for purposes that are wholly or mainly outside that individual's trade, business, craft or profession".

Insurance contracts, and the marketing and selling of insurance products to consumers, must also be compliant with the terms of the Sale of Goods and Supply of Services Act 1980 (as amended by the CRA).

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Ireland has a strong and efficient risk-based prudential regulatory framework, focusing on the application of the proportionality principle.

The Central Bank of Ireland

The CBI has primary responsibility for the prudential supervision and regulation of insurance and reinsurance undertakings in Ireland. It carries out its role through monitoring and ongoing supervision and issues standards, policies and guidance, with which (re)insurance undertakings are required to comply.

The CBI oversees corporate governance functions, risk management and internal control systems of (re)insurance undertakings without placing burdensome administrative requirements on their operators. Such undertakings are required to submit annual and quarterly returns on solvency margins and technical reserves for supervisory purposes. The CBI also conducts regular themed inspections across the (re)insurance sector.

The CBI operates a rigorous authorisation process and conducts fitness and probity assessments of individuals who are to hold certain designated management functions and positions within authorised firms. It also has responsibility for consumer protection issues.

Risks and risk ratings

An administrative sanctions regime provides the CBI with a credible enforcement tool and acts as an effective deterrent against breaches of financial services law. The CBI's supervisory framework, Probability Risk and Impact SysteM (PRISM), is a risk-based framework that categorises regulated firms by the potential impact of their failure on the economy and the consumer. Under PRISM, (re)insurance undertakings are allocated a risk rating on a scale of high (including ultra-high), medium-high, medium-low or low. PRISM recognises that the CBI does not have infinite resources, and selectively deploys supervisors according to a firm's risk rating.

Although relatively few in number, high-impact firms are recognised as the most important for ensuring financial and economic stability and are therefore subject to a higher level of supervision.

The CPRA

The CBI's Consumer Protection Risk Assessment (CPRA) model aims to enhance the manner in which regulated entities manage "the risks they pose to consumers and ensure they have appropriate risk management frameworks to deliver for their customers". (Re)insurance companies are required to implement a consumer protection risk management framework that is tailored to the nature, scale and complexity of their business. The CBI assesses the effectiveness of these internal management frameworks through targeted CPRAs, which are in addition and supplementary to the CBI's PRISM and regular thematic inspections.

II Code and the 2015 Regulations

The Insurance Institute's Code of Ethics and Conduct (the "II Code") is also relevant to the regulation of insurance and reinsurance undertakings. The II Code is a voluntary code of conduct aimed at protecting policyholders resident in Ireland. It has been adopted by members of Insurance Ireland, which is the representative body for (re)insurance undertakings in Ireland.

EU Directive 2009/138/EC ("Solvency II") introduced a common regulatory framework for EEA insurance and reinsurance undertakings and was transposed into Irish law by the European Union (Insurance and Reinsurance) Regulations 2015 (the "2015 Regulations"). The 2015 Regulations impose harmonised capital and solvency requirements, valuation techniques, and governance and reporting standards. They also impose certain restrictions on shareholders of (re)insurance undertakings, as the CBI will not grant an authorisation to an undertaking if it isn't satisfied as to the suitability, fitness and probity of "qualifying" shareholders.

For the purposes of the 2015 Regulations, a qualifying shareholding means a direct or indirect holding in an undertaking that:

- represents 10% or more of the capital or voting rights of the undertaking; or
- makes it possible to exercise a significant influence over the management of the undertaking.

The IDD

The European Union (Insurance Distribution) Regulations 2018 (IDR) transposed the Insurance Distribution Directive (EU) 2016/97 (IDD) into Irish law – thereby harmonising the distribution of insurance and reinsurance products within the EU – with the aim of facilitating market integration and enhancing consumer protection. The IDR were designed to:

- enhance consumer protection and ensure a level playing field across the sector by extending the scope of application to include all participants in the distribution of insurance products;
- identify and mitigate conflicts of interest, particularly in the area of remuneration; and
- introduce increased transparency and conduct of business requirements.

2.2 The Writing of Insurance and Reinsurance

See **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**.

2.3 The Taxation of Premium

Insurance undertakings and intermediaries authorised by the CBI or in another EU/EEA member state carrying on business in Ireland are required to comply with certain Irish general good requirements, such as the CPC. The CPC contains general and specific provisions concerning insurance, including requirements relating to premium handling and contact with consumers – for example, information that must be provided to consumers before entering into a contract for a product or service, records, errors, rebates and claims processing.

Persons carrying out a "controlled function" on behalf of financial service providers are also expected to satisfy the minimum professional knowledge and competency requirements set out in the Minimum Competency Code and Regulations 2017 (MCC).

A range of taxes, levies and duties are applied to insurance policies, including:

- non-life insurance policies attract stamp duty of EUR1 per policy;
- non-life insurance policies also attract a levy of 3% on the gross amount received by an insurer in respect of certain non-life insurance premiums – an additional 2% contribution to the Insurance Compensation Fund applies to premiums received in relation to non-life insurance policies;
- life assurance premiums attract a levy of 1% of gross premiums; and
- health insurance attracts levies that, depending on the cover, range from:
  (a) EUR122 to EUR406 in respect of relevant contracts renewed or entered into on or after 1 April 2022 and on or before 31 March 2023; and
  (b) EUR109 to EUR438 in respect of relevant contracts renewed or entered into on or after 1 April 2023.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Licensing of (Re)insurance Companies

Undertakings wishing to carry on (re)insurance business in Ireland must obtain authorisation from the CBI or another EU regulator through the "single passport" regime. The CBI has published a checklist for completing and submitting applications for authorisation under the 2015 Regulations (the "Checklist"), along with a guidance paper to assist applicants. The applicationcomprises the completed Checklist and a detailed business plan plus supporting documents (the "Business Plan") that is submitted after a preliminary meeting with the CBI.

The principal areas considered by the CBI in evaluating applications include:

- legal structure;
- ownership structure;
- overview of the group to which the applicant belongs (if relevant);
- scheme of operations;
- system of governance, including the fitness and probity of key personnel;
- risk management system;
- Own Risk and Solvency Assessment (ORSA);
- financial information and projections;
- capital requirements and solvency projections; and
- consumer issues (such as MCC and CPC).

A high-level overview of the application for authorisation process is as follows:

- arrange a preliminary meeting with the CBI to outline the proposals, at which the CBI will provide feedback in relation to the proposal and identify any areas of concern that should be addressed before the application is submitted;
- prepare and submit the completed Checklist and Business Plan;
- dialogue with the CBI;
- the authorisation committee of the CBI considers the application;
- once the CBI is satisfied with the application, it will issue an "authorisation in principle", which means that it is minded to grant its approval once certain conditions are satisfied; and
- once all conditions are satisfied, the CBI will issue the final authorisation and the (re)insurer can commence writing business in Ireland.

The application process is an iterative one, involving contact and consultation with the CBI after an application is formally submitted. During the review process, it will typically request additional information and documentation, and is likely to have comments on certain features of the proposal. The CBI may seek additional meetings with the applicant as part of this process in order to discuss aspects of the proposal in further detail.

The CBI will issue a formal authorisation once it is satisfied that the capital requirements and any pre-licensing requirements have been met. Throughout this process there will be multiple meetings, and the CBI may request additional information. The process can take between four to six months. The CBI does not currently charge a fee for licence applications.

The Position of UK-Based Insurers Post 31 December 2020

The Brexit Deal agreed in December 2020 between the UK and the EU was largely silent on financial services. The effect of same is that, as

at the end of the transition period on 31 December 2020, the UK is now a third country and UK-authorised insurers can no longer rely on the EU passporting regime to access the Irish and wider EU market.

In anticipation of this happening, the Irish government introduced a Temporary Run-Off Regime (TRR) through Part 10 of the Withdrawal of the United Kingdom from the European Union (Consequential Provisions) Act 2020 (the "Brexit Omnibus 2020 Act"). This has become crucially important for those UK/Gibraltar (GI) insurers and insurance intermediaries with Irish customers, which decided against establishing an EU authorised entity to access Ireland post Brexit.

Part 10 of the Brexit Omnibus 2020 Act addresses the issue of insurance contract continuity and inserts additional provisions into the 2015 Regulations and the IDR, permitting a UK firm to administer its run-off business in Ireland for a period of 15 years from 31 December 2020 "in order to terminate its activity" in Ireland. Crucially, no new business is permitted but compliance with the general good requirements remains a requirement.

The Insurance (Miscellaneous Provisions) Act 2022 ("2022 Act") amends the 2015 Regulations to provide for technical changes in order to ensure that UK and Gibraltar-based insurance firms who provide reinsurance to Irish based insurers through the third country exemption (pursuant to Regulation 12 of the 2015 Regulations), along with firms in liquidation, can rely on the TRR to run-off their existing Irish insurance contracts.

Third-Country Reinsurers

Third-country reinsurers are excluded from the application of the 2015 Regulations where the following conditions are satisfied:

- the reinsurer has its head office in a third country;
- the reinsurer is lawfully carrying on reinsurance in that third country; and
- the reinsurer is carrying on reinsurance (but no other activity) in Ireland.

The effect of this exclusion is that a third-country reinsurer is not required to be authorised in accordance with the 2015 Regulations in order to carry on reinsurance business in Ireland.

Freedom of Establishment or Freedom of Services basis

(Re)insurance undertakings authorised in an EU/EEA member state may carry on business in Ireland on a freedom of establishment basis through a local branch or operate in Ireland on a freedom of services basis, provided that their home state regulators notify the CBI. Passporting undertakings must comply with the Irish general good requirements.

Special Purpose Reinsurance Vehicle

A reinsurance provider can establish a special-purpose reinsurance vehicle, which provides a quicker and simpler route to authorisation and reduces the extent of supervision compared with fully regulated reinsurers.

Establishing a Third-Country Insurance Branch in Ireland

The 2015 Regulations facilitate a non-EEA insurer establishing a branch in Ireland (a "Third-Country Branch"), subject to the fulfilment of specific regulatory requirements. The 2015 Regulations impose standalone capital require-

ments on a Third-Country Branch and require the Third-Country Branch to:

- hold assets in Ireland of at least 50% of the absolute floor prescribed in the 2015 Regulations in respect of the Minimum Capital Requirement (currently EUR3.7 million); and
- deposit 25% of that amount with the Irish High Court as security.

The local substance requirements for a Third-Country Branch will depend on the nature, scale and complexity of its operations.

The CBI will expect an appropriate number of senior management in Ireland to demonstrate a sufficient level of local oversight and control. As a minimum, a branch manager and a branch management committee in Ireland – with day-to-day responsibility for corporate governance of the branch – will be required. To date, no Third-County Branches have been authorised in Ireland but the CBI guidelines and checklists for third-country insurers applying for branch authorisation have been effective since May 2018.

Significantly, a Third-Country Branch does not have the right to passport into other EU/EEA jurisdictions and, accordingly, is only permitted to write business in the jurisdiction in which it is established. Therefore, a Third-Country Branch is not suitable for third-country insurers seeking to write business across the EU/EEA. Within the current context of Brexit, establishing a Third-Country Branch may not represent a comprehensive solution for UK insurers seeking to maintain access to the single market; therefore, establishing an EEA-authorised subsidiary has been the preferred option.

3.2 Fronting

The CBI does not currently permit 100% reinsurance arrangements.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

The robust M&A environment experienced in 2021 showed some signs of easing in the first half of 2022, with a total of 122 deals recorded (a drop of 14% since the first half of 2021), and the total deal value came to EUR6.4 billion (a decrease of 66% from the first half of 2021). Factors relating to this cooling market include the war in Ukraine, increased equity market volatility, and rising inflation – all of which contribute to uncertainty, lower valuations and increased costs of funding.

While there has been a cooling in the market compared to 2021, M&A has returned to pre-pandemic levels of activity – with the 2022 figures representing, in some measure, an increase from pre-pandemic activity levels. Certain sectors in Ireland continue to demonstrate marked resilience – in particular, sectors such as the insurance broking industry, where there has been a trend towards consolidation. Notably, financial services proved to be the most prevalent sector in the domestic context, accounting for approximately one third of total Irish M&A in the first half of 2022.

In terms of the outlook for 2023, a positive level of activity overall in the market is anticipated. Irish M&A is highly resilient and, although the market has showed a decline in 2022, the outlook for 2023 overall remains positive.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The European Union (Insurance Distribution) Regulations 2018 (IDR)

The distribution or sale of insurance products is governed by the IDR, which applies to persons engaged in insurance distribution business in the Irish market, such as agents, brokers and bancassurance operators. However, insurers can also distribute insurance products directly to customers.

Definition of insurance distribution

Under the IDR, insurance distribution is broadly defined as "any activity involved in advising on, proposing, or carrying out other work preparatory to the conclusion of contracts of insurance, of concluding such contracts, or of assisting in the administration and performance of such contracts – in particular, in the event of a claim, the provision of information concerning one or more insurance contracts in accordance with criteria selected by customers through a website or other media and the compilation of an insurance product ranking list, including price and product comparison, or a discount on the price of an insurance contract, when the customer is able to directly or indirectly conclude an insurance contract using a website or other media".

Certain activities are specifically excluded, such as:

- claim management on a professional basis;
- loss adjusting;
- expert claim appraisal; and
- the mere provision of information if no additional steps are taken by the provider to assist in the conclusion of an insurance or reinsurance contract.

The IDR clarifies that "introducing" is not considered a regulated activity under Irish law.

Impact of the IDR

The IDR introduces enhanced information and conduct of business requirements for insurance distributors. "Ancillary insurance intermediaries" are exempt from the application of the 2018 Regulations where certain conditions are satisfied.

The IDR prescribes certain requirements in relation to product oversight and governance ("POG Requirements"), which aim to:

- enhance consumer protection by ensuring that insurance products meet the needs of the target market; and
- mitigate the risk of mis-selling by insurance distributors.

Insurance undertakings (and relevant intermediaries) are required to implement product oversight and governance procedures prior to distributing or marketing an insurance product to customers.

The IDR also states that distributors must have Product Distribution Arrangements (PDAs) in place containing appropriate procedures to obtain all appropriate information on the products they intend to offer to their customers from the manufacturer. The PDA should be a written document made available to their staff, with the aim of:

- preventing customer detriment;
- managing conflicts of interest; and
- ensuring the objectives, interests and characteristics of customers are taken into account.

The Investment Intermediaries Act 1995
Previously, two pieces of legislation governed intermediaries operating in Ireland – the European Union (Insurance Mediation) Regulations 2005 (IMR) and the Investment Intermediaries Act 1995 (IIA). The IDR has brought much needed clarification in relation to the application of IIA to insurance intermediaries by revoking all references to insurance, and the IMR has been repealed in full.

Authorisation
(Re)insurance brokers/intermediaries must be authorised by the CBI in order to carry out (re) insurance distribution or advise consumers in relation to general insurance products, life assurance products, or health and medical insurance products, or to act as an insurance intermediary on behalf of an insurance company with which they have an agreement or carry out certain activities, such as loss assessing or assisting consumers in dealing with claims under insurance contracts.

(Re)insurance brokers/intermediaries are subject to ongoing CBI supervision of their compliance with the registration requirements, which include completing an annual return and holding an adequate professional indemnity insurance policy. The CBI maintains a register of authorised (re)insurance intermediaries in Ireland. (Re)insurance undertakings involved in the distribution of insurance products must also comply with the national general good provisions that regulate the manner in which such undertakings may sell and market insurance products to consumers in Ireland, as set out under:

- the CPC;
- the MCC;
- the Consumer Protection Act 2007;
- the Sale of Goods and Supply of Services Act 1980;
- the European Communities (Unfair Terms in Consumer Contracts) Regulations 1995; and
- the European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004.

The Position of UK-Based Insurance Intermediaries Post 31 December 2020
See **3.1 Overseas-Based Insurers or Reinsurers**.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Parties to a non-consumer insurance contract are subject to the duty of utmost good faith (Section 17, MIA). The proposer or insured has a duty to disclose all material facts. A material fact is one that would influence the judgment of a prudent underwriter in deciding whether to underwrite the contracts and, if so, on what terms. The duty goes beyond answering questions on a proposal form correctly; every material representation made by the insured or proposer, or their agent, to the insurer must be true.

CICA replaces the duty of good faith for consumer insurance contracts and the MIA no longer applies to these contracts. Since 1 September 2021, the consumer proposer's duty is limited to a duty to provide responses to specific questions asked by the insurer honestly and with reasonable care.

The majority of provisions of CICA took effect from 1 September 2020. The remaining sections – save for section 18(4) – commenced on 1 Sep-

tember 2021, including Section 8 (duty of disclosure) and Section 9 (proportionate remedies).

6.2 Failure to Comply With Obligations of an Insurance Contract

Prior to CICA, the remedy for breach of the duty of utmost good faith was avoidance of the policy. CICA introduced new proportionate remedies (proportionate to the effects of the misrepresentation, depending on whether it was innocent, negligent or fraudulent) for a breach of the new duty of disclosure.

Section 8(6) requires an insurer to establish inducement to avail of the remedies under the act for a breach of the duty of disclosure.

6.3 Intermediary Involvement in an Insurance Contract

Typically, an insurance intermediary is deemed to be acting on behalf of the customer at all times during the negotiation of an insurance contract – except when collecting premiums on behalf of the insurer. However, certain intermediaries act for and on behalf of an insurer as a tied insurance intermediary.

Under the IDR, insurance distributors are required to act honestly, fairly and professionally in accordance with the best interest of their customers. This obligation applies irrespective of whether the intermediary is negotiating an insurance contract as an individual broker or acting as a tied insurance intermediary of a particular insurer. The information and transparency requirements set out in the IDR require an intermediary to promptly disclose whether it is representing the customer, or acting for and on behalf of the insurer, before the conclusion of a contract. Any remuneration received by an intermediary in relation to a contract must also be disclosed to the customer. Additional ongoing key requirements include:

- the good reputation of directors;
- the knowledge and ability of senior management and key personnel;
- the holding of minimum levels of professional indemnity insurance; and
- maintenance and operation of client premium accounts.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

There are no specific rules for the formation of an insurance contract under Irish law, beyond the general principles of contract law, common law and the duty of good faith. There is no statutory definition of an insurance contract and the legislation does not specify its essential legal elements. The main characteristics of an insurance contract were set out in the leading Irish authority of International Commercial Bank plc v Insurance Corporation of Ireland and include the following:

- an insurable interest;
- payment of a premium;
- the insurer undertakes to pay the insured on the happening of an insured risk;
- the risk must be clearly specified;
- indemnification (the insurer will indemnify the insured against actual loss); and
- the principle of subrogation is applied where appropriate.

CICA defines an insurance contract as “a contract of life insurance or non-life insurance made between an insurer and a consumer” and reforms the law relating to insurable interests.

6.5 Multiple Insured or Potential Beneficiaries

There is no information available for this jurisdiction.

6.6 Consumer Contracts or Reinsurance Contracts

Consumer contracts are now governed by CICA. The legal requirements of insurance and reinsurance are the same.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

ART transactions are recognised as reinsurance transactions under the 2015 Regulations and are characterised by the CBI in a manner consistent with the Solvency II Regime.

There has been a slowdown in recent years in the number of ART deals in Ireland. The CBI has concerns relating to the viability of ART transactions and the potential risks for insurance carriers, particularly in relation to basis risks. Further, it is not clear if ART transactions entered into by life insurers comply with the requirements to be "fully funded". Significant growth is not expected in the coming years.

7.2 Foreign ART Transactions

There is no information available in this jurisdiction.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are subject to the same general principles of interpretation as other contracts. The Supreme Court has confirmed in two judgments (Analog Devices v Zurich Insurance and Emo Oil v Sun Alliance and London Insurance Company) that the principles of construction as set out by Lord Hoffman in ICS v West Bromwich Building Society should be applied to the interpretation of insurance contracts.

The Irish courts consider the ascertainment of the meaning that the document would convey to a reasonable person, having all the background knowledge that would reasonably have been available to the parties in the situation in which they were at the time of the contract (sometimes referred to as the "matrix of fact"). However, a number of things are excluded from the admissible background, including previous negotiations and declarations of subjective intent. The meaning of the document is not the same as the particular meaning of the words; it is what the parties using those words against the relevant background would reasonably have understood them to mean.

The courts apply the words' ordinary and natural meaning because it is assumed that people ordinarily do not make linguistic mistakes in formal documents. However, if it is clear from the "matrix of fact" and background that something has gone wrong with the language, judges can attribute to the parties the intention they clearly had.

The court takes an objective approach to determine the intention of reasonable persons in the position of the parties. Where a contractual term is genuinely ambiguous, the contra proferentem rule will apply and the interpretation less favourable to the drafter is adopted. The rule also applies to consumer contracts.

8.2 Warranties

In non-consumer contracts, no specific wording is required to create a warranty. The word "warranty" is not required but may be considered as evidence of the intention to create a warranty. Further, a warranty may be express or implied (Section 33 of the MIA).

A warranty is treated differently to a contractual term in that it must be exactly complied with, whether it is material to the risk or not. The insurer is discharged from liability from the date of breach of the warranty – but without any prejudice to any liability incurred before that date.

The Irish courts construe warranties strictly, as a breach entitles the insurer to repudiate liability even if the breach is not material to the loss. CICA replaces warranties in consumer contracts with suspensive conditions and abolishes basis of contract clauses.

8.3 Conditions Precedent

The effect of a breach of a condition depends on whether the condition is a condition precedent to liability. Condition precedents to liability relate to matters arising after a loss has occurred – most commonly in relation to notification. The Irish courts will generally not construe an insurance condition as a condition precedent unless it is expressed as a condition precedent or the policy contains a general condition precedent provision. Breach of a condition precedent means that an insurer can repudiate liability for the claim without any requirement to demonstrate prejudice. There is no requirement for a link between the breach and the damage.

The consequences for breach of a bare condition are in damages.

In consumer contracts, condition precedents could now be considered "continuing restrictive conditions" following commencement of CICA.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurance contracts typically contain a dispute resolution clause. An insurance contract may contain an arbitration clause or may stipulate another form of ADR, such as mediation. In the case of a consumer contract, a consumer may make a complaint to the Financial Services and Pensions Ombudsman (FSPO).

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Choice of forum, venue and applicable law clauses in (re)insurance contracts are generally recognised and enforced. Where an insured is domiciled in an EU member state, regard should be had to the following regulations that may limit these provisions:

- Regulation (EC) 44/2001 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (Brussels I Regulation);
- Regulation (EU) 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (Recast Brussels Regulation), which replaces the Brussels I Regulation in respect of proceedings and judgments commenced after 10 January 2015;
- Regulation (EC) 593/2008 on the law applicable to contractual obligations (Rome I Regulation);
- Lugano Convention (L339, 21 December 2007) on jurisdiction and the recognition and

enforcement of judgments in civil and commercial matters; and
- the Hague Choice of Court Agreements Convention 2005.

9.3 Litigation Process

In Ireland, the District Court deals with claims up to a monetary value of EUR15,000, the Circuit Court deals with claims with a monetary value up to EUR75,000 (EUR60,000 for personal injury cases), and the High Court hears claims in excess of this as it has an unlimited monetary jurisdiction. Insurance disputes before the courts in Ireland are heard by a single judge with no jury.

The Commercial Court is a specialist division of the High Court and it deals exclusively with commercial disputes. Where the monetary value of a claim or counterclaim exceeds EUR1 million and the dispute is commercial in nature, either party may apply to have the dispute heard in the Commercial Court. There is no automatic right of entry, which is at the discretion of the judge and can be refused if there has been any delay.

Commercial Court proceedings progress at a much quicker pace. Generally, the time from entry into the Commercial Court to the allocation of a trial date ranges from a matter of weeks to four to six months, depending on complexity and the number of parties.

Appeals from the High Court are dealt with by the Court of Appeal, except when the Supreme Court believes a case is of such public importance that it should go directly to the highest court in the State.

Evidence

Evidence is to be given orally, except in the most limited circumstances. Where a party intends to rely upon the (factual or expert) oral evidence of a witness, a witness statement or expert report must be filed – unless a judge orders otherwise.

Costs

Costs typically will follow the event, whereby the loser pays. However, where the litigation is "complex", the Commercial Court will often carry out an analysis of whether the winning party has succeeded on all grounds.

Limitation

The general position under Irish law (the Statute of Limitations Act 1957) is that claims for breach of contract must be brought within six years of the date of breach.

Where a complaint is made to the FSPO, there is an extended limitation period applicable to complaints relating to "long-term financial services" (products or services where the maturity or term extends beyond five years and one month, or life assurance policies not subject to annual renewal) – otherwise a six-year rule applies.

9.4 The Enforcement of Judgments

In the case of non-EU, non-Lugano Convention and non-Hague Convention judgments, an originating High Court summons is required to recognise and enforce a foreign judgment and the High Court must grant leave to issue and serve the proceedings. In order to succeed, such foreign judgment must be for a definite sum, be final and conclusive, and a court of competent jurisdiction must have handed down the judgment. The High Court may refuse to recognise and enforce a judgment on a number of grounds (including fraud, lack of jurisdiction) that it are contrary to Irish law or the principles of natural justice.

9.5 The Enforcement of Arbitration Clauses

See 9.7 Alternative Dispute Resolution.

9.6 The Enforcement of Awards

See 9.7 Alternative Dispute Resolution.

9.7 Alternative Dispute Resolution

Insurance disputes may also be dealt with by ADR. The most common forms of ADR are mediation and arbitration.

Arbitration

Where an insurance contract contains an arbitration clause, a dispute must be referred for arbitration. However, consumers are not bound by an arbitration clause where the claim is less than EUR5,000 and the relevant policy has not been individually negotiated.

The Arbitration Act 2010 (the "2010 Act") incorporates the UNCITRAL Model Law on International Commercial Arbitration. Under the 2010 Act, the decision of an arbitrator is binding on the parties and there is no means of appeal. Where parties have entered into valid arbitration agreements, the courts are obliged to stay proceedings.

Although there are additional costs incurred for an arbitration, there is the benefit of confidentiality.

Ireland is party to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the "New York Convention"), allowing Irish arbitral awards to be enforced in any of the 157 countries party to the Convention.

The courts can set aside an arbitral award under Article 34 of the 2010 Act, albeit on very limited grounds. The party seeking to have the arbitral award set aside must prove that:

- a party to the arbitration agreement was under some incapacity or the agreement itself was invalid;
- the party making the application was not given proper notice of the appointment of the arbitrator or the arbitral proceedings or was otherwise unable to present their case;
- the award deals with a dispute not falling within the ambit of the arbitration agreement;
- the arbitral tribunal was not properly constituted; or
- the award is in conflict with the public policy of the state.

The recent High Court decision in Charwin Limited t/a Charlie's Bar v Zavarovalnica Sava Insurance Company D.D. [2021] IEHC 489 made it clear that the bar is high when seeking to resist a referral to arbitration on grounds of public policy.

Mediation

The Mediation Act 2017 (the "Mediation Act") came into force on 1 January 2018. Under the Mediation Act, solicitors in Ireland must advise their clients of the merits of mediation as an ADR mechanism before proceedings are issued.

The Mediation Act makes provision for any court to adjourn legal proceedings in order to allow the parties to engage in mediation. The court can make such an order on its own initiative or on the application of either party to the proceedings. There may be cost implications where either party fails to engage in ADR following such a direction from the court.

The Financial Services and Pensions Ombudsman

The FSPO is the amalgamation of the Financial Services Ombudsman and the Pensions Ombudsman, pursuant to the FSPO Act 2017. The FSPO is an independent body, established to resolve disputes between consumers and insurance providers either through informal means, such as mediation, or by way of formal investigation. The FSPO's decision is legally binding, with a right of appeal to the High Court.

9.8 Penalties for Late Payment of Claims

There is no cause of action in damages for the late payment of claims in Ireland. However, under Section 26 of CICA, where an insurer is in breach of any of the duties under the act, the court has a discretion to order that a sum payable in a claim under a contract of insurance shall be increased in proportion to the breach involved.

9.9 Insurers' Rights of Subrogation

Insurers have subrogation rights at common law and subrogation provisions in insurance policies are common. Generally, an indemnity must have been provided before the insurer is entitled to subrogate. CICA has introduced certain restrictions on subrogation rights in the context of family and personal relationships (where the consumer has consented to the use of their vehicle) and in employment scenarios.

10. Insurtech

10.1 Insurtech Developments

Irish government bodies, such as Enterprise Ireland and the Industrial Development Authority Ireland (IDA), work in tandem to attract and support foreign direct investment in Ireland and have been promoting Ireland as a destination for companies in the insurtech industry.

In July 2021, 12 stakeholders in the Irish insurance sector joined together to create InsTech.ie in order to promote the country as an EU hub for insurtech. In April 2021, a study commissioned by InsTech.ie and conducted by Deloitte, entitled *Driving Insurtech Growth in Ireland*, was published. The study found that Ireland is well placed to develop an insurtech ecosystem and this should be explored further. It also noted that Ireland is "one of the most developed insurance markets" in Europe and is "well positioned to take advantage of the innovation and technological enhancements being developed within the sector as part of the growth of global insurtech".

One of the most significant Irish insurtech firms is Blink, which was founded in 2016 to build data-driven travel disruption insurance solutions. On the back of this success, the firm launched Blink Parametric in 2020, offering a full suite of parametric insurance solutions. Blink has made it onto The InsurTech100 in 2019, 2020 and 2022.

In 2021 and 2022, Companjon – an innovative insurtech start-up headquartered in Dublin, Ireland – was named in the InsurTech100. Companjon is Europe's leading specialist in unique add-on insurance that is 100% digital. Companjon has been recognised by Forbes as "a tech-driven disruptor that is changing the way people think about insurance".

10.2 Regulatory Response

In Ireland, the CBI is responsive to the challenges posed by the regulatory treatment of financial innovations. It is a robust regulator, and acknowledges the need to strike the appropriate balance between encouraging innovation-related entry to the market and ensuring that new entrants are sufficiently ready to fulfil all their regulatory obligations in relation to financial stability and consumer protection. The CBI is

cognisant of the requirement to keep abreast of the changing technological environment and has committed significant resources to improving its data architectures and establishing quantitative analytical teams in its banking, insurance and markets directorates.

The CBI has taken a range of measures in relation to fintech, including:

- establishing an Innovation Hub in 2018 for engagement with fintech companies;
- creating an Innovation Steering Group and a fintech network within the CBI; and
- engaging with the European Supervisory Authorities (ESAs) and the Single Supervisory Mechanism on the EC's FinTech Action Plan.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

"Emerging risks" refer to new and evolving risks that are difficult for insurers to assess and typically carry with them a high degree of uncertainty with regard to their impact, probability, and amount of losses expected. The CBI expects Irish insurance undertakings to give appropriate consideration to assessing emerging risks (particularly in relation to climate change) and adopt a longer-term perspective than typical business planning and strategy-setting processes. The CBI expects to see evidence of robust analysis and challenge and timely and effective action in relation to emerging risks.

Cyber-risk and longevity risk appear to be the most formidable emerging risks in Ireland. The Governor of the CBI stated in August 2022, on the publication of a consultation paper on proposed Guidance for (Re)insurance Undertakings on Climate Change Risk (CP151), that "climate change is no longer an emerging risk". However, this risk will still be addressed for now as the pronouncement is only recent.

In the last quarter of 2020, the CBI issued a Climate Change and Emerging Risk Survey ("CBI Survey") to better understand Irish insurance undertakings' exposure to and management of emerging risks. On 1 May 2021, the CBI published its feedback and key observations to the industry. Overall, the CBI Survey found that emerging risks were well integrated in the majority of firms' risk management processes and that there was a good level of awareness of climate risk among firms.

Additionally, the exposure level of Irish firms to "affirmative" cyber underwriting risk appears to be limited. While good practices were noted, the CBI outlined a number of recommendations and noted its intention to increase its supervisory focus in these areas in the future. The CBI noted: "Certain good practices are already being embedded in insurance firms in relation to climate risk. However, there is work to do in terms of establishing plans and strategies. Firms can expect that the CBI will become increasingly active and intrusive in its approach to the supervision of climate change-related risks going forward."

Cyber-risk

Digital innovation and the growing sophistication of digital technology have led to increased cybersecurity threats and risk of data breaches. The market for cyber-insurance is seen as one of the biggest growth areas in the insurance industry, globally.

Cyber-risk was ranked by national supervisors as the second-biggest risk for the insurance sector and the sixth for the pensions sector in the European Insurance and Occupational Pensions Authority (EIOPA) Autumn 2019 Qualitative Survey.

The CBI published cross-industry guidance in respect of IT and cybersecurity risks in 2016, which highlighted a variety of emerging threats. This guidance notes that the risks associated with IT and cybersecurity are a key concern for the CBI. The guidance was published at a time when there was little formal supervisory guidance on this topic. However, in October 2020, EIOPA published its Guidelines on ICT Security and Governance. The CBI has confirmed that these guidelines supersede the CBI's 2016 guidance but do not contradict anything in that guidance.

In December 2021, the CBI published its final cross-industry guidance on Operational Resilience, in order to assist financial firms to prepare for, respond to, recover and learn from an operational disruption that affects the delivery of critical or important business services. Anticipating the adoption of the Digital Operational Resilience Act (DORA) at EU level, the CBI noted – in its feedback statement to the consultation paper on the draft guidelines – that the Operational Resilience Guidelines were compatible with and complementary to DORA and that it had determined there were no contradictions between the two.

DORA puts in place a comprehensive framework on digital operational resilience for EU financial firms, including insurance and reinsurance undertakings, intermediaries and ancillary intermediaries, as well as critical third parties that provide ICT-related services to these firms. DORA will come into force on 16 January 2023 and will apply 24 months from the date of its entry into force.

The CBI also has a dedicated IT risk inspection team, operational since April 2015.

As noted earlier, the CBI Survey found that Irish firms' overall level of exposure to "affirmative" cyber underwriting risk appears to be limited – with just 32 of the surveyed firms offering some type of affirmative cybercover.

Longevity Risk

Longevity risk is the potential risk of an individual living longer than expected. The financial implications of exponentially increasing lifespans are colossal. If the average life expectancy were to increase by three years, the cost of supporting the aging population would increase by 50%. As the mortality risk continues to decrease, it is clear that understanding the associated risk is of crucial importance to insurers. The IMF has even highlighted the grave implications for global fiscal stability in its Global Financial Stability Report.

Considering how quickly life expectancy is increasing, projecting future liabilities based solely on data extrapolated from the past is imprecise at best. To address this, certain companies have created insurance subsidiaries to run their pensions schemes, who then reinsure its longevity risk with a reinsurer; this is expected to be a common trend in the future. From a reinsurance perspective, buying this longevity risk may be an attractive financial transaction as it lowers mortality risk and thereby helps balance life insurance risks. However, the IMF has stated that the longevity risk should be appropriately shared between insurers and govern-

ments, as insurers and reinsurers alone may be constrained by capital.

Climate Risk

The CBI's proposed Guidance for (Re)insurance Undertakings on Climate Change Risk aims to clarify the CBI's expectations on how (re)insurers address climate change risks in their business and to assist them in developing their governance and risk management frameworks to do this. The final guidance will apply to authorised insurers and (re)insurers, including captive (re) insurers and third-country branches.

In November 2021, the CBI published a Dear CEO letter setting out its supervisory expectations in relation to climate and other ESG issues. The CBI's expectations, which are based upon international practice and informed by regulatory development at EU level, are not binding on firms.

The CBI has also established a Climate Risk and Sustainable Finance Forum, which brings together stakeholders to share knowledge and understanding of the implications of climate change for the Irish financial system.

11.2 New Products or Alternative Solutions

Warranty and Indemnity Insurance

Warranty and indemnity insurance is being used more frequently in commercial transactions, as are other bespoke transactional products such as litigation buyout policies.

Addressing the Emerging Risks

Cyber-insurance is still a relatively new product on the Irish market, but it has become more popular in recent times and a number of insurers are now offering new cyber products in Ireland. PwC reported that 71% of Irish insurance CEOs believe that the majority of businesses will have cyber-insurance within five years. It is expected to be a growth area in Ireland in the future.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Health Insurance (Amendment) Act 2022

On 24 November 2022, the Health Insurance (Amendment) Act 2022 (the "Health Insurance Act") was published. The Health Insurance Act provides the legislative basis for the rates of risk equalisation credits and stamp duty levies to apply in the private health insurance market in 2023. The Health Insurance Act was signed into law by the President of Ireland on 21 December 2022.

Consumer Insurance Contracts Act 2019

In addition to the changes highlighted earlier in relation to the duty of disclosure, remedies and warranties, other reforms were introduced by CICA, including the following:

- requirements in relation to the provision of information to the consumer by the insurer after the contract has been concluded;
- duties on both the consumer and insurer on renewal (Section 12);
- post-contractual duties of the consumer and insurer (Section 15);
- policy exclusions must be provided to a consumer in writing prior to the commencement of an insurance contract (Section 15(6));
- new obligations in relation to claims handling and duties are imposed on both the consumer and insurer (Section 16);
- provisions in relation to third-party rights and confirmation that a third party may claim

directly against an insurer in certain limited circumstances (Section 21);
- provisions regarding the distribution of funds following a subrogated recovery (Section 24); and
- where a consumer is in breach of a duty under the Act, a court has a discretion to order that a claim be reduced in proportion to the breach – and, similarly, where an insurer is in breach, the court may order that the sum payable be increased in proportion to the breach (Section 26(a)).

The changes introduced by the 2022 Act were effective from 8 July 2022; however, section 18(4) of CICA now stands reworded pursuant to Section 9 of the 2022 Act and is yet to be commenced.

COVID-19

The response to the COVID-19 pandemic, in line with many countries worldwide, involved public health measures to reduce the spread of the virus and therefore the closure of non-essential businesses and subsequent loss of income for many households and businesses.

The CBI's focus throughout the crisis was to ensure "the financial system operate[s] in the best interests of consumers and the wider economy". To that end, the CBI – aligned with other supervisory authorities in Europe – issued a number of communications and statements to the financial services sector on its response to the crisis and its expectations of firms in their response to the crisis.

Business Interruption

There have been a number of test cases in relation to COVID-19 Business Interruption cover litigated before the Irish courts under the COVID-19 and Business Interruption Insurance Supervisory Framework. To date, there have been judgments in five test cases – all of which proceeded on a modular basis, with liability being considered in the first module. In four of the judgments, liability was determined in favour of the insurer; however, in one liability was determined in favour of policyholders, with the court going on to consider quantum issues in subsequent modules. The judgments reinforce that whether a policy responds to losses of this type will depend on the specific wording of the policy.

Insurance (Miscellaneous Provisions) Act 2022

The 2022 Act came into effect in November 2022 and addresses several insurance-related issues, including:

- a new requirement for the CBI to submit a report to the Minister for Finance setting out the steps (if any) it has taken to regulate the practice of price walking;
- a new requirement under CICA to disclose to consumers any deductions of public moneys from insurance claims settlement amounts; and
- amendments to CICA in order to address issues that arose following the initial enactment of this legislation, most notably Section 16(10) and the insertion of Section 16A.

The amendment to CICA Section 16(10) clarifies the scope of disclosure requirements.

The new Section 16A provides for an obligation to disclose information. Where such information is contained within a report that was prepared with a view to maintaining or defending civil proceedings – and which (i) was obtained for the purposes of assessing the validity of the claim, or (ii) contains information that either supports or prejudices the claim – the report must be dis-

closed to the other side no later than 60 days following receipt of the report by the insurer or consumer. This duty to disclose extends to draft reports.

Section 16A specifically states that, despite the fact that such a report is prepared for the purposes of civil proceedings, a claim of litigation privilege may not be maintained over it. However, Section 16A also notes that the concept of legal advice privilege is maintained and provides that the duty of mutual disclosure of reports does not apply to reports prepared by a lawyer, in addition to any communication between a lawyer and "another person".

As noted earlier, the 2022 Act also amends the 2015 Regulations in order to address issues identified in respect of the operation of the TRR for UK and Gibraltar-based insurers.

Personal Injuries Resolution Board Act 2022

The Personal Injuries Resolution Board Act 2022 facilitates an increase in the number of personal injury claims that may be resolved through the Personal Injuries Assessment Board (now called the Personal Injuries Resolution Board, or PIRB).

The Act extends the functions of the PIRB and offers mediation as a means of resolving a claim. The Act also provides that the PIRB will:

- retain claims of a wholly psychological nature;
- have additional time to assess claims; and
- take measures to reduce fraud.

Personal Injury Guidelines

The Personal Injury Guidelines were published in March 2021 by the Judicial Council to achieve a greater consistency in awards for personal injuries. The PIRB and the courts are required to consider the guidelines when making an assessment for damages, which are generally lower as a result of the guidelines.

Consumer Rights Act 2022

The CRA significantly reforms consumer protection law in Ireland. The majority of the reforms are necessitated by the transposition of various EU initiatives, including the "Omnibus Directive", the Digital Content Directive, and the Sale of Goods Directive.

The CRA also overhauls the current Irish regulatory framework by repealing and providing amendments to several existing pieces of Irish legislation, collating all existing provisions together in a single enactment.

The CRA commenced on 29 November 2022, with all sections other than section 161 commencing from 29 November 2022.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Heightened Regulatory Scrutiny

Use of service companies in the insurance sector

On 31 January 2022, the CBI published its final Guidance on the Use of Service Companies for Staffing Purposes in the Insurance Sector. The guidance sets out the CBI's expectations for (re) insurance entities that choose to enter arrangements with separate legal entities for the provision of extensive staffing or hybrid arrangements (which involve a combination of the provision of staff and other outsourced activities). The CBI expects firms to align relevant staffing arrangements with the expectations set out in the guidance by 31 January 2023.

Differential pricing

On 15 March 2022, the CBI published the Central Bank (Supervision and Enforcement) Act 2013 (Section 48(1)) (Insurance Requirements) Regulations 2022 following its consultation paper on recommendations on the Review of Differential Pricing in the Private Car and Home Insurance Markets (published in July 2021). From 1 July 2022, the regulations will:

- ban the practice of "price walking";
- require insurers to review their pricing policies and processes annually; and
- require insurers to provide policyholders with additional information in advance of the automatic renewal of their insurance policy.

Review of the CPC

On 3 October 2022, the CBI launched its review of the CPC. The review is three-phased and will be conducted between October 2022 and sometime in 2024. Phase 1 is a discussion paper on the review. The feedback received from same will inform Phase 2, which is a formal public consultation on the CBI's proposed updates and improvements to the CPC, along with the necessary draft regulations. In Phase 3 of the review, the CBI will publish the updated CPC and supporting regulations, along with a feedback statement clarifying the CBI's approach to the updated CPC.

CBI Dear CEO Letter on protecting consumers in a changing economic landscape

On 17 November 2022, the CBI wrote to all regulated firms to reaffirm its expectations regarding how they treat consumers in the context of the current economic environment. The Dear CEO Letter details the specific actions, as set out in the Consumer Protection Outlook Report published in March 2022, which firms are required to address in order to manage potential risks arising from this changing landscape for consumers, as well as identifying a number of areas for particular attention.

Individual accountability

The Central Bank (Individual Accountability Framework) Bill 2022 (the "IAF Bill") was published on 28 July 2022. The IAF Bill aims to support the advancement of an improved culture in the Irish financial system through greater accountability in the regulated sector by introducing an Individual Accountability Framework (IAF).

The four key pillars of the IAF are:

- conduct standards that set out the behaviour the CBI expects of firms and the individuals working within them;
- a Senior Executive Accountability Regime (akin to the Senior Managers Regime in the UK), which places obligations on certain firms and senior individuals to set out where responsibility and decision-making lies for their business in order to ensure clearer accountability;
- enhancements to the current Fitness and Probity Regime; and
- a unified enforcement process, which would enable the CBI to pursue individuals directly for their own misconduct rather than having to link the misconduct to their participation in a regulatory breach by their firm.

The IAF Bill is expected to be enacted in early 2023. Once enacted, the CBI will publish the relevant draft regulations and supporting guidance, along with a consultation paper. These are expected to be implemented in 2023.

Consultation paper on Guidance for (Re) insurance Undertakings on Climate Change Risk

On 3rd August 2022, the CBI published CP151. The proposed guidance aims to clarify the CBI's expectations regarding how (re)insurers address climate change risks in their business and to assist them in developing their governance and risk management frameworks in order to do this. The consultation closed for feedback on 26 October 2022 and the authors await the publication of the final guidelines.

Consultation paper on Guidance for (Re) Insurance Undertakings on Intragroup Transactions and Exposures

On 4 July 2022, the CBI published a consultation paper on Guidance for (Re)Insurance Undertakings on Intragroup Transactions and Exposures. The CBI is proposing to introduce guidance for (re)insurance undertakings on intragroup transactions and exposures, with the aim of being more transparent about its expectations. The consultation paper closed for feedback until 23 September 2022 and the authors await the publication of the final guidelines.

CBI amendments to the list of PCFs

On 5 April 2022, the CBI published the Central Bank Reform Act 2010 (Sections 20 And 22) (Amendment) Regulations 2022 making a number of changes to the list of pre-approval controlled function (PCF) roles.

Public consultation on the development of a national resolution framework for (re)insurers

On 1 September 2021, the Department of Finance – in collaboration with the CBI – launched a public consultation on the development and scope of a possible domestic resolution framework for insurers.

On 16 May 2022, the Department of Finance published the feedback statement from the public consultation. It was noted that, since the consultation was launched, the EC has published a legislative proposal for a new insurance recovery and resolution directive (IRRD) and that this proposal is, in many ways, aligned with Ireland's proposed potential domestic framework. Therefore, the Department of Finance and CBI will instead input into the IRRD as a means to progress a resolution framework for insurers and will not proceed with a domestic framework.

Insolvency Regime for Insurers

Parallel to the progression of the IRRD, the Department of Finance and the CBI noted they will continue to review the existing corporate insolvency regime for (re)insurers. They will also seek to examine and remedy weaknesses in the current corporate insolvency regime as it applies to insurers, including considering any required legislative amendments.

CBI's cross-industry guidance on operational resilience

On 1 December 2021, the CBI published its final Cross-Industry Guidance on Operational Resilience, which communicates to firms how to prepare for, respond to, recover and learn from an operational disruption that affects the delivery of critical or important business services. Firms should be able to demonstrate that they have applied the guidelines within an appropriate timeframe at the latest within two years of its being issued.

Matheson LLP was established in 1825 in Dublin and has offices in Cork, London, New York, Palo Alto and San Francisco. The firm employs more than 800 people across its six offices, including 120 partners and tax principals, and more 540 legal, tax and digital services professionals. Matheson services the legal needs of internationally focused companies and financial institutions doing business in and from Ireland. The firm counts more than half of the world's top 50 banks, seven of the world's ten largest asset managers and nine of the top ten most innovative companies in the world among its clients, and has advised the majority of Fortune 100 companies. The team's expertise is spread across more than 30 practice groups, including finance and capital markets, insolvency and corporate restructuring, asset management and investment funds, commercial real estate, litigation and dispute resolution, insurance and tax.

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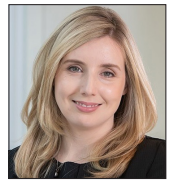

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Trends and Developments

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The Introduction of an Individual Accountability Framework in Ireland

The international trend towards regulating individual accountability and consumer-centric cultures in financial services has also been taken into consideration in Ireland for many years now. This article charts Ireland's journey in this area from 2017 right through to the present day, in addition to setting out the key requirements of the new proposed framework and the timeline for implementation.

Central Bank of Ireland's report on "Behaviour and Culture of the Irish Retail Banks"

Following the completion of the Central Bank of Ireland (CBI)'s Tracker Mortgage Examination, the CBI published a report on the behaviour and culture of the Irish retail banks (the "Report") in response to a mandate by the Minister for Finance and Public Expenditure and Reform in 2017. In the Report, the CBI set out a proposal for the introduction of an Individual Accountability Framework (IAF) based on the details of the findings of its review. This proposal it stated should "apply more widely than to retail banks alone".

The proposal was based on the following four main pillars.

- Conduct standards – these set out the behaviour that the CBI expects of all Regulated Financial Service Providers (RFSPs) and the individuals working within them.
- Senior Executive Accountability Regime (SEAR) – this places obligations on certain firms and senior individuals to set out where responsibility and decision-making lies for their business in order to ensure clearer accountability. The CBI proposed that, in the first instance, the SEAR would apply to credit institutions, insurance undertakings and certain investment firms.
- Enhancements to the current fitness and probity (F&P) regime – these measures will increase the focus on the responsibility of RFSPs by requiring them to assess individuals proactively in controlled functions on an ongoing basis.
- A unified enforcement process – this would enable the CBI to pursue individuals directly for their own misconduct rather than having to link the misconduct to their participation in a regulatory breach by their RFSP.

General Scheme of the Central Bank of Ireland (Individual Accountability Framework) Bill

On 27 July 2021, the Department of Finance published the General Scheme of the Central Bank of Ireland (Individual Accountability Framework) Bill (the "IAF Bill"). The purpose of the IAF Bill was to put the CBI's IAF proposal on a legislative footing. The four key components of the General Scheme broadly reflected the recommendations of the Report.

Central Bank (Individual Accountability Framework) Bill 2022

On 28 July 2022, a full year after the publication of the General Scheme and some four months after the Joint Committee on Finance, Public Expenditure and Reform and Taoiseach's

report on its pre-legislative scrutiny of the General Scheme of the IAF Bill was published, the Department of Finance published the text of the IAF Bill. According to the Explanatory Memorandum to the IAF Bill, its primary purpose is to confer powers on the CBI to strengthen and enhance individual accountability in the financial services industry.

The overall structure proposed in the Report was retained – albeit with some amendments to the details of each pillar, which are examined more closely here.

Enforceable conduct standards

All RFSPs must comply with the conduct standards. The conduct standards set out the CBI's expectations for behaviour of RFSPs and their employees. These include obligations on firms and individuals alike to conduct themselves with honesty and integrity and to act with due skill, care and diligence in the best interest of consumers. The conduct standards comprise:

- common conduct standards that apply to all persons in controlled function roles;
- additional conduct standards that pertain to those holding senior positions (ie, those appointed to pre-approval controlled functions (PCF) roles) and others with significant influence; and
- business conduct standards for RFSPs.

RFSPs are required to notify affected persons of their obligations in relation to the conduct standards that apply to them, as well as to provide necessary training on such standards.

This pillar also imposes a duty on relevant individuals to take reasonable steps in order to meet both the common and additional conduct standards.

Senior Executive Accountability Regime

The aim of the SEAR is to overcome the difficulties the CBI has noted it often encounters when identifying precisely who is in charge of which decisions at RFSPs.

Impacted RSFPs must identify inherent responsibilities pertaining to the PCF role and allocate them to each PCF in the first instance before allocating responsibilities pertaining to the business of the RFSP. Following this, RFSPs must map out the roles, responsibilities and decision-making powers of these individuals. Impacted RFSPs will also have to create statements of responsibilities and responsibility maps pertaining to the RFSP, which describe their governance arrangements and demonstrate clearly that there are no gaps.

In addition to detailing the above-mentioned responsibilities, the IAF Bill states that "a person who has inherent or allocated responsibility for an aspect of the affairs of an RFSP shall take any steps that it is reasonable in the circumstances for the person to take". This has become known as the duty of responsibility. The question that arises concerns the standard that applies to this duty.

The authors believe that the crux of the matter lies in the wording (ie, "shall take any steps that it is reasonable in the circumstances for the person to take…"). This appears to be a subjective test, rather than a more objective requirement to take all reasonable steps as defined by the CBI or another organisation.

There is also a possibility that the term "reasonable in the circumstances" poses a risk of hindsight bias. A certain level of guidance from the CBI on these points is expected; however,

an overly prescriptive approach would not be useful.

As per the Report, the SEAR will initially apply to credit institutions, insurance undertakings and certain investment firms.

Enhancements to the CBI's F&P regime

Firms will have to do more to ensure and proactively certify that the individuals who are responsible for carrying out controlled functions have the requisite competencies and integrity to fulfil those roles.

Holding companies are now brought within the scope of the IAF Bill.

A CBI investigation of a person's F&P can look back as far as six years. Where a person is suspended from performing a controlled function, the maximum period of the suspension is extended to six months; however, the High Court can extend this to 24 months.

Proposed changes to the CBI's administrative sanctions procedure

I. Removal of the "participation link" in the administrative sanctions procedure

Under the current administrative sanctions procedure, the CBI must prove the breaches against the RFSP before it can sanction an accountable individual (otherwise known as the "participation link"). Under the IAF Bill, however, the CBI will be able to sanction an individual directly for breach of applicable conduct standards. This will essentially create an additional avenue of exposure for individuals who perform controlled functions, given that the CBI will also retain the ability to pursue individuals who perform controlled functions in a firm that has been found to have committed a prescribed contravention.

A person's ability to defend an enforcement action will depend on the their ability to demonstrate that they took such reasonable steps in the circumstances to, for example, comply with applicable conduct standards or prevent the prescribed contravention from occurring.

II. Changes following Zalewski v Adjudication Officer and Others

Additional changes were proposed in light of the Supreme Court of Ireland's decision in Zalewski v Adjudication Officer and Others. In this decision, the Supreme Court held that elements of the operations of the Workplace Relations Commission were unconstitutional.

As a result of the judgment and the Attorney General's Office's subsequent examination of the powers of "administrative bodies" with adjudicatory powers, the IAF Bill proposes to introduce a number of notable reforms to the CBI's investigative powers under the F&P regime and under the administrative sanctions procedure. Some of these changes include the following.

- New formalities relating to the commencement and conduct of an enforcement action, including the provision of relevant evidence with a notice of commencement of investigation and the duty to keep the person under investigation informed of progress.
- Separating the investigative and decision-making functions of the Enforcement Division. An authorised officer will be responsible for conducting the investigation and preparing a draft investigation report, which will be provided to the RFSP or individual under investigation. The person will have an opportunity to make submissions on the draft report. The authorised officer conducting the investigation will be prohibited from making any rec-

ommendation or expressing any opinion on a draft or final investigation report.
- If the CBI determines it appropriate to do so, a person will be able to reach a negotiated settlement of an enforcement action without making any acknowledgement (admission) of a breach. The CBI guidelines currently require a person to admit breaches in order to settle an enforcement action, so this will be a novel approach under the new regime.
- The most radical of the proposed changes, however, is that the High Court will be given the power to prevent a sanction from coming into effect if the High Court considers that an error of law has occurred or that the proposed sanction is manifestly disproportionate. This power will be reserved for scenarios in which the person under investigation has made admissions of breaches. The court will not have a confirmatory role where a settlement is reached without any acknowledgement of breaches. Where the High Court has a role, the sanction will not come into effect until the CBI confirms it.
- The IAF Bill makes provisions for the codification of the CBI's sanctioning guidelines – ie, the factors that the CBI will take into account when making a decision to impose a sanction.

Structure of the IAF Bill

As anticipated, the IAF Bill is presented as a series of amendments to the following three pieces of CBI legislation:

- the Central Bank of Ireland Act 1942;
- the Central Bank of Ireland Reform Act 2010; and
- the Central Bank of Ireland (Supervision and Enforcement) Act 2013.

In accordance with the IAF Bill and the Explanatory Memorandum to the IAF Bill, the key amends to these pieces of legislation can be summarised as follows:

- the Central Bank of Ireland Act 1942 now:
  - (a) extends the application of the administrative sanctions procedure to persons performing controlled functions and to certain holding companies;
  - (b) provides for the appointment of a panel from which appointments may be made for the purposes of certain decisions;
  - (c) provides for the admissibility of business records at an inquiry;
  - (d) provides for disclosure agreements; and
  - (e) provides for an application for confirmation by the High Court of a decision of an inquiry under Part IIIC and a decision of the Irish Financial Services Appeals Tribunal under Part VIIA of the Act;
- the Central Bank of Ireland Reform Act 2010 now:
  - (a) extends the regulation and supervision of financial service providers and persons performing controlled functions and pre-approval controlled functions through the introduction of business standards, conduct standards and the duty of responsibility;
  - (b) provides for the independence of persons carrying out an investigation in the performance of their functions;
  - (c) provides for the independence of persons to whom a function of the Head of Financial Regulation, the CBI or the Governor is delegated in the performance of their functions;
  - (d) provides for a right of appeal to the Irish Financial Services Appeals Tribunal against a decision by the Head of Financial Regulation to confirm a suspension

notice;
(e) increases the period for which the High Court may extend the duration of a suspension notice; and
(f) provides for an application for confirmation by the High Court of a decision of the CBI or the Governor to issue a prohibition notice;
- the Central Bank of Ireland (Supervision and Enforcement) Act 2013 now:
(a) extends the regulation-making power of the CBI; and
(b) provides for arrangements that financial service providers shall adopt in relation to the allocation of responsibilities and compliance with obligations under financial services legislation.

Implementation timeline

In October 2022, the IAF Bill commenced its journey through the legislative process. At the time of writing (January 2023), the IAF Bill had completed the Dáil Committee Stage and was moving to Report Stage in the Dáil, which is likely to take place this month when the Dáil reconvenes.

Report Stage and the fifth and final stage in the Dáil are expected to be taken consecutively on the same day, after which the IAF Bill will then be considered by the Seanad. Ultimately, it could be early February 2023 before the IAF Bill is passed by both Houses of the Oireachtas. Enactment will follow thereafter but the details of commencement are not yet known.

As regards the CBI's consultation process, the authors anticipate that this will swiftly follow enactment. The Minister for Finance, when speaking during the Committee Stage consideration of the IAF Bill, said that the CBI would issue its guidance six months after the consultation.

All along, the CBI has indicated in multiple speeches that there would be little or no lead-in time for implementation of the guidance, given that impacted RFSPs have had plenty of time to prepare. There is currently no suggestion that this will change. As a result, RFSPs will need to be in a position to demonstrate compliance with the IAF in early course once the final guidance is issued by the CBI.

What should RFSPs do now?

RFSPs should not underestimate the scale of what needs to be done in order to achieve compliance with the requirements of the IAF Bill. In addition, given the details set out earlier regarding implementation, RFSPs would be well advised to initiate their projects without delay. The following are among some of the factors RFSPs should consider as they embark on this work.

Tone from the Top

Driving the desired cultural outcomes is a priority of the CBI and driving the right "Tone from the Top" is crucial. As such, RFSPs should begin by identifying a senior-level sponsor – ideally CEO or Chief Operating Officer.

Implementation team

RFSPs should then move to create an implementation team of internal experts and external advisers. In terms of composition, the team needs senior-level representatives from HR, the compliance department, the risk department and across the business.

Documentation and processes

A gap analysis should be undertaken on current relevant documentation and processes, as this will help to recognise RFSPs' key pain points while also identifying their quick wins and target areas that will require a more focused effort.

RFSPs should leverage what they can in terms of existing infrastructures and documentation but begin making changes to documents and processes based on the gaps identified.

One area that comes to mind with regard to leveraging existing documents and processes is F&P. RFSPs should ensure that their pre-existing processes and procedures in respect of the F&P regime are fit for purpose and take into account the requirements of the CBI's "Dear CEO" letters on F&P issued in April 2019 and November 2020.

In addition, any results of internal audit and or compliance reviews that have identified deficiencies within the pre-existing control framework should be examined and outstanding actions closed where possible. These steps will provide a good "baseline" from which the IAF can then be implemented.

Training

Training will be key when it comes to the conduct standards. Training needs to address:

- individuals subject to the conduct standards;
- individuals subject to additional conduct standards; and
- all staff on the firm's conduct standards to socialise the CBI's expectations.

Firms need to explicitly advise individuals as to:

- what is expected of them;
- how to act when issues arise; and
- the implications for employees if behaviours or conduct fall short of what is required.

It is worth noting the discussion that took place during the Committee Stage consideration of the IAF Bill on the importance of training. The Minister for Finance said that a lot of focus must be placed on making sure there is sufficient awareness among staff regarding their heightened and legal responsibilities. He went on to say that those employers responsible for overseeing this legislation within their companies "have a solemn duty to make sure that those who are working for them have access across next year to training that will be needed to make sure this legislation is implemented".

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Insurance activities (including both insurance and reinsurance companies' activities) are mainly regulated by the Macau Insurance Ordinance (MIO) (Decree-Law No 27/97/M, as amended by Law No 21/2020 and republished by Macau Chief Executive Dispatch No 229/2020).

Articles 962 to 1063 of the Macau Commercial Code provide the general legal framework applicable to insurance contracts.

Private pension funds activities (which can also be pursued by life insurance companies) are regulated separately by the Legal Framework for Private Pension Funds (Decree law No 6/99/M, as amended by Law No 10/2001 – hereinafter "Private Pension Funds Law").

Insurance intermediaries' activities are mainly regulated by the Macau Insurance Intermediaries Ordinance (MIIO) (Decree-Law No 38/89/M, amended by Administrative Regulation No 27/2001 and 14/2003).

There are a number of general scope laws that are relevant for insurance activities, such as the Consumer Protection Law (Law No 9/2021), the Standard Contractual Clauses Law (Law No 17/92/M) and the Data Protection Law (Law No 8/2005).

The MIO, the MIIO and the Private Pension Funds Law are further enhanced by a set of binding instructions or regulatory guidelines issued by the regulator of the Macau financial sector, the Monetary Authority of Macau (AMCM), by way of notices or circulars.

Macau is a civil law jurisdiction, meaning that legal rules are codified under a set of legal statutes created by the legislator, rather than being based on previous judicial decisions or precedents, as is the case in common law jurisdictions. Previous judicial decisions may be relevant for guidance purposes but they are not legally binding, so they are not as relevant as they would be in a common law jurisdiction.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Insurers, reinsurers and insurance intermediaries are regulated by AMCM, which operates under the authority of the Macau Chief Executive. The Insurance Supervision Department within AMCM is the dedicated unit for the insurance sector. AMCM will issue binding instructions or regulatory guidelines, by way of notices or circulars, to exercise its supervisory functions over the insurance industry in Macau.

Under the MIO, AMCM is also vested with the following powers:

- to promote and encourage insurers and reinsurers to adopt appropriate standards of conduct, and proper and prudent business practices;
- to carry out (extraordinary) inspections of insurers and reinsurers;
- to commence and conduct administrative infringement proceedings, propose respective sanctions to the Chief Executive and effect the collection of fines; and
- to submit to the Chief Executive proposals of laws to regulate matters under its supervision.

In 2014, AMCM entered into a co-operation agreement with the Hong Kong Insurance Authority and the China Insurance Regulatory Commission, which sets out a framework that enables the regulators in these jurisdictions to share information to facilitate the performance of their supervisory and monitoring functions relating to insurance frauds.

In line with the Outline Development Plan for the Guangdong-Hong Kong-Macau Greater Bay Area Plan (GBA), several entities have issued guidance on supporting the development of the GBA through opening up the financial sector. Such guidance features initiatives that shall enable insurers in Hong Kong and Macau to expand their business into the GBA Mainland market. This includes empowering Hong Kong and Macau insurers to establish servicing centres in GBA Mainland cities to facilitate after-sales services, thereby improving customer experience and efficiency. These services shall include renewals, policy servicing and claims. An example of this integration is the recent launch of the cross-border sale of car insurance products to cope with the national policies of the Mainland China government.

2.2 The Writing of Insurance and Reinsurance

Insurers and reinsurers that intend to carry on insurance or reinsurance services in Macau on a regular basis must be authorised to do so before commencing operations, and will operate on either the life or the non-life branch.

Composite licences are not granted. Despite there being no limitations on Macau residents taking out insurance in a different jurisdiction, Macau-related insurance products provided by non-authorised insurance companies are not enforceable in Macau, with the only exception being as stipulated under Article 6 of the MIO.

Insurers and reinsurers can carry on such business through Macau-incorporated subsidiaries or branches of foreign insurers.

The main criteria that will be considered for granting the licence (for either Macau-incorporated subsidiaries or branches) are as follows:

- the financial capability of the company, including the minimum capital requirement;
- the suitability of the shareholders, directors and key managements; and
- the adequacy of corporate governance and business plans.

In addition to the above, and in order to be permitted to establish a branch, a foreign insurer must be licensed and have been in operation for more than five years in its country or territory of origin, and will only be permitted to carry on the classes of insurance it is licensed to operate in its home jurisdiction.

Reinsurance

The sale and distribution of reinsurance products in Macau is a licensed activity that can only be carried out by authorised reinsurance companies.

There are no limitations on Macau licensed insurers reinsuring the risks of their insurance contracts to overseas licensed reinsurers. This does not mean a foreign reinsurer is able to do its business in Macau freely and directly.

A reinsurance company may register in Macau by means of a local incorporated company or representative office. The requirements are contained in the MIO and are similar to those for

the incorporation of an insurance company (with some specificities).

A representative office is an office that represents an insurer or a reinsurer whose head office is overseas, and is not permitted to conduct, directly and in its name, any operations that come within the scope of activity of such insurer or reinsurer. This means that representative offices are merely proxies of the reinsurers they represent, and their exclusive scope of business shall be to place the reinsurance contracts with the entities they represent.

The representative offices may:

- accept reinsurance contracts on behalf and for the account of the entities they represent; and
- attend to the interests generated in Macau as a result of the reinsurance contracts accepted.

The representative offices shall not be permitted to:

- practise acts that transcend or contradict the actions listed above;
- retain any portion of the premiums in respect of the reinsurance contracts placed with the entities they represent; or
- acquire immovable property other than what is indispensable for their installation and operation.

2.3 The Taxation of Premium

Insurance contracts are subject to stamp duty, which is calculated and levied from the customers by the insurers and submitted to the Macau Tax Bureau by the insurer monthly, pursuant to Article 24 of Decree Law No 17/88/M, amended by Law No 24/2020.

Nevertheless, such stamp duty has been exempted as annual tax benefits in the Macau Annual Budget Law over recent years (from 2006 onwards, including for 2023).

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Overseas-based insurers or reinsurers are not permitted to conduct insurance or reinsurance business in Macau unless they are authorised to do so. However, there are no limitations on overseas-based insurers or reinsurers accepting Macau residents or companies, out of their own volition, taking out insurance or reinsurance in a different jurisdiction, provided that the overseas-based insurers or reinsurers have not actively promoted their services and/or marketed their products in Macau.

Overseas insurers or reinsurers will have to go through a licensing process in order to be allowed to carry out insurance or reinsurance business in Macau, with the only exception being the acceptance of specific insurance products as stipulated under Article 6 of the MIO.

The exceptions admissible for overseas-based reinsurers are considered in **2.2 The Writing of Insurance and Reinsurance**.

There is no recognition of overseas licences through passporting or equivalence in Macau.

3.2 Fronting

Fronting is specifically permitted for general insurers in Macau.

According to AMCM Notice 004/2021 "Requirements of Guaranteeing Technical Reserves due to Abnormally High Loss or Fronting Policy" ("AMCM Guideline"), a Macau general insurer may underwrite insurance business through fronting policies. A fronting policy is defined under the AMCM Guideline as the agreement pursuant to which the ceding company (Macau licensed insurer) transfers the risks it has underwritten to a reinsurer, keeping no more than 5% of such risk on its own behalf.

In situations where a fronting policy is put in place, the Macau licensed insurer must require prior approval from the regulator if it wishes to guarantee the technical reserve with the retained portion (ie, the capital insured minus the amount of reinsurance ceded). Several requirements regarding the approval request and the reinsurance company are also applicable.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

M&A activities relating to insurance companies are not common in Macau. There have been only two (indirect) acquisitions of the whole shareholding of Macau insurance companies in the last few years.

Qualified Shareholding

Under the MIO, prior approval from AMCM is required for a direct or indirect acquisition or increase of a qualified shareholding. A qualified shareholding, as defined in the MIO, generally means a shareholding of any shareholder that represents, directly or indirectly, at least 10% of the share capital or the voting rights of the insurer, or that, in any other way, bestows the possibility of exercising a significant influence on the respective management.

In addition, any subsequent and cumulative increase of more than 5% of qualified shareholding or voting rights must similarly be approved by AMCM. An acquisition or increase of a qualified shareholding without prior approval from AMCM shall result in a prohibition on the use of the acquired voting rights as stipulated under the MIO.

For Macau-incorporated insurers, certain modifications shall be subject to prior approval from the Chief Executive, including alteration of the share capital, merger, amalgamations, division or any other form of transformation, by means of an executive order that will be published in the Macau Official Gazette.

Despite the limited number of M&A transactions, there has been a significant growth in the Macau insurance industry in recent years, especially due to the border restrictions between Hong Kong and Mainland China. This has prompted a rapid increase in the business volume of life insurance written in Macau (following an increased demand from Mainland residents). In addition, GBA opportunities (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**) have been driving more attention to the Macau insurance market. Therefore, the Macau insurance market has increased its attraction among foreign stakeholders who have been keen to establish a presence in the region.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The sale and distribution of insurance products is a licensed activity that can only be carried out by authorised insurance companies or by licensed insurance agents and brokers ("Macau licensed intermediaries").

In addition to marketing and sales activities, all activities leading to the effecting or arranging of insurance contracts or insurance operations between policyholders and insurance companies should be conducted by licensed insurance intermediaries only, and should be conducted and take place in Macau.

Under the MIIO, the types of insurance intermediaries are classified as:

- insurance agents (individual or corporate);
- insurance brokers; and
- insurance salesman.

An insurance agent is qualified as an entity (intermediary) who acts in the name of and on behalf of one or more insurers, being competent to effect insurance contracts or insurance operations, or to finalise the settlement of claims, provided they have prior written authorisation for such purpose.

An insurance salesman is qualified as an entity (intermediary) who is simultaneously an employee of an insurance company, of a corporate insurance agent or of an insurance broker and who acts, whilst carrying on insurance intermediary business, in the name of and on behalf of any one of said entities.

An insurance broker is qualified as an entity (intermediary), organised as a corporate entity, who acts in the name of and on behalf of policyholders, with the exclusive object of carrying on insurance intermediary business.

Bancassurance (when banks are licensed as corporate insurance agents) and direct sales are distribution channels commonly used in Macau.

The distribution of reinsurance products in Macau is not common as there is currently only one representative office of a foreign reinsurer established in Macau. Reinsurance contracts are normally entered into based on the internal relationships between the cedant insurer and the reinsurers.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The policyholder is subject to information disclosure obligations regarding risk, and should completely and accurately disclose to the insurer all information related to the risk assessment or evaluation, which is known or ought to be known by the policyholder, no later than the conclusion of the insurance contract.

In particular, the policyholders must declare to the insurer, in a complete and unequivocal manner, all circumstances known to them or that they reasonably should know of that may influence the assessment of risk, regardless of whether they are included in the questionnaire sent to them. This obligation remains applicable throughout the duration of the policy.

Whenever the insurer has sent the policyholder a questionnaire to fill in, it is presumed that the

circumstances mentioned in such questionnaire influence the assessment of the risk.

The insurer has regulatory obligations to proactively require information, including for assessing the suitability or financial capability of the client when negotiating certain types of insurance products.

Disclosure obligations are applicable in consumer or commercial contracts.

6.2 Failure to Comply With Obligations of an Insurance Contract

The consequences shall differ depending on whether the policyholder has failed to comply with the information disclosure obligations with or without bad faith.

- Policyholder acting with bad faith – within one month of the acknowledgement of such non-compliance, the insurer is entitled to terminate the insurance policy and recover any claims paid. The insurer is also entitled to the matured premium, until the moment it informed the policyholder of its intention to terminate the policy.
- Policyholder acting without bad faith – within two months of the acknowledgement of such non-compliance, the insurer is entitled to either terminate the insurance contract or propose a new premium to the policyholder. If the policyholder does not reply or refuses to pay the adjusted premium within 15 days of the date the amendment is notified, the insurer is entitled to terminate the policy within one month.

6.3 Intermediary Involvement in an Insurance Contract

As noted in **5.1 Distribution of Insurance and Reinsurance Products**, insurance agents (individual or corporate) act in the name of and on behalf of insurers, insurance brokers act in the name of and on behalf of policyholders, and insurance salesmen are employed by the insurers, corporate insurance agent or insurance broker and act in the name of and on behalf of any one of said entities.

Insurance intermediaries have to follow detailed conduct requirements and principles applicable to their insurance intermediary activities, as set out in the MIIO and in several notices and circulars issued by AMCM Notice No 008/2021-AMCM – Ethics for Insurance Intermediary Activities and the Guidelines on Conduct Requirements for Agents' and Brokers' Activities (Circular No 009/B/2021-DSG/AMCM and Circular No 010/B/2021-DSG/AMCM respectively).

In particular, Macau licensed intermediaries are obliged to:

- act honestly, ethically and with integrity;
- treat clients fairly and act in their best interests;
- act with due care, skill and diligence;
- possess appropriate levels of professional knowledge and experience, and only carry on insurance intermediary activities in respect of which the insurance intermediary has the required competence;
- comply with personal data protection laws and regulations, and keep customer information confidential;
- make the disclosure of information to the client that is necessary for them to be sufficiently informed prior to making any material decision related to a contract of insurance;
- take into account the client's overall conditions and provide suitable advice to the client thereafter; and

- ensure the funds of the client are promptly and properly accounted for.

Proper internal monitoring measures and procedures are also required to be established by corporate insurance agents, insurance brokers and insurers that conduct business through insurance intermediary distribution channels.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

An insurance contract is specifically defined in the MIO and the Macau Commercial Code as a contract according to which the insurer undertakes, against payment of a premium and upon occurrence of the event covered by the contract, to indemnify, within the agreed limits, the loss or damage so incurred by the insured or to settle a capital sum, a rent or other payments stipulated therein.

Legal Requirements of Insurance Contracts

The legal requirements are regulated under the Macau Commercial Code. The insurance contract must:

- be in writing;
- be written in a clear manner;
- be dated and signed by the insurer; and
- include other minimum mandatory elements as stipulated under Article 969 of the Macau Commercial Code.

In particular, the insurance policy must contain at least the following elements:

- identification and domicile of the parties, and of the insured and the beneficiary if applicable;
- the nature of the insurance;
- the interest covered;
- the risks covered;
- the capital insured;
- the beginning and termination of the contract;
- premiums and applicable additional amounts; and
- excesses, mandatory deductibles and all other conditions agreed by the parties.

Policy wording that determines causes for termination, exclusion, nullity of the policy, restrictive or risk exclusion provisions must be highlighted in order to be valid. Applicable law does not prescribe any specific form of highlighting for such wording.

Risk and Insurable Interest

Risk

The law specifically requires the existence of risk to be insured (with some limitations for carriage insurance). An insurance contract shall be void if, at inception, there is an absence of risk, or if the incident has already occurred.

Insurable interest

The law also requires an insurable interest at the inception of a life policy. Such requirement is expressly stated for property damages insurance. However, although there is no such express reference for life insurance, it likely applies to these policies as well. Such insurable interest relates to the insured, and the expression of such interest differs between life insurance and damages insurance.

In life insurance policies, the insured is the person whose life or health is covered under the policy and, as such, the insurable interest in a life insurance policy is almost inherent and is presumed when the insured is simultaneously the original policyholder. When the policy is taken out by a third party, the insured would have to consent in writing to the policy. Therefore, such

consent may also arguably create the presumption that the person insured has an interest in the policy.

6.5 Multiple Insured or Potential Beneficiaries

As a general rule, the insurance policy shall contain the identification details and address of the beneficiary.

The beneficiary can be the policyholder or anyone named by the policyholder (which does not need to be the insured person if this is different from the policyholder).

Unnamed beneficiaries such as the heirs of the policyholder can be appointed.

Life insurance policies have the specific possibility of not designating a beneficiary at the inception of the policy. If no beneficiary is designated and there are no objective criteria for such determination until the death of the policyholder, the legal and contractual benefits of the policy will be transferred to the estate of the policyholder (ie, to its legal heirs).

Multiple beneficiaries and the respective proportion in receiving the benefits of the insurance are allowed.

The designation of beneficiary could be made by means of a contract, by a written instruction to the insurers or by will.

The policyholder, subject to its own discretion, can revoke the designation of the beneficiaries, unless it is an irrevocable beneficiary (in which case the beneficiary shall have to consent).

There are also the following specific regulations in respect of the interpretation of the clauses of designating the beneficiaries:

- if it is designating the heirs of the insured as the beneficiary, it is interpreted that these are the legitimate or testamentary heirs, in accordance with general rules;
- if it is designating the spouse as the beneficiary, it is interpreted that said spouse is the one to whom the insured is married at the moment of death; and
- if the designation is made in favour of various beneficiaries, the insurer shall distribute the benefit equally, unless there is a declaration to the contrary by the policyholder.

6.6 Consumer Contracts or Reinsurance Contracts

The position of consumer contracts is the same as detailed above, with there being no difference in respect to the legal requirements and distinguishing features.

Macau law contains no specific rules for reinsurance contracts, which shall generally be governed by the principle of contractual freedom of the contracting parties.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

There is no specific regime nor an established practice of local Macau insurers resorting to ART transactions.

However, subject to regulatory approval, it is possible that local insurers may consider ART transactions for the purposes of risk mitigation within their risk management and internal control systems.

7.2 Foreign ART Transactions

There is no specific regime for the recognition of overseas ART transactions.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The interpretation of the general and special conditions of the insurance policy shall comply with the general principles of the interpretation of legal transactions (contained within the Macau Civil Code).

As a general rule, contracts are interpreted with the meaning that a normal recipient placed in the position of the actual recipient would make from the clauses in the contract. Based on such principle, the interpreter shall consider:

- the general knowledge that a reasonable person, normally clear, thoughtful and prudent in the specific kind of transaction, would have; and
- the facts and circumstances of which the parties to the contract were actually aware when they executed the contract.

This general rule is subject to the following exceptions:

- the contract shall not be found to have a meaning that one of the parties could not reasonably expect to be attributed to it;
- if one of the parties was aware of the real intention of the other party and if such intention differed from what is derived from the contract as construed according to the general rule referred to above, the contract shall stand with the meaning corresponding to the real intention of such party; and
- where the law imposes a written form for the contract, its clauses cannot be construed to have a meaning that does not bear at least a minimal correspondence to the text of such document, unless such meaning corresponds to the real intention of the issuer and the reasons imposing the adoption of a written form do not preclude that the declarations stand with a meaning that corresponds to the true will of the parties.

Although the interpretation of the declaration shall be done on a casuistic basis, doctrine and jurisprudence have construed some circumstances or criteria to aid the interpreter. For example:

- the terms of an agreement should be read in context (ie, as a whole) and not as isolated provisions;
- the terms of an agreement should be read considering the business interests of and the objectives pursued by the parties;
- business practices, the business environment and business language should be considered; and
- the parties' commercial and legal sophistication should be taken into consideration.

This means that there are no specific restrictions on extraneous evidence, and market or industry practice may be used as evidence.

If the above-mentioned circumstances or criteria for interpretation lead to a doubtful result, Article 970 No 2 of the Macau Commercial Code provides a special criterion applicable to insurance contracts, according to which any general or special clauses drafted by the insurer shall be

interpreted in the manner most favourable to the insured party.

Such rules are applicable to consumer contracts indistinctively but not to uniform policies (eg, car insurance), which are regulated by specific regulations.

8.2 Warranties

Warranties are generally identified as one of the contractual terms between the parties, and it is not necessary to expressly autonomise them as a standalone section. There are no specific regulations on warranties, which are treated the same as the other contractual terms. A breach of warranties by either party will be considered as a breach of the insurance contract.

8.3 Conditions Precedent

Conditions precedent are generally identified as contractual terms pursuant to which the insurer shall reject a claim or disclaim its liabilities if such conditions are not met. Instead of specifically regulating the conditions precedent, the law requires policy wording that determines causes for termination, exclusion, nullity of the policy, restrictive or risk exclusion provisions to be highlighted in order to be valid.

Regulatory guidelines also impose an obligation of clear disclosure in the policy documents of key or infrequent exclusions to clients, and a breach of such obligation may lead to non-compliance with regulatory obligations.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Disputes and/or complaints over coverage under an insurance contract, regardless of whether the contract is a consumer contract or a reinsurance contract, can be handled as follows:

- directly between the complainant and the insurer;
- through a mediation process pursuant to the "Mediation Scheme for Financial Disputes" launched by AMCM, the Macau Consumer Council and the World Trade Center Macau Arbitration Center;
- through courts of law; or
- through arbitration.

The limitation period to initiate proceedings depends on the types of insurance and the entity to which the complaint and/or dispute is proposed.

As a general rule, the beneficiary should communicate with the insurer within eight days from the day of the event or accident, if no other longer time limit is stipulated in the insurance contract.

For disputes regarding policy terms, premium payments or other claims in general, the law stipulates the following statutes of limitations:

- five years for a life insurance contract, health insurance and insurance against accidents;
- two years for a general insurance contract; and
- three years for civil liability insurance (derived from the practice of illegal acts).

There is no limitation period in respect of the submission of complaints and/or disputes to AMCM.

The same rule applies to unnamed beneficiaries (such as group insurance policies) for non-life insurance contracts and other third parties, provided that their rights against the insurance

contracts are verified. For life insurance contracts, if there is no designation of beneficiary and no objective criteria for such determination until the death of the policyholder, the legal and contractual benefits of the policy will be transferred to the estate of the policyholder (ie, to its legal heirs).

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Macau law does not state specifically that the policies issued by Macau licensed insured companies must be subject to Macau law. As such, pursuant to the general principle of contractual freedom, it is possible for policies issued by Macau-authorised insurers not to be subject to Macau law. Nevertheless, it is normally advisable for the policies issued by authorised insurers to be subject to Macau law, due to the following considerations:

- the rules on insurance policies contained in the Macau Commercial Code (and the MIO) are of an imperative nature, which means that such rules always have to be followed, regardless of the law applicable to the policy; and
- pursuant to the MIO, only Macau courts are competent to give judgments on actions arising from insurance contracts or insurance operations entered into in Macau or in respect of persons or entities who, on the date of such contracts or insurance operations, were resident or domiciled in Macau, or in respect of the assets located therein or of the risks situated therein.

Governing law should be Macau law if there is no relevant connection to any other jurisdiction (eg, if the insurer, policyholder, insured and risks covered are all based in Macau, or if there is no verifiable interest of the parties in choosing a different law).

9.3 Litigation Process

In Macau, the litigation process commences with the submission of a statement of claim to the relevant court. Depending on the nature of the claim, the relevant court could be different sections of the Judicial Base Court. The civil section has general competence to try any matters that do not fall within the specific matters attributed to any other sections.

The initial stage of the proceedings is based on initial written submissions. In a typical civil proceeding, after submission of the statement of claim, when no grounds for preliminary rejection of statement of claim are found, the respondent will be summoned to provide the defence. There may be further pleadings if the respondent invokes any counterclaims.

After the pleadings phase, the court will then issue an interim decision, setting out the list of material facts considered as established and disputed. The disputed facts should be further proven by documentary and testimonial evidence and other types of evidence.

The trial hearing is mainly oral in nature; written statements are exceptionally admitted, and the final arguments of matters of fact are produced orally before the court. The closing legal arguments can be produced orally, if the parties so agree; otherwise, they should be produced in writing before the final decision.

Finally, the decision may be appealed under the procedural rules.

9.4 The Enforcement of Judgments

See **9.2 Insurance Disputes over Jurisdiction and Choice of Law** regarding the jurisdiction of Macau courts over the indicated Macau insurance contracts or insurance operations. A judgment made by a Macau court is an enforcement title, which is a prerequisite to initiate enforcement proceedings.

Although the validity of a Macau insurance contracted with a foreign insurer is not affected, no claim may be brought in a Macau court for debts arising from an insurance contract or insurance management concluded or arranged by insurers who are not authorised to conduct business in Macau. Also, judgments awarded by foreign courts on such insurance contracts or insurance management shall not be enforced in Macau.

Nevertheless, there is an exception provided by the MIO, pursuant to which such contracts can be subject to litigation or enforcement in Macau, if the following conditions are verified:

- the Macau licensed insurers are unwilling or unable to accept certain insurance contracts;
- AMCM is given 15 days' prior notice; and
- AMCM does not oppose the conclusion of these contracts within the pre-notice period.

Enforcement of Foreign Judgments

Unless otherwise provided for in international agreements in force in Macau, foreign judgments can only be enforced in Macau after revision and confirmation by the Macau court.

The procedures for the recognition of foreign judgments are as follows:

- application filed with the Macau Second Instance Court;
- service of court papers on the opposing party;
- defence by the opposing party within 15 days;
- reply by the applicant within ten days;
- analysis of the case file by the Public Prosecutor;
- opposition by the parties within ten days if the Public Prosecutor raises any issues; and
- issuance of award by the Macau Second Instance Court.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses can be included in both commercial insurance and reinsurance contracts, as long as the object of the clause relates to matters that can be subject to the regime of settlement under the law, and the arbitration clause is stipulated in writing, which can be contained in a contract or in form of a separate agreement.

The Macau Arbitration Law (Law No 19/2019) entered into force in May 2020. Arbitral agreements concluded before the entry into force of this new law are valid and enforceable, unless any party objects within 15 days of the commencement of the arbitration. Arbitration clauses enforced after the new law took effect shall follow the procedures under the new law.

9.6 The Enforcement of Awards

An arbitration award is identical to a Macau court decision in terms of enforceability, meaning that the award can serve as an enforcement title in enforcement proceedings in Macau.

See **9.2 Insurance Disputes over Jurisdiction and Choice of Law** regarding the jurisdiction of Macau courts over the indicated Macau insurance contracts or insurance operations. Unless otherwise provided for in international agree-

ments in force in Macau, foreign arbitral awards can only be enforced in Macau after revision and confirmation by the Macau court.

It should be noted that there are agreements for the recognition and enforcement of arbitration awards between Macau and Hong Kong, as well as between Macau and China. The procedure of revision and confirmation of foreign arbitration awards is the same as that for foreign judgments (see **9.4 The Enforcement of Judgments**).

Moreover, Macau is a party to the New York Convention through the extension declaration of its applicability made by China, with the reciprocity reservation (only awards from other signatory states can be enforced) and the commerciality reservation (only awards deemed commercial under national law can be enforced).

9.7 Alternative Dispute Resolution

The "Mediation Scheme for Financial Consumption Disputes" has been launched by AMCM, the Macau Consumer Council and the World Trade Center Macau Arbitration Center, and aims to provide more channels for resolving financial consumption disputes, including insurance disputes.

Members of this scheme should first adopt the mediation services provided by the World Trade Center Macau Arbitration Center to resolve any financial consumption disputes that are within the scope of the scheme.

The same procedure is applicable to consumer contracts and reinsurance contracts.

9.8 Penalties for Late Payment of Claims

The Macau Commercial Code specifically states that compensation corresponding to double the default interest rate shall be added to the amount due if the insurer fails to pay the claims, for reasons imputable to the insurer, within 60 days from its acknowledgement of the incident, situation and consequence.

9.9 Insurers' Rights of Subrogation

Subrogation of the insurers' rights in the position of the insured are typically stipulated as contractual terms.

As a general legal principle, an insurer who has paid compensation is subrogated in the rights of the insured against liable third parties, up to the amount of such compensation. Nevertheless, the following specific limitations are stipulated under the Macau Commercial Code:

- for damage insurance, except for wilful conducts, subrogation shall not be admissible if the damage or loss is caused by the insured's descendants, ascendants, adoptees, lineal relatives by marriage, domestic servants or any other persons living with the insured in a common economy; and
- for life insurance, the insurer cannot subrogate itself in the rights of the insured arising from the incident against third parties with exception to medical and hospital expenses paid by the insurer in case of accident caused by a third party.

10. Insurtech

10.1 Insurtech Developments

There is still plenty of room for insurtech developments in Macau.

There are a few limitations in the market that limit such development, such as regulatory requirements on the necessity of signing all policy documents within the Macau territory for non-

Macau residents, especially for Mainland China customers, and strict regulations imposed on online sales or selling by means of non-face-to-face methods.

However, the use of different types of insurtech solutions – such as online claims portals, mobile apps for after-sale services or administrative services, or the use of AI solutions to improve offerings to policyholders – is becoming more commonly widespread.

10.2 Regulatory Response

There is no specific regulation on insurtech issues (besides the limitations referred to in **10.1 Insurtech Developments**). However, the regulator has been following the market trends and incentivising stakeholders to develop solutions that would benefit Macau policyholders and improve the provision of insurance-related services.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Catastrophe risks are seen as one of the emerging risks that affect the Macau market. As there have been more significant and more severe typhoons in Macau in the past few years, causing huge claims to be made to insurers, the regulator and the current stakeholders (particularly general insurers) are starting to pay special attention to these matters.

Business interruption claims prompted by COVID-19 prevention restrictions represent another risk that has been affecting the market.

In view of the rise of virtual assets, which may typically be used for activities related to money laundering and the financing of terrorism (a risk always raised by the regulator for the insurance industry), the Macau regulator upholds the position of excluding virtual currencies as legal currency and strictly forbids the insurance sector to use virtual assets for the payment of premium and claims.

11.2 New Products or Alternative Solutions

See **11.1 Emerging Risks Affecting the Insurance Market**.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Despite the impact of the COVID-19 pandemic on the Macau market, the Macau insurance sector has still maintained a steady growth. In view of the significant growth in the insurance sector, which necessarily led to a growth in potential financial risks, the regulator has proactively imposed several regulatory obligations on the sector. Considering the risk-based approach adopted by the regulator, the increase in regulatory guidelines and instructions is expected to continue.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Enactment of the Trust Law in Macau

In December 2022, Law No 15/2022 (the Trust Law) came into force. It is the first time that Macau has legislated trusts, which is a legal

concept more typical in common law jurisdictions. The broader policy behind this legislation is economic diversification and the modernisation of Macau's financial system.

Pursuant to the Trust Law, only selected financial institutions, including insurance companies, can act as trustees.

The enactment of the Trust Law aims to provide the public with innovative property transfer models and flexible estate planning. It will also allow banks, insurers and other financial institutions to offer diversified financial and insurance solutions to meet those needs.

Amendments to the Insurance Intermediaries Ordinance

The current Insurance Intermediaries Ordinance was first launched in 1989, with amendments made only back in 2001 and 2003. Following the significant growth in the insurance sector in recent years, there will be a further amendment to the Insurance Intermediaries Ordinance, aimed at facilitating co-operation with industry development, strengthening the protection of policyholders and aligning with international regulatory standards. Enhanced requirements will be imposed on insurance intermediaries, particularly regarding their conduct and behaviour. The new Insurance Intermediary Ordinance is expected to come into effect in 2023.

MdME is a leading Macau full-service law firm, which has been involved in most of the key projects, transactions and investments that have reshaped the local economic landscape over the past decade. With offices in Macau, Hong Kong and Lisbon, the firm represents some of the largest corporations investing and operating in Macau, in such diverse sectors as banking, insurance, finance, gaming, real estate, energy, construction, infrastructure, retail and telecoms. The team currently consists of 35 fee earners, led by ten partners, who are all recognised experts in their fields.

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Carlos Eduardo Coelho is a partner at MdME and advises corporations and financial institutions on a broad variety of corporate matters, including financial and operational restructurings and strategic matters. He has been particularly active in all kinds of M&A deals. Within the firm's corporate finance practice, Carlos has been focusing on the insurance sector. He has been involved in a wide range of insurance transactional, advisory and product development work, including corporate restructuring, licensing, distribution and advising clients on the Macau regulatory environment. He also advises on matters relating to insurance intermediaries, reinsurance and other regulatory and compliance matters.

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Sources of Insurance and Bonding Law in Mexico

The main sources in Mexico are legislation and judicial criteria. Insurance law legislation includes:

- the Law of Insurance and Bonding Institutions;
- the Sole Insurance and Bonding Circular;
- the Insurance Contract Law;
- the general insurance provisions issued by the National Commission for the Protection and Defense of Users of Financial Services;
- the Code of Commerce; and
- the Federal Civil Code.

International legislation is used when there is an international contract (reinsurance or insurance), where, depending on the type of insurance, the provisions that will apply may be Mexican or international laws.

In 1996, Mexico ratified the Inter-American Convention on the Law Applicable to International Contracts, which establishes a framework to determine the law applicable to international contracts, such as reinsurance or insurance contracts. For the regulation of international insurance or reinsurance, international conventions or treaties are considered depending on the type of insurance and the insured objects; for example, in air transport insurance, international treaties specialised in aeronautical law are used so that the insurance complies with all the requirements in international matters.

Additionally, there is the jurisprudence and judicial criteria issued by the Supreme Court of Justice and the highest courts in the country. This source of law is very important in the Mexican legal system, since it sets precedents for the resolution of judicial disputes in insurance matters, and is also a guideline for insurers as to the conduct they must adopt in their operations.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Regulation of Insurance and Surety Bonds

The National Insurance and Bonding Commission is the governing body that regulates insurance and bonding companies, from their incorporation to their operation, and at all times ensures that they comply with their obligations under the relevant regulatory framework, including the correct constitution of their corporate governance, solvency capital, the contracts they issue, and the constitution of their technical reserves, among others.

On the other hand, the National Commission for the Protection and Defense of Users of Financial Services is the governing body that oversees that insurance and surety companies provide adequate service to consumers of their products. Likewise, such authority may sanction them where they fail to comply with any administrative provision related to consumers. Among other provisions, it is in charge of ensuring compliance with the Law for the Protection and Defense of Users of Financial Services.

2.2 The Writing of Insurance and Reinsurance

Corporate Insurance and Reinsurance

The authorisation to subscribe insurance and reinsurance for (small- or medium-sized) companies corresponds to those companies that have the respective authorisation from the National Insurance and Bonding Commission to operate as an insurer and that also have permission to distribute the product required by the company, ie, in the life, accident and sickness or damage line of business. There are no specific or differentiated requirements for insurers to operate consumer insurance or business insurance.

In the case of business insurance, adhesion contracts are also used; however, this is not an obstacle for them to be negotiated by the contracting company, in terms of its specific needs. For an insurer to issue an insurance policy to a company, it must verify, at the time of subscription, what is contained in its policies and subscription manuals. Other issues that are contemplated include:

- the objects to be insured;
- risk profile;
- seniority in the market in question; and
- sector of economic activity.

The restriction for insurers at the time of taking out insurance is that they do not exceed the capacity for which they can assume risks; for this purpose, Articles 256 and 257 of the Law of Insurance and Bonding Institutions provide that they must diversify and disperse the risks through coinsurance or reinsurance with foreign companies, specifying that there is no different or specific regulation when it comes to business or consumer insurance.

Details of all the requirements that insurers must comply with to operate consumer and business insurance can be found in the Sole Insurance and Bonding Circular.

2.3 The Taxation of Premium

The Premium Regime

Under Mexican law, the nature of the premium regime is taxable, since if the contracting party or insured party does not pay the premium within the term established for such purpose, the insurance ceases to be effective. The general rule is that the premium is due in advance; that is, at the beginning of each period of the term of the insurance contract. In some cases, depending on the type of insurance, the premium may be divided and paid in specific periods, but it must be paid in periods of equal duration.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Operation of Foreign Insurance or Reinsurance Companies

The operation of insurance in Mexico is authorised for institutions incorporated under Mexican law. If a foreign company wants to operate in Mexico, it must incorporate an affiliate entity in Mexico to provide insurance services in Mexico.

Regarding the operation of reinsurance, in order to provide this service from Mexico and to hold itself out as a Mexican reinsurer, it is necessary for the company to open an affiliate entity in the country and obtain authorisation from the National Insurance and Bonding Commission. However, if the insurance was granted by a Mexican insurer, the insurer, in order to diversify and disperse the risks and responsibilities

it assumed when carrying out this operation, is allowed to contract reinsurance or coinsurance with a foreign company. For an insurer to enter into reinsurance with a foreign company, the latter must be registered in the General Registry of Foreign Reinsurers, which is obtained through the authorisation of the National Insurance and Bonding Commission, which, prior to granting the registration, will review, among other aspects, the solvency and stability requirements to carry out reinsurance operations.

3.2 Fronting

In Mexican legislation, there is no express provision allowing fronting and, in some cases, there are restrictions in that insurance cannot be contracted with foreign companies when the persons or companies to be insured reside in Mexican territory or when the object to be insured is located in Mexican territory or is the property of a person domiciled in Mexico and, in general, in cases where the risks may occur in Mexican territory.

However, as stated in **3.1 Overseas-Based Insurers or Reinsurers**, Mexican insurance companies may diversify their risks through reinsurance or coinsurance with foreign companies, and it is in these operations that fronting occurs, since through these operations the insurers that assume the risk transfer it to other insurers or reinsurers.

In this respect, there is no percentage limit for reinsurance or coinsurance, nor is there a minimum retention requirement for the transferor company. On the contrary, Mexican law establishes that an insurer cannot retain all the risk if it exceeds its capacity to mitigate the risk, and what it provides is that the surplus must be diversified in reinsurance. In practice, it is common for the entire risk to be reinsured, so that sometimes it is actually the reinsurer who assumes the entire risk; however, it is not the reinsurer but the transferor insurer who will be liable to the insured.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Mergers and acquisitions (M&A) of insurance companies are very common in Mexico, especially when international insurers absorb local insurers, since the absorption facilitates the insurers that arrive, as they already have the authorisation of the Mexican regulatory authority and the permits to operate products. In recent years, M&A have been recurring in Mexico, which is accepted, as there is regulation on M&A in the Law of Insurance and Bonding Institutions and in the Sole Insurance and Bonding Circular.

The absorbing insurer takes over the portfolio of the absorbed insurance institution and assumes all the risks it had insured, for which it must have a contingency plan in place for all the risk it assumes.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The distribution of insurance and reinsurance products is regulated by the Law of Insurance and Bonding Institutions and by the Sole Insurance and Bonding Circular, and is carried out as follows:

- Direct sales – these sales are made by insurance companies.

- Sales through insurance agents – insurance agents offer the general public a wide range of insurance with various institutions and products. In order to be able to sell insurance, the individual or legal entity must be authorised by the National Insurance and Bonding Commission and comply with various requirements set forth in the Insurance and Bonding Agents Regulations, including having completed high school or equivalent, having the technical capacity to perform brokerage activities, not being a public servant, not having been convicted of a property crime, and not having been declared bankrupt. Likewise, it is important to point out that agents are also required to contract and maintain civil liability insurance for errors and omissions.
- Sales through digital media – the sale of insurance and reinsurance products through digital media is also regulated by the Sole Insurance and Bonding Circular, particularly with regard to the terms and conditions under which electronic insurance contracts must be made, since Mexican legislation is very specific in that insurers must provide all the information and documentation clearly to the contracting parties or insured parties.
- Bancasurrance – in Mexico, there is the distribution of products through financial institutions, but this model is known as contracting through a legal entity. In order to start with the distribution of insurance, financial institutions must sign a contract with the insurers which must be authorised and registered before the National Insurance and Bonding Commission. Also, in some cases, before the financial institutions or legal entities distribute the insurance products, they should receive training from the insurance company, or obtain evaluation or certification by the National Insurance and Bonding Commission.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Disclosure of Information about the Risk

In Mexico, as in most jurisdictions, insurance contracts are documents previously drafted by the insurers and in which there is no margin for negotiation by the insured, being classified for such reason as “adhesion contracts”. This type of contract has a distinctive characteristic in that the parties do not agree on equal terms nor do they have the possibility of compromising or negotiating between equals. Thus, the distinguishing feature of the adhesion contract lies in the fact that the clauses are not drafted by both parties, but are predisposed (and sometimes imposed) by one of them to the other, who can only accept or reject them.

Having established the above, it is the insured who is obliged to declare in writing to the insurer, according to the corresponding questionnaire, all the facts important for the appreciation of the risk that may influence the agreed conditions, as they know or should know them at the time of the execution of the contract. There is no obligation on the part of the insurer to actively investigate the important facts on the part of the insured and which may influence the agreed conditions.

The frequent and growing use of insurance contracts has generated the need to regulate their execution; legislation which, in view of the advantageous position of insurance companies, has been directed towards the development of consumer protection and transparency rules, obliging insurance contracts to comply with certain standards.

6.2 Failure to Comply With Obligations of an Insurance Contract

Consequence of Failure to Provide Information in the Subscription of an Insurance Contract

As stated in **6.1 Obligations of the Insured and Insurer**, most insurance contracts are non-negotiated contracts or adhesion contracts. The omission or misstatement of any material fact by the insured party that could influence the terms and conditions of the insurance entitles the insurer to consider the insurance contract legally terminated.

6.3 Intermediary Involvement in an Insurance Contract

Insurance companies act through agents who may be individuals or legal entities that intervene in the contracting of insurance through the exchange of proposals and acceptance of said insurance, through marketing and through the provision of advice to enter into such contracts, and whose activity is subject to the legal framework of the Insurance Contract Law, the Law of Insurance Institutions and Mutual Insurance Companies and the Insurance and Bonding Agents Regulations.

Even though the insurance agent is usually considered an intermediary, the truth is that in Mexican law they are considered an agent of the company, when they act according to its instructions and direction, and represents it, since their activity binds the insurer in the contracting of the insurance; however, they have the obligation to provide advice to the insured in relation to the contracting of the insurance.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

In terms of applicable legislation, in order to be valid, the insurance contract (as well as its additions and amendments) must be in writing, and it is perfected from the moment in which the insurer is aware of the acceptance of the offer by the insurance-contracting party.

The insurer is obliged to deliver to the contracting party a policy stating the rights and obligations of the parties, which must contain at least the following:

- the names and addresses of the contracting parties and the signature of the insurance company;
- the designation of the insured thing or person;
- the nature of the risks guaranteed;
- the time from which the risk is guaranteed and the duration of this guarantee;
- the amount of the guarantee; and
- the insurance fee or premium.

6.5 Multiple Insured or Potential Beneficiaries

Beneficiaries of an Insurance Contract

According to Mexican law, it is possible to take out insurance on one's own behalf or on behalf of another person, even without the designation of the person of the insured third party.

An example of this is D&O liability insurance in which only those persons (without identifying them) who fall within the general conditions of the insurance to be considered as directors and/or officers of a company are established as beneficiaries of the insurance.

6.6 Consumer Contracts or Reinsurance Contracts

The position is no different with regard to consumer contracts or reinsurance.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Alternative risk transfer in insurance refers to non-traditional solutions for transferring risks. In Mexico, this figure has been incorporated in products such as financial guarantee insurance and parametric insurance.

Financial guarantee insurance is regulated in the Law of Financial Institutions and in the Sole Insurance and Bonding Circular, and specific rules for their operation have also been published.

Additionally, parametric insurance is beginning to make inroads into the Mexican market, both by private companies and by the government. In June 2022, the granting of parametric insurance for social protection to small corn farmers in some states such as Oaxaca and Tabasco was announced; this is a pilot programme led by the government and some Mexican insurance companies.

7.2 Foreign ART Transactions

The Law of Insurance and Bonding Institutions does not specify provisions for ART transactions in other jurisdictions with implications in Mexico. However, there are no explicit bans in this matter.

Whether other jurisdictions celebrate ART transactions that may be validated in Mexico will depend on the specific acts celebrated in the foreign jurisdiction with regard to Mexican insurers.

Where ART transactions signed in other jurisdictions are part of a reinsurance or co-insurance contract with a Mexican insurer, this operation will be considered as a reinsurance or co-insurance contract; this applies only where those acts are part of the contract and comply with the requirements of Mexican law for recognition as a reinsurance contract.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are regulated by the Insurance Contract Law and in a supplementary manner by the rules of construction of contracts contained in the Code of Commerce and the Federal Civil Code.

The Insurance Contract Law provides that the policy conditions, scope, terms, exclusions, limitations, deductibles, and *any other modality* established in the coverage or plans offered by the insurance company, as well as the rights and obligations of the contracting parties, insured or beneficiaries must be drafted in terms that leave no room for doubt as to the risks covered *and those that are excepted, restricted or conditioned in any way*.

Regarding the latter, the law is clear in stating that the insurance company must respond to all events that present the nature of risk that has been insured, unless a certain risk or event is expressly *excluded, limited, or subordinated* in a precise manner.

Consequently, if a risk is not expressly *excluded, circumscribed, or reserved* from the coverage established in the policy in a clear and precise

manner, the insurance company shall have the obligation to respond to it upon the occurrence of the incident, under the terms agreed in the contract.

As stated in previous answers, insurance contracts are classified as "adhesion contracts", which are those whose clauses are drafted by only one of the parties, while the other party is limited to accepting or rejecting them, without being able to modify them. It is for this reason that there are special rules different from those applicable to the construction of freely negotiated contracts, so that any doubt is constructed against the stipulating party – ie, the insurer.

Therefore, the obscurity of the clauses in such (adhesion) contracts must be constructed in favour of the insured (consumers), who are not responsible for the drafting of the contract.

8.2 Warranties

As stated in **8.1 Interpretation of Insurance Contracts and use of Extraneous Evidence**, the Insurance Contract Law provides that the policy conditions, scope, terms, exclusions, limitations, deductibles and *any other modality* established in the coverage or plans offered by the insurance company, as well as the rights and obligations of the contracting parties, insured or beneficiaries must be drafted in terms that leave no room for doubt as to the risks covered *and those that are excepted, restricted or conditioned in any way*.

Under Mexican law, there is no particular form of words necessary to constitute a warranty, and, in fact, they are generally treated as a condition precedent and are not treated differently to other contractual terms.

8.3 Conditions Precedent

As stated **8.2 Warranties**, the Insurance Contract Law provides that the policy conditions, scope, terms, exclusions, limitations, deductibles and *any other modality* established in the coverage or plans offered by the insurance company, as well as the rights and obligations of the contracting parties, insured or beneficiaries must be drafted in terms that leave no room for doubt as to the risks covered *and those that are excepted, restricted or conditioned in any way*.

The breach of a condition precedent (if material to the loss that arises) will discharge the insurer from liability under the policy as long as it is clear from the content of the policy that such breach constitutes a discharge of liability.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

In Mexico, there are two procedures to claim insurance coverage: (i) a conciliatory or mediation procedure before the National Commission for the Protection and Defense of Users of Financial Services (CONDUSEF) and (ii) through the competent courts by filing an Ordinary Commercial Trial or Oral Commercial Trial, depending on whether liquid or illiquid benefits are claimed. The filing of the former is not a procedural requirement for the latter.

A claim for the performance of service or consumer contracts can be filed through a conciliatory proceeding before the Federal Consumer Attorney's Office (PROFECO) or through an Ordinary Commercial Trial or an Oral Commercial Trial.

The term to file a lawsuit to claim the compliance of an insurance contract is two years, as

a general rule, and five years in the case of life insurance, which is interrupted in the case of filing a claim before CONDUSEF, and restarts as of the day after the conciliation hearing in which the rights of the parties are safeguarded for not having reached an agreement or where they have agreed to submit to arbitration.

There are several cases in which an unidentified beneficiary or other third party may claim an insurance payment. An example of this would be in the case of liability insurance where the victim can sue the insurer directly. Another example would be in the case of legal expenses insurance where lawyers could sue the insurer directly for payment of their fees.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

For hearing any controversy related to insurance contracts entered into in Mexico by insurance companies authorised as such by the Mexican regulatory authorities, the competent courts shall be those of Mexico.

Since insurance contracts are "adhesion contracts", and in the event that the lawsuit is filed by the insured, the competent courts will be those chosen by the insured, even if the contract has indicated a different court.

9.3 Litigation Process

Suing for the payment of an insurance indemnity must be done by means of an Oral Commercial Trial, which has the particularity that ordinary appeals (ie, appeals and/or revocations) are not admitted, and consists of the following stages.

- The filing of the lawsuit together with the offer of evidence takes place.
- The summons occurs.
- An answer to the claim and an offer of evidence is given, for which purpose the insurer shall have a period of nine business days.
- Once the claim has been answered, the judge will notify the plaintiff with such answer within three business days.
- Once the notification with the answer to the lawsuit has been served, the judge will set a date for the preliminary hearing, which must be held within the following ten business days.
- At the preliminary hearing, the following occurs:
  - (a) the parties will be urged to reach an agreement;
  - (b) the undisputed facts will be determined;
  - (c) the fixing of evidentiary issues will take place;
  - (d) qualification on the admissibility of evidence will take place;
  - (e) summons for the trial hearing within the following 40 days will take place.
- At the trial hearing, the presentation of evidence, pleadings and issue of judgment will take place.

9.4 The Enforcement of Judgments

A foreign judgment may be validly enforced in Mexico, provided that this is not contrary to Mexican public policy.

The requirements for enforcing a judgment issued abroad in Mexico are as follows:

- that the requirements set forth in the Federal Code of Civil Procedures regarding letters rogatory are complied with;
- that it is not a real action;
- that the judge has had jurisdiction to hear and judge the matter;
- that the defendant has been notified or summoned in person;

- that it has the character of res judicata; and
- that the action that gave rise to it is not the subject matter of a lawsuit that is pending between the same parties before a Mexican court and which a Mexican court has previously heard.

9.5 The Enforcement of Arbitration Clauses

As a general rule, in any commercial contract containing an arbitration clause, such a clause is valid and enforceable.

Although it is true that the will of the parties is the supreme law of contracts in commercial matters, including insurance contracts, it is also true that this generic rule in commercial matters is not applicable to the submission agreement when the insured is submitted to the jurisdiction of an arbitration court.

This is because in insurance contracts the aim is to safeguard the rights of the user, and to ensure equity, certainty, and legal security in the relationship between the insurer and the insured. Based on the these premises, the arbitration clause agreed in an insurance contract is not valid in the event of a dispute if it is agreed that it be settled through arbitration, and even more so if the place where the arbitration is to be carried out is different from the place where the insured has his usual place of residence.

Being an adhesion contract, its terms are not negotiable, and although the insured may choose not to enter into it if they do not want to be bound by the terms stipulated therein, this would imply that they could not enjoy the insurance they wish to contract for, which shows that if the consumer wants to enjoy the referred insurance, they are forced to subscribe to the adhesion contract on the terms in which it is drafted and with the conditions imposed by the insurer.

This shows that the insured cannot oppose what was previously stipulated in the referred contract and that therefore there is no evidence that the insured has expressed their will to submit to an arbitration clause.

9.6 The Enforcement of Awards

According to Mexican law, arbitration awards may be validly enforced in Mexico and for such purpose the intervention of the Mexican courts in commercial matters, whether of local, state, or federal jurisdiction, will be required.

Although Mexico is a party to the New York Convention for the enforcement of arbitration awards rendered abroad, its application is not usually very effective, and even the enforcement of an arbitration award in Mexico is usually at least as time-consuming as the arbitration proceeding itself.

9.7 Alternative Dispute Resolution

The authority in charge and empowered to carry out a conciliatory procedure between the insured and the insurer is CONDUSEF, and it is also empowered to act as arbitrator.

Although currently in Mexico there are alternative justice centres in the states that depend on the Superior Courts of Justice of each of the jurisdictions, alternative dispute resolution is still little known and little used, especially in insurance-related matters, where users generally go to CONDUSEF and/or the courts to enforce their rights.

9.8 Penalties for Late Payment of Claims

In terms of Mexican law, in the event that the insurers do not comply with the obligations

assumed in the insurance contract within the terms established for such a purpose, they must pay the creditor an indemnity for late payment.

9.9 Insurers' Rights of Subrogation

The insurer paying the indemnity shall be subrogated, up to the amount paid, in all rights and actions against third parties corresponding to the insured due to the damage suffered.

The insurer may be released in whole or in part from its obligations if the subrogation is prevented by acts or omissions originating from the insured.

The right to subrogation shall not be applicable where the insured has a marital relationship, kinship by consanguinity or affinity up to the second degree, or civil relationship with the person who has caused the damage.

10. Insurtech

10.1 Insurtech Developments

In the insurance sector, the use of technological means has increased every day, both for the distribution, marketing, and operation of insurance, which has been reflected in the modification of the insurance legal framework. Although not to the expected extent, there has also been legislation in various aspects, such as operative areas.

In this regard, in 2018 the "New Model" was implemented, which consists of a model that uses technological tools or means for the rendering of insurance services with modalities different from those existing in the market at the time of granting the authorisation to operate, where such authorisation will be temporary. This model is regulated by the Law to Regulate Financial Technology Institutions and Chapter 41.3 of the Sole Insurance and Bonding Circular.

Through this, a company can be incorporated for a term, to operate insurance through technological means. Among the requirements that are requested for authorisation are the following:

- that the service must be rendered by a controlled means, which represents a benefit to the client;
- that the project must be in a stage of beginning operations and that the project can be started up immediately; and
- that the company must have sufficient means, insurance, guarantees or other mechanisms to compensate the client for any damages caused during the term of the temporary authorisation.

Through this option, a pilot programme operates, which may not be valid for more than one year with a single extension of one more year.

Likewise, insurtech activities have increased in Mexico, including the creation of Asociacion Insurtech Mexico, which estimated that by 2021 there were at least 43 startups engaged in insurtech activity.

10.2 Regulatory Response

In 2018, the Law to Regulate Financial Technology Institutions was issued, through which the services provided by financial institutions through technological means began to be regulated. For insurance matters, such law is also applicable in conjunction with the provisions of the Sole Insurance and Bonding Circular.

As stated in **10.1 Insurtech Developments**, through these provisions insurtech has begun to be regulated, so it is clear that in Mexico there is

a concern and interest to venture into the issues of technological development associated with insurance.

While it is true that there is still a long way to go in terms of insurtech, there is concern both from legislators and from the regulatory entity, the National Insurance and Bonding Commission, to continue developing policies and provisions to achieve progress in insurtech issues.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

In the current scenario, the main emerging risks in Mexico are pandemic diseases, infectious diseases, cybersecurity, social and political movements, and catastrophic risks.

On the one hand, public health continues to be an important risk to be addressed, since, as a result of the COVID-19 pandemic, secondary health effects are just beginning to become known and continue to cause health consequences for the insured population as a whole. Likewise, outbreaks of other diseases have begun to appear in the population, such as simian smallpox and infantile hepatitis.

On the other hand, in view of recent events in the social and political context where there have been several incidents involving hacks, it has also become important to pay attention to cybersecurity issues and also to contingencies due to political matters, such as social movements or even measures adopted by the government that may affect companies.

Finally, catastrophic risks in Mexico are still present, since due to its geographical location, Mexico is constantly exposed to earthquakes and hurricanes.

11.2 New Products or Alternative Solutions

For COVID-19 pandemic issues, health insurance policies contemplated an exclusion of coverage for pandemics or epidemics, which, in most cases, was not applied by the insurers and they covered the claims, registering such modifications to their contracts with the National Insurance and Bonding Commission. In addition, this regulatory authority granted regulatory facilities to insurance institutions so that they could incorporate risks derived from COVID-19 in their products.

Mexican insurance companies have also increased the number of products that include political risks.

Likewise, in recent years, parametric insurance (also known as index insurance) has been evolving and used increasingly, and in Mexico this type of insurance is commonly required for earthquakes and hurricanes, and more recently for pandemics.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Post-Pandemic Regulatory Changes

As noted in **11.2 New Products or Alternative Solutions**, many insurance policies have included changes to the clauses of medical expense insurance policies, in some cases incorporating COVID-19 into their coverage, or limiting the

coverage they provide. In this regard, it should be noted that it was the Mexican insurance companies themselves who incorporated coverage for this disease and, in response to this reaction, the regulatory body, ie, the National Insurance and Bonding Commission, supported the decision and granted facilities so that it would not only remain a matter of practice but would be duly incorporated into regulation.

The COVID-19 claims have not been closed, since the insurance companies are still dealing with judicial disputes of multiple claims resulting from COVID-19 diseases and illnesses, as far as medical expenses and life insurance are concerned.

In view of this panorama, it is very likely that there will be changes in the insurance legal framework, especially with regard to judicial criteria, since the judicial disputes are still ongoing and many of them have yet to be resolved, which will undoubtedly set a paradigm depending on the enforceable obligations and the compliance of the insurers.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Throughout 2022, there have been significant developments in judicial criteria. Relevant regulatory developments include the following:

- in medical expense insurance, prescriptions do not prove the illness claim in trial;
- the obligation of insurers to protect the rights of consumers providing their clients with complete information in a reliable manner; and
- the liability insurance of a car must cover moral damage.

Guerra, Hidalgo y Mendoza, SC was founded in 2020 as a high-tier boutique Mexican firm specialising in bankruptcy and restructurings (both in and out of court) civil, commercial, insurance and bond litigation, arbitration, and other dispute resolution methods. Its partners have more than two decades acting as counsel to individuals, companies, national and international institutions, banking, and government in high-profile disputes. The firm has successfully achieved results in a wide range of complex work, including federal and state, trial and appellate, and through arbitration and other forms of alternative dispute resolution. Its dispute resolution lawyers employ the most appropriate tools and strategies for each stage of the process and each unique situation. Whether through the timely use of innovative alternative dispute resolution techniques or skilful and persuasive work at court, clients can count on the firm's lawyers to maximise their prospects for a successful outcome.

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Trends and Developments

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The New Judicial Interpretation of the Coverage of Non-pecuniary Damages for Automobile Insurance

The protection of consumer interests as a fundamental right

In Mexico, the right to consumer protection has been elevated to constitutional rank and has been one of the most protected rights by the highest courts in recent years, since several judicial criteria have been issued that have laid the foundations of the obligations of insurance companies regarding the obligation to protect the rights of insured parties in their capacity as consumers.

Article 28 paragraph 3 of the Constitution of the United Mexican States provides for the right to protect the interests of consumers, the purpose of which is to counteract the inequalities that may arise between the parties to a consumer relationship, and provides the consumer with the means and legal protection necessary to promote a proper organisation and ensure the best care of his interests in the face of possible disadvantageous situations. In this sense, the aim is to ensure fairness, transparency, and legal certainty in the relationship between consumers and suppliers.

Thus, and as stated, consumer protection has constitutional rank and has been recognised as a fundamental right whose purpose is, essentially, the elimination of inequalities in the consumption process, as well as the organisation and defence of consumer rights, through state intervention, in terms of Article 28 paragraph 3 of the Constitution. Such protection also includes consumers or users of financial services, and particularly those of the insurance sector. In this sense, although the insurance contract is an agreement of wills, there is also a certain inequality between the insurance provider and the users of the insurance or the insured party, since it is generally an adhesion contract, in which there is an imbalance in the positions of the insurer as an expert in the matter and the contracting party or insured party, in terms of compromising or negotiating its general conditions.

The adhesion contract

Contracts whose general clauses are predisposed – that is to say, previously drafted by one of the contracting parties, to uniformly regulate certain conventional relations – are doctrinally called “adhesion contracts”, which are those whose clauses are drafted by only one of the parties, while the other party is limited to accepting or rejecting them without being able to modify them.

In these legal acts there is a will to produce effects, but there is no freedom of configuration of the written content on the part of the adhering party, who must accept or reject the pre-drafted clauses without being able to modify or negotiate them.

Thus, adhesion contracts are created with a clear imbalance between the parties, since the weak contracting party does not have the possibility of negotiating the terms in which the contract must be drafted, leaving said party with only the option of entering into the contract or rejecting it.

The distinctive feature of the adhesion contract is that the parties do not agree on equal terms, nor do they have the possibility of compromising or negotiating as between equals. Therefore, it is highly significant that one of the parties has limited autonomy of will (to the mere "freedom to contract"), since such autonomy is reduced to deciding whether or not to accept the terms of the contract – it thus lacks true "freedom to contract", ie, the freedom to decisively influence the content and regulation of the legal relationship such party enters into.

Thus, the distinguishing feature of the adhesion contract lies in the fact that the clauses are not drafted by both parties, but are predisposed (and sometimes imposed) by one of them to the other, who can only accept or reject them. That is to say, the nature of the adhesion contract does not depend on the fact that it has been drafted by one of the parties, but on the fact that the autonomy of the other party's will is reduced to its minimum expression, either simple acceptance, or limited to small modifications of the articles, and having to adhere fully to what has been previously drafted.

In summary, adhesion contracts are characteristic because:

- their clauses are previously and unilaterally established by a supplier of goods or services;
- all terms and conditions for the acquisition of products or services are set out in uniform formats;
- the offer is made to a community; and
- the contract is drawn up exclusively by one of the parties.

Insurance consumers and the adhesion contract

Pursuant to Article 56 of the Law for the Protection and Defense of Users of Financial Services, an adhesion contract is understood to be a contract prepared unilaterally by a financial institution, whose stipulations on the terms and conditions applicable to the contracting of operations or services are uniform for users.

Additionally, Article 202 of the Law of Insurance and Bonding Institutions states, as applicable, that:

"Insurance institutions may only offer to the public the services related to the operations authorised by this law, through insurance products that comply with the provisions of Articles 200 and 201 of this law.

In the case of insurance products offered to the general public and which are executed and formalised through adhesion contracts, understood as those prepared unilaterally in formats by an insurance institution and in which the terms and conditions applicable to the insured party are previously established, as well as the model clauses prepared to be incorporated through additional endorsements to such contracts, in addition to complying with the provisions of the first paragraph of this article, they must be previously registered before the Commission under the terms of Article 203 hereof. The provisions of this paragraph shall also be applicable to insurance products that, without being formalised through adhesion contracts, refer to group insurance or collective insurance of the operations indicated in Sections I and II of Article 25 of this law, and to surety insurance provided for in subsection (g), Section III of Article 25 hereof."

The automobile insurance contract in Mexico

The primary purpose of insurance contracts, particularly automobile insurances, is to protect the insured automobile with respect to a third party's property with which it may have an incident or accident. However, depending on the coverage, it usually also protects the drivers, passengers and third parties involved in an incident or accident.

In Mexico, in accordance with the Law of Roads, Bridges and Federal Motor Carriers, all vehicles travelling on federal highways, roads and bridges must have a mandatory vehicle liability insurance that guarantees third parties for damages that may be caused to their property and persons. In addition, the Mexico City Traffic Regulations establish that motorists travelling in Mexico City must have a current civil liability insurance policy covering at least civil liability for damages to third parties, both personal injury and property.

In this sense, and as a matter of law, in order to drive a vehicle it is necessary to have a mandatory insurance policy covering civil liability.

By virtue of the foregoing, the driver of a vehicle, even if he is not the contracting party or directly insured, is the beneficiary of the insurance coverage contracted as a user.

In the case of compulsory automobile insurance, such insurance limits the autonomy of the will or contractual freedom and imposes on the insurer the obligation to establish the necessary conditions to comply with the legal provision required by compulsory insurance.

Civil liability in Mexico

Civil liability refers to the obligation of a person to repair the damages caused to another person as a result of an action or omission deriving from the breach of a contract or a duty of care.

According to the doctrine and particularly the theory of civil liability, the person who causes damage to another is obliged to repair it. This damage may be caused by a breach of contract or the non-compliance of the generic duty of every person not to harm another. The first case is known as contractual liability, and the second as tortious liability. In turn, tortious liability may be subjective or objective. Subjective liability is based on the conduct of the tortfeasor, while in objective (or strict) liability the subjective element is absent – ie, fault or negligence, since the damage is caused by the involvement of risk of a good that is considered dangerous.

In the Mexican legal system, subjective and strict liability are regulated, respectively, in Articles 1910 and 1913 of the Federal Civil Code. These legal provisions define subjective liability as that duty to repair the damage caused to a third party when said damage has been caused by the defendant's negligent or culpable conduct, while strict liability is that derived from the damage generated by the materialisation of the risk caused by a good considered dangerous.

In conclusion, *the legal right protected* by both subjective and objective civil liability is precisely *the indemnity* for damages caused by an unlawful conduct or by a created risk. This is on the understanding that such indemnity must be fair and comprehensive, which implies returning things to the state in which they were (the re-establishment of the previous situation), and if this is not possible, establishing the payment of an indemnity as compensation for the damages caused when the duty to repair arises.

Non-pecuniary damages in Mexico

In terms of Mexican civil law, non-pecuniary damages are understood as the effect that a person suffers in his feelings, affection, beliefs, decorum, honour, reputation, private life, prestige or physical appearance. Non-pecuniary damage is believed to exist when the freedom or physical or psychological integrity of persons is illegitimately violated or impaired.

From the foregoing, it can be inferred that in Mexico non-pecuniary damages are regulated as a subjective appreciation effect suffered by a person and that, without expressly stating it, derives from an unlawful act, being that this damage affects rights of a non-monetary nature, ie, that in themselves do not have an economic appreciation.

Thus, it is appropriate to define non-pecuniary damage as the *injury to a non-pecuniary (or spiritual) right or interest that is assumed based on a subjective right.*

Non-pecuniary damage is autonomous and independent to material damage and proceeds by contractual and tortious liability.

The right to full reparation or fair indemnity

The right to full reparation or fair indemnity implies that the person who suffered a damage caused by another person (who has no obligation to compensate) should be returned to the state in which he/she was, or that indemnity should be fixed for such a situation. This necessarily includes satisfying any type of damage caused, whether pecuniary or moral.

Unconstitutionality of the exclusion of non-pecuniary damages from the civil liability coverage in the automobile insurance contract

Recently, the First Chamber of the Mexican Supreme Court of Justice issued Court Precedent number 1a/J 122/2022 (11th) (which is mandatory for all courts in the country), upon resolving the direct writ of amparo under review filed by an insurance company, in which, among other issues, it was determined:

"...that in a compulsory vehicle insurance contract, the civil liability coverage must be comprehensive; that is to say, it must include both material damage and non-pecuniary damage, up to the amount of the insured sum. Therefore, automobile insurance contracts with such coverage, which exclude non-pecuniary damages, are not an effective insurance and their relative clause is unconstitutional since such exclusion cannot be valid to the detriment of the insured or third-party driver entitled to benefit from the insurance in the same position of the former."

The considerations on the part of the Mexican Supreme Court of Justice were, in the relevant part, the following:

"100. Therefore, the issue to be resolved in this case is to determine whether it is appropriate for the insurer, in the liability coverage of the automobile insurance, to exclude (on the basis of the insured amount), the corresponding indemnity for non-pecuniary damages.

101. Thus, in terms of the useful effect of the automobile insurance contract, it is logical that, in the case of civil liability, this should be covered in its entirety; that is to say, contemplating both the material and non-pecuniary damages, of course, up to the amount of the insured

sum. This is also coherent with what the traffic regulations refer to as regards guaranteeing the damages that may be caused to property and persons. Otherwise, the contract would lack effectiveness in terms of its intrinsic purpose and intention in accordance with the regulations on the matter (supra paragraphs 69 to 70), directly impacting the rights of the insured, users and third parties entitled to benefit from the contract. The foregoing could even generate a distortion for, for example, third parties involved in an incident, who, depending on the insurance contracted by the car that caused the incident and its "liability exclusions", could or could not have damages they suffered covered in a known and effective manner.

102. In accordance with the foregoing, the Insurance Contract Law contemplates liability insurance, by virtue of which the insurance company is obligated up to the limit of the insured amount and the right to indemnity corresponds to the damaged third party, in accordance with Articles 145 and 146 of said legislation, (46) without the exclusion of non-pecuniary damages (47).

103. In view of this, even though the insurance contract is governed by the constitutional principle of contractual freedom, although limited in the case of compulsory insurance, an exclusion of non-pecuniary damages cannot be valid in vehicle insurance with civil liability coverage, because it is notorious that it would not comply with its purpose of protecting the patrimony of the insured or third-party driver entitled to the insurance benefits, since the risk run with the use of vehicles generally implies liability for both types of damage.

104. On the other hand, it does not go unnoticed that when the insurance companies calculate the insurance costs and the premiums to be paid by the contracting party, they determine these according to the insured sums for which they accept to be liable; they even insure the fulfilment of the obligations contracted according to the insured sums, so there is no objective and reasonable justification for establishing exclusions of non-pecuniary damages if, in the end, the maximum obligation they assume does not go beyond the insured sum.

105. In this regard, it is reiterated that the expert in the contractual relationship is the insurer and not the clients, who in most cases are unaware of the different concepts that may be involved in an accident in which damages are caused to third parties with the use of vehicles; not so the insurer, who knows well, as part of its business activity, the implications of an incident in this line of business. Therefore, it is not admissible to accept as an effective insurance that which excludes non-pecuniary damages in the civil liability coverage, because with this, it can be presumed the sale of an illusory insurance that will not protect the patrimony of the client and its users to the extent needed. It is reiterated, without any valid justification being observed, if the insurer, in any way, already calculates and charges a premium, which considers the total amount for which it is obliged in the sum insured.

106. Therefore, since there is no objective and reasonable justification for excluding non-pecuniary damages from the civil liability of a compulsory vehicle insurance, such exclusion is not valid and should not operate to the detriment of the insured or third-party driver entitled to benefit from the insurance in the same position of the former."

Conclusions

Judicial disputes in insurance matters and their resolutions generate more and more case law

and transcendental changes in the regulation of insurance operations. Recently, the change that they generated was with respect to compulsory vehicle insurance. The Supreme Court of Justice determined that, for such products, the civil liability coverage must contemplate the payment for non-pecuniary damages and the contracts that exclude such coverage are ineffective, making the stipulation of such clauses unconstitutional.

In this respect, the implementation of the risk of non-pecuniary damages within the civil liability coverage for automobile insurance seems to represent an immeasurable contingency for the insurers, since they would assume risks that they cannot face. The payment for non-pecuniary damages also depends on many factors and, from the beginning of the insurance subscription, it would be very unlikely that they would determine how much a judgment would amount to and on that basis decide whether or not to assume the risk. However, the Court pointed out that the amount for which the insurer will be liable will always be the sum insured of each contract; therefore, the payment of the claim is not left open and insurers are not burdened with assuming risks that they cannot assume.

Conversely, the Court's precedent implies for insurers the implementation of changes in their vehicle insurance products, changes within their actuarial calculations for their reserves and implementation of policies for their underwriting and claims resolution departments, since the Court's decision implies that they incorporate a new risk to their products, which, although in some cases was implicitly contemplated (by contemplating the coverage of property damage), must now be regulated even more rigorously in accordance with the guidelines of the highest court.

Finally, the determination of the Supreme Court of Justice should not only be seen as the implementation of the coverage of non-pecuniary damages for automobile insurance, but also as the implementation of consumer (insured) protection rules in insurance matters, which the Court increasingly dictates by applying them to particular cases (in this case to specific insurance products), and which insurance companies must take into account in the implementation of their products and in the resolution of their claims.

Guerra, Hidalgo y Mendoza, SC was founded in 2020 as a high-tier boutique Mexican firm specialising in bankruptcy and restructurings (both in and out of court) civil, commercial, insurance and bond litigation, arbitration, and other dispute resolution methods. Its partners have more than two decades acting as counsel to individuals, companies, national and international institutions, banking, and government in high-profile disputes. The firm has successfully achieved results in a wide range of complex work, including federal and state, trial and appellate, and through arbitration and other forms of alternative dispute resolution. Its dispute resolution lawyers employ the most appropriate tools and strategies for each stage of the process and each unique situation. Whether through the timely use of innovative alternative dispute resolution techniques or skilful and persuasive work at court, clients can count on the firm's lawyers to maximise their prospects for a successful outcome.

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The sources of insurance law in New Zealand are primarily from the law of contract, as well as insurance principles at common law. There are some specific statutes that apply to particular types of insurance (for example, the Life Insurance Act 1908 and Marine Insurance Act 1908). Two other relevant statutes are the following.

- The Insurance Law Reform Act 1977 (ILRA) applies to contracts of insurance. In summary, it regulates misstatements, requires a link between a breach of policy terms and the loss before an insurer can rely on that breach, and stipulates that an insurer can only rely on a time limit for notifying a claim where the insurer has been prejudiced by the late notification.
- The Insurance Law Reform Act 1985 revoked the insurable interest requirement from policies, and regulates the sale of life insurance products to minors.

Reinsurance contracts are generally regulated by the common law.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Insurance and reinsurance activity in New Zealand is regulated both in terms of conduct and prudential requirements. New Zealand's Reserve Bank (RBNZ) regulates insurers and reinsurers carrying on insurance business in New Zealand.

The Financial Markets Authority (FMA) monitors insurers in relation to the financial advice they give and investment products they sell (including policies of insurance).

Conduct Requirements

Conduct requirements are prescribed by the Financial Advisers Act 2008, which regulates financial advisers providing financial advice relating to insurance policies.

Advisers are required to register on the Financial Service Providers Register (FSPR) (Financial Service Providers (Dispute Resolution and Registration) Act 2008). The FMA supervises the FSPR.

Insurers providing services to retail customers must be members of an approved dispute resolution scheme. This does not apply to reinsurers.

Life insurance policies must comply with the Financial Markets Conduct Act 2013 (policies sold after 1 December 2014).

Codes of conduct apply to most insurers. Almost all life insurers belong to the Financial Services Council, which has a Code of Conduct members must comply with. The Insurance Council of New Zealand (ICNZ), of which most major insurers are members, also has a Fair Insurance Code that requires its members to act ethically and to be financially sound.

Prudential Requirements

The Insurance (Prudential Supervision) Act 2010 (IPSA) sets the regulatory and prudential requirements framework for insurers carrying on business in New Zealand.

Under the IPSA, insurers and reinsurers are treated in the same way, with the regime applying to

every "person" carrying on insurance business. A "person" includes a company or association of persons operating or formed in New Zealand. If the "person" meets the registration requirements under the Companies Act 1993, they are also subject to the IPSA regime.

The "carrying on business" test is met if the person acts or has acted as an insurer in New Zealand or elsewhere, and the person must also be liable to a New Zealand policyholder under a contract of insurance.

General Regulation

Insurers carrying on business are also subject to corporate tax and company statutes, as well as consumer protection and anti-money laundering legislation, including as follows:

- the Anti-Money Laundering and Counter Financing of Terrorism Act 2009;
- the Companies Act 1993;
- the Consumer Guarantees Act 1993;
- the Contract and Commercial Law Act 2017;
- the Fair Trading Act 1986;
- the Financial Reporting Act 2013;
- the Goods and Services Tax Act 1985;
- the Income Tax Act 1994;
- the Tax Administration Act 1994; and
- the Taxation Review Authorities Act 1994.

2.2 The Writing of Insurance and Reinsurance

The RBNZ licenses insurers and reinsurers, and applies the IPSA regime (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**).

A licence is required to carry on insurance business in New Zealand. There are no specifically different licensing requirements between the requirements for writing consumer insurance, SME insurance and corporate insurance.

The insurer must demonstrate to the RBNZ that its governance processes and risk management processes are adequate, and that its directors and senior managers are fit and proper (including the appointed actuary).

The RBNZ can issue a licence subject to conditions.

The IPSA regime exempts overseas insurers from compliance with some provisions where its home jurisdiction imposes solvency and fit and proper requirements that are equivalent to those in New Zealand.

There is no distinction in the IPSA regime applying to the underwriting of excess layers or to reinsurance contracts.

2.3 The Taxation of Premium

General (Non-life) Insurers

Persons carrying on a general (non-life) insurance business in New Zealand are subject to income tax in the same manner as any other taxpayer in business, although specific rules apply to insurers in relation to timing and recognition of income.

General insurance and reinsurance premiums paid offshore to non-resident insurers, with no taxable presence in New Zealand, are taxable at 2.8% of the gross premium amount. Companies or persons paying a premium are treated as being the non-resident insurer's agent and must obtain a separate Inland Revenue Department (IRD) number and account for the tax on the premium income.

Agency obligations also extend to other New Zealand residents – for example, brokers – who may initially collect premiums for payment to a non-resident insurer. If there is any default, the insured person is responsible for the tax.

The following insurers are required to register for and return goods and services tax (GST) at the rate of 15% on premiums charged to persons that are resident in New Zealand, as follows:

- general insurers that operate through a fixed establishment in New Zealand and enter into business-to-business and/or business-to-consumer insurance contracts; and
- non-resident general insurers that enter into business-to-consumer insurance contracts.

However, these insurers are able to recover as a credit the "tax fraction" (three twenty-thirds) of any payments made for claims under those contracts of insurance.

No GST is payable by GST-registered general insurers on reinsurance premiums paid to non-resident reinsurers.

Life Insurers

Life insurance income is generally only taxable in New Zealand to the extent that policies are offered or entered into in New Zealand. The 2.8% of gross premium tax rules that apply to payments of premium to non-resident general insurers do not apply to payments of premium to non-resident life insurers.

Life insurance premiums are exempt from GST, and GST credits cannot be claimed in respect of payments made for claims under contracts for life insurance.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Overseas-based insurers and reinsurers are able to carry on business in New Zealand if they are licensed by the RBNZ (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance** and **2.2 The Writing of Insurance and Reinsurance**). The RBNZ must be satisfied that the insurer's ownership and governance structures are appropriate for the size and nature of its business.

The RBNZ's Governance Guidelines direct it to consider, as relevant, beneficial ownership of an insurer and whether the insurer is part of a group. The RBNZ can also consider the personal behaviour, business conduct and judgement of the individuals who ultimately own the insurance business (including syndicate leads).

Lloyd's of London has a licence with the RBNZ that allows Lloyd's members to carry on business in New Zealand. Lloyd's members must comply with some aspects of the IPSA regime. However, the RBNZ has a wide power to exempt these underwriters from IPSA requirements.

3.2 Fronting

Fronting is not prohibited in New Zealand but is likely to be subject to scrutiny as part of the RBNZ licensing approval process.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Most merger and acquisition activity relating to insurance companies in New Zealand in 2022 was connected with life insurance:

- Cigna Corporation sold its life insurance business to the Chubb Group, with the sale effective from 1 July 2022; and
- Partners Life, one of New Zealand's leading life and health insurance providers, was acquired by Japanese life insurance giant Dai-ichi Life Holdings in August 2022.

Provided there are no licensing issues, and that any mergers will not substantially lessen competition in the market, there is no impediment to mergers and acquisitions relating to insurance companies.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The distribution of insurance and reinsurance products in New Zealand depends largely on the type of insurance product.

Consumer insurance – including home and contents, motor, boat, health and life insurance – are offered both through intermediaries and directly to the public.

Two unique forms of statutory insurance cover in New Zealand are as follows:

- natural disaster cover under the Earthquake Commission Act 1993, which provides cover for up to NZD150,000 plus GST, including for property damage caused by earthquake, landslip, volcanic eruption or tsunami; and
- personal injury cover under the Accident Compensation Act 2001, which also bars the bringing of legal proceedings for personal injury except in very limited circumstances.

Commercial insurance is heavily intermediated through larger broking houses.

Home and Contents

New Zealand home policies typically insure a property (and the contents within) for accidental loss or damage. These policies are typically written subject to sum-insured limits on floor area and special features following the Canterbury Earthquakes (the former practice was indemnity value). This product is sold both directly to the market by insurers, as well as through intermediaries and major domestic banks (but is underwritten by usual domestic insurers).

Health

New Zealand has a comprehensive public health system, but also a network of private healthcare providers. Policies offered typically provide cover for elective procedures that might otherwise require a lengthy wait for the same procedure in the public system.

Motor

Motor policies are offered for both domestic and business use. It is common for insurers to offer policies covering third-party liability, and optional fire, theft and windscreen replacement protection, for a substantially reduced rate compared to comprehensive replacement insurance.

Life

Life policies – including death, trauma, permanent disability and income protection policies – are primarily offered directly to consumers and

through a number of web-based product comparison providers.

Corporate

Many corporates in New Zealand avail themselves of various combined insurance products available from major insurers. These typically comprise broadform third-party cover, property damage, employer liability, directors' and officers' cover, and professional liability, as well as business interruption and contractors' works insurance. A unique feature of New Zealand policies is a no-fault statutory liability cover, which typically provides cover for legal liability for fines or penalties, the costs of defending a prosecution and/or for unintentional breaches of an act of Parliament (note that New Zealand's health and safety legislation, however, prohibits insuring against a fine).

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Both an insurer and an insured owe each other a duty of utmost good faith.

The insured must disclose all material circumstances and not misrepresent facts to the insurer. This duty applies when entering into the insurance contract, as well as during the currency of the insurance policy.

Material circumstances are those a prudent insurer would take into account when calculating the premium, providing terms and conditions to the particular insured or risk, or deciding whether to insure the risk.

The insurer also has an implied obligation to pay claims within a reasonable time of their being lodged. The insurer must also disclose all relevant documents to the insured that relate to the investigation of the claim by the insurer.

See **12.1 Developments Impacting on Insurers or Insurance Products** regarding the review of insurance contract law that has been signalled by the New Zealand government. The scope of the review includes the potential reform of disclosure obligations and narrowing the broad remedies available to an insurer for non-disclosure and misrepresentation (and on this point, see **6.2 Failure to Comply with Obligations of an Insurance Contract**). The review signalled by the government covers all forms of insurance.

6.2 Failure to Comply With Obligations of an Insurance Contract

An insurer may avoid an insurance contract ab initio if the insured does not disclose relevant information, or makes a material misrepresentation at policy inception or on renewal.

The ILRA regulates the types of misstatement that an insurer may rely on in avoiding life insurance and other insurance policies. Marine insurance policies are governed by similar principles to the ILRA under the Marine Insurance Act 1908 (MIA).

An insured may bring an action against the insurer for a breach of the duty of utmost good faith. This can arise from failures in claims handling processes.

The most typical form of redress for an insured where there is a failure to act in good faith is by complaint to a dispute resolution service (see **6.6 Consumer Contracts or Reinsurance Contracts** and **9.7 Alternative Dispute Resolution**). The dispute resolution service first investigates the complaint, and typically conciliates the issue.

Other alternative dispute resolution methods are also used; for example, mediation. If there is no conciliated or mediated outcome, the dispute resolution service will issue a binding decision up to a certain limit.

6.3 Intermediary Involvement in an Insurance Contract

A broker typically acts on behalf of the insured; for example, at the time of obtaining cover and making a claim. However, at the time of negotiating an insurance contract, the broker may act on behalf of the insurer. In that case, its role as an agent of the insurer is to procure persons to insure with that insurer rather than with any other.

Where acting for an insured, brokers have a general duty to exercise reasonable care and skill in all the circumstances, and to act as a reasonable and competent broker would in the insurance market at the same time. Brokers also have a number of other duties that apply at different times and are owed to different parties, including as follows.

- Where instructions are sent by email and are unconditional, the broker has a duty to act on those instructions and has no duty to confirm them or check that they have been duly received.
- The broker has a duty to procure insurance for the insured within a reasonable time.
- The broker must explain to the insured the scope of the cover provided in the insurance contract and whether this meets their requirements.
- While the broker must ensure the policy is reasonably fit for the insured's needs, it is not required to find the insured the cheapest insurance of its type in the market for the particular risks covered.
- Brokers also have duties in relation to disclosure. The broker must ask questions and obtain all material facts from the insured, but it also has an independent duty to the insurer to disclose to the insurer those material facts known to it (Marine Insurance Act 1908, Section 19).

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

A contract of insurance is defined as "a contract involving a transfer of risk and under which a person (insurer) agrees, in return for a premium, to pay to or for the account of another person (policyholder) a sum of money or its equivalent, whether by way of indemnity or otherwise, on the happening of one or more 'uncertain events'" (Section 7(1) of the IPSA).

Contracts of reinsurance come within the definition of a contract of insurance.

An "uncertain event" means an event about which, from the policyholder's perspective, there is an element of uncertainty as to when or whether it will take place, and that event is beyond the insurer's control (Section 7(2) of the IPSA).

A contract of insurance is binding if it complies with the following general contractual principles:

- the parties intended to create legal relations;
- there was a valid offer and acceptance;
- the terms are certain; and
- each party provided consideration.

There are no prescribed legislative requirements as to the form and content of life insurance policies. In New Zealand, typical market practice is for the contract to be in writing. The policy can

only be mortgaged, transferred or assigned if it is in writing.

The requirement for an insurable interest in life insurance and indemnity policies was abolished in New Zealand in 1985 (under the Insurance Law Reform Act 1985).

6.5 Multiple Insured or Potential Beneficiaries

Third parties cannot generally make a claim under an insurance contract, in accordance with the privity of contract doctrine.

A third party can claim under a contract where the contract allows such a claim or confers a benefit on that third party (Contract and Commercial Law Act 2017, or the CCLA); typically, such third parties are named on the placing slip or policy schedule (or the terms of a policy may automatically extend cover to parties directly involved in the risk, such as on a contract works (all risks) policy). Many policies exclude the application of the privity provisions of the CCLA.

A third-party plaintiff can claim directly against the insurer of an insolvent insured defendant. An amount equal to the liability incurred by the insured to the third party crystallises as a charge on the insurance monies from the date of the event giving rise to the liability (Section 9 of the Law Reform Act 1936). A third party claiming in this manner requires the leave of the High Court to commence the claim.

6.6 Consumer Contracts or Reinsurance Contracts

Reinsurance

Reinsurance contracts are regulated in the same way as other contracts of insurance under the IPSA regime. The FMA regulates both insurance and reinsurance companies regarding financial advice they give, and certain investment products that they sell.

Consumer Contracts

Insurers are subject to the consumer protection provisions in the Consumer Guarantees Act 1993 and the Fair Trading Act 1986 (FTA). The FTA prohibits unfair contract terms in standard-form consumer contracts.

Arbitration clauses in contracts for consumer insurance are not binding under the ILRA. It is more common for consumers to access the dispute resolution procedures required under the Financial Service Providers (Registration and Dispute Resolution) Act 2008. This ensures that customers have access to a free dispute resolution service if they have a dispute with their insurer. Reinsurers are not required to register.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

New Zealand insurers engage in conventional reinsurance rather than ART products and the regulator has yet to pronounce on whether ART would suffice to satisfy the reinsurance requirements demanded of insurers regulated in New Zealand.

In principle, however, New Zealand regulators can grant permission for an insurer to carry on insurance business if it is satisfied that the insurer has sufficient security to meet claims, even without reinsurance.

7.2 Foreign ART Transactions

See **7.1 ART Transactions**.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

A policy of insurance is a contract between the insurer and the insured, and it is subject to the same rules of interpretation that apply to any contract in New Zealand (see **1.1 Sources of Insurance and Reinsurance Law** and **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract**).

As a general rule, New Zealand law excludes extrinsic evidence regarding the previous negotiations of the parties where an objective reading shows the parties intended the contract to bear a particular meaning. Words are to be given their ordinary and natural meaning and the policy should be treated as a whole.

Other inadmissible evidence in the insurance context includes declarations of subjective intent and premium calculations used by the underwriters. Such evidence may, however, be relevant to the question of whether there was a misrepresentation or mistake vitiating the contract. Evidence relating to the content of earlier insurance contracts between the parties is admissible.

Most policies written in New Zealand will incorporate the insured's original proposal by reference.

8.2 Warranties

A warranty is a promise by the insured to do or not do some particular thing ("promissory warranty") or an undertaking by the insured that a particular fact does or does not exist ("affirmative warranty"). Warranties in an insurance contract do not need to be expressly described as such.

The formal requirements for the creation of a warranty are outlined in Section 36(2) of the Marine Insurance Act 1908, and the general principle is that a warranty is expected to be found on the face of the policy itself.

At common law, warranties had to be strictly complied with. If a warranty was breached, the risk was discharged automatically, and the insurer had the right to repudiate the contract from the time of the breach. The Contract and Commercial Law Act 2017 and the ILRA restrict an insurer's common law rights to repudiate a contract or deny liability under it for a breach of a warranty or a condition.

8.3 Conditions Precedent

A condition precedent may be created in a number of ways and does not need to be expressly described as such:

- the consequences of a breach of condition may be clearly prescribed;
- the condition may be expressly described as a "condition precedent";
- the policy may contain a general clause that describes all conditions as conditions precedent; and
- it may be implied by the wording or the significance of the condition that it was intended to be a condition precedent.

These clauses are generally construed narrowly by the courts. The relevant act or omission must fall precisely within the language of the policy for there to be a breach. A breach of a condition precedent entitles the insurer to avoid liability under the policy altogether.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Coverage Disputes

Beyond the complaints procedures dealt with by the dispute resolution services (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**, **6.6 Consumer Contracts or Reinsurance Contracts** and **9.7 Alternative Dispute Resolution**), the civil courts of New Zealand will typically deal with insurance disputes as follows.

- The District Court has general civil and commercial jurisdiction to deal with insurance disputes of up to NZD350,000.
- The High Court typically deals with disputes with a value exceeding NZD350,000. Most commercial insurance disputes are dealt with in the High Court, which has a special "Earthquake list" court that operates and streamlines hearing of the large volume of cases arising out of the Canterbury Earthquake sequence of 2010–11.
- The Canterbury Earthquakes Insurance Tribunal was established in 2019 and is an alternative resolution body for resolving disputes about earthquake insurance claims for physical loss or damage to residential buildings, property and land.

A judge alone hears insurance disputes in the New Zealand courts.

Limitation

A claim must be brought within six years of the act or omission on which the claim is based, with limited exceptions (including where the claimant has late knowledge).

Policies may include shorter limitation periods. Section 9 of the ILRA prevents an insurer from relying on such a limitation period unless the insurer has suffered prejudice by reason of non-compliance.

Third Parties

See **6.5 Multiple Insured or Potential Beneficiaries**. Note that an insured has no direct claim against a reinsurer if the reinsurer refuses to pay, because the relationship between the insurer and the reinsurer is a contractual one and not one of assignment, agency or partnership.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Parties are generally free to choose the jurisdiction and choice of law, including as set out in an insurance contract.

In the absence of an express choice-of-jurisdiction clause, the courts take into account a wide range of (mainly practical) factors in determining jurisdiction, including:

- whether the parties, witnesses and evidence are located in New Zealand;
- what the governing law of the insurance contract is;
- what relief a New Zealand court could grant; and
- whether there are already overseas proceedings under way.

9.3 Litigation Process

Insurance litigation in New Zealand is typically conducted in the High Court (usually for claims over NZD350,000). The District Court may also hear insurance disputes (for claims up to NZD350,000).

Most insurance litigation is resolved through private mediation before it gets to a full hearing in

court. Alternatively, a judge may assist parties at a judicial settlement conference.

A typical commercial insurance case heard on the ordinary track in the High Court will take between two and three years from filing to get to a full hearing, assuming there are no significant interlocutory applications to be heard. Complex proceedings will take longer. There is a fast track available, but this is not regularly used.

A party generally has the right (without leave) to appeal to the Court of Appeal, and, in turn (but with leave), to the Supreme Court. Appeals or applications for leave to appeal must generally be made within 20 working days of the decision being made.

9.4 The Enforcement of Judgments

New Zealand judgments are enforced through the civil courts. The most common form of enforcement against a domestic commercial party is liquidation.

Foreign judgments may be enforced in New Zealand, but require a judicial process in New Zealand first:

- Australian civil court judgments against someone in New Zealand may be registrable in New Zealand and enforced in New Zealand under the Trans-Tasman Proceedings Act 2010;
- New Zealand has reciprocal agreements with certain countries under the Reciprocal Enforcement of Judgments Act 1934, which allows judgments (from some common law countries) to be enforceable in New Zealand; and
- other judgments, such as those from the United States of America, may be enforceable at common law in New Zealand, but require proving in a New Zealand court first.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses in commercial insurance and reinsurance contracts are enforceable in New Zealand. Arbitration clauses are not binding in consumer insurance.

An arbitration agreement may be made orally or in writing. It is typically contained as a clause in a contract, or a separate agreement. There is no form of words specifically required under the Arbitration Act 1996 (the "Arbitration Act").

In New Zealand, the courts generally endeavour to give effect to the intention of parties to refer disputes to arbitration. Courts will strive to give arbitration clauses a broad interpretation. This policy reflects the objective of the Arbitration Act 1996, which encourages the use of arbitration in New Zealand to resolve disputes.

Under the Arbitration Act, court intervention in the conduct of arbitration is limited. The High Court may intervene in the arbitration process to make interim orders:

- where the parties cannot agree on the appointment of an arbitrator;
- to determine the jurisdiction of the arbitral tribunal; and
- on questions of law on an appeal from an arbitral tribunal.

9.6 The Enforcement of Awards

Regardless of the country in which it was made, an arbitral award must be recognised as binding. On a written application to the District Court (for awards of less than NZD350,000) or the High Court (for awards of NZD350,000 or more), arbi-

tral awards must be enforced by entry as a judgment in terms of the award, or by action (Arbitration Act 1996, Second Schedule, Article 35).

The District Court Rules 2014 and the High Court Rules 2016 outline the procedure for recognising and enforcing arbitral awards.

New Zealand is party to a number of international conventions, which are transposed into New Zealand's Arbitration Act.

- The Geneva Convention on the Execution of Foreign Arbitral Awards (opened for signature in Geneva on 26 September 1927), implemented by the Arbitration Act (Schedule 3).
- The Convention on the Recognition and Enforcement of Foreign Arbitral Awards (adopted in New York by the United Nations Conference on International Commercial Arbitration on 10 June 1958) (the "New York Convention"), implemented by the Arbitration Act (Schedule 3).
- The Washington Convention on the Settlement of Investment Disputes Between States and Nationals of Other States (18 March 1965). New Zealand became a signatory on 2 September 1970 and the statute implementing this Convention is the Arbitration (International Investment Disputes) Act 1979.

9.7 Alternative Dispute Resolution

Alternative dispute resolution plays a significant role in the resolution of commercial insurance disputes in New Zealand, in particular, mediation (see **9.3 Litigation Process**).

Consumer insurance disputes tend to be resolved by scheme dispute resolution providers. Insurers must have an internal dispute resolution process that must be followed first. If resolution is not achieved, a consumer may refer the complaint to the relevant dispute resolution scheme.

There are four approved schemes currently operating in New Zealand, as follows.

- The Banking Ombudsman.
- The Insurance and Financial Services Ombudsman (IFSO) – most insurers in New Zealand are members of this scheme. The IFSO can make decisions on complaints that are binding only on insurers. The IFSO typically confines any awards within policy terms. It has a limited discretion to award up to NZD3,000 for special inconvenience or cost to the customer.
- The Financial Dispute Resolution Service.
- Financial Services Complaints Limited.

9.8 Penalties for Late Payment of Claims

Insurers in New Zealand do not typically face punitive damages claims. It is possible for general damages to be awarded for the late payment of claims if insurers improperly delay settling claims, which would be at a nominal amount, but this is not typical.

9.9 Insurers' Rights of Subrogation

Insurers may exercise the rights of the insured in pursuing a third party for the insurer's loss in meeting the indemnity under its contract of insurance. There is no need to have a separate clause entitling subrogation, as this is an implied term in insurance contracts. However, the contract itself may also expressly state such a term.

10. Insurtech

10.1 Insurtech Developments

Insurtech developments in New Zealand are limited to date. Some insurers have developed

web-based apps for their clients to access, but which are typically only portals to access basic information and submit claims.

There are some recent notable insurtech product innovations.

- AIA Vitality is a health and well-being programme that AIA policyholders may subscribe to, and access via a smartphone app and connected devices (eg, a smartwatch). Greater participation in the programme generates policy benefits (including premium discounts) and other rewards to redeem at health and well-being retailers.
- Tower Insurance (Tower) has developed a smartphone app called "GoCarma", which monitors a driver's performance and uses averages to analyse those driving habits. Tower policyholders can be rewarded with discounts on excesses for safe driving habits. Tower states that scores using the app will not affect the premiums a person pays or any other conditions of policy cover.

10.2 Regulatory Response

The RBNZ does not have a formal position on insurtech issues. The products described in **10.1 Insurtech Developments** require compliance with privacy laws, which are regulated by the Privacy Commissioner.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Cyber

Cyber-risks to institutions such as insurers are increasing. The RBNZ recently issued non-binding guidance in April 2021, intending to ensure insurers have a sound risk management and auditing framework in place to assess, monitor and respond to cyber-risks. The guidance intends to raise awareness among boards and senior management, and to promote accountability for managing cyber-risk within institutions (including insurers).

Environmental Liability

The New Zealand courts are taking a strict approach to environmental liability, particularly given how damaging the consequences of a pollution incident can be on the environment. Insurance providers in New Zealand are beginning to offer cover for environmental liability, which can include cover for risks such as bodily injury, property damage and/or environmental damage caused by sudden or gradual pollution incidents arising from the insured's property or that occur when the insured is providing services. These types of policies can also cover the cost of emergency response, where there is a legal obligation to contain and/or remediate environmental contamination.

Statutory Liability

A policy unique to New Zealand and Australia is cover for statutory liability. This policy provides cover for legal liability for fines, penalties or reparation, and for costs of defending a prosecution, for unintentional breaches of an act of Parliament. The theme in coverage and exclusion clauses is that strict liability offences are covered, as these offences require no intent or negligence to prove a contravention. Intentional and reckless behaviour is therefore specifically excluded, as is continuous offending. Liability under specific acts is also excluded, such as the Crimes Act 1961.

UAV Operators' Liability

Rapidly emerging and developing technologies have demanded a new form of insurance for operators of unmanned aerial vehicles (UAVs) in New Zealand. Insurance providers are now offering tailored cover for these operators that address specific risks associated with this area of technology. For example, the policy may cover damage to the UAV itself (including the airframe, launch station and ground control system), third-party liability, statutory liability and potential risks in relation to privacy.

Climate Change

New Zealand experiences a wide range of natural hazards, from earthquakes and volcanoes to erosion, landslides, and extreme weather events. Climate change is increasing the severity and frequency of some of those hazards, including flooding, heatwaves, drought, and wildfire. Claims for property damage have increased accordingly. The government has released a National Adaption Plan to consider various alternatives, including options to support access and affordability of flood insurance, or managed retreat from areas where insurers will no longer provide cover.

11.2 New Products or Alternative Solutions

The New Zealand market is responding to emerging risks by offering new products into the market such as cyber, environmental and UAV operator liability cover, as outlined in **11.1 Emerging Risks Affecting the Insurance Market**.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

COVID-19 significantly slowed the operation of the courts in New Zealand in 2021 and 2022, and is forecast to continue to do so into 2023.

While the courts were considered an "essential service", a typical insurance litigation claim was not considered as a priority proceeding. This has resulted in a substantial backlog of non-priority cases, though courts are steadily addressing this backlog.

One way of resolving the backlog has come about from a review into access to justice. The Rules Committee, the body responsible for the rules of procedure in New Zealand's courts, has recommended a range of reforms. These will increase the resourcing of the judicial system, with more judges available for civil claims, and will also encourage parties to engage with the substance of a dispute earlier, determining the real issues, and promoting settlement. For those cases that go on to a hearing, the parties should be able to reach that stage faster, and at less expense. If accepted, these proposals will likely come into effect in 2023.

COVID-19 has also caused delays in insurance law reform, as follows.

- The Financial Services Legislation Amendment Act 2019 (FSLAA) was passed in April 2019. The legislation imposed additional core duties on all financial advisers (including insurance brokers). These duties include putting the client's interests first, disclosing certain information to clients, and maintaining minimum standards of conduct and compe-

tence. The FSLAA came into full force on 15 March 2021.

- Review of insurance contract law – the RBNZ, the insurance regulator, released terms of reference for a review in March 2018. The issues for review were wide-ranging and included reforms of disclosure obligations, and proposed removing the ability for insurers to exercise drastic remedies for non-disclosure and misrepresentation (including avoiding the contract). All forms of insurance are subject to the review. An exposure draft of proposed legislation, featuring significant reform of the current insurance contract law, was issued for public consultation in early 2022, and a draft bill is expected to be introduced to Parliament in mid-2023.
- The Financial Markets (Conduct of Institutions) Amendment Act 2022 was introduced to Parliament on 11 December 2019 and was passed in June 2022. The Financial Markets Conduct Act 2013 is amended by this. Its provisions require certain financial institutions (including insurers) and their intermediaries (for example, brokers) to comply with a principle of fair conduct and associated duties and regulations. The provisions will come into force on 29 June 2025.
- The RBNZ has been undertaking a review of the IPSA since April 2016. The review was relaunched in October 2020 and is reviewing the supervisory regime to ensure it remains cost-effective, risk-based and promotes the soundness and efficiency of the sector. It is expected to take two to three years. The RBNZ is consulting on the following:
  - (a) scope of the legislation – the organisations and products that are captured, and whether definitions of "insurance" and "carrying on business" are workable or need modification;
  - (b) overseas insurers – whether the supervision regime for overseas insurers is effective and any changes are required;
  - (c) statutory funds – whether current mechanisms for statutory funds are effective and appropriate; and
  - (d) solvency regime – how the provisions for solvency standards and requirements operate, whether they support good regulation and supervision, and whether the definitions in the IPSA require reform or updating.

A new consultation paper covering governance, supervisory processes, and disclosure was released in November 2022. This round of consultation will close in February 2023.

In addition, at the start of December 2020, the New Zealand Law Commission released an issues paper asking whether New Zealand should have class actions and litigation funding, and if so, how these should be regulated. New Zealand does not currently have legislation that provides a framework for class actions or commercial litigation funding. In the absence of formal frameworks, the courts and opposing parties have sought to navigate these two issues and establish rules for much of the past decade, particularly on claims against companies and directors following the global financial crisis.

A further consultation paper was released on 30 September, and submissions closed on 12 November 2021. The Law Commission's final report on class actions and litigation funding was released in June 2022, recommending the introduction of a Class Actions Act to be the principal source of law for class actions, and for litigation funding to be available subject to approval and monitoring by the court.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

See 12.1 Developments Impacting on Insurers or Insurance Products.

Duncan Cotterill is one of the longest-established law firms in New Zealand and is consistently ranked as one of New Zealand's top ten law firms. It is a full-service firm with specialist teams for corporate and commercial, property, construction, health and safety, tax, employment, family, environmental, resource management, intellectual property, information technology, and litigation and dispute resolution. The firm has offices in Auckland, Wellington, Nelson, Christchurch and Queenstown.

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NORWAY

Law and Practice

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1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Norway is neither a pure civil law nor a common law system; rather, it falls somewhere in between the two systems (as do the other Scandinavian countries). Having said that, the most important source of law is legislation – and the insurance market, in particular, is rather heavily regulated. There are, however, non-statutory areas of law, which rely heavily on case law. When applying statutory law, the Norwegian courts will place great emphasis on preparatory works and case law, as well as other relevant sources of law. In the case of the insurance sector, the courts will take into consideration court decisions, preparatory works and decisions from the Norwegian Financial Services Complaints Board (*Finansklagenemnda*, or FinKN).

Relevant (Re)insurance Legislation

As previously noted, the insurance market in Norway is rather heavily regulated. The primary legislation governing the insurance and reinsurance market in Norway is the Act on Financial Institutions and Financial Groups 2015 (the "Financial Institutions Act") and the regulations related to the Act – for example, Regulation No 1502 on Financial Institutions and Financial Groups, dated 9 December 2016 (the "Financial Institution Regulation").

The Norwegian Act on Insurance Activity 2005 (the "Insurance Activity Act") outlines the requirements for insurance companies that conduct insurance activities according to the Financial Institutions Act.

The Norwegian Act relating to Insurance Contracts 1989 (the "Insurance Contracts Act", or ICA) sets out the rights and obligations of the insurer and the insured concerning the writing of insurance contracts in Norway. The ICA was updated with new amendments on 1 July 2022, thereby introducing new and stricter pre-contractual regulation on the insurers. The Insurance Contracts Act does not apply for reinsurance.

Norwegian law also contains the Act on Choice of Law in Insurance 1992, which applies to the choice of law in direct insurance contracts.

In addition to the foregoing, the Norwegian Distribution Act – new in 2022 – applies to all brokers and other parties that sell insurance commercially.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Regulatory Bodies and Sanctions

The regulatory framework for insurance and reinsurance is placed within the authority of the Norwegian Ministry of Finance, while the Financial Supervisory Authority of Norway (FSA) is responsible for supervision and regulation. The FSA is an independent government agency that is subject to laws and regulations provided by the Norwegian Parliament and the Norwegian government through the Norwegian Ministry of Finance. The FSA is founded on international standards for financial supervision and regulation.

The FSA and the Norwegian Ministry of Finance are authorised to impose sanctions (eg, corrective orders, fines or withdrawal of licences) in cases of breaches of the regulatory framework.

Legislation and Guidance

The Financial Institutions Act regulates the insurance market, including the licence application process, operating requirements, capital requirements, and the solvency capital requirement. The Financial Institutions Act also includes requirements concerning corporate bodies and functions.

As Norway is a member of the European Economic Area (the EEA), the insurers and reinsurers incorporated in other EEA states who provide insurance or reinsurance services in Norway through branches are – with some exceptions – governed by both the Norwegian regulatory framework and the regulatory requirements in their home state.

However, only a few of the requirements of the Financial Institutions Act and the Insurance Activities Act apply to insurers and reinsurers that conduct activities in Norway on a cross-border basis (eg, obligations to disclose information on sales). Such foreign insurers and reinsurers are otherwise exclusively regulated by the licence and potential requirements applicable in the home state.

2.2 The Writing of Insurance and Reinsurance

Licence

In order to write insurance and reinsurance business in Norway, a licence must be obtained. An application for a licence to provide insurance or reinsurance services must be filed with the FSA, in accordance with the procedure outlined in the Financial Institutions Act.

The insurance or reinsurance company must obtain a licence that reflects the specific type of insurance services it will offer. The applicable requirements vary depending on whether the insurance company is to provide life insurance or not.

An example of the different requirements for different insurances is the required start-up capital. If an insurer intends to provide life insurance or liability insurance for aircraft, motor vehicles, ships or other liability insurances, a start-up capital of EUR3.7 million is required. In respect of other insurance undertakings, a start-up capital of EUR2.5 million is required.

However, there are also some requirements that apply to all types of insurance, such as the following.

- The management of the (re)insurance company, including members of the board of directors, the CEO and other executives who will participate in the management of the entity, must be considered sufficiently experienced and capable of managing the business in compliance with the applicable regulatory framework.
- Pursuant to Chapter 3 of the Financial Institutions Act, the licence application should include information about:
  - (a) the applicant's ownership and management structure;
  - (b) the proposed operational activities the company intends to offer;
  - (c) governance and control systems;
  - (d) how the capital and AML requirements will be met;
  - (e) how payment institutions and electronic money institutions will safeguard customer assets;
  - (f) capital structure and a forecast of the financial position for the first three years running;
  - (g) budgets; and
  - (h) group affiliation.

The FSA will consider whether the application might entail follow-up questions. The Ministry of Finance or the FSA will process the application within six months, either itself or through a delegation.

The FSA also has the authority to set certain conditions for a licence – for example, that the business shall be operated in a specific manner or within certain limits. Any conditions for a licence must be in accordance with the purpose of the Financial Enterprises Act.

2.3 The Taxation of Premium

Insurers that are tax residents in Norway – or are performing business activities that take place or are managed from Norway (ie, permanent establishment) – are subject to Norwegian corporate taxation. Regarding the payment of insurance premiums, these will be considered as income for such insurance companies and thus subject to taxation. An exception to this is life insurance premiums, which in most cases will not be considered taxable. Whether life insurance premiums are subject to taxation must be assessed on a case-by-case basis.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

There is an absolute requirement under Norwegian law that all insurance and reinsurance companies obtain a licence to provide insurance services.

Insurers or reinsurers who seek establishment in Norway must apply for a licence, as per the procedure set out in Chapter 3 of the Financial Enterprises Act. Reference is made to the aforementioned licensing process in **2.2 The Writing of Insurance and Reinsurance**.

The question as to whether a foreign insurer may conduct business in Norway is highly dependent on where the insurer is based – more specifically, whether it is based within the EEA, the EU, or elsewhere.

If an insurer is authorised to provide insurance services in an EEA member state, it will be permitted to carry out insurance services in Norway through either a branch or on a cross-border basis. It is important to note that the insurance company must inform the relevant regulatory authority in the EEA country.

An insurance company established within the EU may passport its rights to offer insurance in Norway on a cross-border basis.

It should be noted that insurers from outside of the EEA will not be able to provide insurance directly in Norway, unless a Norwegian subsidiary is established. This subsidiary must also hold an insurance licence for the particular insurance service that it provides to the market.

The opportunity for insurance companies that are neither domiciled within the EU nor the EEA to provide insurance is much more limited and they will not be allowed unless invited to do so.

Insurers from the United Kingdom

The United Kingdom left the EU on 31 January 2020, whereby a transition period commenced. During this transition period, the United Kingdom was treated as though it were still a member of the EU or EEA and, thus, there were very few practical changes in Norway's relationship with the United Kingdom. The transition period was extended several times but expired on 1 Janu-

ary 2023. Consequently, as of 1 January 2023, UK insurance companies are no longer able to passport their rights to offer insurance in Norway on a cross-border basis.

Reinsurance

The situation is slightly different for reinsurance companies. Reinsurers established in a non-EU country may provide reinsurance in Norway without any need to meet any licence and registration requirements in Norway. Reinsurers established in an EU-country need to have passported their rights to offer insurance on a cross-border basis in Norway. It is not a requirement under Norwegian law for foreign insurers to write reinsurance with a domestic insurer.

3.2 Fronting

Although fronting is not explicitly prohibited under Norwegian law, it is not frequently used. There is also limited guidance concerning the requirements for such fronting, given that the Norwegian industry has remained fairly domestic.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

The M&A market in Norway has been fairly quiet in relation to insurance companies.

However, two substantial mergers have occurred. In 2019, two insurance companies (Sparebank 1 and DNB) merged to create Fremtind Forsikring. On 1 June 2021, the Tryg Group – together with the Canadian company Intact – purchased the British RSA. RSA is a large insurance group that owns, among others, Codan and Trygg-Hansa in Scandinavia. The acquisition made Tryg Group the largest non-life insurance company in Scandinavia and the third largest insurance company measured in market shares in Norway (just ahead of Fremtind Forsikring).

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The Norwegian Insurance Mediation Act applies to all brokers and other parties that sell insurance commercially. It is an absolute requirement under the Act that all insurance intermediaries obtain a licence from the FSA to sell insurance in Norway commercially. On 1 January 2022 the new Norwegian Insurance Distribution Act (IDA) came into force, replacing the older Insurance Mediation Act of 2005. The new legislation was introduced to ensure compliance with the Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (the "EU Insurance Distribution Directive", or IDD).

The new IDA contains stricter requirements for insurance intermediaries. In accordance with the new legislation banks, mortgage firms and investment firms cannot be registered as "ancillary insurance intermediaries". These entities will now have to apply to the FSA and be registered as regular insurance intermediaries. Such entities have been given one year to comply with the new requirements.

According to the IDA, the management is required to have a general knowledge of insurance brokerage. The new IDA has also introduced a requirement that intermediaries must be able to prove that they undergo 15 hours of education relevant to their field of practice annually. This requirement will be enforced from 31 December 2023.

The company is also required to have sufficient liability insurance against claims for damages that it may incur. An insurance brokerage company must run the business, follow good brokerage practice, and not act in a way that creates doubt about its position as an independent intermediary. In order to ensure that the customers interests are safeguarded, the insurance intermediary must not use remuneration schemes, sales targets or other financial incentives that may influence their employees to recommended certain products. The insurance brokerage company must also provide the documentation necessary for an insurance contract to be concluded. The FSA may also set out additional requirements.

There are certain exceptions when it comes to the applicability of the IDA. One practical example is that freight-forwarders who offer goods insurance that covers damage to and loss of goods during transport and storage assignments performed by the freight-forwarder as an additional service will normally not be covered by the exemption.

In Norway, the active distributors include insurance brokers, agents and bancassurance.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The ICA provides several provisions regarding both liability insurance and personal insurance that are mandatory, and thus cannot be deviated from to the disfavour of the insured.

On 1 July 2022 new amendments to the ICA were implemented, as part of Norway's implementation of the EU Insurance Distribution Directive. The new regulation has imposed stricter regulations on insurers when giving advice and recommendations as part of underwriting insurance. If an insurer is providing a "personal recommendation", as defined in the IDD, the insured must also receive a written explanation of why the specific product best meets the needs of the insured.

As regards duty of disclosure of information and the insurance companies' obligation to seek information, the distinction between these two obligations is described here.

Liability Insurance

In connection with the conclusion (or renewal) of an insurance contract, the insurance company can request information on matters that may be relevant to its assessment of the risk. The policyholder must provide correct and complete answers to the insurance company's questions.

The policyholder must also, on their own initiative, provide information about special circumstances that are understood to be of significant importance for the insurance company's assessment of the risk. If the policyholder becomes aware that they have provided incorrect or incomplete information about the risk, the policyholder shall report this to the company without undue delay.

Personal Insurance

With regard to personal insurance, the insurance company must inform the policyholder about the duty of disclosure outlined in the ICA. Before the insurance company agrees to cover the insurance, the policyholder and the insured must answer the questions that the company asks in order to assess the risk, and the policyholder and the insured must provide correct and complete answers to the company's questions.

At the request of the company, the policyholder and the insured shall provide information on special matters that are understood to be of significant importance for the company's assessment of the risk.

Mandatory Nature of the ICA

In respect of commercial liability insurance, the parties to the insurance contract are free to determine the terms of the contract. This applies when the insured enterprise has two of the following criteria:

- more than 250 employees;
- a revenue of more than NOK100 million (based on the most recent available financial statements); or
- assets worth more than NOK50 million (according to its balance sheets).

The exception also applies when the insured's business is mainly based in a foreign country, or in the event that the insurance pertains to vessels or aircraft, or if the insurance concerns goods under international transportation.

6.2 Failure to Comply With Obligations of an Insurance Contract

The failure to comply with duties of disclosure in the negotiations of an insurance contract is also covered by the ICA. For liability and personal insurance, the following applies.

Liability Insurance

If the insured has fraudulently neglected the duty to provide information, and if an insurance event has occurred, the company is without liability towards the insured. If the insured has otherwise neglected their duty to provide information without good reason, the insurance company's liability to the policyholder may be reduced or waived.

If the company becomes aware that the information it has received about the risk is incorrect or incomplete at any significant point, it may terminate the insurance with 14 days' notice. If the policyholder has acted fraudulently, the company may nevertheless terminate this and other insurance agreements it has with the policyholder with immediate effect.

Personal Insurance

If the policyholder or the insured has fraudulently neglected the duty to provide information, and if an insurance event has occurred, the company is without liability. If the policyholder or the insured has otherwise neglected their duty to provide information, and the person in question does not have good reason for doing so, the company's liability can be reduced or waived.

If the company becomes aware during the insurance period that the duty to provide information has been neglected, and it is not just a minor matter to charge the policyholder or the insured, it can terminate the insurance with 14 days' notice. If the policyholder has acted fraudulently, the company may nonetheless terminate this and any other insurance agreements it has with the policyholder with immediate effect. However, if it can be assumed that the company – based on knowledge of the correct circumstances – had charged a higher premium or otherwise covered the insurance on other terms, the policyholder may demand to continue the insurance relationship on such terms before the expiry of the notice period.

Reinsurance

It should be noted that the ICA does not apply in respect of reinsurance contracts. Consequently, the Norwegian Contracts Act 1918 applies; in particular, Section 30 states that fraudulent

misrepresentation will render a contract null and void.

6.3 Intermediary Involvement in an Insurance Contract

As noted in **5.1 Distribution of Insurance and Reinsurance Products**, the IDA regulates all insurance mediation in Norway and consequently applies to all parties performing insurance or reinsurance mediation. Depending on the scope of the mediation provided, an intermediary may be involved in the negotiations of the insurance contract on either the insured's behalf or the insurer's behalf. In addition to the IDA, the insurance intermediary must comply with the ICA. The key duties of the intermediary before entering into an insurance policy, for instance, are regulated by the ICA and its applicable amendments as of July 2022. These regulations include an obligation for the intermediary to obtain customer information and carry out an assessment of the individual needs of the insured before entering into an insurance agreement.

The new IDA of 1 January 2022 also introduced a new legal standard. Any intermediary must act with "good business practice". The standard is incorporated into the law in order to ensure that the insurance distributors are held to a legal standard, whereby they must show that they are acting in the customers' best interests.

The core principles of good business practice as an insurance distributor can be summarised as follows:

- the insurance brokerage company must not act in a way that creates doubt about its position as an independent intermediary;
- the insurance brokerage company must provide the documentation necessary for an insurance contract to be concluded;
- the insurance brokerage company must exercise due care when choosing an insurer and dissuade the client from using insurers whose ability to fulfil their obligations may be questioned or is unknown; and
- the insurance brokerage firm may not – through agreements with insurance companies or in any other way – arrange itself so that it affects the insurance brokerage firm's independence as a broker.

Repeated or gross breach of the duty of good brokering practice can result in fines or imprisonment for up to one year.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

There are no specific requirements or distinguishing features of an insurance contract under Norwegian law. Insurance contracts are governed by the ICA, whereby the insurance company is obliged to draw up an insurance policy when an insurance agreement has been made and the conditions for that insurance have been decided.

In accordance with the newly introduced regulation in the ICA, a standard "insurance product information document" (IPID) will need to be given to an insured when underwriting non-life insurance. This must be done before a policy is issued. Additionally, the insurer must provide the insured with a number of specific details prior to issuing a policy.

This policy should be in writing and confirm that an agreement has been made, as well as

referring to the conditions of that insurance. The policy shall highlight the following points:

- whether the insurance company has reserved that the liability shall only begin to run when the first premium has been paid;
- what reservations it has made regarding the limitation of liability in connection with a change in the risk;
- the safety regulations it has established – the company may refer to safety regulations issued by others if it is reasonable to require the policyholder to know the contents and the insurance certificate must state that the company will, on request, provide the policyholder with a copy of the regulations to which it refers;
- the time limit for giving notice of the insured event (as per Section 8-5, first paragraph, of the ICA); and
- the right to demand tribunal proceedings, or other similar schemes established to resolve disputes.

If the company has neglected its duty to provide the above-mentioned information, it can only invoke the relevant provision if the policyholder or insured was nonetheless familiar with the condition.

For something to be insured, there must be a legal interest.

If a contract is deemed to be an insurance contract, the ICA will also apply. If the ICA is mandatorily applicable, or if not excluded or otherwise deviated from in the insurance agreement, the ICA will also impose a number of obligations on the insured (as well as on the insurance company).

6.5 Multiple Insured or Potential Beneficiaries

As a starting point, the insurance contract is a contractual relationship between a policyholder on the one hand and an insurance company on the other. It is the policyholder who enters into the insurance contract with the company and pays the relevant premium, and who would normally benefit from the insurance through the protection provided by the agreement.

The regulation of third-party status and rights under an insurance contract can be laid down either in law or in the agreement.

In respect of non-life insurance, this issue is mainly solved by two different sets of rules. The main set applies to co-insurance, which provides those other than the policyholder with interest related to the subject of insurance and the opportunity to take advantage of it. Primarily, co-insurance is used in property damage insurance. However, co-insurance may also be used in liability and operational interest insurance. The second set of rules is linked exclusively to liability insurance, aiming to insure the injured party's legal position under the insurance taken out by the policyholder.

In personal insurance, the main issue concerns who is entitled to the company's benefits in the event of an insured event.

As for collective insurance (including both non-life insurance and personal insurance), third parties may also have rights under an insurance policy.

The involvement of several beneficiaries in a contract does not impact the disclosure obligations.

6.6 Consumer Contracts or Reinsurance Contracts

As the ICA is mandatorily applicable for consumers, the contracting parties in a commercial setting (see **6.1 Obligations of the Insured and Insurer**) will have a greater degree of contracting freedom. On a higher level, one can say that a consumer will have less onerous obligations in respect of disclosure and other obligations than a company taking out insurance. Moreover, the insurance company has more onerous obligations to inform the consumer rather than a corporation when entering into an insurance contract. However, it should be noted that the industry generally considers the legal framework well balanced.

As mentioned in **6.2 Failure to Comply with Obligations of an Insurance Contract**, it is noted that the ICA does not apply to reinsurance contracts. Thus, the parties have an even greater degree of contracting freedom. A reinsurance contract will be subject to the Norwegian Contracts Act and Norwegian contract law.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

The use of alternative risk transfer (ART) is still not a common alternative to insurance in Norway. There is no law that is directly applicable to ART transactions.

7.2 Foreign ART Transactions

There is currently no information available on this subject.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The general rules under Norwegian law on the interpretation and completion of agreements, as established through case law, apply to insurance contracts.

However, the negotiation and conclusion of an insurance contract is not performed in the same way as a normal contract. As stated in **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract**, there is no requirement that the parties enter into a written contract of insurance, but the insurer will issue an insurance policy that provides the terms and conditions of the insurance. Consequently, the rules that generally apply to the interpretation of unilaterally set standard terms will be of particular importance for insurance contracts.

Under Norwegian law, an objective principle of interpretation is applied, and it is therefore important when interpreting insurance contracts and insurance terms to find the objectively justifiable and reasonable content of the agreement that has been entered into. The Norwegian courts will look for what objectively appears to be the natural understanding of the terms, not the different view of it that one of the parties may have had.

Conversations, communication and negotiations prior to the conclusion of an agreement can, in many instances, be used to clarify a joint understanding between the parties of the content of a contract that has been negotiated. However, when interpreting insurance contracts, these items will be less relevant and do not normally play any major role. This is due to the fact

that the insurance is taken out on the basis of a standardised and unilaterally stipulated insurance term, which gives little room for actual negotiations. Exceptions to this may occur, however – mainly within the business insurance and in life insurance.

Although most contracts are subject to freedom of contract, it is also worth noting that the ICA directly governs the insurance contract and is mandatorily applicable in many situations (see **6.1 Obligations of the Insured and Insurer**). Therefore, the ICA will more actively be a contributing part of the interpretation or revision of an insurance contract, compared to most commercial contracts for the sale of a service.

In contrast to the way in which insurance contracts are negotiated, reinsurance contracts will be subject to more concrete negotiations. Consequently, the interpretation of these contracts will be focused more on the general practice of interpreting mutually negotiated contracts than on what has been described earlier. Further, it should also be noted that the ICA does not apply to reinsurance contracts, credit or other surety insurances.

8.2 Warranties

Under Norwegian law, warranties are considered similar to all other contractual terms. See **8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence**.

8.3 Conditions Precedent

Although there are conditions for an insurer to be liable, such conditions will not be referred to as "condition precedents". These are contractual terms treated as normal terms of a contract, which must be complied with. By way of an example, there is a requirement under the ICA that the insured notify the insurance company within one year of the insured receiving knowledge of the circumstances that justify the claim.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

The ordinary courts may hear disputes on coverage. It should be noted that there are no special courts for insurance cases in Norway. This applies to all types of insurance agreements, including insurance agreements with a consumer as well as agreements for reinsurance. As the courts in Norway have a general jurisdiction, all insurance proceedings will be subject to the Norwegian Disputes Act.

It should be noted that the new amendments to the ICA introduced new rules on the burden of proof. The insurance company will have the burden of proving that it has complied with statutory and regulatory duties owed to the insured.

According to the Norwegian Disputes Act, for disputes regarding monetary claims, the first instance will be the conciliation council. If agreed by the parties to the insurance agreement, a dispute regarding cover may also be settled by way of arbitration. However, only if the dispute is above NOK200,000 and both parties are represented by lawyers will the case proceed to the first instance.

A dispute regarding cover may also be referred to arbitration. This is rather common within marine insurance matters and reinsurance disputes.

Complaints Board

In the first instance, disputes that arise between an insurer and a consumer regarding insurance coverage will be brought before the Norwegian Financial Services Complaints Board (FinKN).

FinKN is a private complaints board. It does not have the authority to give binding judgements; however, its guidance is often followed by the parties. A condition for being able to pursue a claim against the insurance company with FinKN is that the company must be a member of the complaint organisation.

Time Bars

The limitation periods for notice of an insurance claim and commencement of proceedings are provided for in the ICA and must be followed in order for the claimant to receive payment from the insurer.

The insured loses the right to compensation if the claim is not reported to the company within one year of the point at which the insured became aware of the circumstances justifying the claim.

In addition to the duty to notify the insurer, there is also a general time bar for insurance claims of three years. Time starts to run at the expiry of the calendar year when the insured received the requisite knowledge of the circumstances that justify the insurance claim. The insurance claim becomes time-barred no later than ten years after the end of the calendar year in which the insured event occurred.

In the case of personal insurance, there are special limitation periods for endowment insurance (ten years, no more than 20), other claims for compensation or insurance sums (three years, no more than ten), accident or sickness insurance and pension or annuity insurance (ten years, with three years for overdue instalments).

It should be noted that commercial insurance contracts may provide a time limit for reporting claims that may be shorter than in the insurance contract. An example of this can be found in paragraphs 5–23 in the Nordic Marine Insurance Plan of 2013 Version 2019, which requires that the notice shall have occurred within six months of the insured receiving knowledge of the circumstances that justify the claim.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Norway, through the Lugano Convention, is a party to the Brussels instruments on jurisdiction. Section 3 of the Lugano Convention contains the rules of jurisdiction for insurance matters. In brief, Section 3 offers the insurance customer the benefit of added jurisdictions; in addition to claiming at the insurers' domicile, the insured can also commence proceedings at their own domicile (in addition to where the insurance event took place).

As regards the choice of law, Norway has implemented the Act on Choice of Law in Insurance, which provides mandatory application of Norwegian law in certain categories on insurance (ie, life insurance). The choice of law can be agreed in other areas of insurance, unless mandatory law provides otherwise. If no choice of law is agreed, the choice of law is to be decided on the basis of a closest-connection test.

9.3 Litigation Process

Unlike in many other countries, the district courts have jurisdiction over all cases. Hence, there is no distinction between ordinary courts or administrative courts, or between civil or criminal courts. Consequently, there are no special courts that handle insurance matters.

The courts in Norway have three tiers and are as follows:

- 23 district courts;
- six appeal courts; and

• the Supreme Court.

The first instance for disputes above a certain monetary size (ie, where the claim is above NOK200,000 and both parties have been represented by a lawyer) is the district court. If the dispute is less than NOK200,000 and only one side or neither side is represented by a lawyer, the case will go to a local conciliation board first.

Litigation is initiated when a party submits an application for a summons to a district court that has jurisdiction over the dispute. Before such an application, a letter of demand should first be submitted. An application should, as a minimum, contain the following:

- the courts;
- the names and addresses of the parties, deputies and legal representatives;
- the claim asserted and a claim that states the judgment the plaintiff demands;
- the factual and legal justification of the claim;
- the evidence that will be presented;
- the basis for the court to hear the case if there can be any doubt about this; and
- the plaintiff's view of the further processing of the case, including agreements that may be relevant to the process.

The summons shall provide a basis for a prudent treatment of the case by the parties and the court. Claims and factual grounds must be stated in such a way that the defendant can take a position on the claims and prepare the case. If the application fulfils the requirements, the district court will issue a writ of summons and serve the respondent with the summons. The respondent must thereafter submit their reply.

The Norwegian courts will strive to find an amicable settlement to the dispute if possible.

After the conclusion of preparatory proceedings, in which the parties exchange several written pleadings, a hearing will be held. The main rule is that hearings are held as oral hearings; however, in some cases these can be conducted in writing. A shift to more written proceedings has been experienced during the COVID-19 outbreak. Following the hearing, the court will issue a decision.

A decision from the district court may be appealed if the court's factual or legal grounds for its decision are insufficient or due to a procedural error. The court of appeal may reject an appeal if it clearly cannot succeed. Although the majority of cases are allowed a new hearing by the court of appeal, a much more narrow group of cases will be allowed into the Supreme Court.

On an annual basis, the Supreme Court hears approximately 100 cases. The Supreme Court is the final instance in Norway and the case must have high precedential value or significant public importance – or else there must be other strong reasons – in order for it to be tried by the Supreme Court.

9.4 The Enforcement of Judgments

Norwegian court judgments and arbitral awards will be easily enforced in Norway. Furthermore, Norway is also a party to the Lugano Convention, meaning that it also ensures the enforcement of judgments in the EU and EEA.

Norway is also a member state of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the "New York Convention"). Consequently, the enforcement of foreign arbitral awards is ensured.

9.5 The Enforcement of Arbitration Clauses

There is no requirement under Norwegian law that an agreement for arbitration must be in writing. Arbitration agreements will be just as binding on the parties, regardless of the form the parties select when entering into an agreement. However, it is easier to prove the content of the arbitration agreement if it is in written form in the event of a dispute.

Furthermore, it follows directly from the Norwegian Arbitration Act of 2004 that the courts shall reject legal actions relating to arbitration if a party requests rejection at the same time as the party enters into material questions of the dispute at the latest. This will often be when a party responds to a writ of summons. The court shall bring the case if it finds that an arbitration agreement is invalid or cannot be enforced for other reasons. In other words, there is a condition under Norwegian law that a party must decide to object. The court in question does not have the right to make a decision to reject ex officio. The question of whether or not an arbitration clause is enforceable will be based on substantive contract law.

9.6 The Enforcement of Awards

See **9.4 The Enforcement of Judgments**.

9.7 Alternative Dispute Resolution

The Norwegian courts may, during the course of legal proceedings, propose that the parties conduct court mediation. This is recommended by the courts if they consider the case to be suitable.

A court mediation is a voluntary ADR mechanism, meaning that the court cannot force the parties to mediate any dispute. However, it is generally recommended that parties try court mediation, if the case is suitable for this. Opposing an attempt at an amicable solution can result in negative consequences for the person in question when deciding on legal costs if the dispute later escalates to court proceedings.

Court mediation is conducted with a judge as the mediator. Historically, this ADR mechanism has had a high success rate.

If the mediation is unsuccessful, the case will proceed to a hearing. The judge hearing the case will not have been involved in the mediation.

Also, and as mentioned in **9.1 Insurance Disputes over Coverage**, the FinKN is also an ADR mechanism that can be applied for insurance disputes.

9.8 Penalties for Late Payment of Claims

An insurance policy will frequently have separate provisions regarding the insurance company's obligation to make a payment of a claim. If the insurance policy is silent (or if it refers to a consumer), the ICA does provide that the insurance company shall pay compensation as soon as the company has had a reasonable time to clarify the liability and calculate the compensation. If it is clear at an earlier time that the company must at least pay a part, the company must pay the corresponding amount in advance.

The main rule under Norwegian law is that interests are recoverable in the event of a claim. The ICA also provides the insured with a right to set forth a claim for overdue payments. At the end of 2021, the applicable annual rate was 8%. This rate is subject to adjustments two times a year, in accordance with the general interest level.

Furthermore, a claimant may also be able to claim for damages for losses or damages

incurred by the insured if caused by the insurer's late payment. However, this does require that the insured can show that there is a loss, causation, foreseeability and negligence.

There are no punitive damages available under Norwegian law.

9.9 Insurers' Rights of Subrogation

Under Norwegian law, an insurer's right of subrogation will not be dependent on a separate clause providing that right. Having said that, such clauses are not uncommon. It is a general principle that an insurer will obtain a right of subrogation upon payment of an indemnity. Consequently, the insurer will step into the insured's legal position and proceed with a potential claim against the tortfeasor.

10. Insurtech

10.1 Insurtech Developments

In recent years, there has been an increased focus on insurtech, and several of the large insurance companies are focusing on developing their technology. However, to date, there seems to be a minimal market within insurtech. This may be because the Norwegian insurance market is fairly well developed and because of the start-up requirements of an insurance company. See the start-up capital requirement for different types of insurances in **2.2 The Writing of Insurance and Reinsurance**.

10.2 Regulatory Response

There is currently no information available on this subject.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Cyber-Attacks

An increasing number of Norwegian companies have been targeted by fraudsters using digital tools. The PwC Cybercrime Survey from 2021 shows that 58% of the respondents are more worried about the cybersecurity threat in 2021 compared with the situation in 2020, and that two out of ten respondents planned on investing 26%–50% more on cybersecurity in the following year. As pointed out by PwC, it is not only concerns that are increasing; the number of attacks of Norwegian companies are also on the rise. The report shows that Norwegian companies, to a large extent, experience being exposed to targeted burglary attempts. This reflects a changing threat picture in which attackers are becoming more and more sophisticated. As many as seven out of ten respondents answered that they had experienced a targeted attack on their particular business.

11.2 New Products or Alternative Solutions

As stated in the Capgemini World Insurance Report from 2021, it appears that there is still a rather significant gap in the insurance market generally, as well as in the Norwegian insurance market. The supply of cover from the insurance industry still retains a traditional world view.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

During the COVID-19 pandemic, Norwegian courts gave priority to cases that were considered most important, such as criminal cases or cases involving mental health or children. Norwegian courts have nonetheless initiated numerous measures to limit delays and other effects of the pandemic – in particular, by introducing the extensive use of remote hearings and remote examination of witnesses in other cases. Also, the courts have increased the number of cases that are decided based on written proceedings and have appointed interim judges to prevent further delays and limit the caseload. For the time being, some delays must still be expected.

To date, COVID-19 seems to have had a limited impact on insurance or reinsurance contracts. However, it may take some time before any material changes are experienced.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Although Norway is not a part of the EU, it is obliged to implement certain EU directives and regulations under the EEA Agreement to which Norway is a party.

Insurance is viewed as EEA-relevant and, consequently, the majority of EU directives and regulations concerning this sector will be implemented into Norwegian law. It is worth mentioning that these directives and regulations will not directly come into effect in Norway or provide Norwegian citizens with rights unless they are implemented into Norwegian law. During the past few years, there has been a surge of new laws and amendments that have increased the insurers' and the insurance intermediates' obligations. Consequently, the increased complexity in the regulatory framework is a continued focus area in Norway.

Increased Focus on ESG

There is no doubt that the focus on ESG has increased drastically in recent years. There is an increased obligation for ESG reporting and there is more to come – for example, with the coming into force of the EU Taxonomy Regulation. The EU Taxonomy Regulation is a milestone in the sustainable finance market, providing a classification tool aimed at investors, companies and financial institutions (including insurance companies). Although the Taxonomy Regulation is for the EU – of which Norway is not a member – it is worth noting that the EU is Norway's biggest trading partner. Thus, there is little doubt that the Taxonomy Regulation will also have a great impact on the Norwegian market.

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Kvale Advokatfirma DA (Kvale) is a business law firm dating back to 1988. Throughout the years, Kvale has shown consistent organic growth and today comprises 94 lawyers. Kvale advises on most aspects of business law and is an acknowledged specialist in a number of practice areas. The firm's growth is driven by its pursuit of quality combined with a keen attention to its clients' businesses. Kvale's clients appreciate this, whether they are SMEs or large national and international corporations. The firm's main areas of practice are oil and gas/offshore construction, corporate and M&A, dispute resolution and TMT/IP, but it also boasts respected boutique practices within renewable energy, competition law, employment law, tax and shipping. Kvale is active within dispute resolution across all the aforementioned fields and is consistently involved in major complex arbitration and litigation cases.

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KVALE

Trends and Developments

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Introduction

Throughout 2022 there have been significant developments in Norwegian legislation and case law that have relevance both for insurers and consumers. These changes have led to further clarity regarding the rights and obligations of the parties to an insurance contract. Inter alia, there have been developments aimed at improving consumer protection within the framework of Norwegian insurance contracts.

This article reviews and elaborates on some of these developments.

Implementation of New Insurance Legislation in Norwegian Law

On 1 January and 1 July 2022 respectively, the new Insurance Distribution Act and certain amendments to the Insurance Contracts Act came into force. The goal of these legislative changes was to implement the EU's Insurance Distribution Directive and Solvency II Directive into Norwegian law. In addition to harmonisation, a central goal of the Insurance Distribution Directive is to reinforce and safeguard the interests of policyholders - namely, the consumers.

The purpose of the Insurance Distribution Directive is, among other things, to harmonise the rules on insurance and to increase predictability and protection for insurance customers. The Insurance Distribution Act sought to implement the main provisions of the Insurance Distribution Directive, thereby further integrating the Norwegian insurance market with the common insurance market within the European Economic Area (EEA). The amendments to the Insurance Contract Act similarly sought to strengthen the protection of customer interests by making the rules more comprehensible.

The new Insurance Distribution Act also provided for stricter regulation of remuneration schemes for employees and external consultants. The legislation restricts the use of remuneration schemes, sales targets or other incentives to ensure that the broker does not advise the customer on the basis of personal financial incentives. This is just one example of how the legislation focuses on customer protection, and how it applies both to insurance providers and insurance brokers.

In order to keep control of the various brokering agreements, the Insurance Distribution Act established further regulation on the registering and notification of insurance distribution agreements.

Registration of distribution agreements under the Insurance Distribution Act

The Insurance Distribution Act established a duty for all companies engaged in insurance distribution to register with the Financial Supervisory Authority (*Finanstilsynet*, or FSA) of Norway.

Further to this, the FSA clarified that when the intermediary applies to be registered with the FSA, the application must be accompanied by a confirmation from the insurance companies that the conditions for registration have been met. This is the case when entering into all new agreements on insurance distribution and not

only in connection with the agent's application for registration.

In the event of termination of the agreement between the intermediary and the company, the insurance company must notify the FSA, which can be done by submitting a form to the FSA.

As noted, the above-mentioned requirement applies to all insurance companies and insurance distributors, including foreign companies that are registered in Norway. The FSA is seeking to have a continuous overview of the various insurance distribution agreements that are established between intermediaries and the providers, and to maintain updated registries.

Changes to the Insurance Contracts Act

On 1 July 2022, the new amendments to the Insurance Contracts Act came into force. The most noticeable change was the structuring of the Act, which is now arranged chronologically and resembles the timeline of an insurance relationship.

As regards the material side, stricter duties were introduced on the insurer to inform and map the insurer's needs while guiding the individual customer. A prohibition on discrimination was also implemented.

The opportunity to derogate from the terms of the Insurance Contracts Act at the disadvantage of the insured has also been changed. This is now possible in the following cases:

- insurance of so-called "major risks"; and
- insurance related to commercial activities when the activities mainly take place outside Norway.

The term "major risks" will be further defined in the regulations in order to harmonise the definition with that contained in the EU Solvency II Directive. This will probably create greater clarity around the right to derogate from the terms of the Insurance Contracts Act in comparison with the former version of the Act. That being said, there is a risk that the delimitation regulation will be difficult for consumers to access, as the Solvency II Directive is a comprehensive and detailed set of rules.

The mandatory access to direct action against the insurer in the event of the insured's insolvency is maintained in line with the former version of the Insurance Contracts Act. This is a cornerstone provision of Norwegian insurance law and, as such, not something the legislators wanted to tamper with at this stage.

The above-mentioned changes have not yet manifested in disputes; however, the insurance providers are most likely seeing the effects of the stricter regulations when writing insurance contracts.

Nordic Marine Insurance Plan Version 2023 Introduced

On 3 October 2022, the Nordic Marine Insurance Plan Version 2023 (the "Nordic Plan") was published, thereby updating the 2019 version. The updated version entered into force on 1 January 2023.

The Nordic Plan is a comprehensive marine insurance regime, widely used by the international shipping community. It provides the parties with balanced terms, drafted by a committee consisting of all interested parties in a shipping venture. Both shipowners and charterers frequently underwrite insurance under the terms of the Nordic Plan.

The 2023 version adopted several amendments, including significant changes relating to sustainability, sanctions, extended time limits, and a comprehensive review of the loss of hire rules.

Loss of income

In accordance with Chapter 16 of the Nordic Plan the shipowner can insure loss of income following physical damage to a vessel. In the revised Nordic Plan, the revision committee intended to outline that the loss of hire insurance covers the assured's loss of income, as opposed to income attributed to the vessel. This was confirmed by the Hamburg Cruise judgment (LA-2018-35513), in which the court of appeal concluded that the assured could claim the agreed daily amount even though the assured had continued the employment with a substitute vessel. The Nordic Plan therefore clarified that it is the assured's actual loss of income that is covered.

Sanctions

Recent geopolitical developments also gave rise to some amendments. The Nordic Plan has incorporated exclusions that protect the insurer from an obligation to make payments that could be subject to sanctions. This means that an otherwise covered claim or payment to a third party is relinquished if there are sanctions applicable to the relevant payment. The outbreak of the war in Ukraine necessitated certain amendments in this respect.

Clause 2-17 regulates sanction limitations and exclusions. Previous versions stated that the insurer was not obliged to pay or provide any benefit that was restricted by sanctions imposed by the EU, UK, US, France, Russia, China, or any other state where the insurer has a registered office. Following the amendments, the provision has removed the reference to France, China and Russia. France and China were removed to align the provision with the English market. The reference to Russia was problematic given the risk of counter-sanctions from Russia during the ongoing war. The revision committee therefore sought to remove any uncertainty for the parties by making clear that counter-sanctions from Russia will not limit the insurer's obligation to provide cover for the assured.

Sustainability

The amendments has also shown that there is an increased focus on sustainability. This is reflected in Clause 12-12, which regulates the choice of repair yard following a casualty. The amendment introduced an extra allowance, whereby the shipowner can receive a higher compensation by choosing a repair yard that is more expensive but requires shorter transport. The amendment serves as an incentive for the assured to lower emissions by choosing repair alternatives that require shorter voyages.

New Case Law Within Insurance

Court of Justice of the European Union decision on the scope of the Insurance Distribution Directive

The Norwegian Insurance Distribution Act was introduced to harmonise Norwegian legislation with the EU Insurance Distribution Directive. In the absence of Norwegian case law on the new legislation, jurisprudence from the ECJ is relevant when considering the scope of the Insurance Distribution Directive and, in turn, the scope of the Norwegian legislation.

On 29 September 2022, the ECJ rendered a decision (case C 633/20) that has emphasised the broad scope of the Insurance Distribution Directive. The case concerned a German consumer bringing a claim against TC Medical Air Ambulance Agency GmbH (TC). TC held a group insurance policy that covered both illness and

accidents abroad, as well as repatriation costs. TC did not provide the cover themselves but, rather, sold membership of the group policy to consumers via door-to-door sales through advertising agencies. The consumer paid a membership fee to TC, which was in turn used by TC to pay the premium to the insurers.

The question was what status TC had under the Insurance Distribution Directive, and whether TC was acting as an insurance distributor. If so, TC lacked the necessary licences to carry out the activity of insurance mediation. The court held that, given the circumstances, TC was considered to be engaged in "insurance distribution".

Under the Insurance Distribution Directive an entity who takes up or pursues the activity of insurance distribution in exchange for remuneration is an insurance intermediary. The court further noted that remuneration is where the company has an economic interest of its own, distinct from the interests of the customer who obtains insurance under the policy. The court found that TC was pursuing its own economic interests in the undertaking, thereby meeting the aforementioned requirement.

The court reiterated that the directive, inter alia, aims to ensure equal treatment between all categories of insurance intermediaries and seeks to enhance customer protection in the field of insurance. By including persons operating in the insurance market on the basis of the economic model that TC was operating under, these objectives were met.

The above-mentioned judgment shows that the Insurance Distribution Directive provides a strict regime for insurance distributors and safeguards consumer interests. Should a similar issue arise in a Norwegian court, the judgment will be relevant when interpreting the scope of the Insurance Distribution Act.

LB-2022-66782

On 7 September 2022, the Norwegian Appeals Court issued a judgment (LB-2022-66782) concerning an insurance dispute over whether a claim was within the terms of the insurance. The claim was lodged against the liability insurers of a construction company in the aftermath of a construction failure.

The background of the case involved a Norwegian couple who were building a house in the Bahamas. The house was being built by a Norwegian contractor and the woodwork to be used was from a Norwegian producer.

The load-bearing structures of the house consisted of a specific type of wood and, after the construction was completed in Norway, it was shipped to the Bahamas. When delivered in the Bahamas, it was revealed that the construction could not be used. The reason was that the type of wood was not suitable for the climate and had not undergone the necessary drying process prior to assembly. As a result the wood had dried and the measurements were no longer correct. The couple sued the liability insurers of the construction company and the claim in question was lodged under a Norwegian insurance contract.

The question at hand was where the damage had legally occurred. The insurance company rejected liability, referring to their insurance terms whereby the insurer was only responsible for liability resulting from damage that occurs in Norway. The question before the court was whether the damage had occurred in Norway or in the Bahamas.

The court found that the damage had occurred in Norway. The construction had been assembled in Norway by a Norwegian contractor. The fact that the damage had materialised in the Bahamas was not considered decisive. The problem with the materials (ie, lack of preparation of the wood) was already an issue when the structure was assembled. This was, according to the court, the crux of the matter. Based on this, the liability insurer was held liable.

The judgment shows that – under an insurance agreement – even if the damage has materialised abroad, it can still be considered to have contractually occurred in Norway.

Concluding Remarks

Both the new Insurance Distribution Act and the new Insurance Contracts Act have been in force for about one year and six months respectively. The changes are welcome, as they align Norwegian legislation with the EU regulations. It also shows that there is an increased focus on customer protection, both nationally and throughout the EU. Predictability and clarity is essential for the consumer, in order to ensure sufficient insurance cover for their interests.

As with any new regulations, the content and scope will be determined through case law. Cases relating to the amendments have yet to appear before the Norwegian courts. The above-mentioned ECJ judgment will be relevant for the Norwegian interpretation, and is a clear signal that the Insurance Distribution Directive has been given a wide scope of applicability. The authors therefore have reason to believe that the Norwegian legislation will also be applied broadly.

Based on what has been discussed here, it is likely that the focus on consumer protection will increase, as the insurers have to abide by the stricter regulation that was introduced in 2022.

Contributed by: Kristian Lindhartsen and Preben Berge Helverschou, **Kvale Advokatfirma DA**

Kvale Advokatfirma DA is a leading commercial law firm that has provided assistance to Norwegian and international businesses since 1988. The firm is particularly renowned for assisting some of Norway´s largest companies with their most important and complicated cases. Kvale´s lawyers have extensive experience in negotiations, dispute cases before the ordinary courts, and arbitration. With a broad understanding of the insurance industry, the firm´s lawyers provide assistance within the entire specialist field of insurance law and have particular experience in professional liability insurance (directors' liability, lawyers' professional liability and other adviser liability), construction risk, business interruption insurance, and maritime/industrial insurance.

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PHILIPPINES

Law and Practice

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1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Insurance and reinsurance in the Philippines are mainly regulated by laws enacted by the Philippine Congress. Decisions of the Supreme Court of the Philippines interpreting these laws have the force and effect of law. In addition to laws and Supreme Court decisions, the Philippine Insurance Commission (PIC), a regulatory body established by law to regulate the insurance industry, is empowered to issue rules and regulations that implement and aid the interpretation of the statutes governing or affecting insurance and reinsurance.

The Civil Code of the Philippines provides that "[t]he contract of insurance is governed by special laws. Matters not expressly provided for in such special laws shall be regulated by [the Civil] Code". The principal legislation on insurance and reinsurance in the Philippines is the Insurance Code of the Philippines (Presidential Decree (PD) No 612, as amended by the Republic Act (RA) No 10607). Other special laws on insurance include the following:

- the Revised Government Service Insurance Act of 1977 (PD No 1146, as amended) (for government employees);
- the Social Security Act of 1954 (RA No 1161, as amended) (for employees of private entities);
- the Property Insurance Law (RA No 656, as amended); and
- the RA No 3591, as amended, which established the Philippine Deposit Insurance Corporation.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Insurance and reinsurance are regulated by various laws and regulations. The Insurance Code, as amended (the Code) is the main legislation that governs the insurance business. It grants the Insurance Commissioner "the duty to see that all laws relating to insurance, insurance companies and other insurance matters, mutual benefit associations, and trusts for charitable uses are faithfully executed and to perform the duties imposed upon him by [the] Code," including the "sole and exclusive authority to regulate […] variable contracts as defined by law and to provide for the licensing of persons selling such contracts, and to issue reasonable rules and regulations governing the same. The [Insurance] Commissioner [is empowered to] issue such rulings, instructions, circulars, orders and decisions as may be deemed necessary to secure the enforcement of the provisions of [the Insurance] Code," and such issuances of the Insurance Commissioner are part of the regulatory scheme governing the insurance industry in the Philippines. Decisions by the Insurance Commissioner are appealable to the Secretary of Finance.

Other government agencies involved in the regulation of insurance and reinsurance in the Philippines include the Securities and Exchange Commission of the Philippines (SEC) and the *Bangko Sentral ng Pilipinas* (BSP, the Central Bank of the Philippines). The Anti-Money Laundering Council (AMLC) and the Philippine Competition Commission (PCC) also have regulations that are applicable to or affect the insurance industry.

Entities intending to engage in the business of insurance must submit to the jurisdiction of the SEC, the government agency tasked with regulating corporations, partnerships and associations, and obtain the licence for the appropriate structure in order to be entitled to conduct insurance and reinsurance in the Philippines. The PIC exercises primary authority over insurance companies which are deemed special corporations under the Revised Corporation Code that governs corporations, partnerships and associations.

The BSP is the central monetary authority of the Philippines which supervises the operations and activities of banks and certain non-bank financial institutions. Certain issuances of the Monetary Board of the BSP affect the insurance industry because of the inclusion of bancassurance in the Insurance Code, for instance.

Insurance companies, pre-need companies, and all other persons supervised or regulated by the PIC are considered "covered persons" under the Anti-Money Laundering Act of 2001 and the Terrorism Financing Prevention and Suppression Act of 2012. The Anti-Money Laundering Council, of which the Insurance Commissioner is a member, is tasked with implementing these laws and may promulgate pertinent rules and regulations which will affect companies regulated by the PIC, including those engaged in insurance and reinsurance.

The PCC, created under the Philippine Competition Act (PCA), is tasked with the implementation of the PCA, including the review of proposed mergers and acquisitions, to the extent that the relevant transaction exceeds certain thresholds set out by law and regulations. This means that proposed mergers and acquisitions involving companies engaged in insurance and reinsurance may have to be submitted to the PCC for review and clearance.

2.2 The Writing of Insurance and Reinsurance

The Insurance Code enumerates the entities that may pursue insurance business in the Philippines. These entities are corporations, partnerships and associations. The term insurer or insurance company is deemed to include all partnerships, associations, co-operatives, or corporations including government-owned or controlled corporations or entities, engaged as principals in the insurance business, excepting mutual benefit associations. It also includes professional reinsurers.

As a condition for an insurance company to transact any insurance business in the Philippines, including reinsurance, the appropriate certificate of authority must first be obtained from the Insurance Commissioner. An insurance company must meet certain standards and requirements in order to be eligible for the issuance of a certificate of authority. One statutory requirement for a domestic insurance company organised as a stock corporation is that it must possess paid-up capital equal to at least PHP1 billion for life and non-life insurers and at least PHP2 billion for composite insurers (ie, authorised to engage in both life and non-life insurance business). If organised as a mutual company, in lieu of such net worth, it must have available total members' equity, in an amount determined by the PIC, above all liabilities for losses reported, expenses, taxes, legal reserve, and reinsurance of all outstanding risks, and a contributed surplus fund equal to the amounts required of stock corporations. The Insurance Commissioner may also require a minimum of PHP100 million in cash assets in addition to the paid-up capital stock. The PIC has also issued guidelines on the

risk-based capital ratio and the risk-based capital requirement that must be complied with by all life and non-life insurance companies operating in the Philippines. An insurance company is not allowed to have any equity in an adjustment company, and vice versa.

An insurance company that is solely authorised to transact reinsurance business must possess a capitalisation of at least PHP3 billion paid in cash, of which at least 50% is paid-up and the remaining portion thereof is contributed surplus, which in no case shall be less than PHP400 million.

2.3 The Taxation of Premium

Domestic insurance corporations are subject to income tax on income from sources within and outside the Philippines. Foreign insurance corporations are subject to income tax only on income from Philippine sources. Domestic corporations are subject to ordinary corporate income tax (OCIT) of 25%, effective 1 July 2020 on their taxable income (ie, gross income less allowable deductions) or minimum corporate income tax (MCIT) of 1%, effective 1 July 2020 until 30 June 2023 and 2% thereafter on their gross income, whichever is higher. Foreign corporations doing business in the Philippines (ie, resident foreign corporations) are subject to the same tax, although only on income from Philippine sources. However, domestic corporations with net taxable income not exceeding PHP5 million and with total assets not exceeding PHP100 million, excluding land on which the corporation's office, plant and equipment are situated during the taxable year for which the tax is imposed, shall be taxed at 20%.

Premiums form part of the gross income of the insurance company for the purposes of computing the taxable income subject to the OCIT or for the purposes of computing the MCIT. They are also subject to business taxes and documentary stamp taxes (DST), depending on whether the premium is for life insurance or non-life insurance.

Premiums received by life insurance companies are subject to a 2% business tax based on the total premium collected, with the following exceptions:

- premiums refunded for any reason within six months after payment to a person insured;
- premiums for reinsurance by a company that has already paid the tax;
- premiums collected or received by any branch of a domestic company doing business outside the Philippines on account of any life insurance of a non-resident insured, if any tax is imposed on the premium by the foreign country where that branch is established;
- premiums collected on account of reinsurance if the insured, in cases of personal insurance, resides outside the Philippines and any tax is imposed on those premiums by the foreign country where the original insurance was issued; and
- portion of premiums collected by insurance companies on variable contracts in excess of the amounts necessary to ensure the lives of the variable contract owners.

Fire, marine, or miscellaneous insurance agents, authorised under the Insurance Code to procure insurance policies on risks located in the Philippines for companies not authorised to transact business in the Philippines, must pay twice the aforementioned tax imposed. Where owners of property obtain insurance directly with foreign companies, those owners must report to the

Insurance Commissioner and pay a tax of 5% on their premiums.

Premiums received by non-life insurance companies (except on crop insurance), including surety, fidelity, indemnity and bonding companies are subject to 12% value-added tax.

Life insurance policies are subject to a one-time DST, ranging from PHP20 to PHP200, depending on the amount of insurance.

Property insurance policies are subject to a DST of PHP0.50 on each PHP4, or fraction thereof, of the amount of premium charged. Reinsurance contracts, or any other instruments by which acceptance of insurance risks under any reinsurance agreement is affected, are not subject to DST.

Fidelity bonds and other insurance policies are subject to DST of PHP0.50 on each PHP4, or fraction thereof, of the premium charged.

Cities and municipalities may also impose local business taxes on premiums received by insurance companies at rates not exceeding 0.75% and 0.50%, respectively.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Overseas-based insurers or reinsurers wishing to engage in insurance or reinsurance business in the Philippines must obtain a certificate of authority to transact insurance business in the Philippines from the Insurance Commissioner. For this purpose, insurers or reinsurers must establish either a subsidiary incorporated in the Philippines or a branch office with a licence to do business in the Philippines. A foreign insurer or reinsurer must also file with the Insurance Commissioner a written power of attorney designating a resident agent in the Philippines on whom any notice – provided by law or an insurance policy, and any other legal processes – may be served in all actions or legal proceedings involving the foreign insurer, and consenting that service upon that resident agent will be admitted and held valid as if served upon the foreign insurer at its home office.

Foreign insurers/reinsurers are also required to have unimpaired capital or assets and reserve of not less than PHP1 billion and must deposit, with the PIC, securities satisfactory to the Insurance Commissioner. A new branch office of a foreign insurance company may also be required to have an additional surplus fund in an amount determined by the PIC.

3.2 Fronting

A fronting arrangement, whereby a locally licensed insurance company acts as an agent of an unlicensed foreign insurance company to sell the latter's insurance products in the Philippines, is not allowed. However, it may be possible to structure a fronting activity as one where insurance products are sold in the Philippines by a locally licensed insurance company that reinsures the insurance risk, from the products thus sold, with a foreign unlicensed entity acting as reinsurer. In the Philippines, offshore reinsurance is regulated, and the Insurance Code requires that no insurance company doing business in the Philippines shall cede all or part of its risks situated in the Philippines by way of reinsurance directly to any foreign insurer not authorised to do business in the Philippines, unless that foreign insurer is represented in the Philippines by a resident agent duly registered with the PIC.

In order for a local insurer to have its insurance risks reinsured by a foreign reinsurer, there is a requirement that at least 10% of the outward reinsurance placed with unauthorised foreign reinsurers must first be offered for cession to the National Reinsurance Corporation of the Philippines (NRCP). If the NRCP decides that it cannot take on more risk for reinsurance, it must issue a declination letter in accordance with the requirements issued by the PIC, which must be submitted by the local insurer along with the other requirements for applications for reinsurance placements abroad.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

The insurance industry is imbued with public interest, and thus, is highly regulated. With respect to mergers and acquisitions relating to a domestic insurer, no person, other than an authorised insurer, is allowed to acquire control of any domestic insurer. There are also requirements to provide written notice to the domestic insurance company of the applicant's intention to acquire control, and the approval of the Insurance Commissioner must be obtained, following the submission of certain documentary requirements.

With respect to a merger or consolidation, two or more domestic insurance companies which intend to merge or consolidate into a single corporation, whether resulting in the survival of one of the constituent corporations or the formation of a new corporation, must provide written notice to the Insurance Commissioner at least 30 days prior to any board action to approve any plan of merger or consolidation. Such a plan must include certain provisions or documents required by the Insurance Commissioner, such as the proposed articles of merger or consolidation, or the by-laws of the surviving or acquiring company, among others. This plan of merger/consolidation and the articles of merger/consolidation are also subject to the approval of the Insurance Commissioner, whose endorsement is necessary before these may be filed with the SEC. All proposed mergers and consolidations must be completed within 12 months from the time the Insurance Commissioner was first notified of the intent to merge or consolidate, unless written requests to extend the deadline for completion are filed within the aforementioned period and approved by the Insurance Commissioner.

In addition to these requirements and considerations, any such mergers or acquisitions may be subject to mandatory notification to the PCC, should the transaction and the parties exceed the then prevailing thresholds set by the law and the PCC regulations. Even if the insurer doing business in the Philippines is not a party to the merger or acquisition but the thresholds for compulsory notification are satisfied – which includes an examination of the assets in, and gross revenues from, the Philippines of the ultimate parent entities of the parties to such a merger or acquisition – a notification must still be submitted to the PCC. Beginning 15 September 2022, all mergers and acquisitions (including joint ventures) where the size of the party (as this term is defined under the PCC regulations) exceeds PHP6.1 billion and where the size of transaction (as this term is defined under the PCC regulations) exceeds PHP2.5 billion, are notifiable, and parties to the transaction must wait for the PCC's express or deemed approval before consummating the transaction.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Insurance and reinsurance products are distributed in the Philippines through direct sales by insurers through their employees, through insurance agents, and through insurance brokers. Bancassurance is also recognised in this jurisdiction.

Insurance agents and brokers are required to have the appropriate licences before soliciting or procuring applications for insurance, or providing related services, which are to be renewed every three years. No insurance company doing business in the Philippines, nor any agent thereof, shall pay any commission or other compensation to any person for services in obtaining insurance unless that person has the appropriate licence.

Insurance agents are persons who, for compensation, solicit or obtain insurance on behalf of any insurance company, or transmit, to a person other than himself or herself, applications for a policy or contract of insurance to or from that company, or act in the negotiating of such insurance. An applicant to be an insurance agent or a general agent is required to be a resident of the Philippines, must be trustworthy, and must pass the written examination for the kind of licence applied for (eg, life, non-life, accident and health, variable life). If the applicant is a partnership, association, or corporation, that applicant must be domiciled in the Philippines and authorised by its constitutive documents to transact the kind of insurance business applied for. The individual to be named in the licence applied for must possess the requirements previously mentioned. No person shall be licensed to act as an insurance agent or a general agent of more than one life insurance company, and/or as general agent of more than one non-life insurance company, and as an insurance agent for more than seven other non-life insurance companies. No official or employee of an insurance brokerage or an adjustment company and no individual adjuster shall be licensed to act as an insurance agent or general agent. Such a licence may be suspended or revoked upon a finding of violations of the above-mentioned rules and upon other applicable grounds. The PIC keeps a Negative List of insurance agents in relation thereto.

Insurance brokers are those who – for any compensation, commission, or other thing of value – act or aid in any manner in soliciting, negotiating, or procuring the making of any insurance contract or in placing risk or taking out insurance, on behalf of an insured other than himself or herself.

A reinsurance broker is one who – for compensation and not being a duly authorised agent, employee or officer of an insurer in which any reinsurance is effected – acts or aids in any manner in negotiating contracts of reinsurance or placing risks of effecting reinsurance for any insurance company authorised to do business in the Philippines.

Any new entrant intending to do business, either as an insurance broker or reinsurance broker, must have a minimum capitalisation or paid-up capital of PHP20 million and must maintain a net worth of PHP20 million.

If the new entrant intends to do business as both, it must have a minimum capitalisation or paid-up capital of PHP50 million and must maintain a net worth of at least PHP50 million.

Certain prohibitions are also applicable to insurance brokers. No person licensed as an insurance agent or general agent shall be licensed as an insurance broker, nor shall a person licensed as an insurance broker be licensed as an insurance agent or general agent. No official or employee of an insurance broker shall be licensed to act as insurance agent or general agent. No broker, nor any of its stockholders and officers, shall have a controlling interest in any insurance or reinsurance company, or insurance adjustment company or vice versa.

Bancassurance refers to the presentation and sale to bank customers by an insurance company of its insurance products within the premises of the head office of a bank duly licensed by the BSP or any of its branches, under whatever rules and regulations that the Insurance Commissioner and the BSP may promulgate. To engage in a bancassurance arrangement, a bank is not required to have equity ownership of the insurance company. However, the bank and the insurance company must belong to the same financial conglomerate, or a group of interrelated entities providing significant services in at least two different financial sectors (eg, banking, securities and insurance), pursuant to BSP regulations. The bank must also have secured prior Monetary Board approval to engage in the aforementioned activities. Bancassurance agreements entered into between the bank and the insurance company must also be submitted to the Insurance Commissioner for approval, and must contain certain mandatory provisions, such as provisions stating that areas within the bank premises where bancassurance activities are conducted must be distinct and clearly marked from areas where bank products are being sold. Other requirements and regulations for the public's interest must be complied with as the parties engage in bancassurance activities.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The Insurance Code states that each party to a contract of insurance must communicate to the other, in good faith, all facts within his or her knowledge which are material to the contract and as to which he or she makes no warranty, and which the other has no means of ascertaining. A fact is material depending on its probable and reasonable influence upon the party to whom the communication is due, in forming his or her estimate of the disadvantages of the proposed contract, or in making his or her inquiries.

This right to being informed of material facts may, however, be waived, either by the terms of insurance or through neglect in making inquiries as to those facts, where they are distinctly implied in other facts of which information is communicated. Thus, in the case of the insurer, it must proactively seek more information from the insured if the communication made by the insured implies that there are other material facts that are relevant to the insurer with respect to the negotiation of the contract.

6.2 Failure to Comply With Obligations of an Insurance Contract

Failure to comply with the duty to communicate may amount to concealment, which is the neglect to communicate that which a party knows and ought to communicate, and entitles the injured party to rescind a contract of insurance. It has been held that if the insured has knowledge of a fact material to the risk – and honesty, good faith and fair dealing require that he or she should communicate it – but intentionally withholds that knowledge, this is concealment and, regardless of actual intent to defraud, entitles the injured party to rescind the contract.

A representation is a statement, whether oral or written, made at the time of, or before, the issuance of a policy. If a representation made by a party is false in a material point, whether it is affirmative, which is a representation presumed to refer to the date on which the contract begins, or promissory, which is a representation as to the future, the injured party is entitled to rescind the contract from the time the representation becomes false.

It should be noted that, in life insurance, after a policy of life insurance made payable on the death of the insured has been in force during the lifetime of the insured for a period of two years from the date of its issue or of its last reinstatement, the insurer can no longer prove that the policy is void or is rescindable by reason of the fraudulent concealment or misrepresentation of the insured or his or her agent.

6.3 Intermediary Involvement in an Insurance Contract

An insurance agent acts on behalf of the insurer, while an insurance broker acts for the insured. Both the insurance agent and the insurance broker have certain fiduciary duties. The premium, or any portion thereof which an insurance agent or insurance broker collects from an insured and which is to be paid to an insurance company, is held by the agent or broker in a fiduciary capacity and must not be misappropriated or converted to his or her own use. Any insurer which delivers to an insurance agent or insurance broker a policy or contract shall be deemed to have authorised that agent or broker to receive on its behalf payment of any premium which is due on that policy or contract of insurance. Failure to abide by and comply with these fiduciary obligations is grounds for the denial, suspension, or revocation of the licence of an insurance agent or insurance broker.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

A policy of insurance, or the written instrument in which a contract of insurance is set forth, is required to be printed, or to be in an electronic form subject to the pertinent provisions of the Electronic Commerce Act of the Philippines and regulations issued by the Insurance Commissioner. Such a policy must be in a form approved by the Insurance Commissioner. In addition, the Insurance Code states that any contingent or unknown event, whether past or future, which may cause injury or loss to a person who has an insurable interest, or may create a liability against him or her, may be insured against, subject to certain exceptions and conditions provided under the Code. It can be gleaned from this provision that an insurable interest is a requirement in this jurisdiction. Every person is deemed to have insurable interest in the life and health:

- of himself or herself, of his or her spouse and children;
- of any person on whom he or she depends, wholly or in part, for education or support, or in whom he or she has a pecuniary interest;
- of any person under a legal obligation to him or her for the payment of money, or respecting property or services, of which death or illness might delay or prevent the performance; and
- of any person upon whose life any estate or interest vested in him or her depends.

An insurable interest in property may consist in:

- an existing interest;
- an inchoate interest founded on an existing interest; or
- an expectation, coupled with an existing interest out of which the expectation arises.

The inclusion of the following terms in a policy of insurance are essential and are required by the Code, in addition to any other provisions required by further regulations issued by the Insurance Commissioner:

- the parties to the contract;
- the amount to be insured except in the cases of open or running policies;
- the premium, or a statement of the basis and rates upon which the final premium is to be paid in certain instances;
- the property or life insured;
- the interest of the insured in the property insured, if he or she is not the absolute owner thereof;
- the risks insured against; and
- the period during which the insurance is to continue.

6.5 Multiple Insured or Potential Beneficiaries

Non-parties to an insurance contract may be beneficiaries, depending on the type of insurance product. The beneficiary has to be specified by the insured. The disclosure rules are the same, even if there are multiple insureds or potential beneficiaries under the contract.

6.6 Consumer Contracts or Reinsurance Contracts

The position is essentially the same with respect to reinsurance contracts, subject to any special regulations issued by the Insurance Commissioner specifically on reinsurance placement and treaties.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

The authors have yet to work on alternative risk transfer (ART) transactions, such as insurance loss warranty contracts and insurance-linked securities, and are not aware as to whether any such transactions have been entered into by companies in the Philippines.

Currently, PIC regulations do not make it clear if ART transactions are to be classified as insurance (or reinsurance) transactions. Given this regulatory gap, the prudent practice is to present the contract or arrangement to the PIC. In any case, if the contract or arrangement has a risk-distribution feature, the PIC may consider it as an insurance (or reinsurance) transaction.

Furthermore, registration to the SEC may be required for insurance-linked securities. Generally, public offer and sale of securities (equity and debt instruments) in the Philippines to more than 19 persons within any 12-month period require the registration of those securities with the SEC.

7.2 Foreign ART Transactions

As previously mentioned in **7.1 ART Transactions**, the insurance regulations are not clear with respect to ART transactions.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are usually interpreted using the plain and ordinary meaning of their text, much like any other contract. However, when doubt exists, courts have construed the doubtful provisions in favour of the insured and strictly

against the insurer, as insurance contracts are drafted solely by the insurer. Extraneous evidence is generally not permitted in proving the proper interpretation of an insurance contract.

8.2 Warranties

Warranties mentioned in the insurance policy are not required to be expressly described or denominated as such. However, warranties that are merely pasted or attached to the insurance policy are not binding on the insured unless the descriptive name or title of those warranties are written on the blank spaces provided for in the insurance policy. Similarly, any warranty issued after the original policy should be countersigned by the insured or owner, except if it is applied for by the insured or owner.

If a material warranty is breached, the innocent party is entitled to rescind the insurance policy. However, a breach of warranty without fraud releases the insurer from further liability from the time it occurs; if the breach happens before the inception of the policy, that breach prevents the policy from attaching to the risk sought to be insured against.

8.3 Conditions Precedent

There are no known regulations expressly requiring conditions precedent to be described as such. However, the conditions for the insurer's liability – such as covered and excluded risks, warranties, representations and requirements for claims settlement – should be easily identifiable. Generally, a premium has to be paid before an insurance policy becomes valid and binding. An insurer who unjustifiably refuses to settle or pay claims is liable to pay damages consisting of attorney's fees and expenses incurred by the insured, plus interest.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Disputes over coverage under any kind of insurance contract may be addressed by either going to court or by filing a complaint with the Insurance Commissioner. The Insurance Code gives the Insurance Commissioner concurrent jurisdiction with the civil courts for claims and complaints involving any loss, damage, or liability for which an insurer may be answerable under any kind of policy or contract of insurance, or for which a reinsurer may be sued under any contract of reinsurance that it may have entered into, where the amount of any such loss, damage, or liability – excluding interest, cost and attorney's fees – being claimed or sued upon any kind of insurance, bond, reinsurance contract, or membership certificate does not exceed in any single claim PHP5 million. The filing of a complaint with the Insurance Commissioner precludes the civil courts from taking cognisance of a suit involving the same subject-matter.

If the parties provide a limitation period for starting proceedings in respect of an insurance claim, the period shall not be for less than one year. In the absence of such a stipulation, the Civil Code of the Philippines, which sets a ten-year limitation for causes of action based on written contracts, will apply.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Jurisdiction over the subject-matter is conferred by Philippine law and by the material allegations in the complaint, regardless of whether the plaintiff is entitled to recover all or only some of the claims or reliefs sought therein. It cannot be acquired through a waiver or enlarged by the omission of the parties or conferred by the acquiescence of the court.

When there is a conflict-of-law issue, after establishing that it has jurisdiction over the subject-matter, a Philippine court is obliged to consider whether it is a convenient forum to the parties, based on the facts of the case. The rule of forum non conveniens states that a Philippine court may assume jurisdiction over the case if it chooses to do so, provided that:

- the Philippine court is one to which the parties may conveniently resort;
- the Philippine court is in a position to make an intelligent decision as to the law and the facts; and
- the Philippine court has, or is likely to have, the power to enforce its decision.

As regards choice of law, the Philippine court will rely on the principles of lex loci celebrationis and lex contractus, and the state of the most significant relationship rule. Lex loci celebrationis means the law of the place of the ceremony or the law of the place where a contract is made. The doctrine of lex contractus or lex loci contractus means the law of the place where a contract is executed or to be performed. It controls the nature, construction and validity of the contract and it may pertain to the law voluntarily agreed upon by the parties, or the law intended by them either expressly or implicitly. Under the state of the most significant relationship rule, to ascertain what state law to apply to a dispute, the court should determine which state has the most substantial connection to the occurrence and the parties. In a case involving a contract, the court should consider where the contract was made, negotiated, or to be performed, and the domicile, place of business, or place of incorporation of the parties. This rule takes into account several contacts and evaluates them according to their relative importance with respect to the particular issue to be resolved. All these principles are considered together in relation to the factual circumstances of the case to determine the choice of law.

9.3 Litigation Process

A civil action is initiated by the filing of a complaint by the plaintiff before a court vested with jurisdiction over the subject-matter of the case. The court will then issue a summons requiring the defendant to file an answer to the complaint. After the last pleading has been filed, the case will be set for pretrial. As part of pretrial, the case will be referred to mediation, wherein a mediator will help the parties attempt to reach an amicable settlement. If no settlement is reached, the case may undergo judicial dispute resolution proceedings, wherein a judge will help the parties attempt to reach an amicable settlement, only if the judge of the court to which the case was originally raffled is convinced that settlement is still possible. If there is still no settlement reached, the case will proceed to pretrial, wherein the parties will determine, among other things, the specific issues to be resolved in the case, the facts the parties are willing to stipulate on, and the exhibits and witnesses to be presented by the parties. During trial, the plaintiff will present its evidence first. After presenting the plaintiff's last witness, the plaintiff will formally offer its documentary and object evidence to the court. After the court resolves the plaintiff's formal offer of documentary and object evidence, the defendant will then present its evidence. After presenting the defendant's last witness, the defendant will formally offer its documentary and object evidence to the court. The court will then render a decision, which must state the facts and the law on which it is based.

The aggrieved party may question the trial court's decision by filing a motion for reconsideration within 15 days from receipt thereof.

If the motion for reconsideration is denied, the aggrieved party may file a notice of appeal with the Court of Appeals within 15 days from receipt of the denial of the motion for reconsideration. After the Court of Appeals renders a decision, an aggrieved party is given 15 days from receipt thereof to file a motion for reconsideration. If the motion for reconsideration is denied, the aggrieved party may file a petition for review on certiorari to the Supreme Court, which is the court of last resort, within 15 days from receipt of the denial of the motion for reconsideration. After the Supreme Court renders a decision, the aggrieved party is given 15 days from receipt thereof to file a motion for reconsideration. Failure to file an appeal or to move for reconsideration on time will result in the decision becoming final and executory.

9.4 The Enforcement of Judgments

A judgment or final order of a tribunal in a foreign country which has jurisdiction to render the judgment or final order against a person is presumptive evidence of a right between the parties (and their successors in interest by a subsequent title). That judgment or final order may be repelled by evidence of want of jurisdiction, want of notice to the party, collusion, fraud, or clear mistake of law or fact.

In order to enforce a foreign judgment in the Philippines, the winning party must file a verified petition for recognition and enforcement of the foreign judgment before the Philippine courts. The proceedings in court will follow substantially the same procedure outlined in **9.3 Litigation Process**, solely to determine whether or not there exist any of the grounds for repelling the foreign judgment.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses in commercial insurance and reinsurance contracts can be enforced.

9.6 The Enforcement of Awards

If a party receives an award in domestic arbitration, the award shall be included in the judgment of the arbitral tribunal and enforced like a court judgment. Any party to a domestic arbitration may petition the court that has jurisdiction over the place in which one of the parties is doing business, where any of the parties reside, or where arbitration proceedings were conducted, to confirm, correct, or vacate a domestic arbitral award. An arbitral award shall enjoy the presumption that it was made and released in due course of arbitration and is subject to confirmation by the court.

However, any party to a foreign arbitration may petition the court to recognise and enforce a foreign arbitral award at any time after the receipt of that foreign arbitral award. The recognition and enforcement of a foreign arbitral award shall be governed by the 1958 New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards, to which the Philippines is a party, and Rule 13 of the Special Rules of Court on Alternative Dispute Resolution. It is presumed that a foreign arbitral award was made and released in due course of arbitration and is subject to enforcement by the court. The court shall recognise and enforce a foreign arbitral award unless a ground to refuse recognition or enforcement is established. The decision of the court recognising and enforcing a foreign arbitral award is immediately executory.

9.7 Alternative Dispute Resolution

When court proceedings are filed with respect to any kind of insurance contract, before the case

proceeds to trial, the matter will first be referred to mediation, wherein a mediator will help the plaintiff and the defendant attempt to reach an amicable settlement. If no settlement is reached, the case may undergo judicial dispute resolution proceedings, wherein a judge will help the parties attempt to reach an amicable settlement, only if the judge of the court to which the case was originally raffled is convinced that settlement is still possible. Only after both modes of alternative dispute resolution are unsuccessful will the case proceed to trial.

Parties are also free to include an arbitration clause in their insurance contracts, such that any dispute under the insurance contract will have to be resolved through arbitration.

For micro-insurance contracts, the PIC has issued regulations to the effect that the various modes of alternative dispute resolution are a prerequisite to the filing of a civil action.

9.8 Penalties for Late Payment of Claims

Insurers who unreasonably deny or withhold the payment of claims shall be liable for damages, consisting of attorney's fees and other expenses incurred as a result of the unreasonable denial or withholding of payment, and interest, in the amount of twice the ceiling prescribed by the Monetary Board, on the amount due under the claim of the insured. These damages and interests are in addition to the amount of the insurance claim.

9.9 Insurers' Rights of Subrogation

Payment by the insurer to the insured operates as an equitable assignment of all the remedies that the insured may have against the third party who caused the damage. Accordingly, subrogation is not dependent upon, nor does it grow out of, any privity of contract or upon a written assignment of claim. It accrues simply upon the payment of the insurance claim by the insurer.

However, the right of subrogation is not absolute. For instance, both the insurer and the insured are bound by any contractual stipulations entered into by the insured prior to the subrogation. Moreover, the insurer can be subrogated only to the rights as the insured may have against the wrongdoer. If, by its own acts, the insured releases the wrongdoer liable for the loss or damage, the insurer loses its claim against the latter. Finally, subrogation is also not an available remedy in life insurance and in cases where the insurer pays the insured for a loss or risk not covered by the policy or where the insurer paid in excess of the amount of the loss.

10. Insurtech

10.1 Insurtech Developments

Several local insurers have mobile apps through which all insurance transactions can be performed. Some develop their own platforms or collaborate with fintech companies to provide various products which may be bundled with other services.

10.2 Regulatory Response

The PIC has issued several guidelines on electronic commerce of insurance products. Recently, the PIC issued regulations providing guidelines for a regulatory sandbox framework to promote insurtech.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

There is growing concern over climate change risks, such as stronger typhoons and more severe droughts. The PIC has recently issued guidelines to adopt a regulatory sandbox framework for agriculture insurance, in order to encourage local insurers to encourage non-life insurers to issue agricultural insurance products.

11.2 New Products or Alternative Solutions

Cyber-insurance, which is specifically designed to cover the risk of hacking or data leaks, is now offered in the Philippines and is typically bundled with other products. The PIC is promoting the use of insurtech and for insurers to issue agricultural insurance products.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

The PIC has recently issued several circular letters on the following: new financial reporting framework for mutual benefit associations; guidelines on the materiality threshold to be applied to financial statements of insurance companies and other entities regulated by the PIC; and the transitional financial reporting framework for insurance and reinsurance companies.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

ESG is also taking the spotlight in the insurance industry in the Philippines. In 2021, the PIC issued a regulation for the establishment of a Philippine catastrophe insurance facility which directs non-life insurers to participate in the Philippine Catastrophe Insurance Facility Technical Working Group (PCIF-TWG). It also issued circulars to update the schedule of minimum catastrophe insurance rates and rating structure for all insurance policies providing cover for catastrophe risks, with the effective term beginning on 1 January 2023 for new and renewal business.

SyCip Salazar Hernandez & Gatmaitan (SyCipLaw) was founded in 1945. It is a full-service law firm and is one of the largest firms in the Philippines. The firm offers a broad and integrated range of legal services, with departments in the following fields: banking, finance and securities, special projects, corporate services, litigation and dispute resolution, employment law and immigration, intellectual property and tax. The firm's insurance practice covers a broad range of transactions – from conducting due diligence for an acquisition, the sale or purchase of shares or assets, the establishment of a subsidiary or a branch office, securing from the Philippine Insurance Commission the necessary licences and approvals of products, to closure of an insurer. The firm has extensive experience in insurance coverage disputes.

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Trends and Developments

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Catastrophe Insurance as a Critical Tool in Increasing Resilience Against Natural Disasters

The Philippines is one of the most natural-hazard-prone countries in the world due to its geographical location. It is regularly exposed to several natural hazards such as earthquakes and volcanic eruptions (owing to its location along the Pacific Ring of Fire) as well as typhoons and floods (due to its location in the north-western Pacific Basin).

Based on the Climate Change Knowledge Portal of the World Bank Group as of 2021, around 20 typhoons enter the Philippine Area of Responsibility, with an average of eight of these making landfall and five of which are destructive. It also reported that the strongest typhoon in the Philippines in recent years was Typhoon Haiyan, which killed 6,000 people, devastated 1.1 million homes, and wreaked agricultural and infrastructure damages worth USD802 million. Climate change is only expected to produce stronger, more destructive typhoons.

Philippine Catastrophe Insurance Facility (PCIF)

The Philippine Insurance Commission (PIC), the industry regulator, recognises the critical role of catastrophe insurance in increasing the country's resilience against natural disasters and in hastening the recovery of communities after experiencing devastation from such natural disasters.

In 2021, the PIC issued Circular Letter No 2021-27 providing for the "Strict Implementation of Sustainable Catastrophe Insurance Premium Rates and Establishment of the Philippine Catastrophe Insurance Facility (PCIF)". The general framework of the PCIF will include "(i) the review of current catastrophe insurance rates and rating structure [to shift] to one that is more risk-appropriate and sustainable, (ii) the creation of an environment to ensure adherence to sustainable catastrophe insurance premium rates, and (iii) the optimisation of inclusive access to insurance cover subject to technically sufficient and sustainable rates, terms and conditions".

The circular letter directed non-life insurers to actively participate in the Philippine Catastrophe Insurance Facility Technical Working Group to ensure an inclusive and consultative process for building the structure, governance and implementation details of the PCIF, which included "the determination and adoption of risk-appropriate and sustainable catastrophe insurance rates and rating structure" and "the commitment of participating non-life insurers to adhere to established sustainable catastrophe insurance premium rates through compulsory cession to the PCIF", of an agreed proportion of each earthquake, typhoon and flood risk. The cession will be based on a "reasonable percentage and/or maximum limit per risk/per policy", agreed upon by the industry through the Philippine Insurers and Reinsurers Association. In turn, the PCIF will retrocede the same risks to subscribing authorised non-life insurers.

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Prior to the establishment of the PCIF, domestic insurance companies that provide catastrophe insurance coverage had to reinsure their risks overseas.

With the establishment of the PCIF, the ability of the Philippine insurance industry to take on more risk is augmented. According to the Philippine Department of Finance (DOF), the resources available in the country will be pooled to keep most of the funds within the country and enable non-life insurers to grow the premium base, thereby allowing them to expand the range of catastrophe insurance products available to Filipinos.

The PCIF is expected to benefit micro, small and medium enterprises (MSMEs) and households that are mostly among the most vulnerable when natural disasters strike the country.

Revised Schedule of Risk-Appropriate and Sustainable Minimum Catastrophe Rates

In 2022, the PIC issued Circular Letter No 2022-34 (as amended by Circular Letter 2022-48) entitled "Guidelines on the Adoption of the Revised Schedule of Minimum Catastrophe Rates", which prescribed the revised schedule of minimum catastrophe rates to be observed by all non-life insurance companies for their insurance policies providing cover for earthquake, typhoon and flood risks, with the effective term beginning on 1 January 2023 for new and renewal business.

Under this revised schedule, the catastrophe rates depend on the "local hazard profile" of each province, the construction grade of a building and its number of storeys.

The circular letter also phased the implementation of the rate adjustments to allow the market to adjust over time and to cushion the impact of such adjusted rates.

Stimulating the Expansion of Agriculture Insurance Through the First Public-Private Agreement

The agriculture industry is among the industries hardest hit by natural disasters. Data from the Philippine Office of Civil Defence showed that agricultural damage from 2012 to 2021 comprised 56.7% of the total losses due to natural disasters, amounting to around USD6.1 billion. However, the insurance penetration rate among farmers remains low, ranging from 17-31% for the period from 2017 to 2019.

One of the ways in which the Philippine insurance industry has tried to bridge this protection gap is through the execution of a co-insurance agreement on agriculture insurance between the Philippine Crop Insurance Corporation (PCIC) and CARD Pioneer Microinsurance, Inc. (CPMI) on 3 February 2022, as reported by the PIC in its press release dated 2 February 2022. Supported by the Asian Development Bank (ADB) under its Financial Inclusion Strengthening Framework Technical Assistance Project, this co-insurance agreement was lauded by the PIC as the first public-private agreement on agriculture insurance, with PCIC being a government-owned and controlled corporation, and CPMI being a private insurance company.

The PIC reported that under the co-insurance agreement, CPMI and PCIC will share the risks underwritten for each insurance policy in the ratio of 70:30, with CPMI as the lead insurer and PCIC as the co-insurer. Moreover, CPMI will offer PCIC's agriculture insurance products to farmers using its network of distribution channels.

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In addition, the PIC press release mentioned that PCIC will provide capacity-building support to CPMI in the areas of underwriting, policy administration, actuarial matters and claims management. Meanwhile, CPMI will attempt to increase agricultural insurance penetration by focusing on high-value crops in selected regions where PCIC has limited coverage.

Climate Policy Agenda and Commitments Under Laws and Treaties

For its part, the Philippine government has enacted several laws and ratified several treaties in its commitment to combat the worsening effects of climate change.

For instance, in 2017, the Philippines entered into a Memorandum of Cooperation on Low Carbon Growth Partnership with Japan, establishing a Joint Crediting Mechanism wherein a project using advanced low-carbon technology is set up in the host country and the resulting carbon emission reductions are then credited to the project proponents of Japan and the host country.

In 2021, the Philippines entered into a partnership with ADB to set up the Energy Transition Mechanism which seeks to retire existing coal-fired power plants and replace them with clean power capacity.

The Philippines has also entered into a partnership with the United Kingdom to implement the ASEAN Low Carbon Energy Programme, including the establishment of the "Green Force", which is the Inter-Agency Technical Working Group for Sustainable Finance led by the DOF and the *Bangko Sentral ng Pilipinas* (the Philippine Central Bank).

Moreover, as part of the Nationally Determined Contribution of the Republic of the Philippines Communicated to the United Nations Framework Convention on Climate Change on 15 April 2021, the Philippine government adopted a comprehensive climate policy agenda, including the National Framework Strategy on Climate Change (2010-2022), the National Climate Change Action Plan (2011-2028), the Philippine Development Plan (2017-2022), the Philippine Energy Plan (2020-2040), the Philippine National Security Policy (2017-2022), the National Climate Risk Management Framework of 2019 and the Sustainable Finance Policy Framework of 2020.

There is pending legislation for a Low Carbon Economy Act that sets out provisions for a domestic cap and trade system, although no timeline for its approval has been specified.

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PORTUGAL

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

In Portugal, the main sources of insurance and reinsurance law are the following.

- The Insurance and Reinsurance Law (Insurance Law), approved by Law No 147/2015, dated 9 September 2015, which transposed into the Portuguese legal order Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on taking up and pursuing the business of insurance and reinsurance (Solvency II Directive). The Insurance Law establishes the conditions for taking up and pursuing insurance and reinsurance business.
- The Insurance Contract Law (Ins Contract Law), approved by Decree-Law No 72/2008, dated 16 April 2008, which establishes the main rules applicable to insurance contracts.
- The Insurance Distribution Law (Ins Distribution Law), approved by Law No 7/2019, dated 16 January 2019, which transposed into the Portuguese legal order Directive 2016/97/EU of the European Parliament and of the Council of 20 January 2016 on insurance distribution. The Ins Distribution Law establishes the conditions for taking up and pursuing insurance and reinsurance distribution.

The above-mentioned diplomas are supplemented by other laws or decree-laws with a specific scope (for instance, aiming to regulate a specific type of insurance or distribution channel) or with a general scope, such as the Standard Contractual Clauses Law (Standard Clauses Law), approved by Decree-Law No 446/85, dated 25 October 1985, and the Consumer Protection Law, approved by Law No 24/96, dated 31 July 1996, and are also supplemented by several regulations and circular letters issued by the Regulatory Authority.

Portuguese jurisdiction is based on a civil law system, meaning that legal rules are codified under a set of legal statutes created by the legislature, rather than being based on judicial decisions, as happens in a common law system. Court decisions are only relevant for the purposes of interpretation; they are not legally binding.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

The competent authority for the prudential and regulatory supervision of insurance and reinsurance business, insurance distribution and pension funds is Autoridade de Supervisão de Seguros e Fundos de Pensões (ASF).

The ASF's mission is to ensure the proper functioning of the insurance and pension funds market, by promoting the stability and financial soundness of the entities under its supervision. It is also the ASF's role to ensure high standards of conduct on the part of all the supervised entities aiming to protect policyholders, insureds, subscribers, beneficiaries and any interested parties.

Besides supervision of regulated entities, the ASF's duties include taking part in the macroprudential oversight of the financial system and in the European System of Financial Supervisors, providing technical support to the parliament and government in matters related to the

activities under its supervision and promoting financial literacy in the sector.

The ASF's powers are set out in the following main rules:

- Law No 67/2013, dated 28 August 2013, which establishes the framework law of the public supervisory authorities;
- the ASF's statutes, approved by Decree-Law No 1/2015, dated 6 January 2015;
- the Insurance Law;
- the Ins Distribution Law; and
- the legal framework applicable to crimes in the insurance and pension funds sector and to administrative offences that are the competence of the ASF, approved by Law No 147/2015, dated 9 September 2015.

2.2 The Writing of Insurance and Reinsurance

In accordance with the Insurance Law, insurance and reinsurance business in Portugal can only be carried out by the following entities:

- Portuguese-based insurers and reinsurers authorised by the ASF;
- Portuguese-based mutual insurance and reinsurance undertakings authorised by the ASF;
- branches of insurers and reinsurers established in other EU member states acting in Portugal under freedom of establishment (FoE), provided certain provisions are met;
- branches of insurers and reinsurers established in a third country authorised by the ASF;
- public insurers and reinsurers set up in accordance with Portuguese laws, provided that such undertakings have insurance or reinsurance operations as their object, under conditions equivalent to those under which undertakings governed by private law operate;
- insurers and reinsurers in the legal form of a European company in accordance with the applicable legislation; and
- insurers and reinsurers established in other EU member states acting in Portugal under freedom of services (FoS), provided certain provisions are met.

General Requirements Applicable to Portuguese-Based Insurers and Reinsurers

Insurers

Insurers must have, as exclusive corporate purpose, insurance activity and operations arising directly therefrom, excluding any other commercial business.

The taking-up of direct insurance business is subject to prior authorisation from the ASF, which is granted for a particular class of insurance, covering the entire class, unless the applicant wishes to cover only some of the risks pertaining to that class.

Portuguese law does not allow companies to pursue activity simultaneously in life insurance and non-life insurance, with one exception: the authorisation for life insurance may comprise accidents and sickness (classes of non-life insurance). Other than that, authorisation cannot simultaneously encompass life and non-life insurance.

The minimum share capital is as follows:

- EUR2,500,000 for non-life insurers to conduct business in sickness, legal expenses or assistance;
- EUR7,500,000 in the event the undertaking conducts business in more than one of the classes referred to in the preceding bullet or

in any other class or classes of non-life insurance;
- EUR7,500,000 in the event the undertaking conducts life insurance business; and
- EUR15,000,000 in the event the undertaking conducts business simultaneously in life insurance and one or more classes of non-life insurance, where authorised.

Reinsurers

Reinsurers must have, as exclusive corporate purpose, reinsurance activity and related operations, including the management of shares held in other companies within the financial sector.

The taking-up of reinsurance business is subject to prior authorisation from the ASF, which is granted for non-life reinsurance activity, life reinsurance activity or both.

The minimum share capital is as follows:

- EUR7,500,000 in the event the undertaking conducts non-life reinsurance or life reinsurance business; and
- EUR15,000,000 in the event the undertaking conducts both kinds of reinsurance activity.

Requirements applicable to both insurers and reinsurers

Insurers and reinsurers must be incorporated in the legal form of a public limited company (*sociedade anónima*) with nominative shares and subject to registration at the Commercial Registry Office, tax authorities and social security. The share capital must be totally subscribed and paid up at the incorporation. The shareholders, members of the board and key-functions staff are subject to fit and proper criteria.

The authorisation granted by the ASF permits insurers and reinsurers to pursue business in Portugal, also covering the right of establishment and the freedom to provide services in other EU member states, provided the notification procedure between supervisors is duly complied with.

The ASF must grant authorisation within six months of receiving the application or, where applicable, after receiving any additional information from the applicant – but never after 12 months from the date the application was initially filed. The authorisation will expire in the event the undertaking is not incorporated within six months or does not start its activity within 12 months from the date the authorisation was granted.

Consumer Insurance, SME Insurance and Corporate Insurance

Large risk v mass risk

The Portuguese insurance legal framework is based on two main concepts: mass risk insurance and large risk insurance. The distinction between these two types of insurance arises from the Insurance Law.

Large-risk insurance comprises the following risks:

- risks classified under the following classes: Railway Rolling Stock, Aircraft, Ships, Goods in Transit, Aircraft Liability and Liability for Ships;
- risks classified under Credit and Suretyship classes where the policyholder is engaged professionally in an industrial or commercial activity, or in one liberal profession, and risks relate to such activity;
- risks classified under Land Vehicles, Fire and Natural Forces, Other Damage to Property, Motor Vehicle Liability, General Liability and Miscellaneous Financial Loss classes, in so

far as the policyholder exceeds at least two of the following criteria:
(a) a total balance sheet of EUR6,600,000;
(b) a net turnover of EUR13,600,000; and
(c) an average number of 250 employees during the financial year; and
(d) if the policyholder belongs to a group of undertakings for which consolidated accounts are drawn up, the criteria set out above must be applied on the basis of the consolidated accounts.

Mass risk insurance encompasses all insurances that do not fall under the scope of large-risk insurance.

Consumers v professionals

The Ins Contract Law does not provide for an autonomous category or definition of "consumer insurance". It bases the protection of consumers on the imposition of stricter rules as regards mass risk insurance.

As a rule, insurance contracts are governed under contractual freedom; mass risk insurance, however, is subject to several limitations that aim to protect the consumer, who, depending on the circumstances, may act in the capacity of policyholder, insured or beneficiary.

In this regard, the Ins Contract Law establishes that certain rules are mandatory as regards mass risk insurance. Said rules are divided into:

- absolutely mandatory rules (rules that cannot be waived by the parties); and
- relatively mandatory rules (rules that allow the parties to provide for different solutions other than those established by law, provided said solutions benefit the policyholder, the insured or the beneficiary, where applicable).

Legal Restrictions

The Ins Contract Law settles that the following risks cannot be guaranteed under Portuguese law:

- criminal, administrative or disciplinary liability;
- kidnapping, sequestration and other crimes against personal freedom (save for civil compensation);
- possession or transportation of narcotics or drugs, the consumption of which is forbidden; and
- the death of children under 14 years old or of those who are incapable of governing themselves due to mental incapacity or other cause (save for civil compensation).

2.3 The Taxation of Premium

Portuguese law subjects the premiums of insurance contracts covering risks situated in Portuguese territory or regarding which Portugal is the member state of the commitment, to the indirect taxes and parafiscal charges foreseen in Portuguese law, regardless of the law applicable to the contract.

Policyholders

Life insurance

- Tax to INEM (Medical Emergency Institute): 2.5% on premiums regarding life insurance in case of death, and supplementary covers.
- Stamp duty: exempted.
- Value added tax (VAT): exempted.

Non-life insurance

- Tax to INEM: 2.5% on premiums regarding sickness, accidents, land vehicles and motor vehicle liability.
- Stamp duty (different rates apply):
  (a) suretyship – 3%;
  (b) accidents and health – 5%;
  (c) credit – 5%;

(d) agriculture and livestock – 5%;
(e) goods in transit – 5%;
(f) ships and aircraft – 5%; and
(g) other non-life risk classes – 9%.

- VAT: exempted.
- Other specific taxes (motor insurance guarantee fund, tax on green cards, civil protection, etc).

Personal income tax (PIT)

Income corresponding to the positive difference between the amounts paid as redemption of a life insurance contract and the premiums paid is subject to PIT as investment income, according to the following rules.

- Taxable income will be:
  (a) 100% if payment occurs within the first five years of the contract;
  (b) 80% if payment occurs between the first five and eight years of the contract; and
  (c) 40% if payment occurs after eight years of contract.
- Taxable income reduction will only take place if at least 35% of the premiums are paid in the first half of the contract's term.

Taxable income is subject to a 28% final rate. The policyholder may benefit from reduced taxation provided the deadlines mentioned in b) and c) are met (22.4% and 11.2%, respectively).

Insurers

Premiums received by Portuguese-based insurers are deemed as taxable income and are subject to corporate income tax (CIT) general rules at rates up to 31.5%. Additionally, tax on insurance premiums must be paid at the following rate to the ASF (ASF tax) by Portuguese-based insurers and overseas-based undertakings acting in Portugal:

- life insurance: 0.048% on registered earnings; and
- non-life insurances: 0.242% on registered earnings.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

EU Undertakings

An authorisation granted to an insurer or reinsurer to conduct insurance business by a supervisory authority from another EU member state shall be valid in Portugal (EU passport), covering freedom of establishment (FoE, through a branch) or freedom of services (FoS), where applicable.

Insurers

Any insurer that wishes to act in Portugal under FoS or FoE must first notify the supervisory authorities of its home member state about such intention, which will thereafter communicate this information to the ASF. Within two months of receipt of the information, the ASF will communicate to the supervisory authorities of the home member state the general good provisions that need to be complied with when acting in Portugal.

The insurer may start business:

- under FoS, as from the date on which it is informed by the supervisory authority of the home member state about the communication provided to the ASF; or
- as a branch, from the date on which the supervisory authority of the home member state received said communication from the ASF, or on expiry of the above-mentioned

two-month period (provided the branch is registered with the companies register, tax authorities and social security).

General good provisions

The pursuit of insurance business in Portugal under an EU passport is subject to compliance with several rules considered to be of general good, as determined by the ASF, which include (but are not limited to) the following.

- Payment of the indirect taxes and rates established in Portuguese law as regards premiums of insurance contracts covering risks situated in Portuguese territory or where Portugal is the member state of the commitment, regardless of the law applicable to the contract.
- Compliance with several rules arising from the Ins Contract Law regarding pre-contractual information.
- Prohibition to underwrite certain risks forbidden under the Portuguese legal framework.
- Compliance with market conduct provisions, namely, in terms of client policies, advertising, complaints management and client ombudsman.
- Reporting of periodic information to the ASF under Regulatory Rule No 8/2016-R, as amended.
- General compliance with mandatory provisions, namely, concerning insurance distribution, standard contractual clauses (rules regarding abusive clauses and font size) and advertising.
- Insurances which are compulsory within the Portuguese legal system are additionally subject to the following – they are ruled by Portuguese law, the general terms and conditions of the policy (and any amendments thereto) must be registered with the ASF before the beginning of business or one month thereafter, and a claims representative residing in Portugal must be appointed.
- Having an electronic and/or paper complaints books depending on whether the insurer sells online and/or on-site.
- Per type of insurance:
  (a) life insurances, capital redemption operations and personal accident insurances – compliance with the central register established by Decree-Law No 384/2007, dated 19 November 2007;
  (b) unit-linked life insurances – ex-ante notification of the key information document to the ASF, under Law No 35/2018, dated 20 July 2018;
  (c) motor vehicle insurance – registration at the Portuguese Green Card Bureau, contribution to the national motor guarantee fund and periodic reporting on insured vehicles and claims; and
  (d) work accidents – compliance with mandatory legal and regulatory provisions applicable to this type of insurance and contribution to the national work accidents fund.

Reinsurers

- Acting under FoS: without prejudice to any applicable local rules of the home member state, the pursuit of reinsurance business in Portugal under freedom of services does not require notification to the ASF.
- Acting through a branch: the taking-up and pursuit of reinsurance business in Portugal through a branch is subject to notification to the supervisory authorities of the home member state, which will thereafter communicate this information to the ASF.

Third Countries' (Non-EEA) Undertakings

As a rule, the taking-up and pursuit of insurance and reinsurance business in Portugal

by an undertaking with a head office established outside the EEA (non-EEA undertakings) requires the establishment of a branch and prior authorisation from the ASF. The authorisation will depend on the following conditions being met by the undertaking:

- it is entitled to pursue insurance or reinsurance business under its national law for over five years;
- it has, as exclusive corporate purpose, insurance or reinsurance business;
- it undertakes to set up at the branch accounts that are specific to the business pursued there, and to keep all the records regarding the business transacted;
- it appoints a general representative (natural or legal person), who must fill in the criteria laid down in the Insurance Law and get approval from the ASF;
- it holds assets in Portugal of an amount equal to at least ½ of the absolute floor prescribed in respect of the applicable minimum capital requirement and deposits ¼ of that absolute floor as security;
- it undertakes to cover the solvency capital requirement and the minimum capital requirement in accordance with the applicable requirements;
- in the event it intends to cover motor vehicle liability other than carrier's liability, it appoints in each member state a claims representative responsible for handling and settling claims in the victim's country as regards claims occurring in a member state other than the one in which the victim resides;
- it submits an operations' scheme in accordance with the Insurance Law's requirements; and
- it fulfils the governance requirements laid down in the Insurance Law.

The branch will be authorised to pursue the risk classes and modalities for which the undertaking is authorised in the state where it is established. Life insurance and non-life insurance cannot be pursued simultaneously, unless the undertaking is authorised to such effect and each activity is managed separately.

The application to the ASF must comply with the criteria laid down in the Insurance Law. The undertaking must file, namely, a reasoned report as to why it intends to establish a branch in Portugal, including information about its international business, financial statements and accounts regarding the last three tax years and a certificate from the home country supervisor attesting that the undertaking is duly incorporated and operates in accordance with the applicable law.

The ASF may require additional information or ask the applicant to correct any insufficiencies.

The ASF will grant (or decline) authorisation within six months after receiving the application or, where applicable, after receiving any additional information from the applicant – but never after 12 months from the date the application was initially filed. The lack of notification from the ASF within the relevant deadlines will be deemed as a tacit denial.

The authorisation will expire in the event the branch is not incorporated within six months or does not start its activity within 12 months from the date the authorisation was granted.

Exemption regarding reinsurance

Undertakings from third countries that carry on reinsurance business in Portugal without a branch may benefit from an authorisation exemption provided that the European Commission decided that the solvency regime in that

third country is equivalent to that laid down in the Solvency II Directive.

Insurers with a head office in Switzerland
The establishment of branches of insurers with a head office in Switzerland which intend to pursue non-life insurance business is subject to authorisation from the ASF and compliance with a special regime under the Insurance Law.

Brexit
Insurers based in the UK stopped benefiting from the EU passport from 31 December 2020 and became third country undertakings. To be able to take up and pursue business in Portugal, they are required to establish a branch therein, in accordance with the requirements laid down in the Insurance Law.

Nonetheless, policies that were concluded with a UK-based undertaking under a licence to conduct insurance business in Portugal before the end of the transitional period provided for in the Brexit Agreement, covering risks situated in Portugal or regarding which Portugal is the member state of the commitment, remain valid until the policy's termination date, without prejudice to early termination under general terms. Undertakings must report annually to the ASF by email, up to 31 March, updated information on said policies until run-off, in accordance with the template provided under Decree-Law No 106/2020, dated 23 December 2020.

3.2 Fronting
Fronting is permitted. Portuguese law does not stipulate many rules regarding reinsurance, leaving the contents of the reinsurance agreement and the portion/identification of the risks that are transferred to the reinsurer at the parties' will, depending on the specific arrangements between them. For all matters not specifically stated under the reinsurance agreement, the Ins Contract Law will subsidiarily apply in so far as it does not conflict with any agreed arrangements.

The reinsurance agreement should be formalised by means of a written document between and signed by the parties. Unless otherwise stated, the reinsurer does not have any relationship with customers.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies
Merger
The merger of insurers or reinsurers may be authorised by the ASF provided that the conditions applicable to the taking up and pursuit of the business under the Insurance Law continue to be fulfilled. Several of the provisions regarding incorporation of insurers or reinsurers apply.

Qualifying Holdings
Any person who intends either to acquire, directly or indirectly, a qualifying holding in an insurer or reinsurer or to further increase such qualifying holding, as a result of which the proportion of the voting rights or of the capital held will reach or exceed the thresholds of 20%, ⅓ or 50%, or the company concerned becomes its subsidiary, must notify the ASF of said acquisition project in advance. Notification also applies when the qualifying holding is below the mentioned thresholds, but the acquisition is likely to enable the acquirer to exercise a significant influence over the management of the company. The ASF may decide to oppose the acquisition project if the acquirer fails to guarantee sound and prudent management of the company.

The reduction/disposal of a qualifying holding of a stake to below the above-mentioned thresholds is likewise subject to prior notification to the ASF.

The Insurance Law does not impose limitations regarding foreign ownership/investment, provided there is compliance with the provisions laid down therein.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

The Insurance Distribution Directive (IDD) was transposed into the Portuguese legal order by the Ins Distribution Law without substantial divergences.

Portuguese-Based Intermediaries

Pursuing insurance distribution business is subject to prior authorisation from the ASF, except for activities that are carried out under an exemption.

The Ins Distribution Law provides for the following types of insurance intermediaries:

- ancillary insurance intermediaries (AII);
- insurance agents; and
- insurance brokers.

The requirements applicable to insurance intermediaries can be summarised as follows.

AII

The requirements applicable to AII are:

- acts for and on behalf of one or more insurers pursuant to a mediation contract executed between the parties;
- conducts insurance distribution on an ancillary basis to its professional activity;
- cannot distribute insurance products covering life insurance or liability risks, unless said cover complements the good or service the intermediary provides as its principal professional activity;
- cannot distribute unit-linked insurances;
- has a minimum share capital of EUR5,000;
- is subject to professional qualification and professional indemnity insurance, but with lower requirements than agents and brokers;
- the registration application at the ASF must be filed by an insurer; and
- the ASF will grant authorisation within 60 days of receiving the application or, where applicable, after receiving any additional information from the applicant.

Agent

The requirements applicable to agents are:

- acts for and on behalf of one or more insurers, pursuant to a mediation contract executed between the parties;
- conducts insurance distribution as its main professional activity;
- has a minimum share capital of EUR5,000;
- is subject to professional qualification and professional indemnity insurance;
- must have at least one establishment open to the public;
- the registration application at the ASF must be filed by an insurance undertaking; and
- the ASF will grant authorisation within 60 days of receiving the application or, where applicable, after receiving any additional information from the applicant.

Broker

The requirements applicable to brokers are:

- acts on behalf of its customers;
- must have financial services as its exclusive corporate purpose;
- has a minimum share capital of EUR50,000;
- is subject to professional qualification and professional indemnity insurance;
- must submit an activity programme to the ASF for three years;
- must have organised accounting;
- must have a risk analyst in the event it pursues non-life branches;
- must have at least one establishment open to the public;
- is subject to portfolio diversification according to specific rules;
- the registration application at the ASF is filed by the broker itself; and
- the ASF will grant authorisation within 90 days of receiving the application or, where applicable, after receiving any additional information from the applicant.

Bancassurance

Banks are not subject to a special framework, apart from the fact they cannot be registered as AII, further to the IDD. Banks are usually registered as agents. The Bancassurance channel has significant weight in the Portuguese market.

EU-Based Intermediaries

Any EU-based insurance intermediary that wishes to act in Portugal under FoS or FoE must firstly notify the supervisory authorities of its home member state of its intention, and these authorities will then communicate this information to the ASF.

The ASF will communicate to the supervisory authorities of the home member state the general good provisions to be complied with when acting in Portugal, or the hyperlink where said information is available.

The intermediary may start business:

- under FoS, from the date on which it is informed by the supervisory authority of the home member state about the communication provided to the ASF; or
- as a branch, from the date on which the supervisory authority of the home member state receives said communication from the ASF or within one month if no communication is received (provided the branch is registered in the companies register and with the tax authorities and social security).

General good provisions

The pursuit of insurance distribution activities in Portugal under an EU passport is subject to compliance with several rules considered of general good, determined by the ASF and disclosed on its website.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Policyholder/Insured

The Ins Contract Law has adopted a system based on the policyholder/insured's risk disclosure statements: the policyholder and/or insured must disclose accurately, before the conclusion of any policy, all the facts that they are aware of and that are likely to have an impact on the risk assessment by the insurer (risk disclosure obligation). Said obligation will apply regardless of whether or not the insurer asks them to fill in a questionnaire in which such circumstances are specifically addressed. This obligation remains applicable throughout the life of the policy.

This system implies an effort from the policyholder/insured to recall all circumstances that

may affect the risk (facts that a normal person would reasonably consider relevant to the risk assessment).

Insurer

In turn, the Ins Contract Law sets out some limits to this risk disclosure obligation. Firstly, it states that insurers must explain to policyholders/insureds the scope and consequences of such obligation before the conclusion of the policy, as otherwise, the insurer may be liable for the damage arising from the breach of this duty.

Notwithstanding the risk disclosure obligation from the policyholder/insured, the insurer must proactively seek relevant information that will allow it to carry out a proper risk assessment.

In addition, should the insurer ask the client to fill in a questionnaire, the insurer should:

- ensure that the questions allow for accurate and complete answers;
- review the answers provided by the client to avoid any inconsistencies; and
- ask for any clarification or additional information in the event the answers are incomplete, inaccurate or contradictory.

Unless there is wilful deception by the policyholder/insured, should the insurer accept to underwrite the risk based on the statements provided by the policyholder/insured, the insurer cannot rely on incomplete or inaccurate answers, inconsistencies or other circumstances known to the insurer to refuse the risk.

Consumers v Professionals

As a rule, the risk disclosure obligation applies to any policyholder/insured, regardless of its acting capacity.

6.2 Failure to Comply With Obligations of an Insurance Contract

Policyholder/Insured

The Ins Contract Law provides for different solutions depending on the nature of the breach to comply with the risk disclosure statement.

In the case of an intentional breach, the insurer may terminate the policy in a communication to the policyholder. If no claim has occurred, the communication must be sent within three months of the date on which the insurer became aware of the breach. The insurer is entitled to premiums:

- due until the end of the three-month period unless a deliberate action or gross negligence on the part of the insurer is discovered; or
- due until the end of the policy in the event of intentional breach by the policyholder/insured aiming to obtain an illicit advantage.

In the case of a negligent breach, the insurer may, in communication with the policyholder, within three months of when the insurer became aware:

- propose amendments to the policy, establishing a deadline of no less than 14 days for the policyholder to approve or, if allowed, to provide a counter-offer; or
- terminate the policy, if the insurer can prove that it never enters into policies covering the risks relating to the facts omitted or inaccurately stated.

The policy will terminate within 30 days of the insurer's notice or within 20 days if the insured fails to respond to the amendment proposed by the insurer. Premiums will be returned on a pro rata temporis basis.

Insurer
In the event the insurer fails to provide the policyholder/insured with:

- information about the risk disclosure obligation before the conclusion of the policy, it may be liable to the policyholder/insured for the damages arising therefrom;
- mandatory pre-contractual information (eg, coverage, exclusions, premiums), the policyholder will be entitled to terminate the policy (and to premium reimbursement) within 30 days of receipt of the policy, unless the lack of information has not affected the policyholder's decision to conclude the policy or a claim was triggered by a third party (the lack of pre-contractual information may also give rise to the insurer's liability under general terms); and
- delivery of the policy, the policyholder will be entitled to terminate the policy and to receive premium reimbursement.

6.3 Intermediary Involvement in an Insurance Contract

All and agents act on behalf of and for the account of insurers (or other insurance intermediaries), whereas brokers act independently of the insurers and in representation of their clients.

Nevertheless, although the provision of advice (personalised recommendations) is not mandatory under the Ins Distribution Law, all intermediaries must act in accordance with the customers' best interests, providing information about the insurance contract that best suits each customer's needs and also about their rights and obligations arising from the conclusion of insurance policies. Intermediaries must also explain to customers the reasons why they are providing information or advising a given product (except regarding large risks).

Besides the above, brokers are additionally subject to portfolio diversification rules and impartiality when suggesting a given product to the customer, basing their activity on the analysis of a sufficiently large number of diversified contracts available on the market.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

The Ins Contract Law does not provide for a definition of insurance contract but establishes its main features.

- By means of an insurance contract:
  - (a) the policyholder (natural or legal person, in due capacity) transfers to the insurer a given risk, which must be an existing future (or unknown) risk – the contract will be null and void as regards risks that have ceased before the conclusion of the contract or that do not come to take place; and
  - (b) the insurer undertakes to provide the insured with an agreed benefit in case the aleatory event provided for in the contract occurs (claim).
- Except in those cases legally provided for, the coverage of risks depends on prior payment of the insurance premium (no premium, no risk).
- The insured must have an insurable interest worthy of legal protection related to the risk that is being covered throughout the life of the contract, under penalty of the contract being null and void or terminated ex lege. The contents of the insurable interest will depend on the type of insurance. The following general rules apply:
  - (a) property and casualty – the insurable interest shall regard the preservation and integrity of the object, right or assets;

(b) life insurance – the insured who is not the beneficiary must consent to their life being covered, except when the policy is intended to comply with any legal provision or collective labour regulations; and
(c) personal accident – when the policyholder is the beneficiary but not the insured, the latter must consent to their physical integrity being covered, provided they are individually identified in the contract.

In terms of format, the Ins Contract Law states that the validity of a contract is not subject to any special format. However, regarding mass risk insurance, the insurer must write down the policy, date it and sign it. As a rule, the policyholder's signature is not legally required.

6.5 Multiple Insured or Potential Beneficiaries

Portuguese law allows some flexibility regarding life insurance:

- the beneficiary can be the policyholder or anyone named by the policyholder (or by the insured, in group insurances);
- the beneficiary does not need to be an insured;
- it is possible to name an irrevocable beneficiary (banks are usually named as irrevocable beneficiaries);
- the naming of the beneficiary can be made within the insurance policy, by means of a written statement sent to the insurer subsequent to the policy's execution, or in a last will and testament;
- multiple beneficiaries are allowed; and
- the beneficiary clause can be revoked or changed at any time during the life of the policy (up to the moment the beneficiary is entitled to the benefit), unless the person who is entitled to name the beneficiary has expressly waived such right or, in the case of survival insurance, the beneficiary subscribes to the policy or accepts the benefit provided under the policy.

The insurance policy must contain enough information to allow the identification of the beneficiary (name, address and civil and tax identification numbers) when referring to a "named beneficiary". The Law also allows unnamed beneficiaries such as the "heirs of", or "the children of". In the event the policyholder and the insured are not the same person, the insurer must provide information on the consequences arising from the lack of beneficiary designation or inaccurate/insufficient information regarding the beneficiary's identification.

Moreover, the following rules apply to insurers:

- in the event the premium is not paid within the due date and the policy establishes an irrevocable benefit in favour of a third party, the insurer must notify said third party, within 30 days of the due date, to inform them that they may pay the premium (replacing the policyholder), should the third party wish to do so;
- in the event of the demonstrated impossibility to contact the policyholder or insured (in the event they are not the same person) over the course of a year, the insurer must inform the beneficiary of such fact, provided the policyholder/insured person has expressly authorised this (within 30 days of the last communication made by the insurer to the policyholder/insured, where applicable);
- the obligation to inform the beneficiary of the existence of the insurance policy and their right to receive the benefit, within 30 days of the insurer becoming aware of the insured's death; and

- in the event the policyholder or the insured person (should they not be the same person) does not contact the insurer to claim the benefit over the course of a year after the term of the policy, the insurer has an obligation to inform the beneficiary of such fact, provided the policyholder/insured person has expressly authorised it, within 30 days after one year after the term of the policy.

6.6 Consumer Contracts or Reinsurance Contracts

Mass risk insurances are subject to stricter rules aiming to protect consumers. The Ins Contract Law lists several rules considered mandatory with regard to mass risk insurances, classified into:

- absolutely mandatory rules, which cannot be waived by the parties (eg, format of the policy, insurable interest, rules regarding risk, means to pay the premium, consequences in the event the premium is not paid); and
- relatively mandatory rules, which allow different solutions other than those established by law, provided said solutions benefit the policyholder, the insured or the beneficiary, where applicable (eg, provision of pre-contractual information, risk disclosure obligation and consequences, policy contents).

Reinsurance contracts are in general governed by contractual freedom.

Portuguese law establishes few rules regarding reinsurance (see **3.2 Fronting**).

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Insurers may take into consideration ART transactions for the purposes of risk mitigation within their risk-management and internal control systems.

Should the insurer decide to use ART transactions, it must have a written policy in place, comprising processes necessary to identify, monitor and manage on a continuous basis the use of alternative-risk mitigation techniques, in accordance with the ASF's guidelines on this matter.

7.2 Foreign ART Transactions

Entities that have as a specific purpose the securitisation of insurance risks may pursue business in Portugal subject to the ASF's authorisation, under the conditions laid down in the European Commission's applicable delegated act.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The main principle of the Ins Contract Law is the "freedom of contract", in the sense that the parties are free to agree and determine the terms and clauses of the insurance contract. This is also the main principle of the Portuguese Civil Code (CC) and it applies to other contracts.

The interpretation of insurance contracts is also done in accordance with the rules of the CC, which determines that contracts must be read and interpreted from the perspective of the "average person" – a person with no specific or specialised knowledge of the matters of the

contract – when/if placed in the position of each of the parties to the insurance contract.

However, different rules apply to Standard Form Contracts (SFCs), which are insurance contracts with consumers in which the policyholder has no negotiation power over the terms of the contract. In this case, the Standard Clauses Law specifically determines that the clauses of an SFC will be interpreted in accordance with general civil rules, while always taking into consideration the context in which the contract was construed, accepted by the parties, and signed.

Mandatory pre-contractual information provided by the insurer, explaining the main rules of the insurance contract, is also relevant. When fully disclosed, pre-contractual information is extremely relevant in the interpretation of insurance contracts.

8.2 Warranties

It is not common in Portugal to include representations and warranties clauses in insurance contracts in the same terms as such clauses are included in other types of contracts. There are, however, some standard clauses included in the general terms of insurance contracts that are very similar to warranties, mostly referring to the risk disclosure statement provided by the policyholder to the insurer before the insurance policy is signed.

In addition, and following the general rule concerning the "freedom of contract", the parties are free to include representations and warranties in an insurance contract if they wish, since there is no legal limitation.

Breach of warranties is considered a breach of contract but has a specific regime, as determined in **6.2 Failure to Comply with Obligations of an Insurance Contract**, regarding non-disclosure by the policyholder.

8.3 Conditions Precedent

All terms and conditions which may result in an exemption or reduction of the insurer's liability, must be included in the pre-contractual information, and in the general terms of the insurance contract.

As a rule, there are at least two types of conditions precedent in most insurance contracts, which, in fact, are a result of the law, specifically the Ins Contract Law, and which may result in the exemption or reduction of the insurer's liability.

- The obligation for the policyholder to pay the premium to the insurer. In the case of breach of this condition, the insurer may refuse a claim made with reference to the insurance contract, since there is no coverage unless the premium is paid.
- Duty of disclosure of essential and relevant information for the risk assessment to be made by the insurer prior to the signing of the insurance contract. In the case of breach of this condition precedent, special rules apply, as determined in **6.2 Failure to Comply with Obligations of an Insurance Contract.**

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

If a policyholder, an insured person, or a beneficiary disagrees with the decision of an insurer regarding the terms and amplitude of the coverage of the insurance contract, the first step is to present a complaint to the insurer and request an evaluation of the situation.

If the insurer maintains its terms, the policyholder, insured person, or beneficiary can choose between:

- requesting the intervention of the ASF;
- filing a claim at the Consumer Protection Association;
- presenting a claim to the Justice of the Peace;
- arbitration centres; or
- courts of law.

The limitation period to start a court procedure with respect to an insurance claim depends on the subject of the dispute:

- an insurers' claim for payment of premiums will be made until two years after their due date; and
- other claims will be presented until five years after the date on which the claimant became aware of their rights against the insurer (with a maximum limitation of 20 years starting from the date the event occurred).

The same rule applies to unnamed beneficiaries in life insurance contracts once it becomes possible to identify them and they become aware of their rights.

In Portuguese law, the general rule is that, where the policyholder in a life insurance contract does not name a beneficiary, the insured capital will revert to the insured person's legal heirs, as determined by the CC. Once the heirs are identified and confirmed, they each become the legal and contractual beneficiaries of the insurance policy and entitled to all the rights and obligations of "named beneficiaries".

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

The Ins Contract Law determines that the parties in an insurance contract are free to choose the law that will rule the contract if:

- it concerns the coverage of a risk located in Portugal; and
- in the case of personal insurances, the policyholder resides in Portugal.

The parties are also free to choose the jurisdiction to solve disputes concerning an insurance contract, except regarding insurance contracts with consumers in which the general rule of Civil Procedure Code will apply.

If at least one of the parties does not reside in Portugal, or the risk to be covered is not located in Portugal, the choice of law and jurisdiction will be made in accordance with Private International Rules, and EU Regulations.

If the insurer and the policyholder reside or have their head office in a member state of the EU, the governing law of an insurance contract will be determined in accordance with the provisions set out in Regulation (EC) No 593/2008 of 17 June 2008 (Rome I). The Regulation determines that the parties may freely choose the law applicable to their insurance contracts, provided that the choice is made based on the serious interest of the parties and is connected to any element of the insurance contracts that is acceptable under private law (eg, residence, nationality of the parties).

International disputes over jurisdiction are solved in accordance with the rules set out in:

- Regulation (EU) No 1215/2012 of the European Parliament and of the Council of 12/12/2012; and
- the Portuguese Civil Procedure Code (CPC) which determines that Portuguese courts of law have jurisdiction in any dispute that concerns events or situations with a special connection to the territory, or where the parties have their residence and/or head office in Portugal.

9.3 Litigation Process

The litigation process for the resolution of any disputes arising from an insurance contract follows standard proceedings, as follows.

- The claimant files a statement of claim which is presented in the court of law with jurisdiction.
- The defendant receives note of the claim and is granted 30 days to respond.
- The parties are invited by the court to a preliminary hearing in which they will try to reach an agreement. If it is not possible to reach an agreement, the procedure continues, and the court will set a date for the final hearing.
- The final hearing is the moment when each of the parties presents its witnesses and experts, and other means of proof are analysed and discussed. In the end, the parties present their closing arguments, after which the judge ends the session.
- There is no deadline for the court to issue a judgment.
- In some cases, and if certain requirements are met, the parties may appeal to a higher court.

9.4 The Enforcement of Judgments

The enforcement of judgments issued by a court of law in disputes concerning the execution and/or interpretation of an insurance contract is made in accordance with the same rules as the enforcement of other judgments in civil disputes.

Foreign Judgments

Foreign judgments can also be subject to enforcement as long as the court where the procedure took place respects the basic rules and principles of the Portuguese Constitution, not only in terms of the procedure but also the judgment itself and the laws applied.

EU judgments

Judgments issued by courts of law in the EU are ruled by Regulation 1215/2012 of 12/12/2012, which determines that a judgment issued by the court of an EU member state is enforceable in another EU member state, without any enforceability process being required.

Non-EU judgments

Judgments issued by the courts of law of non-EU countries, are enforceable once confirmed by a Portuguese High Court. The process is simple.

The person must file a request in the Portuguese High Court of law to request the review and confirmation of the foreign judgment, by presenting a certified copy of it. The opposing party in the procedure will receive notice from the Court informing of the request and granting a deadline to oppose to the recognition or present a response.

If the judgment is clear, all formal requirements have been met, there is no violation of the Portuguese Constitution and elementary personal civil rights, and none of the parties oppose its recognition and execution, the court will issue the judgment with the requested confirmation and acceptance by Portuguese Courts of Law.

After that, the judgement is ready to be enforced through the enforcement procedure in accordance with CPC.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses are admissible in insurance contracts, and they are enforceable. There is an arbitration centre specialised in the resolution of disputes concerning insurance contracts (CIMPAS). Nevertheless, in Standard Form Contracts signed with consumers, arbitration cannot be imposed on consumers as the only resource for dispute resolution, especially if it refers to ad hoc arbitration which may represent a higher cost for the consumer and, therefore, may be more difficult to reach.

9.6 The Enforcement of Awards

Arbitration awards can be enforced, but only via the courts of law. The CPC determines that an arbitration award has the same value as a court-of-law judgment and there are no special proceedings to be followed prior to the enforcement procedure.

Arbitration awards made in other jurisdictions can also be enforced by Portuguese courts, if certain requirements are fulfilled, but these must be subject to the process of revision and recognition (see **9.4 The Enforcement of Judgments**). Portugal is a party to several bilateral treaties and conventions, namely, with Portuguese-speaking countries and the Macau Special Administrative Region of the People's Republic of China (due to the historic special connection). Portugal is also a party to:

- the New York Convention;
- the Geneva Convention on the Execution of Foreign Arbitral Awards signed in 1927;
- the Washington Convention on the Settlement of Investment Disputes between States and Nationals of other States; and
- the Inter-American Convention on International Commercial Arbitration.

9.7 Alternative Dispute Resolution

ADR can be very effective in the resolution of insurance disputes, mainly regarding consumer contracts, since they allow the consumer to have a solution sooner than in a court of law, with lower costs. In Portugal, insurance disputes can be solved through:

- mediation;
- institutional arbitration (namely, CIMPAS); and
- the Justice of the Peace.

9.8 Penalties for Late Payment of Claims

If an insurer delays in responding to a claim, or makes late payment of a claim, the insurer must cover any damages caused to the insured and/or the beneficiary because of such delay. Interests are also due in the case of late payment of a claim, at the rate in force at the time of payment.

9.9 Insurers' Rights of Subrogation

When an insurer pays a claim in the name and on behalf of the insured, they become subrogated in the rights of the person to whom the payment was made, namely, the right to file a claim against the insured or a third person, except regarding life insurance, personal accident insurance, health insurance and other personal insurance.

10. Insurtech

10.1 Insurtech Developments

Insurtech plays an important role in the future of the insurance sector. Several insurers have been

establishing partnerships with technology companies aiming to improve their processes and business models and become more competitive.

Telematics

Telematics insurance is increasingly gaining importance. Telematics is used to collect information about the insured's habits. It allows insurers to better identify behaviours that might be relevant in case of a claim; in return, the policyholder/insured is offered rewards or cost savings on their policy for "good behaviour". Whether by means of telematics devices or mobile apps, where the policyholder/insured provides personal information to the insurer about preferences or habits, telematics insurances are getting stronger, namely, in car and health insurances. Telematics insurances enable insurers to offer lower prices and tailor-made products.

AI

Insurers are also resorting to artificial intelligence to automate several operations and administrative tasks, namely, in underwriting, pricing and claims functions; this speeds up operations, reduces costs and offers new value products.

Portugal Finlab

In 2018, the innovation hut "Portugal Finlab – where regulation meets innovation" was launched and has been an important booster in what comes to tech-based start-ups. This is a communication channel between innovators – new players in the market or incumbent institutions having innovative tech-based financial projects or products – and the Portuguese regulatory authorities (the ASF, the Bank of Portugal and the Securities Commission). Its purpose is to support the development of innovative solutions in fintech and insurtech and to provide guidance to innovators on how to operate in the regulatory system.

10.2 Regulatory Response

The ASF has been very active regarding insurtech issues, being aware of the market trends and participating in several insurtech initiatives. Recently, the ASF issued a Rule establishing requirements on security and governance of information and communication technologies and on outsourcing to cloud service providers.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

In Portugal, the emerging risks that presently affect the insurance market are as follows.

Cybersecurity

Although cyber-risks were already on the insurance sector's agenda, the COVID-19 pandemic accelerated insurance offers in terms of cyber-risks. The high connectivity of companies and populations across generations, combined with working remotely (people connecting to their company from outside), increased the risk of cyber-attacks, which could potentially lead to more data theft or blocking. Insurers have adapted their offers and have been presenting a wider choice to companies. However, the sector still faces some difficulties in terms of what falls within the scope of insurance cover, as new forms of attack keep emerging over time.

Catastrophes and Climate Change

Statistics show that the number and severity of natural catastrophes have been increasing over the years. One of the concerns of the insurance sector relates to reducing the "protection gap", which results from the difference between the economic losses arising from natural catastrophes and the compensation paid by the insurer

under the insurance policies in force. To reduce said gap, the industry has been collaborating with several public entities to increase the offer of insurance products with a sustainability-related profile and to make this type of insurance more competitive and available to a wider part of the market.

Demographic Ageing and Social and Health Care

These themes raise some concerns in terms of risk mutualisation. They are not a new topic and the sector is already aware that the offer of products will have to be adapted to gradually become an effective alternative to the public social protection system – while still maintaining affordable pricing – for several population sectors, age groups and layers that typically do not buy insurance.

11.2 New Products or Alternative Solutions

See **11.1 Emerging Risks Affecting the Insurance Market**.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Insurers handled COVID-19 well and managed to take on the challenges related to the pandemic. The insurance sector was, in general, able to meet the market's needs by adapting its products and services (through the increased use of digital channels and video calls) and presenting new offers (eg, cybersecurity insurance). However, some lines of business (personal and commercial lines) suffered increasing of premiums.

In 2023, the insurance industry will continue to face emerging risks arising from cyber-attacks, climate change and demography, aggravated when combined with additional new challenges such as inflation and rising interest rates. These all-interconnected and highly complex threats will require an effort from insurers to understand and prepare forthcoming changes and to rapidly adapt their ecosystems to changes. Furthermore, this context is expected to lead once more to a general increase of premiums.

In terms of consumer's trends, studies revealed that customers are craving seamless experiences and will walk away from very complex online journeys, even if they originate from a trusted brand. On the other hand, customers are increasingly looking for personalised experiences through several different channels, from smartphone applications to live conversations, depending on their needs. Simplifying and humanising the customer experience will certainly make the difference in the insurers' offers in the near future.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

See **12.1 Developments Impacting on Insurers or Insurance Products**.

Espanha e Associados is an independent legal and tax services firm advising companies from all over the world through the international TAGLaw network. Insurance law is one of the many areas in which the firm has a high level of expertise, due to more than 15 years of experience. The firm stands ready to advise on all legal and regulatory aspects of the insurance industry. Espanha e Associados aims to provide its clients with a tailor-made service as well as a global approach, allowing clients to have different perspectives on their business/matters, and to take decisions in their best interests. The insurance department frequently works with the tax team to ensure that all transactions are also analysed from a tax perspective, providing clients with the most efficient solution.

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Trends and Developments

Contributed by:
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Trends and Developments

Introduction

The insurance market in Portugal has been confronted with various challenges and changes over the last few years, the causes of which can be divided, very briefly, into:

- successive legal and regulatory changes;
- the technological revolution, the COVID-19 pandemic;
- the implementation of the IFRS 17 reporting standards; and
- the coverage of severe damages and losses resulting from forest fires and floods.

The response of the Portuguese insurance sector to the above-mentioned events has strengthened its reputation and people are becoming more consciously aware of the importance of private insurance when dealing with the insufficiencies and general lack of response of the public system, notably when they are exposed to high healthcare costs and long waiting lists.

The pandemic crisis, health service difficulties, the recent ransomware attacks and climate change events have awakened Portuguese consumers to the importance of a series of risks that used to be almost unnoticed, such as the risk of business interruption, cyber-risk and climate risk. On the other hand, a number of other themes have gained increased importance due to the pandemic and associated government responses, namely, the level of health protection guarantees and the levels of savings for retirement. It is inevitable that all these events will bring about a considerable change in the insurance industry's list of priorities for the coming years, and it is expected that these risks and themes will be at the forefront of 2023 trends.

The insurance market should definitively look into the small and medium-size segment as a great opportunity to reduce the protection gap. The recent events have demonstrated that these segments are underinsured and may be open for affordable commercial insurance solutions that are tailored for their needs.

This article will attempt to analyse the current situation in the insurance sector in Portugal and predict the main trends and opportunities in 2023.

Overview of the Portuguese insurance market

According to the report prepared by the Insurance and Pension Funds Supervisory Authority (ASF) for the third quarter of 2022, there was a decrease of 7.1% in the production of direct insurance in Portugal when compared with the same period of 2021. There was a decrease of 18.2% in the life sector and an increase of 6.9% in the non-life sector. During this same period, the costs with claims decreased 19.5% as result of a reduction of 30% in the life sector.

The coverage ratios for the Solvency Capital Requirement (SCR) and the Minimum Capital Requirement (MCR) in September 2022 were 200% and 558%, which reflects a reduction of 7% and 18%, respectively, when compared with December 2021.

According to the FY 21 Annual Report prepared by the ASF, 64 insurers were established in Portugal, and there were 26 branches from foreign countries (all from EU countries) and 525 insurers operating under the freedom to provide services regime.

As of 31 December 2021, the top five insurers of the country take around 59.4% of the market share in premiums and the top ten insurers take around 76.8%.

Health insurance

According to the data disclosed by the Portuguese Association of Insurers (APS), Portuguese citizens paid around EUR1 billion in health insurance premiums during the first ten months of the year 2022, which is a historic maximum. According to the APS, Portugal faces a two-digit growth in health insurance premiums and there are currently 3.3 million Portuguese citizens who have private health insurance.

The pandemic had already exposed the weaknesses of the national health system and awakened the population to the importance of health insurance, a class of insurance that was already showing a high level of growth in the pre-pandemic period. The lack of family doctors, the waiting times for specialist consultations and surgeries, and the chaos in several emergency hospital services are some of the factors that have been contributing to the increase of health insurance coverage rates in Portugal. It is also worth mentioning that health insurers are being pressured by medical providers to increase premiums in order to deal with inflation and rising technology costs; therefore, insurance premiums could rise in 2023.

Irrespective of the insurance premium fluctuations in the near future, there are clear signs that health will continue to dominate in the offerings of insurers in 2023, and this trend should continue to have a corresponding response at the level of demand.

Cyber-risk

The increase of cyber-risks in Portugal arising from the high connectivity of companies and populations combined with remote work have led to a "perfect storm" for cyber-insurance.

It is now clear that cyber-insurance shifted to a hard market and companies are finding it more difficult to get coverage due to the significant increase in the frequency and severity of ransomware attacks and cybercrime involving reputed Portuguese companies and State institutions.

The legal obligation to publicise security breaches, the reinforcement of the sanctioning framework and the new approach of self-accountability of organisations that resulted from the General Data Protection Regulation (GDPR) have placed greater emphasis on the reputational risks that can arise from a cyber-attack, and the importance of properly measuring and hedging this risk.

The major insurance groups are natural targets for cyber-attacks because they possess substantial amounts of confidential policyholder data and the ASF has recently issued specific rules on cybersecurity and outsourcing arrangements with cloud computing service providers. Pursuant to this regulation, the Board of Directors is responsible for establishing an effective system for managing information and communications technology and security risks as part of the company's overall risk management system.

Natural catastrophes and the protection gap

Portugal continues to experience heatwaves causing massive forest fires in the summer period followed by severe flooding due to heavy rain in the autumn and winter.

According to the dashboard on insurance protection gap for natural catastrophes that was recently published by the European Insurance and Occupational Pensions Authority (EIOPA), Portugal has the sixth worst protection gap in Europe.

Also, according to the dashboard, the historical protection gap score in Portugal is high, resulting from very low levels of insurance penetration across all risks. Although this study does not take in consideration the events that occurred in 2022, the uninsured losses are higher for perils with higher frequency (ie, wildfire and floods).

Insurance companies are facing increasing pressure to take action to combat climate change and it is inevitable that there will be a considerable increase in the level of investment dedicated to this area as the ability or inability of the insurance market to respond to this new reality could have a considerable reputational impact.

As detailed in the EIOPA dashboard, earthquake risk could present the main concern in the future, with possible systemic repercussions for Portugal, due to the potential for devasting events in areas that experience a very high level of vulnerability and exposure with very low insurance penetration levels (notably Lisbon).

The Portuguese government and other competent authorities cannot continue to postpone the creation of a fund that provides immediate response to damages caused by extraordinary risks like earthquakes, floods, wildfires. The Portuguese government should take the lead in the financing of the fund and local insurers should also be a part of the solution by charging a parafiscal charge on prescribed classes of insurance (eg, multiple risks insurance) that would be paid to the fund. Needless to say that catastrophic reinsurance should also be considered as an important mechanism to spread the risk.

The modern world is getting used to dealing with phenomena that were once considered exceptional or practically impossible and which, for this reason, were largely a dead letter on the list of exclusions of insurance products. It turns out that consumers are already looking at natural catastrophe cover differently, and the time has come to try to migrate certain so-called exceptional risks from the list of exclusions into the scope of cover of policies.

Savings

The increase in average life expectancy and the fragility of the Portuguese social security system have awakened consumers to possible shortages of resources at the end of their working lives and the need to find complementary solutions for their retirement.

This is also why there is some expectation that marketing of the new Pan-European Personal Pension Product (PEPP) will begin, bringing with it important features, such as its portability and the ease of changing provider. It is still unclear when the Portuguese State will give the green light for the launch of the PEPP in the Portuguese market, the tax regime that will apply to the product and the number of providers that will enter the PEPP market.

The potential of complementary retirement and investment products is growing and the insurance industry can play an active role in strength-

ening complementary savings schemes (in particular individual savings), with the restoration of tax benefits for savings products being an essential aspect of this solution.

Business interruption

Another issue on the agenda that was triggered by the COVID-19 restrictions is the coverage of economic losses associated with the pandemic and the possibility of activating an insurance portfolio to cover the so-called operating losses arising from the measures approved under a state of emergency (eg, closure of establishments, restrictions on movement and the exercise of professional activities, etc).

The coverage of operating losses arising from forced business interruption was probably the most debated issue in the insurance industry worldwide in 2021 and 2022 but there is still no clear response from the insurance market on the solutions that will be available to deal with this risk.

The lack of manpower, as well as the shortage of suppliers and customers, has in many cases led to a long interruption or reduction of activity with resulting economic losses. Experience shows that most of the coverage for operating losses that exist in the Portuguese market is not designed for this type of circumstance and that, as a rule, it figures as complementary coverage of indemnity insurance (the so-called all risks). This complementarity means that, as a general rule, cover for business interruption losses can only be activated in the event of interruption or reduction of activity as a result of an insured event linked to the destruction of or physical damage to insured property, ie, damage to a property and/or its contents. This is definitely not the case for business interruption losses resulting from a pandemic.

Insurance sector challenges

Emerging risks

It is inevitable to conclude that the insurance market will be forced to adapt its product offering in order to offer some coverage guarantees associated with epidemics and pandemics. This need for adaptation has already been felt but there is still a long way to go.

However, it is not expected that the industry will experience a revolution in the post-COVID-19 period since the high potential for losses associated with the pandemic, particularly as regards the forced interruption of activity and the resulting operating losses, can only be insured through public-private collaboration.

There are different variables that may also be considered by the industry in order to build a solution and delimit its level of exposure before a risk of this dimension, whether in terms of reinsurance, premiums, deductibles, the time limit of coverage (namely, in the case of operating losses), in terms of exclusions or in the way the solution is presented (complementary/voluntary coverage).

It is important to take advantage of the current experience to reassess the catastrophic and pandemic risks and to analyse, together with the government and the reinsurance sector, the solutions that can be put forward to respond to these risks.

Customised insurance

The demand for customised insurance products is definitely one of the most important challenges that the Portuguese insurance market will have to deal with in the coming years. In fact, there is still a somewhat ingrained practice of replicating the general conditions of products of the same line of business (namely, third-party liability) in

the different variants of that product, referring the specificities of the product to its particular conditions. This practice has been detrimental to insurance consumers, as they are confronted with a series of definitions and contractual provisions which, strictly speaking, have no applicability to their product. The gradual implementation of concepts such as "pay as you drive" and "pay as you live" will necessarily entail effective customisation of insurance products involving the entire contractual package, general conditions included.

It remains to be seen whether the insurance market will have the capacity to create, configure and launch products aimed at niches that are too small to meet the demand from different customer profiles and whether this positioning is financially viable given the size of the Portuguese market.

Insurtech

It is clear that technology will be a consistent and fundamental enabler for the insurance market and there is a growing awareness that clients are increasingly willing to go through an experience when buying their insurance product, anytime, anywhere and with any available device.

This phenomenon has been even more striking in the Portuguese insurance sector since it did not present the same level of development as the banking sector, and the level of penetration of insurtech was clearly below that of fintech.

The lack of specific provisions in the Portuguese legal and regulatory framework governing the implementation of insurtech solutions cannot be an obstacle to the revision of the business model of local insurers in order to meet the demands of a more sophisticated insurance client. The use of tools that allow massive extraction and processing of data and information from an almost infinite number of sources will enable faster and more efficient preparation, submission and analysis of often lengthy and complex dossiers concerning cross-border activities and the transfer of qualifying holdings in supervised entities.

The speed and level of penetration of technological solutions in the Portuguese market are not compatible with bureaucratic and lengthy processes of public consultation followed by the transposition of European directives that still lack regulation in each member state. In line with what has already resulted from the recent amendment to the legal framework for insurance activity, it is essential to strengthen the framework for co-operation between the national supervisor and the European Insurance and Occupational Pensions Authority (EIOPA) so that there can be alignment at the level of supervision and local regulation, regardless of the timing of the revision of fundamental laws and regulations.

It is also worth highlighting the growing number of insurance solutions that have been presented as a result of partnerships between insurers, insurtechs and distributors, and there is still a great margin for the entry of new insurtechs, with solutions in the areas of smart contracts, digital signatures, artificial intelligence, etc.

The insurance industry will have to work in coordination with insurtechs in order to implement solutions that assure a balance between digital innovation and consumer protection, notably in terms of the fulfilment of information duties and disclosure requirements. The ASF is also working in order to meet the new market trends and support new technologies; therefore, other insurtechs are expected to enter the Portuguese market and team up with local insurers in the launch of innovative new products.

There are provisions in Portuguese law governing distance selling of insurance (whether online or by phone) and outsourcing rules (as transposed from the Solvency II Directive) that should be sufficient to deal with the implementation of certain innovative solutions and enable the co-operation between incumbent undertakings and insurtech start-ups.

Transition to the green economy

The national insurance sector is not indifferent to the path taken by banking and investment funds and is also betting on the transition to a green economy.

The role of insurance in this respect is not limited to providing solutions that are in line with the new behaviour of citizens, particularly with regard to sustainable mobility. Without prejudice to the need to find a balance between sustainability and the applicable prudential framework, the insurance industry and pension funds are already considering ESG criteria when selecting their investments and defining the composition of their asset portfolios.

It is noteworthy that the European Commission's recent legislative proposal under the Solvency II revision aims to encourage the insurance industry to actively participate in sustainable investment and the recovery of the European economy with the necessary easing of capital and solvency requirements. Insurers will be called upon to respond to the challenges of sustainable development, making investments within a policy of social and climate responsibility, and it is important to understand how these investments fit in with the regulatory framework applicable in the medium and long term.

Other notes on the Portuguese insurance sector

The current framework of technological revolution and the increased demand for reporting requirements, statutory disclosures and monitoring activities will make it more difficult for traditional small and medium-sized insurers to compete with the top ten insurers. The door to new concentration processes at the level of insurers and distribution channels will remain open but the scale of such operations will certainly be very limited when compared with previous years.

Another challenge that insurers have been facing in recent years is the implementation of the IFRS 17 reporting standards effective as of 1 January 2023. The IFRS 17 insurance accounting standard establishes new principles for the recognition, measurement, presentation and disclosure of insurance contracts and insurers have been spending a lot of time, human resources and money with this implementation process.

In the absence of any major changes at the level of the legislation governing the insurance activity, a reference shall be made to some of the main topics that were subject to specific regulation by the ASF during the year 2022.

- Market conduct and complaint handling with certain requirements being applicable to insurers acting in Portugal under the freedom of services regime, notably the obligation to disclose several documents and information in the Portuguese language through the insurer's website.
- Governance rules, self-evaluation of risk and solvency, management of conflict of interest, policies in terms of fraud and remuneration.
- General requirements and principles on the security and governance of information and

communications technology, including cybersecurity.
- Specific requirements on outsourcing to cloud computing service providers by insurance and reinsurance companies on an individual and group basis.

Although no major changes in law are expected in 2023, a reference shall be made to the transposition of the new EU Directive 2021/2118 amending the Directive 2009/103/EC relating to insurance against civil liability in respect of the use of motor vehicles. The Directive will have to be transposed into national law by 23 December 2023.

Abreu Advogados is an independent law firm present in ten locations and with over 28 years of experience in the Portuguese market. As a full-service law firm, Abreu is one of the largest law firms in Portugal, and works with some of the most prestigious legal firms in the world on cross-border projects. The insurance team collaborates with many well-known and respected companies in the insurance sector, advising throughout the entire lifecycle of insurance products and in dispute resolution cases, via litigation or arbitration. Abreu has participated in some of the largest transactions in the insurance sector in Portugal, as well as advising international insurance companies on the legal and regulatory aspects of their cross-border activities. The team also plays an important role in the insurtech segment, having assisted Habit Analytics in its entry in the Portuguese market, advised on the acquisition of Drivit, a pioneering Portuguese telematics company, by Zego, one of the most well-known insurtechs in the world.

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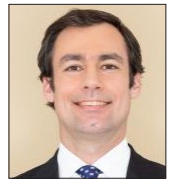

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SINGAPORE

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

Singapore law primarily comprises statutory law and common law.

Statutes become law when bills are passed by the Parliament of Singapore, having been scrutinised by the Presidential Council for Minority Rights and assented to by the President of Singapore. These statutes are often supplemented by subsidiary legislation passed by the relevant government agencies or ministers, and by notices, directives, guidelines and codes issued by the relevant regulatory authority.

Singapore has also inherited the common law system from the British, where a body of law is created incrementally through judgments decided by the courts, setting precedents to be followed by lower courts.

Section 3 of the Application of English Law Act (Cap 7A) states that the common law of England, insofar as it was part of the law of Singapore before 12 November 1993, shall continue to be part of the law of Singapore. Beyond that, the courts of Singapore are bound only by their own decisions.

The sources of insurance and reinsurance law in Singapore are the Insurance Act 1966, the Marine Insurance Act 1906, the Deposit Insurance and Policy Owners' Protection Schemes Act 2011, some subsidiary legislation and case law.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

In Singapore, the Insurance Act (Cap 142) (the "Insurance Act") is the primary legislation that regulates and deals with insurance and reinsurance activities, including insurance intermediaries and related institutions. Under the Insurance Act, the Monetary Authority of Singapore (MAS) has the power to promulgate subsidiary legislation.

The MAS exercises control over financial institutions and their related entities, including insurance companies. by virtue of the Monetary Authority of Singapore Act (Cap 186) and the Insurance Act.

Other pieces of legislation regulate specific types of insurance, such as the Motor Vehicles (Third Party Risks and Compensation) Act (Cap 189), the Work Injury Compensation Act (Cap 354) and the Marine Insurance Act 1906 (Cap 387). In addition, the provisions found in the following English statutes in 1994 continue to have force of law in Singapore:

- the Policies of Assurance Act 1867; and
- the Third Parties (Rights against Insurers) Act 1930.

The provision and conduct of insurance and reinsurance business is primarily regulated under the Insurance Act (Cap 142), while insurance intermediaries are primarily regulated under the Insurance Act (Cap 142) and, in respect of life business, the Financial Advisers Act (Cap 110).

2.2 The Writing of Insurance and Reinsurance

A person who carries on any class of insurance business will need to be licensed under Section 8 of the Insurance Act. To obtain a licence to carry on insurance business in Singapore, the insurer must:

- apply in writing to the MAS for a licence;
- be a company incorporated in Singapore, a company with an established place of business in Singapore or a co-operative society registered under the Co-operative Societies Act (Cap 62);
- fulfil such financial requirements as may be prescribed; and
- satisfy such fund solvency requirements as may be prescribed.

Any person who carries on reinsurance business will need to be authorised under Section 34 of the Insurance Act. There are also other schemes whereby insurers may be subject to different or lighter regulation, which are discussed further in **3.1 Overseas-Based Insurers or Reinsurers**.

2.3 The Taxation of Premium

Singapore adopts a territorial basis of taxation. Therefore, only income accruing in or derived from Singapore or income received (or deemed to be received) in Singapore from outside Singapore will be subject to Singapore income tax.

The current corporate income tax rate is 17%.

Insurance policy premiums are tax deductible only if they are expenses incurred wholly and exclusively in the production of income; see Sections 26 and 43C of the Income Tax Act (Cap 134).

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Unless an applicable exemption applies, any carrying on or solicitation of insurance and reinsurance business in Singapore or to the public in Singapore would be subject to licensing/authorisation requirements in Singapore. This applies even if the act is performed only partly in Singapore or wholly outside Singapore if such act has a substantial and reasonably foreseeable effect in Singapore.

A "foreign insurer" means an insurer that is authorised under the laws of a foreign country to carry on insurance business in that foreign country but is not licensed under Section 8 as an insurer nor authorised under Section 34 as a reinsurer. A foreign insurer will carry on business in Singapore under a foreign insurer scheme established under Section 35B of the Insurance Act.

Under the authorised foreign insurers scheme, overseas reinsurers that do not have a physical presence in Singapore and provide insurance services from overseas to persons in Singapore may avail themselves of a lighter-touch regime by applying to be authorised reinsurers, in which case they are not required to set up and maintain separate insurance funds for policies taken out by persons in Singapore, nor to comply with solvency margin requirements. The assessment criteria are largely the same as those for direct insurers, which are set out in **2.2 The Writing of Insurance and Reinsurance**.

Almost all licensed/authorised insurers and reinsurers must have a presence in Singapore, although there are a few exceptions, such as:

- authorised foreign reinsurers;
- approved marine, aviation and transit insurers; and
- insurers carrying on business under a foreign insurer scheme.

Marine and Aviation

To help develop Singapore as a marine and aviation insurance centre, overseas specialist insurers providing marine, aviation or transit (MAT) insurance that are specifically approved by the MAS shall also be exempt from licensing in Singapore and be subject to lighter regulation. Such overseas insurers must be situated in designated countries and fulfil the following conditions:

- they must not write insurance business, other than the collection or receipt of premiums in relation to MAT insurance business;
- they must not have a physical presence in Singapore; and
- they must provide insurance services from overseas to persons in Singapore.

The Insurance (Approved Marine, Aviation and Transit Insurers) Regulations 2003 (the "Insurance Regulations") set out requirements for insurers approved to write MAT insurance, and approved MAT insurers can operate in Singapore if they are approved under the Insurance Regulations.

3.2 Fronting

There is no outright legal prohibition against fronting or a similar arrangement, unless the purpose is to frustrate regulatory requirements. Insurers would typically engage the MAS before carrying out any such arrangement.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

The COVID-19 crisis has been an extraordinary global shock, disrupting both supply and demand in an interconnected global economy. The devastating impact of the COVID-19 pandemic has caused a vicious cycle of dampening business and consumer confidence, and tightening financial conditions and job losses, worsening economic prospects and sending shockwaves through the global economy and the global M&A market. Recent years, however, have seen a recovery in the Singapore M&A market and rapid growth.

M&A Scheme

An M&A scheme was introduced in Budget 2010 to encourage companies in Singapore to grow their businesses through M&A, by extending several benefits to Singapore-based companies to help with their acquisition strategies. It provides an M&A allowance, calculated on the total costs of the acquisition of shares in the target company, a stamp duty relief and a double tax deduction on transaction costs.

With the ongoing effects of COVID-19, the M&A market is unlikely ever to be "normal" again. Therefore, deal makers should prepare for a new reality by developing strategies and investment opportunities amid the COVID-19 experience to drive future success.

M&A allowance

The M&A scheme seeks to encourage Singapore companies to grow through strategic acquisitions. An M&A allowance is granted to a company that acquires the ordinary shares of the target company under the M&A scheme during the period 1 April 2010 to 31 December 2025. It is a

tax allowance granted to the acquiring company for each year of assessment. In 2016, the existing cap for qualifying M&A deals was doubled from SGD20 million to SGD40 million to support more M&A. The allowance granted is equal to 25% of the total acquisition value for each year of assessment, with a purchase consideration cap fixed at SGD40 million.

Stamp duty relief

The acquiring company is granted a stamp duty relief capped at SGD80,000 under the M&A scheme. Stamp duty relief has lapsed for instruments executed on or after 1 April 2020 as announced in Budget 2020, so relief is not applicable for instruments executed on or after 1 April 2020.

Double tax deduction on transaction costs

The scheme provides a double tax deduction on transaction costs that are incurred in respect of qualifying share acquisitions made during the period 17 February 2012 to 31 December 2025. It includes professional fees and valuation fees, and the cap on the transaction costs is SGD100,000.

Experts say that South-East Asia is on track to witness its busiest year for M&A in over a decade, despite the COVID-19 pandemic, with technology expected to be the hottest sector. According to M&A data provider Dealogic, the region saw 482 deals worth USD85.2 billion announced in the first half of 2021, which was 141% higher than the 406 deals worth USD35.35 billion in 2020.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Insurance products may be distributed in the following ways, amongst others:

- through bank representatives;
- through insurance agents;
- through insurance brokers;
- online distribution without advice; and
- through tied representatives.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The obligations of the insured and insurer will be governed by the contract entered into between the parties.

Generally, the duty of the insured is to disclose material facts that a prudent insurer would take into account when reaching the decision of whether or not to accept that risk or what premium to charge.

In the case of marine insurance, the duty to disclose, and which facts need not be disclosed, is codified in the Marine Insurance Act (Cap 387).

6.2 Failure to Comply With Obligations of an Insurance Contract

An insurer has the right to avoid an insurance policy if there was non-disclosure of material facts on the part of the insured when the insurance contract was written.

A proposer is also entitled to the return of the premium where an insurer has breached its obli-

gation to deal with the proposer with the utmost good faith.

6.3 Intermediary Involvement in an Insurance Contract

The relationship between an intermediary (insurance agent) and the insurance company will be governed by a written contract. The general principles of agency will apply to determine the effect of representations made during negotiations. The Financial Advisers Act (Cap 110) makes it an offence for an intermediary to make representations with an intent to deceive.

On the other hand, any person who has agreed to procure insurance cover for another person may be regarded as that person's agent. In such a case, the principal will be bound by the agreement that it has signed, regardless of whether the agent has procured the insurance policy according to their instructions or the fact that such insurance is outside their usual scope of services.

Section 20 of the Marine Insurance Act (Cap 387) specifically provides for representations made pending negotiation of contract by the assured or their agent.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

The court has not issued a definition of an insurance contract, but reference can perhaps be made to the definition of an insurance business under the Insurance Act (Cap 142), which states that "insurance business in Singapore" means the business of assuming risk or undertaking liability in Singapore under policies, and of:

- receiving proposals for policies in Singapore;
- issuing policies in Singapore; or
- collecting or receiving premiums on policies in Singapore.

However, it does not include such businesses or activities, such class of businesses or activities, or such businesses or activities carried on by such persons or class of persons, as the authority may prescribe.

In general, there must be an offer, an acceptance and a consideration to complete the formation of the contract. Insurance contracts have been recognised as contract uberrimae fidei (ie, a contract based on the utmost good faith); see **6.1 Obligations of the Insured and Insurer**.

A key requirement to ensure that an insurance contract in Singapore is not void is that the policyholder must have an insurable interest over the insured. In the case of life insurance, Section 57 of the Insurance Act specifically provides that a life policy will be void for lack of insurable interest. In the case of general insurance, Section 62 of the Insurance Act (Cap 142) sets out the general position that no person shall purchase insurance for which they have no insurable interest. However, see **12.1 Developments Impacting on Insurers or Insurance Products**.

6.5 Multiple Insured or Potential Beneficiaries

Section 62(2) of the Insurance Act (Cap 142) provides that it shall not be lawful to make any policy on any event without inserting in such policy the names of the persons interested therein, or for whose use or benefit, or on whose account, such policy was made.

6.6 Consumer Contracts or Reinsurance Contracts

Where the position with respect to consumer contracts or reinsurance contracts is different,

this will have been highlighted in the appropriate sections.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Alternative risk transfer is risk protection using techniques other than traditional insurance and reinsurance to provide the business with coverage. ART blends risk retention and risk transfer at the lowest total cost of risk, and results in mutual alignment of the financial interests of both the insurer and the insured.

There are two broad segments to the ART market:

- risk transfer through alternative carriers, which encompasses self-insurance, pools, captives and risk retention groups (RRGs); and
- risk transfer through alternative products, which generally includes transactions such as integrated multi-line products, insurance-linked securities (ILS) or catastrophe (CAT) bonds, credit securitisation, committed capital, weather derivatives and finite risk products.

The MAS has stated that Singapore aims to be a global capital for Asian risk transfer by 2025, offering a wide spectrum of risk financing solutions that go beyond traditional insurance and reinsurance, to risk pools and ART mechanisms such as ILS. In Singapore, ILS were first launched in February 2018 to encourage ILS issuances and to develop the region as Asia's leading hub for ILS business. The ILS grant scheme funds 100% of certain upfront issuance costs of CAT bonds in Singapore, up to SGD2 million. The MAS extended its ILS grant scheme to the end of 2022 alongside the region's desire to expand the range of ILS products available beyond CAT bonds.

The MAS has been running a consultation process seeking feedback on proposals to update two areas of the ILS regulatory regime.

The MAS proposes to exclude special purpose reinsurance vehicles (SPRVs), such as CAT bonds or ILS issuance vehicles, from certain investment-related requirements for insurance and reinsurance companies registered in Singapore.

As policyholders of SPRVs are the sponsors of ILS transactions, these policyholders will have access to relevant information to understand the risks to which the SPRV is exposed, and the manner in which the risks are managed. Therefore, the MAS also proposes adding SPRVs to the list of entities that do not have to make full public disclosures, such as captive insurers, marine mutual insurers and run-off insurers.

Singapore has supported nine CAT bond issuances, including the following landmark transactions:

- the first full Rule 144A CAT bond issued by Security First Insurance Company in May 2020, which reflects Singapore's capabilities to support the most liquid type of ILS offering;
- the first Asian sovereign CAT bond covering earthquake and typhoon risks in the Philippines, which was also the first CAT bond listed on the Singapore Exchange; and
- the first Asian CAT bond covering typhoon and flood risks in Japan, sponsored by Mitsui Sumitomo Insurance.

According to data from Artemis, Singapore played host to four CAT bond transactions in 2021, from three US sponsors and one Japanese sponsor.

Singapore was the domicile of choice for six CAT bond sponsors in 2020 and three in 2019.

7.2 Foreign ART Transactions

There is no specific regime for the recognition of overseas ART transactions. Whether such transactions will be treated as reinsurance for the purposes of the Singapore regulatory regime would therefore depend on whether they meet the common law definition of insurance.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The general contractual principles of interpretation will apply to the interpretation of an insurance contract. Principles that have been observed include the following:

- the aim of the exercise of the construction of a contract is to ascertain and give effect to the objection intentions of the parties;
- a holistic approach will be taken, looking at the whole contract; and
- this exercise will be informed by the surrounding circumstances or external context.

In this regard, the use of extrinsic evidence is subject to the following requirements:

- it is limited to ascertaining the interpretation of the term itself, and not to usurp the authority of the written agreement or contradict, vary, add to or subtract from its terms; and
- it has to be relevant, reasonably available to all contracting parties and relate to a clear and obvious context.

In the case of standard-form contracts, likely to include consumer contracts, the presumption is that all the terms of the agreement between the parties are contained in the contract and it will be almost impossible to allow the use of extrinsic evidence in construing such a contract. In addition, the Singapore Court of Appeal has noted, in particular, the use of the contra proferentum rule in interpreting the scope of conditions precedent in insurance contracts.

8.2 Warranties

In the specific context of insurance law, "warranty" is used to refer to where the insured has undertaken that some particular thing shall or shall not be done or that a particular fact does or does not exist. A warranty does not need to be expressly described as such and may be implied into the contract as well. The result of a breach of a warranty is that the insurer has the right to terminate the contract. It is of no consequence that the breach may have been immaterial to the risk or loss or that the breach was not fundamental.

8.3 Conditions Precedent

A condition precedent is understood as a term in a contract that must be satisfied before the obligations of the other party arise. Where a condition precedent has not been satisfied, the insurer is simply not liable to meet the insured's claim as the insured has failed to carry out the steps required of it to establish the insurer's liability.

The Singapore Court of Appeal has observed that insurance policies are invariably drafted and/or vetted by experts for the benefit of insurers so as to protect the latter's interest. As such,

the contra proferentum rule is frequently raised to interpret the scope of conditions precedent in insurance contracts. Factors that are taken into account in this interpretation exercise are the workability of the contractual obligation as a condition precedent to liability and the purpose of the condition.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

If the parties are unable to come to an agreement about the coverage of the insurance contract, they may choose to enter into alternative dispute resolution (see **9.7 Alternative Dispute Resolution**) or commence legal proceedings (see **9.3 Litigation Process**).

In Singapore, the MAS is the main body that supervises and regulates insurance and reinsurance activities under the Monetary Authority of Singapore Act (Cap 186) and the Insurance Act (Cap 142).

The following associations also play an essential role in the regulation of insurers and insurance intermediaries by issuing internal codes of conduct and guidelines to regulate the conduct of their members:

- the Life Insurance Association (LIA) (the trade association of life insurers); and
- the General Insurance Association (GIA) (the trade association of general insurers).

The complainant may also approach the Financial Industry Disputes Resolution Centre Ltd (FIDReC), which is an independent institution that aims to provide a one-stop shop for consumers (ie, individuals or sole proprietors) to resolve disputes with financial institutions (including insurers) and can hear claims of up to SGD100,000.

An insured who wishes to bring a claim against an insurer can file a complaint with the GIA or the LIA if the insurer is a member thereof; most (if not all) major insurance providers in Singapore are members of the GIA.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Generally, insurance contracts will include clauses that provide for the choice of court and law. The court will give effect to such a clause, so disputes in insurance law concerning the proper forum or governing law are rare. This is further affirmed by the passing of the Choice of Courts Agreement Act 2016, Section 9(6) of which affirms that a proceeding under a contract of insurance and reinsurance is not excluded from the application of the Act by reason only that the contract relates to a matter to which the Act does not apply.

If the contract does not include a choice of law clause, the court will examine a variety of factors in determining the implied law of the contract, including the commercial purpose of the transaction, the places of residence of the contracting parties and the choice of court. If the courts find that there was no implied choice of law term, they will then determine the objective proper law, which is the law with the closest and most real connection with the contract.

If the contract does not include a choice of court clause, the court will examine whether Singapore is forum conveniens, if there is a serious issue to be tried on the merits and if there is a good arguable case that comes within one of the grounds enumerated in the Rules of Court Order 11.

9.3 Litigation Process

There are three courts in Singapore that will likely hear a dispute over an insurance contract at first instance:

- the Magistrate's Court;
- the District Court; and
- the High Court.

The State Courts comprise the Magistrate's Court and the District Court. The Magistrate's Court hears claims not exceeding SGD60,000 and the District Court hears claims exceeding SGD60,000 but under SGD250,000 (or up to SGD500,000 for road accident claims or claims for personal injuries arising out of industrial accidents). The General Division of the High Court hears claims above SGD250,000. The Supreme Court comprises the General Division of the High Court and the Court of Appeal. The Court of Appeal generally exercises appellate jurisdiction.

It should be noted that actions started in the Magistrate's Court will have to go through alternative dispute resolution (ADR) unless parties are able to give a good explanation as to why this would not be appropriate; see **9.7 Alternative Dispute Resolution**.

Overview of Court Proceedings

Civil proceedings may be initiated by writ of summons (if a substantial dispute of fact is likely to arise) or by originating summons (generally appropriate for disputes concerning matters of law).

Under Singapore law and the Singapore court system, there are various means by which proceedings may be resolved or terminated before trial, such as:

- entering a default judgment against the defendant;
- applying for a summary judgment;
- applying for judgment on admission of facts; and
- applying for pleadings to be struck out.

If parties are unable to resolve their conflict, they will have to go through the process of discovery. Parties are expected to disclose all documents upon which they (will) rely, and documents that could adversely affect their own case, affect another party's case or support another party's case and that are relevant and necessary. Parties can also ask for specific discovery of:

- documents upon which a party will rely;
- a document that could adversely affect their own case or another party's case; or
- a document that may lead the party seeking discovery of it to a train of enquiry resulting in obtaining information that may support another party's case and that is relevant and necessary.

Evidence is also given in the form of affidavits of evidence-in-chief, which are sworn on by witnesses before trial and upon which the witnesses can be examined during trial.

The limitation period for contractual claims is six years under the Limitation Act (Cap 163).

9.4 The Enforcement of Judgments

Singapore is a contracting party to the 2005 Hague Convention on Choice of Court Agreements, given effect by the passing of the Choice of Court Agreements Act 2016. Accordingly, judgments obtained from the Singapore courts may be recognised and enforced in the courts of other contracting states. Section 18 of the Choice of Court Agreements Act 2016 spe-

cifically provides that the High Court may not limit or refuse the recognition or enforcement of a foreign judgment of liability under the terms of a contract of insurance or reinsurance on the ground that the liability under the contract includes liability to indemnify the insured or reinsured in respect of a matter to which this Act does not apply or an award of damages that will not be recognised or enforced under Section 16 of the Act.

The Reciprocal Enforcement of Commonwealth Judgments Act (Cap 264) (RECJA) and Reciprocal Enforcement of Foreign Judgments Act (Cap 265) (REFJA) will not apply to any judgment that may be recognised or enforced in Singapore under the Choice of Court Agreements Act 2016. The RECJA is intended to facilitate the reciprocal enforcement of judgments and awards in Singapore and other Commonwealth countries, subject to the restrictions provided in Section 3. The REFJA allows for the recognition and enforcement of judgments of a foreign country that gives reciprocal treatment to judgments obtained from the Singapore courts.

By virtue of the existing Choice of Courts Agreement Act, RECJA and REFJA, foreign judgments obtained from the following countries may be registered in Singapore:

- any European Union country;
- Australia;
- Brunei Darussalam;
- Denmark;
- Hong Kong;
- India (except the state of Jammu and Kashmir);
- Malaysia;
- Mexico;
- Montenegro;
- New Zealand;
- Pakistan;
- Papua New Guinea;
- Sri Lanka;
- the United Kingdom; and
- the Windward Islands.

If the judgment has not been obtained from one of these countries, the court will refer to common law principles – ie, it will need to be shown that the judgment is on the merits and is for a sum of money, that the foreign court has international jurisdiction according to Singapore conflict rules and that the judgment is final and conclusive.

Any application for registration of a foreign judgment in Singapore must be completed within six years after the date of the judgment, or where there have been proceedings by way of appeal against the judgment, after the date of the last judgment given in those proceedings.

9.5 The Enforcement of Arbitration Clauses

The Singapore courts will respect the existence of arbitration clauses in an insurance or reinsurance contract and enforce such a clause.

9.6 The Enforcement of Awards

The recognition and enforcement of arbitral awards is provided for in the Arbitration Act (Cap 10) and the International Arbitration Act (Cap 143A). An arbitral award may, by leave of the High Court, be enforced in the same manner as a judgment or an order to the same effect and, where leave is given, the judgment may be entered in terms of the award.

As Singapore is party to the 1958 New York Convention, foreign arbitral awards made in a Convention country are generally enforceable in the Singapore courts. A foreign award may be

enforced in the same manner as an award of an arbitrator made in Singapore.

9.7 Alternative Dispute Resolution

As Singapore is an ADR hub, the Singapore legal system encourages parties to consider their options before commencing legal proceedings.

For actions that are commenced in the Magistrate's Court, parties are expected to fill out Alternative Dispute Resolution Form 7, requiring them to consider their ADR options, including mediation, conciliation, neutral evaluation and arbitration. For proceedings commenced in the District Court, the duty registrar may also recommend ADR. This is offered for free or for low fees by the State Courts Centre for Dispute Resolution.

The Singapore courts actively support and encourage the use of ADR. Several channels of dispute resolution are available to parties:

- mediation;
- arbitration;
- neutral evaluation; and
- conciliation.

The popular ADR methods in Singapore are mediation, arbitration and neutral evaluation.

Whilst it is not mandatory for parties to make any attempts to resolve claims by mediation or any other means of dispute resolution, there may be cost consequences at the conclusion of the trial if parties have not fully explored such ADR methods.

9.8 Penalties for Late Payment of Claims

Insurers do not generally face penalties for late payments of claims in respect of late and improper delay in the payment of claims. However, see **12.1 Developments Impacting on Insurers or Insurance Products**.

9.9 Insurers' Rights of Subrogation

Subrogation, in the context of insurance, is the process by which the insurer assumes or takes on the rights or conditions of the assured that the assured has the right to exercise or acquire as a result of the loss or diminishment for which the assured is insured. The insurer has no greater right than that of the insured. Therefore, the insured is under a duty to not prejudice this right, including by way of claim against, or settlement with, a third party.

10. Insurtech

10.1 Insurtech Developments

"Insurtech" refers to the innovative technologies and new digital tools developed to optimise the performance of insurance companies, improve the customer experience, enhance back-end processes and save insurance companies money. Insurance technology is poised to mature even more in 2023. Insurance companies are searching for evergreen solutions in technology that can scale and update with changing demands and capabilities to help them stay ahead of competitors. Insurtech companies leverage the latest insurance technologies to reduce costs for customers and insurers, improve operational efficiency, and improve the entire customer experience.

Smart Nation

In light of an increasingly digitised and knowledge-based economy, Singapore launched its Smart Nation initiative in November 2014. Smart Nation is an initiative under which people will be more empowered to live meaningful and fulfilled lives, enabled seamlessly by technology,

and businesses can be more productive and seize new opportunities in the digital economy. The Singapore government's Smart Nation initiatives grant a backdrop to the growth of start-ups offering digital services in the insurance sector.

COVID-19

COVID-19 has had a significant impact on every sector of the global economy and has served to reboot insurance digitalisation. As the consequences of COVID-19 continue to unfold, insurers have started to prepare for the future by accelerating the digitisation of their operations and planning for future business opportunities. There has been an exponential increase in demand for digital touchpoints/electronic interactions between a brand and its consumers along the buying journey from first discovery to follow-up after a sale due to lockdowns across the world and ongoing physical-distancing protocols.

Chatbots and smartphone apps are examples of how insurtech streamlines the back-end process. Chatbots automatically respond to enquiries all the time, and smartphone apps enhance the customer experience; for instance, instead of printing out a photocopy of documents, a customer can snap a picture and submit it through an app, while customer identity verification and the collection of data, proof of insurance and registration of client and account changes can be done through a mobile app or platform.

According to the Singapore Fintech Association's insurtech directory, Singapore has become a hub for insurtech innovation and is boosting the region's largest concentration of insurtech start-ups, with about 80 companies in South-East Asia.

PolicyPal

Singapore-based insurance start-up PolicyPal is the first company to graduate from the FinTech Regulatory Sandbox set up by the MAS in 2016. In 2019, the MAS unveiled the launch of a Sandbox Express, which gives firms a faster option to test certain innovative financial products and services in the market. The MAS fintech sandbox encourages experimentation and innovation in the financial industry. PolicyPal was incubated in the Paypal Innovation Lab, which helps to foster innovation, research and development, and entrepreneurship, and to mature the financial technology ecosystem and capability building in Singapore through collaboration with government agencies, institutes of higher learning, industry associations, etc.

In mid-June 2020, AMTD Digital announced that it completed the acquisition of PolicyPal; this transaction marks the first controlling-stake acquisition in the South-East Asian insurtech industry since the outbreak of COVID-19. Through this transaction, PolicyPal will realise its vision of being the leading innovator of Asia's insurance industry under AMTD Digital's overall lead.

Other Fintech Mergers and Collaborations

According to data from United Overseas Bank, 43 Singapore-based fintech firms received funding in the first half of 2021, totalling USD725 million – the highest in the industry's history. Grab Financial Group (GFG) raised USD300 million in its Series A funding round, which was three times as much as the next-biggest deal (MatchMove's USD100 million Series D funding). This is a major milestone for GFG, as in previous years funds were raised under its parent company's name, Grab.

Other players include:

- GoBear, one of the leading fintech firms in South-East Asia, originally launched as a metasearch engine in 2015 before transitioning into a financial services and data platform;
- Inzsure, an insurtech firm that helps customers to better manage their portfolio of insurance policies and provide integrated services ranging from finding a suitable insurance product to claims and insurance management; and
- well-known insurtech player Singlife, a homegrown insurer that provides life and health insurance. In March 2020, Singlife launched Singapore's first mobile insurance savings plan, the Singlife Account, with an accompanying Visa Debit Card.

Developments in the Fintech Sector

The MAS announced a SGD125 million support package for the financial and fintech sectors to deal with challenges from COVID-19. The financial support will ensure the strong recovery and future growth of the sectors.

Insurtech not only offers the opportunity for insurers to be more consumer-centric but also enables insurers to transition from a product and process-oriented business to a customer-oriented business focused on understanding and satisfying the needs of customers. An interesting question is to what extent the developments in insurtech have resulted in significant changes to the insurance industry as a whole, as opposed to simply providing refinements on how insurance products are distributed in Singapore.

Global–Asia Insurance Partnership

Singapore has launched the Global–Asia Insurance partnership (GAIP), a tripartite partnership between the global insurance industry, regulators and academia to address structural protection gaps in insurance. The aim of GAIP is to produce actionable research insight, develop policy recommendations and co-create innovative solutions for the region.

Singapore Financial Data Exchange

On 7 December 2020, the MAS and the Smart Nation and Digital Government Group (SNDGG) launched the Singapore Financial Data Exchange (SGFinDex), the world's first public digital infrastructure to use a national digital identity and centrally managed online consent system. This enables individuals to access, via apps, financial information held across different government agencies and financial institutions. With SGFinDex, individuals will be able to retrieve their personal financial information – such as deposit accounts, credit cards and loans – by using their Singpass, enabling Singaporeans to consolidate their financial information for more effective financial planning.

SGFinDex is designed to ensure data protection and privacy of personal financial information. It will only transmit, and not store, any personal financial date.

10.2 Regulatory Response

In an innovative way to deliver financial products and services in a live environment, the MAS encourages experimentation and innovation. As such, it has developed a regulatory sandbox and provides an environment for companies to experiment with innovative fintech products and services. To encourage innovation in the financial industry, the MAS allows firms to test their products in the market within a clearly defined space.

There are two sandbox options:

- sandbox – for more complex business models where customisation is required to balance the risks and benefits of the experiment; and
- Sandbox Express – for fast-track approvals for activities where risks are low and well understood by the market. It provides firms with a faster option to test certain innovative financial products and services in the market. Eligible applicants can begin market testing in the pre-defined environment of Sandbox Express within 21 days of applying to the MAS.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Digital transformation expands the options and accessibility of financial services to consumers and is key to business success. New technologies are enabling financial services companies and insurers to overhaul their operations.

The Singapore Cyber-Risk Pool

Cybertechnology can enable and empower business and society if it is safe and trustworthy. A safe cyberspace is the collective responsibility of the government, businesses, individuals and the community. As part of efforts to develop the capacity to deal with cyber-attacks, Singapore set up the world's first commercial cyber-risk pool in 2018. The cyber-risk insurance pool has been developed and set up in collaboration with the Singapore Reinsurers' Association.

The Singapore cyber-risk pool committed up to USD1 billion of capacity to the cyber-insurance problem, bringing together both traditional insurance and ILS markets to provide bespoke cybersecurity coverage. The cyber-risk pool reflects Singapore's standing as a specialty insurance hub and the commitment to creating forward-looking insurance solutions to tackle new and emerging risks.

On 9 July 2020, the MAS announced "Singapore – Pushing the ILS Frontier in ASIA" during the welcome speech by Benny Chey, assistant managing director of the MAS, at the sixth edition of the Artemis Insurance Linked Securities Asia Conference. Mr Chey stated: "The world, and the insurance industry in particular, needs to pay more attention to emerging complex risks such as pandemics, cyber risks, and climate change."

COVID-19

The COVID-19 pandemic has posed questions for the insurance industry on a vast scale, such as loss of profit and business interruption.

Most commercial insurance claims are likely to be made in respect of business interruption losses for the revenue drop suffered as a result of disruption from lockdowns/circuit breakers. There are a few problems that policyholders may encounter in making claims.

- First, many of the more common wordings for business interruption coverage are drafted such that cover is triggered only if the insured's property is physically damaged due to specified perils (eg, fire or floods).
- Second, since the SARS outbreak in 2003, business interruption coverage clauses have expressly drafted exclusions that specify SARS. Therefore, policyholders will have to assess if similar exclusions are present in their policies and, if so, whether such exclu-

sion could be interpreted broadly enough to apply to the COVID-19 pandemic.
- Third, policyholders may also find themselves in potentially difficult situations relating to endorsements that may have actually been purchased to cover COVID-19-type losses. Some Lloyd's underwriters have been sued for not covering COVID-19 business interruption losses under endorsements purchased specifically in response to the 2014 Ebola outbreak, because COVID-19 was not a specifically named disease in the endorsements.

11.2 New Products or Alternative Solutions

With new risks emerging, insurers have to pay more attention to innovating and facilitating products for the market. Examples of such innovation include the following.

- In 2017, the World Bank first launched specialised bonds aimed at providing financial support to the Pandemic Emergency Financing Facility (PEF), which was created by the World Bank to channel surge funding to developing countries facing the risk of a pandemic. This was the first time that World Bank Bonds were used to finance efforts against infectious diseases.
- In 2019, the world's first dedicated climate resilience bond, a new type of socially responsible product that aims to bring more focus on climate adaption, was issued by the European Bank for Reconstruction and Development.

The COVID-19 pandemic, along with the associated economic impact, has had a number of key financial implications for insurers, including uncertainty in business volumes, claim frequency and severity, capital impacts, customers' ability to make premium payments, as well as changing risk profile and business mix. There is a need to reprice current products or modify product offerings to be more relevant in the COVID-19 environment, and to assess the existing reinsurance arrangements to understand the exposure to different counterparties and limits. Some insurance companies have offered detailed coverage for business interruption losses due to an infectious disease outbreak (eg, COVID-19) as a standalone policy or as an endorsement to a policyholder's existing business interruption coverage. Some companies also provide free additional insurance cover against COVID-19 to their customers.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

In February 2020, the Law Reform Subcommittee (Insurance) published its Report on Reforming Insurance Law in Singapore. Such reports tend to be referred to extensively by the Parliament of Singapore and the recommendations by the subcommittee should be taken seriously. Its recommendations can be summarised as follows:

- duties of utmost good faith and related areas of duty of disclosure, misrepresentation, warranties and remedies of fraudulent claims should be adopted as a single Insurance Contract Act;
- Sections 16 and 17 of the Australian Insurance Contracts Act should be adopted, which removes the requirement for an insurable interest in non-life-related or indemnity policies;
- Section 53(1) of the Marine Insurance Act (Cap 387) should be repealed and replaced

with a provision stating that, unless agreed otherwise, a broker is not personally liable to pay the premium;
- Section 53(2) of the Marine Insurance Act (Cap 387) should be amended to make it clear that the lien provided therein should be extended to non-marine insurance; and
- a specific provision should be enacted that requires insurers to make payment within a reasonable time.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

In order to increase insurance coverage and boost regional disaster resilience, the Southeast Asia Disaster Risk Insurance Facility (SEADRIF) was launched in 2019, and is the first regional catastrophe risk facility established in Asia. Although it is domiciled in Singapore, it serves as a regional platform to provide climate and disaster risk management to South-East Asian countries. For a start, the SEADRIF project is to offer a risk insurance pool covering flood risks in Lao PDR, Myanmar and potentially Cambodia, with support from Japan, Singapore and the World Bank to provide immediate financing in the aftermath of a natural disaster. SEADRIF is a platform for ASEAN countries to access disaster risk financing solutions and increase financial resilience to climate and disaster risks. It also provides ASEAN countries with advisory and financial services for post-disaster rapid financing to reduce the impact on people and their livelihoods.

Moody's Investors Service Report

According to Moody's Investors Service Report, Chinese life insurers' resilient profitability and capitalisation, along with rebounding premium growth, support the stable outlook for the industry. Qian Zhu, the vice president and senior credit officer of Moody's Investors Service, said: "life insurers' profitability will be supported by stable spread margins as they should be able to maintain investment yield of around 5% given the recent rebound in long-term yields as well as continued efforts to cap their cost of liability."

SFA and LIA Partnership

On 7 December 2020, The Singapore FinTech Association (SFA) and the Life Insurance Association Singapore (LIA) signed a memorandum of understanding (MOU) on the sidelines of the Singapore FinTech Festival 2020. The MOU reaffirms the commitment of both associations to work towards the progress of the insurtech and fintech industries in Singapore.

Gurbani & Co LLC was founded in 1989 and has established itself as one of the leading firms in Singapore in its main areas of practice, handling all aspects of shipping, all forms of marine and general insurance, reinsurance, and international and domestic commercial arbitration and litigation. It remains on the panel of many leading insurance companies. The firm acts for a solid international and local commercial client base, comprising multinationals, listed and private companies, banks, finance houses, shipping companies, ship-owners, operators, charterers, cargo owners, freight forwarders, international commodity traders, flag states and government-owned carriers, general insurers, marine cargo, hull and machinery, and war risks insurers, reinsurers, P&I insurers, FD&D associations, shipping agencies, ship repairers and bunker suppliers. The firm also works closely with associates in ASEAN countries, China, India, the UK and the USA on various cross-border legal matters, and is well placed to deal with issues in the region.

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Trends and Developments

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Insurance and Reinsurance in Singapore

Introduction

Throughout 2022, Singapore continued to withstand and overcome global financial and economic pressures, emerging strongly from the COVID-19 pandemic. In Z/Yen Partners' latest Global Financial Centres Index (September 2022), Singapore ranked third, behind New York and London.

Singapore's position as an Asia financial hub is also reflected in figures published in October 2022 by the Bank for International Settlements in their Triennial Central Bank Survey. This showed that Singapore retained its position as the world's third largest foreign exchange (FX) centre, after the UK and the US, with FX average daily trading volumes rising to USD929 billion in April 2022, up 45% from April 2019.

This article will highlight some of the legal and regulatory steps that the government of Singapore is taking to ensure financial stability and progress amid significant global financial pressures, and how they stand to impact the insurance and reinsurance industries. These include a continued focus on ESG issues, as well as the digital economy. In particular, we highlight the coming into force of a new Digital Economy Agreement between Singapore and the UK, in an example of international collaboration, as well proposed new regulations applicable to cryptocurrencies. We also summarise proposals to counter ransomware attacks, and highlight legal developments in the insurance sector, with consultation on new legislation underway.

Finally, we set out three developments due to take effect in 2023:

- IFRS 17 (on Insurance Contracts);
- the introduction of an anti-money laundering digital platform; and
- the coming into effect of new business continuity management guidelines.

Focusing on the "E" of ESG

Environmental, social and governance (ESG) considerations are by no means new, but they have been brought into sharp focus by the COVID-19 pandemic and moved firmly into the centre of business decision making during 2022, with every commercial sector coming under increasing pressure to demonstrate its commitment to ESG initiatives.

Regarding environmental considerations specifically, Singapore-based insurers will be aware that the Monetary Authority of Singapore's (MAS) Guidelines on Environmental Risk Management for Insurers (the "ENRM Guidelines") took effect in June 2022. The ENRM Guidelines set out MAS's supervisory expectations for insurers to assess, monitor, mitigate and disclose environmental risk.

In May 2022, ahead of the ENRM Guidelines taking effect, MAS published an Information Paper on Environmental Risk Management for Insurers (as well as similar papers for banks and asset managers). This provides an overview of the progress made in implementing the Guidelines, following on from a thematic review encompassing 16 insurers (as well as various banks and asset

managers). The Information Paper serves as a reference for insurers to facilitate their efforts to strengthen their resilience to, and management of, environmental risk.

The ENRM Guidelines, together with the Information Paper, will help insurers to make progress in what can be seen as a complex area of business. Given the unique characteristics of environmental risks, combined with the difficulty in obtaining accurate and comparable data, insurers (alongside others in the financial sector) continue to grapple with the process of assessing how climate risks can be evaluated and quantified, and how they give rise to financial risks.

The availability of staff skilled in sustainable insurance and finance also presents a challenge for the industry. As insurers rally to build their ESG credentials, under increased regulatory and market scrutiny, they become vulnerable to "competence greenwashing": the misrepresentation of knowledge, skills and competencies relating to sustainability or ESG-related activities. By hiring suitably qualified and talented staff, whose specific experiences and skill sets align with ESG initiatives (or investing in existing staff through specific training), insurers will be better able to keep pace with the speed and complexity of ESG-related regulatory and market developments.

Insurers will need to adopt agile data collection efforts that reflect an evolving understanding of environmental risks and iteratively enhance their risk management practices. In the meantime, they may wish to take advantage of industry initiatives to deepen knowledge and strengthen their in-house capabilities.

Digital Economy Agreement with the UK

In recognition of the increasing importance of the digital economy, the government of Singapore has concluded its third Digital Economy Agreement ("DEA"), this time with the UK government, which came into force on 14 June 2022.

The aim of the DEA is to increase digital trade between the UK and Singapore. The Singapore government has emphasised that the benefits to businesses include "end-to-end digital trade such as safe and secure e-payments and paperless trading, as well as seamless and trusted data flows, which encourage participation in the digital economy". The UK government has hailed the DEA as "the world's most innovative trade agreement, covering the digitised trade in services and goods across the whole economy".

This development should leave insurers – particularly those with operations in the UK and Singapore – in no doubt as to the importance the two jurisdictions place on the digital economy, and highlights the anticipated growth in this area.

Regarding financial services, the governments of both countries have committed to enhancing cross-border electronic data transfers, strengthening co-operation in respect of innovative financial services, including fintech businesses, and promoting greater interoperability between electronic payment systems. Digital trading systems are also an area of focus. In particular, the DEA will pave the way to reducing trading costs through the adoption of electronic transferable records, such as bills of lading – many countries currently only accept these in paper form.

The DEA also sets out a pathway for the UK and Singapore to share best practice and develop governance and policy frameworks for the

responsible development and use of emerging technologies (including Artificial Intelligence).

Regulating cryptocurrencies

Some insurers have begun to enter the cryptocurrency space, while others are reluctant to do so, wary of the associated risks and concerned by the lack of data. All insurers, however, can be expected to welcome the fact that MAS is seeking to promote a stable business environment for investing in cryptocurrencies.

In October 2022, MAS published two consultation papers proposing new regulatory measures to reduce the risks to consumers who trade in cryptocurrencies (also known as digital payment tokens, or DPTs) and to support the development of stablecoins as a credible medium of exchange in the world of cryptocommerce. This marks a significant step after the prohibitions introduced in January 2022 on the advertising of cryptocurrencies on public transport and public websites, and within public venues, broadcast media and periodical publications. MAS has explained that the proposed regulations are to go hand-in-hand with innovation, indicating a wish to foster an innovative and responsible digital asset ecosystem.

Acknowledging that it is not feasible to ban cryptocurrencies, MAS's proposed measures aim to reduce the risk to consumers by requiring DPT service providers to ensure proper business conduct and adequate risk disclosure, as is required of other financial institutions. The proposed measures cover three areas.

- Consumer Access – DPT service providers will be required to provide relevant risk disclosures to enable retail consumers to make informed decisions regarding cryptocurrency trading. Service providers are also required to prevent retail consumers borrowing funds in order to engage in cryptocurrency trading.
- Business Conduct – DPT service providers will be expected to put appropriate measures in place to ensure the segregation of customers' assets, mitigate potential conflicts of interest that arise from the multiple roles they perform, and establish suitable processes for complaints handling.
- Technology Risks – DPT service providers will be required to maintain high availability and recoverability of their critical systems, similar to other financial institutions such as banks.

MAS also proposes to expand the current regulatory framework, which focuses mainly on the risks of money laundering, terrorism financing and technology and cyber, to encompass certain categories of stablecoins, thereby ensuring a high degree of value stability.

Stablecoins are cryptocurrencies whose value is tied to an external reference point, such as the US dollar or the price of gold. MAS proposes to regulate stablecoins that are pegged to a single currency (Single Currency Stablecoins, or SCS) where the value of an SCS in circulation exceeds SGD5 million. There is to be clear labelling in order to distinguish stablecoins that are regulated by MAS from those that are not.

The proposed requirements relate to the following.

- Value Stability – SCS issuers must hold reserve assets in cash (or certain cash equivalents), and these assets must be denominated in the same currency as the pegged currency. Requirements on audits and the segregation of reserves, and timely redemption at par value, will also apply.

- Reference Currency – all SCS issued in Singapore can only be pegged to one of ten specified currencies (including the Singapore dollar).
- Disclosures – issuers of stablecoin will have to publish a white paper disclosing details of the SCS, including the redemption rights of stablecoin holders.
- Prudential Standards – SCS issuers must, at all times:
  (a) meet a base capital requirement of SGD1 million or 50% of annual operating expenses of the SCS issuer, whichever is higher; and
  (b) hold liquid assets valued at 50% of annual operating expenses or an amount assessed by the SCS issuer to be needed to achieve recovery or an orderly wind-down, whichever is higher.

MAS's clear intention to create a stable environment for cryptocurrencies should provide welcome reassurance to insurers in (and those intending to enter) the cryptocurrency space, especially following the well-publicised collapse of cryptocurrency exchange FTX in November 2022.

Combating ransomware attacks

In recent years, insurers have seen a marked increase in cyber claims involving ransomware attacks, across most if not all areas of commerce. To counter this, the Cyber Security Agency of Singapore (CSA) has brought together government agencies across relevant domains in Singapore to establish the Counter Ransomware Task Force (CRTF). In November 2022, the CRTF published its first Report discussing the evolving threat landscape, including the increasingly serious nature of ransomware attacks – which are no longer just isolated and sporadic but can threaten national and economic security, and critical infrastructure.

Highlighting the threat faced, the CRTF notes that 137 ransomware cases were reported by Singapore companies to the Singapore Computer Emergency Response Team during 2021, with most, if not all, of the attacks originating from outside Singapore.

To counter the threat, the Report recommends that the government focuses on four pillars of action:

- strengthening the defences of high-risk targets (such as government agencies, critical information infrastructure and businesses);
- disrupting the ransomware business model to reduce the pay-off for ransomware attacks;
- supporting recovery so that victims of ransomware attacks do not feel pressured to pay the ransom, which fuels the ransomware industry; and
- working with international partners to ensure a co-ordinated global approach to countering ransomware.

The CRTF has identified the tension between the need to discourage the payment of ransoms (Pillar 2) and the availability of cyber-insurance covering ransom payments, and has committed to studying the effects of these policies on the ransomware industry (and the potential impact if such coverage were disallowed). Nevertheless, and in the meantime, the CRTF encourages the take-up of cyber-insurance as a risk management practice among organisations.

The fact that the CRTF is encouraging the take-up of cybercover will be welcome news for insurers in the space, as will the practical advice contained in the CRTF's Report, for example on

strengthening cyberdefences, which will assist insureds to prevent and minimise the impact of attacks.

An updated Insurance Act

On 4 November 2022, MAS published a consultation paper proposing amendments to the Insurance Act 1966 to take into account regulatory and market developments, and to align (where appropriate) the regulatory framework for insurance with that of other financial activities regulated by MAS.

The proposed amendments include closer regulation of both insurance and non-insurance business in Singapore, with the aim being to ensure that insurers remain focused on their core insurance business and competencies and avoid potential contagion from the conduct of non-insurance businesses. This is to be achieved with the introduction of an "anti-comingling policy" to prohibit insurers from directly undertaking business other than insurance business and permissible business. Insurers will also be required to seek MAS's approval before acquiring a major stake in any corporation.

Among the amendments, MAS also proposes to introduce powers to strengthen its oversight of insurers' outsourcing arrangements, requiring additional due diligence to evaluate the abilities of the service provider.

Regarding insurance intermediaries, MAS proposes to widen the scope of circumstances under which statements made by intermediaries would be deemed as false or misleading by:

- removing the restriction that the false or misleading statements must be made with "intent to deceive"; and
- including statements made in connection with the arrangement of contracts of insurance, and if the insurance intermediary has not taken care to ascertain whether the statement is true or false.

To strengthen its gatekeeping powers over registered insurance brokers, MAS proposes to widen the grounds for refusing applications for registration as an insurance broker, but also to provide the right of appeal to persons whose applications have been refused.

MAS also proposes to bring in a requirement that registered insurance brokers have compliance, risk management and internal controls in place, along the lines already set out in legislation for banks, insurers, capital markets intermediaries and licensed financial advisers.

MAS has invited comments from financial institutions and other interested parties, to be submitted by 13 January 2023.

The proposals follow on from a 2020 report published by the Law Reform Committee of the Singapore Academy of Law, although a number of the recommendations from that report have not found their way into the proposed changes – these include a requirement for insurers to pay claims within a "reasonable time", the abolition of contract avoidance as a remedy for breach of the duty of utmost good faith and other provisions from the UK's Insurance Act 2015, which are not part of the current proposals.

International Financial Reporting Standard (IFRS) 17 – insurance contracts

IFRS 17, which presents a number of operational and financial challenges for insurers, is due to take effect in Singapore in January 2023.

IFRS 17 is the first comprehensive global accounting standard for insurance contracts and aims to make the financial position and performance of insurers more comparable and transparent. Its implementation is set to impact the whole of each insurer's business, from policy administration systems and actuarial models to general ledger and consolidation processes. Given the complexity involved in the implementation process, insurers have been making substantial efforts to install, build and test new or upgraded controls, processes and systems to integrate business, finance and IT, at considerable cost.

For many insurers, IFRS 17 is expected to have a substantial impact. Even if the reported numbers do not change significantly, IFRS 17 requires a significant amount of new information, in particular new disclosures, and the effort involved in its successful implementation should not be underestimated.

Anti-money laundering digital platform

Anti-money laundering issues remain high on the agenda of all insurers and on MAS's list of priorities. During the first half of 2023, MAS is due to launch a digital platform to counter money laundering, developed in conjunction with six major financial institutions. The platform is to be named COSMIC, short for "Collaborative Sharing of Money Laundering/Terrorism Financing Information & Cases".

The platform aims to enable financial institutions to collaborate and share relevant information on customers and transactions. This will help financial institutions to identify and disrupt illicit networks, thus helping to safeguard Singapore as a financial centre. The intention is to share information in a structured format to allow for seamless integration with data analytics tools. This will help financial institutions collaborate productively and at scale.

Initially, the platform will focus on three key financial crime risks in commercial banking:

- abuse of shell companies;
- the misuse of trade finance for illicit purposes; and
- so-called proliferation financing (namely the raising, moving or making available of financing, funds, assets or other economic resources to individuals or entities to support the proliferation of weapons of mass destruction).

MAS plans to extend COSMIC's coverage out from the six financial institutions initially involved to encompass more financial institutions and areas, making some aspects of sharing mandatory.

Moving forward, insurers may find it useful to establish whether their insureds are members of COSMIC at the underwriting stage, and the extent to which those insureds consider they are benefiting from such membership. Further useful information might potentially also be gleaned via COSMIC membership when dealing with claims. It remains to be seen whether insurers themselves will be invited to participate in COSMIC.

New Business Continuity Management Guidelines

The scale of the pandemic in the last few years and the resulting economic uncertainty have shone a spotlight on the operational resilience and risk management systems of insurers in dealing with the repercussions of new risks. The past year has also seen an increased regulatory focus on the risk management of insurers, with an aim to boost the soundness of individual

insurers and maintain the stability of the financial system.

In June 2022, MAS issued its long-awaited revised Business Continuity Management Guidelines ("BCM Guidelines") (superseding the previous version published in 2003), outlining the principles and practices that insurers (and indeed all financial institutions) should implement to strengthen their operational resilience.

BCM is clearly not a new concept, but there has been a noticeable shift in focus: MAS now requires BCM to be considered through the lens of business services and their function, rather than on a systems basis, requiring insurers to adopt an end-to-end perspective for each service delivered to customers. Concerns have been raised that this could see some insurers having to overhaul their policies and procedures to achieve a more holistic interdependency between functions and services. Although the BCM Guidelines are non-binding in nature, any deviation from or non-compliance with them could increase an insurer's reputational risk in the industry.

Insurers are expected to meet the BCM Guidelines by June 2023 and to conduct their first BCM audit by June 2024. Insurers will therefore need to evaluate their current BCM to identify any gaps and update it accordingly to ensure compliance with the updated requirements and expectations of MAS.

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SOUTH KOREA

Trends and Developments

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Electric Vehicles Spark Issues in South Korean Insurance Law

By the end of June 2022, more than 25.2 million vehicles were registered in the Republic of Korea ("South Korea"). Of these, 298,000 (ie, 1.18%) were electric. Most electric vehicles (EVs) in South Korea are believed to be new cars that first hit the road no more than three years ago.

The South Korean automobile industry expects that 3.62 million EVs will be on the road in the country by 2030. Enamoured both by the distinctive designs and performance of EVs (in comparison with their traditional counterparts) and their relatively low fuel costs (in light of the surging oil prices), consumers are deciding to go electric.

But which is more economical – driving an EV or driving a more traditional internal combustion engine vehicle (ICEV)? A comparison between the otherwise identical all-electric and hybrid Kia Niro cars currently on the market in South Korea reveals that the retail price of the former is USD8,600 more than its hybrid counterpart. However, if they both run 20,000 km per year for seven years and eight months or more, the total costs for the hybrid vehicle (including the fuel costs, insurance premiums and car taxes) begin to exceed those for the EV by more than the difference in their retail prices.

The battery pack is an essential component in an EV and accounts for 40% of the car price. The popularisation of EVs depends on lowering the price of battery packs. The South Korean government is actively seeking to introduce a battery subscription system in order to reduce the price burden on consumers. In a battery subscription programme, the lessor owns the batteries and the lessee owns the vehicles. When a consumer buys an EV, they pay the vehicle price minus the price of the battery pack, which will be paid in the form of a monthly rent.

The advent of the battery subscription may more than halve EV purchase prices and the average EV owner will pay roughly USD250 in monthly rent for the battery pack. The South Korean government is currently preparing for statutory and regulatory amendments in order to make the battery subscription available and affordable. The amendments, which the government planned to enforce by the end of 2022, will enable separate registration on the vehicle register for EV owners with leased battery packs and those who own their battery packs.

Residual value of used EV batteries – what is it worth?

In order to understand the insurance issues that have emerged along with EVs, one first needs to understand the issues surrounding used electric car batteries. Although the battery pack is the most expensive part of an EV, used batteries are reusable and recyclable resources; therefore, a used battery can drastically slash the purchase price of an EV. Tesla replaces battery packs at a 20%–40% lower cost than Korean automobile companies do, for example, but with one

condition – that the US automaker retrieves the used batteries in exchange for providing new ones at a discounted price. Used batteries can be recycled into new resources, thereby filling the pocket of the EV manufacturer with more than the discounts.

Depending on their performance, used batteries can be used in three ways.

- Reproduced – if a used battery is found to perform 80%–90% as well as a new one, the battery goes through a reproduction process to get a second life as EV battery. As the pie of EVs grows, a battery replacement market will likely appear. Reproduced batteries will represent a non-negligible share of said market.
- Reused – if the performance level of a used battery is 60%–70% of that of a new one, the battery can be reused for energy storage systems (ESS) and the like at charging stations. Such batteries cannot function well enough to drive EVs but are good enough for ESS.
- Recycled – raw materials (eg, nickel or cobalt) can be recovered from batteries whose performance level has dropped 40% or more and used to make new batteries.

Some expect that the used battery recycling industry will emerge as a goose that lays golden eggs. A survey by a market research institute predicts that the used battery market will grow 26% on annual average from 2025 until the market value reaches USD72 billion by 2040. Hence South Korean battery and materials companies (including LG Energy Solution, SK On and Samsung SDI) are scrambling to jump on the used battery wagon and seize leadership of the fledgling market from automobile companies such as Hyundai Motor Company and Kia Corporation.

Uncertainty surrounding the supply and demand of raw materials is the biggest reason that South Korean companies are interested in used batteries. Behind this uncertainty lies the interworking of the inflation surge fuelled by the transition to a greener economy and Russia's invasion of Ukraine with the supply chain disruption caused by COVID-19.

Nations around the world are eager to reduce their dependence on a single country for each important raw material. The four big battery materials markets (cathodes, anodes, separators and electrolytes) were dominated in 2020 by China, whose market shares ranged between 54% and 71%.

However, with governments across the globe imposing ESG policy on industries, the recycling of used batteries looks set to become inevitable. As part of the aptly dubbed "urban mines", used batteries represent a source of raw materials free from geopolitical shackles.

Do EVs have higher accident rates and repair costs?

The accident rate and the loss ratio matter when it comes to insurance. Electric vehicles are generally believed to be more prone to accidents and more costly to repair than ICEVs, thereby leading to higher premiums. A survey by the Korea Insurance Development Institute (KIDI) reports that in 2021:

- the accident rate for EVs was 18.1%, which is 2.1 percentage points higher than 16% for ICEVs; and
- the average repair costs for EVs (in claims for "damage to your auto") were USD2,000, which is about 30% higher than USD1,550 for ICEVs.

According to South Korea's Financial Supervisory Service, the percentage of long-distance drivers who drive at least 15,000 km per year was higher among the EV drivers (24.2%) than the drivers of ICEVs (10.3%). Electric vehicles are expensive but less costly to fuel, so they are economically more beneficial than gas guzzlers for frequent drivers. The greater amount of time that EV drivers spend on the road explains their higher incidence of accidents.

Some believe these accidents are frequently caused by the instant acceleration that is unique to EVs. Most accidents involving EVs are reportedly collisions with concrete pillars in parking lots and can be attributed to the characteristically fast acceleration from low to high speed.

It has also been claimed that EVs tend to hit more pedestrians, presumably because the former are quiet or noise-free. In Norway, between 2011 and 2018, the *European Transport Research Review* reports that:

- 10.4% of all ICEV accidents involved pedestrians (9.9% involved bicycles); and
- 17.8 percent of all EV accidents involved pedestrians (13.7% involved bicycles).

Expensive parts such as the battery, electronic control unit (ECU) and sensor are cited as the major factors that contribute to the high average repair costs for EVs. Once an EV sustains an accident, it is not easy to repair the battery and replacing it is costly. When it comes to high-voltage batteries, there are not enough specialised repair shops; therefore, it is difficult to get them repaired. Even more unfortunately, manufacturers' replacement policies encourage replacement even if the damage is minor.

However, others argue that EVs should not be so readily equated with higher accident rates and repair costs. They argue that the heightened incidence of accidents and cost of repairs for these vehicles are largely because they are new and cutting-edge, rather than solely because they are electric-powered.

The majority of EVs featured in the current statistics are estimated to be three years old at most. Given that new cars are more expensive, have longer ranges, and are equipped with more costly high-tech parts in general, the higher accident rate and average repair costs for EVs are not down to their electric power and should instead be attributed to the fact that they are newer cars with more innovative parts.

Indeed, comparisons between EVs and ICEVs of up to three years old reveal that the accident rate and the loss ratio are higher in the latter. Additionally, the 2020 statistics produced by the Highway Loss Data Institute (HLDI) in the US indicate that – when compared with the same model of ICEV – EVs had fewer accidents and demonstrated lower loss ratios both for property damage liability coverage and coverage for damage to your auto.

Should insurance coverage consider depreciation of batteries?

In the past, the terms and conditions did not clearly stipulate whether to deduct depreciation when compensating for batteries, so there was a risk of disputes. As a consequence, the General Insurance Association of Korea revised the automobile insurance terms and conditions in 2021 in order to deduct depreciation of the EV batteries as per the engines of ICEVs. Moreover, taking into account a possible shortfall in compensation for replacement costs due to the deduction of depreciation, the association had

all insurers introduce a rider that fully compensates for battery replacement if an additional premium is paid.

One technical issue with assessing the residual value of batteries and applying their depreciation is a lack of commonly used technologies and standards to determine the residual value. Data-driven battery diagnosis technology that can assess the present condition of – and predict the future residual value of – a battery is essential but not yet available. The flagship products of the Big Three in the Korean battery industry vary not only in shape (ie, prismatic, pouch-shaped or cylindrical) but also in performance and functions. There is therefore a great need to develop standardised diagnostic criteria in order to officially diagnose batteries, the characteristics of which may vary depending on the manufacturer.

Unique risks call for unique riders

Electric vehicles come with unique risk factors, including battery damage, accidents while charging, high repair costs, and lack of infrastructure such as charging stations and repair shops. In response to these risks, insurers are debuting new riders that cover new battery prices, accidents during charging, or excess repair costs, as well as a rider to provide emergency roadside service for EVs. Some examples are outlined here.

A rider to cover the price of a new battery

The batteries of EVs frequently sustain damage when involved in an accident and, despite their high prices, are replaced more often than not in such cases because they are difficult to repair. Unfortunately, depreciation is not compensated for by coverage for damage to your auto when the battery is replaced. Hence the launch of a rider to cover the amount of depreciation.

A rider to cover accidents during charging

This rider compensates for the insured's injury or death due to a fire, explosion, or electric shock while charging the insured vehicle at a charging station.

A rider to cover excess repair costs

In the case of coverage for damage to your auto, compensation may be given within the limit of the insurance value; however, EVs are more expensive to repair. Hence the repair costs of a vehicle sustained in an accident may easily exceed the vehicle's value at the time of accident. This rider compensates up to 130% of the vehicle value.

A rider to provide emergency roadside service for EVs

In light of the shortage of charging stations, this rider provides towing service to EVs for longer distances (eg, 60, 100, and 150 km) than the towing service for ICEVs.

Is there a conflict between the core charge policy and the right of subrogation?

There is controversy over who has the right to the residual value of an EV's used battery. Is it the insurer who paid the insurance money, given the right of subrogation, or is it the manufacturer of the automobile?

In South Korea, this conflict between the insurer and manufacturer has escalated into litigation. The South Korean damage insurance industry filed a lawsuit against Tesla over its core charge policy.

The US automaker charges around USD13,000 for battery pack replacement – that is, between 20% and 40% less than its Korean competitors, which charge more than USD18,000. The difference is down to the USD5,000 compen-

sation Tesla pays for the recovery of the damaged battery, based on its so-called core charge programme. Core charge is a policy that provides certain discount on a new part in order to receive the used part back. The policy was first introduced by Ford Motor Company back in 2003 and has since been adopted by major US automakers for key parts such as aluminum wheels, bumpers, and lighting assemblies.

Before the Tesla began to collect used batteries, the damage insurance industry in South Korea used to replace the batteries of EVs on behalf of the vehicle owners and sold the used batteries for profit. The insurers, who pay out insurance money in full for EV batteries that are totally destroyed, went to court – asserting that they may subrogate themselves to the insured's right to their used batteries under Article 681 of the Commercial Act of South Korea, which provides for the insurer's right of subrogation.

This issue concerns the legal interpretation of insurance laws and vehicle sales agreements. According to the principle of subrogation, if an EV maker has transferred its ownership of the battery to a vehicle owner who has purchased comprehensive and collision coverage, thenthe insurer legitimately has the right to the used battery – provided the insurer has paid insurance money to compensate the vehicle owner for damage to said battery.

In such case, given that the vehicle owner only receives a price discount on the new battery if they return the used battery to the manufacturer, they would need to buy back the right to the used battery from the insurer. Once the vehicle owner repurchases their right to the used battery, they can return it to the manufacturer and get a discount on the new battery.

However, if the EV manufacturer did not transfer its right to the battery when it sold the automobile to the vehicle owner, the right to the battery remains with the manufacturer. Therefore, the vehicle owner and their insurer cannot exercise any right to the used battery. Even if the two inked an agreement on the battery, the agreement would not be a binding contract in this case because the vehicle owner has no insured interest regarding the battery.

Ultimately, the extent to which there is conflict between the right of subrogation and the core charge policy depends on:

- the terms and conditions of the EV sales agreement; and
- whether or not the insurer and the insured entered into a used battery repurchase agreement.

Dealers of imported cars in South Korea are reportedly preparing to amend their contract polices in order to expressly provide for collection of used batteries in their sales agreements. The conflict between the core charge policy and the right of subrogation is not expected to subside in the near future.

Choi & Kim was the first law firm in South Korea to specialise in insurance law, instantly becoming one of the country's leading firms for shipping and marine insurance. Since its establishment in 1997, Choi & Kim has been the first choice for major P&I clubs and shipping companies around the world, thanks to its excellence in civil litigation and arbitration. The firm now attracts clients facing international trade disputes and cross-border insolvency issues. Most of Choi & Kim's clients are based overseas and the firm is capable of providing legal advisory services on demand in both English and Korean, which is viewed as something only a few of the largest law firms in Korea have the resources to do. Key clients include the North of England Protection and Indemnity Association (North P&I Club), Steamship Mutual, Britannia P&I, the UK P&I Club, Standard Club, West of England P&I Club, Gard, Skuld, and Navios Maritime Holdings.

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1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The Swedish legal system is a hybrid, with similarities to both civil law and common law systems. Although the most fundamental source of law is statutory, Swedish private law heavily relies on case law. However, the courts will generally afford great weight to preparatory works and the intentions of the legislator when interpreting statutory law.

There are several key regulatory acts that apply to insurance and reinsurance undertakings in Sweden, in particular the Insurance Business Act (2010:2043) (the IBA), which to a large extent implements the Solvency II Directive. Insurance distribution is regulated under the Insurance Distribution Act (2018:1219) (the IDA).

Together with a few other acts, the IDA implements the Insurance Distribution Directive (the IDD). Foreign insurance undertakings conducting insurance business in Sweden are primarily governed by the Foreign Insurance Activities Act (1998:293) (the FIAA). Insurance and reinsurance undertakings are also subject to other legislation on consumer protection, marketing and distant sales contracts, for example, as well as data protection.

Insurance contracts and most aspects of the relationship between insurer and insured are governed by the Insurance Contracts Act (2005:104) (the ICA). However, the ICA does not apply to reinsurance contracts (see **6.6 Consumer Contracts or Reinsurance Contracts**).

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

The Swedish Financial Supervisory Authority (the SFSA) regulates insurance and reinsurance undertakings as well as insurance intermediaries. Its primary aim is to ensure the stability of the financial system and to safeguard and further the development of consumer protection. The SFSA co-operates with the European Insurance and Occupational Pensions Authority (the EIOPA).

The SFSA also issues regulations and general recommendations. Where the regulations are binding, the general recommendations apply on a comply or explain basis – ie, the regulated subjects are expected to follow them or explain any departures. The sanctions available to the SFSA include the issuance of remarks, warnings, orders to undertake or refrain from undertaking certain actions and administrative fines.

Regarding insurance undertakings, the SFSA may revoke the authorisation to conduct insurance business and wholly or partially restrict the insurance undertaking's right to dispose of its assets in Sweden and decide on how the insurance business should be conducted.

2.2 The Writing of Insurance and Reinsurance

Insurance Business

Under the IBA, insurance business may not be conducted without authorisation from the SFSA; doing so may result in sanctions from the SFSA (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**).

Insurance business is not statutory defined under Swedish law, and whether an activity constitutes insurance business must be assessed on a case-by-case basis. However, through preparatory works, legal literature and case law, the prevailing view is that a business must meet the following cumulative criteria to constitute an insurance business:

- the business must be conducted commercially;
- the activity must entail a binding commitment by the insurance undertaking to indemnify the insured;
- the commitment must be contingent upon the occurrence of an uncertain event;
- the insurance undertaking must make the insurance commitment in return for a premium; and
- the insurance commitment must be compensatory – ie, it must serve to protect the insured against negative economic effects.

Moreover, the public interest in the authorities supervising and monitoring the business must be considered when deciding whether a business should qualify as insurance business.

Finally, regardless of whether the above criteria are met and the public interest assessment, some activities may still fall outside the scope of insurance business (such as insurance-like undertakings ancillary to a main undertaking concerning vehicles, travel services or construction, for example).

There are, however, exceptions from the authorisation requirement to conduct insurance business. For example, a foreign insurance undertaking within the EEA may generally passport its licence under the principle of single state authorisation within the EEA (see **3.1 Overseas-Based Insurers or Reinsurers**).

When an undertaking is authorised to conduct insurance business, it may issue insurance contracts concerning any type of customer (consumer, SME or corporate), as the law does not differentiate between categories of customers. However, the authorisation is only valid for a specific insurance class within life or non-life, or, in certain specified cases, a combination of insurance classes within both. In addition, an insurance undertaking may only conduct insurance business and operations arising directly therefrom.

Regulations for Insurance Businesses

An insurance undertaking must comply with comprehensive and strict prudential regulation, including a solvency and minimum capital requirement, which are risk-sensitive and adapted to the individual insurance undertaking's aggregate risk level. The prudential regulation also includes a qualitative prudent person principle, with which the insurance undertaking must comply in regard to its investments, for example, as well as various more specific investment regulations concerning the location of assets, risk diversification, investments in derivatives and unlisted assets, among other things.

In addition, the IBA requires insurance undertakings to comply with several Swedish general standards and principles, which do not follow from the Solvency II Directive. However, many requirements are overlapping – eg, to maintain satisfactory financial stability (*stabilitetsprinciper*), abide by generally accepted insurance business standards (*god försäkringsstandard*) and provide sufficient information when selling insurance products.

Importantly, an insurance undertaking may only assume debt if it serves an intention of increasing the efficiency of the capital management or is otherwise required for the insurance business. The insurance undertaking's total debt must also be limited concerning the extent of the business and the size of the capital base. In special circumstances, the SFSA may grant exceptions from the requirement that the total debt must be limited, but such exceptions are rarely granted in practice.

Insurance undertakings are also subject to an array of comprehensive requirements regarding corporate governance and outsourcing, as well as fit and proper requirements for management and individuals responsible for central functions (eg, compliance, internal control and risk management).

2.3 The Taxation of Premium

Under Swedish tax law, there is generally no taxation of premiums, except premiums on motor insurance (*trafikförsäkring*) and group life insurance. Insurance premiums are also exempt from VAT.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Secondary Establishments and Cross-Border Activities

Pursuant to the FIAA, which implements the EU principle of single-state authorisation, an EEA-based insurance undertaking may conduct insurance business through a secondary establishment in Sweden or cross-border activities.

As for secondary establishments, the EEA insurance undertaking may commence its business in Sweden two months after the SFSA has received the notification from the home state authority. Regarding cross-border activities, insurance business may commence as soon as the SFSA receives notification from the home state authority. Due notification is necessary for EEA insurance undertakings regardless of whether they will conduct business actively in Sweden or merely passively accept business from Swedish insureds.

Reverse Solicitation

Under the FIAA, a third-country insurance undertaking may conduct insurance business in Sweden passively by way of so-called reverse solicitation without a licence or notification. However, a third-country insurance undertaking may only undertake active measures on the Swedish market pursuant to specific authorisation from the SFSA through a branch or a general agent (ie, not through cross-border services). Insurance undertakings wishing to establish a branch office in Sweden must appoint a branch manager and must register the branch with the Swedish Companies Registration Office (the SCRO) before commencing business.

A general agent on the other hand is an individual or entity whose task is to lead and manage the foreign insurance undertaking's insurance business in Sweden. The foreign insurance undertaking can only be represented by one general agent, who must be a resident or have its registered office in Sweden.

Regardless of whether the third-country insurance undertaking opts for a general agent or a Swedish branch, it needs the SFSA's authorisation to conduct insurance business on the Swedish market. Unless otherwise stated below, the

same provisions apply to third-country branches and general agents.

Marketing Licences

Alternatively, third-country insurance undertakings may apply for a specific marketing licence, which allows the marketing of insurance products on the Swedish market by way of the intermediation of another insurance undertaking that is licensed to conduct insurance business in Sweden. The third-country insurance undertaking must then either be part of the same group as the relevant, licenced insurance undertaking or have entered into a co-operation agreement with that insurance undertaking for the marketing of the third-country insurance undertaking's insurance products on the Swedish market.

Brexit

The Brexit trade and security deal between the EU and the UK came into force on 1 May 2021, but provides little clarity for insurance companies. At the time of writing, no decision has been made on so-called equivalence or the extent to which UK firms will be allowed to continue to sell their services into the single market from their UK establishments. Therefore, UK insurance undertakings must comply with the aforementioned Swedish provisions on third-country insurance undertakings.

3.2 Fronting

Although historically not a generally accepted market practice in Sweden, fronting now appears to be generally accepted under Swedish law. The fronting insurance undertaking must be directly liable towards the insured in order for the arrangement to constitute insurance. If the fronting insurance undertaking does not assume risk, it may be questioned whether the business is in line with the Swedish provisions under which insurance undertakings may not conduct other business than insurance business, for example.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

Acquisition of Shares

The SFSA's prior approval is required before shares can be acquired in an insurance undertaking that would result in a qualified holding. Under the IBA, a qualified holding is a direct or indirect ownership in a company if the ownership represents more than 10% of the value of the company or more than 10% of the voting rights of the company, or otherwise facilitates a substantial influence over the management of the company. Approval is also required if a qualified holding increases to 20%, 30% or 50% of the shares or the voting rights in the company, or if the insurance undertaking becomes a subsidiary. Approval is only granted if the acquirer is deemed suitable to exercise substantial influence over the company's management and it can be assumed that the acquisition is financially sound.

An insurance undertaking may wholly or partially transfer a portfolio of insurance policies to another Swedish insurance undertaking or a foreign insurance undertaking authorised to conduct insurance business in Sweden or in another EEA country. Portfolio transfers are subject to procedural rules and SFSA approval.

Consolidation of Undertakings

An ongoing trend regarding insurance M&A is the consolidation of smaller insurance undertakings by way of mainly portfolio transfers to the major Swedish insurance undertakings. A likely explanation for this is an increased difficulty for

smaller insurance undertakings to conduct cost-effective insurance business on the Swedish market under an ever-increasing regulatory burden. The benefits of scale appear to give larger insurance undertakings a competitive edge, enabling them to take over smaller portfolios and integrate them into their existing business.

Current Status of the Sector

During recent years, the Swedish insurance market has seen several significant transactions, including acquisitions, listings, portfolio transfers of insurance undertakings and acquisitions of insurance intermediaries. As the M&A market in general has experienced a slowdown, the number of transactions within the insurance sector (similar to other sectors) is likely to decrease. Nonetheless, given potential synergies as well as the nature of the insurance market, consolidations of smaller insurance undertakings and intermediaries may continue as the drivers in transactions within the insurance sector.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Regulations

Insurance distribution conduct is mainly regulated by the IDA and regulations issued by the government and the SFSA in Sweden. The IDA has a broad scope and applies to those who:

- give advice regarding insurance and conduct other preparatory work before the conclusion of insurance contracts;
- assist in the entering into of insurance contracts; and
- assist in the administration or performance of an insurance contract.

In some respects, the IDA goes beyond the IDD's minimum requirements – eg, stricter regulations regarding occupational pensions that are exposed to market fluctuations. Some of the regulations regarding insurance-based investment products are also applicable to occupational pensions exposed to market fluctuations.

Insurance Distribution

Insurance distribution conduct requires some form of authorisation. Authorisation may be obtained either by independent licence from the SFSA or by becoming tied to one or more insurance undertakings via a distribution agreement where the insurance undertaking registers the insurance intermediary as such with the SCRO. A tied intermediary may not commence its distribution before such registration.

The distribution agreement must stipulate that the insurance undertaking is liable for any pure economic loss that the distributor is liable for to customers as a consequence of the distributor's intentional or negligent breach of duties under the IDA. The insurance undertaking must also make sure that the management of the tied distributor has sufficient knowledge and experience to conduct insurance distribution.

However, the distribution of insurance-based investment products or occupational pensions exposed to market fluctuations always requires a licence from the SFSA, regardless of whether the insurance intermediary is tied to one or more insurance undertakings. Also, a distributor tied to one or several insurance businesses may not distribute competing products issued by another insurance business.

The IDA requires insurance distributors to conduct their business under generally accepted insurance distribution standards, design their

systems of remuneration to avoid conflict with the duty to safeguard customers' interests, and disclose information regarding both the insurance distributors' business and the distributed insurance product before the customer enters into the insurance contract, among other activities.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

Insured's Duty to Disclose Information

The ICA stipulates that before entering into, renewing or extending an insurance contract, the insured must, upon the insurance undertaking's request, disclose information that may affect whether the insurance undertaking will issue the insurance policy. This obligation continues throughout the insurance period. The insured must answer the insurance undertaking's questions truthfully.

Regarding information on matters that obviously affect the risk assessment, an insured that is not a consumer must provide the information even without the insurance undertaking's request, and both consumer and non-consumer insureds must correct any previously provided information if the insured realises that it is incorrect or incomplete. If the insured has breached its duty to disclose through intent or negligence, insurance compensation may be reduced. If the insured has acted deceitfully regarding its duty to disclose, the contract is void.

Furthermore, under the ICA, a consumer insurance contract may stipulate that the insured must expeditiously disclose any increase in risk. Failure to do so may result in a reduction of the insurance compensation. Regarding commercial insurance contracts, such a duty exists regardless of whether it is explicitly stated in the contract.

Insurer's Duty to Provide Information

Before entering into an insurance contract, the insurance undertaking has a duty to provide certain information under the ICA and the IDA – eg, information that facilitates the insured's assessment of whether it needs the insurance product in question. The information should give an overview of the insurance coverage and must clearly state notable exclusions.

During the insurance period, the insurance undertaking must provide the insurance policy's terms and conditions and other circumstances that are of importance to the insured. If the insurance undertaking fails to emphasise certain terms of a consumer contract (eg, unexpected or material limits to the insurance coverage), it cannot invoke such terms.

Regarding commercial insurance contracts, the insurance undertaking may omit to disclose the requisite information concerning consumer contracts, if it can be assumed that the insured has no need of the information.

6.2 Failure to Comply With Obligations of an Insurance Contract

See **6.1 Obligations of the Insured and Insurer**.

6.3 Intermediary Involvement in an Insurance Contract

An intermediary may be involved in the negotiation of the insurance contract on behalf of either the insured or the insurer. The intermediary's obligations would then stem from the IDA (see **5. Distribution**), the contract between the intermediary and the insured/insurer, and general

principles of contract law, such as the agent's duty of loyalty towards its principal.

However, regardless of on whose behalf they are acting, the intermediary always has certain obligations towards the customer of insurance products under the IDA, and must adhere to generally accepted insurance distribution standards, which include:

- taking account of the interests of the customer;
- only recommending insurance solutions that are appropriate for the customer; and
- providing the customer with information regarding the distributed insurance product as well as the intermediary's business and the way in which the intermediary is remunerated.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

There is no statutory definition of an insurance contract under Swedish law, and no explicit legal requirements that must be fulfilled for a contract to constitute an insurance contract. Guidance may possibly be sought in the widely accepted definition of insurance business (see **2.2 The Writing of Insurance and Reinsurance**). However, under general contract law, insurance contracts may in theory be entered into by two parties, neither of which conducts insurance business.

For something to be insurable, it must constitute a legal interest. Consequently, it is not possible to insure the risk of unsuccessful criminal activity, for example.

If a contract is deemed to constitute an insurance contract, the ICA applies and imposes several obligations on both insurer and insured.

6.5 Multiple Insured or Potential Beneficiaries

Parties that are not insured may still be beneficiaries of an insurance contract under Swedish law. For example, the use of named beneficiaries is fairly common in life insurance policies.

In addition, pursuant to the ICA, a third party with a security interest in real property or a ground lease is essentially entitled to any insurance compensation available under an insurance policy that covers the value of the property in question. As long as the insurance policy does not stipulate otherwise, a security interest in movable property may also ensure a right to compensation under such an insurance policy.

When there are multiple beneficiaries to an insurance policy, a creditor with a security interest in real property or a ground lease may receive compensation from the insurance undertaking even if the underlying debt is not due for payment. However, if the creditor's security does not decrease significantly as a consequence of the insured event, the owner of the property may still have first priority over any available insurance compensation, unless agreed otherwise.

The ICA, IDA and IBA impose duties to provide the beneficiaries to an insurance contract with required information before the contract is made and during the contractual relationship.

6.6 Consumer Contracts or Reinsurance Contracts

The contracting parties have greater contractual freedom regarding commercial insurance contracts compared to consumer insurance contracts. The ICA imposes more onerous obligations on the insurer and more lenient obligations on the insured in consumer contracts than commercial contracts regarding, for example, the

insurer's provision of information, the insured's disclosure of information regarding the insured risk, exclusions and the effects of breaching contractual or legal obligations.

Reinsurance contracts are governed not by the ICA but by the Contracts Act (1915:218) (the CA). This gives the contracting parties greater contractual freedom as the often mandatory provisions in the ICA do not apply between the parties. However, contractual freedom is not without limit under the CA.

Although practical experience suggests that it is not frequently used, the CA contains a provision to the effect that a court may ignore or adjust a clause in a contract if it finds the clause unreasonable regarding the contract as a whole, circumstances at the time of conclusion of the contract, or circumstances that have occurred after that. In practice, English reinsurance case law and practice appear to influence the construction and application of reinsurance contracts under Swedish law.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

From a Swedish perspective, ART is a collective term encompassing both financial reinsurance and other forms of transfer of risk to the international capital markets, such as industry loss warranties. ART typically serves as an alternative to traditional insurance or reinsurance as a way of transferring risk. Although the Swedish ART market is still at the nascent stage of its development, it appears that ART has developed in areas where the insurance and reinsurance markets have traditionally not responded adequately to customer needs and wishes.

One of the issues with ART is its regulatory treatment and to what extent it will be effective in terms of meeting an insurance undertaking's solvency requirements. The Solvency II Regulation is applicable in Sweden and expressly recognises financial reinsurance as a risk-mitigating technique, and that it serves to provide regulatory credit to the extent that it meets certain criteria set out in the Solvency II Regulation.

7.2 Foreign ART Transactions

ART to other jurisdictions may be treated as reinsurance for Swedish insurance undertakings to the extent that the contract fulfils the Solvency II Regulation requirements for recognition as a risk mitigant.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The Nature of Insurance Contracts

Insurance contracts are primarily governed under specific legislation (the ICA), in addition to the CA, which applies to contracts in general. As with contracts in general, insurance contracts stipulate the parties' obligations. The insured's main obligation is the timely payment of a premium and the insurer's is to bear the risk for the occurrence of an unwanted event. If the risk materialises, the insurer must pay insurance compensation to the insured. For insurance contracts, a factor of uncertainty is key, as to if, when or to what degree the insured event will occur.

Whereas contractual freedom is the main rule in general contract law, this is not always the case for insurance contracts. For example, some types of insurance are compulsory (eg, motor

insurance), and the ICA imposes a contractual obligation (*kontraheringsplikt*) on the insurer for certain consumer insurances.

Against this backdrop, insurance contracts arguably have special features compared to other contracts.

Method for Interpretation

There is no statutory guidance for the construction of contracts but the method for construing contracts under Swedish law is well established in case law. Insurance contracts are mainly interpreted in the same way as other contracts, and the ultimate source for determining the content of an insurance contract is the common intention of the parties at the time of the conclusion of the contract. However, since insurance contracts are typically based on standard forms that are not subject to much (if any) individual negotiation, the common intention of the parties is often not practically possible to establish. Instead, the typical starting point for construing an insurance contract is the language thereof.

The objective meaning of the insurance contract should in turn be understood via the normal meaning of the wording itself. The following aspects, amongst others, may be taken into consideration:

- the systematics of the contract;
- the purpose of the contract as a whole and the specific clause(s) under scrutiny; and
- non-mandatory law or professional practice.

The interpretation of the contract should also give a fair and reasonable result. If an assessment of these factors fails to yield a result, a general principle of contract construction may be used – eg, the in dubio, contra proferentem rule (*oklarhetsregeln*), meaning that a vague or ambiguous clause should be construed against the person who drafted it.

Since Swedish procedural law allows for the free sifting of evidence, extraneous evidence is admissible for the construction when there is a dispute over the meaning of an insurance contract. Therefore, external circumstances (eg, prior negotiations or written communication relating to the agreement) may be used by the court when determining the meaning of the contract.

8.2 Warranties

Warranties are set out in insurance contracts as a way for the insurer to make its promise of cover conditional – ie, to limit the risk or burden of the insurer. As the basis for the promise to assume risk relies on complex calculations, it may indeed be necessary to condition the cover to some extent. This serves to make the insurer's actuarial assessments more accurate and to enable it to charge the correct premium for each specific risk.

While true warranties are not usually set out in Swedish insurance contracts, other important standard conditions may be noted in this context. For example, insurance contracts often include specific standards (eg, locking the doors of business premises, having satisfactory alarm systems or that electric installations are done professionally) to which the insured must adhere in order for the insurer to remain fully liable for the insured risk. This type of condition (*säkerhetsföreskrifter*) is regulated under the ICA.

The insurance contract may stipulate that if the insured fails to comply with these standards the insurer is free from liability to the degree such damage would be limited by the insured following the standards. If the insurer fails to emphasise these conditions to the insured, they cannot

be used against the insured. In some insurance contracts, there is a cap on the amount by which failure to adhere to the stipulated standards may reduce the insured's liability.

8.3 Conditions Precedent

Conditions precedent do not have a distinct definition under Swedish insurance contract law. However, pursuant to the ICA there are certain provisions under which the insurer may reject a claim regardless of whether it has suffered any prejudice.

For example, there is an obligation on the insured to disclose certain information to the insurer in most insurance contracts (see **6.1 Obligations of the Insured and Insurer**). If the insured has been fraudulent or deceitful in providing such information, or has failed to provide such relevant information to the insurer, the contract will normally be considered void.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Dispute Resolution

Disputes over coverage are often addressed in the general court system. However, arbitration is not uncommon when it comes to disputes concerning commercial insurance contracts. To the extent that reinsurance disputes lead to formal proceedings, which are rare nowadays, practical experience suggests that arbitration is the preferred route for reinsurance disputes.

The Swedish general courts recognise two types of private law legal actions:

- claims for specific performance; and
- claims for declaratory judgment.

In other words, an insured may seek a judgment by which the insurer is obligated to pay a certain sum under an insurance contract, or a judgment declaring an insurer liable to pay insurance compensation.

Disputes between consumers and businesses, such as insurance undertakings, may be submitted to the National Board for Consumer Disputes (ARN), which is a public authority that functions in a manner similar to a traditional court. However, ARN only submits non-binding recommendations on how disputes should be resolved. From experience, insurance undertakings often comply with ARN's recommendations.

Preclusion and Time Limits

An insurance claim will become time-barred under the ICA if the insured has not taken legal action against the insurer within ten years after the event that gave rise to the insured's right to insurance compensation. However, provided that the insured has reported an insurance claim to the insurer within those ten years, the insured will always have a period of six months to bring legal action against the insurer after the insurer formally declines to pay insurance compensation. Therefore, if the insurer declines to pay insurance compensation nine years and 11 months after the event that gave rise to the insured's right to insurance compensation occurred, for example, the insured will have six months to take legal action against the insurer (rather than only one month).

In commercial insurance contracts, a time limit for the reporting of claims may be stipulated in the insurance contract (however, the limit may not be less than one year after the circumstances that gave rise to insurance compensation). Furthermore, the insurer may require, in writing, that the insured must take legal action within a

certain time period (not shorter than one year), to bring an end to insurance claims.

For insurance contracts that were concluded before 1 January 2015, the limitation period is three years after the insured became aware that the insurance claim could be made, or ten years after the earliest point in time at which the claim could be made, unless the circumstances that gave rise to the claim for insurance compensation occurred after 1 January 2015 (in which case the new provisions will apply instead).

Third-Party Rights

The general rule under Swedish contract law is that an agreement is binding only between the parties to the agreement (ie, it confers rights and obligations on these parties only). As this main rule also applies on insurance contracts, the ICA stipulates no general right for a third party to claim insurance compensation from the insurer under an insurance policy. However, there are a few exceptions to the main rule – eg, for creditors with a security interest in the insured property (see **6.5 Multiple Insured or Potential Beneficiaries**).

The ICA also stipulates that, if the insured is legally obliged to hold a liability insurance (which is the case for insurance intermediaries, lawyers and real estate agents, for example), a third party against whom the insured is liable is entitled to claim insurance compensation directly from the insurer. A motor vehicle insurance policy is also required by law, and enables a third party to bring claims directly against the insurer.

Furthermore, under the ICA, a third party also has direct access to the liability insurance if:

- the insured has been declared bankrupt or an order has been issued for public composition; or
- the insured is a legal entity that has been dissolved.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

If a dispute falls under the Brussels/Lugano Regime, Swedish courts will resolve disputes over jurisdiction under those rules. There are also other Swedish statutes that explicitly give Swedish courts jurisdiction over specific areas. For example, under the FIAA, foreign insurance undertakings that conduct insurance business in Sweden must adhere to Swedish law and answer before the Swedish courts.

If the dispute does not fall under any EU regulation or a convention to which Sweden is a party, and no other statutes regarding jurisdiction are applicable in the specific case, disputes over jurisdiction will be resolved by the analogous application of Swedish statutes on jurisdiction. In general, for a Swedish court to have jurisdiction, the dispute must have a connection to Sweden, and the Swedish judicial system must have an interest in resolving the dispute.

For insurance contracts covering risks situated in Sweden, the Rome I Regulation restricts choice of law. The main rule is that Swedish law applies to the insurance contract, although there are notable exceptions to this main rule under the Rome I Regulation. Furthermore, parties to an insurance contract covering a large risk generally have full autonomy concerning the choice of law.

9.3 Litigation Process

Application

Litigation in Sweden is initiated by submitting an application for a writ of summons with a district court that has jurisdiction over the dispute. If a member of the Swedish Bar (*advokat*) represents the claimant, the ethical guidelines of the Swedish Bar Association (*Sveriges advokatsamfund*), as a main rule, require the legal representative to issue a letter of demand to the opposing party before submitting the application for a writ of summons to the district court (or requesting arbitration under an arbitration clause). The application should contain:

- a precise claim;
- a detailed description of the circumstances that are invoked in support of the claim;
- information regarding the invoked evidence;
- information on what the evidence is invoked to prove; and
- information regarding the circumstances that render the court competent to hear the dispute.

If the application fulfils these requirements and is not obviously unfounded, the district court will issue a writ of summons and serve the respondent the summons, after which preparatory proceedings are initiated, under which the respondent will be ordered to submit a reply.

Preparatory Proceedings

The preparatory proceedings are intended to clarify the following:

- the parties' claims and the circumstances invoked in support thereof;
- invoked evidence;
- whether further investigation or other measures are necessary before the conclusion of the case; and
- whether it is possible for the parties to find an amicable solution to the dispute.

The preparatory proceedings usually include several exchanges of written submissions and an oral preparatory hearing.

After the preparatory proceedings have been closed, a party may generally only invoke new circumstances or evidence if it has a valid excuse for not invoking the circumstance or evidence earlier, or if the continuation of the proceedings are not substantially delayed if the invocation is allowed.

Oral Hearings and Judgments

As a last step in the proceedings before the judgment, a main oral hearing is normally held, in which the parties present their cases including written evidence and any witnesses are heard. Swedish hearings are characterised by orality, immediateness and concentration. Insofar as is possible, a hearing should be conducted without delay. The court must base its judgment on what has been invoked during the main oral hearing. During the hearing, the parties are only allowed to submit or read from written submissions or sources if the court finds that doing so is suitable for the understanding of a statement or favourable for the proceedings.

District court judgments can be appealed to a Court of Appeal, whose judgments in turn may be appealed to the Swedish Supreme Court. Leave to appeal is required in both of these instances.

9.4 The Enforcement of Judgments

Judgments by Swedish courts are automatically enforceable in Sweden. As a general rule, foreign judgments may only be enforced if they fall within the scope of a convention to which Sweden

is party or an EU regulation. If a judgment falls within the scope of such a convention or an EU regulation, an application may be lodged with a district court to make the judgment enforceable in Sweden.

Judgments under the Brussels Regime (eg, Regulation (EU) No 1215/2012) are automatically enforceable in Sweden if the court proceedings were initiated on or after 10 January 2015. If the court proceedings were initiated before then, an application must be lodged with a district court to make the foreign judgment enforceable in Sweden.

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses in commercial insurance and reinsurance contracts are enforceable in Sweden. There is a precedent that suggests that an arbitration clause may be ignored if enforcement of the arbitration clause would lead to unreasonable results due to the balance of power between the parties. However, if even possible, invalidating an arbitration clause would likely be out of the question unless the balance of powers between the parties is so uneven that it resembles an actual consumer contract rather than a commercial contract.

Arbitration clauses in consumer contracts are not enforceable, except in a few special circumstances – eg, if the contract is a group insurance contract and a group representative has represented the insureds.

9.6 The Enforcement of Awards

Sweden is party to the New York Convention, so arbitral awards rendered in foreign jurisdictions are generally enforceable in Sweden in the same manner as a judgment from a Swedish court, subject to the New York Convention and the Swedish Arbitration Act (1999:116). To enforce an arbitration award from a foreign jurisdiction in Sweden, an application must be lodged with the Svea Court of Appeal.

9.7 Alternative Dispute Resolution

It is common for parties to an insurance dispute to settle their differences in good faith. The Swedish courts have a duty to actively work towards finding an amicable solution between parties at dispute, if possible and appropriate. If the parties agree, the courts may also initiate mediation between them. Mediation is also available through the Stockholm Chamber of Commerce. Furthermore, there is generally nothing preventing the parties from agreeing on and independently appointing a mediator. However, practical experience suggests that meditation between parties in an insurance dispute is rather rare.

9.8 Penalties for Late Payment of Claims

The ICA imposes an obligation on insurers to handle insurance claims expediently. The main rule is that the payment of claims should be made at the latest one month after the insured has reported the claim and presented the evidence that may reasonably be required to determine the insurer's liability to pay insurance compensation. If it is obvious that the insured is entitled to at least a certain sum, the insurer must pay that sum immediately. In commercial insurance contracts, the insurer and the insured may agree to terms that depart from the obligations laid down in the ICA regarding late payment of claims.

The insured is entitled to interest on the insurance compensation if the insurer is late with its payment. Under general contract law, the insurer may also become liable to pay damages for

losses that the insured incurs due to the insurer's late payment.

Insurers must adhere to generally accepted insurance standards under the IBA. Improper delay in settling claims may amount to a breach of said standards and could result in sanctions by the SFSA, at least in flagrant cases.

9.9 Insurers' Rights of Subrogation

The ICA includes a statutory right of subrogation for insurers – ie, they are entitled to pursue recoveries for loss actually incurred by the insured and indemnified by the insurer under the relevant insurance policy. The insurer assumes the insured's claim for damages against the third party that has caused the insured's loss (or against another insurer).

However, the insurer will not assume a better position than the insured against the third party and, thus, the insurer will not be able to claim compensation that exceeds the damages that the third party is liable against the insured for. Regarding life insurance, the insurer is not able to pursue its rights of recovery for insurance of fixed sums.

Generally, the insurance policy may limit the insurer's right of subrogation, which may also be limited due to the Recourse Agreement (*Regressöverenskommelsen*) made between several Swedish insurance companies, or due to any contracts under which the insured has waived any future rights of recovery.

10. Insurtech

10.1 Insurtech Developments

The area of insurtech has seen a steady rise in recent years, although 2021 and 2022 saw investments in insurtech decrease somewhat. The impression is that Sweden is well positioned for new, innovative solutions within insurtech, being one of the world's most advanced digital economies with a well-developed fibre network. Insurtech companies have made established insurance companies aware of shortcomings in digitalisation, which seems to have led the latter to increase digitalisation efforts and collaborations with insurtech companies.

In some areas of the insurance sector, smaller insurance undertakings are being consolidated into larger ones. However, there are still successful insurtech start-ups on the Swedish market that cope with the challenges of a well-regulated and supervised market. Some such entities appear to profile themselves with, and rely heavily on, the use of artificial intelligence, to lower the costs of production and improve the customer experience. Indeed, 2021 saw one such insurtech entity obtain SFSA authorisation to conduct insurance business. This particular entity employs artificial intelligence to handle and settle claims, seemingly in a quick and efficient way.

In addition, Swedish insurtech companies have shown a will to expand both nationally and internationally, and have been successful in this regard.

10.2 Regulatory Response

As a response to insurtech issues, the Swedish government tasked the SFSA with mapping innovations and market needs, especially concerning the SFSA's role as a regulator. Consequently, the SFSA has established an innovation centre, which serves to provide more dialogue with insurtech companies and to give seminars and organise information gatherings. The SFSA also participates in external events on innova-

tion. According to the SFSA, these measures will allow it to better follow market developments and lead insurtech companies to better compliance.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

While cyber-risk is not a new occurrence, it is constantly evolving along with advances in technology and poses problems for all businesses, including insurance undertakings. The risk of cyber-attacks appears to have only increased since Russia's invasion of Ukraine in February 2022.

On 31 March 2022, the Swedish government tasked the SFSA with proposing measures to increase resilience to cyber-attacks in the financial sector. Subsequently, on 6 May 2022, the SFSA proposed, among other things, that:

- the SFSA sharply increase its cyber-related supervision;
- the Swedish National Defence Radio Establishment be allowed to assist corporations with cyberprotection;
- a separate cybersecurity council be established within the Prime Minister's Office;
- the establishment of the National Cyber Security Centre be accelerated; and
- Bank ID and other private e-identifications be subject to adequate supervision, or replaced with a state e-identification.

There is also an emerging risk relating to the increase of large and complex legislative acts in the insurance sector. For insurance undertakings, this results in higher operational costs as more resources will be required in order to understand and implement all measures necessary for compliance. Small and medium-sized enterprises appear to be the most vulnerable to this risk.

Furthermore, the apparently more frequent occurrence of extreme weather is accompanied by new risks, which may be expected to affect primarily property insurance undertakings in the long and short run. One example is the extreme flooding in Sweden in the late summer of 2021, which resulted in several thousand insurance claims, the majority of which related to property insurance.

Finally, on 22 September 2022, the General Board of the European Systemic Risk Board (ESRB) issued a warning on vulnerabilities in the financial system of the EU. Rising geopolitical tensions have led to an increase in energy prices, causing financial distress to businesses that are still recovering from the adverse economic consequences of the COVID-19 pandemic. In addition, higher-than-expected inflation is tightening financial conditions. Therefore, the ESRB concluded that there has been an increase in risks to financial stability and the probability of tail-risk scenarios materialising.

11.2 New Products or Alternative Solutions

To keep pace with emerging risks, insurance undertakings have been establishing new insurance products that will allow businesses to continue their day-to-day operations despite the various emerging risks.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Implementation of Recent EU Directives

The Swedish insurance market has seen several important legal developments during recent years, most of which originate from EU law. For example, the implementation of the EU directive on the activities and supervision of institutions for occupational retirement provision (IORP II) came into force in December 2019 when the Occupational Pension Companies Act (2019:742) (the OPCA) was passed. Swedish life insurance companies offering occupational pension insurance may choose to either comply with the IBA in its entirety, or restructure the company to become an occupational pension company governed by the OPCA. The companies have until the end of 2022 to make their decision.

With the introduction of IORP II, there has also been debate in the Swedish parliament on the possibility for members of a pension scheme to move their funds to other insurers. As a consequence of the impact of COVID-19, the Swedish Finance Ministry issued a government bill that proposed granting a special solvency leeway to pension funds in their IORP II applications. The new legislation entered into force on 15 December 2020.

Review of the Solvency II Directive

The European Commission adopted a comprehensive review of the Solvency II Directive on 22 September 2021, following the EIOPA's technical advice to the European Commission on 17 December 2020, and this will likely impact the Swedish insurance market. The review resulted in a legislative proposal to amend the Solvency II Directive, a Communication on the review of the Solvency II Directive, and a legislative proposal for a new Insurance Recovery and Resolution Directive.

The overall aim is to ensure that insurers and reinsurers in the EU keep investing and support the political priorities of the EU, in particular:

- financing the post-COVID-19 recovery;
- completing the capital markets union; and
- channelling funds to implement the European green deal.

The European Commission's proposal included a new article to the Solvency II Directive, according to which insurance undertakings and reinsurers, when conducting own risk and solvency assessments as part of their risk management, will have to identify any material exposure to climate change risks and, where relevant, assess the impact of long-term climate change scenarios on their business.

Furthermore, 2022 saw amendments to the Solvency II Regulation, pursuant to which sustainability risks have been integrated into the governance of insurance and reinsurance undertakings. For example, insurance and reinsurance undertakings will have to take sustainability risks into account when they identify, measure and assess risks arising from investments, for example. These amendments came into force on 2 August 2022.

Banking and Outsourcing

Alongside the legislative developments, there are other developments worth mentioning in the current context, including advice from the EIOPA on outsourcing, published in February 2020 (see **13.1 Additional Market Developments**).

COVID-19

The COVID-19 pandemic deeply affected the global economy, including the Swedish economy and market, and society has now begun to experience the so-called "post-pandemic effects". Consequently, changes in consumer demand can already be seen on the insurance market, and additional changes are to be expected. A peculiar example is travel insurance. Although air traffic has decreased, demand for travel insurance has only increased in Sweden and this is expected to continue. Furthermore, with more people working remotely (ie, not from a specific workplace), a demand for new types of occupational insurance may be expected.

As for COVID-19-related disputes, a couple of cases have been adjudicated in the Swedish lower courts. In one case, the insured claimed insurance compensation under an epidemic business interruption insurance policy. The question in this case has been whether such a policy covers loss incurred as a consequence of public authorities' decisions in response to COVID-19. The insured had seen its business limited by the generally applicable decisions of the Swedish government and the Public Health Authority to limit the total amount of people allowed on the insureds' premises. However, the applicable terms and conditions stipulated that a loss had to be the result of an "authority's intervention" in order to be covered, and the lower courts found that this term referred to interventions against individual companies, not generally applicable decisions. Thus, the insured was not awarded insurance compensation in the lower instances. The insured has been granted leave to appeal to the Supreme Court, and it remains to be seen how the case will unfold.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

A market development impacting the insurance sector in recent years is ethical considerations in investments. While such considerations may have been part of various companies' investment processes earlier, there has been a significant push in this area, especially relating to sustainability.

Moreover, one area that is currently undergoing legislative development is insurance undertakings' use of cloud service providers and to what extent this is permissible in light of the comprehensive and detailed requirements on their outsourcing arrangements. Cloud service arrangements are often necessarily based on standard terms and conditions, which may not always give the insurance undertakings scope to live up to the stringent requirements applicable to their outsourcing arrangements.

To this end, on 6 February 2020, the EIOPA published a report and new guidelines for market participants on how the outsourcing provisions in the Solvency II Directive, the Solvency II Regulation and the EIOPA's guidelines on the system of governance are to be applied regarding outsourcing to cloud service providers. The SFSA subsequently notified the EIOPA that it intended to apply the guidelines. As of 1 January 2021, the guidelines apply to all cloud outsourcing arrangements entered into or amended on or after this date by insurance and reinsurance undertakings, although undertakings have until 31 December 2022 to fully comply with the guidelines.

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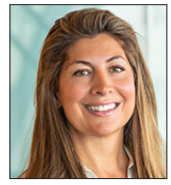

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Trends and Developments

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Updated Sustainability Requirements in Solvency II

Introduction

As part of the broader EU initiative on sustainable finance, a new amendment to the Solvency II Delegated Regulation entered into force on 2 August 2022. The amendment, which was adopted by the European Commission on 21 April 2021, specifically integrates sustainability risks and factors into the Solvency II regime, requiring European insurers and reinsurers to take sustainability risks into account as part of their duties towards policyholders. In essence, the amendment incorporates sustainability considerations into a number of existing requirements under pillar II of the Solvency II regime (pillar II sets qualitative requirements as opposed to quantitative requirements, which are set by pillar I). The changes introduced by the amendment lay the groundwork for more specific ESG-related requirements in Solvency II.

Key changes

To begin with, the amendment introduces a number of sustainability-related terms to the Solvency II framework. For example, the term "sustainability risk" has been added to the Delegated Regulation and is defined as "an environmental, social or governance event or condition that, if it occurs, could cause an actual or a potential negative impact on the value of the investment or on the value of the liability". The term "sustainability factors" has also been introduced, meaning "environmental, social and employee matters, respect for human rights, anti-corruption and anti-bribery matters".

Under the amendment, sustainability considerations have been explicitly integrated into the risk management framework of insurers and reinsurers. The tasks of insurers' and reinsurers' risk management function has been extended to also include the identification and assessment of sustainability risks. In addition, insurance and reinsurance undertakings are now required to integrate sustainability factors and considerations into their policies on investment, underwriting and reserving, renumeration, and other risk management areas. In other words, insurers and reinsurers must update their risk management policies to expressly reflect sustainability risks.

Another notable aspect of the amendment is the addition of a new paragraph to Article 269 of the Delegated Regulation. The new paragraph entails that the risk assessment in the annual ORSA (ie, insurers' and reinsurers' own risk and solvency assessment) must include emerging risks and sustainability risks identified by the undertaking's risk management function. Consequently, the ORSA must include sustainability risks that the insurer or reinsurer undertaking is or could be exposed to, and account for potential future changes in the undertaking's risk profile due to the business strategy or the economic and financial environment, including operational risks.

Furthermore, a new article has been added to the Delegated Regulation that explicitly incorporates sustainability risks into the prudent person principle under Solvency II. Pursuant to the new Article 275a, insurers and reinsurers must consider

sustainability risks when identifying, measuring, monitoring, managing, controlling, reporting and assessing risks arising from investments. To this end, the insurers and reinsurers must consider the potential long-term impact of their investment strategy and decisions on sustainability factors, and, where relevant, those strategies and decisions by the insurers and reinsurers must also reflect the sustainability preferences of their customers taken into account in the product approval process (as required under the Insurance Distribution Directive framework).

Finally, the amendment has integrated sustainability considerations into the actuarial function, which, from now on, will need to consider sustainability risks when providing its opinion on the underwriting policy.

Comment

As a result of this amendment to the Solvency II Delegated Regulation, European insurance and reinsurance undertakings are obliged to adapt the functions, processes and policies covered by the new requirements to ensure that sustainability considerations are adequately integrated. Considering that climate-related risks could have a potentially devastating and irreversible impact on the assets held by insurance and reinsurance undertakings, the new requirements could be considered natural, as they contribute to making the undertakings more resilient to sustainability risks. At the same time, more guidance is likely needed with regards to some of the changes; for example, based solely on the wording of the Delegated Regulation, it may not be evident to all insurers and reinsurers what the inclusion of sustainability risks in the prudent personal principle entails in practice.

From a Swedish perspective, there have not been any specific reactions from Swedish insurers and reinsurers relating to the annotated amendment. As the focus on ESG and sustainability in the financial sector has only increased in recent years, and is set to continue with various other legislative initiatives en route from the European Union, many Swedish insurers and reinsurers have already taken steps to integrate sustainability considerations into their businesses. While the amendment may therefore, in this specific sense, not entail any dramatic changes for many Swedish insurance undertakings, it nevertheless helps to clarify the requirements that are being adopted at an EU level.

Extended Rights for Policyholders to Surrender or Transfer Unit-Linked and Deposit Insurance Policies

Introduction

Following an amendment to the Insurance Contracts Act (the ICA), the rights of policyholders to surrender and transfer certain types of insurance policies have been extended. Previously, if the applicable policy terms and conditions did not prescribe surrender or transfer rights for the policyholder, only insurance contracts entered into after 1 January 2006 (in the case of surrender) or 1 July 2007 (in the case of transfer) could be surrendered or transferred. Now, unit-linked and deposit insurance policies may be surrendered or transferred regardless of when they were subscribed to. In theory, this amendment affects approximately 500,000 insurance contracts and SEK142 billion in insurance capital.

Previous status quo and the amendment

For some types of individual personal insurance, the ICA entitles the policyholder, in conjunction with the termination of the insurance contract, to surrender the insurance policy (ie, to have the value of the insurance policy paid back to the policyholder) or to transfer the full value of the insurance policy to another insurance

policy. These actions are possible for policies that encompass elements of savings and have a positive technical surrender value, and where it is certain that the insured event will occur. In essence, therefore, only unit-linked, deposit and traditional life insurance policies can be surrendered or transferred (the Income Tax Act entails that most pension insurance policies cannot be surrendered but can, conversely, often be transferred).

For a long time, the ICA prescribed surrender and transfer rights only for insurance policies subscribed to after 1 January 2006 and 1 July 2007, respectively. Parties have been able to agree on such rights themselves (ie, in the policy terms and conditions). However, a November 2020 report from the Swedish Supervisory Financial Authority (the SFSA) found that approximately 500,000 unit-linked and deposit insurance policies did not include such rights for the policyholder, and, consequently, that approximately SEK142 billion in capital was barred from surrender and transfer.

Since 1 July 2022, however, policyholders may surrender or transfer unit-linked and deposit insurance policies regardless of when the policies were subscribed to. Notably, this amendment was accompanied by an amendment to the Insurance Business Act (the IBA), which already capped the amount an insurance undertaking can charge a policyholder in the event of a surrender or transfer – 0,0127 price base amounts (approximately SEK600 in 2022) for unit-linked and deposit insurance policies. The IBA amendment applies this cap also to insurance contracts entered into before 1 July 2007.

These amendments constitute retroactive legislation. Whilst no general prohibition against retroactive legislation exists under Swedish law (the caveat being retroactive criminal or tax legislation), the prevailing view is that retroactive legislation requires heavily compelling reasons. Here, the preparatory works, which carry significant weight in the interpretation of Swedish statutes, invoked consumer protection interest (in being able to surrender or transfer insurance savings) as the heavily compelling reason for retroactive legislation.

Indeed, in the preparatory works, it is noted, inter alia, that it is difficult to find any type of contract other than for life insurance where the consumer can be tied to their counterparty for such a long time with an often significant amount of capital, which, in the case of life insurance, often constitutes the consumer's life savings. Notably, such "lock-in effects" were viewed in the preparatory works as being bad not only for consumers but also for competition between insurers.

Citing a report from the SFSA, it was noted in the preparatory works that the legislative amendments could have negative effects on:

- those insurance undertakings that held the majority of contracts still lacking surrender and transfer rights; and
- those insurance intermediaries that had distributed these policies and in return received continuous remuneration.

However, in the preparatory works, it is opined that the possible effects of the amendments would not jeopardise the abilities of the insurer undertakings concerned to meet their capital requirements, and that the affected intermediaries should be able to manage the possible adverse effects.

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Summary
Since 1 July 2022, unit-linked and deposit insurance policies can be surrendered or transferred regardless of when such policies were subscribed to. In theory, this amendment affects approximately 500,000 insurance contracts and entails that approximately SEK142 billion in insurance capital is now available for policyholders to surrender or transfer.

These extended surrender and transfer rights are primarily justified by strong consumer protection interests and should be read together with the provisions in the IBA, which recently saw its caps on how much an insurance undertaking can charge a policyholder in the event of a surrender of transfer become applicable also to insurance contracts entered into before 1 July 2007. These amendments purport to undo "lock-in effects" between policyholders and their insurers, something which is said not only to facilitate consumer protection interests but also to ensure that competition amongst insurers is not curbed.

New Supreme Court Guidance on Burden of Proof in Insurance Cases

Introduction

Insurance compensation disputes often involve evidentiary issues, and courts often decide which party (the insurer or the insured) should bear the burden of proof for a particular question of fact (ie, that a certain question of fact cannot be sufficiently established). Traditionally, a common view under Swedish law has been that the insured bears the burden of proof that an event covered by the insurance policy has occurred, whilst the insurer bears the burden of proof that an exclusion from insurance coverage is applicable. However, on 2 December 2021, the Supreme Court issued a decision that challenges this view.

The facts of the case and the Supreme Court's decision

In the case at hand, an insured had claimed insurance compensation from its insurer for the value of a vehicle that had been destroyed by fire. The applicable terms and conditions provided that such damage was covered by the insurance only if the fire was started by a third party. Whilst designed as a coverage provision, this particular provision operated more like an exclusion. Alluding to the common view on the allocation of the burden of proof and taking the position that the provision in question was a coverage provision, the insurer maintained that the insured had the burden of proof for the fact that the fire had been started by a third party. As the insurer considered that the insured had failed to meet this burden of proof, it denied insurance compensation, after which the insured initiated legal proceedings against the insurer.

After losing in both the District Court and the Court of Appeal, the insured was granted leave to appeal to the Supreme Court. The main issue before the Supreme Court was which party should bear the burden of proof for the fact that the fire had been started by a third party or, conversely, that it had been caused intentionally by the insured or someone who had acted with the insured's consent.

The Supreme Court began by citing the common view on how the burden of proof is allocated in insurance compensation cases – ie, that the insured has the burden of proof for facts relating to the insurance coverage and that the insurer has the burden of proof for facts relating to exclusions from insurance coverage. Noting that some have assumed this starting point to derive from the Supreme Court's case law, the Supreme Court pointed out that a starting point to this effect will often align with how the burden

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of proof is typically decided in civil proceedings, and in general also lead to a satisfactory result.

However, the Supreme Court noted that no rule to this effect could be deduced from the Supreme Court's case law. In the Supreme Court's opinion, it had only decided the burden of proof for certain types of cases by applying the general principles of evidentiary law and considering the circumstances in each case. According to the Supreme Court, it would not be satisfying if the burden of proof were to depend on whether a specific provision in the terms and conditions had been designed as a coverage provision or as an exclusion, pointing out that an insurer often unilaterally decides how provisions are designed regardless of how they in fact operate.

The Supreme Court then explained how the burden of proof should be allocated in insurance compensation cases: by applying the same considerations that apply in civil proceedings in general – eg, the parties' abilities to secure evidence and the interest of ensuring that the substantive law operates effectively. In the case at hand, which concerned a consumer non-life insurance policy, the Supreme Court concluded that the insurer, typically, should bear the burden of proof for the fact that the insured has intentionally caused the damage to which the insurance claim related, regardless of the language in the applicable terms and conditions.

Comment

Some have argued (including the Supreme Court itself, implicitly) that this decision follows logically from the Supreme Court's previous case law. In a theoretical sense, this would entail the Supreme Court's decision changing nothing. In practice, however, many seem to have thus far assumed that the burden of proof was in fact previously split between the insured and the insurer, depending on the type of provision in the terms and conditions.

The Supreme Court's decision may, therefore, alter how parties argue and position themselves in insurance disputes and, perhaps, also in the claims handling phase. That being said, in most cases, the general principles of evidentiary law will likely still lead to outcomes that are similar to the outcomes entailed by the previous common view now refuted by the Supreme Court.

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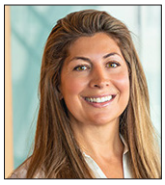

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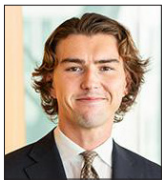

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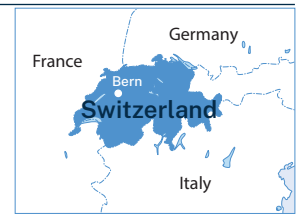

Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The Swiss legal framework for private insurance is based in particular on the laws and regulations set out below.

Federal Regulations

The Federal Insurance Contract Act (ICA) and, subsidiarily, the Swiss Code of Obligations (CO) govern the contractual relationship between insurer, policyholder and insured (Article 100 paragraph 1 ICA). The ICA applies to direct insurance contracts underwritten by insurance undertakings subject to supervision by the Swiss Financial Market Supervisory Authority FINMA (FINMA; Article 101 paragraph 1 No 2 e contrario ICA). Reinsurance contracts are outside the scope of the ICA and are consequently only subject to the general contract law provisions of the CO (Article 101 paragraph 1 No 1 ICA; see **6.6 Consumer Contracts or Reinsurance Contracts**). The partially revised ICA entered into force on 1 January 2022 (see **12. Recent and Forthcoming Legal Developments**).

The Federal Insurance Supervision Act (ISA) sets out the regulatory requirements for insurance and reinsurance undertakings and insurance intermediaries. On 21 October 2020, the Swiss Federal Council issued a dispatch along with a revised draft (Draft revISA) for deliberation in the Swiss parliament (see **13. Other Developments in Insurance Law**). On 18 March 2022, the Swiss Parliament adopted the revISA. Currently, the implementing ordinance is being revised accordingly (Draft revISO). The revISA and revISO are expected to enter into force in summer 2023 or (probably more likely) on 1 January 2024.

Supplemental Ordinances

The ISA is supplemented by the following implementing ordinances:

- the Federal Ordinance on the Supervision of Private Insurance Companies (ISO);
- the FINMA-Ordinance on the Supervision of Private Insurance Companies (ISO-FINMA); and
- the FINMA-Ordinance on Insurance Bankruptcy.

Other Provisions

In addition to the core insurance laws and ordinances listed above, other bodies of law contain relevant provisions with regard to insurance and reinsurance (eg, general consumer protection law, data protection law or the law against unfair competition). Furthermore, Switzerland is a party to three international treaties on direct insurance that supersede the ISA (see **3.1 Overseas-Based Insurers or Reinsurers**):

- the Agreement of 10 October 1989 between the Swiss Confederation and the European Economic Community (now the EU) on Direct Insurance other than Life Insurance (EU Direct Insurance Treaty);
- the Agreement of 19 December 1996 between the Swiss Confederation and the Principality of Liechtenstein on Direct Insurance and Insurance Intermediaries (Liechtenstein Direct Insurance Treaty) that is supplemented by the agreement of 10 July 2015 on insurance against natural disasters by private insurance undertakings; and
- the Agreement of 25 January 2019 between the Swiss Confederation and the UK on Direct Insurance other than Life Insurance (UK Direct Insurance Treaty) (to enter into force once the EU Direct Insurance Treaty ceases to apply to the UK).

FINMA further specifies matters of insurance regulation in numerous circulars (not binding for Swiss courts; however, the courts in Switzerland often take the circulars into account when interpreting the laws and ordinances). In addition, FINMA publishes less formal guidance documents and FAQs on supervisory matters.

Switzerland is a civil law country, however, precedent cases of Swiss courts still play an important role in interpreting and developing the statutory law (Article 1 paragraph 2 Swiss Civil Code).

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

General

Swiss insurance supervisory law is codified in the ISA and its implementing ordinances (see **1.1 Sources of Insurance and Reinsurance Law**), FINMA being the overall competent licensing and supervisory authority. In general, the ISA applies to:

- Swiss-domiciled insurance and reinsurance undertakings;
- foreign-domiciled insurance undertakings engaging in insurance business in or from Switzerland (see **3.1 Overseas-Based Insurers or Reinsurers**);
- insurance intermediaries (see **5. Distribution**);
- insurance groups and insurance conglomerates (see **2.2 The Writing of Insurance and Reinsurance**; Article 2 paragraph 1 litterae a–d ISA); and
- insurance special purpose vehicles (Article 2 paragraph 1 littera e revISA).

Exemptions

Certain specific types of activities and undertakings are exempted from the scope of application of the ISA, namely (Article 2 paragraph 2 ISA):

- insurance undertakings domiciled abroad that only engage in reinsurance activities in Switzerland (see **3.1 Overseas-Based Insurers or Reinsurers**);
- public insurance undertakings;
- private insurance undertakings that are regulated by special federal legislation;
- certain insurance co-operatives (*Versicherungsgenossenschaften*);
- foreign government-owned or state-guaranteed export risk insurance undertakings (ECAs) (Article 2 paragraph 2 littera bbis revISA); and
- insurance intermediaries, if their activities are limited to insurance contracts of minor importance and supplement a product or service (so called "annex insurance") (Article 2 paragraph 2 littera f revISA).

Other regulatory bodies exist – eg, in the area of mandatory health insurance (the Federal Office of Public Health), pension schemes (the Federal Occupational Pension Supervisory Commission) or certain cantonal building insurances (supervisory authority of the relevant Swiss canton).

2.2 The Writing of Insurance and Reinsurance

Insurance and reinsurance undertakings that are within the scope of application of the ISA must obtain an insurance licence from FINMA before engaging in any regulated activities – ie, writing insurance and reinsurance business (Article 3 paragraph 1 ISA). The main licence requirements are set out below.

Organisational Requirements

- Legal form as a company limited by shares (*Aktiengesellschaft*) or a co-operative (*Genossenschaft*; Article 7 ISA).
- Good standing and assurance of proper business conduct by the persons responsible for direction, supervision, control and management of the insurance undertaking (Article 14 ISA; Article 12 et seq ISO).
- Organisational structure allowing the recognition, limitation and monitoring of all significant risks (Article 22 ISA; Articles 96 to 98a ISO; FINMA-Circular 2017/2 Corporate Governance – Insurers).
- Appointment of a responsible actuary who has access to all business records (Article 23 ISA).
- Effective internal control system and an internal audit function which is independent from management (Article 27 ISA).
- Appointment of a licensed audit firm to review the conduct of business (Article 28 ISA).

Financial Requirements

- Minimum capital between CHF3 million and CHF20 million (Article 8 ISA; Articles 6 to 10 ISO).
- Sufficient solvency margin (Swiss Solvency Test (SST); Article 9 to 9b revISA and Articles 21 to 53a ISO).
- Maintenance of an organisational fund (*Organisationsfonds*) (Article 10 ISA; Article 11 ISO).
- Sufficient insurance-related reserves (*versicherungstechnische Rückstellungen*) for all business activities (Article 16 ISA; Article 54 et seq ISO).
- Claims based on insurance contracts have to be covered at all times by tied assets (*gebundenes Vermögen*; Article 17 et seq ISA; Article 1 ISO-FINMA).
- Maintenance of sufficient liquidity in order to be able to satisfy all of its payment obligations, even in stress scenarios (Article 98a ISO).

Other Requirements

Building on the basic regulatory requirements, certain additional requirements or reliefs apply depending on the specifics of the case or the business. These include:

- additional provisions (eg, regarding the scope of admissible activities or the preventive control of insurance tariffs) apply to specific classes and types of insurance only (Article 31 et seq ISA; Article 120 et seq ISO);
- additional requirements apply for foreign insurance undertakings (Article 15 ISA; see **3.1 Overseas-Based Insurers or Reinsurers**); and
- companies, engaging in reinsurance business only, are exempt from certain regulatory requirements under the ISA, inter alia from the requirement to maintain tied assets (no).

Special provisions apply to the consolidated supervision of insurance groups and insurance conglomerates (Articles 64 et seq and 72 et seq ISA; FINMA-Circular 2016/4 Insurance Groups and Conglomerates). FINMA may impose consolidated supervision on an insurance group or insurance conglomerate under certain conditions (Articles 65 and 73 ISA). Consolidated group supervision applies in addition to FINMA's individual supervision over the Swiss insurance undertakings (or other regulated Swiss entities; Articles 66 and 74 ISA).

2.3 The Taxation of Premium

Insurance premium payments are subject to stamp taxes if:

- the policy is part of a Swiss portfolio of an insurance undertaking subject to Swiss insurance supervision or of a Swiss insurance undertaking enjoying public law status; or
- a Swiss policyholder concluded the policy with a foreign insurance undertaking not subject to Swiss insurance supervision (Article 21 Federal Stamp Tax Act (STA)).

Several types of insurance are exempt from this tax, including, in particular, premiums on reinsurance policies (Article 22 STA). In principle, the stamp tax amounts to 5% of the cash premium, with the exception of life insurance policies, where it amounts to 2.5% (Article 24 STA).

Meanwhile, insurance and reinsurance turnovers are exempt from Swiss VAT (Article 21 paragraph 2 No 18 Value Added Tax Act).

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

General

Insurance undertakings with a registered seat abroad engaging in insurance activities in or from Switzerland fall within the scope of the ISA (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**), unless an international treaty provides otherwise (see below) or an exemption under the ISA applies (eg, foreign insurance undertakings engaging only in reinsurance activities in Switzerland (Article 2 paragraph 2 littera a ISA)), regardless if conducted cross-border or through a Swiss branch office; foreign insurance undertakings that have not established a branch office in Switzerland if their insurance activities in Switzerland exclusively covers:

- insurance risks in connection with ocean shipping, aviation and cross-border transports;
- risks located abroad; and/or
- war risks (Article 1 paragraph 2 ISO).

Furthermore, the ISA provides for a de minimis exemption (Article 2 paragraph 3 ISA) that, however, rarely applies.

In the revISA, a new exemption for innovative business models has been proposed (see **13. Other Developments in Insurance Law**).

An insurance activity is deemed to take place in Switzerland, irrespective of the place and circumstances of the conclusion of the contract, if:

- the policyholder or the insured is a natural person or a legal entity domiciled in Switzerland; or
- the insured goods are located in Switzerland (Article 1 paragraph 1 ISO).

Foreign insurance undertakings that fall within the scope of the ISA are required to obtain a licence from FINMA prior to taking up insurance activities in or out of Switzerland (Article 3 paragraph 1 ISA) and are subject to ongoing supervision by FINMA (Article 2 paragraph 1 littera b ISA; Article 3 littera a Federal Act on the Swiss Financial Market Supervisory Authority). Compared to a Swiss-domiciled insurance undertaking (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**), a foreign insurance undertaking seeking to obtain a licence to be active in or from Switzerland has to fulfil additional regulatory requirements (subject to differing rules in international treaties; Article 15 paragraph 2 ISA). It is, in particular, required to establish a branch in Switzerland and appoint a general agent (*Gen-*

eralbevollmächtigter) for that branch (Article 15 paragraph 1 littera b ISA). The general agent has to be a Swiss resident and have the knowledge necessary to operate in the insurance business (Article 16 ISO). Furthermore, the foreign insurance undertaking has to comply with the additional licence requirements (see Article 15 ISA).

International Treaties

The EU Direct Insurance Treaty (Agreement of 10 October 1989) facilitates the access of EU insurance companies to the Swiss market. While it does not exempt them from a Swiss licence requirement in connection with the establishment of a Swiss insurance branch, relief is granted.

Under the Liechtenstein Direct Insurance Treaty (Agreement of 19 December 1996), insurance undertakings domiciled in Liechtenstein may engage in direct insurance business in Switzerland either on a pure cross border basis or through a Swiss branch office without requiring a FINMA licence.

Brexit

Switzerland and the UK concluded the UK Direct Insurance Treaty (Agreement of 25 January 2019) that guarantees freedom of establishment for insurance undertakings operating in the field of direct insurance by converting the content of the EU Direct Insurance Treaty to apply to the bilateral relationship between Switzerland and the UK post-Brexit. The content of the agreement between Switzerland and the UK is essentially the same as in the agreement between Switzerland and the EU (Agreement of 10 October 1989 between the European Economic Community and the Swiss Confederation concerning direct insurance other than life assurance). The direct insurance agreement between the UK and Switzerland entered into force on 1 January 2021.

3.2 Fronting

In Switzerland, fronting is, in principle, permitted. Swiss law does not provide for a specific retention obligation on the part of the cedent in fronting arrangements.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

In recent years, transaction activity in Switzerland has been noticeably high. Several insurance groups have restructured, consolidated and realigned their group operations. Further, several private equity investors have been active buyers of insurance and reinsurance undertakings, including in particular businesses in run-off (and such buyers have become increasingly accepted by FINMA as qualified or controlling investors in insurance undertakings). Moreover, several transactions and co-operations in the insurtech space have been closed. Further, an innovative reinsurance solution to hedge interest rate commitments has been applied in a large volume transaction as a novelty in the Swiss market. Under the agreement, the reinsurer has taken over the market and insurance risks of a legacy portfolio of individual life insurance products, within the framework of quota share reinsurance. In addition, a certain consolidation in the Swiss insurance brokerage industry can be observed.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

General

In Switzerland, insurance and reinsurance products may be distributed directly (ie, by the insur-

ance and reinsurance undertakings themselves) or through insurance intermediaries. Insurance intermediaries in the meaning of the law are persons who offer or conclude insurance contracts in the interest of insurance undertakings or other persons (Article 40 ISA). The law furthermore distinguishes between so-called tied and untied insurance intermediaries (regarding the distinction between brokers and agents see **6.3 Intermediary Involvement in an Insurance Contract**).

Registration

Untied insurance intermediaries are insurance intermediaries that are neither legally, nor economically, nor in any other way tied to an insurance undertaking (obligation to register in the public register of insurance intermediaries maintained by FINMA). Tied insurance intermediaries are those that are, in a relevant manner, legally or economically tied to an insurance undertaking (under the revISA, tied insurance intermediaries will no longer be able to register, unless the exception applies that a registration is required for activities abroad) (Article 43 ISA/Article 41 and 42 revISA).

For an intermediary to be eligible for registration in the FINMA register, certain requirements must be fulfilled, including the demonstrable capacity to act (*Handlungsfähigkeit*), proof of appropriate professional qualifications and professional indemnity insurance (Article 44 ISA in conjunction with Article 184 et seq ISO/Article 41 paragraph 2 revISA in conjunction with Article 184 et seq Draft revISO). In addition, insurance intermediaries (both tied and untied) are subject to information duties vis-à-vis the insured (see **6.1 Obligations of the Insured and Insurer**).

Registered insurance intermediaries are not subject to ongoing prudential supervision by FINMA, but FINMA may examine them from time to time to verify their compliance with regulatory requirements. Furthermore, in case of any indication of irregularities, FINMA may take enforcement action.

Any intermediary activities in Switzerland for the benefit of insurance undertakings that fall within the scope of the ISA but are not licensed by FINMA to carry out insurance activities in or from Switzerland are prohibited (Article 41 ISA/Article 44 revISA).

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

When concluding an insurance contract, the policyholder has a duty of disclosure which is limited in its content and scope by the written questions provided by the insurer (Article 4 paragraph 1 ICA). The insurer has to proactively seek information as the policyholder need not disclose any facts which the insurer has not asked about. The policyholder must answer the questions and in this context inform the insurer in writing of all facts relevant to the assessment of the risk, to the extent and as they are known or should have been known to them when the contract was concluded. Facts are considered relevant for the risk assessment if they may potentially influence the insurer's decision to conclude the contract at all or on the agreed terms (Article 4 paragraph 2 ICA).

An insurer must inform the policyholder, prior to conclusion of the contract, of:

- the identity of the insurer; and
- the main content of the insurance contract (Article 3 paragraph 1 ICA).

It may delegate its information obligations (eg, to an insurance intermediary). However, in relation to third parties (including the policyholder) the insurer remains solely responsible for the performance of the information obligation as Article 3 ICA is mandatory and cannot be contractually modified to the disadvantage of the policyholder (Article 98 ICA).

Furthermore, information duties apply to insurance intermediaries who must provide their clients with information on, for example, the intermediary's identity and address, its contractual relationships with the insurance undertakings on whose behalf it acts and the names of these insurance undertakings on a durable medium before taking up any intermediation activity (Article 45 ISA).

6.2 Failure to Comply With Obligations of an Insurance Contract

If the policyholder breaches its information duty pursuant to Article 4 ICA and misinforms or fails to inform the insurer of a material risk factor, the insurer may terminate the contract by written notice within four weeks after it becomes aware of the breach of the information duty (Article 6 ICA). The contract is terminated retroactively, and the insurer is not liable to pay any benefits under the insurance contract and may reclaim insurance benefits already paid together with default interest of 5%. Despite a breach of the duty of disclosure by the policyholder, an insurer may not terminate the contract in circumstances described in Article 8 ICA – eg, if the insurer knew or should have known the incorrect or concealed fact or concluded the contract even though the policyholder did not answer a question (Article 8 ICA).

If the insurer fails to comply with its information duty pursuant to Article 3 ICA, the policyholder has the right to terminate the insurance contract by written notice (Article 3a paragraph 1 ICA). This right of termination expires four weeks after the policyholder becomes aware of the breach of duty, but no later than one year after the breach of duty (Article 3a paragraph 2 ICA).

The information duties of the insurance intermediary are supervisory duties and their breach may expose the insurance intermediary to administrative and criminal sanctions, including punishment with a fine of up to CHF500,000 (in the future: up to CHF100,000 under the revISA) if the breach is committed intentionally, and up to CHF150,000 (in the future: up to CHF50,000 under the revISA) if committed negligently (Article 86 ISA). Furthermore, this breach may also result in civil liability for the intermediary.

6.3 Intermediary Involvement in an Insurance Contract

An insurance intermediary is either a tied intermediary or an untied intermediary (see **5. Distribution**). In an untechnical sense, tied insurance intermediaries are often referred to as insurance agents and untied insurance intermediaries are often referred to as insurance brokers, indicating the typical set-up of the contractual relationship between the insurance intermediaries, the insurance undertakings and/or the policyholders. However, the contractual qualification pursuant to Swiss private law does not always correspond with the qualification pursuant to Swiss insurance supervisory law.

An insurance agent has a dominant contractual relationship with an insurance undertaking and primarily acts in its interest and/or on its behalf. The knowledge of the insurance agent is, in principle, attributed to the insurance undertaking (Article 34 ICA). The insurance undertaking pays

the insurance agent the remuneration agreed in their contract.

An insurance broker is typically in a contractual relationship with both the insurance undertaking and the policyholder but acts primarily in the interest and/or on behalf of the policyholder, to whom it owes diligent advice on suitable insurance from an adequate spectrum of available products. The knowledge of an insurance broker is, in principle, attributed to the policyholder. However, the broker's remuneration/commission is typically paid by the insurance undertaking with which the policy is ultimately concluded.

The commission is typically priced into the insurance premiums the insured pays to the insurance undertaking. Consequently, from an economic perspective, it is the insured that ultimately pays the insurance broker. This regularly entails potential conflicts of interest which must be adequately mitigated by the broker; in this regard, the revISA provides for new measures (Article 45a and 45b revISA; see **13.1 Additional Market Developments**).

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

Elements of an Insurance Contract

There is no specific statutory definition of the term insurance or contract of insurance. Based on precedent cases of the Swiss Federal Supreme Court, the following five elements characterise an insurance contract.

- Risk transfer – the insured person must have an interest which they protect against a certain risk through the economic performance of the insurers.
- Payment of a premium – the premium is, in principle, the price the insured (or the policyholder) pays in exchange for the performance by the insurer in the event that the insured risk materialises.
- Performance by the insurer/cover – the insurer must be under an obligation to perform to the insured or another beneficiary if the insured risk materialises.
- Independence of the operation – the insurance contract refers to an independent operation that is not an ancillary agreement or a mere feature or term of a non-insurance contract (eg, a warranty for a purchased good is usually not an insurance).
- Compensation of risks according to the laws of statistics (Systematic Business Activity).

The first three elements are generally considered to be the defining and essential elements of an insurance contract (essentialia negotii), while the last two are particularly relevant from a supervisory law perspective.

Form Requirements

The insurance contract, in principle, need not comply with any particular form requirements to be valid, with some exceptions (eg, a third person whose life is covered under the life insurance has to agree to the insurance in writing before the insurance contract is concluded (Article 74 paragraph 1 ICA)). Nevertheless, the application for an insurance policy and acceptance by the insurer are usually in writing. In addition, the insurer must issue a policy to the insured stating the rights and duties of the parties (Article 11 ICA) and on the insured's request and against reimbursement, the insurer must provide a copy or transcript of the insured's statements in the application, which were determining for the conclusion of the insurance contract (Article 11 paragraph 2 ICA).

Mandatory Provisions

A number of mandatory provisions (and provisions that are mandatory for the insurer only) in the ICA limit the freedom of content for insurance contracts (see Article 97 and 98 ICA). Furthermore, insurance-specific grounds for nullity (eg, the prohibition of retroactive insurance) (Article 10 ICA), as well as general restrictions on the freedom of content (eg, Article 20 CO) apply.

6.5 Multiple Insured or Potential Beneficiaries

Collective Insurance Contract

A collective insurance contract is generally described as a legally uniform contract that insures several persons or several independent objects (Article 3 paragraphs 3 and Articles 7, 31 and 95a ICA). It might be an indication of the existence of a collective insurance contract if – eg, the insured is not identical to the policyholder.

In principle, the same rules as for individual insurance contracts apply. However, there are certain provisions in the law that are specific to collective insurance, inter alia the following.

Information duties

If the collective insurance contract grants a direct entitlement to benefits to persons other than the policyholder, the policyholder is under an obligation to inform the insured about:

- the essential content of the agreement (needs to be determined on a case-by-case basis and is not identical with Article 3 paragraph 1 ICA);
- any amendments; and
- its termination, whereby the insurer has to provide the necessary information (Article 3 paragraph 3 ICA).

Breach of the information duty

If the information duty of the policyholder is only breached in respect of a part of the insured objects or persons, the insurance remains effective for the remaining part, provided that the insurer would have insured this part alone under the same conditions (Article 7 ICA).

Requirements for entering into the insurance contract

Some legal authors suggest that the requirement that the person whose life is covered by the life insurance has to agree in writing (Article 74 paragraph 1 ICA), is limited to individual life insurance and does not extend to collective life insurance.

Insurance for the Benefit of Third Parties

A policyholder may, in principle, appoint a third party as beneficiary without the consent of the insurance undertaking (Article 76 paragraph 1 ICA). Even if a third party is appointed as beneficiary, the policyholder may freely dispose of the entitlement; the right to revoke the appointment of the beneficiary only lapses if the policyholder has signed a written waiver of revocation in the policy and has handed the policy over to the beneficiary (Article 77 ICA). Unless the policyholder disposes otherwise, the beneficiary obtains a separate claim against the insurance undertaking (Article 78 ICA). There are also specific provisions on the attachment of an insurance claim and the opening of bankruptcy proceedings and for the interpretation of beneficiary clauses (Articles 79 et seq ICA).

6.6 Consumer Contracts or Reinsurance Contracts

Insurance contracts (including consumer contracts) are generally subject to the provisions of the ICA, eg, information duties of insurers and mandatory and semi-mandatory provisions that limit the contractual freedom of insurance under-

takings (see **6.1 Obligations of the Insured and Insurer** and **6.2 Failure to Comply with Obligations of an Insurance Contract**).

Reinsurance contracts are excluded from the scope of the ICA (Article 101 ICA). In Switzerland, as in many other countries, there is no specific and distinct reinsurance contract law. Reinsurance contracts are governed by the general provisions of the CO and by generally (and often internationally) recognised reinsurance customs and standards.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

Alternative Risk Transfer (ART) includes, in particular, the passing on of insurance risks to investors on the capital market through securitisation, including – eg, the issuance of insurance-linked securities (ILS) such as catastrophe bonds (Cat Bonds) or industry loss warranties (ILW). In many cases, the risk transfer is effected by way of the conclusion of a risk transfer contract between the insurer/reinsurer and a special purpose vehicle (SPV) specially created for this purpose. The insurer/reinsurer transfers its own risk while the SPV agrees to pay an agreed amount upon occurrence of a certain trigger. The SPV then issues bonds in the capital market, the term, interest and repayment of which are linked to the occurrence of the trigger.

The exact legal nature of the contracts between (i) the insurer/reinsurer and the SPV, and (ii) the SPV and investors is controversial in Swiss legal literature, as is the question of whether the SPV and/or the investors are subject to insurance supervision. The contract between the insurer/reinsurer and the SPV on the one hand will generally fulfil all requirements of an insurance/reinsurance contract (see **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract** and **6.6 Consumer Contracts or Reinsurance Contracts**), at least in such cases where no or only a low risk remains with the insurer/reinsurer. As Swiss law does not provide for a tailored regulatory regime nor for a specific exemption from insurance supervision for (insurance) SPVs, ART securitisations are typically handled through other financial centres. The contract between the SPV and investors, however, is unlikely to qualify as an insurance contract under Swiss law.

7.2 Foreign ART Transactions

A risk transfer agreement is treated as a reinsurance contract under Swiss law if it fulfils all five insurance contract criteria (see **7.1 ART Transactions**). This is generally the case for ILS transactions. The place of domicile or the qualification of the counterparty as a (regulated) reinsurer abroad is not decisive.

The SST explicitly provides for the recognition of reinsurance and retrocession in the context of quantified risk transfers (Article 46 paragraph 4 ISO). Consequently, if the risk transfer through ILS fulfils the requirements of a reinsurance contract, the cover claims against SPVs may, in principle, be credited to the insurance/reinsurance undertaking's solvency capital.

Moreover, the risk transfer through ILS may be credited to the insurance-related reserves or, if the transfer agreement cannot be qualified as a reinsurance contract, it may be treated as a derivative financial instrument. Because reinsurance companies in Switzerland – unlike direct insurance companies – do not have to form tied assets, it is much easier for them to effectively resort to risk transfer through ILS.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

The rules applying to the interpretation of insurance contracts and general insurance terms and conditions (GTC) under Swiss law correspond with those applicable to the interpretation of contracts in general (Article 100 paragraph 1 ICA). The same applies to reinsurance contracts (Article 101 paragraph 2 ICA). This means that the starting point of every interpretation is the wording of the agreement (ie, grammatical interpretation), based on the usual meaning of the words and expressions used. Furthermore, not only the wording but the mutually agreed true intention of the parties is decisive (Article 18 paragraph 1 CO).

To establish the true intention of the parties under Swiss law, all relevant circumstances must be taken into consideration. These include, in particular:

- the place, time and other circumstances of the formation of the contract;
- the behaviour of the parties previous to the formation of the contract and during contract negotiations, including possible drafts of the contract;
- the behaviour of the parties after the formation of the contract, such as performance of an obligation under the contract;
- the interests of the parties at the formation of the contract; and
- the prevailing custom in the industry.

The relevant clause must not be interpreted separately, but within the context of the entire agreement. If the true intention of the parties cannot be established, their behaviour must be interpreted in accordance with the principle of good faith: the true intention is replaced by the intention that reasonable parties would have agreed on.

GTC form an integral part of the insurance contract if the parties have accepted them in the context of the conclusion of the insurance contract in advance. Additional rules apply to GTC, such as the "rule of unusual clauses" (*Ungewöhnlichkeitsregel*) and the rule of ambiguity (*Unklarheitsregel*).

In the context of consumer contracts, the use of GTC that, to their detriment and contrary to the requirement of good faith, provides for a significant and unjustified imbalance between contractual rights and contractual obligations, is prohibited by unfair competition law (Article 8 Swiss Federal Act Against Unfair Competition).

8.2 Warranties

Swiss law does not require warranties to be specifically identified as such.

8.3 Conditions Precedent

In Switzerland, parties may agree that the liability of the insurer is subject to the condition that the policyholder has complied with certain specific obligations. However, the insurer may not deny coverage based on a breach of a condition precedent, if the breach cannot be regarded as the fault of the policyholder (Article 45 paragraph 1 ICA). The insurer may not deny coverage if the policyholder's breach of its duty to reduce the risk or to prevent an increase in risk did not influence the occurrence of the feared event and/or the scope of insurer's obligation (Article 29 ICA).

The ICA itself provides for certain obligations of the policyholder. Accordingly, the insured is obliged to notify the insurer as soon as it

becomes aware of the occurrence of the insured event and of the claims under the insurance policy (Article 38 paragraph 1 ICA). In principle, late notification does not have any legal consequences for the insured except where it is at fault and the delay leads to an increase in the loss.

In severe cases, the compensation may be forfeited entirely. Furthermore, in the event of gross negligence causing the insured event, the insurer may reduce the compensation (Article 14 paragraph 2 ICA). If the insured event is caused intentionally, the compensation can be refused entirely (Article 14 paragraph 1 ICA).

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

In Switzerland, the parties to an insurance contract often seek out-of-court settlements, and litigation and arbitration are relatively rare. An insured may also consult the Swiss Ombudsman of Private Insurance and of Suva (Ombudsman) if the insurance undertaking is a member company (Ombudsman has no decision-making powers).

If no out-of-court settlement can be reached, claims under insurance contracts need to be settled in civil proceedings. They are, in principle, subject to the jurisdiction of the civil courts (Article 85 paragraph 1 ISA), unless the contract provides for an arbitration clause (see **9.5 The Enforcement of Arbitration Clauses**).

In a domestic context, the general rules of the Swiss Civil Procedure Code (CPC) apply and, in principle, the ordinary court at the domicile or registered office of the defendant, or at the place where the characteristic performance must be rendered, has jurisdiction (Article 31 CPC). There are only a few insurance-specific (Article 38 paragraph 1 CPC with regard to motor vehicle or bicycle accidents) and consumer-specific provisions (Article 32 paragraph 1 CPC).

Usually, the policyholder has a direct claim against the insurance undertaking – eg, under a collective accident or health insurance contract (see **6.5 Multiple Insured or Potential Beneficiaries**), and an unnamed beneficiary (in whose favour the policyholder concluded the insurance contract) has an independent claim against the insurance undertaking if the accident or illness occurs (Article 95a ICA). In this case, the beneficiary can take direct proceedings against the insurance undertaking. The same applies in principle to insurance for the benefit of third parties (Article 78 ICA).

Statute of Limitations

Claims based on an insurance contract are, in principle, subject to a statute of limitations of five years from the date of the triggering event which raises the obligation to provide indemnification. However, the statute of limitation for collective insurance for per diem indemnity for sickness (*Krankentaggeldversicherung*) is restricted to two years. The statute of limitations cannot be contractually shortened (Article 46 ICA).

Reinsurance contracts are not subject to the ICA (see **6.6 Consumer Contracts or Reinsurance Contracts**). Therefore, the general provision of the CO on the statute of limitations for contractual claims of ten years running as of the day on which the claim becomes due applies to claims based on a reinsurance contract (Article 127 CO). This limitation period cannot be contractually altered (Article 129 CO).

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Domestic Disputes

In a domestic context, choices of forum are, in principle, admissible (Article 17 CPC). However, if an insurance contract qualifies as a consumer contract under Article 32 CPC, a choice of forum can be concluded only after a dispute has arisen (Article 35 paragraph 1 littera a and Article 35 paragraph 2 CPC).

International Disputes

The Lugano Convention

Switzerland is a contracting state of the Lugano Convention on Jurisdiction and the Recognition and Enforcement of Judgments in Civil and Commercial Matters ("Lugano Convention"). The Lugano Convention applies if there is, inter alia, a connecting factor to a contracting state. The connecting factors need to be determined separately for each provision in the Lugano Convention. Please note that as a result of Brexit, the United Kingdom is no longer a contracting state of the Lugano Convention.

The Lugano Convention provides for special jurisdiction rules with regard to insurance matters (Article 8 et seq Lugano Convention; however, these provisions do not apply to reinsurance matters). It provides, in particular, that the policyholder, insured or beneficiary may also sue an insurer domiciled in a contracting state in the courts in their own domicile. If the (defendant) insurer is not domiciled in a contracting state, a fiction of domicile is assumed nonetheless if a branch, agency or other establishment exists in the contracting state (Article 9 paragraph 2 Lugano Convention). A choice of forum is only possible to a limited extent – eg, only if the choice of forum was concluded after the dispute had arisen (Article 13 Lugano Convention).

Swiss Private International Law Act

In the context of a dispute that does not fall within the scope of the Lugano Convention, the general provisions of the Swiss Private International Law Act (PILA) apply. The jurisdiction pursuant to the PILA is determined on the basis of the contractual agreement (Articles 112 and 113 PILA) and choice of forum clauses are generally admissible (Article 5 PILA). However, if an insurance contract qualifies as a consumer contract pursuant to Article 120 PILA, the consumer cannot waive in advance the jurisdiction at their domicile of residence or usual place of residence (Article 114 paragraph 2 PILA).

Choice of law

When determining the choice of law in an international dispute, Swiss courts apply the PILA, except where the special provisions of Articles 101b and 101c ICA apply (as this is currently only the case with regard to the Principality of Liechtenstein it will not be discussed in detail). Under the PILA, choice of law clauses are generally admissible (Article 116 PILA), if they are explicit or clearly evident from the contract or the circumstances. However, if an insurance contract qualifies as a consumer contract, choice of law clauses are inadmissible (Article 120 paragraph 2 PILA).

9.3 Litigation Process

In principle, before the commencement of litigation proceedings, a conciliation proceeding (*Schlichtungsverfahren*) has to take place (Article 197 et seq CPC). If no agreement can be reached during the conciliation proceeding, the conciliation authority grants authorisation to proceed with litigation. Within three months, the plaintiff has to initiate proceedings before the ordinary court by filing the statement of claim (Articles 209, 220 CPC). An exchange of written submissions (Articles 221, 222, 225 CPC) is in

general followed by the main hearing, where the parties present their claims and legal arguments and evidence is taken (Article 228 et seq CPC). Afterwards, the court renders the final decision (Article 236 CPC).

Against a final decision of the ordinary court, the losing party may file an appeal (*Berufung*) or an objection (*Beschwerde*) with the superior cantonal court, if the requirements have been met.

Final decisions of the superior cantonal court are, under certain conditions, subject to appeal before the Swiss Federal Supreme Court.

Rules that differ from the procedure described above apply, in particular, to proceedings before a Commercial Court, where, inter alia, no conciliation proceedings are required (Article 198 littera f CPC) and – because it is the only cantonal court – the decision may only be appealed directly to the Swiss Federal Supreme Court. Further differences apply to – eg, disputes in simplified (Article 243 et seq CPC) or summary proceedings (Article 248 et seq CPC; as opposed to ordinary proceedings).

9.4 The Enforcement of Judgments

The enforcement procedure in Switzerland differs depending on the type of judgment that is to be enforced: the enforcement of cash and surety payments is governed by the Swiss Federal Debt Enforcement and Bankruptcy Act (DEBA; Article 335 paragraph 2 CPC), while any other claims must be enforced in accordance with the CPC (Article 337 et seq CPC). In order to enforce claims under insurance contracts, which are typically cash payments, the creditor has to file an application for debt enforcement (Article 67 paragraph 1 DEBA) and take further steps under the DEBA.

Enforcing Foreign Judgments

Enforcement within the scope of the Lugano Convention

With regard to the enforcement of foreign judgments, Switzerland is, inter alia, a contracting state of the Lugano Convention. Under the Lugano Convention, as a general principle, a judgment of a contracting state is enforceable in any other contracting state, where the creditor requests a declaration of enforceability. The procedure to gain a declaration of enforceability could be described as follows: the creditor must produce a copy of the judgment which satisfies the conditions necessary to establish its authenticity (Article 41 in conjunction with Article 53 Lugano Convention). At this stage, the debtor does not participate in the proceeding and therefore cannot raise any objections and the decision is declared enforceable without delay (Article 41 Lugano Convention). However, both parties may appeal against the decision (Article 43 No 1 Lugano Convention).

In this second proceeding, any potential objections of the debtor (eg, if the recognition of the judgment is manifestly contrary to public policy) are examined (Article 45 paragraph 1 in conjunction with Article 34 Lugano Convention). However, the foreign judgment may not be reviewed as to its substance (Article 45 paragraph 2 Lugano Convention). Moreover, in principle, the jurisdiction of the foreign court is not reviewed, with the exception of insurance matters (Article 35 Lugano Convention). Therefore, a review of the jurisdiction takes place for insurance contracts, but not for reinsurance contracts. The actual enforcement of the judgment itself is not subject to the Lugano Convention but rather to the law of the state enforcing the judgment – ie, with regard to Switzerland pursuant to the DEBA or the CPC.

Enforcement without treaties

If no international or bilateral treaty applies, a foreign judgment is only enforceable in Switzerland if it has been recognised pursuant to Article 25 et seq PILA. A foreign judgment is recognised if:

- the courts or authorities of the country where the decision was rendered had jurisdiction from a Swiss law perspective;
- the judgment is final and absolute; and
- there are no grounds for refusal (Article 25 PILA).

Upon the request of the creditor, the recognised judgment is declared enforceable (Articles 28 and 29 PILA). The actual enforcement is governed by the DEBA or the CPC.

Only in the event that neither international treaties nor the PILA provide otherwise, the CPC applies for the recognition, declaration of enforceability and enforcement of foreign judgments as so-called lex fori (Article 335 paragraph 3 CPC).

9.5 The Enforcement of Arbitration Clauses

In Switzerland, in principle, any monetary claim can be submitted to arbitration proceedings in an international context (Article 177 paragraph 1 PILA). The admissibility to arbitration in a domestic context requires an arbitrable claim (Article 354 CPC). Consequently, arbitration clauses in insurance and reinsurance agreements are generally enforceable, if the arbitration clause is in writing or in any other form allowing it to be evidenced by text (Article 7 and Article 178 paragraph 1 PILA; Articles 61 and 358 CPC). The revision of the PILA (entry into force on 1 January 2021) does not change this.

9.6 The Enforcement of Awards

Regarding the enforcement of foreign arbitral awards, the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards (NYC), to which Switzerland is a party, applies. The NYC applies irrespective of whether the award is rendered in another contracting state or not (Article 194 PILA). Foreign arbitral awards have to be recognised in principle (Article III NYC). However, the NYC also provides grounds for objections to the enforcement (Article V NYC). Grounds pursuant to paragraph 2 must even be observed ex officio (ie, they do not have to be put forward by the other party).

The requesting party must submit the duly authenticated signature of the award and the signature of the arbitration agreement together with the application for recognition or enforcement (Article IV paragraph 1 NYC). Moreover, if the arbitral award is not written in an official language of Switzerland, a translation must be enclosed. According to the Swiss Federal Supreme Court, awards in English do not have to be fully translated, a translation of the holdings of the court is sufficient. The procedure for the enforcement of the foreign arbitral award is governed by domestic law – ie, in Switzerland by the CPC or the DEBA (Article III NYC).

9.7 Alternative Dispute Resolution

Alternative dispute resolution has steadily gained in importance and is ideally suited for large liability cases where very unequal parties are involved, and the injured party tends not to be able to afford long disputes.

If the insurance undertaking is a member company, the insured may refer to the Ombudsman before commencing litigation proceedings (see **9.1 Insurance Disputes over Coverage**).

In Switzerland, mediation, where an impartial third party helps to resolve disputes by facilitating settlement negotiations, is not very established in commercial matters (including insurance and reinsurance matters), and the mediator has no decision-making power. Upon request of all parties, mediation may replace conciliation proceedings (Article 213 CPC). The parties may also request mediation at all times during the court proceedings (Article 214 paragraph 2 CPC). However, the court cannot oblige the parties to mediate their dispute but only recommend that they do so (Article 214 CPC).

9.8 Penalties for Late Payment of Claims

Punitive damages are not available under Swiss law. However, there are certain specific provisions under Swiss law that generate results that may, to a very limited extent, seem similar, such as the disgorgement of profits under supervisory law.

Further, a Swiss court, in principle, cannot award or enforce the full award of punitive damages even if the applicable foreign substantive law provides for those damages as this usually constitutes a violation of Swiss public policy.

An insured's claim becomes due four weeks after the date on which the insurer has received sufficient information to assess whether the claim is correct (Article 41 paragraph 1 ICA). As soon as the claim is due, the insured may demand payment from the insurer and may put the insurer in default by sending a reminder (Article 102 paragraph 1 CO). No reminder is necessary if an expiry date has been agreed (Article 102 paragraph 2 CO). Default triggers the obligation to pay interest that amounts to 5% per annum absent any other agreement (Article 104 CO) and possibly further damages that arose because of late payment, such as the cost of obtaining "replacement money" (Article 103 CO).

9.9 Insurers' Rights of Subrogation

To the extent that the insurance undertaking has paid compensation to the policyholder, the policyholder's claim against third parties is transferred to the insurance undertaking, save for certain exceptions (Article 72 paragraph 1 ICA and Article 95c paragraph 2 and 3 reICA). In other words, the insurance undertaking subrogates to the policyholder's claims against the third parties and the insurance undertaking can thus assert the claims against the third parties. According to the Swiss Federal Supreme Court, this applies not only to claims in tort (*unerlaubte Handlung*), but also to claims arising from causal and strict liability (*Kausal- und Gefährdungshaftung*).

The question of whether subrogation also applies to the policyholder's contractual claims against the third party has not yet been clarified by the Swiss Federal Supreme Court; however, according to prevailing doctrine, it can be assumed that the insurance undertaking subrogates to the policyholder's claims in this case as well. However, the policyholder benefits from a quota privilege: In the event of subrogation, the claim of the policyholder has priority over the claim of the insurance undertaking. The latter can only enforce its claim once the claim of the policyholder has been fully satisfied.

10. Insurtech

10.1 Insurtech Developments

Insurtech combines traditional insurance business with modern technologies and fosters alternative business models and distribution channels, inter alia in the following areas:

- contract management/digital brokers offer brokerage of insurance policies through online platforms and mobile apps and facilitate the management of insurance policies for the customer (eg, Knip in Switzerland);
- comparison portals offer easy comparison between various (insurance) products and provider types (eg, Comparis, Anivo and wefox in Switzerland);
- peer-to-peer insurance enables grouping of insured persons (eg, Versicherix in Switzerland);
- health insurance uses health data originating from new data sources; and
- on-demand insurance offers short-term and situation-related insurance (eg, Simpego in Switzerland).

Furthermore, insurtech encompasses new technology solutions for insurance undertakings, enabling them to increase efficiency of their own value chain through the use of artificial intelligence, blockchain applications or Internet of Things (IoT) devices. In Switzerland, for example, the B3i Initiative, cardossier or Fizzy are examples of blockchain-based insurtechs that, in particular, aim at automating the insurance business.

If an insurance undertaking participates in an insurtech start-up, the licensing and information requirements pursuant to the ISA must be observed (see **4. Transaction Activity**). Moreover, insurance undertakings have to obtain FINMA permission to conduct non-insurance business (Article 11 ISA).

10.2 Regulatory Response

Since 2016, the Swiss Federal Council has gradually been introducing regulatory reliefs for fintech and insurtech businesses.

In particular, under the revISA, the Swiss Federal Council is able to exempt insurance undertakings with innovative business models from supervision. The Draft revISO provides for relief and exemption from supervision (see **13. Other Developments in Insurance Law**).

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Emerging risks are new risks that are not recognisable or only recognisable to a very limited extent (eg, health risks regarding asbestos). Their damage potential is difficult to estimate and there is often a long time gap between the cause and the occurrence of the consequences or the realisation of the risk. The full damage potential usually only crystallises at a later point in time. Dealing with emerging risks poses a major challenge for society, the regulator and the insurance industry.

In connection with emerging risks, the question arises, in particular, as to who should be liable for risks that were not identifiable, according to the state of the art in science and technology, at the time of their placement on the market (so-called development risks). In Switzerland, liability may, inter alia, arise from contractual law, the Swiss Federal Product Safety Act (ProdSA), the Swiss Federal Product Liability Act (PLA) or the employment relationship. In this context, the statute of limitation plays a major role. The limitation period varies depending on the basis of the claim, eg:

- general non-contractual liability – three years after the injured party has become aware of the damage and of the liable person or in

principle ten years after the date on which the damage was caused (Article 60 CO);
- product liability – three years after the injured party has become aware of the damage, the mistake and of the person of the producer (Article 9 PLA) or ten years after the date on which the product that caused the damage was placed on the market (Article 10 PLA); and
- contractual liability – in principle ten years (Article 127 CO).

With the entry into force of the new rules on 1 January 2020, the statute of limitations has partially been extended (eg, the absolute statutes of limitations for claims based on long term health damage or death were extended from ten to 20 years (eg, in the case of asbestos; Article 60 paragraph 1bis CO)).

11.2 New Products or Alternative Solutions

Generally speaking, measures to address emerging risks can be taken at the level of the legislature or by the insurers themselves. Risks can, for example, be countered by means of regulatory prohibitions, restrictions or conditions regarding the handling of certain technologies or, indirectly, by the introduction of strict liability in favour of the injured (ie, as is the case in the field of nuclear energy).

From the perspective of the insurer, new policy types have been developed in respect of emerging risks, such as policies to cover computer and network hacking risks, data or identity theft or loss of reputation. The Swiss market still shows substantial room for development in the area of emerging risks.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

The partially revised ICA entered into force on 1 January 2022 (see **1.1 Sources of Insurance and Reinsurance Law**) and introduced various changes such as:

- introduction of a right of revocation (Article 2a and 2b ICA);
- elimination of deemed approval rules (abolishing the former Article 12 ICA);
- extension of the statute of limitations from two to five years (with some exceptions, Article 46 ICA);
- introduction of an ordinary right of termination (Article 35a ICA);
- extension of the absolute statute of limitations regarding claims arising from a breach of information from one to two years (Article 3a ICA);
- introduction of retroactive cover (Article 10 ICA); and
- introduction of more relaxed rules for "professional policyholders" (eg, financial intermediaries pursuant to the Banking Act; Article 98a ICA).

As a result of COVID-19, insurance and reinsurance companies have been confronted with various topics. In particular, there have been disputes on the interpretation of insurance contracts and the GTC (see **8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence**), and whether or not and to what extent they cover damages incurred in connection with COVID-19 (eg, the term "epidemic" versus "pandemic", exclusion clauses concerning damages related to pathogens for which the WHO pandemic levels five or six apply nationally or

internationally, business interruption insurance). One other effect was that insurance undertakings in some areas incurred fewer losses during the lockdown – eg, in motor insurance because the policyholders had lower mileage or did not use their cars at all.

Furthermore, in some insurance policies the question arises whether COVID-19 qualifies as one single "event" or multiple "events". As far as can be seen, no measures regarding insurance/reinsurance are planned by the legislator.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

On 18 March 2022, the Swiss Parliament adopted the revISA, which is expected to enter into force in summer 2023 or (probably more likely) on 1 January 2024. The revISA will, in particular, introduce the following amendments of the law:

- specific disclosure rules for investment-linked life insurance products (eg, requirement for base information leaflet) and rules of conduct for the distribution of such products (Article 39a et seq revISA);
- new distinction of "professional policyholders" – insurance undertakings that provide services to professional policyholders only (see **12. Recent and Forthcoming Legal Developments**) benefit from various regulatory reliefs (Article 30a et seq revISA);
- expanded information duty of untied insurance intermediaries to inform the policyholder about certain circumstances (see Article 45 and Article 45b revISA);
- organisational requirement and information duty of insurers and insurance intermediaries regarding conflicts of interest (Article 14a and 45a revISA);
- regulation on restructuring and bankruptcy of insurance undertakings (Article 52a et seq revISA);
- to safeguard the potential for innovations within the Swiss financial market, the Swiss Federal Council can exempt insurance undertakings from supervision under certain conditions (Article 2 paragraph 5 littera b revISA);
- new regulation on insurance group supervision (Article 67 revISA);
- new legal basis for the Swiss Federal Council to subject Swiss reinsurance branches of foreign insurers to a FINMA licence requirement (with supervisory reliefs) should this be required in the future because of recognised international standards (Article 2 paragraph 5 littera a); and
- insurance special purpose undertakings are expressly listed as not subject to insurance supervision law according to Art. 2 paragraph 1 littera e revISA. Insurance special purpose undertakings are companies that underwrite risks from insurers and cover them by issuing subordinated debt instruments (eg, cat-bonds).

Moreover, on 17 May 2022, the draft on the revISO was published. First and foremost, the draft revISO is implementing provisions for the revISA, including – eg, the implementation of exemptions and relief for small insurance undertakings from supervision as well as the concretisation of the requirements for the special purpose insurance company.

The proposal of the Swiss Federal Council to require insurance undertakings and insurance intermediaries to affiliate with an Ombudsman's office has been rejected by the Swiss Parliament.

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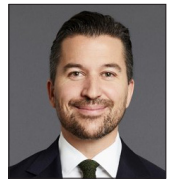

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TAIWAN

Law and Practice

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The legal system in Taiwan is essentially a civil law system rather than common law. The sources of insurance and reinsurance law can be roughly sub-divided into:

- the direct source of law (also known as statutory law); and
- indirect sources of law (such as past court judgments, practice, and expert theory).

The direct source of law comes from legislation such as the Insurance Act and the Regulations for Establishment and Administration of Insurance Enterprises. Moreover, in order to promote international co-operation, the Taiwan government and relevant agencies may – based on the principle of reciprocity – enter into a bilateral or multilateral co-operative treaty or agreement with a foreign government or with an international organisation. Therefore, bilateral or multilateral treaties and agreements may also be part of the direct source of insurance and reinsurance law.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

In Taiwan, insurance and reinsurance activity is regulated by a government agency (the Financial Supervisory Commission, or FSC) in accordance with the Insurance Act and the relevant laws and regulations.

For insurers, both non-life insurance entities and life insurance entities are regulated by the FSC and need to comply with the basic principles of insurance and reinsurance – for example, the insurable interest principle and the utmost good faith principle. However, according to Article 138(1) of the Insurance Act, insurance entities shall not concurrently engage in both non-life insurance business and life insurance business except where a non-life insurance entity is approved by the FSC to engage in personal injury insurance and/or health insurance.

Moreover, pursuant to Article 176 and 177 of the Insurance Act, there are detailed procedures for the establishment, registration, transfer, merger, dissolution and rehabilitation of insurance entities – making the insurance and reinsurance business a highly regulated industry. And regulations governing the legal compliance of insurance solicitors (ie, representatives of the insurance entity) in insurance operations are set forth by the FSC in further detail and cover:

- obtaining solicitor qualification certificates;
- registration (including voidance or revocation of registration);
- education;
- training; and
- disciplinary matters.

Reinsurers are required to have a high autonomous management capability – for example, a reinsurer must receive a credit rating above a certain level from an international credit rating agency and allocate certain special reserves. However, in practice, the actual operation of reinsurance entities is less heavily regulated once all the permits and licences for reinsurance are obtained – given that the reinsurer is the expert and more able to self-regulate.

2.2 The Writing of Insurance and Reinsurance

According to Article 144 of the Insurance Act, the FSC is entitled to issue guidelines to regulate insurance and reinsurance policies as it deems necessary. As such, the FSC has issued the Regulations Governing Pre-Sale Procedures for Insurance Products, the Guidelines for the Examination of Non-Life Insurance Products and the Guidelines for the Examination of Life Insurance Products.

Whether consumer insurance, SME insurance or corporate insurance, insurance entities are required to comply with the applicable guidelines and submit the insurance products for the FSC's review and approval before such products can be made available to the Taiwan market. Besides, in order to ensure the soundness of the insurance market or safeguard the interests of the insured, the FSC has the authority to order the self-regulated Association of Insurers to:

- amend its constitution, by-laws, rules and resolutions; or
- provide reference materials, reports or contracts where necessary (based on Article 165(5) of the Insurance Act).

For traditional personal life insurance products, an insurance agent, broker and solicitor should provide the insured with an unlimited amount of time in which to review the insurance policy before duly signing it. (Please see Article 9 of the Regulations Governing Online Insurance Business and Online Insurance Services of Insurance Agent Companies and Insurance Broker Companies.)

Regarding the solvency risk of insurers, pursuant to Article 143(4) of the Insurance Act, the capital adequacy ratio of an insurance entity must not be lower than 200%. The capital adequacy ratio is categorised into four different levels – that is, adequate capital (200% or above), inadequate capital (150%–200%), significantly inadequate capital (50%–150%) and seriously inadequate capital (lower than 50%).

Depending on the level of the capital adequacy, the FSC may take measures such as:

- ordering the insurance entity or its responsible person to propose a plan for the capital increase;
- ordering the insurance entity to cease selling insurance products or restrict its launch of new insurance products;
- restricting the scope of the capital utilisation;
- restricting the remuneration to its responsible person;
- exercising receivership over the insurance entity;
- ordering the entity to suspend and wind up the business; or
- liquidating the entity.

2.3 The Taxation of Premium

In principle, exemptions apply in the case of income tax on the compensation payment made for:

- life insurance;
- labour insurance; and
- insurance for public servants, military personnel and teachers.

Moreover, according to Article 17 of the Income Tax Act, the premiums paid by or for the taxpayer, their spouse or lineal dependents on life insurance, labour insurance, national pension insurance and insurance for military personnel, public servants or teachers have a deductible

amount not exceeding TWD24,000 for each person per year.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Should a foreign insurance or reinsurance entity seek to establish a new insurance company or reinsurance company for the purpose of doing insurance business in Taiwan, the following steps must be taken:

- apply to the Ministry of Economic Affairs (MOEA) for reservation of the new company's Chinese name and business scope;
- apply to the Investment Commission (IC) for a foreign investment approval (FIA) for foreign shareholders' equity investment in the new company (please note that this step is only required for investments funded by foreigners or foreign entities);
- apply to the FSC for a special permit to establish a new insurance company or reinsurance company in the Republic of China (ROC) ("special permit");
- apply to the IC for verification of the new company's capital;
- apply to the MOEA for incorporation registration;
- apply to the FSC for the issuance of a business licence;
- apply for business registration with the local tax authority;
- apply for membership of the Life Insurance Association of the Republic of China (the "Life Insurance Association")/the Non-Life Insurance Association of the Republic of China (the "Non-Life Insurance Association") in Taiwan; and
- apply for the issuance of a certificate to operate foreign exchange business ("FX Licence") from the Central Bank of the Republic of China (Taiwan) (CBC) if the new company intends to sell insurance policies that are denominated in foreign currency.

In summary, a foreign insurance entity may not commence its business operation in Taiwan unless it has obtained a special permit from the FSC, completed establishment registration, posted a bond, and secured a business licence in accordance with the law (based on Article 137(1) of the Insurance Act). Doing business illegally in Taiwan may subject the responsible person at the offending insurance/reinsurance entity to criminal liability otherwise, as per Article 167 and Article 167(1) of the Insurance Act.

It usually takes between six and eight months at least to obtain a special permit and such permit is at the discretion of the authority, making difficult to comment on the chances of overseas licences being recognised, etc, given that the uncertainty thereof is so high. Moreover, there is a minimum paid-in capital requirement that the promoters (ie, the shareholders who subscribe to company shares in the initial subscription) must contribute the equivalent of at least 20% of the minimum paid-in capital at the time of registering the company's establishment.

In addition, a bond equal to 15% of the paid-in capital should be deposited with the National Treasury. Then, within three months of registering its establishment, the insurance enterprise must submit the documents stipulated under Article 11 of the Regulations for Establishment and Administration of Insurance Enterprises and apply to the FSC for the business licence, which would usually take between one and two months.

Nevertheless, this time schedule is for reference only, and the actual time required is decided on a case-by-case basis. Furthermore, the permission of the Central Bank must be obtained first if the business involves foreign exchange business.

Foreign insurers or overseas-based insurers that have not completed the above-mentioned registration process and deposited the sum of the operating bond cannot write insurance business directly in Taiwan. However, the FSC allows foreign or overseas-based insurers or reinsurers to write reinsurance with a domestic insurer to a certain extent without punishment under Article 167 and 167(1) of the Insurance Act.

3.2 Fronting

According to Article 7 of the Regulations Governing Insurance Entities Engaging in Operating Reinsurance and Other Risk Spreading Mechanisms, if an insurance entity would like to cede its insurance business then the undertaking insurance entity must be one of the following:

- an insurance entity approved by the competent authority to engage concurrently or exclusively in reinsurance business in Taiwan;
- a foreign insurance entity approved by the competent authority to engage concurrently or exclusively in reinsurance business in Taiwan;
- a foreign reinsurance or insurance organisation with a credit rating above a certain level from an international credit rating agency;
- a reinsurance organisation, insurance organisation or risk-spreading mechanism allowed to engage in reinsurance business according to the laws of Taiwan; or
- other reinsurance organisations, insurance organisations or risk-spreading mechanisms approved by the competent authority.

Such ceding insurance entity must also establish its own risk management mechanism for its ceded reinsurance business, taking its risk-bearing capacity into consideration, and draft a reinsurance risk management plan that should include:

- management guidelines for the method of cession;
- arranging cession to the reinsurer once the original insurance policy is in force; and
- choice of reinsurer, reinsurance broker and operational process for cession to the reinsurer.

Moreover, according to Article 10 of the aforementioned regulation, the reinsurance premium rates shall be adequate, reasonable, and reflect costs. If a non-life insurance entity arranges proportional reinsurance, the retention premium rate shall not be lower than the reinsurance premium rate and original premium rate. However, if a non-life insurance entity arranges non-proportional reinsurance, none of the retention-layer premium rates must be lower than the higher-layer premium rate or the weighted average reinsurance premium rate of the same layer.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

When it comes to the M&A of insurance companies in Taiwan, the FSC focuses on protecting the rights of shareholders and investors, and the disclosure of relevant information.

In general, if the insurance company can meet relevant insurance regulations and be approved by the FSC, M&A activities are allowed in Taiwan. However, in order to ensure that M&A activities of life insurance companies do not interrupt the

service provided to the insured, the FSC may require the life insurance company to:

- issue a statement promising that the rights and interests of the original insured will not be affected in any way; and
- take the initiative to send a letter to notify those already insured.

Moreover, according to Article 5 of the Financial Institutions Merger Act, if a property insurance company is merged with an insurance cooperative, the Surviving Institution or Newly Incorporated Institution shall be the property insurance company. When insurance company are merged, it shall make public announcement and report within two days from the occurrence of merger and make a public announcement of the content of the resolution and particulars to be stated in the merger agreement within ten days (Article 9 of the Financial Institutions Merger Act).

In practice, if the merger or acquisition is relatively complicated, the FSC may require the insurance company to – inter alia – provide more capital or have more of an ability to integrate the different information systems.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

In Taiwan, insurance is categorised into non-life insurance and personal insurance. Non-life insurance includes fire insurance, marine insurance, land and air insurance, liability insurance, bonding insurance, and any other type of insurance approved by the competent authority. Personal insurance includes life insurance, health insurance, personal injury insurance, and annuities.

The following types of distributors are active in the market in Taiwan:

- insurance agent – a person who, on the basis of a contract of agency or a letter of authorisation, collects remuneration from an insurer and acts as a business agent on the insurer's behalf;
- insurance broker – a person who, on the basis of the interests of the insured, negotiates an insurance contract or provides related services and collects a commission or remuneration; and
- insurance solicitor - a person who acts as the individual representative of insurance entity in order to solicit insurance business on behalf of:
  (a) said insurance entity;
  (b) an insurance broker company;
  (c) an insurance agent company; or
  (d) a bank concurrently engaged in insurance agent/insurance broker business operations.

According to Article 163 of the Insurance Act, an insurance broker and agent must have obtained permission from the competent authority, posted bond and obtained related insurance, and obtained a practice licence before beginning business operations or practice. For more details on the qualifications and management of insurance brokers and agents, please refer to the Regulations Governing Insurance Brokers and Regulations Governing Insurance Agents.

If an insurance agent or broker violates laws or regulations, or is suspected of improper management, then the competent authority may – depending on the circumstances – take disciplinary action (such as issuing an official reprimand or ordering the agent or broker to take corrective action within a specified period of time).

If the bank wants to sell the insurance policy on the bank counter, it will need to obtain either an insurance company licence, an insurance agent licence, or an insurance broker licence. The distribution of the insurance products will depend on the nature of the particular licence.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

According to Article 64 of the Insurance Act, when an insurance contract is negotiated, the proposer must respond truthfully to the written enquiries made by the insurer. Where there is concealment, non-disclosure or misrepresentation on the part of the proposer or insured in the disclosure of risk, the insurer may rescind the insurance contract within one month of becoming aware of the situation – as long as this does not occur more than two years from the date on which the insurance contract was signed.

In Taiwan, the insurer is required by the FSC to include a list of questions concerning matters that would influence the risk assessment in a proposal form for the insured to answer. The duty of disclosure in insurance law should also be guided by data protection regulations and the principle of good faith (as per the Civil Code).

Although there is no clear ruling with regard to the differences between consumer insurance and commercial insurance when it comes to the insured's disclosure duty, in practice the court favours the consumer more in cases of consumer insurance. Therefore, in cases of commercial insurance, the insured will actually be required by the court to meet a higher standard of disclosure.

6.2 Failure to Comply With Obligations of an Insurance Contract

If the proposer has made any concealment, non-disclosure or misrepresentation – and such concealment, non-disclosure or misrepresentation is sufficient to alter or diminish the insurer's estimation of the risk to be undertaken – the insurer may rescind the contract (see **6.1 Obligations of the Insured and Insurer**).

6.3 Intermediary Involvement in an Insurance Contract

In Taiwan, the "insurance intermediary" usually refers to insurance brokers and insurance agents. The insurance brokers need to clearly understand the needs of the proposer before further helping to choose the suitable insurance product for the insured to sign. In accordance with Article 33 of the Regulations Governing Insurance Brokers and Article 33 of the Regulations Governing Insurance Agents, when practising or operating business, the broker must:

- exercise due care as a good manager;
- exercise fiduciary duties in order to uphold the interests of the insured;
- ensure that they have provided professional explanations to the insured; and
- ensure that they have disclosed all information relating to:
  - (a) the core components of the insurance product in question; and
  - (b) the key rights and obligations of the insured.

In 2022, the FSC even amended the regulations that require insurance brokers to protect the rights of clients over the age of 65 and prohibit the sale of unsuitable insurance products to them.

Although the insurance agent is the agent of the insurer according to Article 8 of the Insurance Act, the agent is considered to act on the insurer's behalf and thus has fiduciary duties to the insurer.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

In general, the insurer provides the written enquiries to the insured or the proposer and an insurance contract is drawn up in the form of a policy or a binder (based on Article 43 of the Insurance Act). The insurance contract is normally in writing and includes the parties, insurance interest, insurance incidents, insurance period, insurance amount and insurance premium.

However, based on the past court practice, courts in Taiwan do not necessarily consider the contents of an insurance contract to be limited to written documents, as long as there is proof of mutual consent to the contents. Nonetheless, it is worth noting that a life insurance contract entered into by a third party without written consent from the insured and stipulation of the insured amount will be considered void (based on Article 105 of the Insurance Act).

Furthermore, in the reinsurance contract, the FSC have promulgated the Regulations Governing Insurance Enterprises Engaging in Operating Reinsurance and Other Risk Spreading Mechanisms and set out additional criteria (eg, applicable law and court of jurisdiction).

The proposer and the insured must have the insurance interest, otherwise the insurance contract will lose its validity as per Article 17 of the Insurance Act.

6.5 Multiple Insured or Potential Beneficiaries

Generally speaking, there are no explicit regulations concerning the eligibility of insurance beneficiaries in Taiwan. This will depend on mutual consent from the insurance contract parties and verification by the court.

As mentioned in **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract**, courts in Taiwan may determine the contents of the insurance contract based on evidence other than the written contract itself. Therefore, it is possible to let the beneficiaries of the insurance contract include tenants, subcontractors and mortgagors, as long as it is possible to confirm and verify the mutual consent of the parties on such content (as well as the insurable interest) before the court.

Normally, the court will investigate the correspondence between parties and interrogate the witness (or even the expert witness). It is difficult to say what the rules are regarding the identification of beneficiaries in the contract, as this really depends on the judge in each case.

If the beneficiaries of the insurance contract include someone other than the named insured in the written contract, the court will likely take into consideration:

- whether it was ever implied that such beneficiaries were included in the insurance contract during the contract negotiation; and
- whether such failure to disclose the unnamed insured is enough to alter or diminish the insurer's estimation of the risk to be undertaken, thereby justifying the partial or whole annulment of the insurance contract.

6.6 Consumer Contracts or Reinsurance Contracts

There are no exact guidelines concerning the difference between consumer insurance contracts and commercial insurance contracts in Taiwan. Given that the Taiwan courts are usually pro-consumer, however, it is possible that the court may make room to include unnamed beneficiaries within the scope of coverage if the insured is a consumer rather than a commercial entity.

Given that the insured in a reinsurance contract is also the insurance entity, the court tends to place more emphasis on the written documents and correspondence – as both parties are experts in insurance business and shall be prudent with regard to the written information. Alternatively, the court may engage an independent surveyor to help reach a decision on including unnamed beneficiaries within the scope of coverage because both parties are experts and will therefore usually respect the opinion provided by an independent third-party expert.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

In the capital market, the alternative risk transfer (ART) management mechanisms can be used to diversify or transfer risks to those who are more capable to bear the risk – rather than concentrating on a single insurer, insurance company, reinsurance company or capital market investor. To some extent, therefore, ART transactions may function in a similar way to insurance or reinsurance.

As such, it is possible that the regulator in Taiwan may recognise ART transactions as part of insurance or reinsurance, although the authors are not aware of any cases of this actually happening in Taiwan. The FSC currently prefers to encourage providing diversified financial products, responding to the needs of the market, and improving the efficiency of the traditional insurer. The FSC might supervise ART transactions in a more flexible way if it considered how they can assist the current insurance market.

7.2 Foreign ART Transactions

As mentioned in **7.1 Art Transactions**, the authors are not aware of any actual cases of ART transactions in Taiwan. In general, ART transactions written in other jurisdictions may be treated as reinsurance contracts, given their similarity to the method in which an insurer shares its insurance risk with another insurance entity.

It is worth noting that the insurance entity is normally required to undergo a solvency assessment in a timely manner, which includes:

- assessment of provisions for various kinds of reserves;
- evaluation of asset quality;
- the match of assets and liabilities;
- resolution of overdue loans and non-accrual loans;
- management of investment and fund liquidity;
- assessment of financial conditions and capital adequacy;
- insurance entity risk management; and
- self-assessment of the insurance entity's risks and solvency.

Therefore, the authors tend to believe that the regulator in Taiwan should accept ART transactions for solvency purposes as they do not introduce or increase risk. Nevertheless, it is uncertain whether ART transactions written in other jurisdictions will be wholly recognised as reinsurance contracts in Taiwan, as this remains at the discretion of the FSC.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Generally speaking, insurance law in Taiwan tends to favour the insured. Article 54 of the Insurance Act provides that "the interpretation of insurance contracts shall seek the true intent of the parties, and may not adhere blindly to the language employed; where there is doubt, interpretations should, in principle, be favourable to the insured". Furthermore, according to Article 54(1), such part of the contract clause will be considered void if the insurance contract contains either:

- any term or condition that is unfavourable towards the consumers; or
- provisions that are unreasonably advantageous towards the insurance company.

In court practice, both parties to the insurance contract are allowed to provide extraneous evidence to the court in order to interpret the insurance contract.

In addition, according to Article 7(2) of the Financial Consumer Protection Act, provisions under a contract entered into by a financial services enterprise and a consumer are invalid if they are clearly unfair. Therefore, where there is doubt, the interpretation should favour the financial consumer.

Hence, under most circumstances, interpretation of insurance contracts is sought based on the true intent of both parties. However, the insurance contract is usually drafted by the insurance entity and the law rules that the provisions of such contract must be interpreted in favour of the consumer where the wording is ambiguous. In order to eliminate any ambiguity, the court usually will allow the extraneous evidence in addition to the wording of the contract itself.

8.2 Warranties

In Taiwan, a special provision (according to Article 66 of the Insurance Act) is one whereby parties warrant performance of a special obligation apart from the basic provisions of the insurance contract. Such special provisions are usually known as a kind of warranty even the term "warranty" is not used. According to the Insurance Act, all matters – whether past, present or future – that relate to an insurance contract may be stipulated as a special provision by mutual consent of the parties; however, when a party to an insurance contract breaches such special provision, the other party may rescind the insurance contract. The same rule also applies after the risk has occurred.

In order to determine whether these clauses are warranties, the court will usually examine whether these clauses were reviewed during the negotiation procedure and take into account:

- whether the clauses were formed by the parties on an equal footing;
- the legitimate expectations of the parties; and
- the principle of good faith as well as the usual practice.

8.3 Conditions Precedent

Insurers in Taiwan have the obligation of indemnification, in accordance with the insurance contract, when an insured peril occurs. The conditions precedent to the insurer's liability is usually not imposed in favour of the insured. It is uncertain whether such a conditions precedent will be considered by the court as unfair to the insured and thus render the insurance clause null and void. Therefore, in order to reduce possible dis-

putes, it is advisable to expressly describe any conditions precedent in the contract. Otherwise, the court might directly refuse to accept them as part of the contract without making further effort to verify whether it is unfair to the insured. According to the Civil Code, if the court considers the conditions precedent to be a valid part of the contract, the violation of said conditions precedent will entitle the insurer to refuse to perform its indemnification obligation.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurance coverage in Taiwan depends on the parties' mutual consent in the insurance contract. According to the Insurance Act, where there is doubt, interpretations of the insurance contract should in principle be favourable t the insured. Therefore, when there is a dispute over coverage, the agreement should first be reviewed to see whether there is any mutual consent on the coverage or exemption. However, if the agreement is vague or not specific enough, its interpretation must favour the insured. There are no major differences in the application of these principles, regardless of whether the contract in question is a consumer insurance contract, reinsurance contract or commercial insurance contract.

In general, any right to claim arising from an insurance contract shall be extinguished if not exercised within two years of the date on which it becomes possible to exercise the right. However, if any of the following circumstances apply, the two-year time period commences as set forth in the Insurance Act.

- If there is concealment, non-disclosure or misrepresentation on the part of the proposer or insured in the disclosure of risk, the period commences from the date on which the insurer becomes aware of the situation.
- If – after a risk occurs – an interested party can prove that its lack of awareness was not due to negligence, the period will begin from the date on which it becomes aware of the situation.
- If the claim of a proposer or insured against an insurer arises out of the claim of a third party, the period will begin from the date on which the proposer or insured is presented with the third-party claim.

Third parties or unnamed beneficiaries are not usually contractual parties to the insurance contract and therefore are not permitted to bring a direct action against an insurer – unless the court otherwise considers that they have the rights to claim under the insurance contract. However, there is one exception to this rule: liability insurance.

Where the insured is considered liable to indemnify a third party for loss, Article 94(2) of the Insurance Act provides that the third party may claim for payment of indemnification – within the scope of the insured amount and based on the ratio to which the third party is entitled – directly from the insurer. That is to say, under the circumstances, if the insured is liable for a third party's damages, such third party may demand the insurer provide indemnification for the damage it has suffered. However, it is worth noting that the scope of such indemnification is restricted to the sum that the insurer has agreed to undertake under the liability insurance.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Although Taiwan cannot be a member of many international conventions, owing to international

political factors, its laws follow the main concepts and spirit of these international conventions. If a civil case in Taiwan involves a foreigner or a foreign country, the jurisdiction and choice of law are addressed by the Act Governing the Choice of Law in Civil Matters Involving Foreign Elements.

Generally speaking, in a civil matter involving foreign elements, the court in the domicile of the proposer (ie, the insurance policy buyer) or the insured has jurisdiction over the insurance disputes concerned. The parties may further stipulate the jurisdiction, as long as the stipulation will not be unfair to the insured.

As regards the choice of law, in general, the applicable law regarding the formation and effect of a juridical act that results in a relationship of obligation is determined by the intention of the parties. However, where the parties have no express intention or their express intention is void under the applicable law determined by them, the formation and effect of the juridical act is governed by the law that is most closely connected with the juridical act.

In principle, the parties to the insurance contract may stipulate the governing law – provided that the stipulation will not be unfair to the insured – and, if there is no valid mutual agreement on the governing law, the law that is most closely connected with the insurance contract shall govern. Additionally, pursuant to Article 29 of Act Governing the Choice of Law in Civil Matters Involving Foreign Elements, an injured person's direct claim against the insurer of the person liable for the tort is governed by the law applicable to the insurance contract. However, if it favours them, the injured person also may assert that the law applicable to the tort's obligation shall be the governing law.

9.3 Litigation Process

In Taiwan, there are three instances in the court system – district courts, high courts, and the Supreme Court.

In principle, the district courts are the courts of first instance. The losing party in the first instance may pay the court of appeal fee and appeal to the court of second instance if it finds the judgment unfavourable.

As per the district courts, the high court in the second instance will review and investigate the facts as well as the legal issues. The high court in the second instance will also allow the parties to submit new evidence and present new arguments, apart from in exceptional circumstances.

However, in the second instance, the losing party in the high court may only appeal to the court of third instance (ie, the Supreme Court) on the grounds of a matter of law rather than a matter of fact. Furthermore, only cases with a claim amount exceeding TWD1.5 million (approximately USD50,000) can be appealed to the Supreme Court.

9.4 The Enforcement of Judgments

Compulsory enforcement can be carried out by courts in Taiwan on the grounds of an irrevocable final judgment.

According to Article 402 of the Code of Civil Procedure, a judgment rendered by a foreign court must be recognised, apart from in the following circumstances:

- where the foreign court lacks jurisdiction pursuant to ROC laws in Taiwan;
- where a default judgment is rendered against the losing defendant (except in cases where the notice or summons of the initiation of

action was legally served in a reasonable time in the foreign country or served through judicial assistance provided under ROC laws in Taiwan);
- where the performance ordered by such judgment or its litigation procedure is contrary to ROC public policy or morals; or
- where there exists no mutual recognition between the foreign country and the ROC.

According to Article 4(1) of the Compulsory Enforcement Act, the holder of the judgment rendered by a foreign court must apply for the Taiwan court's recognition and enforcement order first. Once the holder obtains the final order, the foreign court judgment will be enforced by the Taiwan court. When deciding whether to grant the recognition and enforcement order, the Taiwan court will not review the merits of the case; rather, it will only examine whether there are limited statutory defects from a procedural viewpoint.

9.5 The Enforcement of Arbitration Clauses

The arbitration clause is based on the mutual consent of the parties and, according to the Arbitration Act, this must be in writing. Courts in Taiwan do not intervene the arbitration, except in exceptional statutory circumstances (eg, the application of interim relief, an application for the withdrawal of a sole arbitrator, and the arbitral award revocation procedure).

The validity of an arbitration clause forming part of a principal contract between the parties may be determined separately from the rest of the principal contract. A decision that the contract is nullified, invalid, revoked, rescinded or terminated will not, in principle, affect the validity of the arbitration clause. The courts tend to enforce foreign arbitral awards – provided that they have none of the statutory defects listed in the Arbitration Act, which is modelled on the 1985 UNCITRAL Model Law. The aforementioned principles commonly apply, regardless of whether it is a commercial insurance contract or a reinsurance contract.

9.6 The Enforcement of Awards

An arbitral award made in Taiwan, based on the laws of Taiwan, will have the same effect as a final court judgment and can thus be enforced by the court.

Although Taiwan cannot be a member of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the "New York Convention"), owing to international political factors, many foreign arbitral awards have been successfully enforced in Taiwan in the past. The holder of arbitral awards rendered by a foreign arbitration tribunal must apply for the Taiwan court's recognition and enforcement order first. Once the holder obtains the final order, the foreign arbitral award will be enforced by the Taiwan court. In the process of granting the recognition and enforcement order, the Taiwan court will not review the merits of the case. It will only examine whether there are limited statutory defects from a procedural viewpoint.

9.7 Alternative Dispute Resolution

The parties may choose to initiate a court mediation before or after the case is pending in Taiwan. The court mediation is conducted by a judge (ie, as a mediator); therefore, if an agreement is successfully reached, such agreement has the same legal effect as a final judgment and the parties will be bound by it. On the other hand, if no agreement can be reached through court mediation, the application for a court mediation will be deemed as the initiation of a civil lawsuit.

The Chinese Arbitration Association, Taipei (CAA) also provides a mediation mechanism and, by law, a successful mediation agreement can have the same effect as a court judgment and can be enforced.

The aforementioned principles apply to consumer contracts, reinsurance contracts and commercial contracts.

9.8 Penalties for Late Payment of Claims

Under the Insurance Act, if insurers improperly delay settling claims, for reasons attributable to themselves, they must pay default interest at a rate of 10% per annum. The Insurance Act does not rule other punitive damage.

9.9 Insurers' Rights of Subrogation

The insurer has an automatic right of subrogation upon payment of its indemnification obligation, according to Article 53 of the Insurance Act. However, the amount of the subrogated claim that the insurer may claim must not exceed the amount of the indemnification paid to the insured.

In addition, it is also ruled that where the loss or damage is caused by a family member or employee of the insured, the insurer does not have the right of subrogation upon payment. However, if such loss or damage resulted from the wilful misconduct of said family member or employee, the aforementioned rule does not apply and thus the insurer can still claim by subrogation.

10. Insurtech

10.1 Insurtech Developments

In Taiwan, many insurance companies use innovative insurtech to:

- design new insurance products and solutions;
- improve process and operational efficiency; and
- enhance the satisfaction of customer.

Blockchain, AI, and data analysis are specific ways in which insurtech is used.

The value of the insurance industry has gradually transformed along with the development of insurtech. The purpose of traditional insurance is to compensate for risks, but now insurance can aim to effectively eliminate risks.

10.2 Regulatory Response

In recent years, Taiwan's insurance technology has become more and more digital. The government has tried to promote the "Preservation and Claims Alliance Chain" (see **12.1 Developments Impacting on Insurers or Insurance Products**) and its plan to allow online-only insurance companies to operate, meaning that AI and blockchain will be more widely used to reduce labour costs and improve operating procedures.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

On 21 December 2021, the FSC announced its policy purpose and plans to allow online-only insurance companies to operate while imposing a minimum capital requirement of TWD1 billion (approximately USD35.97 million). An online non-life insurer should be capitalised at no less than TWD1 billion, whereas an online life insurer's minimum capital size has been set at TWD2 billion. The FSC recently also announced that an online-only insurance company will need to

have financial institutions and financial technology providers as its shareholders.

Insurance is a highly regulated industry in Taiwan and a special permit is required. Entities intending to enter the insurance market in Taiwan must comply with the numerous requirements set out in the Insurance Act, as well as other related regulations.

Moreover, where foreign insurers wish to set up a subsidiary in Taiwan, an FIA from the IC is required in addition to the aforementioned requirements. In the past, the review and approval of the foreign investment – along with the verification of capital injection by the IC – usually only took around three weeks. However, owing to the political tension between Taiwan and the PRC, the government of Taiwan now adopts a stricter review procedure for all foreign investments in order to prevent PRC entities investing in Taiwan under the name of shell companies incorporated in other foreign countries.

11.2 New Products or Alternative Solutions

The Financial Technology Development and Innovative Experimentation Act (the "Experimentation Act"), effective as of April 2018, was enacted for the purpose of creating a safe environment for experimentation involving innovative financial technologies in order to develop technology-based financial products or services.

In addition, the Insurance Act was also amended to allow the regulatory sandbox to encourage experimentation in fintech innovation. Under Article 136(1) of the Insurance Act, insurance enterprises, brokers, agents and surveyors may apply for approval to undertake innovative experimentation within the insurance business (in accordance with the Experimentation Act) for the purpose of facilitating the development of inclusive finance and financial technologies.

Moreover, the insurance industry is also adapting to the challenges arising from digital innovation and distance selling. Two examples that provide more instruction on digital selling and distance selling are:

- the Regulations Governing Online Insurance Business and Online Insurance Services of Insurance Agent Companies and Insurance Broker Companies; and
- the Directions for the Insurance Enterprises Conducting E-Commerce.

In addition, the insurance products that are denominated in TWD are categorised as "financial products or services approved by the FSC to make the payment through an agent" in accordance with the Act Governing Electronic Payment Institutions. Therefore, insurance customers can use electronic payment to pay premiums and other fees. In this respect, it is not only customers who will enjoy more convenience; the insurance industry – along with "electronic payment institutions" – may also benefit.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

In response to people who needed to purchase insurance products but were unable to go out because of COVID-19, the FSC formulated the Regulations Governing Online Insurance Business and Online Insurance Services of Insurance Agent Companies and Insurance Broker Companies to provide consumers with convenient

and safe insurance services that were no longer face-to-face.

With the advancement of modern technology and changes in lifestyles, the FSC's Insurance Bureau anticipates that Taiwan's insurance industry will gradually enter the era of full digitisation in 2023. In March 2020, the FSC approved a trial of a new blockchain insurance project called the "Preservation/Claims Alliance Chain", which aims to bring the insurance industry in Taiwan into a digital and more convenient era. Under the project, if a person needs to change their address and has multiple policies with different insurers, they only need to update their data once for it to be shared with other insurers. Furthermore, if a person has multiple insurance policies and makes a claim on one, a blockchain smart contract will instruct the other companies with which they have coverage to initiate a claim.

Looking ahead, more and more digital information will be used in insurance disputes and this can be expected to impact the process of litigation, arbitration or mediation for insurance disputes in Taiwan. With more insurance companies participating in the project, it is anticipated that systems for the digital settlement of insurance claims will become more comprehensive within the next three to five years.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

In 2022, the FSC announced that it will start accepting applications for the establishment of online-only insurance companies from 1 August 2022 to 31 October 2022. According to Article 29(1) to 29(7) of the Regulations for Establishment and Administration of Insurance Enterprises, an insurance company that uses the internet or other electronic communication channels to sell insurance products to customers is defined as an online-only insurance company. Furthermore, the minimum paid-in capital must be:

- TWD1 billion for non-life insurance; and
- TWD2 billion for life insurance.

Moreover, an online-only insurance company must submit a successful business model and have a promoter engaged in big data analysis, interface design, software development, IoT, wireless communication, or other financial technologies. The business plan submitted by an online-only insurance company should include items such as:

- customer identity verification mechanisms;
- an assessment by a Certified Public Accountant to ensure the budget is sufficient to meet the needs of such an information system and to operate the business properly for the next five years; and
- plans for the business model and insurance products.

In order to enable prompt basic protection in case of injury or death caused by a micro-electric scooter accident, Taiwan passed the draft amendment of the Enforcement Rules for the Compulsory Automobile Liability Insurance Act in November 2022. This provides that owners of micro-electric scooters must purchase compulsory liability vehicle insurance.

Lee and Li has been recognised as the leading advisor on insurance law in Taiwan. Lee and Li has a practice that focuses on insurance law, with expertise and extensive experience in handling the establishment and legal compliance of insurance companies, compensation under insurance or reinsurance, and dispute resolution. The firm provides effective representation and strategic advice and has successfully represented local and international clients in most of the landmark cases in Taiwan. Lee and Li has outstanding capabilities when it comes to insurance practice in Taiwan and, within a five-year period, handled insurance-related deals and litigations worth a total of more than USD200 million for various multinationals and Taiwanese companies.

Author

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Contents

1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

The Financial Services and Markets Act 2000 (FSMA) is the principal source of law governing (re)insurance in the UK. FSMA and other regulations provide the main framework for the UK's regulatory regime, but a large proportion of the law applicable to (re)insurers in the UK that became law prior to Brexit was influenced by or derived from European Community legislation, with the most significant source being EU Directive 2009/138/EC, commonly known as "Solvency II".

Solvency II has been transposed into UK law in a number of ways: through FSMA itself, in statutory instruments (the "Solvency 2 Regulations 2015" (SI 2015 No 575)) and through new rules in the UK regulators' "rulebooks". Prior to Brexit, as in other European jurisdictions, (re) insurers in the UK were also subject to directly applicable regulations made under Solvency II, notably Commission Delegated Regulation (EU) 2015/35 (the "Solvency II Regulation"), which have been incorporated into English law so as to apply post-Brexit. (Re)insurers should continue to comply with relevant EU guidance issued prior to Brexit. References to Solvency II in this article are to the Solvency II Directive and the Solvency II Regulation (see **3.1 Overseas-Based Insurers or Reinsurers** and **13.1 Additional Market Developments** for further information about the impact of Brexit).

Prior to Brexit, UK legislation in respect of other specific aspects of insurance business often supplemented these sources, including the Insurance Act 2015, which came into force on 12 August 2016 and reformed insurance contract law (IA 2015). Post-Brexit, all relevant legislation will derive from the UK.

The UK is a common law jurisdiction, so as well as statute, precedent judicial decisions have an impact on the development of the UK's legal system. In the context of (re)insurance, this may be particularly relevant in the interpretation of insurance contracts and in filling any gaps left by statute.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

Under FSMA, (re)insurers in the UK are regulated by the Prudential Regulation Authority (PRA) and the Financial Conduct Authority (FCA), which are responsible for authorised firms' prudential regulation and conduct supervision, respectively. UK (re)insurers are therefore often referred to as being "dual-regulated". Insurance intermediaries such as brokers and managing general agents (MGAs) are regulated by the FCA only.

The PRA Rulebook, the FCA Handbook and associated supervisory statements are important sources of rules and guidance for the financial services firms to which they apply, including (re)insurers.

The specialist (re)insurance market, Lloyd's of London ("Lloyd's"), is also regulated by the PRA and FCA, as are managing agents, and managing agents/underwriters participating in the Lloyd's market are also subject to Lloyd's supervision.

2.2 The Writing of Insurance and Reinsurance

As a result of the "general prohibition" in Section 19 of FSMA, a firm seeking to conduct (re)insurance business in the UK must obtain authorisation or permissions under Part 4A of FSMA from the PRA (unless it is exempt – see **3. Overseas Firms Doing Business in the Jurisdiction**). The FCA must consent to the PRA's granting authorisation. Insurance intermediaries apply to the FCA rather than the PRA.

To obtain authorisation, a firm must be able to satisfy the "threshold conditions" set out in FSMA on an ongoing basis. These conditions include:

- legal status – ie, being a company, friendly society or member of Lloyd's;
- demonstrating that the firm's head office and registered office are in the UK or that it carries out business in the UK;
- being adequately capitalised to conduct the (re)insurance business in question; and
- the individuals who manage the firm being fit and proper and suitably qualified to do so.

The PRA-regulated activities that are referred to broadly as "(re)insurance business" are set out in the Financial Services and Markets Act 2000 (PRA-Regulated Activities) Order 2013, and include effecting or carrying out contracts of insurance (in other words, entering into or performing contracts of insurance, respectively) and managing the underwriting capacity of a Lloyd's syndicate as managing agent at Lloyd's.

A regulated activity is subject to the general prohibition to the extent that it is carried on "by way of business" in the UK. This restricts the applicability of the rules to persons who undertake the activity in a commercial context and with some degree of regularity. Assuming the activities themselves are carried out in the UK, it is irrelevant if the underlying risks are located outside the UK or if the contracts are subject to a different governing law. If the activity is not carried on in the UK, authorisation is not required under FSMA even if policyholders and/or the underlying risks are located in the UK.

Statute does not fully define the term "contract of insurance". The Financial Services and Markets Act 2000 (Regulated Activities) Order 2001 does not set out the features that determine whether a contract is an insurance contract, so it is useful to look to the common law for this analysis. There is also detailed regulatory guidance on the identification of contracts of insurance in the FCA's Perimeter Guidance manual (PERG 6). Although the regulators may determine whether a contract is a contract of insurance and therefore subject to regulation, this may be challenged in court.

A firm will need to seek PRA authorisation for each class of business it intends to write. FSMA divides insurance business into 18 classes of general business and ten classes of long-term (or life) business.

Capital and Reserve Requirements under Solvency II

UK (re)insurance companies are subject to the capital requirements contained in Solvency II, as set out and expanded upon in the PRA Rulebook. There are basic requirements that apply to all authorised (re)insurers, plus additional and different requirements for general insurers, life insurers and pure reinsurers. The PRA can impose additional capital requirements on individual firms if deemed necessary to address certain risks, such as operational or conduct risks.

The capital requirements under Solvency II consist of the minimum capital requirement (MCR – ie, the minimum amount of capital a (re)insurer needs to cover its risks) and the solvency capital requirement (SCR – ie, effectively the amount of capital a (re)insurer needs to operate as a going concern), assessed on a value at risk measure. A firm's SCR can be calculated according to a standard formula or, with PRA approval, using its own internal model. Capital requirements apply at the entity and group level. Lloyd's Solvency II capital requirements are calculated as a whole based on its internal model and apply to the market as a whole across all Lloyd's syndicates. Lloyd's operates its own capital assessment of each syndicate, the Economic Capital Assessment, which is broadly based on Solvency II.

Solvency II and the PRA Rulebook also provide the requirements as to reserves to be maintained by UK (re)insurance companies. Reserves, or technical provisions, must be calculated in a prudent, reliable and objective manner, with the value of the technical provisions corresponding to the amount the (re)insurer would have to pay if its (re)insurance obligations were immediately transferred to another Solvency II firm. Technical provisions must represent a best estimate, as well as including an additional risk margin, calculated in the prescribed manner.

Excess of Loss

There is no different regulation specifically for writing excess of loss (XOL) layers in the UK and authorisation requirements apply equally to insurers and reinsurers. A contract of insurance includes a contract of reinsurance, although a company may be licensed as a "pure reinsurer" and therefore not permitted to write direct business. Fewer of the conduct rules apply to pure reinsurers, as the insureds are regulated insurers rather than individuals. Therefore, XOL reinsurance may be subject to lighter regulation – eg, not being subject to all the consumer conduct rules. Since the introduction of the IA 2015, which applies to business insurance and reinsurance contracts and contains the duty of fair representation of the risk, as well as specifying remedies the (re)insurer has for a breach, there has been a move away from reinsurers being favoured under the common law on insurance contracts.

Consumers' Rights

The IA 2015 followed on from other changes to amend the common law and insurance contracts in favour of consumers, including the Third Parties (Rights Against Insurers) Act 2010, which made it easier for third parties to claim directly against insurers (on liability insurance) where the insured was insolvent, and the Consumer Insurance (Disclosure and Representations) Act 2012, which curtailed an insurer's rights to avoid the contract at common law.

2.3 The Taxation of Premium

Insurance premium tax (IPT) derives from European Community law (although it has not changed as a result of Brexit) and was introduced in the UK by the Finance Act 1994 and the Insurance Premium Tax Regulations 1994.

IPT is a tax on premiums paid under all contracts of insurance, wherever written or wherever the insurer or insured is located, except those specifically exempted from IPT (which includes those where the contract relates only to non-UK risks, reinsurance or life assurance). IPT is generally payable to HMRC by the insurer (or in some cases by a taxable intermediary). In practice, groups of insurers that are UK corporates may account for IPT under a single registration, while other special registration arrangements

apply to Lloyd's syndicate members, non-UK insurers and partners in a partnership.

IPT is chargeable at 12% (standard rate) or 20% (higher rate) of the IPT exclusive amount of the premium paid to the insurer by the insured (or taxable intermediary), depending on the type of insurance contract and who arranges it.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

The starting point for firms deemed to be carrying on (re)insurance business in the UK (even if they do not have a permanent establishment in the UK, for example, by acting through agents) is that authorisation under FSMA is required.

Business Not Carried on in the UK

As noted in **2. Regulation of Insurance and Reinsurance**, a risk in the UK can be insured without UK authorisation if the regulated activity is not being carried on in the UK. It may be possible for overseas (re)insurers to arrange to carry out their business in such a way that they are not deemed to be doing so in the UK itself, thereby avoiding the need for approval under FSMA. This may not be an entirely straightforward approach, however, given that the position is not entirely certain, there is a significant amount of guidance from the regulators and case law around what activities constitute "effecting" or "carrying out" a contract of insurance and whether business is therefore being carried on "in the UK" and, under FSMA, permission may still be required for other activities connected to the main regulated insurance activities. For example, making arrangements in the UK in connection with the "effecting" of a contract of insurance is an FCA-authorised activity and would require authorisation.

Third-Country Branches

Non-UK insurers may apply for authorisation to establish a UK branch if they meet the relevant regulatory requirements to do so. There are certain distinctions under Solvency II; for example, a single branch cannot carry out both life and non-life insurance activities (subject to certain "grandfathering" provisions), and Solvency II sets no particular standards for pure reinsurers to establish a branch.

Effect of Brexit

The PRA and FCA have implemented a "temporary permissions regime" that, under certain conditions, permits non-UK European Economic Area (EEA) firms to continue to passport into the UK for a limited period. Provisions have also been implemented to preserve the validity of contracts written cross-border into the UK pre-Brexit where the EEA insurer does not intend to apply for UK authorisation. While other EEA member states have implemented broadly similar transitional provisions that allow UK-authorised firms to continue to service policyholders resident in those member states under existing contracts, the respective time periods have been set by each individual member state and vary considerably.

3.2 Fronting

There is no prohibition on fronting in the UK. Historically, the UK regulators have tended to look unfavourably on the practice, but it is possible and, indeed, a number of financial guaranty firms have entered into fronting arrangements, whereby business was written in the UK and 100% reinsured back to the parent entity.

The Financial Services Authority (FSA) – the PRA and FCA's predecessor – had concerns around counterparty credit risk of the non-UK parent and the possible risk of UK policyholders not being paid, which was perceived as less of an issue for commercial lines such as financial guarantees, particularly where obligations were collateralised. This concern was dealt with in the regulator's rulebook through a presumption that reinsurance above a certain amount of reserves assumed too much credit risk unless it could be justified and mitigated; for example, by collateral or a guarantee. In practice, the regulators would now expect retention of at least 10% of the risk (as a general rule of thumb). This figure has also been raised more recently as "a good referential" by the European Insurance and Occupational Pensions Authority (EIOPA) in its Brexit guidance.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

After a period of active deal making in 2021, M&A activity in the global (re)insurance industry cooled off in the first half of 2022 in light of various factors, including rising interest rates, inflation and geopolitical instability. However, insurance M&A activity has shown evidence of rebounding in the second half of 2022.

Continued interest by private equity firms and asset managers, seeking to explore opportunities across the full spectrum of the insurance market, remains a key driver of deal activity, particularly as insurance business is a form of non-correlated asset, which, given the current economic uncertainty may be a more prudent investment than other sectors.

The hardening of the insurance market in recent years has also been a key driver of deal activity. Until earlier in 2022, the sustained low-interest rate environment undoubtedly also increased pressure on (re)insurers to refine their business models, increasing scale and/or exiting classes of unprofitable or non-core business. However, rising interest rates may well increase the profitability of life insurance and long-duration property and casualty (P&C) insurance businesses, which may encourage interest in the acquisition of such targets. This follows considerable activity in the life insurance market following the implementation of Solvency II, with a number of insurers exiting lines of business with higher capital requirements, such as annuities or other products with long-term guarantees. There has also been an impact on the run-off market as firms look to be as capital-efficient as possible and offload non-core business through share sales, reinsurance or business transfers, or often a mixture of the two latter approaches.

In the non-life sector, a number of acquirers continue to be interested in Lloyd's businesses. Membership of Lloyd's gives a presence in the global (re)insurance and specialty markets using Lloyd's international licences and capital rating, thus avoiding the need for separate authorisations and individual capital requirements in each jurisdiction. 2022 saw the launch of new "syndicates-in-a-box" (SIAB) such as Greenlight Re's Syndicate 3456 and MIC Global's Syndicate 5183 as part of the broader Future at Lloyd's programme.

(Re)insurers have also sought to rebalance their portfolio through M&A. This may result in offloading underperforming and non-essential assets unlocking capital which can be redeployed (see also **12. Recent and Forthcoming Legal Developments**).

The broker market is continuing to experience significant consolidation due to regulatory change and the challenging economic environment.

Despite an active insurtech market in 2021, deal activity in the insurtech space has remained modest in 2022. Acquisitions by (re)insurers of insurtech firms may be further motivated by the shift in the insurance sector to digital platforms and innovations such as automation, data analytics and modelling, a trend which was accelerated by the COVID-19 pandemic (see **10. Insurtech**). Much M&A activity has continued to be driven by financial investors with plenty of capital and an interest across the full spectrum of the insurance sector.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

(Re)insurance distribution in the UK takes place through a wide variety of channels, including through direct sales, brokers acting on behalf of their clients in arranging (re)insurance cover, agents acting on behalf of the (re)insurer, independent intermediaries and banks (through bancassurance or partnership arrangements).

Distribution at Lloyd's takes place through brokers and through insurance agents or coverholders, holding binding authorities on behalf of the managing agents/syndicates for whom they underwrite. Such intermediaries have to be separately approved by Lloyd's in addition to receiving any other intermediary authorisation required in the jurisdictions where they operate.

Regulation of distribution in the UK is based on the EU's Insurance Distribution Directive (Directive 2016/97/EU) (IDD), which replaced the Insurance Mediation Directive (Directive 2002/92/EU). The IDD aimed to improve intermediary regulation to cover all sellers of insurance, including insurers themselves, and ensure the same level of protection for consumers regardless of the distribution channel used. In the UK, intermediation by (re)insurers was already regulated and, therefore, fewer changes were required to implement the IDD. The IDD is implemented in the UK through FSMA and associated statutory instruments, as well as through the FCA Handbook.

The FCA is responsible for the authorisation and both the prudential and conduct regulation of intermediaries operating in the UK. Every person in the intermediation chain from customer to insurer must be authorised or exempt. Intermediation is defined widely to include arranging a contract of insurance, making arrangements with a view to someone entering into a contract of insurance, dealing in a contract of insurance as agent, advising on a contract of insurance or assisting in the administration and performance of a contract of insurance. A lighter conduct regime applies to reinsurance intermediation.

Rules for intermediaries range from compliance with capital and professional indemnity insurance requirements through training and competence requirements to information required to be provided to potential customers.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

The IA 2015 reformed UK insurance contract law in relation to misrepresentation and non-disclosure in commercial contracts. It applies to all (re)insurance contracts entered into wholly or

mainly for the purposes of trade, business or profession that are entered into or varied after 12 August 2016.

Duty of Fair Presentation

The IA 2015 places the insured's common law duty of full and frank disclosure on a statutory footing, imposing a duty on insureds to make disclosures in a manner that would be reasonably clear and accessible to a prudent insurer. The "accessibility" requirement is intended to prevent "data dumping" – ie, disclosing a mass of data without highlighting material considerations.

Representations of fact by insureds must be "substantially correct", and representations of expectations or belief must be made in good faith. An insured must make a "reasonable search" of the information available to them, including information held by their agents or others who are intended to be covered by the insurance.

An insured will need to disclose every material circumstance they know or ought reasonably to know, or sufficient information to put a prudent insurer on notice that the insurer needs to make further enquiries for the purposes of revealing the material circumstances.

A "material circumstance" for these purposes is anything that would, or is reasonably likely to, influence the judgement of a prudent insurer in determining whether to take the risk and, if so, on what terms.

6.2 Failure to Comply With Obligations of an Insurance Contract

In the case of commercial contracts, where the breach of the duty of fair presentation by the insured was deliberate or reckless, the insurer can avoid the contract, keep the premium and refuse to pay claims. Where the breach was not deliberate or reckless, the remedy depends on what the insurer would have done if a fair presentation had been made. If the insurer would not have entered into the contract at all, it can return the premium, avoid the contract and refuse to pay claims. If the insurer would have entered into the contract but on different terms, the contract is treated as if the different terms had been agreed. If the insurer would have charged a higher premium, the insurer can proportionately reduce the amount it pays on a claim.

In relation to consumer contracts, the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA 2012) requires the insurer's remedies to be proportionate to the failings of the insured.

6.3 Intermediary Involvement in an Insurance Contract

An insurance intermediary may act on behalf of the insurer or the insured. Where an insurance broker is acting on behalf of the insured, its duty is to exercise reasonable care and skill in the fulfilment of its instructions and the performance of its obligations. An insurance broker is also under a duty to carefully ascertain its client's insurance needs and to use reasonable skill and care to obtain insurance that meets those needs, together with carefully reviewing the terms of any quotations or indications given to its clients. An insurance broker must also ensure that it explains to its client the terms of the proposed insurance to ensure the client is fully informed and satisfied that all its insurance requirements are met. An intermediary acting on behalf of an insurer must comply with the conduct of business requirements applicable to the selling of insurance.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

At common law, there is no requirement for a contract of insurance to be in any particular form or even to be in writing, although there is usually a document (called a policy) that evidences the contract. Some insurance contracts, such as contracts for marine insurance, are required by statute to be expressed in a policy.

Insurable Interest

The Marine Insurance Act 1906 and the Life Assurance Act 1774 (which is not restricted to life insurance) require an insured person to have an insurable interest in the subject matter of the insurance. This means that, in order for an insurance contract to be valid, the person taking out the insurance should stand to benefit from the preservation of the subject matter of the insurance or suffer a disadvantage should it be lost.

The law on insurable interest differs depending on whether the contract is for non-indemnity insurance (insurance that pays out a lump sum on the occurrence of a specified event, such as death, personal accident or critical illness, regardless of the loss suffered) or indemnity insurance (which compensates the policyholder for loss suffered). In the case of non-indemnity insurance, the Life Assurance Act 1774 makes null and void any policy on the life or lives of any person(s) or on any event made by any person having no interest.

The English and Scottish Law Commissions have consulted on the topic of insurable interest at various times over the past ten years, suggesting that the law of insurable interest is complex and uncertain, and not required at all in relation to indemnity insurance. In 2016, the Law Commissions conducted a short consultation on a draft bill to reform the law on insurable interest, and published an updated draft bill on 20 June 2018. At the time of writing, the Law Commissions were analysing responses to the consultation on the updated draft bill and indicated that they will produce a report with final recommendations in due course.

6.5 Multiple Insured or Potential Beneficiaries

Generally, an insurable interest is required for multiple insureds and beneficiaries who are not named in the contract; mortgagees, for example, do have an interest in the relevant policy through their loan secured on the relevant property. For life policies, the position is a little less straightforward – where there are "mid-term beneficiaries" in multi-life policies, the requirement for an insurable interest at the time the policy is taken out means that, in theory, the policyholder lacks an insurable interest in respect of those potential beneficiaries. The draft bill (see **6.4 Legal Requirements and Distinguishing Features of an Insurance Contract**) contains wording intended to clarify the position in favour of such potential beneficiaries.

6.6 Consumer Contracts or Reinsurance Contracts

Consumer contracts tend to have more protection for the insured through regulation. CIDRA 2012 provides clarity to consumers on what information they need to provide to insurers when taking out an insurance policy. It removes the duty on consumers when buying or renewing insurance to volunteer information, replacing it with a duty to take reasonable care not to make a misrepresentation. Generally, representations will be made by consumers in response to questions raised by the insurer.

In relation to consumer contracts, CIDRA 2012 also requires the insurer's remedies to be proportionate to the failings of the insured. This means that an insured is not unfairly deprived of all cover in circumstances where an insurer would still have accepted the risk had it known the full facts.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

The term "alternative risk transfer" encompasses a number of alternative techniques used to transfer risk as compared with traditional contracts of (re)insurance. As such, the type and structure of an ART transaction will affect its regulatory treatment. (Re)insurers in the UK have used ART for a number of years and where the technique used includes some transfer of risk, regulatory credit will be given for that transfer if it meets the specific criteria set out in the Solvency II Regulation. The Solvency II Regulation explicitly recognises risk mitigation techniques used to transfer a variety of risks, including underwriting risk, but only if they fulfil the relevant criteria.

Industry loss warranties (ILWs) are a type of contract that pays out upon the occurrence of a market loss of agreed severity in response to certain catastrophe events. There might also be a double trigger of loss to the (re)insured in addition to market loss. There can, however, be considerable basis risk – ie, the risk that whatever loss the (re)insured suffers will not be fully compensated by the ILW recovery because the two do not exactly match or because the market trigger is not reached. They may not therefore attract much Solvency II credit and for that reason there may be more careful matching of triggers and more payouts based on indemnity rather than fixed-sum payouts.

A new onshore insurance-linked securities (ILS) regime was implemented in the UK with effect from 4 December 2017. The UK regime has been set up to be fully compliant with Solvency II rules on special-purpose vehicles and therefore the appropriate reinsurance credit under Solvency II should be received.

7.2 Foreign ART Transactions

ART transactions from other jurisdictions will be treated as reinsurance for UK cedents if the contract can be shown to fulfil the common law definition of insurance and also fulfils the Solvency II Regulation's requirements for recognition as a risk mitigant. ART transactions structured as derivative contracts can also be recognised as a risk mitigant if they fulfil the conditions for derivatives as risk mitigants.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Insurance contracts are construed according to the principles of construction generally applicable to other contracts. The following general rules of construction apply:

- words will be given their ordinary meaning, but will be understood in the context of the contract and not in isolation;
- where words have a technical meaning in law, they will be taken to bear that meaning; if words are defined in the contract, their own definitions will prevail;
- when construing the contract, the court may consider evidence of background circumstances (the factual matrix);
- if words are ambiguous, they will be construed contra proferentem so that any rea-

sonable ambiguity in the wording will be construed in favour of the insured;
- the contract will be construed in accordance with sound commercial principles and good business sense;
- the contract will be construed in a manner that avoids unreasonable results, provided "no violence" is done to the words used; and
- terms may be implied if this is necessary to give business efficacy to the contract; however, no term will be implied unless it is reasonable.

8.2 Warranties

The IA 2015 reformed the law of warranties and remedies for fraudulent claims in relation to consumer and business insureds.

The IA 2015 abolished the "basis of contract" clause in insurance contracts, which turns an insured's representations into warranties. Breaches of warranty that are irrelevant to the loss that occurs will no longer discharge insurers from liability.

Where the insured can demonstrate that a failure to comply with a contractual term, including a warranty, could not have increased the risk of the loss that occurred, insurers will no longer be able to rely on the breach to exclude, limit or discharge their liability. A breach of warranty will discharge the insurer from liability for loss occurring after the breach but not from liability for loss occurring before the breach or after the breach has been remedied.

8.3 Conditions Precedent

Contracting Out of the IA 2015

The IA 2015 provides that breaches of warranty that are irrelevant to the loss that occurs will no longer discharge insurers from liability (see **8.2 Warranties**). In consumer contracts, any attempt to contract out of any part of the IA 2015 will be of no effect. In commercial contracts, an insurer seeking to contract out of the provisions of the IA 2015 must take sufficient steps to bring the relevant term to the insured's attention and ensure that the term is clear and unambiguous as to its effect.

Fraudulent Claims

The IA 2015 enables insurers to treat the insurance contract as terminated from the date of the fraudulent act. The previous common law position of insurers not being liable for fraudulent claims and being able to recover payments made to the insured in respect of a fraudulent claim remains unchanged.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Coverage Disputes

It is common for an insurance contract to specify a mechanism for dealing with disputes prior to resorting to litigation or arbitration. This may range from an initial attempt to resolve the dispute through nominated senior executives or managers to other dispute resolution mechanisms, such as an independent expert determination or mediation. It is common for commercial insurance contracts and reinsurance contracts to contain an arbitration clause providing for disputes to be settled through arbitration rather than the courts.

Consumer contracts have to contain certain provisions required by law or regulation to protect consumers. Whilst consumer contracts are sometimes litigated, insurers must provide consumers with details of complaints procedures and their right to refer disputes to the financial ombudsman. They are also under a regulatory

duty to treat customers fairly. Consumer disputes will therefore often be settled through internal procedures or an ombudsman ruling rather than through the courts.

Limitation Period for Insurance Claims

There is no specific statutory limitation period for making a claim under an insurance or reinsurance contract. Insurance contracts are subject to the normal limitation period under the Limitation Act 1980 for causes of action founded on breach of contract (six years from the date on which the cause of action accrues).

As well as the statutory limitation period, (re) insurance contracts typically include a notification clause requiring the insured to give the insurer notice of claims or losses, or of circumstances that give rise to a claim or loss, in a particular manner (usually in writing) and within a particular period (for example, "as soon as reasonably practicable"). An insured can lose the right to an indemnity for failure to comply with a notification clause where compliance is a condition precedent to bringing the claim. "Claims made" policies provide cover for claims actually made within the policy period – usually a year.

Enforcement of Insurance Contracts by Third Parties

The Contracts (Rights of Third Parties) Act 1999 allows for third-party enforcement in certain circumstances. For example, a third party may be able to enforce a contractual term in an insurance contract if:

- they are specifically mentioned in the contract as someone who has rights under the insurance contract; or
- the insurance contract purports to confer a benefit on them.

In practice, however, contracts of insurance usually exclude the Contracts (Rights of Third Parties) Act 1999.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

The rules applicable to disputes over jurisdiction regarding civil and commercial matters largely depend on the domicile of the defendant and the date when the proceedings were instituted.

The European Regime

The European regime will apply (i) where the defendant is domiciled in an EU or European Free Trade Association (EFTA) state or has a specified connection to one of these states and (ii) where the proceedings were initiated in the UK on or before 31 December 2020. The "European regime" refers to the application of Council Regulation (EC) 44/2001 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, commonly known as the "2001 Brussels Regulation" (applicable to proceedings instituted before 10 January 2015) and Regulation (EU) No 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, commonly known as the "Recast Brussels Regulation" (applicable to proceedings instituted after 10 January 2015). It also refers to the 2007 Lugano Convention.

Common Law Rules

Common law rules (i) will apply where the defendant is domiciled outside the EU and (ii) will also apply to EU and EFTA-domiciled defendants for proceedings commenced after 31 December 2020, subject to what is said immediately below.

The Hague Convention

The Hague Convention on Choice of Court Agreements (2005) (the "Convention") applies to contracting states of the Convention and requires the court designated in an exclusive jurisdiction agreement (entered into after the Convention came into force) to hear the case, generally preventing courts of other contracting states from hearing parallel proceedings. As the UK joined the Convention in its own right on 1 January 2021, the view of the European Commission is that the Convention will only apply after that date. The UK, on the other hand, is of the view that it will apply from October 2015, when the UK became a party to the Convention by virtue of its EU membership. The position in this regard has yet to be definitively clarified.

The Recast Brussels Regulation and Rome I

Where the European regime applies, jurisdiction in matters relating to insurance is determined on the basis of distinct reforms in Chapter II, Section 3 of the Recast Brussels Regulation, which aim to protect the so-called weaker party. Section 3 provides an exception to the general rule that a defendant should be sued in the country in which they are domiciled.

Disputes over the law applicable to contracts concluded after 17 December 2009 are resolved on the basis of the rules set out in Regulation (EC) 593/2008 of 17 June 2008 on the law applicable to contractual obligations, commonly known as "Rome I". Unlike the previous European regime set out in the Rome Convention on the Law Applicable to Contractual Obligations 1980 (transposed in the United Kingdom through the Contracts (Applicable Law) Act 1990), Rome I applies to insurance contracts, with the exception of certain life assurance contracts.

Rome I has been incorporated into UK domestic law through UK Rome I, a retained EU Law version of Rome I with minor operational amendments that do not affect the substance of the law. In practice, this means that UK courts will continue to apply Rome I in respect of contracts entered into on or prior to 31 December 2020 (ie, the end of the transition period), and UK Rome I to contracts entered into after this date.

9.3 Litigation Process

Civil litigation in England and Wales is adversarial in nature. The first stage in typical court proceedings following pre-action correspondence is the issuance of a claim form, which contains the names of the parties, details of the claim and its value. The claimant then serves the claim form on the defendant, and must also prepare and serve the particulars of the claim, stating the facts on which it relies, the remedy sought, and any other relevant information. The defendant can then choose to defend against the claim by serving a defence. The claimant can reply to the defence. If the defence includes a counterclaim, the claimant's reply must also include a defence.

Next steps include disclosure, when each party is required to disclose to the other documents within its control that are relevant to the issues in dispute. The disclosure obligation in English litigation is wide and requires each party to disclose documents that support or harm their case or their opponent's case. The High Court has taken steps to try to reform the disclosure process to ensure that it is as targeted and efficient as possible. Parties will also typically exchange witness statements on issues of fact and expert reports.

The case will then proceed to trial. English trials principally involve each party's counsel making oral submissions and drawing the judge's atten-

tion to the relevant evidence and law, including calling on the evidence of witnesses and experts upon which they seek to rely, and cross-examining opposing witnesses and experts.

The parties must take each step within prescribed periods of time set out in the civil procedure rules, or decided by the court, including in case management conferences (CMC) where the parties and the judge decide how the case should be conducted, including setting a timetable for all the steps up to trial.

9.4 The Enforcement of Judgments

If an unsuccessful party does not voluntarily comply with the judgment of the court, various enforcement procedures are available, including the seizure and sale of that party's assets or the imposition of a charge over certain assets.

There are four regimes for the enforcement of foreign judgments in the UK, and which regime is applicable will depend on when and where the proceedings were initiated.

The UK regime

Judgments from Scotland or Northern Ireland will follow the UK regime.

The European Regime

Judgments from EU and certain EFTA countries will fall under the European regime (which combines provisions contained in the 2001 Brussels Regulation, the Recast Brussels Regulation and the 2007 Lugano Convention) if the judgment was handed down on or before 31 December 2020. Under the European regime, the judgment creditor requires the leave of the court to enforce a foreign judgment, following which it can be enforced as if it were an English judgment. Enforcement procedure in these cases will still depend on the law of the enforcing state. For judgments issued after 31 December 2020, the statutory regime or the common law rules that apply to the enforcement of judgments from non-EU/EFTA countries will apply instead. So far, the UK's attempts to accede to the Lugano Convention after 31 December 2020 have proved unsuccessful. The only agreement that the UK has reached in this respect to date is the treaty signed with Norway on 13 October 2020, which provides for the continued application of the enforcement provisions of the 2007 Lugano Convention.

The Statutory Regime

Judgments from most Commonwealth countries and certain other countries covered by statutory instruments such as the Administration of Justice Act 1920 and the Foreign Judgments (Reciprocal Enforcement) Act 1933 are enforced under the statutory regime. Enforcement under the statutory regime requires a registration of the foreign judgment, without the need to commence a fresh action or to issue notice to the debtor until registration is to be ordered. The onus falls on the debtor to apply to set the registration aside.

The Common Law Regime

Judgments from the rest of the world (ie, countries that are not covered by the European regime after 31 December 2020 or by the statutory regime) are enforced under the common law regime, unless they are subject to other arrangements. When enforcement is sought under the common law regime, the judgment debtor needs to commence fresh proceedings to enforce the foreign judgment as a debt. The grounds for resisting the enforcement under the statutory regime and common law regime are wider than under the European regime, and will depend on the country where the judgment was given, since a foreign judgment is only enforceable under

the common law regime if the original court had jurisdiction according to the rules that English law applies in such cases.

Exclusive Jurisdiction Clauses

In addition to the above, if there is an exclusive jurisdiction clause, then the Hague Convention will apply. If the exclusive jurisdiction clause was entered into after 31 December 2020, then the Hague Convention provides for the enforcement of judgments in a similar way to the Recast Brussels Regulation and will apply to the enforcement of judgments from the signatory countries, including the EU member states, Mexico, Singapore and Montenegro. If the exclusive jurisdiction clause was entered into before 31 December 2020, then the situation is currently unclear given the uncertainty of the application of the Hague Convention to exclusive jurisdiction clauses agreed after 1 October 2015 but before the end of the transition period (see **9.2 Insurance Disputes over Jurisdiction and Choice of Law**).

9.5 The Enforcement of Arbitration Clauses

Arbitration clauses in commercial insurance and reinsurance contracts can be enforced in the same way as arbitration clauses in other kinds of contracts. Indeed, arbitration is a popular method of resolving insurance disputes. The Insurance and Reinsurance Arbitration Society (ARIAS (UK)) has prepared a recommended arbitration clause, which takes into account the ARIAS Arbitration Rules and the provisions of the Arbitration Act 1996 (the 1996 Act).

9.6 The Enforcement of Awards

Under Section 66 of the 1996 Act, arbitral awards can be enforced as a judgment with leave of the court, whether they are domestic or foreign.

The UK is a signatory to the New York Convention, which entered into force on 23 December 1975, with a reciprocity reservation. The UK has submitted notifications extending the territorial application of the New York Convention to Gibraltar, the Isle of Man, Bermuda, the Cayman Islands, Guernsey, Jersey and the British Virgin Islands.

For foreign awards governed by the New York Convention, Section 103 of the 1996 Act contains the grounds of review for recognition and enforcement, which are set out in Article V of the New York Convention. In practice, the UK is an "arbitration-friendly" jurisdiction and the grounds for review of foreign awards are limited.

In addition to the New York Convention, the UK is a party to the Geneva Convention on the Execution of Foreign Arbitral Awards of 1927, the Convention on the Settlement of Investment Disputes between States and Nationals of Other States of 1965 and numerous other bilateral and multilateral investment treaties.

9.7 Alternative Dispute Resolution

Arbitration is commonly used in insurance and reinsurance disputes, and a clause requiring this form of dispute resolution to be used may be contained in the policy. The International Chamber of Commerce (ICC) and the London Court of International Arbitration (LCIA) are frequently used.

A contract might also require resolution of a dispute through another form of alternative dispute resolution, such as mediation. The court will encourage mediation before litigation for insurance and reinsurance contracts, and failure to attempt it may result in costs penalties.

9.8 Penalties for Late Payment of Claims

The Enterprise Act 2016 introduced an implied term to (re)insurance contracts that insurers must pay sums owed to policyholders within a reasonable time. The type of insurance, the size and complexity of the claim, compliance with any relevant statutory or regulatory rules or guidance, or factors outside the (re)insurer's control will be taken into account when assessing what constitutes a reasonable time.

A breach of this implied term could give rise to a claim for damages. The limitation period for the insured to bring the claim for damages is one year from the date of the last payment in respect of the relevant loss (Limitation Act 1980).

Parties to a non-consumer contract can contract out of the reasonable time obligation, provided they comply with the IA 2015 transparency provision.

9.9 Insurers' Rights of Subrogation

As a result of the doctrine of subrogation, an insurer may pursue third parties for claims pursuant to which the insurer may be liable to the insured. The insurer can "step into the shoes" of the insured and pursue in the insured's name or require the insured to pursue claims that may lie against third parties in respect of the insured event giving rise to a claim under the policy. To trigger subrogation, at common law it is necessary for the insured to be fully indemnified as a condition to the insurer exercising its subrogation rights. In practice, the extent of – and circumstances for – the exercise of subrogation and procedures applicable is specified in the policy.

10. Insurtech

10.1 Insurtech Developments

An increasing number of start-ups are applying new technologies in the insurance space. Incumbent insurers are focused on partnering with and acquiring these businesses in order to avoid disruption, meet evolving customer demands and capitalise on insurtech's potential.

Strategies/Collaboration

Several of the most common strategies are listed below. Importantly, these strategies are not mutually exclusive and global players typically utilise several in parallel, if not all of them.

- Establish incubator – it is common for insurers to establish incubators with the aim of accelerating seed or early-stage technology ventures. Incubators often take the form of external acceleration programmes that admit and train applicants, though they may equally be internal research and development outfits.
- Venture capital investment – these investments are made directly through a business unit or through a standalone venture capital-focused investment fund.
- Partnerships – by allowing incumbent insurers and disruptors to combine resources, partnerships offer potential benefits to incumbents and start-ups.
- Licensing technology – rather than incurring the risk and expense of growing or acquiring technology, insurers may seek to license fully developed technology from third parties.
- M&A – insurers also seek to acquire insurance-oriented technology companies outright and integrate them into their global brand.

Products

Below are some of the products involved in insurtech.

- Artificial intelligence and machine learning (together, AI) – AI promises substantial improvements in operational efficiencies and pricing accuracy. Products in this area vary, from drones analysing crop health from aerial images of farms to companies offering a completely automated claims service.
- Intelligent agents – virtual and digital assistants and chatbots capable of interacting with customers are becoming increasingly common.
- Internet of things (IoT) and big data analytics – IoT refers to the connection of devices to the internet and/or each other. Insurers use data from wearables to project health outcomes, whilst data from automobiles can predict the likelihood of future accidents.
- Blockchain – this is a digital peer-to-peer ledger system designed to securely record transactions in digital assets, and ownership thereof. Global and UK insurers remain focused on the technology, as is evidenced by their near-universal participation in the B3i initiative, which involved launching a (re)insurance contract management platform using distributed ledger technology (DLT) and smart contract technology. In April 2022, Allianz and Swiss Re placed the first excess of loss reinsurance contract using DLT but despite this, B3i filed for insolvency in July 2022 raising questions on the future of blockchain technology in insurance.

10.2 Regulatory Response

Efforts have been made by regulators to adapt to insurtech, demonstrated by the launch of Project Innovate by the FCA in 2014. A key component of the project is the regulatory sandbox which in August 2021 moved to an "always open" model, meaning applications are now accepted all year round. This involves early, open and honest communication between insurtech firms and their respective regulators, who provide individual guidance, potential modification of rules and letters of no enforcement action for a limited duration. The FCA closely monitors the pilot and receives information regarding current innovations.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

As a centre for the global (re)insurance industry, the UK industry – particularly Lloyd's and the London market – is focused on the many emerging risks common to those in the rest of the world, including the Russia-Ukraine conflict, catastrophe and environmental risk from climate change, cybersecurity risk and the changing risk profile of common types of insurance, such as motor and liability, with the development of automation and AI (see also **12. Recent and Forthcoming Legal Developments** in connection with the developments arising from the COVID-19 pandemic).

Russia-Ukraine Conflict

The ongoing Russia-Ukraine conflict has had significant financial implications for the (re) insurance market, as well as the broader global economy. The brunt of the underwriting impact has been borne by (re)insurance companies with exposure to lines of insurance such as terrorism, political violence, aviation and marine. Furthermore, the Russia-Ukraine conflict has accelerated the inflationary pressures already in place due to the COVID-19 pandemic. Such economic pressures affecting global markets are likely to depress demand for taking out insurance contracts and affect the financial performance of the insurance industry as a whole. The Russia-

Ukraine conflict has also created new sanctions compliance regulation across the market that (re) insurance companies have to comply with.

Climate Change

Climate change has in recent years ranked amongst the top emerging risks identified by the UK and global (re)insurance industry. Given the ongoing impacts to global economies arising from the effects of climate change, as well as the impact to (re)insurers in respect of the asset and liability side of the balance sheet, it may be unsurprising that climate change remains a key emerging risk affecting the market.

The UK government has indicated its commitment to the green economy and the PRA and FCA have shown that they are aware of the risks facing the industry from climate change. HM Treasury has indicated the importance of supporting the green economy in the ongoing UK Solvency II review. In June 2021, the PRA conducted the 2021 Climate Biennial Exploratory Scenario (CBES) stress test, which explored the resilience of the UK financial system to the physical and transition risks associated with different climate pathways. The results of this stress test were published in May 2022, and reflected that there was a range of different approaches across organisations in the assessment and modelling of these risks and all participating firms had more work to do to improve their climate management capabilities. It was highlighted that the results of the stress test may inform the UK regulators' future work on capital requirements in connection with "green investment".

Cyber-Risk

UK businesses have a heightened awareness of the threat that cybercrime poses, following a number of recent high-profile data breaches. The joint report on the cyberthreat to UK business from the National Cyber Security Centre (NCSC) and the National Crime Agency (NCA) acknowledged the pace at which cyberthreats evolve, and urged collaboration between government, law enforcement agencies and business to tackle this universal threat. In the government's Cyber Security Breaches Survey 2022, it was reported that 39% of businesses in the UK suffered a cyber-attack in the 12 months to July 2022 and 20% of these faced a material outcome (such as loss of money or data). Whilst (re)insurers face cyber-risks themselves, it is also an opportunity for them to offer cyber-risk insurance protection to others.

The UK government is committed to making the UK a leader in cybersecurity, and the FCA and PRA are alive to the risks that financial services firms such as (re)insurers face from cyberthreats. The PRA and FCA are engaging with industry and co-operating with each other and the Bank of England (BoE) to monitor the use of new technologies, assess emerging regulatory risk and test firms' operational resilience and cyber-resilience through stress tests – and to enforce penalties when regulatory and data breaches occur.

Longevity Risk

Longevity risk has been an increasing focus of the regulators, due in part to the peculiarities of Solvency II. In 2017, the PRA recognised that the design of the risk margin makes it highly sensitive to interest rate conditions. In the BoE's public response to the European Commission's Call for evidence: EU regulatory framework for financial services, the PRA noted that interest rate sensitivity, coupled with historic low rates in the UK, meant that the risk margin is disproportionally large for UK insurers writing interest rate-sensitive risks, which are usually long term. The PRA also noted that the volatility was undesirable from a prudential viewpoint because of

its potential to promote pro-cyclical investment behaviour by insurers.

In the ongoing review of Solvency II announced by HM Treasury for the UK post-Brexit, reform to the risk margin has been identified as a key part of the agenda. On 17 November 2022, HM Treasury proposed to reduce the risk margin significantly (a 65% reduction for long-term life insurance business and a 30% reduction for general insurance business) (see **12. Recent and Forthcoming Legal Developments**).

11.2 New Products or Alternative Solutions

Blockchain

Several features of DLT, such as blockchain, justify its reputation of offering a high standard of protection against cybersecurity risk. The ability to protect data from cyber-attacks or malicious tampering is not only beneficial from a business risk point of view, but it also makes a product based on DLT more attractive to both consumers and regulators, who must balance innovation against risks to markets and customers. However, weaknesses in DLT have been revealed through a series of cyber-attacks against digital currencies that use DLT.

To manage the policy and regulatory implications of DLT and crypto-assets in financial services, in March 2018 the BoE, the FCA and HM Treasury created a Cryptoassets Taskforce, which published a report in October 2018 detailing specific actions to be taken by regulatory authorities to mitigate the risks that come with the potential benefits of DLT. In April 2022, HM Treasury published a response to a previous consultation on the UK's regulatory approach to crypto-assets and stablecoins, which sets out, among other things, the UK's approach to stablecoin regulation, the wholesale uses of crypto-assets, and new market developments in the space.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

COVID-19

The impact of the COVID-19 pandemic in 2020 and 2021 has seen above-average major claims activity, particularly with business interruption insurance. The industry has strongly advised the UK and other governments globally to introduce a public-private risk-financing mechanism for future pandemics, referred to as "Pandemic Re", which is modelled on the UK government-backed terrorism risk mutual "Pool Re".

In addition, regulators have taken an active role in approaching the issues posed by COVID-19. In the UK, the FCA initiated a test case on business interruption insurance and, in January 2021, the Supreme Court issued a judgment that substantially allowed the appeals of the regulator. However, there were certain qualifications given to the Supreme Court's findings, meaning that insurers and insureds will need to continue to carefully consider their policy language.

With regard to the issue of causation, rather than following the "but for" test, the Supreme Court determined that where there are multiple concurrent causes of loss, only one of which is covered by the policy, unless the other cause is specifically excluded, the insurer may be liable. However, it remains dependent on the policy wording itself to determine whether this causal connection is sufficient to trigger the insurer's obligations. In addition, the Supreme Court overruled the Orient Express case, which is likely to have

wider implications for business interruption policies beyond the pandemic. The judgment is also likely to result in potentially difficult discussions between cedants and reinsurers, and, in some cases, may result in litigation over the extent of coverage. In October 2022, the UK High Court handed down judgments in preliminary issues trials in three COVID-19 business interruption cases in the hospitality industry, which clarified to a degree the way the courts should approach the issue of aggregation. At the time of writing (January 2023), the insurers have indicated that they will be appealing the judgments. The FCA continues to collect and publish data from insurers on their progress with business interruption claims.

Part VII Transfers

In the UK there are specific provisions (in Part VII of FSMA) allowing one insurer to transfer its business to another, without the requirement for policyholder consent or consent from any other affected counterparties (a "Part VII transfer scheme"). There have been a large number of these over the past few years due to M&A activity and reorganisations driven by Solvency II or Brexit. However, it is no longer possible to commence a Part VII transfer to transfer business between a UK authorised firm and a firm authorised in an EEA state.

A judgment of the High Court delivered on 16 August 2019 by Mr Justice Snowden refused to sanction a proposed Part VII transfer scheme whereby Prudential proposed to transfer annuity policies (constituting approximately GBP12.9 billion of liabilities) to Rothesay Life. Upon appeal, the Court of Appeal overturned the refusal to sanction the proposed transfer and the High Court has subsequently approved the transfer.

UK Solvency II Review

In April 2022, HM Treasury published a new consultation paper on the UK's Solvency II review setting out the package of proposed reforms. Following this consultation, in November 2022, HM Treasury issued a paper setting out the government's final reform package. The key areas of reform include:

- reducing the risk margin significantly (a 65% reduction for long-term life insurance business and a 30% reduction for general insurance business) and to enable a modified cost of capital approach to its calculation;
- maintaining the existing methodology and calibration of the fundamental spread, while increasing the risk sensitivity (the UK government has indicated that this will be reviewed again in five years' time);
- increasing investment flexibility, in particular broadening the matching adjustment eligibility criteria to include assets with highly predictable cash flows and
- removing branch capital requirements for foreign firms with "appropriately capitalised" parent companies.

The government has indicated that it will legislate (or work with the PRA to amend the PRA Rulebook) as necessary to implement this new regime, although the detail on these proposals (and therefore the practical impact) remains outstanding.

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Brexit

The transitional period ended on 31 December 2020. Although a trade agreement was agreed

between the UK and the EU, it contains very few provisions on (re)insurance and the UK is now treated as a third country (resulting in a loss of passporting rights between the UK and the rest of the EU). The UK and the EU committed to agreeing a memorandum of understanding (MoU) on a framework for co-operation between financial regulators by March 2021. The MoU is intended to facilitate discussions between the UK and the EU on how to move forward with equivalence determinations.

Although the UK and EU confirmed in March 2021 that a text had been agreed in principle, no MoU has yet been formally agreed or published. The UK has granted a package of equivalence decisions to the EU and EEA member states, including for the three equivalence areas under Solvency II, insurance, group solvency calculation and group supervision. However, as yet, the EU has not reciprocated so the UK has not been granted equivalence under Solvency II.

Insurers had been planning for some time, on the basis of a no-deal or hard Brexit, to set up new authorised subsidiaries or branches so as to be able to access both the UK and EU markets.

The UK government has drafted legislation intended to maintain EU laws and regulations currently directly applicable in the UK, including those relating to (re)insurance, and in particular Solvency II, but without the references to EU institutions and the reciprocal arrangements that come with being a member, by incorporating these into domestic law through statutory instruments under the European Union Withdrawal Act. The effect is that there is no difference in (re)insurance regulation as it currently applies in the UK and to UK authorised (re)insurers post-Brexit to the regulations that applied immediately prior to Brexit, with the amendments being made purely to reflect the UK's withdrawal from the EU and its institutions.

Notwithstanding the UK's ongoing Solvency II review (see **12.1 – Developments Impacting on Insurers or Insurance Products**), it is unlikely that the regulators or the UK (re)insurance industry will wish to diverge greatly from Solvency II, given the amount of effort, time and money spent on its implementation. However, changes have been suggested in areas that are already heavily criticised by the regulators and the industry, notably the risk margin, the matching adjustment and the treatment of certain long-term investments.

FSM Bill

As part of the UK's efforts to reshape its financial services industry in light of Brexit, the Financial Services and Markets Bill 2022-23 (the "Bill") has been introduced before Parliament and, at the time of writing, had completed its third reading in the House of Commons and is currently in the correspondence process in the House of Lords.

Proposals in the Bill that are directly relevant to the insurance industry include:

- the setting up of a legislative architecture and consultation process that regulators must comply with to allow a smooth transition from EU to UK legislation;
- greater accountability over the UK regulators;
- a new secondary objective for UK regulators to facilitate the UK's economic growth and international competitiveness in the medium to long term;
- a new regulatory principle for the FCA and PRA to have regard to the need of ensuring that their measures comply with net zero UK carbon emissions by 2050; and

- a series of amendments to insolvency arrangements for (re)insurers.

Insurance-Linked Securities Regime

The new ILS regime for the UK was implemented after a significant amount of work between the regulators, the industry and HM Treasury to design an onshore regime that would allow the UK to compete with more established ILS jurisdictions, whilst ensuring that ILS issued in the UK would be compliant with Solvency II.

The new rules introduced protected cell companies into the UK for the first time, together with an attractive tax regime and a bespoke approach to regulation and supervision to reflect the nature of ILS transactions. The UK government has launched a tax consultation aiming to make the UK's ILS regime more competitive.

Debevoise & Plimpton LLP is a premier law firm with market-leading practices and approximately 800 lawyers working in nine offices across three continents, within integrated global practices, serving clients around the world. The lawyers prioritise developing a deep understanding of their clients' business, and then pursue each matter with intensity and creativity to achieve optimal results. Since opening in 1989, the London office – the firm's second largest – has developed remarkable talent and experience in Debevoise's core practice areas, including insurance, private equity, international disputes and investigations, financial institutions, M&A, finance, capital markets and tax. The European insurance practice advises leading (re)insurers and other financial institutions on sophisticated M&A, as well as on capital raises and regulatory issues in the UK and European insurance market.

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1. Basis of Insurance and Reinsurance Law

1.1 Sources of Insurance and Reinsurance Law

State Insurance Law

Insurance within the USA is primarily regulated by the various states, rather than by the national, or federal, government. State legislatures enact insurance laws, which are implemented and enforced by state regulators primarily through adoption of rules and regulations governing the business of insurance and insurer conduct.

Each state has its own insurance laws and regulations and its own supervisory authority (usually called the state insurance department), headed by its own state official (usually called the state insurance commissioner) (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**). Each state has broad authority and discretion to regulate insurance activity within its borders, including activities by insurers and insurance intermediaries (brokers and agents), claims adjusters, and rating organisations. There is considerable uniformity among the states when it comes to the underlying principles and there are a number of uniform insurance laws that the various states have adopted; however, specific rules can vary between states in important respects.

Federal Insurance Law

Although the states are the primary regulators of insurance, federal laws and regulations also target certain aspects of US insurance business. The federal role can take many forms – for example, all insurers with US operations are subject to federal regulation that affects businesses generally, such as investor protection rules under federal securities laws, rules relating to the disclosure and security of non-public personal information of customers and consumers, AML rules, and anti-bribery and trade sanction rules (see **2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance**).

Common Law Precedent

State and federal courts play a significant role in the interpretation and enforcement of insurance law in the USA. State common law, in particular, is an important source of law for dispute resolution (such as the validity and enforceability of insurance contracts, and the settlement of claims). Courts also have significant roles in the enforcement (or restriction) of regulatory actions imposed by state insurance commissioners, as well as in proceedings involving financially distressed insurers.

2. Regulation of Insurance and Reinsurance

2.1 Insurance and Reinsurance Regulatory Bodies and Legislative Guidance

State Regulation

The US state-based supervisory framework is generally designed to satisfy two principal objectives: consumer protection and insurer solvency. How this is expressed, the structure of mandates, and how clearly these general objectives are addressed can differ significantly among the states.

An officer in each state's executive branch is designated as the chief supervisory official for implementation and enforcement of that state's insurance laws and is called the insurance commissioner, insurance superintendent or insurance director. This official may be elected or appointed by the governor, depending on the state. The official presides over a regulatory

agency that is generally referred to as the insurance department – although the exact name of the agency varies from state to state.

National Association of Insurance Commissioners

State regulation of the insurance industry is co-ordinated through the National Association of Insurance Commissioners (NAIC), a voluntary organisation whose membership comprises the chief insurance regulatory officials of each of the 50 states, the District of Columbia, and the five US territories. The NAIC provides a forum for the development and implementation of uniform policy. Its chief tools include:

- developing model laws and rules, which may or may not be enacted by each state or territory;
- developing standardised financial reporting and solvency ratios;
- co-ordinating information sharing among state insurance regulators; and
- co-ordinating insurer examinations.

Federal Regulation and Programmes

Although the states are the primary regulators of the insurance industry in the USA, the federal government also has a significant impact on insurers and the business of insurance. This role can take several forms, including:

- prudential regulation by the Federal Reserve of insurers that are designated for heightened supervision by the Financial Stability Oversight Council and banks or savings and loan holding companies that own insurance companies;
- the regulation of financial products or markets that include – but are not limited to – insurance, such as the SEC's regulation of securities (including certain life insurance products), the Commodities Future Trading Commission's regulation of derivatives, and the Department of Labor's regulation of employee benefit plans;
- monitoring and reporting on the insurance industry, and developing federal policy on prudential aspects of international insurance matters through the Federal Insurance Office (FIO);
- taxation of insurers and their products through the Internal Revenue Service (IRS) under the US Department of the Treasury ("the Treasury")'s supervision; and
- federal insurance programmes, including the Federal Emergency Management Agency's administration of the National Flood Insurance Program and the Treasury's administration of the Terrorism Risk Insurance Program.

2.2 The Writing of Insurance and Reinsurance

Form of Insurer

Insurance companies operate under various forms of corporate or non-corporate organisation. Each insurer is organised and formed under the laws of a specific jurisdiction, known as the insurer's state of domicile. The laws of the insurer's state of domicile determine how the insurer is formed or organised and typically include rules regarding corporate governance, solvency, and similar matters. The most common forms of insurance companies are stock and mutual companies, although many other forms of organisational structure also exist under state insurance law.

Licensing

Licensed insurers (also called "admitted" insurers) are subject to various regulatory requirements in each of the states where they are licensed to transact insurance business. The first licence an insurer must obtain is the licence

issued by the insurer's state of domicile. Many insurance laws and regulations apply expressly only to companies organised under the laws of the insurer's domestic state. In addition to satisfying the state's requirements for corporate formation, corporate governance and capitalisation, the company must also satisfy the state's requirements for insurance licensure.

Most states, as a condition to licensing an insurance company, require the submission of information regarding the ownership and control of the insurer. Generally, persons who "control" an insurance company – as well as the individuals who are directors and executive officers of the insurance company – must demonstrate that they are competent and fit and, in some states, that they are "trustworthy".

A licence application typically would include information such as the following:

- a description of the insurer's ownership structure and holding company system;
- information on – including biographical affidavits executed by – the insurer's directors and executive officers;
- pro forma financial projections and a business plan for the insurer;
- a description of the lines of insurance business the insurer seeks to transact; and
- other additional information the individual state may require.

Certain requirements, such as capitalisation, vary based upon the licence type (for example, a property and casualty licence) and vary from state to state.

The process of becoming licensed must be repeated in each new state in which the insurer seeks to transact insurance. Virtually all states now use an online uniform licensing process called the Uniform Certificate of Authority Application (UCAA), which permits an insurer to file copies of a single application in all "uniform states" where the insurer is seeking admission. Each state then performs its own independent review of the application.

Reinsurers

Reinsurers licensed in the USA are generally subject to the same state-based regulation as licensed primary insurers, and licensed primary insurers are generally permitted to reinsure risk for which they would be permitted to write on a direct basis. Reinsurers that are not licensed in the USA can reinsure risks in the USA without being licensed or accredited; however, they generally must be licensed in a jurisdiction in which they establish offices to conduct business. Unless designated as a "certified" or "reciprocal" reinsurer (see **3. Overseas Firms Doing Business in the Jurisdiction** and **13. Other Developments in Insurance Law**), unlicensed and unaccredited reinsurers must provide qualifying collateral to ceding insurers in order for ceding insurers to receive financial statement credit for the ceded reinsurance. These collateral requirements serve as a substitute for financial regulation of unauthorised reinsurers under the current rules.

2.3 The Taxation of Premium

Every state imposes some form of premium tax on direct premium written by an insurer in the state. A small number of states also impose a tax on income. "Direct" premium refers to premium derived from policies issued directly to insureds – as distinct from reinsurance premium, which is premium on reinsurance contracts. States commonly impose a tax on the premiums derived from insurance on "property, subjects or risks located, resident to be performed" in the state.

All but a handful of states exempt annuities from the tax on premiums, either by statute or administrative position. Virtually all states impose a retaliatory tax, under which "foreign" insurers – that is, licensed insurers that are domiciled in another state – pay the taxing state the same level of tax that is imposed by the state of the foreign insurer's domicile on insurers domiciled in the taxing state.

3. Overseas Firms Doing Business in the Jurisdiction

3.1 Overseas-Based Insurers or Reinsurers

Insurers

As discussed in **2. Regulation of Insurance and Reinsurance**, any person who "transacts" insurance within a state is required to obtain a licence from that state – irrespective of whether that person is doing business from within or without that state (including outside the USA). States broadly define "transacting insurance". Typically, any of the following acts in the state – whether done in person or effected by mail or telephone from outside the state or otherwise – constitute transacting insurance business:

- making, or proposing to make, any insurance contract;
- issuance or delivery of a policy or contract of insurance;
- solicitation of applications for any such policies or contracts;
- collecting any premium or other consideration for any policy or contract of insurance; and
- doing anything else that is substantially equivalent to any of the above-mentioned in a manner designed to evade the provisions of the state's insurance law.

The limited exceptions to the general prohibition against doing unauthorised insurance business include:

- lawful placements made under a state's excess or surplus lines law;
- reinsurance;
- self-insurance; and
- marine, aviation and transportation/railroad exemptions.

In addition, certain large, sophisticated commercial buyers can access unauthorised insurers directly under limited circumstances.

Reinsurers

Unauthorised reinsurers must provide qualifying collateral to ceding insurers in order for ceding insurers to receive financial statement credit for the ceded reinsurance. These collateral requirements serve as a substitute for financial regulation of unauthorised reinsurers under the current rules. Under the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, collateral requirements are determined exclusively by the ceding insurer's state of domicile.

Unauthorised reinsurers must generally provide qualifying collateral in an amount equal to 100% of the reinsurer's gross liabilities to the ceding insurer for the ceding insurer to receive financial statement credit for the reinsurance. Exceptions exist for reinsurers that establish a trust in the USA for the benefit and protection of their US cedents (a "multi-beneficiary trust") or reinsurers that have been designated "certified reinsurers" or "reciprocal reinsurers" under newly enacted legislation and rules.

Reinsurers can be "certified" by a state if they meet certain criteria concerning financial strength and reliability as indicated by their credit ratings

and are domiciled in countries that are found to have strong systems of domestic insurance regulation. The amount of collateral a certified reinsurer is required to provide is reduced and is tied to the reinsurer's financial strength ratings.

Reciprocal reinsurers are reinsurers with USD250 million in capital and surplus that meet certain other requirements and are domiciled in jurisdictions that have been designated by the cedent's domicile state as a reciprocal jurisdiction. Jurisdictions that have entered into covered agreements with the USA are automatically designated reciprocal jurisdictions. This includes EU member states and the UK. Other jurisdictions (eg, Bermuda, Japan, and Switzerland) may be designated as reciprocal jurisdictions by the state insurance commissioners.

3.2 Fronting

"Fronting" is a term that usually refers to an arrangement whereby an insurance company issues policies that are reinsured in their entirety (or nearly in their entirety) by a reinsurer. In many cases, the reinsurer or one of its affiliates is responsible for managing the business written by the insurance company. Fronting is typically used where the reinsurer lacks necessary licence(s) or rate and form approvals to write the insurance directly or lacks necessary credit quality acceptable to customers.

Some state insurance departments have taken the position that the licensed (or fronting) insurance company may be "aiding and abetting" the unlawful transaction of insurance by the unlicensed reinsurance company if the licensed company retains no part of the risk and does not conduct its own underwriting, thereby subjecting both the insurer and reinsurer to adverse action. To address issues of aiding and abetting, fronting arrangements are often designed so that the "fronting" insurance company retains at least some portion of the risk and other interests in the arrangement.

4. Transaction Activity

4.1 M&A Activities Relating to Insurance Companies

M&A activity relating to insurance companies can take a variety of forms. The acquisition can involve the purchase of an ownership interest in the insurance company through the acquisition of stock or, in the case of a mutual company, a sponsored demutualisation. Alternatively, it can involve the acquisition of a portion of the business of the insurer through reinsurance or other risk transfer mechanisms, a purchase of a portion of the insurer's assets, or a purchase of renewal rights with regard to policies issued by the insurer.

Regulatory requirements applicable to M&A activity vary depending on the form of the transaction. If the acquisition involves a change of "control", it is subject to the prior approval of the insurance department in the to-be acquired insurer's domicile state. Control is generally defined by the states as the power to direct the management and policies of an insurer, and is presumed to exist if any person acquires voting securities representing 10% or more of the voting power of an insurer or its parent company (although a few states set the threshold at 5%). Acquisitions not involving a change of control do not typically require state approval; however, reinsurance transactions outside the ordinary course of business may be subject to requirements for prior notice and approval, depending on the type and size of the transaction.

After a period of sluggishness during the first part of the COVID-19 pandemic, M&A activity in the US picked up during the third quarter of 2020 and remained very active through 2021.

In early 2022, however, the pace of deal activity began to slow somewhat amid macroeconomic concerns. The concerns may continue to restrain activity in the near term, as higher interest rates have increased financing costs for buyers and raised target valuations in the life and annuity sector, while inflation has hurt the attractiveness of some property and casualty targets by increasing claim costs.

On the other hand, other factors could result in an uptick in activity in at least certain sectors of the market, including:

- the increased involvement of private equity firms in the insurance deal market, especially in the life and annuity business;
- a push for increased capital efficiency, propelling reinsurance deals; and
- a desire by companies to enhance their technological capabilities, including through the acquisition of "insurtech" companies.

5. Distribution

5.1 Distribution of Insurance and Reinsurance Products

Parties involved in the sale, marketing, negotiation or distribution of insurance products within the USA are primarily regulated by the various states, not the federal government. Insurance brokers and agents that serve as intermediaries between the customer and the insurer (collectively, "producers") must be licensed to sell insurance and must comply with various state laws and regulations governing their activities. An insurance producer must be licensed in any state in which the producer sells, solicits or negotiates insurance.

The type of licence (ie, agent, broker or producer) granted varies by state. A small number of states classify producers as either agents or brokers and require producers to be specifically licensed as agents or brokers. Other states recognise the distinct roles of agents and brokers but issue only producer licences.

Insurance Agents

States generally define an insurance agent as any individual or firm that sells, solicits or negotiates contracts of insurance on behalf of an insurance company. An insurance agent may not act as an agent of an insurer unless they have been licensed by the state insurance department and duly appointed by the insurance company the agent represents. An "appointment" by an insurer confers authority to a licensed agent to sell insurance on behalf of the insurer. An insurance agent may act as:

- an "independent agent" in selling insurance on behalf of several insurers; or
- a "captive agent" in selling insurance on behalf of only one insurer (or an affiliated group of insurers).

Insurance Brokers

States generally define an insurance broker as any individual or firm that sells, solicits or negotiates contracts of insurance and who aids in any manner in soliciting, negotiating or selling any insurance contract on behalf of an insurance buyer or the insured. An insurance broker is not appointed by an insurance company or other person or entity and acts as an independent insurance salesperson who works with many insurance companies to find the policies appro-

priate for their clients (ie, the insurance purchasers).

Corporate Entities

Every state permits a corporation to obtain a producer licence. In addition, most states also permit limited liability companies and limited liability partnerships to obtain a producer licence. A business entity licensee is typically permitted to engage in the insurance business only in the lines of business for which its individual licensees are authorised.

Lines of Business

A producer, agent or broker may receive qualification for an insurance licence in one or more classes of insurance, including (but not limited to):

- life insurance coverage on human lives;
- variable contracts;
- accident and health or sickness coverage;
- property insurance coverage for loss or damage to property;
- casualty insurance coverage against legal liability;
- personal lines property and casualty insurance coverage sold to individuals and families for non-commercial purposes;
- title insurance; or
- any other line of insurance permitted under state laws or regulations.

Surplus Line Brokers and Reinsurance Intermediaries

An excess and surplus lines broker is a specialty broker who is empowered to place insurance with surplus lines eligible insurers under the state's surplus lines law but who must first obtain a surplus lines broker licence. Reinsurance intermediaries are the agents and brokers of the reinsurance market and are also subject to licensing.

Other Regulated Activities

Other providers of insurance- or reinsurance-related activities that may require a licence are:

- managing general agents (organisations that handle most or all of the functions of an insurance company but do not retain risk);
- insurance consultants (insurance professionals who specialise in assisting businesses and individuals in assessing their insurance needs and creating an insurance plan to meet those needs);
- claims adjusters (insurance professionals who specialise in investigating and negotiating insurance claims – a "public adjuster" represents the insured and an "independent adjuster" represents the insurer); and
- third-party administrators (organisations that handle the claims processing and employee benefits plans for the insurer).

Federal Registration

Producers who sell variable life insurance and annuities must be registered with the Financial Industry Regulatory Authority (FINRA), in addition to holding state insurance agent/broker licences. The agency or entity that supervises those agents must be registered with the SEC.

6. Making an Insurance Contract

6.1 Obligations of the Insured and Insurer

An insured's obligation(s) to disclose information about the risk as part of the application process is governed by state laws and regulations and the terms/provisions in the application and insurance contract. Generally, an applicant/insured

has an affirmative obligation to truthfully disclose all material information requested by the insurer during the application process. In the application, the applicant/insured will typically attest that their statements and information provided about the risk are true, accurate, and complete and that the insurer can rely on the information to determine if an insurance contract may be issued. As a rule, an insurer does not have an affirmative obligation to investigate an applicant/insured at the time of the application and is entitled to believe what an applicant/insured claims to be true in the application. This applies equally to consumer and commercial insurance contracts.

The insurer will evaluate the information provided in the application in order to:

- assess whether or not the applicant/insured poses a significant risk under the insurer's underwriting rules and guidelines; and/or
- determine whether the insurer may issue the insurance contract at a different schedule premium rate to account for the disclosed potential risks and/or hazards to be assumed by the insurer in the issuance of the insurance contract.

The insurer has legal remedies available if it discovers that the applicant/insured made any false or fraudulent statements, material misrepresentations, or omissions in the application. The insurer can file a civil action against the applicant/insured in order to:

- rescind the insurance contract;
- return any premiums collected; and
- request that the court issue a declaratory judgment finding that the insurance contract is null and void.

The insurer would argue that it would not have issued the insurance contract or would have offered different coverage to account for the undisclosed risk(s)/hazard(s). The applicant/insured could be subject to civil and/or criminal prosecution if it is determined that the applicant/insured engaged in insurance fraud.

6.2 Failure to Comply With Obligations of an Insurance Contract

If the insured/applicant fails to disclose information requested by the insurer during the application process for purposes of evaluating whether the risk is acceptable under the insurer's underwriting rules and guidelines, the insurer has the right to deny the application and not issue the insurance contract to the insured.

The insurer has legal remedies available if it discovers that the applicant/insured made any false or fraudulent statements, material misrepresentations, or omissions in the application (see **6.1 Obligations of the Insured and Insurer**).

6.3 Intermediary Involvement in an Insurance Contract

The role of an agent or broker can become blurred, particularly in the case of independent agents, and is usually determined by commercial considerations. Whereas it is understood that brokers place insurance on behalf of their customers, both brokers and agents often play an active direct role in the negotiation of insurance contracts on behalf of the applicant/insured – even though they may be appointed as agents of the insurer.

The full extent of an agent's or broker's duties as a representative of the insurer or the insured are generally determined by state common law; however, states do have specific disclosure requirements relating to compensation. One

clear duty for both agents and brokers is to hold funds received as premiums in a fiduciary capacity, meaning they cannot be commingled with the agent's or broker's own funds or used for purposes other than remittance of the premium.

6.4 Legal Requirements and Distinguishing Features of an Insurance Contract

In general, in the USA, a contract of insurance is an agreement where one party (the insurer) agrees to confer a benefit of monetary value on another party (the insured) upon the happening of a specified event – which is beyond the control of either party – in return for receiving premium payments from the insured. In some states, the pooling and spreading of risk is also an essential component of insurance.

Insurable Interest

To procure insurance, the insured must have an insurable interest that would be adversely affected by the happening of the specified event. A person generally would only have an insurable interest, for instance, in any property that they own, that is in their possession, or that serves as security for repayment of a loan by them.

Policy Requirements

Typically, an insurance policy must be in writing and must identify:

- the insurer;
- the insured;
- any additional insureds;
- coverage terms and conditions (including the amount of insurance);
- the premium or rate charged for the insurance;
- the length of duration of the insurance;
- the specific subject insured (for example, the life of the insured person, property insured, liability exposures);
- requirements with regard to providing notice of a claim under the policy; and
- any exclusions that may apply to the coverage.

Rate and Form Approval

Under the current regulatory system in most states, insurance contracts covering risks in a state must meet state law requirements as regards content. Contract forms used by licensed insurers must be filed with the state insurance department for most lines of insurance and may be disapproved (some states require prior approval). Rates to be charged are subject to filing and disapproval or prior approval for some lines of insurance. Reinsurance contracts are generally not regulated when it comes to form and content.

Large-risk commercial lines can be non-regulated or deregulated, depending on the jurisdiction and the particular type of risk. Insurers for deregulated lines are not required to file policy or rate changes with the state, but they generally must adhere to substantive state laws as to coverage, terms and conditions. Insurance placed as excess and surplus lines is exempted from state rate and form-filing requirements. Reinsurance contracts are altogether exempted from state rate and form requirements.

Other Risk-Transfer Contracts

Certain derivative contracts, such as swaps, may confer the same economic benefits as insurance but are not considered to be insurance due to the absence of a contractual requirement that the holder have an insurable interest in the event(s) that triggers payment under the contract. They are not regulated as insurance as a result. The

purchase and sale of derivatives nonetheless may be regulated as such by the Commodities and Futures Trading Commission (CFTC).

6.5 Multiple Insured or Potential Beneficiaries

Generally, insureds or potential beneficiaries must possess an insurable interest under the insurance contract. In the context of property and casualty coverage, the insured(s) to an insurance contract, including mortgagees holding a security interest in the insured property, are identified in the insurance contract. Coverage does not automatically extend to other insureds or beneficiaries not specifically identified in the insurance contract.

In the context of life insurance or retirement/pension benefits coverage, the insured or policyholder and the primary and/or contingent beneficiaries (if any) are typically identified in the insurance contract. The insured(s) can name one or more beneficiaries who will receive the death or retirement benefits payable upon the death of the insured(s). The "primary beneficiary" is the first in line to receive the death or retirement benefits. If the primary beneficiary is not available – that is, if they cannot be found or they are deceased – the secondary or contingent beneficiary is next in line to receive the death or retirement benefits.

If the insured(s) fails to designate a beneficiary prior to their death, the terms/provisions in the insurance contract – governed by the Employees Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. (ERISA) – will determine the default order of payment of the disputed benefits, which may include payment of the benefits to the insured's spouse, children, parents, and/or the insured's estate. In the context of retirement/pension funds, if the insured(s) dies without a named beneficiary, the insured's assets will likely be held in probate.

6.6 Consumer Contracts or Reinsurance Contracts

The basic elements required for insurance contracts (including consumer and commercial contracts) and reinsurance contracts to be legally enforceable are substantially similar (see **6.1 Obligations of the Insured and Insurer**). However, unlike primary insurance contracts, which impose upon the parties a simple duty of good faith and fair dealing, reinsurance contracts require ceding insurers to disclose all material facts about the risks being reinsured. The failure to do so renders the contract voidable. This duty of utmost good faith requires the cedent to disclose material facts, even if the reinsurer fails to expressly ask about it. The duty is ongoing – that is, it continues throughout the life of the contract.

7. Alternative Risk Transfer (ART)

7.1 ART Transactions

US insurers are active users of insurance-linked securities (ILS) and industry loss warranty contracts as alternative risk transfer (ART) mechanisms. A majority of US ILS issuances involve the use of a special purpose Bermuda reinsurer that issues securities whose payout is linked to an indemnity reinsurance agreement entered into between the reinsurer and the US cedent. The securities placed with US investors are generally treated in the US as securities under federal and state securities laws. The reinsurance contract between the reinsurer and the cedent is generally treated in the US as a reinsurance contract under state insurance laws.

An industry loss warranty (ILW) can be written as either a derivative or an indemnity reinsurance

contract. In both cases, the payout under an ILW is triggered only if industry losses in respect of an agreed risk event exceed an agreed threshold. However, if written as a reinsurance contract, to qualify as reinsurance under statutory accounting principles, the US ceding insurer must also suffer losses in the amount of the payout. If an ILW is written as a derivative and purchased by a US entity, it is generally subject to regulation as a swap under the Commodity Exchange Act and CFTC rules. If written as a reinsurance contract and purchased by a US insurer or reinsurer, it is generally regulated as reinsurance under state insurance laws.

An "Insurance Safe Harbour" under the Commodity Exchange Act provides a basis for exclusion from regulation as swaps for certain products that are regulated as insurance.

7.2 Foreign ART Transactions

See **7.1 ART Transactions**.

8. Interpreting an Insurance Contract

8.1 Interpretation of Insurance Contracts and Use of Extraneous Evidence

Interpretation of insurance contracts is subject to the general rules of contract interpretation under applicable state laws. Courts interpret insurance contracts in favour of providing coverage to the insured and implement only the objectively reasonable expectations of the insured at the time of contracting. This applies equally to consumer and commercial insurance contracts.

Generally, if the language of a provision in the insurance contract is clear and unambiguous, the courts will give effect to the plain meaning of the provision. If a court determines that a provision in the insurance contract is ambiguous or uncertain, that issue will be resolved in favour of the insured and against the drafter, which in insurance is almost always the insurer.

A policy provision will be considered ambiguous when it is capable of two or more reasonable constructions. An undefined term in the policy does not make it ambiguous. A court may consider evidence of custom and usage in a particular trade or industry to understand the context in which the parties have used a specialised term or "term of art" in the policy. Depending on the state's laws, a court may consider extrinsic evidence (eg, evidence to support course of dealing or course of performance) to determine:

- whether or not a provision in the insurance contract is ambiguous; and/or
- the objectively reasonable expectations of the insured when they entered into the insurance contract.

Any exclusions and/or limitations regarding the extent of coverage provided in an insurance contract must be "conspicuous, plain, and clear" and clearly identified in the insurance contract because these terms may result in a denial of coverage to the insured when a loss occurs.

8.2 Warranties

A warranty in an insurance contract must be expressly included in the insurance contract.

A warranty must clearly show that the parties intended that the rights of the insured/insurer would depend on the truth of the statement or warranty contained in the insurance contract.

An insured's failure to comply with a warranty could void the insurance contract and discharge the insurer from all liability under the insurance

contract from the date of the breach. Some states protect insureds from cancellations due to misrepresented warranties and provide that no misrepresented warranty should void an insurance contract if the misrepresentation was not fraudulent and/or did not increase the risk covered in the insurance contract.

8.3 Conditions Precedent

A condition precedent in an insurance contract must be expressly included in the insurance contract. All insurance contracts impose certain duties on the insured. In order to perfect an insurance claim and/or obtain insurance benefits, an insured must comply with the various duties contained in the insurance contract or establish that they were excused from compliance.

Generally, as an initial matter, the insured's insurance claim must satisfy the terms of the coverage – that is, the claim must fall within the policy's coverage and not a specified exclusion. Insurance contracts impose on the insured additional conditions/requirements during the claims process, which include – but are not limited to – the following:

- a duty to notify the insurer of any casualty loss, third-party liability claim, or occurrence that could rise to a liability claim;
- a duty to co-operate with the insurer; and/or
- an obligation to obtain the insurer's consent for any settlement of claims and/or waiver of subrogation rights.

The terms/provisions in the insurance contract and applicable state law will determine if an insured's failure to comply with a condition precedent could discharge the insurer from its coverage obligations under the insurance contract. Most states (majority rule) require the insurer to prove that the insured's failure to satisfy the condition precedent prejudiced the insurer in its ability to investigate the loss, defend a liability claim, or develop a defence to coverage. Other states (minority view) do not require a showing of prejudice to discharge the insurer from its coverage obligations.

9. Insurance Disputes

9.1 Insurance Disputes Over Coverage

Insurance coverage disputes in the US encompass a wide array of insurance policies and coverage, which include – but are not limited to – large-scale professional liability, employment practices liability, directors' and officers' liability, comprehensive general liability, employment benefits, fidelity, excess, and reinsurance.

An insurer, insured, or beneficiary can address insurance coverage disputes by:

- filing a lawsuit in federal or state court; or
- submitting the dispute to arbitration or mediation by agreement of the parties.

This applies equally to consumer and commercial insurance contracts.

The limitation period in which a party must bring a lawsuit to challenge an insurance coverage dispute is subject to:

- the contractual limitation period in the insurance contract (if any); and/or
- the statutory limitation period in the jurisdiction where a party intends to file a lawsuit.

If a plaintiff fails to file a lawsuit in a timely manner within the contractual and/or statutory limi-

tation period(s), the plaintiff risks forfeiting their rights to assert that claim.

9.2 Insurance Disputes Over Jurisdiction and Choice of Law

Many insurance contracts contain a choice-of-law provision in which the parties agree to use a particular state's laws to govern the contract. However, these choice-of-law provisions are not always automatically enforceable. A court will not apply a state's laws in a choice-of-law provision if:

- the choice-of-law provision conflicts with a state's fundamental public policy; and/or
- another state/jurisdiction has a materially greater interest in the determination of the insurance dispute than the contractually chosen state.

Federal courts generally apply the forum state's conflicts-of-law rules to determine what law should govern. State rules and laws vary from state to state. In many states, courts will apply the doctrine of lex loci contractus, under which a court will apply the substantive law of the state where the contract is made and/or is to be performed. Some states find that the insurance contract is "made" in the state where the policy is issued or delivered, whereas in other states it is where the contract is executed and the premiums paid.

In other states, courts apply the "most significant relationship" doctrine, under which a court will apply the law of the state that has the most significant contacts with the matter in dispute. In making this determination, the court takes into account the following:

- the place of contracting;
- the place of negotiating;
- the place of performance;
- the location of the subject matter of the contract;
- place of incorporation; and/or
- place of business of the parties.

Likewise, many insurance contracts contain a forum-selection clause in which the parties agree to a specific jurisdiction and/or court where a dispute should be brought. Whether or not a specific forum-selection clause will be enforced is subject to state law. Generally, a court will abide by the doctrine of forum non conveniens to determine whether the selected forum is proper or whether the forum is unreasonable/unfair to a party or counter to public policy.

9.3 Litigation Process

The US judicial system comprises two different court systems in which a plaintiff could litigate an insurance coverage dispute: the federal court system and the state court system. Each system is different and subject to different rules and laws.

In the federal system, there are three levels of courts:

- the district courts, which are the federal trial courts;
- the interim appellate courts (also known as the circuit courts of appeal); and
- the US Supreme Court, which is the final appellate court.

Only two types of cases are heard in the federal system:

- cases dealing with issues of federal question; and
- cases between citizens of two different states or between a US citizen and a foreign entity,

provided that the amount in dispute meets a USD75,000 minimum threshold.

Typically, state court systems are made up of two sets of trial courts: trial courts of limited jurisdiction and trial courts of general jurisdiction. All states have one final appellate state court or Supreme Court.

To commence a lawsuit to challenge an insurance coverage dispute, a plaintiff must file a complaint and serve the defendant with a copy of the complaint and summons pursuant to the rules of procedure. Once served with process, the defendant will then need to file a response to the complaint, which may include filing a motion to dismiss if the defendant believes that the complaint fails to allege sufficient facts to support a viable claim or file an answer to the complaint.

Once the defendant answers the complaint, the parties will engage in discovery that typically can last months (if not years) and may include written discovery and fact and expert depositions. At the end of discovery, the parties may file a motion(s) for summary judgment requesting that the court enter judgment in their favour arguing that no issue remains in dispute for a jury. If the court denies the motion(s) for summary judgment, the parties will then proceed to trial.

9.4 The Enforcement of Judgments

In the US, recognition of a foreign judgment is governed by state or common law. Many – but not all – of the states have adopted a version of the Uniform Foreign Money-Judgment Recognition Act (the 1962 or 2005 Model Act), which codifies the process for a US court to recognise/enforce a foreign judgment. The party seeking recognition/enforcement will need to file an action in a state or federal court that has a basis to exercise jurisdiction over the defendant.

The Uniform Foreign Money-Judgment Recognition Act is typically used to enforce a foreign judgment for a fixed sum of money, excluding judgments based on the penal law of the foreign jurisdiction (eg, fines, penalties, or taxes).

Enforcing a foreign judgment in a US court could be delayed if the foreign judgment is appealed in the foreign tribunal. A final and enforceable judgment is the starting point for a party to file an action in a state or federal court requesting that the court recognise/enforce the foreign judgment. US courts will often stay the litigation if the foreign judgment is on appeal.

9.5 The Enforcement of Arbitration Clauses

The Federal Arbitration Act (FAA) mandates that all arbitration clauses be enforced by the courts, and pre-empts state legislatures from banning them.

However, uncertainty regarding the enforceability of insurance policy arbitration clauses exists owing to the conflict between the US Constitution's Supremacy Clause, which gives federal laws and international treaties pre-emptive authority over conflicting state law, and the McCarran-Ferguson Act, which gives state insurance laws "reverse pre-emptive" authority over federal statutes that interfere with state regulation of the insurance business.

As of December 2021, there are approximately 13 states that have banned mandatory arbitration clauses in insurance contracts and at least three states have restricted mandatory arbitration through regulation.

This issue is still being litigated in federal courts and has caused a federal circuit split. Recent federal court decisions, however, support a trend towards the enforceability of insurance policy arbitration clauses – even if state law explicitly prohibits these provisions in insurance contracts.

9.6 The Enforcement of Awards

Pursuant to the Federal Arbitration Act (FAA), a party must initiate proceedings to confirm an arbitration award. This requires the party to file a petition/motion to confirm the award in a federal or state court. A party to an arbitration may apply for an order confirming the arbitration award within one year of the arbitrator making the award.

The party seeking confirmation of an arbitration award must file with the petition:

- the arbitration agreement;
- a copy of the arbitration award; and
- any documents a party submitted in connection with any application to modify/correct the award.

The process to confirm an arbitration award is a summary proceeding; therefore, the court does not need to hear argument, gather evidence, or hold a hearing with witnesses. If no party opposes the motion and the court finds no basis to vacate/modify the arbitration award, the court will confirm the arbitration award and enter a judgment.

9.7 Alternative Dispute Resolution

Alternative dispute resolution can play a major role in resolving insurance coverage disputes – for example, the parties may agree in the insurance contract to submit the dispute to binding arbitration, including agreed-upon choice-of-law and/or jurisdiction.

If a party files a lawsuit in a federal or state court, the parties can participate in a court-ordered or private mediation session to attempt to resolve the claim before an impartial mediator or a retired judge/lawyer. The parties often decide to engage in mediation sessions to avoid incurring the excessive costs/fees involved in prosecuting or defending an insurance coverage dispute, which in some cases can span months or take years to get to trial – only for the parties to then risk having an adverse judgment entered against them.

9.8 Penalties for Late Payment of Claims

Insurers have an obligation to act in good faith in the oversight and administration of the claims process. Typically, this obligation is governed by the states' insurance codes and regulations that require all licensed insurers to promptly review and investigate claims and issue final determination(s) as to whether a claim/coverage should be approved or denied. Insurers have a duty to promptly investigate all claims and keep the claimant(s) apprised of any delays in the claims process, including requests by the insurer for additional time to make a determination on a claim.

A plaintiff has numerous options available to challenge or address an insurer's delays and/or acts of bad faith. A plaintiff can:

- file a complaint against the insurer with the state insurance department and request that the state commence an investigation; and/or
- file a lawsuit against the insurer in a federal or state court.

Some states require that a plaintiff "exhaust its administrative remedies" and first file a complaint against the insurer with the state insurance department and have a decision issued by the state insurance department before filing a lawsuit in federal or state court. Depending on the jurisdiction, an insurer may be subject to damages in excess of policy limits for bad faith.

9.9 Insurers' Rights of Subrogation

Under the doctrine of subrogation, an insurer that has paid its insured for a loss under an insurance contract can recoup the payment(s) from the responsible party/wrongdoer for the loss. In exercising its right of subrogation, an insurer "stands in the shoes" of its insured to enforce the insured's rights against the responsible party/wrongdoer.

An insurer's right of subrogation can be based upon:

- equitable subrogation under state law; or
- agreed-upon terms and provisions in the insurance contract.

An insured can waive the subrogation clause in an insurance contract explicitly prohibiting the insurer from seeking to recoup payment(s) form the responsible party/wrongdoer; this may subject the insured to higher premium rates. Typically, an insurer does not have a right of subrogation against its insured because the insurer can simply deny coverage for a loss caused by the insured's intentional acts. However, if an insurer pays a claim to a third-party for a loss caused by its insured's intentional acts, the insurer may then seek recovery from the insured under the doctrine of subrogation.

Further, the doctrine of subrogation ensures that an insured who suffered a loss cannot claim recovery of benefits/damages twice via a claim payment issued by the insurer and the filing of a lawsuit against the responsible party/wrongdoer to recover damages.

10. Insurtech

10.1 Insurtech Developments

The FIO defines insurtech simply as "the innovative use of technology in connection with insurance". In that context, the term may be used to describe new market entrants and new products or technologies employed by others in the industry.

Insurtech Start-Ups

Insurtech start-ups can generally be classified as one of following types of entities:

- technology service providers, which provide innovative services to insurers or other insurance regulated entities (often pertaining to product design, marketing, underwriting or claims management);
- licensed insurance producers (see **5.1 Distribution of Insurance and Reinsurance Products**) that distribute innovative products to consumers, but partner with licensed insurance companies to handle most other functions;
- managing general agents (see **5.1 Distribution of Insurance and Reinsurance Products**) that handle most or all of the functions of an insurance company, apart from assuming the risk and liability for claims; and
- "full stack" – that is, fully licensed insurance companies that underwrite their own policies, assume the risk, and typically also manage the claims process.

Insurtech Products and Services

Insurtech companies are being employed by insurers and other regulated insurance entities across the insurance value chain. Some of the more prominent cases of insurtech use include the following.

Embedded insurance

Insurance is offered or included as an add-on with another non-insurance product – for example, offering insurance in conjunction with the purchase of a phone or vehicle.

Accelerated underwriting

Predictive models or machine learning algorithms are used to analyse data pertaining to life insurance applicants. Such data includes both traditional and non-traditional underwriting data provided by the applicant directly, as well as data obtained through external sources (see **10.2 Regulatory Response**).

Sensors and telematics

In the context of auto insurance, "usage-based insurance" programmes collect telematics data about an insured's usage, driving habits and behaviours in real time – typically through the insured's phone or vehicle in order to effectively price risk.

In the context of property insurance, insurers are offering new loss prevention devices that indicate and mitigate risk in equipment and appliances, such as leak detectors that can shut off water to prevent flooding (see **10.2 Regulatory Response**).

10.2 Regulatory Response

Insurtech Start-Ups

State insurance regulators' receptiveness to insurtech start-ups varies from state to state. A small number of states have passed legislation to create regulatory "sandboxes" to permit insurers and other regulated entities to develop and test new products, or employ AI or machine learning processes, in exchange for additional regulatory oversight and guardrails. Certain state insurance departments work closely with insurtech accelerators and incubators to provide regulatory guidance and assistance to new market entrants. In addition, through the NAIC, state insurance regulators have established a directory of insurtech contacts at each state's insurance department who serve as a first point of contact for those with insurtech-related questions.

Accelerated Underwriting

In 2022, state insurance regulators finalised a non-binding "educational report" that addressed certain issues associated with accelerated underwriting and proposed recommendations and best practices on the use of external data and data analytics in life underwriting. Regulators' work regarding accelerated underwriting remains ongoing. Among the issues regulators are expected to address with regard to algorithmic underwriting are:

- whether the underlying traditional and non-traditional data provide a reliable basis for making underwriting decisions;
- how algorithms in accelerated underwriting can be tested for unfair bias and mitigation;
- whether the factors used in algorithmic underwriting serve as proxies for other prohibited factors that propagate historic inequities; and
- whether AI systems can be transparent and maintain consumer privacy.

Artificial Intelligence

The growth of AI across the industry has led to regulatory focus on the hidden risks in AI systems, with a focus on the fair and ethical use of

trustworthy AI. In 2019, state insurance regulators – through the NAIC – drafted a set of *Principles for the Use of Artificial Intelligence in the Insurance Industry* ("the Principles"). The non-binding Principles expect AI actors to:

- engage proactively in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and the avoidance of unfair discrimination against protected classes; and
- engage in a systematic risk management approach to each phase of AI to address risks of AI, including privacy, digital security and unfair discrimination as defined by applicable laws and regulations.

In 2022, the NAIC established a dedicated workstream to consider how to implement the expectations raised in the Principles.

Sensors and Telematics

In 2021, state insurance regulators – through the NAIC – initiated the process of modernising the anti-rebating laws in force in nearly all states in order to permit insurers to provide certain "value-added" products and services, as long as they are related to the insurance coverage and satisfy one or more specified conditions, such as mitigating loss, reducing claim costs, enhancing health, or assisting the administration of employee benefits. The amendments could permit, for example, property insurers to provide policyholders with flood detection devices, and life insurers to provide health sensors (including smart watches) to policyholders. Although a minority of states have adopted the amendments, they remain pending in most states.

11. Emerging Risks and New Products

11.1 Emerging Risks Affecting the Insurance Market

Data Use

Insurers and third-party providers collect and store massive amounts of consumer data and are likely to have access to and, in some instances, acquire an even greater amount of data as innovation continues. New analytics technology (including those leveraging AI) – in conjunction with access to new, more granular data (see **10. Insurtech**) – present opportunities for greater efficiencies and more precise underwriting techniques. However, additional data points and technologies have prompted a number of questions from state insurance regulators, including:

- how to strike the proper balance of an improved customer experience with policyholder protection;
- whether insurance departments have the necessary resources to evaluate complex models; and
- the ability of regulators and insurers to supervise models that evolve based on their own operations.

Additional Emerging Risks

Data security

Owing to the amount of data they retain, insurance stakeholders – including insurers, regulators, and third-party vendors – continue to be potential targets for cyber-incidents.

Climate/natural catastrophe risk

Owing to its exposure to property risks and investment volatility, the insurance industry faces significant impacts from the escalating effects of climate change. US property and casualty insurers, for example, face increasing

physical risks from extreme weather, including hurricanes, droughts and wildfires, as well as long-term changes in climatic patterns.

11.2 New Products or Alternative Solutions

Data Use

State insurance regulators have recently undertaken a number of initiatives concerning insurers' use of public and private data, including:

- the addition of a new NAIC committee dedicated to AI, innovation, and cybersecurity as part of insurance regulators' strategic focus on studying developments related to innovation and emerging technology in insurance and cybersecurity;
- the adoption of an educational report concerning accelerated underwriting and the use of external data and data analytics in life underwriting (see **10.2 Regulatory Response**); and
- the adoption of guiding principles on AI in insurance emphasising the importance of accountability, compliance and transparency, as well as safe, secure and robust outputs (see **10.2 Regulatory Response**).

In addition, in 2021, Colorado enacted a new law that is intended to ensure that Colorado insurers use external data sources in a responsible manner and protect consumers from unfair discrimination. Among other things, the new law requires insurers to stress test "big data" systems and take corrective action to address consumer harms. The law applies to:

- personal and certain commercial policies with annual premiums of less than USD10,000; and
- a number of insurer business functions, including marketing, underwriting, pricing, utilisation management, premium reimbursement, and claims management.

The law also requires the Colorado Division of Insurance to issue regulations on how insurers will be required to demonstrate compliance with the new law. Stakeholder meetings between the Colorado Division of Insurance and interested parties (which are required to be held prior to adopting rules under the law) remain ongoing. It is unclear at this time when the new law will ultimately go into effect.

Data Security

In 2017, state insurance regulators – through the NAIC – adopted the Insurance Data Security Model Law, which addresses:

- insurer implementation of information security programmes;
- the investigation of cybersecurity events (including risk assessment and risk management);
- oversight of third-party service providers; and
- notification to state insurance regulators about cybersecurity events.

To date, just under half of the states have enacted the Insurance Data Security Model Law.

Climate/Natural Catastrophe Risk

State regulators, investors, and consumer advocates are increasingly focused on climate risk disclosures, as the following examples demonstrate.

- In May 2021, President Biden issued an Executive Order on Climate-Related Financial Risk that, among other items, directs the FIO to assess climate-related issues or gaps in the supervision and regulation of insurers. These include the potential for major disruptions

of private insurance coverage in regions of the country particularly vulnerable to climate change-related events. In August 2021, the FIO issued a Request for Information to solicit public comments on FIO's future work relating to the insurance sector and climate-related financial risks. Finally, in October 2022, the FIO issued a request for public comment regarding a proposed collection of data from property and casualty insurers to assess climate-related financial risk across the USA. The New York State Department of Financial Services (DFS) recently issued final guidance for New York domestic insurers on managing financial risks from climate change. The DFS also announced the creation of a new Climate Risk Division tasked with integrating climate risks into its supervision of regulated entities and supporting the industry's growth in managing climate risks.

- Fourteen states and the District of Columbia now mandate insurer environmental reporting using either an NAIC-developed survey or the Task Force on Climate-Related Financial Disclosures (TCFD) survey. The majority of these states implemented the requirement in 2021.

12. Recent and Forthcoming Legal Developments

12.1 Developments Impacting on Insurers or Insurance Products

Federal Surety Bonds

Insurers seeking to underwrite or reinsure US federal surety bond obligations are required to obtain a certificate of authority from the Treasury and comply with federal regulations governing the corporate federal surety bond programme. The Treasury's guidance for such insurers, known as "T-Listed" insurers, covers a wide range of issues, including:

- application requirements;
- annual reporting requirements;
- liabilities;
- rules governing the valuation of assets; and
- rules governing credit for reinsurance.

One of the most notable requirements provides that no T-Listed insurer may underwrite any risk on any bond or policy that is greater than 10% of the insurer's paid-up capital and surplus. Another requirement provides that T-Listed insurers are only allowed credit for reinsurance ceded to another T-Listed insurer (for federal bonds) or reinsurers that are otherwise authorised by Treasury (for all risk other than federal bonds).

In March 2022, the Bureau of the Fiscal Service published a Notice of Proposed Rulemaking ("Proposed Rule") that would permit T-Listed insurers to take credit for reinsurance on certain transactions for which credit for reinsurance may already be taken under state insurance laws. Specifically, the Proposed Rule that would permit T-Listed insurers to obtain credit for reinsurance on business ceded to reinsurers in either of two new categories of approved reinsurers without the need for such reinsurer to post collateral. Comments on the Proposed Rule were due in May 2022. The Treasury has yet to finalise the Proposed Rule as of the date of this publication (January 2023).

13. Other Developments in Insurance Law

13.1 Additional Market Developments

Group Capital Calculation

In 2020, the NAIC adopted amendments that (when adopted by states) will require the ultimate controlling person of an insurance holding company system to file an annual Group

Capital Calculation (GCC) with the group's lead state, unless the ultimate controlling person or its insurance holding company system is exempt from the filing requirement. The GCC is designed to assist state insurance regulators in understanding:

- the financial condition of non-insurance entities that are part of an insurance holding company system; and
- the degree to which insurance companies are supporting those non-insurance entities by aggregating the existing regulatory capital calculations for all entities within a holding company group, including US and non-US insurers and non-regulated entities.

The 2020 GCC amendments are expected to become an NAIC accreditation standard (which is, in effect, a requirement) for all states on 1 January 2026.

Reinsurance Collateral

In June 2019, the NAIC approved changes to US reinsurance collateral requirements that (when adopted by the states) will eliminate collateral requirements imposed by US regulators on certain non-US reinsurers domiciled in the EU, the UK, and NAIC reciprocal jurisdictions such as Bermuda, Japan and Switzerland. States had until September 2022 to adopt these changes to avoid pre-emption by the federal government. At time of writing, all states have adopted the legislative and regulatory changes necessary to avoid federal pre-emption; however, a small number of states may still need to make "technical" changes to avert pre-emption altogether.

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Trends and Developments

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Changes in US Insurance and Reinsurance

The following trends and developments have emerged in the US insurance and reinsurance market during the past year or two.

Diversity, equity and inclusion

Insurers are increasingly focused on insurer diversity, equity and inclusion (DEI) efforts across the industry. Since 2021, many US insurers reaffirmed their commitment to increase the representation of under-represented groups in entry-level positions, senior management, and in the workforce more generally.

Financial regulators are also concentrating more on insurer DEI efforts, including the diversification of insurer boards and management, and disclosure of the diversity composition of the same. California became the first state in the USA to enact legislation instituting gender and other under-represented community quotas for public companies headquartered in its state. A number of other US states are considering similar legislation.

State legislators and insurance regulators share this focus – for example, the California Department of Insurance recently sent a letter to certain insurance company CEOs to encourage board diversification. In March 2021, the New York State Department of Financial Services issued a circular letter to all New York-regulated companies, indicating that:

- it "expects" them to treat diversity as they would other strategic priorities; and
- it would collect gender, racial and ethnic data from certain large insurers.

The National Association of Insurance Commissioners (NAIC) – which published an internal DEI plan in February 2021 – is also actively addressing DEI efforts across the industry and within state insurance departments. In July 2021, the NAIC formally adopted directives for each of the four workstreams of its Special (EX) Committee on Race and Insurance, which include – among others – a workstream to assess DEI efforts within state insurance departments and a workstream to address industry DEI efforts. These workstreams remain ongoing.

Cannabis

Cannabis is legalised to varying degrees in states throughout the USA. However, cannabis production, distribution, and possession of any kind remains illegal under federal law, thereby creating a conflicting and fractured legal landscape.

On 6 October 2022, President Biden issued a directive asking the Secretary of Health and Human Services and the Attorney General to "expeditiously" review "how marijuana is scheduled under federal law". Re-scheduling cannabis to a lower schedule would not legalise cannabis per se, but would loosen federal restrictions on the drug. The outcome has yet to be decided, and the directive does not impose a specific deadline for the agencies to complete their review.

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In an attempt to address the fractured federal–state landscape, lawmakers have proposed various bills in recent years that would provide a safe harbour for banks and insurers seeking to provide services to marijuana-related businesses.

In March 2021, the Secure and Fair Enforcement (SAFE) Banking Act and the companion Clarifying Law Around Insurance of Marijuana (CLAIM) Act were reintroduced in the House and Senate. The SAFE Act provides certain safe harbours to banks and other financial institutions in servicing cannabis-related businesses. The CLAIM Act legislation operates similarly for insurers serving cannabis-related businesses.

The CLAIM Act has languished in committee since its reintroduction, but the SAFE Banking Act passed in the House for the seventh time in July 2022 – this time as a rider to the 2023 National Defense Authorization Act. In view of the current political landscape and the rapidly approaching end of the current congressional term, the legislation's potential to become law remains uncertain.

Artificial intelligence

The growth of AI across the industry has led to regulatory focus on the hidden risks in AI systems, with a focus on the fair and ethical use of trustworthy AI.

In 2019, the NAIC formed the Artificial Intelligence Working Group, which drafted a set of *Principles for the Use of Artificial Intelligence in the Insurance Industry* ("the Principles"). The Principles is a high-level guidance document that does not carry the weight of law but is intended to be used by regulators and NAIC committees as they address the application of AI to the insurance industry. The Principles expresses general expectations for all those involved in AI and emphasises the importance of accountability, transparency and compliance, along with safe, secure, fair and robust outputs. The Principles expects AI actors to:

- engage proactively in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and the avoidance of proxy discrimination against protected classes; and
- engage in a systematic risk management approach to each phase of AI in order to address risks of AI, including privacy, digital security, and unfair discrimination as defined by applicable laws and regulations.

In December 2021, the NAIC established a new committee dedicated to AI, innovation, and cybersecurity as part of insurance regulators' strategic focus on studying developments related to innovation and emerging technology in insurance and cybersecurity. The mission of the Innovation, Cybersecurity, and Technology (H) Committee ("the Committee") is to:

- provide a forum for state insurance regulators to learn and have discussions regarding cybersecurity, innovation, data security and privacy protections, and emerging technology issues;
- monitor developments in these areas that affect the state insurance regulatory framework;
- maintain an understanding of evolving practices and use of innovation technologies by insurers and producers in respective lines of business;
- co-ordinate NAIC efforts regarding innovation, cybersecurity and privacy, and technology across other committees; and

- make recommendations and develop regulatory, statutory or guidance updates, as appropriate.

In 2022, the Committee established a number of "workstreams" to, among other things:

- evaluate the necessity of an AI model law;
- consider whether state insurance regulators have proper tools and resources to properly monitor AI systems and processes; and
- develop a rubric for analysing third-party data and modelling providers in order to determine the appropriate regulatory oversight of information they provide to insurers.

Accelerated underwriting

During the past decade, algorithms, processing power and big data – the building blocks for algorithmic underwriting and biometrics – have become increasingly accessible and affordable to insurers and insurtech vendors.

Continuing innovation by public cloud providers means that some of the world's most powerful computer systems are available to insurers by paying only for usage time without having to build out extensive hardware infrastructures. Sophisticated computer algorithmic models, including those using AI, are being developed and fed by massive amounts of data at an ever-increasing rate.

US insurers use a combination of information provided by applicants and external data sources, such as prescription-drug databases, to gain as much information as they can about the mortality risks associated with an individual as a replacement for the traditional sources of personal information provided by lengthy analysis of invasive blood and urine tests. By back-testing the outcomes of algorithmic modelling against previously underwritten policies, insurers are able to test and fine-tune the accuracy and reliability of their rating and pricing models.

Algorithmic underwriting is subject to the same type of state and federal oversight as traditional methods of underwriting. Some states place restrictions on what individual characteristics may be used in underwriting and prohibit the use of factors such as race, gender or religion in classifying risks.

Insurers must get permission from consumers to access their personal information from consumer reporting agencies and they must give a privacy notice to applicants that complies with Gramm-Leach-Bliley Act. The Fair Credit Reporting Act and some state insurance laws prohibit certain information sharing, and may require consumers to be notified that they can correct errors in the database if an adverse underwriting decision is made in whole or in part based on information in the consumer report.

In 2022, state insurance regulators finalised a non-binding "educational report" that addressed certain issues associated with accelerated underwriting and proposed recommendations and best practices on the use of external data and data analytics in life underwriting. Regulators' work regarding accelerated underwriting remains ongoing.

Among the issues regulators are expected to address with regard to algorithmic underwriting are:

- whether the underlying traditional and non-traditional data provide a reliable basis for making underwriting decisions;
- how algorithms in accelerated underwriting can be tested for unfair bias and mitigation;

- whether the factors used in algorithmic underwriting serve as proxies for other prohibited factors that propagate historic inequities; and
- whether AI systems can be transparent and maintain consumer privacy.

Cybersecurity and data privacy

The California Consumer Protection Act (CCPA), which went into effect in January 2020 and which the California Attorney General has begun to enforce as of July 2020, provides new privacy rights to California residents and employs an expansive definition of personal information. The CCPA requires companies that process information that can be tied to identifiable California residents to make new disclosures about their data collection, use and sharing practices, and it allows individuals to opt out of certain data sharing with third parties. Although certain financial data is exempt from the CCPA pursuant to federal law, certain insurer data (eg, marketing data) may fall under the CCPA.

Additionally, a California ballot initiative proposing significant amendments and additions to the CCPA, known as the California Privacy Rights Act of 2020 (CPRA), has passed as part of the November 2020 ballot. The CPRA substantially amends the CCPA – bringing it more in line with Europe's GDPR and providing for additional consumer privacy rights and regulatory obligations for businesses – and creates a new privacy-focused California regulatory agency. New obligations imposed on businesses under the CPRA became operative on 1 January 2023.

Colorado, Connecticut, Utah and Virginia have adopted similar consumer privacy laws that also provide for a range of consumer rights for their residents. Additional comprehensive privacy laws are expected to be adopted by other states in the coming years.

Climate/natural catastrophe risk

US insurers and regulators continue to assess the impact of climate change and natural catastrophe risk on insurers. Fourteen states and the District of Columbia now mandate insurer environmental reporting using either an NAIC-developed survey or the Task Force on Climate-Related Financial Disclosures Survey (TCFD), with the majority of these states implementing the requirement in 2021.

In September 2020, the New York State Department of Financial Services (DFS) issued Insurance Circular Letter No 15 (2020) (the "Circular Letter") relating to the impact of climate change on insurers. Among other things, the Circular Letter states that the DFS "expects" all insurers licensed in New York to start integrating the consideration of the financial risks from climate change into their governance frameworks, risk management processes, and business strategies. The Circular Letter notes that "insurers should designate a board member or a committee of the board, as well as a senior management function, as accountable for the company's assessment and management of the financial risks from climate change".

The DFS also integrated questions pertaining to an insurer's approach and activities related to the financial risks from climate change into the DFS' examination process in 2021. More recently, the DFS announced the creation of a new Climate Risk Division tasked with integrating climate risks into its supervision of regulated entities and supporting the industry's growth in managing climate risks.

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In May 2021, President Biden issued an Executive Order on Climate-Related Financial Risk (the "Executive Order") that directs federal agencies to begin analysing and mitigating the risks that climate change presents to homeowners, consumers and business workers, as well as the US financial system and federal government as a whole. Among other things, the Executive Order directed the Federal Insurance Office (FIO) to:

- assess climate-related issues or gaps in the supervision and regulation of insurers, including as part of a financial stability analysis to be undertaken by the Financial Stability Oversight Council; and
- further assess, in consultation with the states, the potential for major disruptions of private insurance coverage in regions of the country particularly vulnerable to climate change-related events.

In August 2021, the FIO issued a Request for Information to solicit public comments on FIO's future work relating to the insurance sector and climate-related financial risks. Finally, in October 2022, the FIO issued a request for public comment regarding a proposed collection of data from property and casualty insurers to assess climate-related financial risk across the United States.

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