Hogan Lovells

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European Union - Recent Cases

GENDER NO LONGER PERMISSIBLE AS INSURANCE RISK FACTOR

The European Court of Justice has ruled that the use of gender as a pricing factor is contrary to the principle of equality for men and women. Insurers must apply unisex premiums and benefits from 21 December 2012 onwards. For a more detailed commentary of this case please click here.

European Union - Regulatory and Legislative Developments

INSURANCE MEDIATION DIRECTIVE

The European Commission consultation on the IMD ended on Deadline 28 February 2011. The European Commission is expected to present a revised text of IMD (**IMD2**) to the European Council and Parliament at the end of the year.

INSURANCE GUARANTEE SCHEMES

On 14 February 2011 the European Commission published the responses to the white paper on Insurance Guarantee Schemes. The FSA/HMT issued a joint UK response. The majority of respondents are in favour of measures at an EU level to harmonise national insurance guarantee schemes. The next step will be for legislative proposals to be published in December 2011.

EUROPEAN INSURANCE AND OCCUPATIONAL PENSION AUTHORITY - INSTALLATION

The new European supervising authority in the insurance sector, named the European Insurance and Occupational Pension Authority ("**EIOPA**") was implemented on 1 January 2011 as of when it replaced the former Committee of European Insurance and Occupational Pensions Supervisors ("**CEIOPS**"). Its principal tasks are to support the stability of the financial system, the transparency of markets and financial products as well as the protection of policyholders, pension scheme members and beneficiaries. It will also oversee implementation of the Solvency II directive.

SOLVENCY II DIRECTIVE - TRANSITIONAL MEASURES AND OMNIBUS II DIRECTIVE

The European Commission has published a proposal for the Omnibus II Directive which makes amendments to the Solvency II Directive and the Prospectus Directive to ensure that two of the newly established European Supervisory Agencies (**ESAs**), the European Insurance and Occupational Pensions Authority (**EIOPA**) and the European Securities and Markets Authority (**ESMA**) can work effectively.

The areas in which amendments are necessary fall broadly into the following categories:

- definition of the appropriate areas in which the two ESAs will be able to propose technical standards as an additional tool for supervisory convergence and with a view to developing a single rule book to ensure strengthened stability, equal treatment, lower compliance costs and to prevent regulatory arbitrage;
- detail of how the two ESAs will settle disagreements between national supervisors in a balanced way, in those areas where common decision-making processes or cooperation between national supervisors already exist in sectoral legislation; and
- general amendments which are necessary for the existing Directives in the financial services sector to operate in the context of new ESAs, for example, renaming the level 3 committees as the new authorities and ensuring the appropriate gateways for the exchange of information are present.

In relation to the Solvency II Directive, the proposed Directive contains a limited set of amendments. These amendments include the provision of more specific tasks for EIOPA such as ensuring harmonised technical approaches on the use of ratings in relation to the Solvency Capital Requirements, and extending the implementation date by two months to ensure better alignment with the end of the financial year for the majority of insurance and reinsurance undertakings. The amendments will also enable the European Commission to specify transitional measures in certain areas if deemed necessary to avoid market disruption and to allow a smooth transition to the new regime under Solvency II.

The proposed Directive will now be sent to the European Parliament and the Council of the European Union for consideration.

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UK - Recent Cases

UPDATE ON RECENT DECISIONS ON PPI

In light of the topicality of payment protection insurance issues in the UK at present, we have included below, a selection of recent judgments dealing with complaints by purchasers of PPI against the banks from which they purchased it.

NON-DISCLOSURE OF COMMISSION GIVES RISE TO UNFAIR RELATIONSHIP

The borrowers purchased PPI through an independent broker at a cost of £15,000, more than half of which comprised commission payable to the broker and lender. Neither the broker nor the lender disclosed the amount of commission to the borrowers. The judge stated that the PPI was very expensive and, given the cost, the customer was entitled to know in the interests of fairness that more than half of the premium constituted commission. The reason for this was that the amount of the commission was such that it would create an incentive for the broker to sell the product, which thus gave rise to a potential conflict of interest. The primary duty of disclosure was upon the broker, but that did not remove the necessity for the lender to ensure that the broker had discharged his duty, or to disclose the amount of the commission itself. The court held that the fact that there was no such disclosure gave rise to an unfair relationship.

Yates v Nemo Personal Finance
Manchester County Court
HMJ Platts
14 May 2010

NO REPRESENTATION THAT PPI MANDATORY - NO BREACH OF ICOB

The borrowers entered into a loan agreement with a bank, repayable over 62 months and agreed to take out a PPI Policy. There was a dispute as to whether the bank employee selling the loan had explained what PPI was and why it was needed. The borrower defaulted on the loan and the bank sought judgment on its claim for payment of the outstanding monies due on the loan, including PPI sums. The court gave judgment for the bank, finding that it had not required the borrowers to take out PPI as a condition of granting the loan. The bank employee went through the relevant documentation with the borrowers, including a questionnaire and no misrepresentation had arisen because the bank had never represented that PPI was mandatory. On that basis the loan agreement was enforceable and there had been no breach of ICOB. The borrowers had alleged an unfair relationship, but on the basis of the findings, the court held that the issue of whether there was an unfair relationship did not arise.

Black Horse v Speak
District Registry (Manchester)
HHJ Waksman QC
21 July 2010

IF GIVEN THE OPTION TO PURCHASE PPI, THE BORROWER WOULD HAVE DECLINED

The case concerned a fixed-sum personal loan agreement made with a bank to discharge a previous car loan. The old loan had no PPI cover but, when taking out the new loan, the borrower had purportedly signed up to a PPI plan with a premium of 20 percent of the value of the loan repayments. The borrower contended that the entire loan agreement was unenforceable on the basis that he had not been given the option of taking out the PPI. Judgment was given for the borrower. It was found on the evidence that the borrower had phoned an agent of the bank and the agent had sent out a draft agreement that contained the insurance as an addition for the borrower to sign at the local bank branch. It was found that there had been no discussion between the agent and the borrower about the PPI and that the borrower did not agree to sign up to any such PPI cover. Further, as the borrower already had a measure of sickness cover in place elsewhere it was decided that if he had been given the option, he would likely have declined to take out the PPI. It was found that the insurance was unilaterally inserted by the bank as a condition of the loan; the borrower had no choice in the matter and, as a result, the loan agreement was wholly unenforceable in law.

Wollerton v Black Horse
Leicester County Court
Recorder Dawson
26 March 2010

UK - Recent Cases

Continued…

LENDER UNDER NO OBLIGATION TO TELL BORROWERS TO BORROW MORE RATHER THAN USE CREDIT TO PAY FOR PPI

The borrowers entered into a fixed sum loan agreement with a bank and took out PPI cover with a third party insurer at a cost of £11,000, which they borrowed from the bank. The borrowers argued that the relationship was unfair because: the bank paid a commission out of the premium so that the sales person received a bonus; the PPI was expensive; and instead of advancing £11,000 to pay the premium, the bank should have offered to lend more money to them without selling the PPI. The court decided that the agreement was fair on the basis that:

- Commissions paid by the insurer to the lender were widespread and meant that it was not necessary to charge borrowers for the provision of the service. Further, the fact that the salesperson would receive a bonus did not make an agreement unfair. Indeed, such a bonus existed "*to incentivise her to carry out the procedures properly*".
- It was clear that the borrowers "*knew that they were being asked to pay and decided to do so*" and a consumer is "*fully able to decide whether something is sufficiently attractive to make it an item that he wished to buy*". The simple fact that the PPI was expensive did not make the relationship unfair.
- A lender is under no obligation to tell prospective borrowers that, instead of using credit to pay for the premium, they could borrow more.

Norman Vernalls & Ann Vernalls v Black Horse Limited
Unreported
HHJ Harris QC
4 November 2010

WHERE BENEFIT RECEIVABLE UNDER PPI COULD EXCEED PREMIUM - NO BREACH OF ICOB

By way of telephone sale between the borrowers and the bank, the borrowers took out a loan for £3,500 together with PPI. They also opted to take further credit of £1,573.79 to pay the premium for the PPI. The court was required to determine:

- whether the bank failed to make the borrowers aware of the fact that the PPI was optional (so that they considered the taking out of the PPI a condition of the loan) such that the PPI was unenforceable;
- whether the bank complied with ICOB; and
- whether there was an Unfair Relationship between the parties (per s.140A of the CCA).

The court found on the facts that discussions did take place concerning the PPI; there were a number of references to the PPI clearly marked on the loan agreement, including a tick box which was signed and ticked; and the borrowers had a general awareness of PPI as they had obtained loans with PPI previously. The PPI was enforceable and the first issue was decided against the borrowers. The judge decided that, whilst the level of premium was not insignificant, the benefit received under the PPI could easily exceed this amount and the claim for breach of ICOB failed as the suitability of the PPI had been considered by the bank. Given the findings on unenforceability and ICOB, the court did not go on to consider the question of unfair relationship.

David Woodward & Sarah Woodward v Black Horse Limited
Warrington County Court
District Judge Little
30 November 2010

DECISIONS ON UNFAIR RELATIONSHIPS OF NO ASSISTANCE TO OTHER CASES INVOLVING UNFAIR RELATIONSHIP ISSUES

(Decision was given on appeal from the District Court)

The borrowers took out a loan for £46,000 and a PPI policy costing £11,500. They later refinanced this package and borrowed £60,000, cancelling the original PPI policy and taking out a new one at a cost of £10,200. They then refinanced again, cancelling the PPI altogether. The total cost of the PPI to the borrowers was £10,529.70. The bank sold the PPI as agent for the actual insurer and earned commission of £8,887.49 which was 87 percent of the premium. It was common ground between the parties that the bank did not disclose the fact, or the amount, of this commission to the borrowers. The court determined that there was no unfair relationship between the parties. It commented on the wide discretion granted to the courts by s.140A of the CCA, saying that "*save where clear issues of principle are involved, a decision as to unfair relationship in one particular case based on one particular set of facts is unlikely to be of any real assistance in another*." The fact that the features of the PPI were clearly explained, known of, and freely accepted by the borrowers was a relevant factor to take into account when weighing up whether there was an unfair relationship.

Harrison v Black Horse
Mercantile Court, Queen's Bench Division
HHJ Waksman QC
1 December 2010

UK - Recent Cases

Continued…

OTHER INSURANCE AND REINSURANCE RELATED JUDGMENTS

AGENT LIABLE TO INSURER FOR OUTSTANDING PREMIUMS AND DISHONESTLY REPRESENTING LOSS RATIOS TO THE INSURER

Motorcare Warranties ("MW") acted as the insurer's agent in selling mechanical breakdown insurance. The insurer claimed against MW and a number of individuals involved in the company for outstanding premiums under the terms of four separate slips under which MW failed to abide by the strict terms of the slips in respect of business underwritten and rates for such business. MW maintained that an established practice over a course of years estopped the insurer from enforcing the terms of the slips. The judge found that since MW did not provide accurate information to the insurer, the insurer was not estopped from enforcing the terms of the slips and allowed the claims for outstanding premium to succeed including an amount of premium at a higher loading on account of excluded business which was underwritten. The insurer also claimed that MW fraudulently misrepresented loss ratios on the first three slips with the intent to conceal the true extent of the losses and thus induce the insurer to enter into a fourth slip without knowing the true loss ratio of the business. The judge found that misrepresentations had been made and that MW and two representatives of the company had acted dishonestly in making such representations.

Templeton Insurance Limited v Motorcare Warranties Limited and others
High Court, Queen's Bench Division (Commercial Court)
Simon J
3 December 2010

NO DISTINCTION BETWEEN DISEASE AND CAUSE OF DISEASE

The insured, fish farm owners, sought a declaration from insurers that cover was available for loss of farmed fish to sea lice. Insurers refused cover on the basis that the policy expressly excluded sea lice from cover for loss caused by predators and sea lice did not fall within the cover for disease, as sea lice caused disease but were not a disease themselves. The Court declared cover for the Insured, finding that an exclusion in one clause did not mean exclusion from the entire policy. Commercial common sense meant there was no distinction to be drawn between disease and its cause.

Green Island Organics Ltd v QBE Insurance (Europe) Ltd
Court of Session, Outer House
Lord Menzies
27 January 2011

CIVIL LIABILITY (CONTRIBUTION) ACT – "IN RESPECT OF THE SAME DAMAGE" MUST BE CONSTRUED NARROWLY

The court granted an insured's application for strike out and summary judgment in respect of contribution proceedings brought against the insured by its insurer relating to personal injuries caused by the insured. The court was asked to interpret the terms "*in respect of*" and "*same damage*" in Section 1(1) of the Civil Liability (Contribution) Act 1978 (the "Act"). Applying the interpretation of those terms from jurisprudence, the judge found that both terms had to be construed narrowly and that the cause of the parties' liability had to be the same for a contribution claim under the Act to succeed. The judge ruled that the insurer was not entitled to seek a contribution from the insured since the insured was not liable in respect of the same damage as was the insurer: the insured's liability was that of a wrongdoer having caused physical injuries, whereas, the insurer's liability arose from a liability under a contract of insurance.

Jubilee Motor Policies Syndicate 1231 v Volvo Truck & Bus (Southern) Ltd
High Court, Queen's Bench Division
John Bowers QC
20 December 2010

"CARRYING OUT" AND "EFFECTING" INSURANCE WITHOUT PART IV PERMISSION - WHAT AMOUNTS TO INSURANCE?

The FSA applied to wind-up two companies ("the companies") that had sold and carried out extended warranty cover for satellite television equipment ("the covers") without Part IV permission. There was no obligation under the covers to pay repair/replacement costs incurred by customers. The court held that a contract providing a repair/replacement service in relation only to breakdown or malfunction could amount to a contract of insurance. It was not necessary that there was no monetary payment. Contracts of insurance could include contracts for some benefit corresponding to the payment of money, including money's worth (which the provision of repair services clearly amounted to). As regards "financial loss" under Schedule 1 of the Regulated Activities Order, there was no distinction between contracts providing for repair only and those providing for an indemnity for replacement costs. It was the cover that was different, not the risk.

Digital Satellite Warranty Cover Ltd, Re
Companies Court, Chancery Division
Warren J
31 January 2011

UK - Recent Cases

Continued…

COINSURANCE, CONTRIBUTION AND WAIVER OF LIABILITY

A vessel underwent conversion work at a shipyard under a conversion contract between the vessel owners and the shipyard owners. The vessel was insured - the vessel owner and the shipyard owner were co-insureds. The vessel suffered fire damage at the shipyard. The insurance policy contained a condition precedent that a shipyard risk assessment be carried out by a specified firm of surveyors. The insurer settled the claim brought by the insureds and in exercising its subrogation rights the insurer commenced proceedings against the surveyors, alleging negligence in conducting the risk assessment. Surveyors argued that the fire was caused by the shipyard owner and claimed a contribution from it. The shipyard owner argued that under the conversion contract, the vessel owner had agreed to waive its liability and therefore it was not required to pay a contribution (whether it had been negligent or not).

The court accepted that the shipyard owner was intended to benefit from a waiver of liability under the conversion contract. It concluded that since the shipyard owner was not liable to the vessel owner for the loss, there could be no claim for contribution since the surveyor and the shipyard owner were not together "liable in respect of the same damage" under the Civil Liability (Contribution) Act 1978.

BMT Marine and Offshore Survey Ltd v Lloyd Werft Bremerhaven GmbH
Commercial Court, Queen's Bench Division
Simon J
24 January 2011

BROKER UNDER DUTY TO DRAW INSURED'S ATTENTION TO ENDORSEMENT

The insured suffered loss caused by a fire at its premises in Camden Market. The fire was caused by a portable heating appliance which had been identified in a pre-loss survey by the insurer as hazardous and the insurer had, by endorsement, required removal of the heaters. The broker failed to communicate the removal requirement to the insured. The court decided that the broker was negligent by their failure to draw the insured's attention to the endorsement and to explain that failure to meet the requirement to remove the heaters may prejudice cover.

Ground Gilbey Ltd v Jardine Lloyd Thomson UK Ltd
Queen's Bench Division, Commercial Court
Blair J
2 February 2011

MARINE INSURANCE - EXCLUSIONS IN RESPECT OF 'INHERENT VICE' IN THE INSURED SUBJECT MATTER

Insurers cover the carriage of an oil rig by sea. The policy excluded *'loss, damage or expense caused by inherent vice or nature of the subject matter insured*'. During the voyage three of the legs of the rig broke off resulting from metal fatigue caused by the motion of the waves. The impact of a 'leg breaking wave' caused the final fracture. The weather on the voyage was within the range that could reasonably have been contemplated. The Supreme Court found that the cause of the loss was an insured peril, in the form of stresses put upon the oil rig by the height and direction of the waves encountered, rather than the 'inherent vice' of the legs not being capable of withstanding the normal incidents of the insured voyage. If that were the case, the cover would only extend to loss caused by the perils of the sea that was exceptional or unforeseeable and that would frustrate the purpose of all risks cargo insurance.

Global Process Systems Inc and another v Syarikat Takaful Malaysia Berhad
Supreme Court
Clarke, LJ, Collins LJ, Dyson LJ, Mance LJ, Saville LJ
1 February 2011

WHEN IS AN EXCESS LAYER PROFESSIONAL INDEMNITY COVER TRIGGERED?

A captive underwrote a professional indemnity insurance on a 'claims made and reported' basis (the "first policy"). It also underwrote a cover in excess of the first policy ("the excess policy") which was then reinsured. Unlike the first policy, the excess policy and the reinsurance did not cover claims from the US. The excess policy also provided that liability would not arise unless the captive had either paid, admitted liability or been found liable to pay the full amount of indemnity under the underlying policy. Claims comprising both US and non US claims were made under the underlying policies against the captive. The court was asked as to the order in which those claims should be brought into account for the purposes of determining whether the first policy had been exhausted. The court reaffirmed the general approach that an insured must present its losses in the order in which the losses had been incurred and this was not affected by the wording in the excess policy.

Teal Assurance Co Limited v W R Berkley Insurance (Europe) Ltd
Commercial Court, Queen's Bench Division
Smith J
31 January 2011

UK - Recent Cases

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CAPTURE OF A VESSEL BY PIRATES NOT AN ACTUAL TOTAL LOSS - NO IRRETRIEVABLE DEPRIVATION AS A RESULT OF RANSOM PAYMENT

The insured cargo owner served a notice of abandonment on its insurers following capture by Somali pirates of a vessel carrying its cargo. Subsequently, the vessel's owner paid a ransom and the voyage was completed. The cargo had not deteriorated during its delay, but had missed its market. The court had to determine:

(i) whether the capture of the vessel by the pirates created an immediate actual total loss ("ATL"); or

(ii) whether the law could take account of the payment of a ransom as a relevant, legitimate reason for calculating the possibilities of recovery.

Applying the statutory test for an ATL of irretrievable deprivation (Section 57(1) of the Marine Insurance Act 1906), Rix LJ found the test had not been met since there was not only a chance, but a strong likelihood, that a ransom of a comparatively small sum relative to the value of the vessel and the cargo would secure recovery of both. Further, it was held that the fact that there may have been no duty to make a ransom payment could not turn a potential loss capable of being averted by the payment of a ransom into an ATL.

Masefield AG v Amlin Corporate Member Ltd
The Bungua Melati Dua
Court of Appeal, Civil Division
Rix LJ, Moore-Bick LJ and Patten LJ
26 January 2011

INSURER ENTITLED TO AVOID WHERE INSURED DISHONEST

The insured claimed an indemnity from their insurers for damage caused by fire to their bakery. Previously, the insured had entered into a financing arrangement with a third party and presented an invoice, which the insured knew to be false, to the financiers. Insurers avoided the policy on the grounds of material non-disclosure, stating they should have been told about the use of the false invoice in the financing transaction. Insurers were permitted to avoid for material non-disclosure and the false invoice was used as a fraudulent means to obtain an insurance indemnity, therefore all benefit under the policy was forfeited by the insured.

Sharon's Bakery (Europe) Limited v Axa Insurance UK plc and Aviva Insurance Limited
High Court, Queen's Bench Division (Commercial Court)
Blair J
9 February 2011

COLLECTIVE CONTROL SUFFICIENT FOR EXEMPTION

The Public Procurement Regulations 2006 (the "Regulations") provide that public authorities must follow the procedure laid down in the Regulations when entering certain supply and service contracts, including contracts of insurance. There is an exemption to compliance with the Regulations known as the Teckal exemption. The exemption is available where public authorities exercise control over the contracting entity and where no private capital or interests are involved. The Supreme Court has provided clarification on the requirement for control, stating that it need not be exercised by the public authorities individually - it is sufficient if, acting collectively, they exercise control over the contracting entity.

Brent London Borough Council and others v Risk Management Partners Limited
Supreme Court
Lords Hope, Rodger, Brown, Walker, Dyson, J.S.C.
9 February 2011

PART VII TRANSFER SANCTIONED BY THE COURT

Sompo applied to the court to sanction an insurance business transfer scheme pursuant to section 111 of FSMA. A number of the transferring policyholders objected. However at the hearing, only one objector persisted (and did not appear). The court granted Sompo's application notwithstanding a marginal reduction in the confidence level attributable to the transferring policyholders after the scheme was effected. It did so since the reduction remained within a satisfactory level of security within the FSA's benchmark of a 97.5 percent confidence level on a run-off to ultimate basis. The fact that the confidence level for Transfercom's existing policyholders increased from 95.2 percent pre-scheme to 97.5 percent post-scheme might have been relevant had this been at the expense of the transferring policyholders, but this was not so. Further, Sompo's desire to achieve finality in respect of the transferring business was an entirely rational commercial purpose for the transfer. Finally, the fact that many of the transferring policies were governed by laws other than English law did not prevent the court from sanctioning the scheme provided it would not be acting in vain in making the order and this did not undermine the independent expert's analysis.

Sompo Japan Insurance Inc, Re Transfercom Ltd, Re
Companies Court, Chancery Division
Briggs J
16 February 2011
Hogan Lovells for the Applicant

UK - Recent Cases

Continued…

ENTIRE AGREEMENT CLAUSES - LIABILITY FOR MISREPRESENTATION NOT EXCLUDED

Axa entered into similar Adviser Appointment Agreements ("the Agreements") with a number of companies under which it appointed those companies as its appointed representatives. The companies alleged that they were induced to enter the Agreements by negligent and fraudulent misrepresentations and/or collateral warranties made by Axa. The main issue for the Court of Appeal was whether the entire agreement clause excluded liability for misrepresentation. The Court of Appeal held that it did not exclude liability for misrepresentation and it went on to give guidance on the use of entire agreement clauses. The Court of Appeal also considered the application of Unfair Contract Terms Act 1977 on the entire agreement clause.

Axa Sun Life Services Plc v Campbell Martin Ltd
Axa Sun Life Services Plc v Kymin Mortgage Services Lts
Axa Sun Life Services Plc v Ideal Financial Planning Ltd
Axa Sun Life Services Plc v Harry Bennett & Associates Ltd
Court of Appeal (Civil Division)
Rix LJ, Wilson LJ and Stanley Burton LJ
18 February 2011

SHIP ARREST OUTSIDE ORDINARY JUDICIAL PROCESS - NOT EXCLUDED FROM COVER

A ship was arrested in Egypt. The insured owner appealed the arrest and claimed that it was improper - the vessel remains under arrest pending the appeal hearing in Egypt. In the meantime, the insured claimed under its War Risks insurance for a total loss of the ship. Insurers defended the claim on the basis that it was excluded under its rules as a claim arising out of ordinary judicial process or because there had been a breach of the sue and labour clause. The court found on the facts that the arrest of the ship was not ordinary judicial process and the insured had not breached the sue and labour clause.

Melinda Holdings SA v Hellenic Mutual War Risks Association (Bermuda) Ltd
Queen's Bench Division (Commercial Court)
Burton J
18 February 2011

FRAUDULENT CLAIMS - RESULTS IN REPAYMENT OF ALL INSURANCE COMPENSATION

The insured claimed under his policy of insurance for losses resulting from subsidence of his property. Insurers agreed the claim. Subsequently, insurers brought proceedings to recover the sums it paid under the policy on the basis that the claim by the insured for alternative accommodation was fraudulent. On the facts of the case, the court held that the insured had acted fraudulently and thus insurers were entitled to recover back the sum that they had paid in respect of alternative accommodation. Further, it was held that insurers were entitled to recover back sums they had paid in respect of repairs to the property.

Aviva Insurance Limited v Brown
Queen's Bench Division
Eder J
25 February 2011

ENGINEERS' REPORTS NOT PROTECTED BY LITIGATION PRIVILEGE

In litigation between an insurer and reinsurers, the insurer applied for disclosure of civil engineering reports commissioned by reinsurers in the aftermath of damage to a Mexican Highway, the subject of the reinsurance. Reinsurers claimed litigation privilege over the reports which required them to show that the reports were produced for the predominant purpose of litigation between the insurer and reinsurers. The judge found that the reports had not only been commissioned for the purpose of anticipated litigation but also for verifying the quantum figures for remedial work to the highway with the result that no single predominant purpose prevailed and litigation privilege did not apply.

Axa Seguros SA de CV v Allianz Insurance and others
Queen's Bench Division, Commercial Court
Christopher Clarke J
2 March 2011

UK - Recent Cases

Continued…

CCFA SUCCESS FEE RECOVERABLE WHERE INSURER EXERCISES SUBROGATION RIGHTS

The insured suffered damage to his property caused by roots of a tree owned by the local authority. Insurers settled the claim and, in exercising their rights of subrogation, required the insured to pursue a claim against the local authority. The insured instructed a firm of solicitors at the request of insurers - with whom the insurers had a collective conditional fee agreement. The solicitors negotiated settlement of the claim. On assessment of costs, the local authority disputed the insured's recovery of the success fee. The Court of Appeal dismissed the Local Authority's appeal and held that the insured was entitled to recover the success fee. They looked at the reality of the situation - which is that the CCFA was between insurers and solicitors - and commented that if CFAs are open to all they are also open to insurers.

Sousa v Waltham Forest LBC
Court of Appeal (Civil Division)
Ward LJ, Moore-Bick LJ and Etherton LJ
3 March 2011

Judgment texts available on
www.bailii.org

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UK - Regulatory and Legislative Developments

PAYMENT PROTECTION INSURANCE - UPDATE

(i) Judicial Review

The Judicial Review hearing to determine whether changes in complaints handling demanded by the FSA and Financial Ombudsman Service are wrong in law began in the High Court on 25 January and lasted four days. The BBA is asking the court to determine whether the regulators can impose new requirements on firms which go beyond what was stated in the FSA's own rulebook - specifically those on handling complaints about PPI sales. Judgment is due to be delivered shortly.

(ii) Competition Commission issues final order

In January 2009 the Competition Commission (CC) published its final report into payment protection insurance (PPI), which concluded that businesses that offer PPI alongside credit face little or no competition when selling PPI to their credit customers. However the report and, in particular, the proposed point-of-sale prohibition were the subject of a legal challenge to the Competition Appeal Tribunal (CAT) by Barclays, supported by Lloyds Banking Group and Shop Direct Group Financial Services Ltd. Whilst upholding the CC's conclusions as to the competition problems in this market, the CAT ruled that it must in particular consider further the role and importance of a potential drawback to the prohibition, namely that it might inconvenience customers.

In October 2010 the CC's confirmed that a central part of the planned package of measures, the point-of-sale prohibition for all forms of PPI (with the exception of retail PPI), would benefit customers.

In November 2010 the CC published a draft Order (together with an explanatory note for consultation setting out how measures to introduce competition into the PPI market would be implemented. The consultation period closed and the CC has now published the responses it received to the consultation. In light of the 26 responses to the consultation the CC revised the Order and comments were requested.

A final order has now been issued. The Order imposes a prohibition on selling PPI at the point of sale of credit for all PPI except retail PPI. It sets out in detail how the remedies will be implemented including the requirements in relation to the provision of personal PPI quotes, information that has to be included in marketing material and provided to third parties, a prohibition on the sale of single premium policies, and requirements to provide customers with an annual review.

It is planned to introduce the measures in two phases to coincide with annual Government common commencement dates (6 April and 1 October) for new legislation and regulations and also to allow sufficient implementation time. Some of the information requirements will come into force in October 2011 and the POSP and other measures in April 2012.

(iii) PPI Draft Order: Questions and answers published

The Competition Commission (CC) has published a set of questions and answers on the application of the draft Payment Protection Insurance (PPI) Market Investigation Order, which was published for consultation on 25 November 2010.

BRIBERY ACT 2010

The Bribery Act 2010 was originally intended to come into force in April 2011, with Ministry of Justice guidance on section 9 of the Act (about procedures which commercial organisations can put in place to prevent persons associated with them from bribing) being published in advance, in the early part of 2011 (a three month notice period between publication of the guidance and the date of implementation of the Act). Both were delayed by the MOJ guidance has now been published and the Act is due to come into force on 1 July 2011. Click here to read our newsflash on the Section 9 Guidance.

EMPLOYERS' LIABILITY INSURANCE

Following its consultation (CP 10/13) which closed on 14 September 2010, the FSA published on 25 February 2011 a policy statement (PS11/4) on its proposals for helping consumers trace their existing or former employers' liability insurers more easily. The policy statement reports on the main issues arising from CP 10/13 and publishes the FSA's final rules. The two main developments are:

(i) the creation, by the FSA, of a comprehensive list of insurers potentially liable for UK commercial lines employers' liability insurance which will also include a link to the tracing information; and

(ii) the requirement for insurer to produce an Employers' Liability Register.

The FSA is continuing to consult on how to deal with historical policies. Meanwhile, the Department for Work and Pensions is due to produce its response to the consultation it issued in February 2010. For more information on this development please click here to read our note on this development.

UK - Regulatory and Legislative Developments

Continued...

INSURANCE CONTRACT LAW REFORMS - UPDATE

On 15 December 2010 the Law Commission and Scottish Law Commission published a Summary of Responses to Issues Paper 7: The Insured's Post-Contractual Duty of Good Faith. The Law Commissions commented that "*Fraudulent claims are a serious and expensive problem, and consultees told us that the current law was unduly complex and in need of clarification. The approach taken under the Marine Insurance Act does not sit easily with modern insurance industry practice, and the continuing disjuncture between law and practice operates to the detriment of all stakeholders in the insurance market*". The next step is for the Law Commissions to produce their joint consultation on various issues (including Issues Paper 6: Damages for Late Payment and the Insurer's Duty of Good Faith & Issues Paper 7: The Insured's Post-Contractual Duty of Good Faith) and to issue their policy paper with recommendations on the law of non-disclosure and warranties for business insurance.

EQUITABLE LIFE (PAYMENTS) BILL RECEIVES ROYAL ASSENT

The Equitable Life (Payments) Bill received the Royal Assent on 16 December 2010 and the Equitable Life (Payments) Act 2010 has now been published. The Act will enable payments to be made to Equitable Life Assurance Society policyholders, by enabling implementation of an Equitable Life payments scheme.

THE FINANCIAL SERVICES AND MARKETS ACT 2000 (ADMINISTRATION ORDERS RELATING TO INSURERS) ORDER 2010

The above Order, SI 2010/3023, which came into force on 1 February 2011, consolidates the modifications made to Part II of the Insolvency Act 1986 in relation to insurers and makes further modifications:

(i) imposing a duty on the administrator of an insurer to assist the Financial Services Compensation Scheme in administering the compensation scheme in relation to contracts of insurance, and in securing continuity of insurance in relation to contracts of long-term insurance; and

(ii) ensuring that an administrator of an insurer is subject to the same duties as liquidator to carry on the insurer's business as far as it relates to contracts of long-term insurance.

An explanatory memorandum has also been published.

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US - Recent Cases

NEW YORK COURT ALLOWS ANTITRUST CASE AGAINST EQUITAS TO PROCEED

An appellate court in New York has reversed a decision by the trial court dismissing an antitrust action against Equitas Ltd. The case will now proceed in state court in New York.

In 2007, Global Reinsurance Corp. – US Branch filed a complaint against Equitas Ltd. and other Equitas defendants in state court in Manhattan alleging, in the words of the appellate court's decision, "*that the Equitas defendants are the hub of a conspiracy that violates New York's antitrust law*." Global's predecessor had purchased retrocessional protection from various Lloyd's underwriters. Global alleged that the restructuring of Lloyd's for pre-1993 business through the 1996 Reconstruction and Renewal Plan (the "**R&R Plan**") that led to Equitas resulted in antitrust violations. Prior to the R&R Plan, as alleged by Global, participants in the Lloyd's marketplace competed for business, including by paying certain claims even when the contract terms might provide a basis to reject the claims. Global alleged that combining claims-handling authority for all pre-1993 business in Equitas changed that competitive landscape. As the appellate court said, "*According to plaintiff, Equitas engaged in claims payment behavior – i.e., denying claims and, when they were not denied, paying less and later – that retrocessionaires subject to competitive constraints could not have engaged in . . .*."

The trial court dismissed the complaint with prejudice, but the Appellate Division, First Department reversed, holding that Global had adequately alleged violations of New York's antitrust statute, the Donnelly Act. The complaint was reinstated and the action remanded to the trial court for discovery on the merits of the allegations. The full text of the Appellate Division decision can be found on the court's website.

NO NY COMMON-LAW DUTY OBLIGING INSURANCE BROKER TO INFORM CLIENTS OF INCENTIVE ARRANGEMENTS

On 17 February 2011, the New York Court of Appeals (the highest state court in New York) ruled that insurance brokers do not have a common-law fiduciary duty to disclose incentive arrangements to their customers. The New York attorney general's office brought an action against Wells Fargo Insurance Services, Inc. ("WFIS"), alleging that WFIS had entered into incentive arrangements in which WFIS was rewarded for directing business to insurance companies. The court noted that there was no allegation that consumers were persuaded to buy inferior or overpriced insurance by WFIS. The complaint alleged that WFIS had not informed the customers about the incentive arrangements with the insurance companies.

The court held that "the rule that one acting as a fiduciary in a particular transaction may not receive, in connection with that transaction, undisclosed compensation from persons with whom the principal's interests may be in conflict", did not apply in this case. The court discussed the broker's "dual agency status" and stated that "the word 'broker' suggests an intermediary – not someone with undivided loyalty to one or the other side of the transaction."

However, such non-disclosure may be a bad practice, according to the court, and it is prohibited by Regulation 194 with effect from 1 January 2011 (as discussed in Circular Letter No. 18 (2010)). The court held that a "regulation, prospective in effect, is a much better way of ending a questionable but common practice than…by creating a new common-law rule". ■

The People v Wells Fargo Insurance Services, Inc., et al.
New York Court of Appeals
February 17, 2011

US - Regulatory and Legislative Developments

NEW YORK REVISES COLLATERAL REQUIREMENTS FOR UNAUTHORIZED REINSURERS

Effective 1 January 2011, the Superintendent of Insurance of the State of New York promulgated a revised regulation that could have significant effect on the amount of collateral unauthorized assuming reinsurers are required to post so that their ceding insurers can take credit for the reinsurance. Under the revised regulation, it is possible in some circumstances that a highly-rated alien insurer would not be required to post any collateral.

As with most states, New York regulates whether and how a ceding insurer can take credit on its financial statements for ceded reinsurance. New York had long required that, in order for a ceding company to take full credit for a cession to an unauthorized reinsurer (either an alien reinsurer from outside the US or one domiciled in a US jurisdiction other than New York), the unauthorized reinsurer was required to post collateral in the full amount of the credit the ceding insurer wished to take. Such collateral is usually posted by letter of credit or through a trust. The 1 January revision to Regulation 20 (11 NYCRR 125) provides a way for unauthorized reinsurers to achieve a reduction in the amount of collateral required to be posted – potentially down to zero.

The revision to Regulation 20 applies to reinsurance contracts entered into or renewed on or after 1 January 2011. The assuming reinsurer can apply to the Superintendent for one of five ratings that would be used for determining the minimum collateral that the reinsurer would need to post. The ratings are set out in the chart below:

Ratings	**Minimum Amount Withheld for Full Credit**
Secure – 1	0 percent
Secure – 2	10 percent
Secure – 3	20 percent
Secure – 4	75 percent
Vulnerable - 5	100 percent

The maximum rating a reinsurer can receive is tied to the lowest financial strength rating the reinsurer receives from Best, S&P, Moody's or Fitch. The determination of a security rating under Regulation 20, however, lies in the discretion of the Superintendent and goes beyond the financial strength rating. The reinsurer must submit an application to the Superintendent along with a US$10,000 nonrefundable application fee. (The rating must be renewed annually by submission of an application with a US$5,000 nonrefundable renewal fee.) The revised regulation provides that when setting a rating the superintendent may also consider factors such as, *inter alia*, the reinsurer's "business practices in dealing with its ceding insurers," "regulatory actions against the [reinsurer]," and "any other information deemed relevant by the superintendent." The regulation also requires that the reinsurance contract between the ceding insurer and the reinsurer contain certain provisions, including one that would require the reinsurer to fund the entire amount for which the ceding insurer has taken credit if the ceding insurer enters any insolvency proceedings.

Shortly after the revision to the regulation became effective, Hannover Re became the first reinsurer to obtain a security rating, qualifying to post 20 percent of loss reserves rather than the previous 100 percent required. More recently, XL Insurance and XL Re also qualified to post collateral at 20 percent.

The full text of the regulation with the revised collateral provisions can be found on the New York Insurance Department's website.

US - Regulatory and Legislative Developments

Continued...

"UNDER WATER" - PROPOSED CHANGES TO THE NATIONAL FLOOD INSURANCE PROGRAM

On 25 January 2011, Rep. Candice Miller introduced the National Flood Insurance Program Termination Act of 2010 to the United States House of Representatives. Rep. Miller proposed the elimination of the National Flood Insurance Program ("**NFIP**"), which is managed by the Federal Emergency Management Agency ("**FEMA**") and currently has a deficit of over US$19 billion, by 31 December 2013. Rep. Miller, and other critics of the NFIP, argue that NFIP rates for high-risk areas are unfairly subsidized at the expense of lower-risk areas. They propose that liability for flood damage should be transferred to the private sector, thus cutting federal spending and creating new opportunities for insurers and reinsurers. However, insurers are concerned that premiums may be capped, rendering the business unviable.

On 11 March 2011, the Subcommittee on Insurance, Housing and Community Opportunity of the House Financial Services Committee held a hearing on the future of the NFIP. Committee chairman Rep. Judy Biggert declared, "for many years, the NFIP has been – for want of a better phrase – under water". Rep. Biggert proposed a discussion draft of the "Flood Insurance Reform Act of 2011". The proposed Act contains an extension of the NFIP's authorization, aims to reform the NFIP, tackles existing mapping issues and requests reports on how the NFIP may be privatized. Craig Fugate of FEMA was scheduled to testify at the hearing but was unable to attend due to concerns that the tsunami created by the earthquake in Japan may cause flooding on the west coast.

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Germany - Recent Cases

INEFFECTIVE LEGAL CONSEQUENCE IN OLD CONTRACTS

The German Insurance Contract Act ("VVG") was revised with effect from 1 January 2008. Section 28 of the revised Insurance Contract Act stipulates that the insurer is released from its obligation to perform if the policyholder wilfully (*vorsätzlich)* violates his duty (*Obliegenhei)* to the insurer. It is not permitted to deviate from section 28 if this would result in a disadvantage for the policyholder. In the case in question, however, a clause in the parties' terms of insurance - dating back to 1988 - stated that the insurer would be released from its obligation to perform if the policyholder violates a duty through gross negligence (*grobe Fahrlässigkeit*). The insurer failed to change the clause in question within the one-year-period allowed by section 1 subsection 3 of the introductory law of the Insurance Contract Act as revised effective 1 January 2008.

As expected, the Court of Appeals of Cologne ruled that the clause in question violated section 28 of the revised Insurance Contract Act and was therefore invalid. Any validity-preserving reduction of the clause is prohibited by section 306 of the German Civil Code. The invalid clause is therefore replaced by statutory provisions, i.e. section 28 of the revised Insurance Contract Act. However, the court pointed out that under the provisions of the revised Insurance Contract Act a release of obligations in the event that the damage is caused by gross negligence is still possible.

Court of Appeals of Cologne,
17 August 2010

ADOPTION OF THE BROKER'S QUESTIONNAIRE BY THE INSURER / CO-INSURANCE (DORNBRACHT)

A questionnaire which was drawn up by a policyholder's broker and also answered by the broker is not regarded as a questionnaire of the insurer within the meaning of section 19 paragraph 1 of the German Insurance Contract Act ("VVG"). An exception to this principle can be made only if the insurer adopted the questionnaire as his own. In this context, the Court of Appeals of Hamm points out that the fact that it was customary prior to the revision of the Insurance Contract Act for the broker to draft and answer questions for a certain kind of insurance does not suffice for the questionnaire to be deemed adopted by the insurer. Rather, for such an adoption, a respective statement from the insurer is necessary at the time the policyholder or its broker answers the questionnaire. The court did not comment on whether and under which conditions a retroactive adoption could be possible.

Furthermore the court decided that if a co-insurer informs the policyholder that one of the co-insurers is now the lead insurer and asks the policyholder for submission of the lead co-insurer's future inspection report, this is considered as an external power of attorney for the co-insurer that is to lead the consortium. As a consequence, any knowledge available to the lead insurer is imputed to the co-insurer and therefore is also considered as knowledge of the co-insurer (in application of Section 166 of the German Civil Code).

Court of Appeals of Hamm,
3 November 2010

POLICYHOLDER CAN HAVE A DUTY TO PROVIDE INFORMATION EVEN WITHOUT A REQUEST FOR INFORMATION

Under section 31 of the German Insurance Contract Act ("VVG") the policyholder has to provide information to the insurer, but only insofar as the insurer has requested such information. The Court of Appeals of Frankfurt has made an exception to this principle by holding that a policyholder has to provide information even without an insurer's request if the insurer's interest in the information is obvious to everyone and the importance of the information to the insurer is evident to the policyholder.

In this case the policyholder had been informed about the fact that, due to its personal bankruptcy, any potential payment made by a third party to the policyholder would not fulfil the respective obligations intended to be fulfilled and the third party would therefore have to pay the respective amount once more to the trustee. Despite this, the policyholder did not inform its insurer about the prohibition of disposition. Due to the risk for the insurer of having to make the payment twice, the court made an exception to the principle that a policyholder has to provide information to its insurer only insofar as the insurer has requested such information.

Court of Appeals of Frankfurt am Main,
9 November 2010

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France - Recent Cases

SCOPE OF THE TWO YEAR TIME BAR APPLICABLE TO THE INSURANCE CONTRACT

A collective insurance policy providing for two different types of guarantees was entered into by a company. Its purpose was to grant the employees of the company (who were the insureds) a complementary retirement capital and, in case of death of an insured at the time of its retirement, payment to the surviving spouse of the capital earned at that time. The policy also provided in case of total disability of the insured before retirement, the insured would be exempted from paying his premiums (the "exemption provision"). The insurer alleged that one of the employees had benefited improperly from the exemption provision. The employee commenced proceedings in order to restore his right to be exempted from paying contributions, since he had become totally disable. The insurer alleged that the action was time-barred. The Court of Appeal dismissed the insurer's time bar argument. It held that since the insurance policy, and the action deriving from it, was a retirement insurance contract which related to the duration of human life the applicable time bar should be ten years as opposed to two years. However, pursuant to Article L. 114-1 of the French Insurance Code, the French Supreme Court dismissed the decision of the Court of Appeal and held that only actions introduced by the beneficiary of a life insurance policy shall benefit from the ten years time-bar where the beneficiary is a separate person from the policyholder. In this case the insured was also a policy holder and thus the action was subject to the two years time-bar.

Cour de cassation, Civ.2, 3 February 2011

SCOPE OF THE FALSE INTENTIONAL DECLARATION MADE BY THE POLICYHOLDER

We reported in the November 2010 edition of *Global* Insurance and Reinsurance Bulletin that a false statement or omission made by a policyholder could nullify an insurance contract only if, and when, the false statement or omission changed the subject of the insured risk or if it altered the insurer's evaluation of the risk. (Cour de Cassation, Civ. 1°, 14 October 2010). In this new case the French Supreme Court held that an insurance policy can be nullified by the non-disclosure by the insured of the fact that his previous insurance contract had been terminated by the insurer because of non-payment of premium - the non-disclosure could have altered the insurer's opinion of the risk. The Supreme Court held that the insurer would not have agreed to enter into a contractual relationship with the insured if he was aware of the fact that the insured's previous insurance contract had been terminated by another insurer due to default in payment of premiums.

Cour de Cassation, Civ. 2°, 16 December 2010

France - Regulatory and Legislative Developments

ACP: POSITION ON SALES WITH PREMIUM

On 4 November 2010, the *Autorité de Contrôle Prudentiel* ("**ACP**") issued a position related to sales with premiums in life insurance contracts, which is defined as granting a sum of money, called premiums, upon subscription of a life insurance contract or a new payment made on an existing contract . This position has been adopted in order to remind insurance companies of the recent modification of the regulation regarding guaranteed rates in life insurance contracts adopted by a ministerial order of 30 July 2010. When the premiums are paid by an insurance undertaking, the ACP considers that it qualifies as a commitment of the latter which as such must comply with the regulation related to the guaranteed amounts of technical interest and profit participation. When the premium is paid by an insurance intermediary after the subscription, the ACP considers that the sales with premium might qualify as an insurance operation carried out without authorisation since the payment of the premium is related to the duration of the life of the insured

INSTRUCTIONS OF THE ACP - MONEY LAUNDERING

On 18 October 2010 the ACP issued three instructions in relation to information that entities (which are subject to its authority) had to communicate by no later than 17 December 2010 for the purpose of the fight against money laundering. Charts are provided as appendices to the instructions which detail the data to be transmitted to the ACP, such as the internal procedures, the identity of the person in charge of setting up the system for evaluating and managing risks of money laundering, the identity of the informants and correspondents for Tracfin, the list of foreign branches and subsidiaries.

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Spain - Recent Cases

COMPENSATION IN AGENCY CONTRACTS

According to the judgment, even if there is a limitation of liability clause within the Insurance Agency Agreement limiting any right to obtain compensation for clients, the insurer shall be obliged to pay such compensation to the agent. In the Spanish legal system, the agent is entitled to obtain compensation for clients when, after the termination of this kind of contract, the insurer continues receiving profits related to the clients and activities achieved by the agent during the term of the agreement. In this case, the Supreme Court recognizes the binding nature of this kind of compensation clauses, which can not be annulled by the parties, as a "*safeguard to guarantee the rights of the agent".*

Supreme Court
Civil Division
8 October 2010

DARK AND AMBIGUOUS CLAUSES IN A LIFE INSURANCE UNIT-LINKED CONTRACT

In 2005 an insured purchased a life insurance unit-linked contract with a premium of EURO 100,000 from a Portuguese bank branch in Spain. The insured requested a conservative investment product. However, the insured did not receive all the information schedules and conditions of the policy until Lehman Brothers bankruptcy; until this bankruptcy he had not received any document that reflected the investment had been made through the U.S. entity. According to the judgement, the policy information "*can only be described as dark and ambiguous*". The judge held that the bank and insurer had been grossly negligent in relation to their actions in the execution and duration of the policy. The insured was awarded EURO 200,000 by the court.

Civil Court of Madrid
19 January 2011

COMPENSATION IN A MOTORCYCLE ACCIDENT CLAIM

As a result of a judgment issued by the Appeal Court of Seville on 29 September 2010, an insurer was ordered to pay compensation to its insured's estate, where the insured motor cyclist died following a motor collision. The court made the award despite the fact that it had been proven that the insured had violated traffic rules, was not wearing a helmet and had previously ingested narcotics. The court considered that the circumstances regarding an insured's violation of traffic rules (for example, making a u-turn in a prohibited place, driving without helmet, and being under the effects of drugs) "*does not constitute the cause of exoneration from liability of the insurer*" under the Insurance Contract Act.

Appeal Court of Seville
Civil Division
13 February 2011

CIVIL LIABILITY INSURANCE CASE

A construction company ("the company") was negligently managed by its directors. However, the fact of this negligent management was not apparent from the audit reports produced by the company's auditors ("the auditors") over a period of more than five years. The company went bankrupt following which, the claimants (people who purchased houses being built by the company) had to pay different construction companies to continue building the houses which had not been completed by the company. The Spanish Supreme Court held that the audit reports had not been correctly executed. The court therefore delivered a verdict of guilty to the auditors, its auditor identified "JMFR." (the person who actually audited the company over that period of time), and the auditors' insurer (a branch of an EU insurer operating in Spain). The three parties were ordered to reimburse one thousand of those people affected by the bankruptcy of the construction company. The judgment established that there was a "*negligent act of the drafters of the reports, required and necessary for the claimants so as to understand the situation of the Company*". It also says that the reports did not contain any warnings in relation to the irregularities of the annual accounts - the irregularities in the annual accounts made by the company's directors over the years, should have been taken into account by the auditors in their reports. The Supreme Court sentenced the auditors, JMFR and its insurer, to reimburse the claimants who had had to pay other companies to complete the building of their houses. The total amount awarded to the claimants amounted to seven percent of the initial building costs. The ruling concludes that all of them have to respond jointly *"not only to the one who are bound by the Contractual Relationship, but also to third parties who enter into relationship with the audited Company*", in accordance with the European Directive number 2006/43/CE that regulates auditor's conduct.■

Supreme Court
Civil Division
16 February 2011

Spain - Regulatory and Legislative Developments

INFORMATION RELATED TO ACQUISITIONS AND MANAGEMENT

Ministerial Order EHA/3241/2010 dated 13 December 2010 approves the list of the compulsory information to be sent to the "*Dirección General de Seguros y Fondos de Pensiones*" (Spanish Insurance Regulator) in case of acquisition or increase of significant participation in an insurance company, as well as the information related to those who intend to hold administrative and management positions in insurance companies, reinsurers and corporations whose principal activity is to hold shares in these entities. The order introduces two very interesting novelties. Firstly, it sets out the exemption of certain requirements in an acquisition of a significant stake when the purchaser has been assessed by the "*Dirección General de Seguros y Fondos de Pensiones*" during the two previous years in relation to other deals. Secondly, it also introduces the possibility to exempt the potential purchaser from the obligation to disclose part of the information, when it considered not being relevant to assess the acquisition.

Order EHA/3241/2010
13 December 2010

UPDATING THE INSURER´S ACCOUNTING PLAN

At its meeting held on 23 December 2010, the Spanish Council of Ministers approved Royal Decree 1736/2010 which amends the accounting plan of insurance companies approved in July 2008. The amendment adapts the accounting plan to the new European accounting standards, regarding the consolidated annual accounts.

Royal Decree 1736/2010
23 December 2010

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Italy - Recent Cases

AUTONOMY OF THE PAYMENT OF THE INDEMNITY TO THE INSURED PERSON

With regards to non life insurance contracts, the Italian Supreme Court (the "**Court**") has reaffirmed that the obligation to pay the indemnity is totally independent from the obligation of compensation due by the insured to the third party harmed. In particular the Court stated that the two obligations are to be considered different and separate. This principle applies also in the event the indemnity is paid directly to the third party by the insurance company in accordance with the option provided for by article 1917, paragraph no. 2, of the Italian Civil Code. In light of the above interpretation, the Court confirmed the judgement of the Court of Appeal of Campobasso of 8 March 2006, which correctly stated that an employee could not directly sue the insurance company for the compensation of damages caused by the employer covered by the insurance.

14 April 2010
Italian Supreme Court
Labour Section, no. 8885

DUE INTERPRETATION OF INSURANCE CONTRACTS

The Italian Supreme Court (the "**Court**") reaffirmed the importance of the interpretation of an insurance contract based on the principle of correspondence between premium paid by the policyholder and risk covered by the insurance company. In particular, the Court stated that the interpretation of an insurance contract, given its bilateral and mutual nature, shall be conducted in light of the principle of there being a "*necessary correspondence between the amount of premiums and insurance performances*": accordingly the premium amount is to be considered relevant by judges for determining the kind and limits of the insured risk, so that the balance between the mutual obligation is ensured. On the basis of the above interpretation, the Court annulled the prior judgement of the Court of Appeal of Turin of 17 March 2005, since it had not given sufficient relevance to the amount of premium paid by the policyholder in relation to the insurance coverage.

30 April 2010
Italian Supreme Court
Sect. III, no. 10596

SEIZURE OF INDEX-LINKED INSURANCE POLICIES

On 10 August 2010, the Tribunal of Parma (the "**Tribunal**") reaffirmed the possibility of seizure of sums due under an index-linked policy. The Tribunal made reference to a previous judgement of the Supreme Court (the "**Court**") no. 8271/2008 where the Court affirmed that it was not possible to proceed to the seizure of insurance policies since Article 1923, paragraph 1, of the Italian Civil Code provides that the "*sums due to policyholders or beneficiaries by the insurer may not be subject to enforcement proceedings or interim injunctions*": In fact the aim of the above article is to ensure that the "welfare" purpose of life insurance policies are fulfilled. However, given that compared to other types of life insurance policies, index-linked policies do not pursue welfare purposes and that these latter should be considered more similar to financial instruments, the Tribunal stated that Article 1923 does not apply to this particular kind of insurance policy, and accordingly enforcement proceedings or interim injunctions should be allowed in relation to the payments made under index linked policies. ■

10 August 2010
Tribunal of Parma,

Italy - Regulatory and Legislative Developments

ISVAP OPENS NEW CONSULTATION PHASE ON CONFLICT OF INTERESTS OF INTERMEDIARIES

On 27 October 2010 the Regional Administrative Courts annulled, by admitting a claim of a certain number of important Italian banks, article 52 of ISVAP Regulation no. 35/2010, preventing intermediaries of insurance policies from being appointed beneficiaries under the same, since the provision had not been included in the previous public consultation phase. The Italian Insurance Regulator ("**ISVAP**") opened on 16 December 2010 a public consultation on the same provision, aimed at reinstating the same wording of article 52, without the need of any further proceedings in court. The consultation phase ended on 31 January 2011 and many operators, especially those offering insurance policies attached to loans, personal loans and mortgages, this time, submitted their remarks. For more information please click here.

GUIDELINES ON ASSETS ELIGIBLE FOR TECHNICAL RESERVES

On 31 January 2011, ISVAP released the definitive version of the regulation on technical reserves, a previous draft of which was issued for consultation in July 2010. The regulation applies exclusively to Italian insurance companies and Italian-based establishments of extra-EU insurance undertakings. The major novelties of the regulation concern the governance requirements imposed on supervised undertakings, aimed at ensuring that any undertaking's determination of the types of assets used as technical reserves be adopted by means of a corporate resolution on their investment strategy: such resolution must be notified to the Italian insurance regulator within 15 days of its adoption. The regulation will enter into force on the day subsequent to its publication in the Italian official gazette but insurance undertakings are required to adopt the corporate resolution on investment strategy within three months of the entry into force of the regulation. Companies which have already invested in structured notes and securitisation notes for technical reserve purposes by 31 December 2010 are not impacted by the regulation, on the condition that such investments do not exceed five percent of their technical reserves.

Click here for the ISVAP website.

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Latin America - Recent Cases

THE CONSTITUTIONAL COURT OF COLOMBIA SETS OUT THE REQUIREMENTS OF PERMANENT INVALIDITY CONCERNING THE COMPULSORY TRAFFIC INSURANCE (SEGURO OBLIGATORIO DE ACCIDENTES DE TRÁNSITO "SOAT")

The Constitutional Court of Colombia has confirmed that in calculating the indemnity payable under the SOAT, the Regional Board of Invalidity method has been consolidated in order to grant a qualification to the invalidity of an insured. The court specifically referred to the maximum amount foreseen under this Act in order to provide an indemnification to the insured under certain conditions.

Constitutional Court of Colombia
Judgment T-282
19 November 2010

INSURANCE COMPANIES MUST APPEAR AS CO-DEFENDANTS IN CLAIMS FOR WORK ACCIDENTS

A miner claimed against his employer for loss incurred as a result of his permanent invalidity caused by his employment as a miner for 13 years. The miner had in place, two critical illness insurance policies relating to the period in question. The Constitutional Court of Peru adjourned the proceedings on the basis that the two insurance companies who provided the miner with the relevant insurance policies, should be joined to the proceedings as co-defendants.

Constitutional Court of Peru
Civil Division
10 January 2011

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Latin America - Regulatory and Legislative Developments

THE BRAZILIAN INSURANCE REGULATOR "SUSEP" ISSUES TWO NEW RESOLUTIONS AGAINST GLOBAL INSURERS AND REINSURERS

With the aim to develop the Brazilian insurance market, the Brazilian Insurance Regulator "SUSEP" has issued two new resolutions, resolution number 224 and number 225, which have been strongly criticized by the market. On the one hand, Resolution number 224, dated 10 December 2010, provides a new wording stating in its article 14 that the risks undertaken by Brazilian insurers, reinsurers or by retrocessionaires will not be allocated to foreign linked companies or foreign conglomerates. On the other hand, Resolution number 225 replaces the existing article 15 of Resolution number 168 stating that insurance undertakings will allocate to local reinsurers at least 40 percent of each automatic or facultative reinsurance contract they underwrite. These measures are said to provide a competitive advantage to local reinsurers but they may lead to a negative development for global insurers and reinsurers. Indeed, the Risk Management Association of Brazil ("ABGR") has issued a communication requesting their immediate revocation.

SUSEP
Resolutions 224 and 225
10 December 2010

CHILE PROPOSES A BILL WHICH WILL ESTABLISH A COMPULSORY INSURANCE REGISTRY

On 19 January 2011 the Chilean government proposed a bill which will establish a compulsory insurance registry. This measure is intended to provide information of the insurance products underwritten by policyholders in order to fight against potential claims brought as a result of the lack of information. This registry will include health, car, credit cards and credit insurance products.

Chilean Government communication
19 January 2011

THE ARGENTINEAN INSURANCE SUPERVISOR ESTABLISHES A TRAINING PLAN AIMED AT INSURANCE MEDIATORS IN ARGENTINA

The Argentinean Insurance Supervisor has issued the Resolution nº 35.577 which establishes the training plan that will have to be carried out by those who intend to become insurance mediators. This Resolution also sets out the requirements these mediators must meet so as to be registered.

Official Bulletin of Argentina
Resolution nº 35.577
4 February 2011

China - Regulatory and Legislative Developments

CIRC ANNOUNCES RECTIFICATION CAMPAIGN AGAINST ILLEGAL BUSINESS PRACTICES IN THE INSURANCE INTERMEDIARY MARKET

On 1 January 2011, the CIRC issued the *Circular on Advancing and Expanding Investigation and Rectification of Illegal Insurance Company Intermediary Business Practices*, requiring each local bureau of the CIRC to target at least one provincial-level insurance company within its jurisdiction for an audit of business dealings with intermediaries. The enforcement campaign primarily focuses on correcting the following problems:

- extracting funds by transferring direct insurance business to intermediaries or salesmen;
- extracting funds by overstating the number of insurance salesmen, the amount of management costs or issuing false invoices;
- extracting funds through submitting false policy surrenders or false claims through intermediaries;
- illegally providing benefits to others (such as family members of insurance company management personnel) through intermediaries; and
- other illegal acts such as commercial bribery.

Upon discovery of illegal intermediary business practices involving provincial-level subsidiary insurance companies, the circular requires follow-up investigations of the parent insurance company to determine ultimate responsibility. The circular also encourages closer CIRC cooperation with the Public Security Bureau, tax authorities and the Ministry of Justice to ensure that proper remedial measures are taken against illegal business practices. Cases of illegal activities uncovered during the CIRC investigations will be disclosed to the media for publication to increase the impact of findings.

CIRC TARGETS INSURANCE SALES PYRAMID SCHEMES

The CIRC issued the *Circular on Preventing and Attacking Suspected Pyramid Sales Schemes of Insurance Intermediaries* on 19 January 2011, directing insurance companies to strengthen compliance controls and examine the activities of intermediaries in the course of their business cooperation. Insurance companies discovering pyramid sales schemes at intermediary entities are directed to cease all cooperation with such intermediaries and immediately report their findings to the relevant local CIRC bureau.

CIRC SEEKING PUBLIC COMMENTS ON DRAFT MEASURES FOR INSURANCE BUSINESS TRANSFERS

On 21 March 2011, the CIRC issued draft *Provisional Administrative Measures for Administration of Insurance Business Transfers by Insurance Companies* and is soliciting public opinion until 11 April 2011. Under the draft measures, insurance companies would be required to apply for CIRC approval before transferring all or part of their insurance business by submitting copies of the following documents:

- resolutions of the board of directors or shareholders of each party approving the transfer;
- basic information on insurance companies involved in the transfer;
- the insurance business transfer agreement;
- procedural arrangements for the transfer;
- a feasibility study on the operation and management of transferred business;
- an evaluation report issued by professional intermediaries;
- an evaluation report on the reserve fund of the transferred business; and
- the most recent annual solvency reports of the transferee insurance company and an analysis of how the transaction would impact solvency of the transferee.

Both insurance companies which are parties to a transfer of business agreement would be required to retain a law firm, accounting firm and other professional services organizations to advise on the transaction. Following CIRC approval, the transferor must provide detailed written notice of the transfer to policyholders and insureds and obtain their consent. In addition, both the transferor and transferee must publicly announce the transfer of business by posting information on their websites and publishing notices at least three times through designated media outlets during a period of at least one month.

The draft measures note that they would not apply to reinsurance transactions or transfers of business mandated due to bankruptcy or insolvency of the transferor insurance company.

China - Regulatory and Legislative Developments

Continued…

NEW DRAFT MEASURES ON REPRESENTATIVE OFFICES BY INSURANCE INSTITUTIONS PUBLISHED FOR PUBLIC COMMENT

The CIRC published the draft *Administrative Measures for Representative Offices of Foreign Insurance Institutions* on 22 March 2011 and is seeking public comment until 11 April 2011. The draft measures would replace previously effective measures enacted in 2006. Changes and additions include: (1) a requirement that foreign insurance companies establishing a representative office have total assets exceeding US$2 billion; (2) a requirement that foreign insurance brokers, agencies and asset valuation institutions establishing a representative office have total assets exceeding US$200 million; and (3) a prohibition on representative office personnel holding positions at any type of commercial entity. The changes incorporated in the draft measures focus on preventing representative offices from engaging in commercial operating activities: penalties for such violations would be dramatically increased under the proposed draft, potentially including confiscation of "illegal proceeds" and additional fines ranging from one to five times the amount of illegal proceeds confiscated.

CIRC LAUNCHES ONLINE SYSTEM FOR SOLVENCY SUPERVISION

Beginning 1 January 2011, the CIRC requires all insurance companies and insurance asset management companies to submit solvency reports, quarterly and annual financial reports and various other reports through an online solvency supervision information system as detailed in the *Circular on Launching an Online Solvency Information Supervision System*. Submissions through the online system should begin with filings for the fourth quarter of 2010 and insurance group companies are responsible for submitting information on behalf of their subsidiaries.

CIRC DEVELOPS PILOT PROGRAM FOR INSURANCE PRODUCTS SUPPORTING CULTURAL INDUSTRIES

On 29 December 2010, the CIRC and the Ministry of Culture jointly issued the *Circular on Insurance Industry Support for Development of Cultural Industries*, launching a two year pilot program aimed at encouraging development of insurance products covering cultural activities and assets. Three state-owned insurance companies (PICC, CPIC and Sinosure) have been chosen to participate in the pilot program by launching eleven types of insurance products relating to cultural activities, including insurance for cancellation of performances, comprehensive insurance for artworks and intellectual property infringement insurance for cultural enterprises. The circular also encourages insurance companies to invest in bonds or investment funds issued by cultural enterprises subject to applicable regulations on investment by insurance companies.

CIRC ISSUES *CIRCULAR ON RELEVANT MATTERS CONCERNING STANDARDIZING PROVISION OF EXTERNAL GUARANTEES BY INSURANCE INSTITUTIONS*

The circular, effective 20 January 2011, prohibits insurance companies and insurance asset management companies from providing guarantees to third parties for the debt of others, with the exception of the following guarantees provided in the ordinary course of business:

- guarantees provided in the course of litigation;
- export credit security provided by export credit insurance companies; and
- maritime security.

Insurance group companies can only provide guarantees for debts of their subsidiaries. External guarantees prohibited by the circular and issued before 20 January 2011 should be reported to the CIRC and in principle should be terminated by 30 June 2011. The circular directs insurance institutions to review their articles of association and internal governance systems and make any necessary amendments to ensure compliance with the general prohibition on external guarantees. Amendments to the articles of association should then be submitted to the CIRC for approval.

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Russia - Regulatory and Legislative Developments

THE FINANCIAL MARKETS REGULATOR TAKES OVER THE INSURANCE REGULATOR

Following the Decree of the President No. 270 of 4 March 2011, the Federal Insurance Supervision Service (the Russian Insurance Regulator) was merged with immediate effect into the Federal Financial Markets Service (the "**FFMS**"), which is now a single authority for the regulation and supervision in the financial services market (except banking and audit). Under the Decree, the Government shall ensure proper supervision over the insurance market in the interim and pass legislation to allocate legislative and regulatory functions between the Ministry of Finance and the FFMS in two months' time. In practice this may mean a shift of the legislative and regulatory functions to a higher-rank authority.

THE ASSOCIATION OF COMPULSORY ROAD INSURERS RECEIVES NEW STATUTORY POWERS

Combating fraud and unfair practices in the compulsory road insurance market, the new law which came into force on 10 January 2011 extends the powers of the Association of Compulsory Road Insurers to introduce and enforce on its members the policy to supply and use the forms of compulsory insurance policies depending on the members' financial soundness and creditworthiness and their compliance with the terms of membership. The Association's policy is subject to approval by the insurance regulator (the FFMS) and the competition authority (the Federal Antimonopoly Service).

CERTIFICATION OF INSURANCE AGENTS DRAFT BILL

A new draft bill on the certification of insurance agents was introduced to the State Duma (the Russian legislature). The draft bill aims to create a tougher framework for insurance agents in view of public concerns regarding quality, conflict of interest and professional conduct matters. The draft bill introduces the requirements for continuous professional development and regular professional aptitude tests for agents. It also aims to create a register of certified insurance agents to protect customers against fraud and combat practices where agents representing a number of insurance companies de facto carry out a separately licensed and regulated insurance brokerage business.

PROPOSAL FOR COMPULSORY INSURANCE FOR REAL ESTATE AGENTS

The Russian Guild of Real Estate Agents has come forward with a proposal of statutory self-regulation in the industry. Apart from the compulsory membership, the proposal envisages that the agents must draw up compulsory professional indemnity insurance covering their clients' claims. The liability cap is proposed at RUR 2,000,000 (EUR 50,000) per claim.

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Insurance and Reinsurance Planner

Everyone in the insurance and reinsurance market will know that the number of insurance and reinsurance related events is huge and that it is difficult to keep track of training and information gathering opportunities. The aim of the Insurance and Reinsurance Planner is to provide a one-stop source of information on forthcoming major international insurance and reinsurance conferences, seminars and symposia around the world.

The Planner is a valuable notice board for the international insurance and reinsurance community, providing information on what is taking place, when and where.

It is available online (entirely free of charge) at **www.reinsuranceevents.com** where it is possible to search for events and courses by date, country or organisation and drop those you are interested in attending into your electronic diary. You can also use the online form to submit events which can be viewed online.

This bulletin contains short reports of significant recent developments in the law of insurance and reinsurance and related topics around the globe. In this form, and due to the vast pace at which legislative and regulatory issues develop, it cannot be fully comprehensive. It is written in general terms and its application to specific circumstances will depend on the particular facts. The contents of this bulletin are current as at the date of publication.

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