Prudential—Insurance Rulebook (PINS)

Version No. 5

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Miscellaneous Amendments Rules 2009
QFCRA Rules 2009-2

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Background to this Rulebook

1. The Prudential – Insurance Rulebook (*PINS*) sets out the *Regulatory Authority's* prudential requirements for all *Insurers*. *QFC* legislation allows the following legal entities to seek authorisation as an *Insurer*: a *QFC* body corporate; a non-*QFC* incorporated *Insurer* (a *Branch*); or a *Protected Cell Company*. *Insurance Business* includes direct insurance, reinsurance, captive insurance and takaful (including re-takaful) for all *Categories* of *General Insurance Business* and *Long Term Insurance Business*.

2. This rulebook sets out the detailed financial resources and prudential standards which the *Regulatory Authority* applies to *Insurers*. The *Rules* and guidance in this rulebook will assist the *Regulatory Authority* to meet its objective of providing appropriate protection to those authorised to carry out *Insurance Business* in the *QFC* and their policyholders. This rulebook does so by setting a *Minimum Capital Requirement* and other risk management standards thereby mitigating the possibility that *Insurers* will be unable to meet their liabilities and commitments to policyholders.

3. *Insurers* may be subject to conditions on their authorisation that limit which *Categories* of *Insurance Business* or types of business they can conduct in or from the *QFC*.

4. The *Regulatory Authority* will continue to monitor international developments (especially the ongoing development of international standards under the auspices of the International Association of Insurance Supervisors) in respect of prudential standards, capital adequacy and corporate governance. The *Regulatory Authority* will address these matters and the operation generally of this rulebook in a future review of *PINS*.

1 General Requirements

1.1 Application

1.1.1 This rulebook (*PINS*) applies to every *Insurer* except where otherwise provided.

1.1.2 For the purposes of *PINS*, except where otherwise provided, conducting *Insurance Business* includes *Effecting a Contract of Insurance* or *Carrying out a Contract of Insurance* or both.

1.1.3 For the purposes of *PINS*, the defined term *Takaful Entity* will be used where the requirements apply to both *Islamic Financial Institutions* and *Insurers* operating an *Islamic Window*.

Guidance

1. The *Regulatory Authority* may modify or waive the operation of certain *Rules* or specified parts of such *Rules* in appropriate circumstances. The *Regulatory Authority* is more likely to consider such modifications or waivers in the case of those *Insurers* operating in the *QFC* through a *Branch*. *Rules* and guidance on applying for a waiver or modification are contained in GENE chapter 7.

2. Failure by an *Insurer* to comply with any *Rule* in the rulebook that applies to the *Insurer* may be a contravention of a *Relevant Requirement*. If the *Regulatory Authority* considers an *Insurer* has contravened a *Relevant Requirement*, it may impose upon the *Insurer* a range of disciplinary and enforcement actions as provided for under Part 9 of the *FSR*.

1.2 Financial Resources

1.2.1 An *Insurer* must:

(A) have and maintain at all times financial resources of the kinds and amounts specified in, and calculated in accordance with the *Rules* in this rulebook; and

(B) ensure that it maintains financial resources in addition to the requirement in (A) which are adequate in relation to the nature, scale and complexity of its business to ensure that there is no significant risk that its liabilities cannot be met as they fall due.

Guidance

For the purposes of Rule 1.2.1, the *Insurer's Governing Body* should assess whether the minimum financial resources which are required by the *Regulatory Authority* as set out in this rulebook are adequate in relation to the *Insurer's* specific business. Additional financial resources should be maintained by the *Insurer* where its *Governing Body* has considered that the required minimum financial resources do not adequately reflect the nature, scale and complexity of the *Insurer's* business.

1.3 Governing Body Certification

1.3.1 Requests for views of insurer's governing body

(1) The *Regulatory Authority* may, by *written* notice given to an *insurer*, request the *governing body* of an *insurer* to give the authority, within a stated reasonable period, its view in *writing* about—

(A) the Insurer's compliance with any relevant Rule or requirement to which the Insurer is subject to under QFC law;

(B) any prudential returns or any other statement or return being true and correct and not false or misleading; or

(C) any other matter the *Regulatory Authority* specifies in the request.

(2) The *authorised firm* must ensure that the request is complied with.

(3) The power given by this rule is additional to the *Regulatory Authority's* other powers.

Note See eg *Financial Services Regulations*, art 48 (Powers to obtain documents and information).

1.4 Prudential returns

1.4.1 (1) An *insurer* must, in accordance with rule 1.4.2, prepare the annual, biannual and quarterly prudential returns that it is required to prepare by notice published by the *Regulatory Authority*.

(2) The *Regulatory Authority* may, by notice given to an *insurer*—

(a) require the *insurer* to prepare additional prudential returns; or

(b) exempt the *insurer* from the requirement to prepare annual, biannual or quarterly returns or a particular annual, biannual or quarterly return.

(3) An exemption under subrule (2) (b) may be subject to conditions, restrictions or requirements.

(4) An *insurer* given an exemption under subrule (2) (b) must comply with all conditions, restrictions and requirements to which the exemption is subject.

1.4.2 (1) A prudential return must be prepared—

(a) using the appropriate forms approved and published by the *Regulatory Authority*; and

(b) in accordance with any instructions (***relevant instructions***)—

(i) in the forms; or

(ii) published by the *Regulatory Authority*.

(2) Without limiting subrule (1) (b)—

(a) a prudential return must be signed in accordance with any relevant instructions; and

(b) a declaration or certification required by any relevant instructions must be completed, and provided to the *Regulatory Authority*, in accordance with the instructions.

Note *GENE*, ch 5 applies to the provision of prudential returns to the *Regulatory Authority*.

(3) To remove any doubt, subrule (2) has effect despite *GENE*, rule 5.2.2.

1.4.5 If the *Regulatory Authority* notifies an *Insurer*, or the *Insurer* itself forms the view, that a prudential return that has been submitted to the *Regulatory Authority* appears to be inaccurate or incomplete, the *Insurer* must consider the matter and correct it, if applicable, within such periods as required by the *Regulatory Authority*, or otherwise within a reasonable period of the date of notification, and re-submit the relevant parts of the return to the *Regulatory Authority*.

1.4.6 Time limit for annual prudential returns of insurers

An *insurer* must give an annual prudential return to the *Regulatory Authority* within 4 *months* after the day the relevant financial year of the *insurer* ends.

Example
If a financial year of an *insurer* ends on 31 December in a year, the annual prudential return for the year must be given to the *Regulatory Authority* before 1 May in the next year.

1.4.7 Time limit for biannual prudential returns of insurers

(1) An *insurer* must give a biannual prudential return to the *Regulatory Authority* within 1 *month* after the day the relevant standard biannual period ends.

Example
If a standard biannual period ends on 30 June in a year, the biannual prudential return for the period must be given to the *Regulatory Authority* before 1 August in the year.

(2) In this rule:

standard biannual period means the 6-month period ending on 30 June or 31 December.

1.4.8 Time limit for quarterly prudential returns of insurers

(1) An *insurer* must give a quarterly prudential return to the *Regulatory Authority* within 1 *month* after the day the relevant standard quarter ends.

Example

If a standard quarter ends on 31 March in a year, the quarterly prudential return for the period must be given to the *Regulatory Authority* before 1 May in the year.

(2) In this rule:

standard quarter means the 3-month period ending on 31 March, 30 June, 30 September or 31 December.

1.5 Restrictions on insurance business

1.5.1 An insurer must not carry on, in or from the QFC, both long term insurance business and general insurance business unless the general insurance business is restricted to categories 1 (accident) and 2 (sickness).

1.5.2 An insurer that is a protected cell company must ensure that, when it carries on insurance business, the business is attributable to a particular cell of the insurer.

1.5.3 An insurer must not carry on any activity other than insurance business unless the activity is directly connected with, or carried on for the purposes of, insurance business.

1.5.4 For this rule, managing investments is not an activity directly connected with, or carried on for the purposes of, insurance business.

Guidance

1. The following activities will normally be considered to be directly connected with, or carried on for the purposes of, *insurance business* carried on by an *insurer*:

   a. investing, reinvesting or trading, as investor or rabb ul maal and for the *insurer's* own account, that of its *subsidiary*, its *holding company* or any *subsidiary* of its *holding company* but not any other party, in *shares*, *debt instruments*, investment accounts, *units* in *collective investment funds*, certificates of mudaraba, certificates of musharaka or other forms of investments that are intended to earn profit or return for the investor;

   b. rendering other services related to *insurance business* operations including actuarial, risk assessment, loss prevention, safety engineering, data processing, accounting, claims handling, loss assessment, appraisal and collection services;

   c. acting as agent for another insurer in relation to *contracts of insurance* in which both insurers participate;

   d. establishing *subsidiaries* or *associates* engaged or organised to engage exclusively in 1 or more of the businesses mentioned in a. to c.;

   e. *insurance mediation business*.

2. The *Regulatory Authority* may give individual guidance on other business activities that may be taken to be directly connected with, or carried on for the purposes of, *insurance business* carried on by an *insurer*.

2 Risk Management

2.1 Application and Purpose

2.1.1 This chapter applies to every *Insurer*.

Guidance

1. CTRL Rule 4.4.1 requires an *Insurer* to establish and regularly review its risk management policy which must be appropriate in light of the nature, scale and complexity of its business.

2. CTRL Rule 4.4.2(A) requires an *Insurer* to identify and assess those risks relating to the *Insurer's* activities, processes and systems.

3. The purpose of this chapter is to:

   a. identify those risks that must be specifically addressed in an *Insurer's* risk management policy for the purposes of CTRL Rule 4.4.2(A); and

   b. set out requirements for an *Insurer* to document its risk management policy through the establishment and maintenance of a *Risk Management Strategy* in accordance with section 2.3.

4. The governance, management and solvency of an *Insurer* remains the responsibility of the *Governing Body*. The *Governing Body* should have in place effective governance and management arrangements within the *Insurer*.

2.2 Risks to be addressed in an Insurer's Risk Management Policy

2.2.1 An *Insurer* must address, at a minimum, the following risks in its risk management policy:

(A) credit risk;

(B) balance sheet and market risk;

(C) reserving risk;

(D) insurance risk;

(E) reinsurance risk;

(F) operation risk;

(G) group risk;

(H) concentration risk, including risk type, counterparty, geographical, and industry concentration risks which may arise as a result of any of the above-listed risk categories; and

(I) strategic and tactical risks that arise out of the *Insurer's* business plan.

Guidance

1. Appendix 1 contains guidance for *Insurers* in respect of risk management for these risks.

2. The business plan in Rule 2.2.1(I) is required under CTRL section 4.8.

2.3 Insurer's Risk Management Strategy

Guidance

1. The *Risk Management Strategy* is a high level, strategic document intended to describe the key elements of an *Insurer's* risk management policy, including the risk appetite, policies, procedures, management responsibilities and controls, as set out in Rule 2.3.5.

2. An *Insurer's Risk Management Strategy* would typically not contain policies or procedures that underpin the risk management policy, but may refer to them for illustrative purposes.

3. An *Insurer's Risk Management Strategy* should be appropriate to the nature, scale and complexity of the *Insurer's* business.

4. It is of fundamental importance that *Branches* have in place a risk management policy and *Risk Management Strategy*. Local and regional factors and circumstances can differ significantly from those facing the head office. It is important not just for the *Regulatory Authority*, but also for the head office of the *Insurer*, to understand the risk position of their *Branch* operations.

2.3.1 An *Insurer* must maintain a written *Risk Management Strategy* in accordance with the requirements in Rule 2.3.5.

2.3.2 An *Insurer* conducting *Insurance Business* who is in the legal form of a *Protected Cell Company* must ensure that each *Cell* maintained by the *Insurer* maintains a *Risk Management Strategy* that relates to that *Cell* and which also addresses the risks affecting the *Protected Cell Company* as a whole that have a bearing on that *Cell*.

2.3.3 An *Insurer* must not intentionally deviate in a material way from its *Risk Management Strategy* except where this deviation has been approved by the *Governing Body* and notified to the *Regulatory Authority* prior to the deviation occurring.

2.3.4 (1) An *Insurer* must review its *Risk Management Strategy*, in accordance with the process described by the *Insurer* in Rule 2.3.5(H), at least annually to ensure that it accurately documents its risk management policy, including the key elements identified in Rule 2.3.5.

(2) An *Insurer* must review, and amend if necessary, its *Risk Management Strategy* whenever there has been a material change to its risk management policy, including the key elements identified in Rule 2.3.5.

2.3.5 An *Insurer* must ensure that at a minimum, subject to relevance, its *Risk Management Strategy*:

(A) outlines the risk governance relationship between the *Governing Body*, *Governing Body* committees and *Senior Management*;

(B) describes the process for identifying and assessing risks;

(C) describes the process for establishing mitigation and control mechanisms for individual risks;

(D) describes the process for monitoring and reporting risk issues (including communication and escalation mechanisms);

(E) describes the processes for ensuring the *Insurer's* reinsurance arrangements are being prudently and soundly managed, and, at a minimum:

(i) defines and documents the *Insurer's* objectives and strategy for reinsurance management and control, reflecting the *Insurer's* appetite for risk;

(ii) describes the systems for the selection of reinsurance brokers and other reinsurance advisers;

(iii) describes the systems for selecting and monitoring reinsurance programmes;

(iv) clearly defines managerial responsibilities and controls;

(v) describes clear methodologies for determining all aspects of a reinsurance programme, including:

(a) identification and management of aggregations of risk exposure;

(b) selection of maximum probable loss factors;

(c) selection of realistic disaster scenarios, return periods and geographical aggregation areas; and

(d) identification and management of vertical and horizontal coverage of the reinsurance programme;

(vi) provides a summary of the process for ensuring accurate and complete reinsurance documentation is put in place;

(vii) describes the selection of participants on reinsurance contracts, including consideration of diversification and creditworthiness;

(viii) describes the processes for monitoring the creditworthiness of participants selected for reinsurance contracts;

(ix) describes the systems for identifying credit exposures (actual and potential) to individual reinsurers or *Groups* of connected reinsurers on programmes that are already in place; and

(x) describes the processes for entering into any limited risk transfer arrangement;

(F) describes the approach to ensuring relevant staff have an awareness of risk issues and instilling an appropriate risk culture, including the level of accessibility of the *Risk Management Strategy*;

(G) identifies those persons in *Senior Management* and their positions in the *Insurer* (or insurance *Group*) with responsibility for the risk management policy, and sets out their roles and responsibilities;

(H) describes the processes by which the risk management policy, in accordance with the requirement in CTRL Rule 4.4.1, and the *Risk Management Strategy*, in accordance with the requirements in Rule 2.3.4, are reviewed, and outlines the broad coverage for these reviews;

(I) provides an overview of the mechanisms in place for monitoring and ensuring continual compliance with the *Minimum Capital Requirement*;

(J) provides an overview of the processes and controls in place for ensuring compliance with all other prudential requirements;

(K) if the *Insurer* is part of a *QFC* or global corporate *Group*, or is a *Branch*:

(i) includes a summary of the *Group* policy objectives and strategies;

(ii) states whether the local *Risk Management Strategy* is derived wholly or partially from the *Group* risk management arrangements;

(iii) summarises the linkages and significant differences between the local *Risk Management Strategy* and *Group* risk management arrangements including relevant local business and other conditions;

(iv) outlines the process for monitoring by, or reporting to, the *Parent Entity* or head office as well as summarising the key procedures, the frequency of reporting, and provides the approach to reviews;

(v) where any element of an *Insurer's* risk management policy is controlled by another entity in the *Group*, or by head office, describes how this arrangement works;

(vi) includes, if applicable, a summary of the *Group* policy objectives and strategies relating to reinsurance;

(vii) summarises the linkages between the local and *Group* reinsurance arrangements;

(viii) where any element of an *Insurer's* reinsurance management policy is controlled by another entity in the corporate *Group*, or by head office, includes details of all such arrangements, including claims settlement procedures where the *Parent Entity* or head office purchases reinsurance on a global *Group* basis;

(ix) details any arrangements relating to the existence of, and accessibility to, intra-group reinsurance arrangements; and

(x) where an *Insurer*:

(a) is part of a global insurance *Group* where the head office or ultimate *Holding Company* is outside of the *QFC*; or

(b) is a *Branch*,

includes a summary of the home regulator's supervisory arrangements regarding risk management; and

(L) clearly addresses, and distinguishes between, the risks in respect of:

(i) the business of the *Insurer* conducted in or from the *QFC*;

(ii) the business of the *Insurer* conducted in the *State* otherwise than in or from the *QFC*; and

(iii) the business of the *Insurer* conducted in any other country other than the *State*.

2.4 Approval by Governing Body

2.4.1 (1) An *Insurer* must ensure that its *Risk Management Strategy* is approved by the *Governing Body* of the *Insurer* and that in giving such approval the *Governing Body* of the *Insurer* is satisfied that:

(A) the *Risk Management Strategy*, including any change to it, describes the key elements of the *Insurer's* risk management policy; and

(B) the risk management policy described in the *Risk Management Strategy* is appropriate and provides reasonable assurance that all material risks facing the *Insurer*, including, as a minimum, those identified in Rule 2.2.1, are being prudently and soundly managed having regard to such factors as the nature, scale and complexity of the *Insurer's* business.

(2) An *Insurer* must ensure its *Governing Body* reviews and approves under Rule 2.4.1(1) the *Risk Management Strategy* whenever there is any change to it, or whenever the *Insurer's* risk management policy is materially altered, and, in any event, no less than on an annual basis.

(3) An *Insurer* must lodge its *Risk Management Strategy* with the *Regulatory Authority*, including any subsequently amended version of the *Risk Management Strategy* approved by the *Governing Body*, within ten *Business Days* of it being so approved.

3 Minimum Capital Requirement

3.1 Application and Purpose

3.1.1 This chapter applies to every *Insurer* incorporated in the *QFC*.

3.1.2 In addition, for an *Insurer* which is in the legal form of a *Protected Cell Company*, the requirements of this chapter apply to every *Cell* that the *Insurer* maintains as if each *Cell* were a single *Insurer*.

Guidance

1. The amount of capital is fundamental to the financial strength of an *Insurer*. It provides a buffer against losses that have not been anticipated and, in the event of problems, enables the *Insurer* to continue operating while those problems are addressed or resolved. In this way, the maintenance of adequate financial resources can engender confidence on the part of policyholders, creditors and the market more generally in the financial soundness and stability of the *Insurer*. An *Insurer's* financial resources must be adequate for the nature, scale and complexity of its business.

2. The purpose of this chapter is to require *QFC* incorporated *Insurers* to meet at all times a *Minimum Capital Requirement* that is responsive to the risk profile of each *Insurer* and is calculated in accordance with the *Rules* of this chapter.

3. An *Insurer's Minimum Capital Requirement* is the highest of either the applicable *Base Capital Requirement* (a set figure, for example US$10 million for all direct *Insurers*), or the figure calculated using either the *Regulatory Authority's* standardised risk based capital model, the *Insurer's Internal Model* if approved to do so by the *Regulatory Authority*, or a combination of the *Regulatory Authority's* model and the *Insurer's Internal Model* if so approved by the *Regulatory Authority*.

4. As *Insurers* authorised to conduct *Insurance Business* in or from the *QFC* in the legal form of a *Branch* will be subject to the regulatory capital requirements applicable in their home jurisdiction, the requirements of this chapter do not apply to *Branches*.

3.2 General Requirement

3.2.1 An *Insurer* must at all times have *Eligible Capital* equal to or higher than the amount of its *Minimum Capital Requirement* as determined by Rule 3.3.1.

3.2.2 For the purposes of Rule 1.2.1 and Rule 3.2.1, the *Governing Body* of an *Insurer* must ensure suitable systems and controls are in place to allow it to identify, manage and monitor the risks associated with the *Insurer's* business activities to ensure the *Insurer* holds capital commensurate with its overall risk profile.

Guidance

Rules for determining *Eligible Capital* are contained in chapter 4.

3.2.3 For the purposes of Rule 3.2.2, the systems and controls must include an analysis of:

(A) realistic scenarios which are relevant to the circumstances of the *Insurer*; and

(B) the effects of those scenarios, if they occurred, on the *Insurers* ability to meet its *Minimum Capital Requirement*, and on its financial resources generally.

Guidance

Appendix 2 provides guidance on the nature and type of stress and scenario testing the *Insurer* should be undertaking to support its view that it has adequate financial resources to meet its obligations.

3.2.4 An *Insurer's* systems and controls for the purposes of Rule 3.2.2 must allow the *Insurer* to demonstrate to the *Regulatory Authority*, if at any time it is asked to do so by the *Regulatory Authority*, the *Insurer's* compliance with Rule 1.2.1 and Rule 3.2.1.

Guidance

As an *Insurer* is required to maintain adequate financial resources at all times, its systems and controls need to enable the *Governing Body* to determine and monitor the capital requirements of the *Insurer* and the financial resources it has available, and to identify occurrences where the financial resources fall short of the capital requirements of the *Insurer*, or where they may fall short in the future.

3.3 Minimum Capital Requirement

3.3.1 (1) An *Insurer's Minimum Capital Requirement* is the highest of:

(A) the applicable *Base Capital Requirement* as determined by Rule 3.4.1; or

(B) the *Risk Based Capital Requirement*.

(2) An *Insurer* must calculate its *Risk Based Capital Requirement* in accordance with Rule 3.5.1

Guidance

If the *Regulatory Authority* considers that a higher capital requirement is appropriate for a particular *Insurer*, the *Regulatory Authority* may impose higher requirements by the imposition of a condition on the relevant *Insurer's Authorisation* under Article 31 of the *FSR*.

3.4 Base Capital Requirement

3.4.1 (1) The table below sets out the *Base Capital Requirement* for all *Insurers* other than *Captives*.

Type of Insurer	Base Capital Requirement
Direct *Insurer*	US $10 million
Reinsurer	US $20 million

(2) The table below sets out the *Base Capital Requirement* for all classes of *Captives*.

Type of Insurer	Base Capital Requirement
Class 1 Captive Insurer	US $150 thousand
Class 2 Captive Insurer	US $1 million
Class 3 Captive Insurer	US $250 thousand

3.5 Risk Based Capital Requirement

3.5.1 An *Insurer's Risk Based Capital Requirement* is:

(A) the total of:

(i) the *Investment Risk Requirement*; and

(ii) the *Insurance Risk Requirement*; or

(B) if the *Insurer* has been approved to do so by the *Regulatory Authority* under Rule 3.8.1, the figure calculated using the *Insurer's Internal Model*; or

(C) if the *Insurer* has been approved to do so by the *Regulatory Authority* under Rule 3.8.2, the figure calculated by combining the *Insurer's Internal Model* and those components of the *Investment Risk Requirement* and *Insurance Risk Requirement* in accordance with Rule 3.8.2(2).

3.6 Investment Risk Requirement

Guidance

Imposing a capital charge for the *Investment Risk Requirement* is in response to the risk of an adverse movement in the value of an *Insurer's* assets and/or off-balance sheet exposures. The methodology for determining each of the components of the *Investment Risk Requirement* is set out in Appendix 3.

3.6.1 An *Insurer* must calculate its *Investment Risk Requirement* as the sum of the following components:

(A) credit risk component;

(B) volatility risk component;

(C) off-balance sheet asset risk component;

(D) off-balance sheet liability risk component; and

(E) concentration risk component

in accordance with the *Rules* contained in Appendix 3.

3.7 Insurance Risk Requirement

Guidance

Imposing a capital charge for the *Insurance Risk Requirement* is in response to the risk that the true value of an *Insurer's* net *Insurance Liabilities* may be greater than the value determined under chapter 8 (Measurement of Assets and Liabilities of Insurers). The methodology for each of the components determining the *Insurance Risk Requirement* is set out in Appendix 3.

3.7.1 An *Insurer* must calculate its *Insurance Risk Requirement* as the sum of the:

(A) premium risk component;

(B) technical provision risk component; and

(C) long term insurance risk component

in accordance with the *Rules* contained in Appendix 3.

3.8 Internal Modelling

Guidance

Insurers around the world use internal models for assessing their capital requirements. From an internal perspective, risk models provide an opportunity for the management to identify and measure risks. It is also possible to quantify the minimum level of capital corresponding to a given risk appetite, which in turn guides capital allocation/management. Risk models offer the advantage of combining all relevant operations of an insurer (e.g. underwriting, investment, pricing, assets, and liabilities) into an integrated model which provides an insight into future operations and capital requirements. They can also be useful for evaluating alternative business strategies and focusing on major risk scenarios, including what might happen if more than one thing goes wrong. If the model is well developed, an insurer would have sufficient information for assessing its major risk areas and allocating resources accordingly.

3.8.1 An *Insurer* may, if it has obtained written approval from the *Regulatory Authority*, use its own *Internal Model* in order to calculate its *Risk Based Capital Requirement*.

3.8.2 (1) An *Insurer* may, if it has obtained written approval from the *Regulatory Authority* to do so, use its own *Internal Model* to replace specified components of the *Investment Risk Requirement* and *Insurance Risk Requirement.*

(2) An *Insurer* must continue to use those components of the *Investment Risk Requirement* and *Insurance Risk Requirement* not specified as per (1), when calculating its *Risk Based Capital Requirement* as required by Rule 3.5.1.

3.8.3 The *Regulatory Authority* will only consider approving the use of an *Internal Model* if the following criteria are met:

(A) the *Regulatory Authority* is satisfied that the *Insurer's Internal Model*:

(i) operates within a risk management environment that is conceptually sound and supported by adequate resources;

(ii) addresses all material risks to which the *Insurer* could reasonably be expected to be exposed and is commensurate with the relative importance of those risks, based on the *Insurer's* business mix;

(iii) is closely integrated into the day-to-day management process of the *Insurer*;

(iv) is supported by appropriate audit and compliance procedures; and

(v) is subject to adequate processes established by the *Insurer* to validate the accuracy of the *Risk Based Capital Requirement*, or components of the *Risk Based Capital Requirement*, as determined by the *Internal Model*, as well as for monitoring and assessing its ongoing performance; and

(B) the *Insurer's* home regulator, or if the *Insurer* is part of a *Group*, the *Group's* home regulator, has approved the *Internal Model* for calculating a risk based statutory capital requirement equivalent to the *Risk Based Capital Requirement*.

3.9 Failure to maintain appropriate financial resources or comply with capital requirements

3.9.1 Possible breach of r 1.2.1 or ch 3

If an *insurer* becomes aware, or has reasonable grounds to believe, that it may be, or may be about to be, in breach of rule 1.2.1 or any provision of this chapter, it must—

(a) tell the *Regulatory Authority* orally about the matter immediately, but within 1 *business day*; and

(b) by *written* notice given to the authority by no later than the next *business day*—

(i) confirm the oral notification; and

(ii) explain why the *insurer* considers it may be, or may be about to be, in breach of the provision; and

(iii) set out the action that the *insurer* proposes to take to avoid the breach; and

(c) not make any distribution to its shareholders or members, whether by way of dividends or otherwise, without the authority's *written* permission.

Examples—meaning of 'within 1 business day'

1 If, on a *business day*, the *insurer* becomes aware that it may be in breach of this chapter or rule 1.2.1, the *insurer* must tell the authority immediately, but on that day.

2 If, on a day that is not a *business day*, the *insurer* becomes aware that it may be in breach of this chapter or rule 1.2.1, the *insurer* must tell the authority immediately, but by no later than the next *business day*.

3.9.2 Breach of r 1.2.1 or ch 3

If an *insurer* becomes aware that it is in breach of rule 1.2.1 or any provision of this chapter, it must—

(a) tell the *Regulatory Authority* orally about the matter immediately, but within 1 *business day*; and

Examples
See examples to rule 3.9.1 on the meaning of 'within 1 *business day*'.

(b) by *written* notice given to the authority by no later than the next *business day*—

(i) confirm the oral notification; and

(ii) explain the nature of the breach; and

(iii) set out the action that the *insurer* proposes to take about the breach; and

(c) cease *effecting contracts of insurance* in or from the *QFC* until the authority gives it *written* permission to recommence; and

(d) not make any distribution to its shareholders or members, whether by way of dividends or otherwise, without the authority's *written* permission.

Note See also r 4.4.2 (1) (b) (i) which prohibits the payment of interest or principal for subordinated debt included as part of the *insurer's* eligible capital if the *insurer* is in breach of its minimum capital requirement.

Guidance for s 3.9
In dealing with a breach, or possible breach, of this chapter, the *Regulatory Authority's* primary concern will be the interests of policyholders, both existing and prospective. It recognises that there will be circumstances in which a problem may be resolved quickly, for example by support from a *parent entity*, without jeopardising the interests of policyholders. In such circumstances, it will be in the interests of all parties for there to be minimum disruption to the *insurer's* business. The authority's normal approach will be to seek to work cooperatively with *insurers* to deal with any problems. There will, however, be circumstances in which it is necessary to take firm action to avoid exposing further policyholders to the risk of the *insurer's* failure, and the authority will not hesitate to take disciplinary action if it considers this necessary.

4 Eligible Capital

4.1 Application and Purpose

4.1.1 This chapter applies to every *Insurer* incorporated in the *QFC*.

4.1.2 In addition, for an *Insurer* which is in the legal form of a *Protected Cell Company*, the requirements of this chapter apply to every *Cell* that the *Insurer* maintains as if each *Cell* were a single *Insurer*.

Guidance

1. In assessing the adequacy of an *Insurer's* financial resources, attention must be paid not only to the types of events or problems that it might encounter, but also the quality of the support provided by various types of capital instruments.

2. The purpose of this chapter is to identify those capital instruments that can be included as *Eligible Capital* to meet the *Insurer's Minimum Capital Requirement*. In determining the rules governing whether a capital instrument is adequate for supervisory purposes, the *Regulatory Authority* has identified the following relevant matters, namely the extent to which each instrument:

   a. provides a permanent and unrestricted commitment of funds;

   b. is freely available to absorb losses from business activities;

   c. does not impose any unavoidable servicing charges against earnings; and

   d. ranks behind the claims of policyholders and other creditors in the event of the winding-up of the *Insurer*.

3. As *Insurers* authorised to conduct *Insurance Business* in or from the *QFC* in the legal form of a *Branch* will be subject to the regulatory capital requirements applicable in their home jurisdiction, the requirements of this chapter do not apply to *Branches*.

4.2 Calculation of Eligible Capital

4.2.1 (1) An *Insurer* must calculate its *Eligible Capital* in accordance with the table in Rule 4.2.2 and the provisions in sections 4.3 through to 4.7.

(2) A ✓ in the table in Rule 4.2.2 denotes that the item is included in the calculation of an *Insurer's Eligible Capital*, whereas an **X** denotes that the item is not included.

Guidance

The *Regulatory Authority* may recognise forms of capital instruments in addition to those set out in the table in Rule 4.2.2 for inclusion in an *Insurer's Eligible Capital* where those instruments comply with accepted international standards.

4.2.2 The *Eligible Capital* calculation table:

	Takaful Entity	**All other *Insurers***
(A) *Tier One Capital:*		
Permanent Share Capital	✓	✓
Audited reserves	✓	✓
Share premium account	✓	✓
Externally verified interim net profits	✓	✓
Fund for future appropriations	✓	✓
Owners' Equity in a *Takaful Entity*	✓	X
(B) Deductions from *Tier One Capital:*		
Investments in own *Share*s	✓	✓
Intangible assets	✓	✓
Interim net losses	✓	✓
(C) *Tier One Capital* after deductions = A-B		
(D) *Upper Tier Two Capital:*		
Perpetual qualifying hybrid capital instruments	✓	✓
Fixed dividend ordinary *Shares*	✓	✓
(E) *Lower Tier Two Capital*		
Subordinated debt	✓	✓
Fixed term preference *Share*s	✓	✓
(F) Total *Tier One Capital* plus *Tier Two Capital* = C+D+E		
(G) Deductions from Total of *Tier One* and *Tier Two Capital*:		
Investments in *Subsidiaries* and *Associate*s	✓	✓
Connected lending of a capital nature	✓	✓
Inadmissible assets	✓	✓
Amount in any Zakah fund	✓	X
(H) Total *Tier One Capital* plus *Tier Two Capital* after deductions = F-G = Total *Eligible Capital*		

4.3 Components of Capital: Tier One

4.3.1 For the purposes of the items under line (A) *Tier One Capital* in the table in Rule 4.2.2:

(A) *Permanent Share Capital* means ordinary paid-up *Share* capital, or equivalent however called, which meets the following conditions:

(i) it is fully paid up;

(ii) any dividends in relation to it are non-cumulative;

(iii) it is available to absorb losses on a going concern basis;

(iv) it ranks for repayment upon winding up or insolvency after all other debts and liabilities;

(v) it is undated;

(vi) the proceeds of an issue of *Permanent Share Capital* is immediately and fully available to the *Insurer*;

(vii) the *Insurer* is not obliged to pay any dividends on the *Shares* (except in the form of *Shares* that themselves comply with this *Rule*);

(viii) the *Insurer* does not have any other obligation or commitment to transfer any economic benefit in relation to that *Permanent Share Capital*; and

(ix) dividends and other charges on the *Shares* can only be paid out of accumulated realised profits;

(B) audited reserves are audited accumulated profits retained by the *Insurer* after deduction of tax and dividends, and other reserves created by appropriations of *Share* premiums and similar realised appropriations;

(c) audited reserves also include capital contributions if—

(i) the capital contributions satisfy the requirements of paragraph (a); and

(ii) the *insurer* told the *Regulatory Authority* in *writing* of its intention to include the capital contribution at least 1 *month* before the day they were included;

(D) the share premium account records the difference between the nominal value of *Shares* issued and the fair value of the consideration received;

(E) externally verified interim net profits are interim profits verified by an *Insurer's* external auditor net of tax, anticipated dividends or other appropriations;

(F) fund for future appropriations means the fund comprising all funds the allocation of which either to policyholders or to shareholders has not been determined by the end of the financial year, or the balance sheet items under international accounting standards which in aggregate represent as nearly as possible that fund;

(G) *Owners' Equity* can only form part of a *Takaful Entity's Tier One Capital* if under the constitutional documents of the *Takaful Entity* or the terms of the insurance contract or both, participation in the surpluses and losses of the *Insurance Business* is limited to the policyholders of the *Insurer*;

(H) intangible assets include goodwill, capitalised development costs, brand names, trademarks and similar rights and licences; and

(I) cumulative losses and other negative reserves must be deducted from *Tier One Capital*.

Guidance

The *Regulatory Authority* may request an *Insurer* to provide it with a copy of its external auditor's opinion referred to in Rule 4.3.1(E) on whether the interim profits are accurately stated.

4.4 Components of Capital: Tier Two

Guidance

1. *Tier Two Capital* consists of instruments that, to varying degrees, fall short of the quality of *Tier One Capital* but nonetheless contribute to the overall strength of an *Insurer*. Such instruments include some forms of hybrid capital instruments that have the characteristics of both equity and debt, that is they are structured like debt, but exhibit some of the loss absorption and funding flexibility features of equity.

2. *Tier Two Capital* is divided into *Upper Tier Two Capital* and *Lower Tier Two Capital*. A major distinction between *Upper Tier Two Capital* and *Lower Tier Two Capital* is that only perpetual instruments may be included in *Upper Tier Two Capital* whereas dated instruments are included in *Lower Tier Two Capital*.

Perpetual Qualifying Hybrid Capital Instruments

4.4.1 An *Insurer* may only include perpetual qualifying hybrid capital instruments as part of its *Upper Tier Two Capital* if:

(A) they are unsecured, subordinated and fully paid-up;

(B) they are perpetual; and

(C) they are available to absorb losses on a going concern basis.

Guidance

A perpetual cumulative preference share is an example of a capital instrument that would meet the criteria of Rule 4.4.1.

Subordinated Debt

4.4.2 (1) An *Insurer* must not include subordinated debt as part of its *Eligible Capital* unless it meets the following conditions:

(A) the claims of the subordinated creditors must rank behind those of all unsubordinated creditors;

(B) no interest or principal may be payable:

(i) at a time when the *Insurer* is in breach of its *Minimum Capital Requirement*; or

(ii) if the payment would mean that the *Insurer* would be in breach of the *Rules* in this rulebook;

(C) the only events of default must be non-payment of any interest or principal under the debt agreement or the winding-up of the *Insurer*;

(D) the remedies available to the subordinated creditor in the event of non-payment in respect of the subordinated debt must be limited to petitioning for the winding up of the *Insurer* or proving for the debt and claiming in the liquidation of the *Insurer*;

(E) any events of default and any remedy described in (D) must not prejudice the matters in (A) and (B);

(F) in addition to the requirements about repayment in (A) and (B), the subordinated debt must not become due and payable before its stated final maturity date except on an event of default complying with (C);

(G) the agreement and the debt are governed by the laws of a *jurisdiction*—

(i) under which the other conditions mentioned in this subrule can be met; or

(ii) that is otherwise acceptable, generally or in a particular case, to the *Regulatory Authority*;

(H) to the fullest extent permitted under the *Rules* of the relevant jurisdictions, creditors must waive their right to set off amounts they owe the *Insurer* against subordinated amounts owed to them by the *Insurer*;

(I) the terms of the subordinated debt must be set out in a written agreement or instrument that contains terms that provide for the conditions set out in (A) to (H);

(J) the debt must be unsecured and fully paid up; and

(K) the *Insurer* has notified the *Regulatory Authority* in writing that it intends to include subordinated debt as part of its *Eligible Capital* and the *Regulatory Authority* has not advised the *Insurer* in writing within thirty days of the date of the notification that the subordinated debt must not form part of its *Eligible Capital*.

(2) An *Insurer* must not include in its *Eligible Capital* subordinated debt issued with step-ups in the first five years following the date of issue.

(3) An *Insurer* may include subordinated debt in its *Lower Tier Two Capital* only if:

(A) it has an *Original Maturity* of at least five years or is subject to five years' notice of repayment; and

(B) payment of interest or principal is permitted only if after such payment the *Insurer's Eligible Capital* would be greater than the amount required by Rule 3.2.1.

4.4.3 For the purposes of calculating the amount of subordinated debt that may be included in its *Eligible Capital*, an *Insurer* must amortise the principal amount on a straight-line basis by 20% per annum in its final four years to maturity.

4.5 External Opinion on Tier Two Capital

4.5.1 (1) An *Insurer* must obtain a written external legal opinion stating that the requirements in section 4.4 for any *Tier Two Capital* have been met in relation to any instrument that the *Insurer* is proposing to include as *Eligible Capital*.

(2) An *Insurer* must provide copies of the opinions referred to in (1) to the *Regulatory Authority* if requested by the *Regulatory Authority* to do so.

4.6 Deductions from Total of Tier One and Tier Two Capital

Investments in Subsidiaries and Associates

4.6.1 An *Insurer* must deduct investments in *Subsidiaries* and *Associates* from the total of *Tier One Capital* and *Tier Two Capital*.

4.6.2 A *Captive Insurer* may seek the approval of the *Regulatory Authority* to include investments in *Subsidiaries* and *Associates* in its *Eligible Capital*.

Guidance

When considering a request under Rule 4.6.2, the *Regulatory Authority* will take into consideration, amongst other things:

a. the amount of indirect and direct third party risk;

b. the financial soundness of the parent; and

c. the structure of the loan agreement.

Connected Lending of a Capital Nature

4.6.3 An *Insurer* must deduct connected lending of a capital nature from the total of *Tier One Capital* and *Tier Two Capital*.

Guidance

The *Regulatory Authority* regards connected lending of a capital nature to be any lending to a *Company* in the same *Group* as the *Insurer* for activities which that *Company* would find hard to finance from another source, and is typically on a long term basis. Unless there is a genuine ability for the funds to be repaid within a short time, it is generally considered that the loan is of a capital nature.

Inadmissible Assets

4.6.4 For the purposes of the table in Rule 4.2.2, inadmissible assets are:

(A) tangible fixed assets, including inventories, plant and equipment and vehicles;

(B) deferred acquisition costs;

(C) deferred tax assets;

(D) deficiencies of net assets in *Subsidiaries*;

(E) debts and other loans owed to the *Insurer* by policyholders and intermediaries, where they are more than 90 days overdue;

(F) any investment by a *Subsidiary* of the *Insurer* in the *Insurer's* own *Shares*; and

(G) holdings of other investments which are not *Readily Realisable Investments*.

Guidance

The above assets have been identified as inadmissible assets because:

a. a sufficiently objective and verifiable basis of valuation does not exist;

b. their realisability cannot be relied upon with sufficient confidence;

c. their nature presents unacceptable custody risks; or

d. the holding of these may give rise to significant liabilities or onerous duties.

Amount in any Zakah fund

4.6.5 A *Takaful Entity* must deduct any amount held in any Zakah fund from the total of *Tier One Capital* and *Tier Two Capital*.

4.7 Limits on the use of Different Forms of Capital

Guidance

The table in Rule 4.2.2 describes the following terms that are used in this section:

a. '*Tier One Capital*' is equal to line A in the table;

b. '*Tier One Capital* (net of deductions)' is equal to line C in the table;

c. '*Tier Two Capital*' means the sum of line D and line E in the table; and

d '*Lower Tier Two Capital*' is equal to line E in the table.

4.7.1 A capital instrument is not eligible for inclusion in *Tier Two Capital* to the extent that its inclusion will result in the aggregate amount of *Tier Two Capital* exceeding 100% of eligible *Tier One Capital* (net of deductions).

4.7.2 A capital instrument is not eligible for inclusion in *Tier Two Capital* to the extent that its inclusion will result in the aggregate amount of *Lower Tier Two Capital* exceeding 50% of eligible *Tier One Capital* (net of deductions).

4.8 Reduction of Eligible Capital

4.8.1 An *Insurer* must not reduce the *Tier One Capital* component of its *Eligible Capital* without the prior approval of the *Regulatory Authority*.

Guidance

A reduction of an *Insurer's Eligible Capital* includes, but is not limited to:

a. *Share* buybacks;

b. the redemption, repurchase or early repayment of any *Eligible Capital* instruments issued by the *Insurer* or a *Special Purpose Vehicle* trading in its own *Shares*; or

c. where aggregate interest and dividend payments on *Tier One Capital* exceed the *Insurer's* after-tax earnings in the year to which they relate (i.e. dividend and interest payments on *Tier One Capital* wholly or partly funded from retained earnings).

4.8.2 An *Insurer* must provide to the *Regulatory Authority* when seeking approval for a reduction under Rule 4.8.1 a capital plan that has incorporated the effects of the proposed reduction and:

(A) demonstrates that the *Insurer* will remain in excess of its *Minimum Capital Requirement* for two years without relying on new capital issues;

(B) is consistent with the *Insurer's* business plan; and

(C) takes account of any possible acquisitions, locked-in capital in *Subsidiaries* and the possibility of exceptional losses.

Guidance

An *Insurer* can rely on the analysis undertaken as required under Rule 3.2.3(B) in order to ascertain the effect of exceptional losses on the financial resources required by the *Insurer*.

4.8.3 An *Insurer* must notify the *Regulatory Authority* of its intention to reduce its *Tier Two Capital* at least 6 *months* before the actual date of the proposed reduction, providing details of how it will meet its *Minimum Capital Requirement* after such repayment.

4.9 Notification

4.9.1 An *Insurer* must report to the *Regulatory Authority* all dividends and other distributions to shareholders within 15 *Business Days* following the declaration of the dividend or distribution.

5 Additional Requirements for Long Term Insurance Business

5.1 Application and Purpose

5.1.1 This chapter applies to all *Insurers* conducting:

(A) *Long Term Insurance Business*; or

(B) *General Insurance Business* attributed to *PINS Category 1* under Rule 5.3.2(2).

Guidance

This chapter sets out additional requirements in respect of *Long Term Insurance Business*.

5.2 Establishment of Long Term Insurance Funds

5.2.1 An *Insurer* that is not a *Protected Cell Company* conducting *Long Term Insurance Business* must either:

(A) establish and maintain one or more *Long Term Insurance Funds*; or

(B) notify the *Regulatory Authority* in writing that the *Insurer* is deemed to constitute a single *Long Term Insurance Fund*.

5.2.2 An *Insurer* that is a *Protected Cell Company* conducting, through a *Cell*, *Long Term Insurance Business* must either:

(A) establish and maintain, in respect of that *Cell*, one or more *Long Term Insurance Funds*; or

(B) notify the *Regulatory Authority* in writing that the *Cell* is deemed to constitute a single *Long Term Insurance Fund*.

5.2.3 (1) A *Branch* that is subject to a regulatory requirement in another jurisdiction to arrange its affairs in a manner that is equivalent or substantially equivalent to the requirements of this section, may make a written application to the *Regulatory Authority* for that arrangement of its affairs to be deemed for the purposes of these *Rules* to constitute a *Long Term Insurance Fund*.

(2) If the *Regulatory Authority* approves that application, it must inform the *Branch* in writing, and must state in its notice to the *Branch* the manner in which the arrangement will be deemed for the purpose of these *Rules* to constitute a *Long Term Insurance Fund*.

5.2.4 An *Insurer*, or a *Cell* of an *Insurer*, that is deemed in accordance with Rule 5.2.1(B) or Rule 5.2.2(B) to constitute a single *Long Term Insurance Fund*, shall be treated for all purposes relating to these *Rules* as though the *Insurer* had established a *Long Term Insurance Fund* to which all of the assets and liabilities of the *Insurer* or of the *Cell* are attributed.

5.3 Attribution of Contracts to a Long Term Insurance Fund

5.3.1 An *Insurer* must attribute all *Long Term Insurance Business* that it conducts to a *Long Term Insurance Fund*.

5.3.2 (1) Except as allowed for in (2), an *Insurer* may not attribute *General Insurance Contracts* to a *Long Term Insurance Fund*.

(2) An *Insurer* may attribute *Contracts of Insurance* in *PINS Category 1* to a *Long Term Insurance Fund*.

5.4 Segregation of Assets and Liabilities

5.4.1 An *Insurer* that is required under rule 5.2.1 or 5.2.2 to establish and maintain one or more *Long Term Insurance Funds*, or has attributed *Contracts of Insurance* in *PINS Category 1* to a *Long Term Insurance Fund* under Rule 5.3.2(2), must:

(A) identify separately in its books and records the assets, liabilities, revenues and expenses attributable to that business; and

(B) ensure those assets, liabilities, revenues and expenses are recorded separately and accounted for as a *Long Term Insurance Fund*.

5.4.2 An *Insurer* must record all assets, liabilities, revenues and expenses in respect of a *Contract of Insurance* that is attributed to a *Long Term Insurance Fund* as assets, liabilities, revenues and expenses of that *Long Term Insurance Fund*.

5.4.3 An *Insurer* may at any time attribute any of its assets to a *Long Term Insurance Fund* that were not previously attributed to such a *Long Term Insurance Fund*.

Guidance

A transaction described in Rule 5.4.3 is sometimes described as a transfer of capital into the *Long Term Insurance Fund*.

5.4.4 All revenues and expenses arising by way of earnings, revaluation or other change to the assets and liabilities of a *Long Term Insurance Fund* must be recorded as revenues and expenses, or movements in capital, of that *Long Term Insurance Fund*.

5.4.5 An *Insurer* must maintain adequate accounting and other records to identify the contracts and the assets, liabilities, revenues and expenses attributable to the *Long Term Insurance Fund* in accordance with the requirements of section 5.4.

5.5 Limitation on use of Assets in Long Term Insurance Fund

5.5.1 An *Insurer* must ensure that, except as provided in section 5.5, assets that are attributable to a *Long Term Insurance Fund* are applied only for the purposes of the business attributed to the *Long Term Insurance Fund*.

5.5.2 An *Insurer* must ensure assets attributable to a *Long Term Insurance Fund* are not transferred so as to be available for other purposes of the *Insurer* except:

(A) where the transfer constitutes appropriation of a surplus determined in accordance with Rule 9.5.3(G), provided that the transfer is performed within 4 *months* of the *Reference Date* of the *Financial Condition Report* that this determination forms part of;

(B) where the transfer constitutes a payment of dividend or return of capital, in accordance with Rule 5.5.4;

(C) where the transfer is made in exchange for other assets at fair value;

(D) where the transfer constitutes reimbursement of expenditure borne on behalf of the *Long Term Insurance Fund* and in respect of expenses attributable to the *Long Term Insurance Fund*; or

(E) where the transfer constitutes reattribution of assets attributed to the *Long Term Insurance Fund* in error.

5.5.3 An *Insurer* must not make any distribution by way of dividend, or return of capital assets attributable to a *Long Term Insurance Fund*, if by doing so that would result in a breach of chapter 5.

5.5.4 An *Insurer* or a *Cell* that is deemed to constitute a single *Long Term Insurance Fund* may only make a dividend or return of capital where the dividend or return of capital constitutes appropriation of a surplus determined in accordance with Rule 9.5.3(G), and:

(A) if the payment is made within 4 *months* of the *Reference Date* of the actuarial investigation (the *Financial Condition Report*) determining that surplus, the payment does not cause the total aggregate amount of the dividends or returns of capital made by the *Insurer* or the *Cell* since that *Reference Date* to exceed the amount of that surplus; or

(B) if the payment is made more than 4 *months* after the *Reference Date* of the actuarial investigation (the *Financial Condition Report*) determining that surplus, the payment does not cause the total aggregate amount of the dividends or returns of capital made by the *Insurer* or the *Cell* since that *Reference Date* to exceed 50% of the amount of that surplus.

5.5.5 An *Insurer* must not lend or otherwise make available for use for any other purposes of the *Insurer*, or any purposes of any party *Related* to the *Insurer*, assets attributable to a *Long Term Insurance Fund*.

5.5.6 An *Insurer* may not enter into any arrangement, whether or not described as a contract of reinsurance, whereby a *Long Term Insurance Fund* of the *Insurer* stands in the same relation to the *Insurer* as though the *Insurer* were the reinsurer in a contract of reinsurance in which the *Long Term Insurance Fund* is the cedant.

Guidance

Rule 5.5.6 operates to prohibit reinsurance between *Long Term Insurance Funds* of the same *Insurer*, as well as arrangements of the nature of internal contracts of reinsurance where the cession transaction is attributed to a *Long Term Insurance Fund* but the corresponding reinsurance acceptance transaction is not.

6 Additional Requirements for Takaful Entities

6.1 Application and Purpose

6.1.1 This chapter applies to any *Insurer* that has an endorsed *Authorisation* under ISFI Rule 2.3.1 authorising it to conduct *Islamic Financial Business*:

(A) as an *Islamic Financial Institution*; or

(B) by operating an *Islamic Window*

and this *Islamic Financial Business* is the conducting of *Insurance Business*.

6.1.2 (1) The requirements of this chapter only apply to that portion of *Insurance Business* conducted by a *Takaful Entity* that constitutes *Islamic Financial Business*.

(2) For the purposes of *PINS*, *Takaful Business* will be used to refer to that *Insurance Business* that meets the criteria in (1).

Guidance

1. A *Takaful Entity* is required to comply with the requirements in the *ISFI* and any other relevant regulatory requirements.

2. For the purposes of applying the requirements in this chapter, the following definitions from the *INAP Rulebook* are important:

   a. *Islamic Financial Institution* means an *Authorised Firm* whose entire business operations are conducted in accordance with Shari'a;

   b. *Islamic Window* is an *Authorised Firm* which conducts *Islamic Financial Business* as part of its business operations; and

   c. *Islamic Financial Business* is the business of carrying on one or more *Regulated Activities* in accordance with Shari'a.

3. The purpose of this chapter is to outline additional requirements applying to *Takaful Entities*. A *Takaful Entity* must also comply with all other requirements in *PINS* relevant to the *Takaful Business* it conducts.

6.2 Establishment of Takaful Funds

6.2.1 A *Takaful Entity* must establish and maintain one or more *Takaful Funds* for its *Takaful Business*.

6.3 Attribution of Contracts to a Takaful Fund

6.3.1 A *Takaful Entity* must attribute all *Takaful Business* that it conducts to one or more *Takaful Funds* established and maintained under Rule 6.2.1.

6.4 Segregation of Takaful Funds

6.4.1 A *Takaful Entity* must:

(A) maintain separate books of account in respect of each *Takaful Fund* it maintains; and

(B) maintain any additional books of account required by this chapter for its *Takaful Business*.

6.4.2 A *Takaful Entity* must maintain such accounting and other records as are necessary for:

(A) identifying the assets and liabilities attributed to a *Takaful Fund* established and maintained by it under Rule 6.2.1; and

(B) complying with the requirements of Rule 8.4.2(A).

6.4.3 A *Takaful Entity* must ensure the assets allocated to a particular *Takaful Fund* are only allocated, apart from the exceptions provided for in Rule 6.4.4, for the purposes of the *Takaful Fund* to which it is attributed as required by Rule 6.3.1 and must not be allocated or made available for any other purpose of the *Takaful Entity*.

6.4.4 (1) Rule 6.4.3 does not preclude the reimbursement of expenditures borne by the shareholders (in the same or the preceding financial year) in discharging liabilities wholly or partly attributable to a *Takaful Fund*.

(2) Rule 6.4.3 does not apply to the payment of management fees by a *Takaful Fund* to the takaful manager even where the manager is the shareholder, provided that the *Shari'a Supervisory Board* has approved those fees.

(3) Rule 6.4.3 does not prevent a *Takaful Entity* from exchanging, at fair market value, *Takaful Business* assets of any *Takaful Fund* for other assets of the *Insurer* including assets held by another *Takaful Fund* or the shareholder.

6.4.5 A *Takaful Entity* must have adequate arrangements for ensuring that transactions involving assets of the *Takaful Entity* (other than transactions outside its control) do not operate unfairly between a *Takaful Fund* established and maintained under Rule 6.2.1 and the shareholder assets of the *Takaful Entity* or, in the case where the *Takaful Entity* has more than one 'identified fund', between those funds.

6.5 Loans From a Takaful Fund

6.5.1 A *Takaful Entity* must not make or attribute any loans from a *Takaful Fund* it maintains to another *Takaful Fund* or to any other party, including but not limited to:

(A) the takaful operator (the shareholder fund);

(B) a person in a *Controlled Function*;

(C) a participant (policyholder); and

(D) a *Controller* or *Person* with *Close Links* to the *Takaful Entity*.

6.6 Distribution of a Surplus or Funding a Deficit in a Takaful Fund

Guidance

1. *Takaful Entities* by definition are co-operative in nature and, as such, participants (policyholders) are entitled to a return of any surpluses of the *Takaful Funds* operated by the *Takaful Entity*.

2. A *Takaful Entity* is also required, under ISFI Rule 3.1.3, to disclose in its financial statements all matters set out in *AAOIFI* 12 and 13, which includes among other matters the basis for treating insurance deficits and surpluses in a *Takaful Fund*.

6.6.1 (1) Every *Takaful Entity* must have a written policy, or subject to Rule 6.6.2, policies, for determining the surplus or deficit arising from its *Takaful Business*, the basis of distributing that surplus or deficit between the participants and the shareholders, and the method of transferring any surplus or deficit to the participants.

(2) The policy or policies must comply with all relevant *AAOIFI* standards including Financial Accounting Standard No. 13 'Disclosure of Bases for Determining and Allocating Surplus or Deficit in Islamic Insurance Companies'.

(3) Each policy must be approved by the *Takaful Entity's Shari'a Supervisory Board*.

6.6.2 More than one policy may be developed where the *Takaful Entity* offers different *Categories* of *Takaful Business*.

6.6.3 (1) A *Takaful Entity* must provide a copy of the policy referred to in Rule 6.6.1 to the *Regulatory Authority* immediately following its approval by the *Takaful Entity's Shari'a Supervisory Board,* but within 1 *business day* after the day the approval is given.

(2) A *Takaful Entity* must not amend the policy once it has been provided to the *Regulatory Authority* without the approval of the *Shari'a Supervisory Board* and the *Regulatory Authority*. A revised copy of the policy must be provided to the *Regulatory Authority* immediately following that approval.

(3) A *Takaful Entity* must ensure that a copy of each policy approved under Rule 6.6.1 or Rule 6.6.3(2) forms part of each and every insurance policy sold by the *Takaful Entity*.

Guidance

In considering whether to approve any changes to a policy under Rule 6.6.3(2), the *Regulatory Authority* will consider the impact of the proposed amendments on existing policyholders of the *Takaful Entity* affected by the proposed amendments.

6.6.4 (1) On an annul basis, every *Takaful Entity* must determine any surplus or deficit arising on each separate *Takaful Fund*.

(2) A *Takaful Entity* must not distribute a surplus or deficit from a *Takaful Fund* it has established and maintains where the *Takaful Business* attributed to this *Takaful Fund* is *Long Term Insurance Business* until the value of this surplus or deficit has been determined by an *Approved Actuary* in accordance with Rule 9.5.3.

(3) Any distribution must be performed within 4 *months* of the *Reference Date* of the actuarial investigation referred to in (2).

6.6.5 A *Takaful Entity* must report to the *Regulatory Authority* all distributions of profit or surplus (however called or described) to policyholders within 15 *Business Days* of the date of declaration of the distribution.

6.6.6 A *Takaful Entity* must not make any distributions to participants, regardless of the rules governing the *Takaful Entity*, if the *Takaful Entity* does not, or through the payment of the distribution, would not, meet its *Minimum Capital Requirement*.

7 Additional Requirements for Protected Cell Companies

7.1 Application and Purpose

7.1.1 This chapter applies to all *Insurers* that are *Protected Cell Companies*.

Guidance

1. The *Regulatory Authority* will examine each application for authorisation to conduct *Insurance Business* from a *Protected Cell Company* on a case by case basis. The *Regulatory Authority* is of the view that if any *Protected Cell Companies* are authorised, they will generally be restricted to establishing *Cells* conducting *Insurance Business* as a *Class 1 Captive Insurer*.

2. This chapter sets out additional *Rules* and guidance on how the *Base Capital Requirement* and *Eligible Capital* requirements apply to an *Insurer* which is a *Protected Cell Company*.

7.2 General Requirement

7.2.1 An *Insurer* which is a *Protected Cell Company* must at all times hold *Eligible Capital* equal to or higher than its *Non-Cellular Base Capital Requirement*.

7.2.2 The *Non-Cellular Base Capital Requirement* is US$ 50,000.

7.3 Eligible Capital for Protected Cell Companies

7.3.1 Subject to Rule 7.3.2, the *Non-Cellular Eligible Capital* of an *Insurer* is to be calculated in accordance with Chapter 4.

7.3.2 All *Cell Shares* and any capital instruments or equity reserves of the *Insurer* that are attributable to a *Cell* must be excluded from the *Non-Cellular Eligible Capital*.

7.4 Capital Adjustment to Eligible Capital

7.4.1 Where an *Insurer* that is a *Protected Cell Company* is organised such that *Non-Cellular Assets* may be used lawfully to meet *Cellular Liabilities* of a *Cell* and the *Regulatory Authority* has approved such use, the *Insurer* may determine a non-cellular capital adjustment in respect of that *Cell*'s *Eligible Capital.*

Guidance

The purpose of the non-cellular capital adjustment is to permit an *Insurer* to allocate all or part of its *Non-Cellular Eligible Capital* to support the *Eligible Capital* of its *Cells*. The adjustment is limited to the amount of *Non-Cellular Eligible Capital* that could be made available to meet *Cellular Liabilities*.

7.4.2 The amount of the non-cellular capital adjustment in respect of a *Cell* is an amount selected by the *Insurer*, subject to the following constraints:

(A) the non-cellular capital adjustment in respect of a *Cell* must not be negative;

(B) the non-cellular capital adjustment in respect of a *Cell* must not exceed the amount that could be made available to meet the liabilities of that *Cell* in the event of insolvency of the *Insurer*, after taking into consideration all other potential calls on the *Insurer's Non-Cellular Eligible Capital*; and

(C) the sum of the non-cellular capital adjustments in respect of all *Cells* must not exceed the amount that could be made available to meet the *Cellular Liabilities* in the event of insolvency of the *Insurer*, after taking into consideration all other potential calls on the *Insurer's Non-Cellular Eligible Capital*.

8 Measurement of Assets and Liabilities of Insurers

8.1 Application and Purpose

8.1.1 This chapter applies to every *Insurer*.

Guidance

1. This chapter establishes a set of principles for the consistent measurement of the assets and liabilities of an *Insurer* for the purposes of reporting under *PINS* and for determining compliance with chapters 3 and 4.

2. This chapter is not intended to establish a basis of accounting for general purpose financial statements of *Insurers*. This chapter does not prevent *Insurers* from adopting measurements of assets and liabilities that might be considered excessively prudent if adopted in the *Insurer*'s general purpose financial statements. *Insurers* are not, however, expected to mislead the *Regulatory Authority* as to the financial position or financial performance of the *Insurer*.

8.2 General Provisions

8.2.1 An *Insurer* may measure the value of an asset at less than the value determined in accordance with this chapter.

8.2.2 An *Insurer* may measure the value of a liability at more than the value determined in accordance with this chapter.

8.2.3 An *Insurer* may use approximate methods to measure an asset or a liability, where the result obtained by the use of that approximate method would not be materially different from the result obtained by applying a measurement method prescribed in this chapter.

8.2.4 Notwithstanding any other provision of this chapter, the *Regulatory Authority* may, by written notice, direct an *Insurer* to measure an asset or a liability in accordance with principles specified by the *Regulatory Authority* in that written notice.

Guidance

Rule 8.2.4 may be used where the *Regulatory Authority* has any concerns over any asset, or class of assets, for example reinsurance assets that may be limited risk transfer arrangements, being counted as an asset at full value.

8.3 Classification of Insurance Business

8.3.1 An *Insurer* must, in its own records, classify all *Contracts of Insurance* carried out by it as *Insurer* and all reinsurance contracts entered into by it as cedant, according to the *Category* to which the *Contracts of Insurance* relate.

8.3.2 Where a *Contract of Insurance* relates to more than one *Category*, the *Insurer* must record separately the portions of the *Contract of Insurance* that relate to each *Category*, except that immaterial portions need not be separately recorded.

Guidance

A portion of a *Contract of Insurance* insuring a risk of a *Category* other than the principal *Category* to which the contract relates, will not normally be regarded as material if the interest that it insures is both related and subsidiary to the principal interest or interests insured under the contract, and constitutes less than ten per cent of the *Gross Written Premium* under the contract.

8.4 Basic Principles of Recognition and Measurement

8.4.1 An *Insurer* must, except where this chapter provides otherwise, recognise its assets and liabilities in accordance with a basis of accounting set out in Rule 8.4.2, and the values attributed to those assets and liabilities must be measured in accordance with that basis of accounting.

Guidance

The exceptions provided in this chapter relate to the following:

a. specific *Rules* in respect of certain assets and liabilities, intended to achieve a regulatory objective not achieved by application of either or both of the bases of accounting set out in Rule 8.4.2;

b. assets and liabilities that are not dealt with in either or both of the bases of accounting set out in Rule 8.4.2; and

c. the overriding power of the *Regulatory Authority*, set out in Rule 8.2.4, to require an *Insurer* to adopt a particular measurement for a specific asset or liability.

8.4.2 An *Insurer* must adopt one of the following as the basis of its accounting:

(A) in the case of a *Takaful Entity*, the standards of the *AAOIFI*; or

(B) in any other case:

(i) *IFRS*;

(ii) *UK GAAP* or *US GAAP*; or

(iii) any other accounting standards or principles prescribed in *Rules* made by the *Regulatory Authority*.

8.4.3 An *Insurer* must, where the valuation of an asset or liability is dependent upon the adoption of assumptions or the adoption of a calculation method, ensure that any change in the assumptions or methods adopted is reflected immediately in the value attributed to the asset or liability concerned. The recognition of the effects of changes in assumptions or methods may not be deferred to future reporting periods.

8.4.4 The *Regulatory Authority* may also specify actuarial principles to be used by an *Insurer* in measuring assets and liabilities.

8.5 Discount Rate

8.5.1 An *Insurer* must, for the purposes of determining the net present value of expected future payments in accordance with Rule 8.6.10 and Rule 8.7.12 and the net present value of expected future receipts in accordance with Rule 8.6.11 and Rule 8.7.13, use as a discount rate the gross redemption yield, as at the *Solvency Reference Date*, of a portfolio of *Grade* 1 rated sovereign risk *Debt Instruments* with a similar expected payment profile to the liability being measured.

Guidance

1. *Grade* 1 ratings are defined in the table in Rule A3.1.1.

2. Where an *Insurer's Insurance Business* includes more than one *Category*, the *Insurer* will normally be expected to establish payment profiles separately for each material *Category*.

3. Where the expected payment profile of assets or liabilities cannot be matched (for example, because the duration is too long) the *Insurer* should assume a discount rate regarded as consistent with the intention of this section.

8.6 Recognition and Measurement of Insurance Assets and Liabilities in Respect of General Insurance Business

8.6.1 This section applies to assets and liabilities in respect of *General Insurance Business*.

8.6.2 Premiums in respect of direct insurance contracts, facultative reinsurance contracts and non-proportional treaty reinsurance contracts entered into by an *Insurer* as *Insurer* must be treated as receivable from the date of entering into the *Contract of Insurance*.

8.6.3 Premiums in respect of proportional treaty reinsurance contracts entered into by an *Insurer* as *Insurer* must be treated as receivable in accordance with the pattern of the cedant entering into the underlying insurance contracts.

8.6.4 Premiums in respect of facultative reinsurance contracts and non-proportional treaty contracts entered into by an *Insurer* as cedant must be treated as payable from the date of entering into the reinsurance contract.

8.6.5 Premiums in respect of proportional treaty reinsurance contracts entered into by an *Insurer* as cedant must be treated as payable in accordance with the pattern of carrying out the underlying *Contract of Insurance*.

8.6.6 An *Insurer* must treat expenses incurred in respect of *Contracts of Insurance* conducted by the *Insurer* as payable at the time the contracts are carried out.

8.6.7 An *Insurer* must treat as a liability the *Premium Liability*, which is the value of future claims payments and associated direct and indirect settlement costs, arising from future events insured under policies that are in force as at the *Solvency Reference Date*.

Guidance

The liability referred to in Rule 8.6.7 is commonly represented by *Insurers* as two separate provisions, the unearned premium provision and the premium deficiency provision. The sum of the two provisions is

sometimes referred to as the unexpired risk reserve, though this term is also sometimes used to describe the premium deficiency provision alone.

8.6.8 An *Insurer* must treat as a liability the value of future claims payments and associated direct and indirect settlement costs, arising from insured events that have occurred as at the *Solvency Reference Date*.

Guidance

The liability referred to in Rule 8.6.8 is commonly referred to as the liability for outstanding claims. Some *Insurers* represent this liability as three separate provisions, being the liability in respect of reported claims, the liability in respect of claims incurred but not reported, and the liability in respect of settlement costs, also known as loss adjustment expenses.

8.6.9 An *Insurer* must treat as an asset the value of reinsurance and other recoveries expected to be received in respect of claims referred to in Rule 8.6.7 and Rule 8.6.8.

8.6.10 Where this section requires an *Insurer* to recognise as a liability the value of expected future payments, that liability must be measured as the net present value of those expected future payments.

8.6.11 Where this section requires an *Insurer* to recognise as an asset the value of expected future receipts, that asset must be measured as the net present value of those expected future receipts.

8.7 Recognition and Measurement of Assets and Liabilities in Respect of Long Term Insurance Business

8.7.1 This section applies to assets and liabilities in respect of *Long Term Insurance Business*.

8.7.2 Premiums in respect of direct insurance contracts, facultative reinsurance contracts and non-proportional treaty reinsurance contracts entered into by an *Insurer* as *Insurer* must be treated as receivable from the date of entering into the *Contract of Insurance*.

8.7.3 Premiums in respect of proportional treaty reinsurance contracts entered into by an *Insurer* as *Insurer* must be treated as receivable in accordance with the pattern of the cedant entering into the underlying insurance contracts.

8.7.4 Premiums in respect of facultative reinsurance contracts and non-proportional treaty contracts entered into by an *Insurer* as cedant must be treated as payable from the date of entering into the reinsurance contract.

8.7.5 Premiums in respect of proportional treaty reinsurance contracts entered into by an *Insurer* as cedant must be treated as payable in accordance with the pattern of carrying out the underlying insurance contracts.

8.7.6 Premiums in respect of reinsurance contracts entered into by an *Insurer* as *Insurer* must be treated as receivable from the date on which the premium on the underlying *Contract of Insurance* is due and receivable by the cedant.

8.7.7 Premiums in respect of reinsurance contracts entered into by an *Insurer* as cedant must be treated as payable from the date on which the premium on the underlying insurance contract is due and receivable by the cedant.

8.7.8 Expenses incurred in respect of *Contracts of Insurance* entered into by an *Insurer* must be treated as payable:

(A) in the case of expenses directly related to the premiums in respect of the contract, at the same time as the premium is treated as receivable; and

(B) in the case of expenses not directly related to the premiums in respect of the contract, at the time the contract is effected.

8.7.9 An *Insurer* must treat as a liability the amount of *Policy Benefits* that are due for payment on or before the *Solvency Reference Date*.

8.7.10 An *Insurer* must treat as a liability the net value of future *Policy Benefits* under policies that are in force as at the *Solvency Reference Date*, taking into account all prospective liabilities as determined by the policy conditions for each existing contract, and taking credit for premiums payable after the *Solvency Reference Date*.

8.7.11 In measuring the liability referred to in Rule 8.7.10, the *Insurer* must:

(A) use actuarial principles;

(B) make proper provision for all liabilities on prudent assumptions that include appropriate margins for adverse deviation of the relevant factors; and

(C) take specifically into account:

(i) all guaranteed *Policy Benefits*, including guaranteed surrender values;

(ii) vested, declared or allotted bonuses to which policyholders are already either collectively or individually contractually entitled;

(iii) all options available to the policyholder under the terms of the contract;

(iv) discretionary charges and deductions from *Policy Benefits*, in so far as they do not exceed the reasonable expectations of policyholders;

(v) expenses, including commissions; and

(vi) any rights under contracts of reinsurance in respect of *Long Term Insurance Business.*

8.7.12 Where this section requires an *Insurer* to recognise as a liability the value of expected future payments, that liability must be measured as the net present value of those expected future payments.

8.7.13 Where this section requires an *Insurer* to recognise as an asset the value of expected future receipts, that asset must be measured as the net present value of those expected future receipts.

8.7.14 Rule 8.7.10 does not require an *Insurer* to obtain a valuation by an actuary or actuaries performing the *Actuarial Function* of the liability referred to in that *Rule*, at a *Solvency Reference Date* other than the *Insurer's* annual reporting date.

Guidance

An *insurer* conducting *long term insurance business* is required to provide a *financial condition report* on its *insurance liabilities* that is prepared by an actuary or actuaries who are performing the *actuarial function*. The relevant provisions are set out in sections 9.3 and 9.5..

9 Actuaries

9.1 Application and Purpose

9.1.1 This chapter applies to every *Insurer*.

9.1.2 For the purposes of *PINS*, an *Approved Individual* registered by the *Regulatory Authority* to perform the *Actuarial Function* is referred to as the *Approved Actuary*.

Guidance

1. The *Regulatory Authority* believes it is fundamental that the *Directors* and *Senior Management* of an *Insurer* are provided with impartial actuarial advice in relation to the *Insurer's* financial condition and *Insurance Liabilities*. This advice is designed to assist the *Directors* and *Senior Management* in carrying out their responsibilities for the sound and prudent management of the *Insurer*.

2. The frequency and scope of this actuarial advice is calibrated to the level of uncertainty inherent to specific *Categories* of *Insurance Business*. *Insurers* conducting *Long Term Insurance Business*, or material levels of *General Insurance Business* in *PINS Category 1* or *PINS Category 4*, are required under INDI Rule 2.3.3 and 2.3.4 to appoint one or more individuals registered to perform the *Actuarial Function*. *Insurers* conducting *General Insurance Business* in all other *PIN Categories* are only required to obtain a actuarial report prepared by a *Reporting Actuary* on a triennial basis.

3. The purpose of this chapter is to outline:

    a. the key reporting requirements to be performed by the *Approved Actuary* and *Reporting Actuary*; and

    b. the criteria to be met by an individual performing the duties of the *Reporting Actuary*.

9.2 General Provisions

9.2.1 An *Insurer* must ensure that any actuary referred to in INDI Rules 2.3.3 or 2.3.4 (the *Approved Actuary*), or Rule 9.4.2 or Rule 9.4.3 (the *Reporting Actuary*), has access to all relevant data, information, reports and staff of the *Insurer* (and must take all reasonable steps to ensure access to contractors of the *Insurer*) that the actuary or actuaries reasonably believe are necessary to fulfil their responsibilities.

9.3 Reporting Requirements Performed by the Actuarial Function

Guidance

The primary role of the *Actuarial Function* is to provide advice on the valuation of an *Insurer's Insurance Liabilities* and to provide an impartial assessment of the overall financial condition of the *Insurer*.

9.3.1 (1) The *Approved Actuary* must, on an annual basis, undertake an investigation to enable the preparation of the *Financial Condition Report* as required by section 9.5.

(2) The *Financial Condition Report* must be prepared and signed by the *Approved Actuary*.

(3) The day the *approved actuary* signs the *financial condition report* under subrule (2) is the *reference date* for the purpose of dating the *financial condition report*.

9.3.2 The *Approved Actuary* must provide the *Financial Condition Report* to the *Insurer* within such time as to give the *Governing Body* of the *Insurer* a reasonable opportunity to:

(A) consider and use the *Financial Condition Report* in preparing the *Insurers* annual returns; and

(B) provide the *Financial Condition Report* to the *Regulatory Authority* on or before the day that the *Insurer's* annual returns are required to be given to the *Regulatory Authority* in accordance with the *Rules* contained in this rulebook.

Guidance

The *Financial Condition Report* should form an important input into the decision-making by the *Governing Body* and *Senior Management* in respect of the operations of the *Insurer*.

9.3.3 (1) The *Regulatory Authority* may, in writing, specify that an *Insurer's Approved Actuary* must:

(A) prepare a *Financial Condition Report* more frequently than required by Rule 9.3.1(1) if the *Regulatory Authority* considers it necessary or desirable to obtain the *Financial Condition Report* more frequently for the purposes of the prudential supervision of that *Insurer*; or

(B) undertake a special purpose review of matters specified by the *Regulatory Authority* relating to the *Insurer's* operations, risk management or financial affairs, and prepare a report in respect of that review. The review must be completed in accordance with the relevant professional standards.

(2) The cost of the special purpose review referred to in Rule 9.3.3(1)(B) will be borne by the *Insurer*. The report must be submitted by the *Approved Actuary* simultaneously to the *Regulatory Authority* and the *Insurer* within 3 *months* of the date of the written notice, unless the *Regulatory Authority* grants an extension of time in writing.

9.4 Actuarial Reporting Requirements for General Insurance Business

9.4.1 An *Insurer* conducting *General Insurance Business*, other than an *Insurer* subject to INDI Rule 2.3.4, must consider annually the need to commission an independent actuarial report.

9.4.2 If the *Governing Body* of a *General Insurer* resolves to obtain an independent actuarial report, a copy of this report, prepared and signed by the *Reporting Actuary*, must be provided to the *Regulatory Authority*.

9.4.3 (1) An *Insurer* referred to in Rule 9.4.1 must obtain an independent actuarial report prepared and signed by the *Reporting Actuary* at least once every three-years.

(2) The *Regulatory Authority* may at any time, if it believes it is necessary to do so, require an *Insurer* referred to in Rule 9.4.1 to obtain, at the *Insurer's* expense, an actuarial report relating to the *Insurer's* operations, risk management or financial affairs. The report must be submitted within 3 *months* of the *Regulatory Authority* requesting the report, unless the *Regulatory Authority* grants an extension of time in writing.

(3) The *Regulatory Authority* may chose a *Reporting Actuary* to provide the report if is not satisfied with the candidate chosen by the *Insurer* for the purposes of (2).

9.5 Financial Condition Report

9.5.1 (1) The *Financial Condition Report* must provide an objective assessment of the overall financial condition of the *Insurer*.

(2) For an *Insurer* conducting *Long Term Insurance Business*, the *Financial Condition Report* must include an objective assessment of the financial condition of each *Long Term Insurance Fund* established by the *Insurer*.

9.5.2 In preparing the *Financial Condition Report*, the *Approved Actuary* must have regard to the relevant professional standards.

9.5.3 An *Insurer* must ensure that, subject to relevance, a *Financial Condition Report* includes, at a minimum, the following matters:

(A) a business overview;

(B) an assessment of the *Insurer's* recent experience and profitability, including at least the experience during the year ending on the valuation date;

(C) an assessment of the value of those *Insurance Liabilities* that fall within the meaning of Rule 8.7.9 and Rule 8.7.10;

(D) an assessment of the value of those *Insurance Liabilities* that fall within the meaning of Rule 8.6.7 and Rule 8.6.8 if conducted by an *Insurer* that INDI Rule 2.3.4 applies to;

(E) an assessment of the adequacy of past estimates for these *Insurance Liabilities*, especially where there has been a change in the assumptions or in the valuation method from that adopted at the previous valuation;

(F) an explanation, in regard of the liability valuations, of:

(i) the assumptions used in the valuation process;

(ii) the adequacy and appropriateness of data made available to the *Approved Actuary* by the *Insurer*;

(iii) the procedures undertaken by the *Approved Actuary* to assess the reliability of the data;

(iv) the model or models used by the *Approved Actuary*;

(v) the approach taken to estimate the variability of the estimate; and

(vi) the sensitivity analyses undertaken;

(G) a determination of the value of surplus in each *Long Term Insurance Fund* established by the *Insurer* (as required prior to any distribution of such surplus in accordance with Rule 5.5.2 and Rule 5.5.4);

(H) a determination of the value of any surplus or deficit in each *Takaful Fund* a *Takaful Entity* has established and maintains where the *Takaful Business* attributed to this *Takaful Fund* is *Long Term Insurance Business* (as required prior to any distribution of such surplus in accordance with Rule 6.6.4(2));

(I) an assessment of asset and liability management, including the *Insurer's* investment strategy;

(J) an assessment of current and future capital adequacy and a discussion of the *Insurer's* approach to capital management;

(K) an assessment of pricing, including adequacy of premiums;

(L) an assessment of the suitability and adequacy of reinsurance arrangements, including documentation of reinsurance arrangements and the existence and impact of any limited risk transfer arrangements; and

(M) an assessment of the suitability and adequacy of the *Insurer's* risk management policy.

9.5.4 The *Approved Actuary* must consider the future implications and outlook for each of the matters listed in Rule 9.5.3. Where these implications are adverse, the *Approved Actuary* must propose recommendations designed to address the issues.

9.5.5 For a *Branch*, the *Financial Condition Report* must be prepared in respect of the *QFC* operations, but with consideration given to the financial position of the head office.

Guidance

The *Approved Actuary* may rely on other expert opinions in order to address those matters required by the *Financial Condition Report* the *Approved Actuary* may feel unqualified to comment on. All such third party opinions should be clearly identified in the *Financial Condition Report*.

9.6 Independent Actuarial Report

9.6.1 The independent actuarial report referred to in section 9.4 must provide details, in respect of each *Category* of *General Insurance Business* conducted by an *Insurer* (other than an *Insurer* subject to INDI Rule 2.3.4), of:

(A) recent trends in the business of the *Insurer*;

(B) the *Reporting Actuary's* estimate of the value of the *Insurance Liabilities* and assets arising in respect of those liabilities, determined in accordance with chapter 8;

(C) where there has been a change in the assumptions or in the valuation method from that adopted at the previous valuation, the effect of those changes on the *Insurance Liabilities* and assets arising in respect of those liabilities, as at the reporting date;

(D) the adequacy and appropriateness of data made available to the *Reporting Actuary* by the *Insurer*;

(E) procedures undertaken by the *Reporting Actuary* to assess the reliability of the data;

(F) the model or models used by the *Reporting Actuary*;

(G) the assumptions used by the *Reporting Actuary* in the valuation process including, without limitation, assumptions made as to inflation and discount rates, future expense rates and, where relevant, future investment income;

(H) the approach taken to estimate the variability of the estimate; and

(I) the nature and findings of sensitivity analyses undertaken.

9.7 Criteria for Reporting Actuary

9.7.1 The report referred to in section 9.4 must be must be prepared and signed by the *Reporting Actuary*.

9.7.2 An individual can only act in the role of *Reporting Actuary* if he also meets the following additional criteria:

(A) he is not carrying on the *Controlled Functions* of *Senior Executive Function*, *Executive Governance Function* or *Non-Executive Governance Function* of the *Insurer*, or of a *Related Body Corporate* (except when that *Related Body Corporate* is a *Subsidiary* of the *Insurer*);

(B) he is neither an approved auditor (under Article 85(1) of the QFC Companies Regulations or Article 37 of the Limited Liability Partnerships Regulations) for the *Insurer*, nor an employee or director of an entity of which that auditor is an employee or director nor a partner of that auditor;

(C) he has appropriate formal qualifications and is a member of a recognised professional body; and

(D) he has a minimum of five years relevant experience in the provision of actuarial services to *Insurers*, either in the *QFC* or in other jurisdictions, that has been sufficiently recent to ensure that he is familiar with current issues in the provision of actuarial services to *Insurers*.

Guidance

The above criteria are designed to ensure the independence, education, skill and experience of any individual performing the duties of the *Reporting Actuary*.

10 Consolidated Supervision

10.1 Application and Purpose

10.1.1 This chapter applies to every *Insurer*.

Guidance

1. An *Insurer* is exposed to risks through the relationships that it has with other insurance and non-insurance companies.

2. The purpose of this chapter is to require an *Insurer* to provide the *Regulatory Authority* periodically with information relating to the structure and financial position of any *Group* of which it is a member, to assess significant related party transactions, and to notify certain other transactions.

3. An *Insurer* is subject to separate reporting requirements in respect of changes in its *Controllers*. Those requirements are set out in GENE. It may be also be required to provide reports in respect of any *Close Links* it possesses.

10.1.2 In this chapter:

surplus means—

(A) for an *insurer* that is not a *protected cell company* — the *insurer's eligible capital*; and

(B) for an *insurer* that is a *protected cell company*— the *insurer's eligible capital* in relation to the *cell* to which the transaction relates or, if the transaction does not relate to a *cell*, the *insurer's non-cellular eligible capital*.

10.1.3 In this chapter, a series of connected transactions between an *Insurer* and a *Related* party, or between an *Insurer* and parties who are *Related* to each other, is deemed to constitute a single transaction.

10.2 Group Financial Resources

10.2.1 The *Regulatory Authority* may, by written notice, require an *Insurer* to provide the *Regulatory Authority* with a statement of the consolidated financial position of any *Group* of which the *Insurer* is a member, made up as at a date specified by the *Regulatory Authority* in that notice and in accordance with principles stated by the *Regulatory Authority* in the notice.

10.2.2 An *Insurer* must comply with a notice made under Rule 10.2.1 within 3 *months* of receiving the notice, unless the *Regulatory Authority* is satisfied that a shorter period is required and specifies that period in the notice.

Guidance

An *Insurer* will normally be permitted to comply with a notice given under Rule 10.2.1 by presenting a copy of a statement, relating to the *Group* specified in the notice, made up in compliance with an equivalent or substantially equivalent regulatory requirement to which the *Insurer* or a *Subsidiary* or *Associate* of the *Insurer* is subject in a jurisdiction other than the *QFC*. If that statement is not in English, the *Insurer* will be required to provide a certified translation of the statement into English.

10.2.3 If the *Regulatory Authority* considers the financial position of a *Group* or sub-*Group* may have a materially adverse impact on an *Insurer* that forms part of this *Group* or sub-*Group*, the *Regulatory Authority* may, in addition to any other powers it has, take action under Article 31 of the *FSR* to protect the interests of the *Insurers* policyholders or the *Financial System*.

10.3 Transactions within a Group

10.3.1 This section applies to all *Insurers* in respect of all transactions that are material.

Guidance

A single transaction or series of connected transactions that constitute a sale, purchase, exchange, loan or extension of credit, investment or guarantee involving one-half of one per cent (0.5%) or less of surplus as at the end of the reporting period immediately preceding the effective date of the transaction will not normally be considered material for the purposes of this section.

10.3.2 An *Insurer* must ensure that transactions it enters into with *Related* entities comply with the following conditions:

(A) be entered into on an 'arms length' basis;

(B) the terms of the transactions must be fair and reasonable; and

(C) the books, accounts and records of the *Insurer* must clearly and accurately disclose the nature and details of the transactions including any accounting information necessary to support the fairness and reasonableness of the terms and conditions of the transactions.

10.4 Significant Transactions other than Group Transactions

10.4.1 A *QFC* incorporated *Insurer* must not enter into a transaction of the type described in this *Rule* unless the *Governing Body* of the *Insurer* is satisfied following reasonable enquiry that the transaction does not adversely affect the interests of policyholders. The transactions to be considered are:

(A) a sale, purchase, exchange, loan or extension of credit, guarantee or investment where the amount of the transaction, as at the end of the reporting period immediately preceding the transaction, equals or exceeds three per cent of the *Insurer's* surplus;

(B) a loan or extension of credit to any *Person* who is not *Related* to the *Insurer*, where the *Insurer* makes the loan or extension of credit with the agreement or understanding that the proceeds of the transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to purchase assets of, or to make investments in, any *Related* party of the *Insurer* making the loans or extensions of credit, where the amount of the transaction, as at the end of the reporting period immediately preceding the transaction, equals or exceeds three per cent of the *Insurer's* surplus;

(C) a reinsurance agreement or modification to a reinsurance agreement in which the reinsurance premium or a change in the *Insurer* liabilities equals or exceeds five per cent of the *Insurer's* surplus;

(D) a reinsurance agreement or modification to a reinsurance agreement involving the transfer of assets from an *Insurer* to a *Person* not *Related* to the *Insurer*, if an agreement or understanding exists between the *Insurer* and that *Person* that any portion of the assets will be transferred to one or more other *Persons Related* to the *Insurer* and the reinsurance premium or a change in the *Insurers* liabilities equals or exceeds five per cent of the *Insurer's* surplus; and

(E) any management agreement, service contract or cost-sharing arrangement.

11 Transfer of Insurance Business

11.1 Application and Purpose

11.1.1 This chapter applies to every *Insurer*.

Guidance

1. A transfer of insurance business, or *Relevant Scheme*, is the transfer of all the rights and obligations associated with this business from one insurer (the transferor) to another insurer (the transferee). When the transfer is complete, the transferee insurer is augmented by the assets and liabilities (and all future and past incidents attaching to those assets and liabilities) of the transferor insurer so that the policyholders and reinsurers continue to be subject to the same terms and conditions as those originally agreed. A transferor may transfer all its insurance business, or only some (such as a class or classes of insurance business).

2. Transfers of insurance business can be undertaken for a variety of reasons, including restructuring (for example, exiting a line of business), assisting an *Insurer* in financial difficulty, and protecting policyholders. A *Relevant Scheme* does not refer to the ceding (reinsuring) of some or all of its policyholder liabilities to another insurer (reinsurer).

3. To provide for the possibility of either a transfer of insurance business into the *QFC*, or a transfer of insurance business out of the *QFC*, the terms insurer and insurance business are not to be taken as defined terms unless identified as such by being capitalised and in italics.

4. The purpose of this chapter is to set out requirements for a *Relevant Scheme*, as provided for under *FSR* Articles 97 and 98, governing:

   a. the form and content of a *Scheme Report*; and

   b. the form, content and timing of the publicity regarding the proposed transfer.

11.2 Scheme Report

11.2.1 (1) The *Scheme Report* prepared in accordance with Article 97 of the *FSR*, must be in written form and include the following matters:

(A) a rationale for the proposed *Relevant Scheme*;

(B) the terms of the agreement or deed under which the proposed transfer is to be carried out;

(C) the categories of insurance business to be transferred;

(D) the amount of technical provisions, premiums, claims incurred and details of assets to be transferred; and

(E) particulars of any other arrangements necessary to give effect to the proposed *Relevant Scheme*.

(2) The *Scheme Report* must also include a written actuarial report on the *Relevant Scheme* confirming that:

(A) there will be no materially adverse consequences from the proposed transfer to the policyholders of either the transferor or transferee insurer; and

(B) the transferor and/or transferee insurer continue to meet, if applicable, their *Minimum Capital Requirement* after taking the proposed transfer into account.

(3) The *Scheme Report* must also include a summary of the *Relevant Scheme* which contains, at a minimum, the following advice for affected policyholders:

(A) that the insurer proposes to transfer the policyholder's policy or policies to another insurer, on or after a specified date;

(B) the full name and contact details of the other insurer;

(C) the effect of the transfer (this explanation may be brief and may, for example, explain that from the date of the transfer all rights and liabilities under the policies will be transferred to the other insurer, so that premiums will have to be paid to, and claims will have to be lodged with, that insurer);

(D) any action the policyholder will need to take before or as a result of the transfer (for example, any changes in arrangements relating to paying premiums or lodging claims);

(E) how the *Relevant Scheme* compares with possible alternatives;

(F) if the policyholder does not need to take any action before or as a result of the transfer, notice of such to the policyholder;

(G) details of the compensation offered to policyholders for any loss of rights or expectations; and

(H) how the policyholder can obtain further information and inspect relevant documents as may be available for public inspection.

11.3 Notification of Proposed Transfer

11.3.1 (1) Whichever party to the *Relevant Scheme* is an *Insurer* must ensure that the notification requirements in Rule 11.3.2 are met.

(2) If both parties to the *Relevant Scheme* are *Insurers*, the transferor must ensure that the notification requirements in Rule 11.3.2 are met.

11.3.2 (1) The *Insurer* must provide a notice of intention regarding the proposed transfer, which must include, at a minimum, details of the place or places, dates (which must not be for a period less than 30 days) and times that an affected policyholder may obtain a copy of the *Relevant Scheme* and any associated documentation.

(2) The *Insurer* must publish the notice of intention in two national papers in the *State* approved by the *Regulatory Authority* (one being in English and one in Arabic).

11.3.3 The *Insurer* must provide the summary of the *Scheme Report* referred to in Rule 11.2.1(3), to every policyholder resident in the *State* who is affected by the *Relevant Scheme*.

12 Insurers in Run-off

12.1 Application and Purpose

12.1.1 This chapter applies to:

(A) every *QFC* incorporated *Insurer*; and

(B) every *Branch* in respect of its *QFC Insurance Business* operations.

12.1.2 In this chapter:

(A) an *Insurer* in run-off means an *Insurer* that has ceased to effect *Contracts of Insurance* in respect of the whole or a *Category* of its *Insurance Business* (or, in the case of a *Branch*, the whole or a *Category* of its *QFC Insurance Business*), and a *Cell* in run-off, a *Takaful Fund* in run-off and a *Long Term Insurance Fund* in run-off are construed accordingly; and

(B) going into run-off or placing *Insurance Business* into run-off means ceasing to effect *Contracts of Insurance*, and placing a *Cell*, *Takaful Fund* or a *Long Term Insurance Fund* into run-off are construed accordingly.

12.1.3 An *Insurer* in run-off by virtue of a decision or notice of the *Regulatory Authority* to the effect that the *Insurer* is to cease to effect *Contracts of Insurance* shall comply with this chapter except to the extent the *Regulatory Authority* acting under its powers in the *FSR* directs otherwise.

Guidance

1. The purpose of this chapter is to set out prudential provisions applying to *Insurers* that cease to effect *Insurance Business*, either wholly or in respect of a particular *Category*. The provisions are also applicable to *Cells*, *Takaful Funds* and *Long Term Insurance Funds*, but do not (because of the effect of Rule 12.1.2) apply to non-*QFC Insurance Business* of a *Branch*.

2. An *Insurer* may be in run-off because of a decision or notice of the *Regulatory Authority* under its powers in the *FSR* requiring an *Insurer* to cease to effect certain *Contracts of Insurance*.

12.1.4 For the purposes of this chapter, in determining whether an *Insurer* is effecting *Contracts of Insurance*, or has ceased to effect *Contracts of Insurance*, including *Contracts of Insurance* effected through a *Cell*, *Takaful Fund* or a *Long Term Insurance Fund*, *Contracts of Insurance* effected under a term of an existing *Contract of Insurance* will be ignored unless the *Regulatory Authority* decides otherwise in respect of any particular contract.

Guidance

The effect of Rule 12.1.4 is to disregard, for the purposes of determining whether the chapter applies, *Contracts of Insurance* that are effected by the *Insurer* as a consequence of a term of an existing *Contract of Insurance*. A contract will normally only be regarded as being effected under a term of an existing contract if the *Insurer* does not have discretion to decline to effect the new contract or if it would be unreasonable for the *Insurer*, having regard to the interests of the policyholder, to decline to effect it.

12.2 Insurers Ceasing to Effect Contracts of Insurance in a Category

12.2.1 This section applies to an *Insurer* that ceases or decides to cease to effect new or to renew *Contracts of Insurance*:

(A) in a *Category* in which the *Insurer* has previously effected *Insurance Business*; or

(B) in respect of a *Cell*, *Takaful Fund* or a *Long Term Insurance Fund*, in a *Category* in which the *Insurer* has previously effected *Insurance Business* through that *Cell*, *Takaful Fund* or *Long Term Insurance Fund*.

12.2.2 An *Insurer* to which this section applies must, within 28 days of a decision to cease to effect new *Contracts of Insurance* in a *Category*, notify the *Regulatory Authority* of its decision, in a written notice specifying the following details:

(A) the effective date of the decision to cease effecting *Contracts of Insurance*;

(B) the *Category* to which the decision relates; and

(C) where relevant, the *Cell*, *Takaful Fund* or *Long Term Insurance Fund* to which the decision relates.

12.2.3 An *Insurer* who has provided a notice to the *Regulatory Authority* in accordance with Rule 12.2.2 must not effect any *Contracts of Insurance* in that *Category* without the written permission of the *Regulatory Authority*. Where the notice referred to in Rule 12.2.2 relates to a *Cell*, *Takaful Fund* or *Long Term Insurance Fund* of the *Insurer*, the restriction set out in this *Rule* applies only to that *Cell*, *Takaful Fund* or *Long Term Insurance Fund*.

12.3 Run-off Plans

12.3.1 This section applies to:

(A) *Insurers* that go into, or are in, run-off, or that maintain *Cells*, *Takaful Fund* or *Long Term Insurance Funds* that are in run-off;

(B) *Insurers* that make a decision to go into run-off or to place a *Cell*, *Takaful Fund* or *Long Term Insurance Fund* into run-off; and

(C) *Insurers* whose authorisation to effect *Contracts of Insurance* in respect of their entire *Insurance Business* or in respect of the entire business of a *Cell*, *Takaful Fund* or *Long Term Insurance Fund* is withdrawn by the *Regulatory Authority*.

12.3.2 If an *Insurer* decides to go into run-off or to place a *Cell*, *Takaful Fund* or a *Long Term Insurance Fund* into run-off, the *Insurer* must, at the same time as the notice referred to in Rule 12.2.2, provide the *Regulatory Authority* with a written run-off plan in respect of the *Insurance Business* being placed into run-off.

12.3.3 If the *Regulatory Authority* withdraws an *Insurer's* authorisation to effect *Contracts of Insurance* in respect of the *Insurer's* whole, or a *Category* of, *Insurance Business* or the whole, or a *Category* of, *Insurance Business* of a *Cell*, *Takaful Fund* or *Long Term Insurance Fund*, the *Insurer* must, within 28 days of the written notice of withdrawal of authorisation (or, if later, the period specified in that notice), provide the *Regulatory Authority* with a written run-off plan in respect of that *Insurance Business*.

12.3.4 An *Insurer* must ensure a run-off plan provided to the *Regulatory Authority* in accordance with this section covers the period until all liabilities to policyholders relating to the *Insurance Business* in run-off are met and includes:

(A) an explanation of how, or the extent to which, all liabilities to policyholders will be met in full as they fall due;

(B) an explanation of how, or the extent to which, the *Insurer* will maintain its compliance with the requirements of *PINS* until such time as all liabilities to policyholders are met;

(C) a description, appropriate to the scale and complexity of the *Insurer's* business, of the *Insurer's* business strategy;

(D) financial projections showing, in a form appropriate to the scale and complexity of the *Insurer's* operations, the forecast financial position of the *Insurer* as at the end of each reporting period during the period to which the run-off plan relates;

(E) an assessment of the sensitivity of the financial position of the *Insurer* to stress arising from realistic scenarios relevant to the circumstances of the *Insurer*;

(F) details of the planned run-off reinsurance protections and the extent to which the planned reinsurance protections match the run-off realistic scenarios;

(G) details of the claims handling and reserving strategy; and

(H) details of the cost of the management of the run-off.

12.3.5 Where an *Insurer's Insurance Business* in run-off relates to a *Cell*, *Takaful Fund* or a *Long Term Insurance Fund* of that *Insurer*, the run-off plan must deal with the matters set out in Rule 12.3.4 so far as they relate to that *Cell*, *Takaful Fund* or *Long Term Insurance Fund*.

12.3.6 Insurer to monitor run-off plan etc

(1) This rule applies to an *insurer* that has given a run-off plan to the *Regulatory Authority*.

(2) The *insurer* must monitor the matters provided in the run-off plan.

(3) If there is a significant departure from the run-off plan, the *insurer* must tell the *Regulatory Authority* in *writing* immediately, but by no later than the second *business* day after the day the departure happens or starts.

12.3.7 Where an *Insurer* has notified a matter to the *Regulatory Authority* in accordance with Rule 12.3.6, the *Regulatory Authority* may by notice in writing require the *Insurer* to provide an amended run-off plan. The *Insurer* must provide an amended run-off plan within 28 days of receipt of the notice, unless the notice specifies a longer period.

12.4 Provisions in respect of Contracts Relating to Insurance Business in Run-off

12.4.1 Application—s 12.4

This section applies only to an *insurer* that—

(A) is in run-off as regards its entire *Insurance Business* or the entire *Insurance Business* of a *Cell*, *Takaful Fund* or *Long Term Insurance Fund*;

(B) has provided a notice to the *Regulatory Authority* in accordance with Rule 12.2.2 in respect of its entire *Insurance Business* or the entire *Insurance Business* of a *Cell*, *Takaful Fund* or *Long Term Insurance Fund*; or

(C) has received a written notice from the *Regulatory Authority* withdrawing the *Insurer's* permission to effect *Contracts of Insurance* in respect of its entire *Insurance Business* or the entire *Insurance Business* of a *Cell*, *Takaful Fund* or *Long Term Insurance Fund*.

12.4.2 Insurer with business in run-off to notify authority of certain contracts

(1) An *insurer* to which this section applies must—

(a) within 10 *business days* after the day its *insurance business* enters into run-off, tell the *Regulatory Authority* in *writing* about the existence and principal features of any notifiable contract that existed at the time the business entered into run-off; and

(b) within 10 *business days* after the day it enters into a notifiable contract in relation to its *insurance business* in runoff, tell the *Regulatory Authority* in *writing* about the existence and principal features of the contract.

(2) To remove any doubt, subrule (1) (b) applies whether or not the *insurance business* is conducted through a *cell*, *takaful fund* or a *long term insurance fund* that is in run-off.

(3) In this rule:

notifiable contract means—

(a) a contract with a *person related* to the *insurer*, other than a *contract of insurance* effected by the *insurer* before going into run-off; or

(b) a contract with any *person* relating to the management of all or any of the *insurance business* in run-off; or

(c) a contract with any *person* for reinsurance of all or any of the *insurance business* in run-off; or

(d) any other contract with a *person* mentioned in paragraph (b) or (c) or a *person* related to such a *person*.

12.4.3 Request for additional information about contract notified under r 12.4.2

(1) The *Regulatory Authority* may, by *written* notice given to an *insurer* that has notified the authority about a contract under rule 12.4.2, require the *insurer* to give the authority, within a stated reasonable period, additional information in *writing* about the contract.

(2) The *insurer* must comply with the requirement.

(3) The power given by subrule (1) is additional to the *Regulatory Authority's* other powers.

Note See eg *Financial Services Regulations*, art 48 (Power to obtain documents and information).

12.5 Limitations on Distributions by QFC Incorporated Insurers in Run-off

12.5.1 (1) An *Insurer* incorporated in the *QFC* in run-off must not make any distribution to shareholders or members of the *Insurer*, whether by way of dividends or otherwise, or any payment of management fees (other than fees payable under a contract notified to the *Regulatory Authority* in accordance with Rule 12.4.2), without the written consent of the *Regulatory Authority*.

(2) Any such distribution or return of capital or payment of management fees must be made within the period, if any, specified in the written notice of consent given by the *Regulatory Authority*.

App1 Risk Management Policy

Guidance

Rule 2.2.1 identifies risks that an *Insurer* must address in its risk management policy and the following guidance material provides greater detail on what the *Regulatory Authority* would expect to see in an *Insurer's* risk management policy for addressing these risks. It has been prepared to assist the *Directors* and *Senior Managers* of *Insurers*, their auditors, *Approved Actuaries* and others concerned in applying these *Rules*. The *Regulatory Authority* recognises that the exact content of each *Insurer's* risk management policy will be determined by what is appropriate in light of the nature, scale and complexity of the *Insurer's* business.

Credit risk

Introduction

1. Credit risk is the risk of default by borrowers and transactional counterparties as well as the loss of value of assets due to deterioration in credit quality. Exposure to credit risk results from financial transactions with securities issuers, debtors, borrowers, brokers, policyholders, reinsurers and guarantors.

Credit exposures

2. Credit exposures can increase the risk profile of an *Insurer* and adversely affect financial viability. A credit exposure includes both on-balance sheet and off-balance sheet exposures (including guarantees, derivative financial instruments and performance-related obligations) to single counterparties and groups of related counterparties. The *Regulatory Authority* envisages that actual and potential credit exposures to reinsurers arising from current or possible future claims, and other exposures, would be managed as part of the process of credit risk management.

3. In relation to credit exposures, the *Regulatory Authority* envisages that the risk management policy would incorporate the following elements:

    a. a mandate setting out the acceptable range, quality and diversification of credit exposures, including those to reinsurers (e.g. reinsurance recoveries), brokers and policyholders (e.g. premium receivables) and investments. This may be integrated with a more general investment mandate;

    b. limits for credit exposures to:

        (i) single counterparties and groups of related counterparties;

        (ii) intra-group asset exposures (to subsidiaries and related entities);

        (iii) single industries; and

        (iv) single geographical locations

        at both an individual and consolidated level;

    c. a process for approving changes in the credit mandate and changes in limit structures;

    d. a process for approving requests for temporary increases in limits and a process to ensure excesses are brought within the pre-approved limits within a set timeframe;

    e. a process for reviewing and, if necessary, reducing or cancelling exposures to a particular counterparty where it is known to be experiencing problems;

    f. a process to monitor and control credit exposures against pre-approved limits;

g. a process to review credit exposures (at least annually, but more frequently in cases where there is evidence of a deterioration in credit quality);

h. a management information system that is capable of aggregating exposures to any one counterparty (or group of related counterparties), asset class, industry or region in a timely manner; and

i. a process of reporting to the *Governing Body* and *Senior Management*:

(i) any breaches of limits; and

(ii) large exposures (an exposure to an asset or counterparty (including *Related* entities) of greater than 10 per cent of the *Insurer's* capital base would generally be regarded here as a large exposure) and other credit risk concentrations.

Balance sheet and market risk

Introduction

4. Balance sheet and market risk includes, but is not limited to, investment and asset-liability management risk and the risks associated with liquidity management and the use of derivatives. Due to the nature of an *Insurer's* business, there is a close relationship between investment risk and asset liability mismatch risk.

Investment risk and asset-liability mismatch risk

5. Investment risk refers to the possibility of an adverse movement in the value of an *Insurer's* assets, including off-balance-sheet exposures. Investment risk derives from a number of sources, including market risk (e.g. equity, interest rate and foreign exchange risk), credit risk and investment concentration risk. Related to this is asset-liability mismatch risk.

6. Asset-liability mismatch risk is the risk of adverse movements in the relative value of assets and liabilities due to changes in general market factors, such as interest rates, inflation and, where relevant, foreign exchange rates. Assets and liabilities are considered to be well matched if their changes in value in response to market movements are highly correlated. If assets and liabilities are not well matched, the possibility of a reduction in asset value that is not offset by a reduction in liability value, or an increase in liability value that is not offset by an increase in asset value, becomes significant.

7. The expected payment profile of an *Insurer's* liability portfolios is a crucial element of asset/liability management, as it determines the exposure of the portfolios' value to interest rates. Property business, such as household insurance, is typically short-term. Liability business, such as public liability, is typically long-term. The interest rate sensitivity of assets and liabilities is broadly determined by the timing of cash flows, although that will not always be the case (e.g. in the case of floating-rate notes or options). Timing of cash flows also affects the level of liquidity risk.

8. The systemic part of market risk is included under asset-liability risk. Market risk also includes non-systemic or specific risk, which principally arises in the process of implementing the investment strategy.

9. In relation to investment risk, the risk management policy would typically include the following elements:

a. the investment objective;

b. formulation of an investment strategy, including allowable asset classes, strategic asset allocation, asset allocation ranges, benchmarks, risk limits and target currency exposures and ranges. The investment strategy would typically be formulated taking account of the investment objective, the *Insurer's* capital position, the term and currency profile of its expected liabilities, liquidity requirements and the expected returns, volatilities and correlations of asset classes;

c. a process for how individual asset classes will be managed, including which of those tasks are done internally and which are outsourced to investment managers;

d. responsibilities of individuals and committees (e.g. investment committee, asset-liability committee) for deciding and implementing the investment strategy, and for monitoring and controlling investment risk, including reporting lines, decision-making powers and delegations;

e. a process for selection of investment managers who are qualified and competent to carry out their assigned task;

f. limits and other restrictions on the actions of investment managers, whether internal or outsourced, and the means by which compliance with those limits is monitored;

g. modelling and stress-testing of the impact of the current and alternative investment strategies on financial outcomes and asset-liability mismatch;

h. processes for:

(i) ensuring the continuing appropriateness of the investment strategy, including timing and nature of strategy reviews;

(ii) ensuring the continuing appropriateness of the investment implementation process, including the timing and nature of reviews of investment managers and the manager configuration;

(iii) monitoring compliance with the investment strategy; and

(iv) putting into place contingency plans to mitigate the effects of deteriorating investment conditions;

i. segregation of duties (which may also be covered by the operational risk management policy); and

j. performance monitoring and its role in the oversight and control of the investment process.

Liquidity

10. The *Regulatory Authority* expects an *Insurer* to have sufficient liquidity to meet all cash outflow commitments to policyholders (and other creditors) as and when they fall due. The nature of insurance activities means that the timing and amount of cash outflows are uncertain. This uncertainty may affect the ability of an *Insurer* to meet its obligations to policyholders or may require *Insurers* to incur additional costs through, for example, raising additional funds at a premium on the market or through the sale of assets.

11. Typically, in relation to liquidity, the risk management policy would include:

a. consideration of the level of mismatch between expected asset and liability cash flows under normal and stressed operating conditions;

b. the liquidity and realisability of assets;

c. commitments to meet insurance and other liabilities;

d. the uncertainty of incidence, timing and magnitude of *Insurance Liabilities*;

e. the level of liquid assets needed to be held by the *Insurer*; and

f. other sources of funding including reinsurance, borrowing capacity, lines of credit and the availability of intra-group funding.

Derivatives

12. Derivative transactions are financial contracts in instruments such as forwards, futures, swaps, options and other similar transactions.

13. An *Insurer's* risk management policy for derivatives would typically incorporate the following elements:

    a. the *Insurer's* objectives and policies in using derivatives;

    b. the risk tolerances of the *Insurer* and a limit framework consistent with those risk tolerances;

    c. appropriate lines of authority and responsibility for transacting derivatives, including trading limits; and

    d. consideration of worst case scenarios and sensitivity analysis and reporting of that analysis.

Reserving risk

14. Reserving risk is the risk that *Insurance Liabilities* recorded by the *Insurer*, net of reinsurance and other recoveries in respect of those liabilities, will be inadequate to meet the net amount payable when the *Insurance Liabilities* crystallise. *Insurance Liabilities* include the liability for claims incurred up to the reporting date, as well as the *Premium Liability*. In the case of *General Insurance Business*, reinsurance recoveries anticipated in respect of those liabilities are generally recognised as a separate asset. In the case of *Long Term Insurance Business*, *Insurance Liabilities* include also the net value of future *Policy Benefits* and the effects of reinsurance arrangements are taken into account when these are estimated.

15. An *Insurer's* risk management policy should therefore include a process for ongoing review and appraisal of the *Insurance Liability* valuation framework (i.e. assumptions made, reinsurance recoveries estimated etc). In conducting this review, consideration should be given to emerging pricing and claim payment trends.

16. An *Insurer* should maintain appropriate systems, controls and procedures to ensure that the provision for *Insurance Liabilities* is, at all times, sufficient to cover any liabilities that have been incurred, or are yet to be incurred, on *Contracts of Insurance* accepted by the *Insurer*, as far as can be reasonably estimated.

17. Appropriate methods should be applied in estimating the provision for *Insurance Liabilities*, including provisions in respect of individual notified incurred claims. In determining a provision estimation method, managers may consider using alternative approaches before selecting those which may be regarded as most appropriate to the nature of the business.

18. Appropriate methods should be applied in estimating the amount of the asset in respect of reinsurance recoveries that are expected to arise on crystallisation of the gross *Insurance Liabilities*. The manner of estimating those assets should be consistent with the manner estimating the gross liabilities, except where there is a sound justification for doing otherwise.

19 Suitable systems and controls should be put in place to ensure that the selected approaches are applied accurately and on a consistent basis.

20. Procedures should be in place to review and monitor, on a regular basis, the out-turn of provisions made in previous years for *Insurance Liabilities*, both gross and net of reinsurance recoveries.

21. Aside from the actuarial advice an *Insurer* is required to obtain under chapter 9, an *Insurer* should consider the use of actuaries or other appropriately qualified and experienced loss reserving specialists to estimate *Insurance Liabilities* periodically through the year. The *Insurer* should in any case undertake periodic testing of its reserving processes and the level of its reserves, including continual reassessment of assumptions used, and testing the sensitivity of the valuation of *Insurance Liabilities* to stress arising from realistic scenarios relevant to the circumstances of the *Insurer*. Whether in-house or outside experts are used, appropriate procedures should be in place to ensure that the specialist selected possesses the appropriate level of skill and experience and has available the necessary information to carry out the estimation required.

22. Suitable controls should be in place to ensure that the data used in determining the *Insurance Liabilities* are extracted from the underlying records accurately and to the necessary level of detail. The level of detail should be sufficient to ensure that the data available to managers in their assessment of *Insurance Liabilities* covers the whole of its liabilities and exposures under *Insurance Contracts*.

23. Scenario testing should cover a period of several years into the future, particularly in the case of an *Insurer* carrying on *Long Term Insurance Business*.

Insurance and reinsurance risk

Introduction

24. Insurance risk is the risk that inadequate or inappropriate underwriting, claims management, product design and pricing will expose an *Insurer* to financial loss and the consequent inability to meet its liabilities.

Product design

25. Product design involves the introduction of a new product or the enhancement or variation of an existing product.

26. In relation to product design and approvals, an *Insurer's* risk management policy would typically cover the product classes and types of risks in which the *Insurer* chooses to engage.

27. In this regard, the risk management policy would typically include the following elements:

    a. setting a business case for new or enhanced products;

    b. market testing and analysis;

    c. cost/benefit analysis;

    d. risk identification and assessment;

    e. requirements for limiting risk through, for example, diversification, exclusions and reinsurance (including confirmation that either the existing reinsurance will provide protection or new reinsurance protection is being provided);

    f. processes to ensure that policy documentation is adequately drafted to give legal effect to the proposed level of coverage under the product;

    g. an implementation plan for the product, including milestones;

    h. clearly defined and appropriate levels of delegation for approval of all material aspects of product design;

    i. post-implementation review; and

    j. methods for monitoring compliance with product design policies and procedures.

Pricing

28. The pricing of an insurance product involves the estimation of claims costs and other business costs arising from the product and the estimation of investment income arising from the investment of the premium income attaching to the product. Pricing risk may occur where the claims, costs or investment returns arising from the sale of a product are inaccurately estimated.

29. An *Insurer* could consider incorporating ongoing actuarial review and involvement in the pricing process and, where relevant, undertaking specific independent reviews of pricing for schemes and larger or more complex risks.

30. In relation to pricing, the *Insurer* could consider including in the risk management policy the following elements:

    a. clearly defined and appropriate levels of delegation for approval of all material aspects of pricing;

    b. risk identification and assessment;

    c. a process for the reflection of emerging experience in price adjustments;

    d. profit and loss analysis including monitoring the effect of price movements on the bottom line;

    e. price discounting authorities;

    f. a process for the *Insurer's* product pricing to respond to competitive and other external environmental pressures;

    g. a process for and the ability to monitor deviations of actual price from the technical underwriting pricing; and

    h. methods for monitoring compliance with pricing policies and procedures for proposed pricing variations.

Underwriting

31. Underwriting is the process by which an *Insurer* determines whether or not to accept a risk and, if accepted, the terms and conditions to be applied and the level of premium to be charged. Weaknesses in the underwriting process and in the types and levels of controls and systems can expose an *Insurer* to the risk of operational losses which may threaten the long-term viability of the *Insurer*.

32. In relation to underwriting, the risk management policy would typically include the following elements:

    a. a statement of the *Insurer's* willingness and capacity to accept risk;

    b. the nature of *Insurance Business* that the *Insurer* is to underwrite including:

        (i) the classes of insurance to be underwritten;

        (ii) the geographical areas in which these classes will be underwritten;

        (iii) the types of risks that may be underwritten and those that are to be excluded; and

        (iv) the criteria for the use of reinsurance in the different classes of *Insurance Business* to be underwritten;

    c. details of the formal risk assessment process in the underwriting of insurance including:

        (i) the criteria used for risk assessment;

        (ii) the method(s) for monitoring emerging experience; and

        (iii) the method(s) by which the emerging experience is taken into consideration in the underwriting process;

    d. the process for setting approval authorities and the definitive limits to those authorities (including controls surrounding delegations given to intermediaries of the *Insurer*);

    e. risk and aggregate concentration limits; and

f. methods for monitoring compliance with underwriting policies and procedures such as:

(i) internal audit (where it is established that the internal audit unit has the appropriate skills and experience to perform such activities);

(ii) reviews by area heads or portfolio management;

(iii) peer review of policies underwritten (including details of the staff responsible for undertaking the peer review, the frequency of such reviews and the reporting arrangements for the results);

(iv) assessments of brokers' procedures and systems to ensure the quality of information provided to the *Insurer* is of a suitable standard; and

(v) in the case of reinsurers, audits of ceding companies to ensure that reinsurance assumed is in accordance with treaties in place.

Claims management

33. Claims settlement is the process by which *Insurers* fulfil their contractual obligations to policyholders. In the management of the claims handling process, the following procedures would be triggered when a loss occurs and claims notification is made to the *Insurer*:

a. verifying the contractual obligation of the policy to pay the claim;

b. making an assessment of the claims liability quantum, including loss adjustment expenses; and

c. ensuring the claims settlement process is handled promptly and efficiently within the terms of the policy.

34. Weaknesses in the controls and systems surrounding the claims management process can expose an *Insurer* to additional or increased losses which may impact upon its capital position.

35. In relation to claims management, the *Regulatory Authority* envisages that the risk management policy would include the following elements:

a. clearly defined and appropriate levels of delegations of authority;

b. claims settlement procedures, including loss estimation and investigation procedures;

c. criteria for accepting or rejecting claims;

d. dispute resolution procedures; and

e. methods for monitoring compliance with claims management processes and procedures such as:

(i) internal audit (where it is established that the internal audit unit has the appropriate skills and experience to perform such activities);

(ii) reviews by area heads or portfolio management;

(iii) peer review (including details of the staff responsible for undertaking the peer review, the frequency of such reviews and the reporting arrangements for the results);

(iv) assessments of brokers' procedures and systems to ensure the quality of information provided to the *Insurer* is of a suitable standard; and

(v) in the case of reinsurers, audits of ceding companies to ensure that the value of claims paid is in accordance with treaties in place.

Operational risk

Introduction

36. Operational risk is the risk of financial loss resulting from inadequate or failed internal processes, people and systems or from external events. An *Insurer* may determine a definition of operational risk appropriate to the nature, scale and complexity of its activities and operating environment. The *Regulatory Authority* envisages that this definition of operational risk would be clearly understood throughout the *Insurer* in order to effectively identify and manage this risk.

37. The management of operational risk would typically include (but is not limited to) the risks associated with outsourcing, business continuity, inadequate human resources, internal and external fraud, project management, underwriting and claims, business processes and the introduction of new products.

Outsourcing

38. Financial firms frequently decide to outsource aspects of their operations to other parties, *Related* or not. Outsourcing can bring significant benefits to a firm in terms of efficiency, cost reduction and risk management. However, both the process of implementing outsourcing arrangements and the outsourcing relationship itself may expose a firm to additional risk. It is therefore important that firms take care to supervise the conduct of activities that are outsourced. CTRL Rule 5.2.1 requires an *Authorised Firm* to inform the *Regulatory Authority* prior to entering any *Material Outsourcing* arrangement.

39. The activities of outsource contractors have the ability to undermine the risk management activities of *Insurers*. *Insurers* should take particular care if outsourcing activities such as underwriting and claims management, where inappropriate performance of the functions can expose the *Insurer* to serious financial loss, for example through acceptance of inappropriate insurance risks, mis-pricing, failure to obtain appropriate reinsurance cover, or failure to detect invalid claims. These considerations apply to such arrangements as binding authorities and other agencies appointed by *Insurers*.

40. In negotiating a contract with an outsource contractor or in assessing an existing agreement, an *Insurer* should give consideration to matters relevant to risk management, including the following:

    a. the setting and monitoring of authority limits and referral requirements;

    b. the identification and assessment of performance targets;

    c. the procedures for evaluation of performance against targets;

    d. the provisions for remedial action;

    e. the reporting requirements imposed on the outsource contractors (including both content and frequency of reports);

    f. the ability of the *Insurer* and its *Risk Management Function* and its external auditors to obtain access to the outsource contractors and their records;

    g. the protection of intellectual property rights;

    h. the protection of customer and firm confidentiality;

    i. the adequacy of any guarantees, indemnities or insurance cover that the outsource contractor agrees to put in place;

    j. the ability of the outsource contractor to provide continuity of business; and

    k. the arrangements for change to the outsource contract or termination of the contract.

41. *Insurers* should take care to manage the risk that the sound and prudent management of the *Insurer*'s business may be compromised by conflicting incentives in the outsource agreement. In particular, *Insurers* should consider whether the remuneration structure creates any perverse incentives. For example, an outsource contractor with underwriting authority may have an incentive to accept poorer quality business if remuneration is based on commission (especially if bonuses are given for volume) and remuneration is not affected by the performance of the insurance contracts accepted.

42. Intra-group outsourcing may be perceived as subject to lower risks than using outsource contractors from outside a *Group*. However it is not risk-free and an *Insurer* must still assess the associated risks and make appropriate arrangements for their management.

Business continuity

43. Disruptions in an *Insurer*'s business can lead to unexpected losses of both a financial and non-financial nature (e.g. data, premises and reputation). Disruptions may occur as a result of events such as power failure, denial of access to premises or work areas, systems failure (computers, data, building equipment), fire, fraud and loss of key staff.

44. An *Insurer*'s risk management policy in respect of business continuity planning risk will normally be expected to include at least the following policies and procedures:

a. processes for identifying:

(i) events that may lead to a disruption in business continuity;

(ii) the likelihood of those events occurring;

(iii) the processes most at risk; and

(iv) the consequences of those events.

b. a business continuity plan (BCP) describing:

(i) procedures to be followed if business continuity problems arise;

(ii) detailed procedures for enacting the BCP, including manual processes, the activation of an off-site recovery site (if needed) and the person(s) responsible for activating the BCP;

(iii) a communications strategy and contact information for relevant staff, suppliers, regulators, market authorities (including exchanges), major clients, the media and other key people;

(iv) a schedule of critical systems covered by the BCP and the timeframe for restoring these systems;

(v) the pre-assigned responsibilities of staff and procedures for training staff on all aspects of the BCP; and

(vi) procedures for regular testing and review of the BCP; and

c. procedures for backing up important data on a regular basis and storing the information off site.

Legal risk

45. Legal risk refers to the possibility of an *Insurer* being exposed to loss, penalties or reputational damage through legal matters such as breaches of laws or regulatory obligations, inadequate contracts, or by changes in law affecting the *Insurer*. Legal risk includes, but is not limited to, exposure to fines or penalties or punitive damages resulting from supervisory actions, as well as ordinary damages in civil litigation, related legal costs and private settlements. An example of contract inadequacy is where an *Insurer's* reinsurance arrangements potentially exposes the *Insurer* to significant legal risk where the contract is not valid, binding or enforceable, or does not clearly set

out the respective rights and obligations of the parties, or where a policy document inadequately sets out what exclusions apply.

46. The *Regulatory Authority* would expect legal risk to be addressed under various areas of the risk management policy, including, but not limited to:

a. processes for ensuring accurate and complete documentation;

b. processes to ensure polices are adequately drafted so the *Insurer* does not have to pay out for risks not priced into the original premium; and

c. processes and controls in place for ensuring the *Insurer* is compliant with all legal prudential and other regulatory requirements.

Human resources

47. In relation to human resources, the risk management policy may include the following elements or such elements as the *Insurer* deems relevant to its circumstances:

a. risk identification and assessment of the *Insurer's* human resource needs; and

b. monitoring and supervision of staff.

Unauthorised or fraudulent activities

48. The *Regulatory Authority* envisages that the risk management policy would address the risk of unauthorised and fraudulent activities. Unauthorised activities would include those activities that breach the controls, procedures, limits or other restrictions in place in the *Insurer's* policies and procedures as well as applicable legal and regulatory requirements. Fraud risk relates to the risk associated with intentional acts, undertaken with the objective of personal benefit, to tamper with or manipulate the financial or operational aspects of the business.

49. The *Regulatory Authority* would expect that the risk of unauthorised activities would be addressed in various other areas of the *Insurer's* risk management policy, including, but not limited to:

a. appropriate segregation of duties; and

b. appropriate processes for monitoring compliance with the controls, procedures, limits or other restrictions in place, for example those placed on investment managers or those making decisions on underwriting.

50. Fraudulent activity can arise from internal sources (e.g. premium redirection) or external sources (e.g. fictitious claims) and exposes the *Insurer* to the risk of financial loss if not managed appropriately. In relation to fraud, the risk management policy would typically include (but is not limited to) the following elements:

a. risk identification and assessment;

b. internal controls and mitigation strategies;

c. segregation of duties at both an operational level and in relation to functional reporting lines;

d. financial accounting controls; and

e. staff training and awareness.

Project management

51. An *Insurer* could consider addressing project management risk in its risk management policy. Project management risk is the risk that projects will not achieve the desired objectives or will have a negative impact on resource levels of the *Insurer*.

52. In relation to project management, the risk management policy would typically include (but is not limited to) the following elements:

    a. a formal project methodology for the promulgation of project initiatives including:

        (i) setting a business case for the project;

        (ii) cost/benefit analysis;

        (iii) risk identification and assessment; and

        (iv) stakeholder sign-offs;

    b. clearly defined and appropriate levels of delegations of authority;

    c. ongoing monitoring of project objectives and timeframes; and

    d. post-implementation review.

Group risk

53. *Group* membership may be a source of both strength and weakness to an *Insurer*. The purpose of requiring an *Insurer* to include *Group* risk in its risk management policy is to ensure that the *Insurer* takes proper account of the risks related to the *Insurer's* membership of a *Group*.

54. The *Senior Management* of an *Insurer* remains responsible for its regulatory compliance, including in any areas that are delegated or outsourced to other *Group* members.

55. The overall governance, high-level controls and reporting lines within the *Group* should be clear so far as they affect the *Insurer*. An *Insurer* should not, for example, be subject to material control or influence from other *Group* members that is exercised through informal or undocumented channels.

56 Reliance upon functions performed at a *Group* level (for example, *Group* risk management, capital planning, liquidity and compliance) should be subject to approval and monitoring by *Senior Management* of the *Insurer*.

57. Where an *Insurer* relies upon functions that are performed at a *Group* level the protocols for the performance of those functions should be clear.

58. *Senior Management* should establish and maintain systems and controls to identify and monitor the effect on the *Insurer* of its relationship with other members of the *Group* and the activities of other members of its *Group*. These systems and controls should include procedures to monitor the following matters:

    a. changes in relationships between *Group* members;

    b. changes in the activities of *Group* members;

    c. conflicts of interest arising within the *Group*; and

    d. events in the *Group*, particularly those that may affect the *Insurer*'s own regulatory compliance (e.g. failures of control or compliance in other *Group* members).

59. The *Insurer* should have in place procedures to insulate the *Insurer*, so far as practicable, from potentially adverse effects of *Group* activities (e.g. transfer pricing or fronting) or *Group* events that may expose the *Insurer* to risk. Such procedures could include requirements for transactions with *Group* members to be at arm's length, and for maintenance of Chinese walls, and development of contingency plans.

60. *Senior Management* should take reasonable steps to ensure that:

a. relevant *Group* members are aware of the *Insurer's Group* risk management and reporting obligations;

b. *Group* capital and *Group* risk reporting requirements are complied with; and

c. information in respect of the *Group* provided to the *Regulatory Authority* is of appropriate quality.

App2 Capital

Stress and Scenario Testing

Guidance

1. Stress and scenario testing seeks to anticipate possible losses or risks that might occur or become manifest. In applying them an *Insurer* needs to decide how far forward to forecast and may want to consider the following factors:

    a. how quickly it would be able to identify events or changes in circumstances that might lead to a loss occurring or risk crystallising; and

    b. after the event or circumstance has been identified, how quickly and effectively the *Insurer* could act to prevent or mitigate any resulting loss occurring or risk crystallising and to reduce its exposure to any further adverse event or change in circumstance.

2. For example, the time horizon over which stress and scenario testing would need to be carried out for the risks arising from the holding of investments would depend upon:

    a. the extent to which there is a regular, open and transparent market in those assets, which would allow fluctuations in the value of the investment to be more readily and quickly identified; and

    b. the extent to which the market in those assets is liquid (and would remain liquid in the changed circumstances contemplated in the stress or scenario test) which would allow the *Insurer*, if needed, to sell its holding so as to prevent or reduce its exposure to future price fluctuations.

3. *Insurers* should focus on those scenarios and combinations of scenarios that are considered reasonably likely to occur. For this purpose other risks and losses include business risk (i.e. the potential impact of changes in business plans, future activities, and the business or economic environment).

4. In identifying what realistic combinations of losses or risks might occur or crystallise, an *Insurer* should take into account scenarios in which expected correlations occur and where they might break down.

5. In identifying scenarios and assessing their impact, an *Insurer* should take into account how changes in circumstances might impact upon:

    a. the nature, scale and mix of future activities; and

    b. the behaviour of *Counterparties*, and of the *Insurer* itself, including the exercise of choices (including *Option*s embedded in *Financial Instrument*s or *Contracts of Insurance*).

6. In determining whether it would have adequate financial resources in the event of each identified adverse scenario, an *Insurer* should:

    a. only include financial resources that could reasonably be relied upon as being available in the circumstances of the identified scenario; and

    b. consider any legal or other restriction on the purposes for which financial resources may be used, including any restriction on the transfer to the *QFC* of assets held overseas.

App3 Risk Based Capital Requirement

Guidance

The purpose of this appendix is to outline the calculations an *Insurer* must make for each component of the *Investment Risk Requirement* and *Insurance Risk Requirement* as specified under Rule 3.6.1 and Rule 3.7.1 respectively.

A3.1 Counterparty Grades

A3.1.1 An *Insurer* must use the following table whenever the *Rules* in *PINS* require an *Insurer* to determine a particular counterparty *Grade*.

Grade	Standard & Poor's	Moody's	AM Best	Fitch
1	AAA	Aaa	A++	AAA
2	AA+ AA AA-	Aa1 Aa2 Aa3	A+	AA+ AA AA-
3	A+ A A-	A1 A2 A3	A	A+ A A-
4	BBB+ BBB BBB-	Baa1 Baa2 Baa3	A-	BBB+ BBB BBB-
5	BB+ to B-	Ba1 to B3	B++ to C+	BB+ to B-
6	CCC+ and below	Caa and below	C and below	CCC and below

A3.2 Credit Risk Component

Guidance

1. Credit risk is the risk incurred whenever an *Insurer* is exposed to loss if another party fails to perform its financial obligations to the *Insurer*, including failing to perform them in a timely manner. Credit risk includes a reinsurer failing to fulfil its financial obligation to repay an *Insurer* upon submission of a claim.

2. The purpose of the credit risk component is to require an *Insurer* to hold capital against this risk. The basic calculation for this component, set out in Rule A3.2.1, is modified by additional provisions that permit an *Insurer* to take account of reduced credit risk (e.g. where an asset is covered by guarantees or collateral).

A3.2.1 An *Insurer* must calculate its credit risk component as the sum of the amounts obtained by multiplying the value of each asset of the *Insurer*, graded according to the counterparty *Grade* of the asset, by the percentage applicable to that asset, as set out in the tables (A) and (B) contained in this *Rule* and subject to the provisions of Rule A3.2.2, A3.2.3 and A3.2.4.

(A) Assets that are *Invested Assets*

	Asset	%
(a)	Grade 1 sovereign bonds	0.0
(b)	All other Grade 1 bonds	0.4
(c)	Grade 2 bonds	1.2
(d)	Grade 3 bonds	2.0
(e)	Grade 4 bonds	3.5
(f)	Grade 5 bonds	10.0
(g)	Grade 6 bonds	20.0
(h)	Unrated bonds	12.0
(i)	Secured loans - performing	2.0
(j)	Secured loans – *Non-Performing*	14.0
	Unpaid premiums due less than 6 *months* previously • Grades 1 to 3 • Grades 4 to 6	 2.0 4.0
	Unpaid premiums due more than 6 *months* previously • Grades 1 to 3 • Grades 4 to 6	 6.0 8.0
(k)	• Loans to directors of the *Insurer* or to directors of *Related* parties, or to the dependent relatives of such directors • Unsecured loans to employees (except loans of less than US$1,000) • Assets under a fixed or floating charge	100.0
(l)	Other bonds and loans	50.0

(B) Assets that are not *Invested Assets*

	Asset	%
(a)	Reinsurance assets due from reinsurers with a counterparty rating of Grade 1	0.75
(b)	Reinsurance assets due from reinsurers with a counterparty rating of Grade 2	1.5
(c)	Reinsurance assets due from reinsurers with a counterparty rating of Grade 3	2.5
(d)	Reinsurance assets due from reinsurers with a counterparty rating of Grade 4	4.7
(e)	Reinsurance assets due from reinsurers with a counterparty rating of Grade 5	11.0
(f)	Reinsurance assets due from reinsurers with a counterparty rating of Grade 6	100.0
(g)	Reinsurance assets - unrated	16
(h)	Other assets	3.0

A3.2.2 (1) Assets that have been explicitly, unconditionally and irrevocably guaranteed for their remaining term to maturity by a guarantor with a counterparty rating in *Grades* 1, 2 or 3 who is not a *Related* party to the *Insurer* may be assigned the credit risk charge that would apply to a debt instrument issued from the guarantor.

(2) Where an *Insurer* holds collateral against an asset, and this collateral takes the form of a charge, mortgage or other security interest in, or over, cash, or any debt security whose issuer has a counterparty rating of *Grades* 1, 2 or 3, the *Insurer* may apply the credit risk charge relevant to the collateral (instead of applying the credit risk charge that would otherwise apply to the asset).

(3) The provisions in (1) and (2) above apply only to so much of the asset that is covered by the guarantee or the collateral.

A3.2.3 (1) Subject to Rule A3.2.3 (2), assets of the *Insurer* that are under a fixed or floating charge, mortgage or other security are subject to a credit risk charge of 100% to the extent of the indebtedness secured on those assets. This would replace the credit risk charge that would otherwise apply to the secured assets.

(2) Where the security supports an *Insurer's Insurance Liabilities*, the credit risk charge of 100% is applicable only to the amount by which the market value of the charged assets exceeds the *Insurer's* supported liabilities.

A3.2.4 An *Insurer* does not need to include an amount in its credit risk for any assets excluded from *Eligible Capital* in accordance with the requirements as laid out in the table in Rule 4.2.2.

A3.3 Volatility Risk Component

Guidance

Volatility risk is the risk of an adverse movement in the value of an *Insurer's Invested Assets* which is not offset by a corresponding movement in the value of liabilities. The purpose of the volatility risk component is to require an *Insurer* to hold capital to cover the risk of deteriorations in the value of *Invested Assets*. *Invested Assets* that are linked to liabilities of *Investment Linked Insurance* contracts are exempted from the calculation, since there is a direct correlation between the values of the assets and the values of the liabilities to which they are linked.

A3.3.1 An *Insurer* must calculate its volatility risk component as the sum of the amounts obtained by multiplying the value of each *Invested Asset* of the *Insurer* with the percentage applicable to that asset, as set out in the following table.

	Asset	%
(a)	All bonds up to 1 year to maturity	0.25
(b)	Bonds between 1 and 2 years to maturity	0.75
(c)	Bonds between 2 and 5 years to maturity	1.5
(d)	Bonds between 5 and 10 years to maturity	2.5
(e)	All other bonds	3.75
(f)	Equity investments*	12.0
(g)	Preference shares	6.0
(h)	Land and buildings	18.0

*Notes: Item (f) includes equity shares, participations in collective investment schemes (whether or not the underlying investments are themselves equity investments), participations in joint ventures, and certificates of Mudaraba and Musharaka.

A3.3.2 No amount must be included in the calculation of the volatility risk component in respect of investments that are linked to liabilities of *Investment Linked Insurance* contracts.

A3.4 Off-balance Sheet Asset Risk Component

Guidance

An *Insurer* may be exposed to various investment risks through transactions or dealings other than those reflected in its balance sheet. The purpose of the off-balance sheet asset risk component is to require an *Insurer* to hold capital to cover the risk of default and deterioration in value of exposures that the *Insurer* has because it is party to a derivative contract.

A3.4.1 An *Insurer* must calculate an off-balance sheet asset risk component, if the *Insurer* is, as of the *Solvency Reference Date*, a party to a derivative contract, including a forward, future, swap, option or other similar contract, but not:

(A) a put option serving as a guarantee;

(B) a foreign exchange contract which has an original maturity of 14 calendar days or less; or

(C) an instrument traded on a futures or options exchange which is subject to daily mark-to-market and margin payments.

A3.4.2 An *Insurer* must calculate its off-balance sheet asset component as the sum of the amounts obtained by applying the calculations set out in Rule A3.4.3 in respect of each derivative contract entered into by the *Insurer* that meets the description in Rule A3.4.1.

A3.4.3 To calculate the amount of the off-balance sheet asset component, the asset equivalent value of each derivative, as determined in Rule A3.4.4 is multiplied by the credit risk component as determined in Rule A3.2.1 and the volatility risk component as determined in Rule A3.3.1, as though the asset equivalent value were a debt obligation due from the derivative counterparty.

A3.4.4 (1) The asset equivalent value is the current mark-to-market exposure of the derivative (where positive) and a potential exposure add-on.

(2) The potential exposure add-on is determined by multiplying the notional principal amount of the derivative in accordance with the following table, according to the nature and residual maturity of the derivative.

Residual maturity	Interest rate contracts	Foreign exchange & gold contracts	Equity contracts	Precious metal contracts (except gold)	Other contracts
Less than 1 year	Nil	1.0%	6.0%	7.0%	10.0%
1 year to less than 5 years	0.5%	5.0%	8.0%	7.0%	12.0%
5 years or more	1.5%	7.5%	10.0%	8.0%	15.0%

A3.5 Off-balance Sheet Liability Risk Component

Guidance

1. An *Insurer* may be exposed to various investment risks through transactions or dealings other than those reflected in its balance sheet. The purpose of the off-balance sheet liability risk component is to require an *Insurer* to hold capital to cover the risk that it will be required to perform on a guarantee, letter of credit of other credit substitute that it has entered into should the guaranteed party default or fail to deliver. Although such items are not liabilities of the *Insurer* as at the *Solvency Reference Date* they have the capacity to crystallise as liabilities at a subsequent date and therefore to affect the *Insurer's* capital position.

2. Credit substitutes do not include *Contracts of Insurance* for credit and surety insurance business.

A3.5.1 (1) An *Insurer* must calculate its off-balance sheet liability risk component by applying, to the face value of any credit substitute it has issued, including letters of credit, guarantees and put options serving as guarantees, the credit risk component as determined in Rule A3.2.1 and the volatility risk component as determined in Rule A3.3.1, that would be applied to the obligation or asset over which the credit substitute has been written.

(2) Where the credit substitute is supported by collateral or a guarantee, the provisions of Rule A3.2.2 (1) and A3.2.2 (2) may be applied by the *Insurer*.

A3.6 Concentration Risk Component

Guidance

1. An *Insurer* may be exposed to risk arising from an excessive exposure to a particular asset (including reinsurance recoveries). The purpose of the concentration risk component is to require an *Insurer* to hold capital to cover the sensitivity that it has to default or volatility in respect of assets and exposures to single counterparties or groupings of connected counterparties, or single properties. The additional capital requirement applies to investment exposures, including off-balance sheet exposures, and amounts outstanding under finite risk reinsurance contracts in respect of *Long Term Insurance Business*. It is calculated on the basis of the *Insurer's* total exposure to the counterparty, grouping of connected counterparties or property, and operates on a sliding scale depending on the scale and counterparty *Grade* of that exposure relative to the *Insurer's* total assets. Certain assets that are left out of account in calculating an *Insurer's Eligible Capital* are excluded from the calculation.

2. Due to the nature of captive insurance business (for example, the use of a *Captive's* assets as collateral for fronting insurers), *Captives* are not required to include a concentration risk component to their *Risk Based Capital Requirement*.

A3.6.1 An *Insurer*, other than a *Captive*, must calculate a concentration risk component if the *Insurer* has an investment exposure to a single counterparty or (taken in the aggregate) to a grouping of two or more counterparties who are *Related* to each other, or to a single property, that exceeds four per cent of the *Insurer's* total assets.

A3.6.2 For the purposes of the calculation referred to in Rule A3.6.1:

(A) 'investment exposure' means the aggregate value of all equity, bond or other investments in or in respect of the counterparty or grouping of *Related* counterparties or property in question, together with off-balance sheet exposures to the same counterparty or grouping of *Related* counterparties or property that the *Insurer* has because it has issued guarantees, letters of credit or other credit

substitutes (other than insurance contracts), or because it has entered into derivative contracts, and any amounts referred to in Rule A3.9.5 in respect of that counterparty or grouping of *Related* counterparties, but excluding any assets excluded from *Eligible Capital* in accordance with the requirements as laid out in the table in Rule 4.2.2;

(B) where an *Insurer's* investment exposure is to a group of *Related* counterparties, the concentration risk component must be calculated on the basis of the lowest counterparty *Grade* of a counterparty in this grouping;

(C) *Grade* 1 rated Governments and Government agencies are not counterparties; and

(D) property should be categorised as a counterparty *Grade* of 4-6 when determining which formula to use in Rule A3.6.3.

A3.6.3 An *Insurer* must calculate its concentration risk component as the sum of the amounts obtained by applying to each investment exposure that exceeds four per cent of the *Insurer's* total assets the relevant formula for the counterparty *Grade* as set out in the following table, subject to Rule A3.6.4.

Exposure expressed as a percentage of total assets	**Counterparty *Grade***	**Formula to determine concentration risk component**	
Over 4 up to 7	1-3	0%	
	4-6	20%	of the amount by which the investment exposure exceeds four pre cent of total assets.
Over 7 up to 16	1-3	20%	of the amount by which the investment exposure exceeds seven per cent of total assets.
	4-6	0.6%	of the total assets, plus 30% of the amount by which the investment exposure exceeds seven per cent of total assets.
Over 16 up to 40	1-3	2%	of the total assets, plus 30% of the amount by which the investment exposure exceeds 16% of total assets.
	4-6	3.2%	of the amount of total assets, plus 50% of the amount by which the investment exposure exceeds 16% of total assets.
Over 40	1-3	9%	of the amount of total assets, plus 40% of the amount by which the investment exposure exceeds 40% of total assets.
	4-6	15%	of the amount of total assets, plus 70% of the amount by which the investment exposure exceeds 40% of total assets.

A3.6.4 If the amount included in the concentration risk component in respect of an investment exposure, aggregated with the sum of the amounts included in the credit risk component, volatility risk component and off-balance sheet asset risk component in respect of the assets and off-balance sheet exposures comprising that investment exposure, exceeds 100% of that investment exposure, the concentration risk component in respect of that investment exposure must be reduced so that the total of the four components in respect of that investment exposure is equal to 100% of that investment exposure.

A3.7 Premium Risk Component

Guidance

An *Insurer* may be exposed to the risk that the cost of claims in respect of *General Insurance Business* will exceed the cost implicit in the premiums being charged. The purpose of the premium risk component is to require an *Insurer* to hold capital against this risk in accordance with the calculations set out in Rule A3.7.1. The basic calculation model set out in Rule A3.7.1 applies different factors to the premium in respect of each *PINS Category*, based on the different perceived risk of variability associated with each. The model is modified by additional provisions dealing with certain classes of business with each *PINS Category*. This section also restricts the extent to which reinsurance may be taken into account when calculating the premium risk component.

A3.7.1 An *Insurer* must calculate its premium risk component as the sum of the amounts obtained by multiplying the base premium that falls within each *PINS Category* by the relevant percentage factor set out in the table below, subject to Rule A3.7.6.

PINS Category	**Percentage factor**				
	Direct insurance	Reinsurance: facultative proportional	Reinsurance: facultative non-proportional	Reinsurance: treaty proportional	Reinsurance: treaty non-proportional
PINS Category 1	16	16	17	19	21
PINS Category 2	11	11	12	13	14
PINS Category 3	15	15	16	18	19
PINS Category 4	22	22	24	25	26

A3.7.2 For the purposes of this section, and subject to Rule A3.7.3, the base premium of an *Insurer* means the higher of the following two amounts:

(A) the amount of the *Insurer's Net Written Premium* during the reference period; or

(B) 50% of the amount of the *Insurer's Gross Written Premium* during the reference period.

A3.7.3 The *Regulatory Authority* may, on written application by an *Insurer* who is a *Captive*, give consent in writing to the *Insurer* to use a different percentage of its *Gross Written Premium* for the purposes of calculating its base premium as required under Rule A3.7.2.

A3.7.4 In Rule A3.7.2 the reference period means the reporting period ending next before the *Solvency Reference Date*, except where the *Insurer's* forecast *Net Written Premium*, according to its business plan, for the reporting period next after that reporting period, is higher, in which case the reference period will be the second of the two reporting periods and the *Net Written Premium* and *Gross Written Premium* used for the purposes of Rule A3.7.2 must be the forecast *Net Written Premium* and *Gross Written Premium* for that second reporting period.

A3.7.5 Where an *Insurer* underwrites *Contracts of Insurance* in *PINS Category 1*, and those contracts constitute *Long Term Insurance Contracts*, the *Insurer* must not calculate a written premium component in respect of those contracts but must instead calculate a long term insurance risk component as set out in Rule A3.9.1.

A3.7.6 The *Regulatory Authority* may, on written application by an *Insurer* carrying on business in *PINS Category 1*, give consent in writing to the use of percentages other than those stated in the table in Rule A3.7.1, if the *Regulatory Authority* is satisfied that adequate mortality and morbidity information exists in respect of that business, to provide a reasonable basis for reliance on actuarial principles. The percentages that may be used must be those stated in the notice giving consent, but may not be lower than 12% in the case of direct insurance and proportional reinsurance, and 16% in the case of non-proportional or facultative reinsurance.

A3.7.7 (1) Where the *Insurer's* estimated net retention as at the *Solvency Reference Date* in respect of a property catastrophe exceeds the sum of the amounts calculated in accordance with Rule A3.7.1 in respect of those *Categories* of *Insurance Business* identified below in (2), before taking account of this rule, the sum of those amounts must be replaced by the *Insurer's* estimated net retention in respect of a property catastrophe when calculating the premium risk component.

(2) Rule A3.7.7(1) applies to the following two *Categories* of *Insurance Business* in *PINS Category 3*:

(A) General Insurance Category 8: Fire and natural forces; and

(B) General Insurance Category 9: Damage to property.

A3.7.8 For the purposes of Rule A3.7.7(1), the *Insurer's* net retention means the sum of claims expected to be paid, associated direct and indirect settlement costs and reinstatement premiums expected to be paid in respect of reinsurance recoveries resulting from those claims, less the sum of reinstatement premiums expected to be received and reinsurance and other recoveries expected to be received resulting from those claims, in the event of a property catastrophe representing a return period of not less than 100 years.

A3.7.9 Where an *Insurer* enters, as *Insurer* or cedant, into a *General Insurance Contract* of longer than 12 *months* duration, the premium or reinsurance premium on that contract must not be included fully in the calculation of base premium in the reporting period in which the contract was effected, but must be apportioned over the duration of the contract by allocating to each reporting period a fraction of the premium proportionate to the fraction of the contract period that falls into that reporting period, or on a different basis approved in writing by the *Regulatory Authority*.

A3.7.10 Where an *Insurer* enters as reinsurer into a finite risk reinsurance contract in respect of *General Insurance Business*, the premium risk component in respect of that contract, regardless of the *PINS Category* it relates to, must be four per cent of the base premium on the contract.

A3.8 Technical Provision Risk Component

Guidance

An *Insurer* may be exposed to risk that the cost of claims in respect of *General Insurance Business* will exceed the amounts recorded as liabilities in the *Insurer's* balance sheet. The purpose of the technical provision risk component is to require an *Insurer* to hold capital against this risk in accordance with the calculations set out in Rule A3.8.1. This calculation only applies to liabilities in respect of outstanding claims (*Premium Liabilities* being addressed in the premium risk component in section A3.7).

A3.8.1 An *Insurer* must calculate its technical provision component as the sum of the amounts obtained by multiplying the *Insurer's* base claims reserve that falls within each *PINS Category* by the relevant percentage factor set out in the table below, subject to Rule A3.8.5.

PINS Category	**Percentage factor**				
	Direct insurance	Reinsurance: facultative proportional	Reinsurance: facultative non-proportional	Reinsurance: treaty proportional	Reinsurance: treaty non-proportional
PINS Category 1	19	19	21	20	22
PINS Category 2	10	10	12	11	13
PINS Category 3	13	13	15	14	16
PINS Category 4	15	15	17	16	18

A3.8.2 For the purposes of Rule A3.8.1, and subject to Rule A3.8.3, the base claims reserve of an *Insurer* means the higher of the following two amounts:

(A) the amount of the *Insurer's* provision for *Gross Outstanding Claims*, less the amount of reinsurance and other recoveries expected to be received in respect of that liability; or

(B) 50% of the amount of the *Insurer's* provision for *Gross Outstanding Claims*.

A3.8.3 The *Regulatory Authority* may, on written application by an *Insurer* who is a *Captive*, give consent in writing to the *Insurer* to use a different percentage of its *Gross Outstanding Claims* for the purposes of calculating its base claims reserve as required under Rule A3.8.2.

A3.8.4 Where an *Insurer* underwrites *Contracts of Insurance* in *PINS Category 1*, and those contracts constitute *Long Term Insurance Contracts*, the *Insurer* must not calculate a technical provision component in respect of those contracts but must instead calculate a long term insurance risk component as set out in Rule A3.9.1.

A3.8.5 The *Regulatory Authority* may, on written application by an *Insurer* conducting *Insurance Business* in *PINS Category 1*, give consent in writing to the use of percentages other than those stated in the table in Rule A3.8.1, if the *Regulatory Authority* is satisfied that adequate

mortality and morbidity information exists in respect of that business, to provide a reasonable basis for reliance on actuarial principles. The percentages that may be used must be those stated in the notice giving consent, but may not be lower than eight per cent.

A3.8.6 Where an *Insurer* enters as reinsurer into a finite risk reinsurance contract in respect of *General Insurance Business*, the technical provision risk component in respect of that contract, regardless of the *PINS Category* it relates to, must be six per cent of the claims reserve on the contract.

A3.9 Long Term Insurance Risk Component

Guidance

The purpose of the long term insurance risk component is to require an *Insurer* to set aside capital to address the risk that the net present value of future *Policy Benefits* will vary from the amounts recorded as *Long Term Insurance Liabilities* in the *Insurer's* balance sheet.

A3.9.1 An *Insurer* must calculate its long term insurance risk component as the sum of the amounts specified in Rule A3.9.2.

A3.9.2 The long term insurance risk component is calculated as the sum of the following six amounts, so far only as they relate to the *Long Term Insurance Business* of the *Insurer*:

(A) two per cent of the amount of the *Insurer's Net Written Premium*;

(B) three per cent of the amount of provisions in respect of *Long Term Insurance Business* that is annuity and pensions business and is not *Investment Linked Insurance*;

(C) 1.25% of the amount of provisions in respect of *Long Term Insurance Business* that is *Investment Linked Insurance*, where the contracts are subject to a capital guarantee;

(D) 0.5% of the amount of provisions in respect of *Long Term Insurance Business* that is *Investment Linked Insurance*, where the contracts are not subject to a capital guarantee;

(E) 0.5% of the amount of provisions in respect of *Long Term Insurance Business* other than business described in Rules (B), (C), and (D); and

(F) the amount obtained by applying to the aggregate amount of capital at risk in respect of *Long Term Insurance Contracts* the formulae set out in the following table:

	Amount of capital at risk expressed in dollars	Formula to determine the amount referred to in (F)	
(a)	less than US$500 million	0.20%	of the amount of capital at risk
(b)	over US$500 million up to US$5 billion	0.13%	of the amount of capital at risk, plus US$350,000
(c)	Over US$5 billion up to US$25 billion	0.10%	of the amount of capital at risk, plus US$1,850,000
(d)	over US$25 billion	0.08%	of the amount of capital at risk, plus US$6,850,000

A3.9.3 In Rule A3.9.2:

(A) contracts of finite risk reinsurance must be excluded from the calculations in Rule A3.9.2 as they are addressed by Rule A3.9.4;

(B) provisions in respect of *Long Term Insurance Business* means the amount of *Long Term Insurance Liability* in respect of the contracts concerned, except that the amount may not be less than 85% of the liability determined without taking reinsurance into account; and

(C) capital at risk means the aggregate amount of sums assured on *Long Term Insurance Contracts* issued by an *Insurer*, minus the aggregate amount of provisions in respect of those contracts. Where the contract is an annuity, the sum assured must be taken to be the present value of the annuity payments. The capital at risk must be determined separately for each contract, and where the capital at risk calculated for a contract is less than zero, the capital at risk for that contract must be taken as zero.

A3.9.4 Where an *Insurer* enters as reinsurer into a finite risk reinsurance contract in respect of *Long Term Insurance Business*, the long term insurance risk component is the sum of the following three amounts:

(A) subject to rule A3.9.5, the sum of the amounts obtained by applying, to the amount outstanding in respect of each cedant, the percentages set out in Rule A3.2.1(A)(j) as though the cedant were a reinsurer and the amount outstanding were reinsurance recoverable;

(B) the sum of the amounts obtained by applying, to the amount outstanding under each contract, the percentages set out in Rule A3.3.1, as though the amount outstanding were a bond; and

(C) 2.25% of the amount outstanding.

A3.9.5 In Rule A3.9.4, the amount outstanding means the amount of any experience account or advance, however called or described, that, under the terms of the contract, will be paid to the *Insurer* on or before the termination of the contract.

A3.9.6 For the purposes of Rule A3.9.4(B), Rule A3.2.2 applies mutatis mutandis to the amount outstanding.

Endnotes

1 Abbreviation key

a	=	after	om	=	omitted/repealed
am	=	amended	orig	=	original
amdt	=	amendment	par	=	paragraph/subparagraph
app	=	appendix	prev	=	previously
art	=	article	pt	=	part
att	=	attachment	r	=	rule/subrule
b	=	before	renum	=	renumbered
ch	=	chapter	reloc	=	relocated
def	=	definition	s	=	section
div	=	division	sch	=	schedule
g	=	guidance	sdiv	=	subdivision
hdg	=	heading	sub	=	substituted
ins	=	inserted/added			

2 Rulebook history

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Miscellaneous Amendments Rules 2009 (QFCRA Rules sch 1, pt 1.11 and sch 2, pt 2.5)
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3 Amendment history

Background to this Rulebook

par 4	orig par 4 om RM2007/01
	prev par 5 renum as par 4 RM2007/01
par 5	orig par 5 renum as par 4 RM2007/01

s 1.3 Governing Body Certification

r 1.3.1	am Rules 2009-2

s 1.4 Submission of Prudential Returns

s 1.4hdg	sub RM2008/02
r 1.4.1	sub RM2008/02
r 1.4.2	sub RM2008/02
r.1.4.3	om RM2008/02
r 1.4.4	om RM2008/02
r 1.4.6	sub RM 2008/02; sub Rules 2009-2
r 1.4.7	am RM2008/02; sub Rules 2009-2
r 1.4.8	am RM2008/02; sub Rules 2009-2

s 1.5 Restrictions on insurance business

s 1.5	ins RM2007/01
r 1.5.1	ins RM2007/01
r 1.5.2	ins RM2007/01
r 1.5.3	ins RM2007/01
r 1.5.4	ins RM2007/01
g(a r 1.5.4)	ins RM2007/01;am RM2008/01

s 3.9 Failure to maintain appropriate financial resources or comply with capital requirements

s 3.9hdg	sub Rules 2009-2
r 3.9.1	sub Rules 2009-2
r 3.9.2	sub Rules 2009-2
s 3.9g	sub Rules 2009-2

s 4.3 Components of Capital: Tier One

r 4.3.1	am Rules 2009-2

s 4.4 Components of Capital: Tier Two

s 4.4.2	am RM2008/02

s 4.8 Reduction of Eligible Capital

r 4.8.3	am Rules 2009-2

s 5.2 Establishment of Long Term Insurance Funds

r 5.2.2g	om RM2007/01

s 5.4 Segregation of Assets and Liabilities

r 5.4.1	am Rules 2009-2

s 5.5 Limitation on use of Assets in Long Term Insurance

r 5.5.2	am Rules 2009-2
r 5.5.4	am Rules 2009-2

s 6.6 Distribution of Surplus Funding a Deficit in a Takaful Fund
r 6.6.3 am Rules 2009-2
r 6.6.4 am Rules 2009-2

s 8.7 Recognition and Measurement of Assets and Liabilities in respect of Long Term Insurance Business
r 8.7.14g sub RM2007/01

s 9.3 Reporting Requirements Performed by the Actuarial Function
r 9.3.1 am RM2007/01
r 9.3.3 am Rules 2009-2

s 9.4 Actuarial Reporting Requirements for General Insurance Business
r 9.4.3 am Rules 2009-02

s 10.1 Application and Purpose
r 10.1.2 sub RM2007/01

s 10.2 Group Financial Resources
r 10.2.2 am Rules 2009-02

s 12.3 Run-off Plans
r 12.3.6 sub Rules 2009-2

s 12.4 Provisions in respect of Contracts Relating to Insurance Business in Run-off
r 12.4.1 am Rules 2009-2
r 12.4.2 sub Rules 2009-2
r 12.4.3 sub Rules 2009-2

App3 Risk Based Capital Requirement
r A3.2.1 am Rules 2009-2
r A3.7.9 am Rules 2009-2

App4 Reporting to Regulatory Authority
App 4 om RM2008/02