

# London Market

## January 2009

This edition includes a brief update on:

### Market seminar

Our next London Market Seminar will be at The Captains' Room at Lloyd's on 12 March 2009. The subject will be Directors and Officers' liability coverage.

Ling Ong (Partner) will chair the seminar in which Colin Peck (Partner) will be joined by guest speaker Alexis Rogoski, Partner in the New York office of US law firm Traub Lieberman Straus & Shrewsbury LLP, to review some of the recent developments in US and UK D&O claims and litigation.

Invitations will be emailed shortly, but anyone who is interested in attending or in receiving a copy of the seminar pack should contact Louise Smith at [louise.smith@weightmans.com](mailto:louise.smith@weightmans.com)

### EL Trigger Litigation set for appeal

Judith Peters reports on the appeal lodged in the recent case of **Durham v BAI and Others**.

### Retrocessionaire not entitled to avoid 'WCA carve-out' contracts

Colin Peck reports on the decision in **Crane v Hannover Ruckversicherungs AG**.

### Offer and acceptance of reinsurance contract

Ling Ong takes a look at the decision in **Allianz Insurance Co Egypt v Aigaion Insurance Co SA**.

### Failure of 'Machinery'

Karen Purchase reports on the recent decision in **John Reilly v National Insurance & Guarantee Corp**.

### Scheme report not necessary on issue of application for Part VII Transfer

Colin Peck considers the case of **Re Names at Lloyd's**.

### Guest article

Dr Herbert Palmberger and Manfred Oesinghaus, both partners in the German law firm Heuking Kühn Lüer Wojtek, consider the first twelve months under the new Insurance Contract law which came into force in Germany on 1 January last year.

### Catch up

Where to find members of our team in the Market over the next few months.

## EL Trigger set for appeal

As anticipated, run-off insurers have appealed Burton J's judgment handed down on 21 November 2008 in **Durham v BAI and Others** in what is commonly referred to as the Employers' Liability Policy Trigger Litigation. They have appealed on the question of policy construction, in particular whether 'sustained' and/or 'contracted' means the same as 'injury occurred'.

As said by Burton J at the beginning of his first instance judgment, the result "has considerable consequences for several thousand people and will have a continuing impact for many years" so an appeal was expected. The decision is significant not only for those involved in the lead cases, but to current and future claimants and the respondents to the claims including insurers and their policyholders who had always assumed they could obtain indemnity in respect of such claims.

The litigation incorporated six actions and in the first instance judgment the word "Claimants" is used to describe the individual claimants, local authorities and other solvent policyholders, and Zurich Insurance, all of whom argued that the trigger for indemnity under Employers' Liability policies was exposure/inhalation of asbestos fibres. The term "Defendants" is used to denote the four insurance companies – BAI, Independent, Excess and MMI – who argued that the trigger was when the malignant mesothelioma developed, or as Burton J described them, those who took the "date of tumour position".

### Background

The first shot fired in the policy trigger arena in the UK jurisdiction was the Court of Appeal decision in **Bolton v MMI & CGU** which related to a Public Liability insurance policy. The Court of Appeal held that the policy to respond in a mesothelioma claim was the one in force at the time the mesothelioma developed.

MMI's Employers' Liability policy had a different but similar wording to their Public Liability policy. All the Defendant insurers' Employers' Liability policies referred to "sustaining injury" or "contracting disease", and the four Defendant insurers declined indemnity in respect of claims that had been made by or on behalf of former employees suffering from mesothelioma arising from exposure to asbestos fibres during their policy period. At the time of the hearing, it was confirmed there were 645 claims where indemnity had been declined by the four Defendants.

### The medical issue

The court had the benefit of the expert evidence of Dr Rudd and Dr Moore Gillon, whose evidence had been accepted in **Bolton**, and also from Professor Geddes who had previously undertaken research on rates of tumour growth. It remained common ground between the medical experts that asbestos fibres in the body cannot be causative of mesothelioma during the last 10 years, prior to symptoms becoming manifest. This was on the basis that there had been occasional recorded deaths from mesothelioma as early as, but no earlier than, 10 years after exposure to asbestos. The medical experts also confirmed that the "single fibre theory" could not be sustained, but that it was exposure to quantities of asbestos fibres which caused mesothelioma and the greater the number of fibres, the greater the chance that one will cause a malignancy.

However, the development of the first malignant cell 10 years or more before manifestation of symptoms is not a tumour and the question of when a tumour developed was central to the Defendants' argument.

The evidence of the chest physicians was that whilst many asbestos fibres will be inhaled, only some get as far as the lungs. The process of clearance and destruction, part of the body's natural defences, will destroy many fibres before they get to the lungs or whilst they are in the lungs. Such fibres that do reach and remain in the lung may go on and reach the pleura and there they may affect mesothelial cells in such a way that may cause

a mutation. However, it is only when such a mutation eventually develops the potential for malignancy including obtaining its own blood supply, that there is no restriction on continued growth and the tumour can become sufficiently large to start creating symptoms by way of breathlessness. Evidence was also heard from two biochemists, who considered that the stage at which the tumour obtained its own blood supply was probably only four to five years prior to death.

### Findings

Burton J found in favour of the Claimants on the basis of construction of the policy wordings. In coming to his conclusion, he took into account the “factual matrix” which relates to the surrounding circumstances including background knowledge that would have been available to the parties at the time of the contract and anything that would have affected the way in which the language would be understood. Construction of the wording had to be approached as at the date that the contract was entered into. At that time, there was no appreciation of mesothelioma as a disease let alone its aetiology.

Burton J found it was necessary to resolve the ambiguity that was applicable to Employers’ Liability policies only: that the policies applied to employees. He did not accept the Defendants’ argument that there was no ambiguity as ex-employees were covered if they developed a tumour when no longer an employee. The wordings under discussion derived in many cases from wordings relating back to the old Workers’ Compensation Act under which the injury or disease had to be sustained while the employee was employed and the employer was insured. Policy wordings remained that were dedicated to employees in employment during the policy period even after the many changes over the years and the end of the old Workers’ Compensation Act regime. Evidence of proposals was given and accepted which listed numbers and categories of employees and made no reference to ex-employees.

Burton J also found there was ample evidence that all insurers paid on an exposure basis so far as disease was concerned, although the reasons why they did this were varied rather than because of custom or usage. Whilst he found that the Employers’ Liability Compulsory Insurance Act of 1969 did not prescribe a causation wording, he did find that a policy trigger based on date of inhalation best complied with the Employers’ Liability Compulsory Insurance Act.

Burton J also concluded that when deciding a point of construction, the court should have an eye to the consequences. Whilst he was at pains to stress that sympathy was not a consideration, he noted that construction in one way would allow victims or their families to be compensated whilst at the same time, would make little difference to the insolvent insurers, taking into account that the majority of any payments would be made by the FSCS, and would prevent what he described as “a windfall” to the solvent run-off companies.

On the use of the words “sustained” and disease “contracted”, he found these equated to injury or disease “caused” and that the policies should be construed on a causation basis and therefore that the policy in force at the time of exposure should respond to the claim.

However Burton J found against the Claimants’ arguments in respect of a number of issues:

- He found, consistent with the findings in **Bolton** and in **Rothwell** (Pleural Plaques), that there is no disease at the time of inhalation. Whilst the medical process leading to malignancy may start soon after inhalation, this does not answer the question of when the injury took place.
- Even in the event he had found that an injury was sustained on inhalation, he did not consider that inhalation would constitute actionable damage.

- There was no custom or universal usage to pay out mesothelioma or similar claims under Employers' Liability policies by reference to the date of exposure, whatever the wording. Whilst accepting there was undoubtedly a practice of paying out mesothelioma claims, he did not find this constituted an established usage. The actual evidence indicated that some Underwriters were unaware of the different wordings in use or even if they were aware, either considered them inter-changeable in meaning or effect or did not consider there was much difference between them.
- The Employers' Liability Compulsory Insurance Act did not require, but encouraged, a causation policy.

Burton J confirmed that nothing in his judgment changed the position as set out by the Court of Appeal in **Bolton**. He acknowledged that "If I were to ask someone when their injury occurred and when their injury was sustained, those questions would be treated as duplicative, and the same answer would be given to each" (Paragraph 242). However, when considering the construction of the policy in **Bolton**, the court was construing a Public Liability policy worded on an occurrence basis and when considering the relevant factual matrix necessary to construe wording in a legal context, the Court of Appeal in **Bolton** did not consider any aspects in relation to Employers' Liability.

### The appeal

An appeal has now been lodged by the Defendants against the findings on the construction argument and it remains to be seen whether there will be a cross appeal on the question of date of injury and actionable damage.

The market will have to wait until the autumn to find out whether or not the existing market practice for asbestos related employers' liability claims is endorsed by the Court of Appeal.

**Judith Peters**

Partner, Weightmans LLP

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## Retrocessionaire not entitled to avoid 'WCA carve-out' contracts

In **Crane v Hannover Ruckversicherungs AG** (19 December 2008) Legion Insurance Company provided casualty insurance to businesses in the USA, including Workers Compensation Act (WCA) cover referred to as the "Mainframe Account". It was standard for such cover to comprise two sections. Section A gave cover for statutory benefits in respect of death or bodily injury arising from an accident at work. Section B gave cover for payments in respect of an employer's fault based liability for an accident, killing or injuring an employee.

In 1998, Hannover Re underwrote some excess of loss reinsurance policies giving cover to Legion for its liabilities in respect of business allocated to the Mainframe Account.

The claimant was active underwriter in Syndicate 53 at Lloyd's. By four excess of loss retrocession contracts, the Syndicate was a retrocessionaire of some of the Mainframe Accounts. For three of the four retrocession contracts the reinsured included Hannover Re.

The retrocession contracts did not apply to all classes of business covered by the Mainframe Account but were limited to Section A of the WCA cover. This was accordingly known as "WCA carve-out" reinsurance. The 1998 Mainframe Account carve-out contracts applied to occurrences during the 12 month period commencing on 1 October 1998. Two of the contracts provided a first and second layer of specific cover and the remaining two

provided a first and second layer of aggregate cover. Hannover was reinsured only under the first specific layer and the two aggregate layers.

The Syndicate avoided as against Hannover for misrepresentation and/or non-disclosure. Initially, the Syndicate alleged that Hannover had not disclosed “a series of grave concerns about Legion’s underwriting and claims handling”, and had not disclosed that the renewal for 1998 was driven at least partly “by political factors”. It was also alleged that false representations were made as to the existence of these features of the underwriting requirements.

During the course of the trial, the syndicates’ allegations were refined, to the three following final complaints:

- Non-disclosure by Hannover of underwriting and claims audits which it had conducted.
- Misrepresentation and/or non-disclosure concerning the comparative strictness of the underwriting requirements for the Mainframe Account.
- Misrepresentation and/or non-disclosure concerning the manner of Legion’s underwriting, in that Legion had allegedly underwritten by reference to an “underwriting box” and had not used actual loss histories provided by prospective insureds to calculate expected losses. The term ‘underwriting box’ in this context had nothing to do with Lloyd’s but rather refers to a special set of criteria to be met before program business could be allocated to the Mainframe Account.

Counter to these arguments, Hannover contended:

- The underwriting audits were not relevant. The Syndicate’s pleaded case concerned criticism of Legion’s loss rating approach to program business and as to that, Mr Crane had ample information to form his own judgment. As to the claims audits, they did not reveal any serious problems relating to the Mainframe carve-out renewal proposal.
- No prudent reinsurer could have made any sense of the vague representation asserted by the Syndicate. Hannover’s representations were no more than statements of its expectation and belief.
- The alleged misrepresentations were too vague and imprecise to have been material.

Mr Justice Walker held as follows:

- The underwriting and claims audits contained serious findings and concerns and these were known to Hannover. Hannover took them into consideration when making its decision to renew its participation in the reinsurance of the 1998 Mainframe Accounts but Mr Crane had not been able to consider these audits. However, as for any concerns arising from the underwriting audits, the 1998 carve-out renewal proposals described Legion’s loss rating approach. The major concern about the use of such an approach was in relation to heterogeneous business. Accordingly, Mr Crane was in just as good a position as Hannover to form his own view about Legion’s use of loss rating. As for the claims handling audits, overall the audits described Legion’s practises as no better or worse than average. This would not affect the judgement of a prudent underwriter.
- As for allegations that there was a misrepresentation and/or non-disclosure concerning the “comparative strictness of the underwriting requirements for the Mainframe Account”, Mr Crane was not given an inaccurate picture. He was given a full explanation about the arrangements for program business to be allocated. There was no evidence of falsity in relation to the actual loss history representation. No representation was made by Hannover about the prescribed methodologies used to calculate expected losses.

- As for the allegation regarding the misrepresentation and/or non-disclosure of the use by Legion of an 'underwriting box', this failed to have regard to the way in which the 'underwriting box' actually worked. The agreement between Hannover and Legion in relation to the 'underwriting box' was that Legion's underwriters would individually underwrite each new piece of business going into the program and that business had to have enough experience to qualify it for the Mainframe Account. Thus on each occasion when Legion agreed to provide cover for a particular program on the basis of the 'underwriting box' arrangement, it was providing cover to individual insureds by reference to their actual loss histories. The requirements for use of the 'underwriting box' were not inconsistent with the actual loss histories representation. Moreover, on the evidence before him, Walker J found that Mr Crane was told about the 'underwriting box' at a meeting in November 1998.
- The Syndicate must at least demonstrate that, but for the representations in question Mr Crane would not have written the 1998 Mainframe carve-outs on the terms that he did. The court considered that his reconstructions, in this regard, were unreliable therefore the Syndicate had not shown reliance on the representations.

Accordingly, the Syndicate was not entitled, as against Hannover, to avoid the 1998 Mainframe carve-outs.

**Colin Peck**  
**Partner, Weightmans LLP**

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## Offer and acceptance of reinsurance contract

In **Allianz Insurance Co Egypt v Aigaion Insurance Co SA** (19 December 2008), the claimant was reinsured by the defendant. The negotiations for a contract of marine reinsurance were conducted entirely by email via a broker between offices in different countries. Towards the end of negotiations, the defendant asked the broker to forward a slip recording the parties' agreement. The broker did so, but omitted from the slip a class warranty which had previously been stipulated by the defendant and agreed between the parties. Presumably failing to note the omission, the defendant responded in terms: "Cover is bound with effect from 31.03.05 as we had quoted" but did not expressly refer to the class warranty clause, although that clause was part of the original quote.

Following a casualty in a fleet of insured tugs, the question arose as to whether the defendant's final message was agreeing to cover with or without the class warranty clause. The claimant argued that it did not matter and that either way, there was a contract. The defendant submitted that there was no contract because the offer was on the basis the clause was not there and the "acceptance" was unsuccessful because it was on the basis previously quoted, i.e. including the clause. The issue was whether there was a contract in existence.

At first instance, it was held that although the defendant had agreed to provide cover that was limited to the terms of the slip in ignorance of the fact that the slip did not contain the warranty, in reality, the parties had agreed the terms of the policy should include the warranty. There was therefore a contract and the defendant was liable to the claimant for its share of the loss.

The defendant appealed on the basis that the issue of whether there was a contract or not could not be resolved without deciding whether the offer and acceptance were directed to the same terms. They were not, as the acceptance was limited to the terms stipulated. The parties were not *ad idem*.



The Court of Appeal dismissed the appeal. It is impossible to read the warranty into the slip. The slip was intended to be the definitive reference point, pending the issue of the policy document, of the terms of the parties' contract. On a true construction of the relevant email, the defendant was agreeing with the terms set out on the slip without realising that the slip had any difference from the terms quoted and previously agreed. It follows that there was a contract, but one which did not include the warranty.

(There was no issue as to breach of the class warranty on the facts. However, Rix LJ indicated that if this had been an issue, the parties may ask for rectification of the contract on the basis that the class warranty was mistakenly omitted from the contract).

**Ling Ong**  
Partner, Weightmans LLP

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## Failure of 'Machinery'

In **John Reilly v National Insurance & Guarantee Corporation Ltd** (19 December 2008), Reilly's business supplied and installed fire protection and detection systems. The respondent provided Employer's Liability and Public Liability insurance to Reilly.

The latter section of the policy excluded cover in respect of liability arising out of products supplied by Reilly. The section was subject to extensions, including one that excluded cover for any claim arising out of "the failure of any fire or intruder alarm switchgear control panel or machinery to perform its intended function".

Reilly supplied and installed fire suppression equipment to printing presses owned by a customer. The equipment consisted of cylinders of carbon dioxide gas which could be discharged through fixed pipes to the likely seats of fire in each press. A fire occurred in one of the presses and the system failed to operate as intended. The fire spread and damaged the press and surrounding property. The customer claimed against Reilly and obtained judgment.

Reilly claimed under his insurance policy but the Respondent declined to indemnify him. At first instance, the court ordered, on the trial of a preliminary issue, that Reilly's claim was excluded from cover under the insurance policy. The clause was to be construed as referring to fire and intruder alarms, switch gear, control panels and machinery as separate items of equipment, which constituted "machinery" within the meaning of the policy. Therefore, the failure of the system arose out of the failure of a piece of machinery to perform its intended function.

Reilly appealed against that order, contending that the words "fire or intruder alarm" governed everything that followed, so that the clause as whole was limited to the failure of fire and intruder alarm systems to perform their intended function. In that case, the clause would not exclude Reilly's claim because he supplied fire *suppression* equipment.

The Court of Appeal allowed the appeal in part, holding that:

- The commercial object of the contract as a whole, or the clause in question, is relevant in resolving any ambiguity in the wording. The clause is to be read as containing a list of various items in respect of whose failure to perform as intended cover is excluded. The failure of the system as a whole constituted a failure of machinery to perform its intended function with the result that the insurer is not liable under the policy.

- There is no commercial sense in construing the clause in a way that requires a distinction to be drawn between different components of an alarm system when damage has been caused following its failure. What matters to the insurer is whether the alarm system has worked as intended.
- The Court of Appeal was unable to accept the first instance judge's conclusion that the equipment as a whole in this case can properly be described as 'machinery'. Rather, it is equipment which incorporates various components, some of which could be described as machinery and some of which could not.
- In this case, the master cylinder valves and actuators were designed to operate as a single mechanical unit to allow the release of gas and were therefore machinery because of their complexity and reliance on moving parts. However, that description did not extend to the cylinders themselves or pipe work because, although connected, they were separate components.
- It follows that if the system failed due to the failure of the piston in the actuator mechanism to latch properly, that was a failure of "machinery" to perform its intended function and the claim was excluded from cover. If the failure was due to insufficient pressure in the master cylinder, the claim would not be excluded from cover as the cylinder was not "machinery". Equally, if the failure was caused by insufficient pressure in the master cylinder resulting from leakage from the valve, the claim would not be excluded.

**Karen Purchase**  
**Weightmans LLP**

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## **Scheme report not necessary on issue of application for Part VII Transfer**

In **Re Names at Lloyd's** (3 December 2008), the court had to determine whether to waive the requirements of s.109(1) of the Financial Services and Markets Act 2000 (FSMA) in certain circumstances. That section required an application under s.107 of FSMA to be accompanied by a scheme report.

The case was unusual in that the application for the waiver was made before the publication of a scheme report. The applicants, Equitas Ltd and Speyford Ltd, had made an application in respect of the interests of Names at Lloyd's concerning 1992 and prior years, for a waiver of certain publicity requirements associated with transfer of insurance business under Part VII of FSMA.

The application was granted for the following reasons:

- The word "application" took its meaning from context and purpose. There was nothing to indicate that the word "application" in s.109(1) was directed solely at the originating process itself. "Application" was a broad term taken to refer to the originating process, but it could also refer to the proceedings thereafter.
- If "application" was read in a wider sense, the requirement that it be accompanied by the scheme report did not of necessity relate to the time of issue of the originating process. The court drew an analogy between the statutory requirements here and some provisions under the Civil Procedure Rules, which stipulate that certain types of application must be supported by evidence.

- The purpose of the scheme report was that it should be available to the court and policyholders before the scheme was sanctioned. However, in order to satisfy that purpose, it was not necessary for it to be annexed to the claim form at the date of issue of the originating application. It was sufficient if the report was available when it was needed and well before the court sanctioned the scheme.

**Colin Peck**  
**Partner, Weightmans LLP**

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## Guest article

We are delighted to have a guest article in this edition from Dr Herbert Palmberger and Manfred Oesinghaus both partners in the insurance and reinsurance group at law firm Heuking Kühn Lüer Wojtek in Dusseldorf, Germany.

Our London Market team has good relations with a number of insurance and reinsurance law firms throughout the globe and we are pleased to count Heuking Kühn Lüer Wojtek amongst those contacts.

Please note, however, that there are no formal ties between Weightmans and any other law firm and the views expressed in this article are those of the authors.

### 2008 – One Year of Experience under the New German Insurance Contract Law

During the course of the year 2009 the German (re)insurance market could experience in its day to day business practice the effects of the new Insurance Contract Law which entered into force on 1 January 2008. It replaced the former Insurance Contract Law which first was enacted almost 100 years ago. The primary insurers in particular are in the process of gaining first experiences with completely new requirements for designing and selling insurance products, particularly in the area of life insurance.

The existing Insurance Contract Law – although continuously amended – no longer corresponded to many aspects of modern jurisprudence and consumer protection. In part the jurisprudence which had been developed over the last decades was distinct from – and often contrary to – the law. The German legislator considered this situation no longer tolerable. Further, a number of EU Directives had to be integrated and implemented into German law. Examples include the Distance Selling Directive and the Directive on Insurance Mediation.

The reform of the Insurance Contract Law modernises the insurance regulatory landscape and intensifies the insured's' protection. Furthermore, the transparency of policy conditions has been improved by numerous duties which ensure the information of the insureds.

The new Insurance Contract Law applies to all new contracts which came into force on or after 1 January 2008, the date of its enactment. During the course of 2008 existing contracts still fell under the previous law. However, since 1 January 2009 even insurance contracts that came into force prior to 1 January 2008 will have to be treated in accordance with the new law. Insurance companies had the right to adapt the policy conditions of the old contracts to the new law during 2008. This had to be communicated to the insureds by 30 November 2008 at the latest, thus giving them sufficient time to become acquainted with the new rules.

## **The essentials of the reform with impact on the design and sale of insurance products**

The new Insurance Contract Law's most substantial changes include:

- Improved advice and information for insureds
- Abandonment of the "all or nothing principle"
- Modernisation of life insurance

### **Duty to advise and to inform**

One of the most significant changes within the new Insurance Contract Law is the expansion of the insurer's duty to advise the insured. In the future the insurers themselves have to advise the insureds before the conclusion of an insurance contract, and they have to do so comprehensively, unless the insurance contract is concluded through the medium of an insurance broker or by way of distance selling. This duty to advise exists even during the full period of duration of the insurance contract. Advice has to be given by the (tied) insurance agent or by the in-house sales manager of the insurer, to whom the client may turn to with such a request.

The advice has to be clear and comprehensible, and the wishes and needs of the insured have to be taken into account fully. The advice given has to be recorded in writing; therefore, insurers have developed a unified form which is distributed for that purpose to all the agents, brokers and in-house personnel.

Additionally, the insurer has to inform the insured about the contractual and the general insurance conditions well before the conclusion of an insurance contract. These conditions have to be handed over to the insured in written form or otherwise (e.g. as an e-mail, on a compact disc or memory stick).

The amount and quality of the information which has to be conveyed to the insured – and the manner of how such information has to reach the insured – is prescribed in the Regulation on Duties of Information, which came into force on 1 July 2008. In accordance with the rules of the regulation a so called "product information sheet" (Produktinformationsblatt) has to be handed over to any insured who neither is a tradesman (Gewerbetreibender) nor a freelancer (Freiberufler). This product information sheet is the cover note of all the following contractual information and has to contain the essential parameters of the insurance policy and relevant duties of the insured in a brief and comprehensive form.

### **Abandonment of the "all or nothing principle"**

The "all or nothing principle" was relevant particularly in the areas of non-life and accident insurance. The absolutely inflexible principle of the expiring law (i.e. that the violation of duties of disclosure and of contractual obligations of the insured would lead to the effect that the insured would lose any right on his insurance claim), frequently led to unjust results. The Insurance Contract Law reform therefore has introduced completely new and general principles for consequences of violations of contractual obligations.

Now, the legal consequences are differentiated, particularly in cases of increased perils or the violation of contractual or legal obligations of the insured. Intentional and malicious acts still lead to a complete release of the insurer from his obligations. Gross negligence of the insured, results in a claim decrease depending on the gravity of the insured's fault. Acts by the insured that are merely negligent (i.e. not "grossly negligent") no longer have any consequence on the amount of the claim. Except in the event of malicious acts by the insured towards the insurer, the consequence of a decrease of the claim occurs only if the violation of the duty of disclosure or of obligations of the insured has caused an error or misconception on the side of the insurer.

### **Modernisation of life insurance**

For the first time in German legal history the insured is granted a legal claim to participate in the hidden reserves as part of the surplus participation of his life insurance contract. The customer now is able to participate also in those profits which have not yet realised but have been achieved by his premiums. The insurance companies have to disclose their hidden reserves and to inform the insured about his share which is

attributable to his contract on an annual basis. Some 50 % of the hidden reserves which are attributable to the premiums of the insured have to be paid out at the termination of the insurance contract. The remaining 50% are for the benefit of the insureds who remain customers of the company in order to equalise fluctuations in value of such hidden reserves. From the date of enforcement of the new Insurance Contract Law on 1 January 2008 each customer has such a claim with respect to the remaining period of his contract.

For purposes of the calculation of the redemption value in the event of a cancellation of the insurance contract, the acquisition costs have to be spread on a fictitious basis over five years. This means that a customer in the event of cancellation of his policy within the first five years achieves a considerably higher repurchase value than in the past. The insurer, on the other hand, under normal practice will pay the acquisition costs to brokers and agents as a one-off payment in the beginning of the contract period.

Life and health insurers now have to disclose their respective acquisition and distribution costs for each insurance policy. The specifics are ruled in the above mentioned regulation on information duties. In particular this item led to massively controversial discussions between the insurers and the legislator, due to the fact that the acquisition and distribution costs are a factor of competition between the various insurance companies which may influence the choice of the customer when it comes to the conclusion of an insurance contract.

### **Conclusions**

Time will tell whether the primary insurers will be able to comply with these new demands of the legislator and whether the new situation in fact will have the expected negative impact on the calculation of premiums, the amount of the insurance benefits and the design of the insurance products.

Further, the market is interested to see how the courts will interpret and apply the new rules, particularly the quotation of claims. However, to date not too many litigious cases have reached the courts. Even now, it seems clear that the increased demands for administration which are added to the burden of the insurers will be added to the costs of the insurance products.

Nevertheless it will take a few years – on the basis of the so-gained experience – until conclusions may be drawn also for the long term cooperation with reinsurers. Therefore, all market participants have high financial and factual interests in future developments.

**Herbert Palmberger**  
Partner, Heuking Kühn Lüer Wojtek

**Manfred P. Oesinghaus**  
Partner, Heuking Kühn Lüer Wojtek

## Catch up

You can catch up with members of our London Market team at the following events:

- **AirSP 6<sup>th</sup> Anniversary drinks**, London – 4 February 2009 – Colin Peck and Ling Ong attending
- **Charity Quiz Night (Brownie Points the Third)**, London – 5 February 2009 – Ling Ong & members of our professional risk team attending
- **BILA Charitable Trust Event**, London – 10 February 2009 – Colin Peck and Ling Ong attending
- **ARC Congress**, London – 24–25 February 2009 – Colin Peck and Ling Ong attending
- **Weightmans Seminar at Lloyd's**, London – 12 March 2009 – Colin Peck and Ling Ong speaking

If you need to contact any members of our London Market team before these events or if any queries arise from the contents of this newsletter, please see below for contact details:



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