PRUDENTIAL – INSURANCE BUSINESS (PIN) INSTRUMENT (NO 128) 2013

The Board of the Dubai Financial Services Authority in the exercise of the powers conferred on them by Article 23 of the Regulatory Law 2004, hereby make the Rules in the appendix to this instrument. The appendix to this instrument also contains the guidance made by the Chief Executive in the exercise of the powers conferred on him under the Regulatory Law 2004.

Commencement:

(1) This instrument is made on 13 June 2013 and shall come into force on 14 July 2013.

Amendments to Modules:

(2) The Prudential – Insurance Business (PIN) module – (PIN/VER12/07-12) is repealed and replaced by Appendix 1 to this instrument and may be identified by the following reference – (PIN/VER13/07-13).

Citation:

(3) This instrument may be cited as the Prudential – Insurance Business Rule-making Instrument (No. 128) 2013.

(4) Appendix 1 to this instrument may be cited as the Prudential – Insurance Business module or PIN.

By Order of the Board

Saeb Eigner
Chairman
13 June 2013
RM128/2013

Ian Johnston
Chief Executive

The DFSA Rulebook

Prudential – Insurance Business Module

(PIN)

Contents

The contents of this module are divided into the following chapters, sections and appendices:

1 APPLICATION

1.1 Application

1.1.1 Subject to Rule 1.1.2, this module (PIN) applies to every Insurer except to the extent that a provision specifies a narrower application.

Guidance

1. An Insurer is defined in the GLO as an Authorised Firm which is authorised under its Licence to carry on in or from the DIFC, one or more of the Financial Services constituting Insurance Business.

2. The Rules in PIN apply in relation to all activities of an Insurer, whether carried on within the DIFC or elsewhere.

1.1.2 Chapters 2, 3, 4, 6, 7 and 9 do not apply to an Insurer that is an Authorised ISPV, unless expressly provided otherwise.

2 MANAGEMENT AND CONTROL OF RISK

2.1 Introduction

2.1.1 This chapter applies to every Insurer.

Guidance

1. All Authorised Firms are subject to the systems and controls provisions of GEN chapter 5. This chapter expands on the relevant requirements of GEN as those provisions apply in the context of an Insurer.

2. App2 contains guidance for Insurers in respect of specific areas of risk management that are of particular relevance to Insurers.

2.2 Risk management

2.2.1 An Insurer's risk management systems must:

(a) be appropriate to the size, business mix and complexity of the Insurer's operations;

(b) address all material risks, financial and non-financial, to which the Insurer is likely to be exposed;

(c) describe the relationships between the Insurer's risk tolerance limits, its capital requirements, economic capital and the processes and methods for monitoring risk; and

(d) be supported by adequate risk management policies and procedures which explain the risks covered, the measurement approaches used, and the key assumptions made.

2.2.2 The risk management systems maintained by an Insurer must include:

(a) a written risk management strategy approved by senior management, which in the opinion of senior management addresses all material risks to which the Insurer is likely to be exposed;

(b) risk management policies and procedures that in the opinion of senior management are adequate to identify, assess, mitigate, control, monitor and report on the material risks to which the Insurer is exposed; and

(c) clearly identified managerial responsibilities and controls, designed to ensure that the policies and procedures established for risk management are adhered to at all times.

2.2.3 Subject to Rule 2.2.4, where an Insurer is a member of a Group, the Insurer must take reasonable actions to ensure that the Group as a whole complies with the requirements of Rule 2.2.1 and 2.2.2 as though the Group as a whole were an Insurer.

2.2.4 Rule 2.2.3 does not apply in respect of a Group where the Insurer is not the Holding Company and where the Holding Company of the Group is:

(a) another Insurer; or

(b) a Subsidiary of another Holding Company.

Guidance

1. The effect of Rule 2.2.4 is to avoid duplication arising from complex Group structures. If an Insurer is a member of a Group whose Holding Company is another Insurer, the first Insurer need not apply Rule 2.2.3 in respect of that Group, because the Insurer that is the Holding Company is already required to apply that Rule. Where an Insurer is a member of two or more Groups that are also sub-groups of a single Group, the Insurer may consider that single group as a whole for the purposes of this section. An Insurer that is a Holding Company is however still required to apply Rule 2.2.3 in respect of any Group of which the Insurer is the Holding Company.

2. An Insurer should describe how its risk tolerance limits described in Rule 2.2.1(c) link with its corporate objectives, business strategy and current circumstances. An Insurer is expected to embed its risk tolerance limits into its day-to-day operations and its risk management policies and procedures.

2.3 Management of particular risks

2.3.1 An Insurer must develop, implement and maintain a risk management system to identify and address balance sheet and market risk, including but not limited to:

(a) reserving risk;

(b) investment risk (including risks associated with the use of derivatives);

(c) underwriting risk;

(d) claims management risk;

(e) product design and pricing risk; and

(f) liquidity management risk.

2.3.2 An Insurer must develop, implement and maintain a risk management system to identify and address credit quality risk.

2.3.3 An Insurer must develop, implement and maintain a risk management system to identify and address the non-financial or operational risk of that Insurer, including but not limited to:

(a) technology risk (including processing risks);

(b) reputational risk;

(c) fraud and other fiduciary risks;

(d) compliance risk;

(e) outsourcing risk;

(f) business continuity planning risk;

(g) legal risk; and

(h) key person risk.

2.3.4 An Insurer must develop, implement and maintain a risk management system to identify and address reinsurance risk. Reinsurance risk refers to risks associated with the Insurer's use of reinsurance arrangements as cedant.

2.3.5 Without limiting the generality of Rule 2.3.4, an Insurer's risk management system in respect of its use of reinsurance arrangements must include the development, implementation and maintenance of a written reinsurance management strategy, appropriate to the size and complexity of the operations of the Insurer, defining and documenting the Insurer's objectives and strategy in respect of reinsurance arrangements.

2.3.6 An Insurer must develop, implement and maintain a risk management system which includes an explicit asset-liability management (ALM) policy, which must clearly specify the nature, role and extent of ALM activities and their relationship with product development, pricing functions and investment management.

Guidance

1. An Insurer's ALM policy should be appropriate taking into account the nature, scale and complexity of its ALM risks.

2. The ALM policy should include details as to how:

   (a) the investment and liability strategies adopted by the Insurer allow for the interaction between assets and liabilities;

   (b) the correlations are taken into account;

   (c) the liability cash flows will be met by cash inflows; and

   (d) the valuations of assets and liabilities will change under an appropriate range of different scenarios.

2.3.7 Deleted

2.4 Record-keeping

2.4.1 An Insurer must maintain records adequate to enable it to:

(a) fulfil its obligations under Contracts of Insurance effected by it; and

(b) demonstrate that it complies with the Rules in PIN.

2.5 Insurers that undertake surety insurance business

2.5.1 This section applies only to Insurers that undertake Insurance Business in Class 7(b).

2.5.2 An Insurer that undertakes Insurance Business in Class 7(b) must ensure that:

(a) in any reporting period, the amount of its Gross Written Premium attributable to Class 7(b) does not exceed 5% of its total Gross Written Premium in all classes of non-life insurance;

(b) the Person insured under any Contract of Insurance in Class 7(b) is:

(i) a Body Corporate; or

(ii) if not a Body Corporate, a Financial Institution;

(c) at the time of effecting a Contract of Insurance in Class 7(b), the Person insured under that contract has a rating of BBB or better; and

(d) the maximum period of any Contract of Insurance in Class 7(b) does not exceed twenty years.

2.5.3 Rule 4.1.4 applies in respect of determination of ratings for the purposes of Rule 2.5.2(c).

2.5.4 An Insurer that is a Protected Cell Company that undertakes Insurance Business in Class 7(b) must comply with Rule 2.5.2 in respect of each Cell to which such business is attributable.

2.5.5 (1) An Insurer intending to undertake Insurance Business in Class 7(b) must:

(a) notify the DFSA in writing of its proposal to undertake such business; and

(b) give to the DFSA a business plan for the business intended to be undertaken.

(2) An Insurer must not effect any contract of insurance in Class 7(b) if the DFSA has objected to a proposal it has made under (1).

Guidance

1. If all the information required is provided to the DFSA relating to the proposal to effect Contracts of Insurance in Class 7(b), generally, it will take about 45 calendar days for the DFSA to be able to determine whether an Insurer should be allowed to conduct this type of business. If the DFSA decides to object to the proposal, it will notify the Insurer of its decision and the reasons for that decision before imposing a restriction to that effect on the Insurer's licence. An Insurer may make an appeal to the DFSA's Regulatory Appeals Committee relating to such a decision.

2. The current requirements relating to Class 7(b) do not cater to monoline specialist financial guarantee insurers. However, if such an Insurer wishes to operate in the DIFC, the DFSA will consider what requirements should apply to it. In doing so, the DFSA will consider capital

adequacy and other requirements that are generally applied to such specialist Insurers in other jurisdictions.

3 LONG-TERM INSURANCE BUSINESS

3.1 Introduction

3.1.1 This chapter applies to all Insurers.

Guidance

1. This chapter sets out requirements in respect of Long-Term Insurance Business. An Insurer is required to maintain a separate fund in respect of Long-Term Insurance Business or to subject itself to the same restrictions as apply to a Long-Term Insurance Fund.

2.. Requirements in this section that are not specified as applying to Direct Long-Term Insurance Business apply to all Long-Term Insurance Business.

3.2 Establishment of long-term insurance funds

3.2.1 An Insurer that is required, under the provisions of section 3.3, to establish or maintain a Long-Term Insurance Fund in respect of a part of its business must identify separately in its books and records the assets, liabilities, revenues and expenses attributable to that business. Those assets, liabilities, revenues and expenses must be recorded separately and accounted for as a Long-Term Insurance Fund.

3.2.2 Where an Insurer that is not a Protected Cell Company carries on Long-Term Insurance Business that, under the provisions of section 3.3, must be attributed to a Long-Term Insurance Fund, it must either:

(i) establish one or more Long-Term Insurance Funds; or

(j) notify the DFSA in writing that the Insurer is deemed to constitute a single Long-Term Insurance Fund.

3.2.3 When an Insurer that is a Protected Cell Company carries on, through a Cell, Long-Term Insurance Business that, under the provisions of section 3.3, must be attributed to a Long-Term Insurance Fund, it must either:

(a) establish, in respect of that Cell, one or more Long-Term Insurance Funds; or

(b) notify the DFSA in writing that the Cell is deemed to constitute a single Long-Term Insurance Fund.

Guidance

Because of the prohibition set out in COB part 1, Insurance Business of an Insurer that is a Protected Cell Company can only be carried out through its Cells.

3.2.4 An Insurer that is subject to a regulatory requirement in another jurisdiction to arrange its affairs or any part of its affairs in a manner that is equivalent or substantially equivalent to the maintenance of a Long-Term Insurance Fund required by this section, may make a written application to the DFSA for that

arrangement of its affairs or that part of its affairs to be deemed for the purposes of these Rules to constitute a Long-Term Insurance Fund. If the DFSA approves that application, it must inform the Insurer in writing, and must state in its notice to the Insurer the manner in which the arrangement will be deemed for the purpose of these Rules to constitute a Long-Term Insurance Fund.

3.2.5 An Insurer, or a Cell of an Insurer, that is deemed in accordance with Rule 3.2.2(b) or Rule 3.2.3(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.

3.2.6 Notwithstanding anything to the contrary contained in the above provisions, the DFSA may, at its sole discretion, direct that an Insurer which conducts Long-Term Insurance Business establish one or more Long-Term Insurance Funds in respect of its Long-Term Insurance Business or any part of such business. An Insurer shall establish one or more Long-Term Insurance Funds where so directed by the DFSA.

3.3 Attribution of contracts to a fund

3.3.1 All contracts of Long-Term Insurance effected by a DIFC Incorporated Insurer must be attributed to a Long-Term Insurance Fund.

3.3.2 All contracts of Long-Term Insurance effected by an Insurer that is not a DIFC Incorporated Insurer through an establishment in the DIFC must be attributed to a Long-Term Insurance Fund.

3.3.3 Except as allowed in Rule 3.3.4, an Insurer may not attribute General Insurance contracts to a Long-Term Insurance Fund.

3.3.4 An Insurer may attribute insurance contracts in General Insurance Class 1 or Class 2 to a Long-Term Insurance Fund.

3.4 Segregation of assets and liabilities

3.4.1 All assets, liabilities, revenues and expenses in respect of a Contract of Insurance that is attributed to a Long-Term Insurance Fund must be recorded as assets, liabilities, revenues and expenses of that Long-Term Insurance Fund.

3.4.2 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 3.4.2 is sometimes described as a transfer of capital into the Long-Term Insurance Fund.

3.4.3 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.

3.4.4 An Insurer which is required to maintain a Long-Term Insurance Fund 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.

3.5 Limitation on use of assets in long-term insurance fund

3.5.1 Except as provided in this section, assets that are attributable to a Long-Term Insurance Fund must be applied only for the purposes of the business attributed to the Long-Term Insurance Fund.

3.5.2 Assets attributable to a Long-Term Insurance Fund may not be 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 section 7.3, provided that the transfer is performed within four months of the Reference Date of the actuarial investigation referred to in that Rule;

(b) where the transfer constitutes a payment of dividend or return of capital, in accordance with Rules 3.5.3 and 3.5.4;

(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.

3.5.3 Assets attributable to a Long-Term Insurance Fund must not be distributed by way of dividend or by way of return of capital, except by an Insurer or a Cell that is deemed to constitute a single Long-Term Insurance Fund.

3.5.4 A dividend or return of capital by an Insurer or a Cell that is deemed to constitute a single Long-Term Insurance Fund may only be made where the dividend or return of capital constitutes appropriation of a surplus determined in accordance with section 7.3, and:

(a) if the payment is made within four months of the Reference Date of the actuarial investigation 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 four months after the Reference Date of the actuarial investigation 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 per cent of the amount of that surplus.

3.5.5 Assets attributable to a Long-Term Insurance Fund must not be lent or otherwise made available for use for any other purposes of the Insurer or any purposes of any party Related to the Insurer.

Guidance

Rule 3.5.5 operates to prohibit, among other things, lending between Long Term Insurance Funds of the same Insurer. Assets must not be organised in such a manner as to create indebtedness between Long Term Insurance Funds.

3.5.6 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 3.5.6 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.

3.6 Other requirements

3.6.1 (1) Except as permitted in this Rule, a DIFC Incorporated Insurer must not effect any Direct Long-Term Insurance contract the terms of which include any of the following:

(a) investment components of Policy Benefits, that are wholly or partly guaranteed;

(b) options to receive Policy Benefits on expiry, maturity or surrender as annuities, where annuity rates are wholly or partly guaranteed at the inception of the contract;

(c) bonuses on participating contracts where those bonuses become vested Policy Benefits or guaranteed by the Insurer at a date prior to expiry, maturity or surrender; or

(d) other options or discretionary Policy Benefits that expose the Insurer to investment, expense or other risk that is not readily definable at the inception of the contract.

(2) An Insurer may request the permission of the DFSA to effect Direct Long-Term Insurance contracts with features of the kind referred to in (1). A request must be made in writing and must include:

(a) details of the terms of the proposed contracts;

(b) an explanation of how the Insurer intends to price such contracts, and to value them for the purposes of its capital adequacy calculations; and

(c) an explanation of how the Insurer intends to quantify, monitor and manage the risks to its capital adequacy represented by such features of contracts.

(3) The DFSA may give an Insurer permission to effect Direct Long-Term Insurance contracts having one or more features of the kind referred to in (1). Permission shall be given in writing and shall be subject to such terms or conditions as the DFSA may specify in its notice giving permission. Where any terms and conditions are imposed on the Insurer, the Insurer shall comply with such terms and conditions.

(4) The DFSA may on its own initiative at any time vary or revoke permission given under (3) above. Variation or revocation shall be communicated to the Insurer in writing.

Guidance

1. The features described in Rule 3.6.1(1) have the potential to expose an Insurer to risks that are not adequately provided for in the capital adequacy framework set out in this Rulebook. The DFSA retains the power to prohibit or limit the inclusion of such features in a Long-Term Insurance contract where it is of the view that the inclusion of such features may have a materially adverse impact upon the long term viability of the Insurer. It is natural for Insurers to seek to stimulate a market by offering features such as guarantees or options. However, the solvency of Insurers could be threatened if they have not adequately valued, stress-tested and set aside adequate capital to service such features. Therefore, the DFSA will expect Insurers seeking permission to write contracts with such features to demonstrate that these steps have been undertaken, and that their procedures provide adequately for ongoing monitoring of the associated risks. Permission to undertake such business may be subject to conditions, for example, a requirement to maintain additional capital, or to restrict business of this nature by reference to total business. The DFSA may also as a condition of granting permission require additional information relating to the business in question to be reported to the DFSA in the Insurer's periodic regulatory returns, or in the Actuary's report referred to in Rule 7.3.4.

2. If all the information required is provided to the DFSA relating to a request for permission under Rule 3.6.2, generally, it will take about 45 calendar days for the DFSA to be able to determine whether an Insurer should be permitted to effect Direct Long-Term Insurance contracts with features of the kind referred to in that Rule. If the DFSA decides to object to the proposal, grant conditional permission or vary or revoke a permission already granted, it will notify the Insurer of its decision and the reasons for that decision. An Insurer may make an appeal to the DFSA's Regulatory Appeals Committee relating to such a decision.

3.6.2 A DIFC Incorporated Insurer which undertakes Direct Long-Term Insurance Business must supervise adequately the conduct of its Direct Long-Term Insurance Business in each jurisdiction in which that Business is undertaken.

Guidance

1. In order to demonstrate compliance with Rule 3.6.2, the senior management of a DIFC Incorporated Insurer should have mechanisms in place such that adequate information, in appropriate detail, is reported internally to senior management on a timely basis, and that this information is appropriately considered and acted upon.

2. In discharging its responsibilities under Rule 3.6.2, and under the high level requirements to which it is subject under GEN Rule 5.3.1, senior management will need to consider specific risks to which the Insurer is exposed as a consequence of its activity within each jurisdiction. Internal governance procedures such as Internal Audit should include examination of non-DIFC activities. Compliance procedures should be designed to ensure that the Insurer complies with any domestic regulation to which it may be subject in the jurisdiction in which

it is doing business. Insurers are also expected to ensure that conduct of business by them in other jurisdictions does not pose any risk to the reputation of the DIFC. Consequently, senior management should ensure that adequate standards of customer protection are adopted by the Insurer's operation in each jurisdiction. Senior management should have regard to the provisions of GEN section 4.2 and in particular Principles 6, 7, 8 and 9 in considering whether standards of consumer protection are adequate. Review of persistency statistics may assist in identifying problems in the area of conduct of business.

3. Rule 3.6.2 does not preclude the establishment of appropriate local management structures with responsibility for the Insurer's business in the jurisdiction in question. However, the overall responsibility for ensuring compliance with domestic and DIFC regimes rests with the senior management of the Insurer.

4 CAPITAL ADEQUACY

4.1 Introduction

4.1.1 This chapter applies to all Insurers.

Guidance

1. The amount of capital is fundamental to the financial health of any insurance undertaking and therefore to the protection of its policyholders. All Insurers are therefore required to maintain a minimum level of capital resources in accordance with this chapter.

2. This chapter establishes minimum required levels of capital resources applicable to Insurers of different types. Section 4.2 establishes provisions that are applicable to all Insurers, wherever they are incorporated and of whatever type they are. Section 4.3 establishes Minimum Capital Requirements in respect of Insurers other than Protected Cell Companies, and section 4.4 establishes equivalent requirements in respect of Protected Cell Companies. Additional provisions are established by section 4.6, in respect of Insurers maintaining Long-Term Insurance Funds, and by section 4.7, in respect of Insurers that are not DIFC Incorporated Insurers.

3. The DFSA has the power under the Regulatory Law 2004 to act if it believes that any requirement of this chapter is breached, or that it may be breached in the future.

4.1.2 For the purposes of this chapter, assets and liabilities must be valued in accordance with chapter 5.

4.1.3 In this chapter and in the appendices referred to in this chapter, references to ratings are made according to the rating hierarchy (AAA, AA, etc) of Standard & Poor's. Where, for the purposes of a provision of this chapter or of an appendix, an Insurer uses ratings from a Rating Agency other than Standard & Poor's, the Insurer must apply that provision as though the Standard & Poor's rating referred to in the provision were replaced by the rating from that other Rating Agency that is equivalent to the Standard & Poor's rating.

4.1.4 An Insurer must not, for the purposes of this chapter or the appendices referred to in this chapter, use ratings provided by any Rating Agency other than Standard & Poor's, Moody's, AM Best, and Fitch Ratings, except where the DFSA has given written approval to the Insurer for the use of ratings provided by that other Rating Agency.

4.2 Basic requirement

4.2.1 This section applies to all Insurers.

4.2.2 An Insurer must always have capital resources that are, in the opinion of its directors formed on reasonable assumptions, adequate for the conduct of its business, taking into consideration the size of the Insurer and the mix and complexity of its business.

Guidance

1. Where an Insurer effects Direct Long-Term Insurance contracts, Rule 4.2.2 implies that the Insurer must also be able to fund and service its Long-Term Insurance Business in the long term.

2. To be able to demonstrate to the DFSA that the Insurer meets the obligation of Rule 4.2.2 on an on-going basis, the DFSA expects the Insurer to develop internal capital models to support the self-assessment of capital adequacy. Those internal capital models should include mechanisms to estimate in a realistic manner the impact on the Insurer's capital position of possible scenarios relevant to the Insurer's business. The results of scenario testing should be communicated to the appropriate levels of management within the Insurer. Insurers should be able to demonstrate to the DFSA that the Insurer has adequate capital resources to withstand external and internal shocks to which they may plausibly be exposed.

3. Compliance with quantitative capital requirements set out in the PIN Module does not guarantee compliance with Rule 4.2.2.

4.2.3 (1) Without limiting the generality of Rule 4.2.2, an Insurer that effects Direct Long-Term Insurance contracts must ensure that:

(a) premiums for any Direct Long-Term Insurance contracts it effects are sufficient at that time for the formation of technical provisions relating to future Policy Benefits in accordance with the applicable valuation rules; and

(b) each Long-Term Insurance Fund to which Direct Long-Term Insurance contracts are attributed holds at all times Invested Assets of appropriate safety, yield and marketability adequate to provide the future Policy Benefits under those contracts that are attributed to the Fund.

(2) For the purposes of (1)(b), assets of the type described in Rule A3.4.3 must be excluded.

Guidance

1. Rule 4.2.3(1)(a) applies at the time that a contract is effected. Circumstances may arise in which premiums subsequently prove to be inadequate. However, this does not create a breach of the requirement in that subparagraph. Neither does the fact that an individual contract might suffer a large loss.

2. An Insurer should be able to demonstrate that its procedures allow for prior assessment and periodic review of premium adequacy of Direct Long-Term Insurance contracts that it writes. The assessment will consider the adequacy of premiums taking into account projected revenues and expenses in respect of the relevant contracts, including the likely impact of any discretionary features. In making this assessment, credit should not be taken for the impact of voluntary discontinuance (lapse, surrender of or making the contract paid-up) by the policyholder. The DFSA does not consider it appropriate for the projected profitability of Direct Long-Term Insurance contracts to be dependent on 'lapse support'.

3. Rule 4.2.3(1)(a) generally prevents an Insurer from writing 'loss leader' Direct Long-Term Insurance products. An Insurer that wishes to conduct business on a loss-leader basis would need to apply for an appropriate waiver. Such an Insurer would need to demonstrate that its resources are adequate to cover an appropriate level of technical provisions in respect of the contracts concerned, without detriment to its ability to comply with this Rule in respect of its other business.

4.2.4 Systems and controls maintained by directors for the purposes of Rule 4.2.2 and Rule 4.2.3 must include analysis of realistic scenarios relevant to the circumstances of the Insurer and the effects that the occurrences of those scenarios would have on the capital requirements of the Insurer and on its capital resources.

Guidance

Because an Insurer is required to maintain adequate capital resources at all times, its systems and controls need to enable the directors to determine and monitor the capital requirements of the Insurer and the capital resources that it has available, and to identify occurrences where the capital resources fall short of the capital requirements or may fall short in the future. An Insurer is not required to measure the precise amount of its capital resources and its capital requirements on a daily basis. However an Insurer should be in a position to demonstrate its capital adequacy at any time if asked to do so by the DFSA.

4.3 Minimum capital requirement for insurers that are not protected cell companies

4.3.1 This section applies only to Insurers that are not Protected Cell Companies.

4.3.2 An Insurer that is not a Protected Cell Company must always have Adjusted Capital Resources equal to or higher than the amount of its Minimum Capital Requirement.

4.3.3 An Insurer's Adjusted Capital Resources must be calculated in accordance with App3.

4.3.4 An Insurer's Minimum Capital Requirement must be calculated in accordance with App4.

4.4 Minimum capital requirement for insurers that are protected cell companies

4.4.1 This section applies only to Insurers that are Protected Cell Companies.

4.4.2 An Insurer that is a Protected Cell Company must ensure that at all times the Insurer has Adjusted Non-Cellular Capital Resources equal to or higher than the amount of the Minimum Non-Cellular Capital Requirement.

4.4.3 An Insurer that is a Protected Cell Company must ensure that at all times, in respect of each of its Cells, the Insurer has Adjusted Cellular Capital Resources equal to or higher than the amount of the Minimum Cellular Capital Requirement in respect of that Cell.

4.4.4 The Adjusted Non-Cellular Capital Resources in respect of an Insurer that is a Protected Cell Company must be calculated in accordance with App5.

4.4.5 The Minimum Non-Cellular Capital Requirement in respect of an Insurer that is a Protected Cell Company must be calculated in accordance with App6.

4.4.6 The Adjusted Cellular Capital Resources in respect of a Cell must be calculated in accordance with App5.

4.4.7 The Minimum Cellular Capital Requirement in respect of a Cell must be calculated in accordance with App6.

4.5 Deleted

4.6 Insurers that undertake long-term insurance business

4.6.1 Subject to Rule 4.6.2, this section applies only to Insurers that undertake Long-Term Insurance Business through a Long-Term Insurance Fund.

4.6.2 This section does not apply to either:

(a) an Insurer that is deemed to constitute a single Long-Term Insurance Fund in accordance with Rule 3.2.2(b); or

(b) an Insurer that is a Protected Cell Company in respect of a Cell that is deemed to constitute a single Long-Term Insurance Fund in accordance with Rule 3.2.3(b).

4.6.3 An Insurer that undertakes Long-Term Insurance Business through a Long-Term Insurance Fund must ensure that at all times, in respect of each Long-Term Insurance Fund maintained by it, the Insurer has Adjusted Fund Capital Resources equal to or higher than the amount of the Minimum Fund Capital Requirement in respect of that Long-Term Insurance Fund.

4.6.4 The Adjusted Fund Capital Resources in respect of a Long-Term Insurance Fund maintained by an Insurer must be calculated in accordance with App7.

4.6.5 The Minimum Fund Capital Requirement in respect of a Long-Term Insurance Fund maintained by an Insurer must be calculated in accordance with App8.

4.7 Availability of assets of insurers incorporated outside the DIFC

4.7.1 This section applies only to Insurers that are not DIFC Incorporated Insurers.

Guidance

The provisions in this section require an Insurer to have assets, of a minimum quality, available to meet its gross Insurance Liabilities arising from its DIFC Insurance Business plus a margin. Although the Insurer is required to cover its Insurance Liabilities gross of reinsurance, an Insurer still has benefit of its reinsurance arrangements because assets may include amounts receivable from reinsurers in respect of gross Insurance Liabilities, including amounts potentially receivable from reinsurers in respect of the exposures reflected in the Insurer's Premium Liability. No credit, however, may be taken in respect of a reinsurer that is Rated worse than BBB.

4.7.2 An Insurer that is not a DIFC Incorporated Insurer must always have assets, of a type referred to in Rule 4.7.3, that are available to meet Insurance Liabilities of the Insurer arising in respect of operations conducted by the Insurer in the DIFC, at least equal to the sum of the following:

(a) the sum of the default risk component and the investment volatility risk component in respect of those assets, calculated according to the methods set out in sections A4.4 and A4.5 respectively, applying those methods so far as concerns those assets only;

(b) Insurance Liabilities of the Insurer in respect of its DIFC Insurance Business; and

(c) the Insurer's DIFC Business Risk Capital Requirement, calculated in accordance with App9.

Guidance

1. Assets are not normally available to meet Insurance Liabilities of an Insurer arising in respect of operations conducted by the Insurer in the DIFC, if those assets are required to meet liabilities of the Insurer in jurisdictions other than the DIFC, except where those liabilities are also Insurance Liabilities of the Insurer arising in respect of operations conducted by the Insurer in the DIFC.

2. Assets are not normally available to meet Insurance Liabilities of an Insurer arising in respect of operations conducted by the Insurer in the DIFC, if those assets are required, under the laws of any jurisdiction, to be located in a jurisdiction other than the DIFC, except where the assets are required to be located in that jurisdiction to meet, or as collateral against, either:

   a. liabilities that are Insurance Liabilities of the Insurer arising in respect of operations conducted by the Insurer in the DIFC; or

   b. liabilities that may arise in the future and that would, if they arose, be Insurance Liabilities of the Insurer arising in respect of operations conducted by the Insurer in the DIFC.

4.7.3 The assets available to an Insurer for the purposes of Rule 4.7.2 may comprise any combination of the following types of asset:

(a) bonds Rated 'BBB' or better;

(b) equities listed on an Approved Stock Exchange;

(c) reinsurance recoverable in respect of General Insurance Liabilities referred to in Rule 4.7.2(b), where the reinsurer is Rated 'BBB' or better; and

(d) land and buildings.

4.7.4 An Insurer subject to this section must demonstrate to the satisfaction of the DFSA that the Insurer complies with Rule 4.7.2, when the DFSA requests it by written notice to do so.

4.8 Failure to comply with this chapter

4.8.1 An Insurer that becomes aware that it does not comply with this chapter:

(a) must immediately notify the DFSA in writing;

(b) must not effect any Contracts of Insurance through an establishment in the DIFC until the DFSA has given it written permission to recommence business;

(c) must not, if the Insurer is a DIFC Incorporated Insurer, effect any Contracts of Insurance until the DFSA has given it written permission to recommence business; and

(d) must not make any distribution of profits or surplus however called or described, or return of capital, without the written permission of the DFSA.

4.8.2 An Insurer that believes that it may not be in compliance with this chapter or may not continue to comply with this chapter in the future must immediately provide the DFSA with a written statement of:

(a) the reasons for the Insurer's belief that it may not be in compliance or may not continue to comply; and

(b) the action that the Insurer is taking to avoid non-compliance.

4.8.3 An Insurer to which Rule 4.8.2 applies must not make any distribution of profits or surplus, however called or described, or return of capital without the written permission of the DFSA.

Guidance

In dealing with non-compliance, or possible non-compliance, with this chapter, the DFSA'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 company, 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 DFSA's normal approach will be to seek to work cooperatively with firms to deal with any problems. There will, however, be other 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 DFSA will not hesitate to do so.

4.9 Limitations on distributions by insurers

4.9.1 No Insurer may make any distribution of profits or surplus, however called or described, or return of capital if such distribution or return would cause the Insurer to fail to comply with any provision of this chapter.

5 MEASUREMENT OF ASSETS AND LIABILITIES OF INSURERS

5.1 General provisions

5.1.1 This chapter applies to an Insurer in relation to Returns made to the DFSA.

Guidance

1. This chapter establishes a set of principles for the consistent measurement of the assets and liabilities of Insurers for the purposes of reporting under chapter 6 and for determining compliance with chapter 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 DFSA as to the financial position or financial performance of the Insurer.

5.1.2 Subject to Rules 5.1.3, 5.1.4, 5.1.5 and 5.1.6, an Insurer must recognise and measure its assets and liabilities in accordance with so many of sections 5.3, 5.4, 5.5 and 5.6 as apply to the Insurer.

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

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

5.1.5 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.

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

5.2 Classification of insurance business

5.2.1 An Insurer must, in its own records, classify all insurance contracts effected by it as Insurer and all reinsurance contracts entered into by it as cedant, according to the Class of Business to which the contracts relate.

5.2.2 Where a contract relates to more than one Class of Business, the Insurer must record separately the portions of the contract that relate to each Class of Business, except that immaterial portions need not be separately recorded.

Guidance

1. The Classes of Business are set out in GEN App4.

2. A portion of a Contract of Insurance, insuring a risk of a Class of Business other than the principal Class of Business 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.

5.3 Basic principles of recognition and measurement

5.3.1 Except where this chapter provides otherwise, the assets and liabilities of an Insurer must be recognised in accordance with a basis of accounting set out in Rule 5.3.2, 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 5.3.2;

b. assets and liabilities that are not dealt with in either or both of the bases of accounting set out in Rule 5.3.2; and

c. the overriding power of the DFSA, set out in Rule 5.1.6, to require an Insurer to adopt a particular measurement for a specific asset or liability.

5.3.2 The basis of accounting adopted by an Insurer for the purposes of Rule 5.3.1 must be:

(a) in the case of a Takaful Insurer, the standards of the Accounting and Auditing Organisation for Islamic Financial Institutions; or

(b) in any other case, International Financial Reporting Standards.

5.3.3 Where the valuation of an asset or liability is dependent upon the adoption of assumptions or the adoption of a calculation method, any change in the assumptions or methods adopted must be 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.

5.4 Recognition and measurement of insurance assets and liabilities in respect of general insurance

5.4.1 This section applies to assets and liabilities in respect of General Insurance contracts.

5.4.2 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 insurance contract.

5.4.3 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.

5.4.4 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.

5.4.5 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 effecting the underlying insurance contracts.

5.4.6 Expenses incurred in respect of insurance contracts effected by an Insurer must be treated as payable at the time the contracts are effected.

5.4.7 An Insurer must treat as a liability, the premium liability, which is the value of future claim 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 5.4.7 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.

5.4.8 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 5.4.8 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.

5.4.9 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 Rules 5.4.7 and 5.4.8.

5.4.10 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.

5.4.11 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.

5.4.12 Rules 5.4.10 and 5.4.11 do not require an Insurer to obtain a valuation by an Actuary of the assets and liabilities referred to in those Rules, at a Solvency Reference Date other than the Insurer's annual reporting date.

Guidance

An Insurer is also required to provide a periodic report on its General Insurance Liabilities and associated assets, prepared by an Actuary. The relevant provisions are contained in chapter 7.

5.5 Discount rates

5.5.1 The DFSA may specify actuarial principles to be used by an Insurer in measuring assets and liabilities.

5.5.2 For the purposes of determining the net present value of expected future payments in accordance with Rule 5.4.10, an Insurer must use as a discount rate the gross redemption yield, as at the Solvency Reference Date, of a portfolio of AAA-Rated sovereign risk securities with a similar expected payment profile to the liability being measured.

5.5.3 For the purposes of determining the net present value of expected future receipts in accordance with Rule 5.4.11, an Insurer must use as a discount rate the gross redemption yield, as at the Solvency Reference Date, of a portfolio of AAA-Rated sovereign risk securities with a similar expected payment profile to the asset being measured.

Guidance

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

2. 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.

5.6 Recognition and measurement of assets and liabilities in respect of long-term insurance

5.6.1 This section applies to assets and liabilities in respect of Long-Term Insurance contracts.

Guidance

5.6.2 Premiums in respect of reinsurance contracts entered into by an Insurer as insurer must be treated as receivable from the date on which they are due and receivable.

5.6.3 Premiums in respect of reinsurance contracts entered into by an Insurer as cedant must be treated as payable from the date on which they are due and payable.

5.6.4 (1) Acquisition costs incurred in respect of insurance contracts 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.

(2) Expenses associated with the maintenance of insurance contracts, including, but not limited to, the costs of reporting to policyholders and the

costs of managing investments, must be treated as payable as they are incurred.

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

5.6.6 An Insurer must treat as a liability the net present 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.

5.6.7 In measuring the liability referred to in Rule 5.6.6, 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) assign a liability value greater than or equal to zero to each contract or to each homogeneous group of contracts;

(d) not make allowance for any future lapse, surrender, making paid-up or revival of a contract where such an allowance would result in a decrease in the liability in respect of that contract;

(e) take specifically into account:

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

(ii) vested, declared or allotted bonuses or other forms of participation to which policy holders are already either collectively or individually contractually entitled;

(iii) reasonable expectations of policyholders in respect of bonuses or other forms of participation, other than as set out in (ii);

(iv) all options available to the policy holder under the terms of the contract;

(v) discretionary charges and deductions from Policy Benefits, in so far as they do not exceed the reasonable expectations of policy holders;

(vi) expenses, including commissions; and

(vii) any rights under contracts of reinsurance in respect of Long-Term Insurance Business: and

(f) apply a discount rate determined with reference to the expected risk-adjusted yield on the assets allocated to cover the liability and investment of net receipts attributable to the policies. In arriving at the discount rate, prudent allowance must be made for the risk of adverse deviation in those expected yields.

Guidance

1. Because of Rule 5.6.7(c), no policy may be treated as an asset in the valuation and policies must be valued individually, unless they form part of a homogeneous group of contracts. This means an Insurer may treat groups of homogeneous contracts together and not breach the requirements in that Rule, provided that the valuation in respect of that group of homogeneous contracts does not collectively represent an asset. The onus is on the Insurer to demonstrate that the contracts represent a homogeneous group. In deciding whether to treat a group of contracts as homogeneous, an Insurer should consider whether the group would remain homogeneous under realistic scenarios to which the Insurer could be exposed.

2. Rule 5.6.7(d) prevents an Insurer from reducing the valuation by taking into account future lapses and surrenders, or future action by the policyholder to make the policy paid-up or to 'revive' a paid-up policy where the product features allow such action. Since persistency may be volatile, it is considered imprudent for an Insurer to rely upon 'lapse support' in its valuation. However, voluntary discontinuance of policies may increase a valuation as well as reduce it (for example, a guaranteed surrender value may exceed the actuarially-calculated liability for part of the life of the contract). In performing the valuation, the insurer should therefore make prudent allowance for the effect of lapses, surrenders, and related policyholder actions where these increase the valuation. The impact may vary over the life of a particular contract; for example, lapse at one stage in the contract life may represent a cost to the Insurer, whereas at another, it may represent a benefit.

3. Rule 5.6.7(e)(iii) requires an Insurer to take into account bonuses not yet allocated in determining the liability for capital adequacy purposes. In essence, this Rule prevents an Insurer from counting as capital any surplus on participating contracts that is expected, under the terms of the contracts concerned, to inure to the policyholders in the future. Therefore, although attribution of surplus on participating contracts is discretionary, the Insurer must make a reasonable estimate, taking into account the perceived and reasonable expectations of policyholders. Assumptions made in reaching this estimate (for example, on future investment income) should be consistent with those made for other purposes of the valuation. However, the recognition of future bonuses or other forms of participation in this liability does not affect the determination of surplus for other purposes, such as allocation of bonuses of surplus prior to allocation of those bonuses.

4. For the purposes of Rule 5.6.7(f), an Insurer should ensure that yields used to determine the discount rate are adjusted to take account of the risk that yields will decrease. High yields that represent compensation for risks such as credit or currency risk should be adjusted down to normalise for those elements of the yield.

5.6.8 The DFSA may specify actuarial principles to be followed by Insurers in measuring the liability referred to in Rule 5.6.6.

5.6.9 Rule 5.6.6 does not require an Insurer to obtain a valuation by an Actuary of the liability referred to in that Rule, at a Solvency Reference Date other than the Insurer's annual reporting date.

Guidance

An Insurer is also required to provide a periodic report on its Long-Term Insurance Liabilities, prepared by an Actuary, including an actuarial investigation of the financial condition of its Long-Term Insurance Business. The relevant provisions are set out in section 7.3.

5.7 Value of investments in subsidiaries and associates that are subject to minimum capital requirements

5.7.1 This section applies to all Insurers.

5.7.2 Where an Insurer is the Parent of a Financial Group, the value of the Insurer's investment in any Subsidiary or Associate that is an Authorised Firm or a Financial Institution must be taken as the amount of the Insurer's proportionate share of that Subsidiary or Associate's Capital Resources or Adjusted Capital Resources determined in accordance with Rule 8.3.4(1)(b), reduced by the Insurer's proportionate share of the Subsidiary or Associate's Capital Requirement determined in accordance with Rule 8.3.3(2).

Guidance

The impact of Rule 5.7.2 is that an Insurer's capital resources are calculated on a basis consistent with the manner of calculation of Financial Group Capital Resources, and that capital resources required to support the capital adequacy of Group companies are not used to support the individual capital adequacy of the Insurer itself. The Insurer's capital adequacy calculation is therefore also an indication of the degree of capital adequacy of the Financial Group of which it is the Parent. In this and other Rules where reference is made to a Parent for the purposes of calculating capital adequacy of a group of companies, generally, it is a reference to the ultimate Parent within the group.

5.7.3 Deleted

5.8 Transfer of risk by an Insurer to an ISPV

5.8.1 This section applies to all Insurers.

5.8.2 An Insurer may not:

(a) treat amounts recoverable from an ISPV as:

(i) an asset; or

(ii) reinsurance for the purposes of calculating its liabilities under contracts of insurance it has effected; or

(b) otherwise ascribe a value to such amounts;

unless it has first obtained a waiver from the DFSA.

Guidance

In considering:

a. whether to grant such a waiver; and

b. the amount which the DFSA will allow the Insurer to bring into account for these purposes;

the DFSA will take into account the following factors:

c. where the ISPV is an Authorised ISPV, the DFSA will wish to be satisfied that the ISPV complies with Rules 10.1.2 to 10.1.7 The DFSA may rely on information supplied in

connection with the ISPV's application for authorisation. However, if the application for a waiver is made some time after authorisation was granted, the DFSA may request confirmation that there has been no material change to the information originally supplied;

d. where the ISPV is not authorised, the DFSA will expect to receive confirmation that the ISPV is subject to regulation by a Financial Services Regulator in a jurisdiction acceptable to the DFSA. In addition, it will need details of the debt issuance or other financing mechanism by which the ISPV's reinsurance liabilities are funded. The DFSA will also expect to receive information about the ISPV's key management and control functions, including details of the ISPV's auditors and arrangements for claims handling, and any material outsourcing agreements. The DFSA will also need information about the structure of any Group of which the ISPV is a member;

e. no credit will be allowed for a contract of reinsurance with an ISPV unless there is an effective transfer of risk to the ISPV. The DFSA will require evidence that the contract of reinsurance and the extent of the credit that the Insurer proposes to take for it satisfy the risk transfer principle; and

f. the DFSA will also expect to receive an analysis of the potential for risk to revert to the Insurer or any of its associates under realistic adverse scenarios or for liabilities to arise in respect of the risks transferred for which no provision has been made.

6 FINANCIAL AND OTHER REPORTING BY INSURERS

6.1 Introduction

6.1.1 This chapter applies to all Insurers.

Guidance

6.2 Annual regulatory return

6.2.1 An Insurer must, at the end of each reporting period, prepare an Annual Regulatory Return.

6.2.2 The Annual Regulatory Return must comprise the statements set out in App10, together with any Supplementary Notes pertaining to those forms, and including a Statement by Directors.

6.2.3 The form and content of the statements comprising the Annual Regulatory Return (including the Statement by Directors) is set out in App10, PRU and the DFSA's electronic prudential reporting system.

Guidance

The Returns and instructional guidelines are provided in App10, PRU and the DFSA's electronic prudential reporting system.

6.2.4 Where an Insurer includes in its Annual Regulatory Return a value for General Insurance Liabilities or for assets associated with those liabilities which is inconsistent with the amount referred to in Rule 7.2.4 (b), the Insurer must notify the DFSA in writing of:

(a) the reasons for not including in its Annual Regulatory Return the value of General Insurance Liabilities or of associated assets as reported by the Actuary; and

(b) details of the alternative assumptions and methodologies used for determining the value of General Insurance Liabilities or of associated assets.

Guidance

Assets that are associated with Insurance Liabilities will predominantly be reinsurance recoveries, which are reported as assets in accordance with widely accepted accounting practice. Assets representing salvage or subrogation recoveries may also be associated with Insurance Liabilities.

6.2.5 Where an Insurer includes in its Annual Regulatory Return a value for Long-Term Insurance Liabilities which is inconsistent with the amount referred to in Rule 7.3.6 (b), the Insurer must notify the DFSA in writing of;

(a) the reasons for not including in its Annual Regulatory Return the value of Long-Term Insurance Liabilities as reported by the Actuary; and

(b) details of the alternative assumptions and methods used by the Insurer for determining the value of Long-Term Insurance Liabilities.

6.3 Quarterly regulatory return

Guidance

The Quarterly Regulatory Return is not subject to audit.

6.3.1 Subject to Rule 6.3.4, an Insurer must, at the end of March, June, September and December in each year, prepare a Quarterly Regulatory Return in respect of the period commencing at the start of the Insurer's reporting period and ending on that date.

6.3.2 The Quarterly Regulatory Return must comprise the statements set out in App10, together with any Supplementary Notes pertaining to those forms, and including a Statement by Directors.

6.3.3 The form and content of the statements comprising the Quarterly Regulatory Return (including the Statement by Directors) are set out in App10, PRU and the DFSA's electronic prudential reporting system.

Guidance

The Returns and instructional guidelines are provided in App10, PRU and the DFSA's electronic prudential reporting system.

6.3.4 The following Insurers are not required to prepare a Quarterly Regulatory Return unless required in writing by the DFSA to do so:

(a) a Class 1 Captive Insurer; and

(b) an Insurer that is a Protected Cell Company where every Cell maintained by the Insurer is a Captive Cell.

6.4 Audit of annual regulatory return

6.4.1 Subject to Rule 6.4.2, the Annual Regulatory Return of every Insurer must be audited in accordance with International Statements on Auditing relevant to the audit of the Annual Regulatory Return, by the Insurer's auditor.

Guidance

The Quarterly Regulatory Return is not subject to audit. The qualifications and appointment of the auditor of an Authorised Firm are specified in GEN chapter 8.

6.4.2 The statements in the Annual Regulatory Return that are not subject to audit are set out in App10, PRU and the DFSA's electronic prudential reporting system.

6.4.3 The report of the auditor on the Annual Regulatory Return must be made in writing to the directors of the Insurer and to the DFSA and must state whether, in the

opinion of the Auditor and so far as concerns those parts of the Annual Regulatory Return that are subject to audit:

(a) the Annual Regulatory Return has been prepared in accordance with this chapter;

(b) the statements in the Annual Regulatory Return present fairly, in accordance with the basis of preparation prescribed in this chapter, the financial position of the Insurer as at the reporting date and financial performance of the Insurer during the reporting period ended on that date, and the other information required to be presented; and

(c) the statements in the Annual Regulatory Return are in accordance with the books and records of the Insurer.

6.5 Submission of Returns to the DFSA

6.5.1 Subject to Rule 6.5.2, an Authorised Firm must, submit its Annual Regulatory Return in writing to the DFSA within four months of the Insurer's reporting date to:

Supervision Division
DFSA
Level 13, The Gate
PO Box 75850
Dubai, United Arab Emirates

6.5.2 An Authorised Firm must, prepare and submit its Annual Regulatory Return in the following manner:

(a) the Annual Regulatory Return, excepting the parts of the Annual Regulatory Return referred to in (b) and (c), must be submitted to the DFSA using the DFSA's electronic prudential reporting system:

(i) in accordance with any instructions set out in the notice and any instructions provided through such a system or specified in App10 and PRU; and

(ii) within four months of the Insurer's reporting date;

(b) the Statement by Directors need not be submitted to the DFSA, but must be signed and a copy maintained in accordance with Rules 6.5.3 and 6.5.4; and

(c) the Global Return for a Branch must be submitted in the manner provided in Rule 6.5.1.

Guidance

The Returns and instructional guidelines are provided in App10, PRU and the DFSA's electronic prudential reporting system.

6.5.3 The Statement by Directors forming part of the Annual Regulatory Return must be signed before the time of submission by:

(a) the Senior Executive Officer; and

(b) a Director of the Insurer not being the Person in (a).

6.5.4 An original signed hard copy of the Statement by Directors together with a copy of the Annual Regulatory Return submitted to the DFSA using the DFSA's electronic prudential reporting system, must be kept for at least 6 years for inspection by the DFSA.

6.5.5 The auditor's report on the Annual Regulatory Return, and any actuarial report prepared as at the reporting date in accordance with section 7.2 or 7.3, must be submitted in writing by the Insurer with the DFSA within four months of the Insurer's reporting date.

6.5.6 An auditor's report or an actuarial report submitted to the DFSA must be signed by the auditor or the Actuary preparing that report.

6.5.7 Subject to Rule 6.5.8, an Authorised Firm must, submit its Quarterly Regulatory Return in writing to the DFSA within two months of the end of each period in respect of which the Insurer is required to prepare a Quarterly Regulatory Return to:

Supervision Division
DFSA
Level 13, The Gate
PO Box 75850
Dubai, United Arab Emirates

6.5.8 An Authorised Firm must, prepare and submit its Quarterly Regulatory Return in the following manner:

(a) the Quarterly Regulatory Return, excepting the parts of the Quarterly Regulatory Return referred to in (b) and (c), must be submitted to the DFSA using the DFSA's electronic prudential reporting system:

(i) in accordance with any instructions set out in the notice and any instructions provided through such a system or specified in App10 and PRU; and

(ii) within two months of the Insurer's reporting date;

(b) the Statement by Directors must be signed and a copy maintained in accordance with Rules 6.5.9 and 6.5.10; and

(c) the Global Return for a Branch must be submitted in the manner provided in Rule 6.5.7.

Guidance

The Returns and instructional guidelines are provided in App10, PRU and the DFSA's electronic prudential reporting system.

6.5.9 The Statement by Directors forming part of the Quarterly Regulatory Return must be signed before the time of submission by:

(a) if the Insurer is a DIFC Incorporated Insurer, one Director of the Insurer; or

(b) if the Insurer is not a DIFC Incorporated Insurer, the Senior Executive Officer and, if that Person is not a Director, one Director of the Insurer.

6.5.10 An original signed hard copy of the Statement by Directors together with a copy of the Quarterly Regulatory Return submitted to the DFSA using the DFSA's electronic prudential reporting system, must be kept for at least 6 years for inspection by the DFSA.

6.5.11 If within 24 months of the date that an Annual Regulatory Return or Quarterly Regulatory Return is submitted to the DFSA, the DFSA notifies the Insurer that a Return appears to be inaccurate or incomplete, the Insurer must consider the matter and within one month of the date of notification it must correct any inaccuracies and make good any omissions and re-submit the relevant parts of the Return.

6.5.12 An Insurer must submit, at the same time as every Annual Regulatory Return of that Insurer or as soon as practicable thereafter, any report on the affairs of the Insurer submitted to the shareholders or policyholders of the Insurer in respect of the reporting period to which the Annual Regulatory Return relates.

6.5.13 (1) When a Return of the kind specified under Rule 6.5.2(a) or Rule 6.5.8(a) is not submitted on or before the due date or within the prescribed period, such non-submission incurs a late payment fee of $1,000.

(2) Nothing in this Rule limits the right of the DFSA to take any other action.

Guidance

If a Return is not submitted by the date on which it becomes due, the Person is in breach of a Rule and the DFSA is entitled to take action including, but not limited to, taking steps to withdraw authorisation to conduct Financial Services.

6.6 Reporting of group capital adequacy

6.6.1 An Insurer must, at the end of each reporting period and at the mid-point of each reporting period, prepare a report on the Financial Group capital adequacy of any Financial Group of which it is a member and in respect of which it is required by Chapter 8 to calculate Financial Group Capital Requirements and Financial Group Capital Resources. This Report shall be known as the Financial Group Capital Adequacy Report.

6.6.2 (1) The Financial Group Capital Adequacy Report must be filed in writing by the Insurer with the DFSA:

(a) within four months of the Insurer's reporting date in the case of a report at the end of a reporting period; or

(b) within two months of the Insurer's mid-year date in the case of a report at the mid-point of a reporting period.

(2) The Financial Group Capital Adequacy Report must state:

(a) the name of the Insurer;

(b) the reference date of the report;

(c) the name, location and activity of the Parent entity of the Financial Group in respect of which the report is made;

(d) the Financial Group Capital Resources, calculated in accordance with Rule 8.3.4;

(e) the Financial Group Capital Requirement, calculated in accordance with Rule 8.3.3;

(f) the amount of surplus or deficit, expressed as the amount in (d) minus the amount in (e);

(g) a list of all Authorised Firms and Financial Institutions in the Financial Group;

(h) if any Authorised Firm in the Financial Group is itself a Parent, the items referred to in (d), (e) and (f) in respect of the Financial Group headed by that Authorised Firm; and

(i) particulars of any Authorised Firm or Financial Institution in the Financial Group in respect of which the capital requirement calculated in accordance with Rule 8.3.3 exceeds its Capital Resources or Adjusted Capital Resources calculated in accordance with Rule 8.3.4(1)(b).

(3) Amounts in the Financial Group Capital Adequacy Report must be expressed in thousands of dollars.

(4) The Financial Group Capital Adequacy Report must be signed by:

(a) the Persons specified in Rule 6.5.3 in the case of a report at the end of a reporting period; or

(b) the Persons specified in Rule 6.5.9 in the case of a report at the mid-point of a reporting period.

(5) The Financial Group Capital Adequacy Report must be accompanied by a statement by the Insurer's auditor, made in writing to the directors of the Insurer and to the DFSA, and stating whether any significant matter has come to the attention of the auditor to indicate that the report has not been properly compiled in accordance with the requirements of this section, from information provided to the Insurer by other members of the Financial Group and from the Insurer's own records.

Guidance

1. Where information that would be contained in the Financial Group Capital Adequacy Report would be identical with information previously or concurrently provided to the DFSA pursuant to this or another provision of the Rulebook, and that information has not changed, the DFSA will normally accept a statement to that effect in the report in place of that information.

2. Form IN 170 in PRU may be used by an Insurer to present the Financial Group Capital Adequacy Report. Use of this form is not mandatory, however if the form is used the instructional guidelines in PRU must be observed.

7 ACTUARIES

7.1 Introduction

Guidance

This chapter requires an Insurer to provide the DFSA with a report by an Actuary in respect of its Insurance Liabilities and assets arising in respect of those liabilities (that is, assets which are contingent on the existence and amount of the liabilities, such as reinsurance, salvage and subrogation recoveries). Separate provisions apply in respect of reports on General Insurance Business and Long-Term Insurance Business.

7.2 The requirement for an actuarial report on general insurance business

7.2.1 Subject to Rule 7.2.2, this section applies to Insurers conducting General Insurance Business.

7.2.2 Where an Insurer attributes General Insurance Business to a Long-Term Insurance Fund in accordance with Rule 3.3.4, this section does not apply to that business.

7.2.3 Every Insurer must provide to the DFSA as at each reporting date a written report relating to its General Insurance Business, prepared by an Actuary who has the qualifications set out in section 7.5.

7.2.4 This report must provide details in respect of each Class of Business, of:

(a) significant aspects of the recent experience of the Insurer;

(b) the Actuary's estimate of the value of General Insurance Liabilities and of assets arising in respect of those liabilities, determined in accordance with chapter 5;

(c) where there has been a change in the assumptions or in valuation method from that adopted at the previous valuation, the effect of these changes on the General 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 Actuary by the Insurer;

(e) procedures undertaken by the Actuary to assess the reliability of the data;

(f) the model or models used by the Actuary;

(g) the assumptions used by the 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.

7.3 The requirement for an actuarial investigation of and report on long-term insurance business

7.3.1 This section applies to Insurers conducting Long-Term Insurance Business, in respect of each Long-Term Insurance Fund maintained or deemed to be maintained by the Insurer.

7.3.2 Every Insurer must arrange for an actuarial investigation of the assets and liabilities of every Long-Term Insurance Fund maintained or deemed to be maintained by it, including a determination of surplus in each such fund, to be performed as at a Reference Date which must be not more than one year later than the date of establishment of the Long-Term Insurance Fund or the previous Reference Date (if later).

7.3.3 An investigation of the type set out in Rule 7.3.2 must in any case be performed as at every reporting date of the Insurer.

7.3.4 An actuarial investigation under this section must be performed by an Actuary who has the qualifications set out in section 7.5, and must be conducted according to principles approved by the DFSA.

Guidance

Principles set out in professional standards issued by a professional actuarial body that is a full member of the International Actuarial Association will normally be approved by the DFSA for the purposes of Rule 7.3.4, to the extent that they do not conflict with the provisions of this chapter.

7.3.5 When an Insurer arranges for an actuarial investigation under this section, the Insurer must provide to the DFSA a written report prepared by the Actuary conducting the actuarial investigation, not later than four months from the Reference Date of the actuarial investigation.

7.3.6 This report must provide details of, in respect of each Class of Business:

(a) the product range;

(b) any discretionary charges and benefits, options and guarantees, and reversionary bonus entitlements, where such features are included in a product;

(c) reinsurance arrangements;

(d) significant aspects of the recent experience of the Insurer, including, where relevant, a commentary on significant deviations of actual experience compared to the assumptions made in the previous valuation;

(e) the Actuary's estimate of the value of Long-Term Insurance Liabilities, determined in accordance with chapter 5;

(f) the method and assumptions used by the Actuary in the valuation process, including, where relevant, a commentary on significant differences between the assumptions used and recent actual experience of the Insurer;

(g) any expense reserves, mismatching reserves and any other special reserves included by the Actuary in the value of the Long-Term Insurance Liabilities, or recommended by the Actuary to be maintained, although not included in the valuation;

(h) a determination of the value of surplus in the Long-Term Insurance Fund, before any distribution of such surplus;

(i) a description of the Invested Assets used to determine the risk-adjusted yield on which the discount rate used in the valuation was based;

(j) the adequacy and appropriateness of data made available to the Actuary by the Insurer;

(k) procedures undertaken by the Actuary to assess the reliability of the data;

(l) the model or models used by the Actuary;

(m) the approach taken to estimate the variability of the estimate;

(n) the sensitivity analyses undertaken;

(o) any significant changes to the matters reported on during the period since the previous valuation, including, in the case of the matters referred to in (f), and otherwise, where relevant, an estimate of the effect of these changes on the Long-Term Insurance Liabilities as at the Reference Date; and

(p) commentary on any other factors affecting the valuation.

Guidance

1. The assumptions and comparisons referred to in Rule 7.3.6(d) and (f) should cover all significant components of the valuation, including consideration of persistency, mortality, expense levels, and investment returns.

2. Where the business of the Insurer includes participating Long-Term Insurance Business, it will be necessary for the determination at Rule 7.3.6(h) to deal separately with surplus for the purposes of a decision on allocation of bonuses and surplus for the purposes of determining the capital adequacy of the Fund. For the former of these two purposes, the insurer is identifying the pool, commonly known as surplus, that is available for allocation as bonuses (or equivalent) on participating policies. The allocation then reduces the surplus (note – by convention, this is treated as happening as at the reporting date). By contrast, for the latter of the two purposes, that portion of the remaining surplus that is expected to be allocated eventually to policyholders is also treated as a liability (in Rule 5.6.7), on the grounds that it is not available to absorb losses of the Insurer. For that purpose, declaration of bonuses merely represents a transfer from one recognised liability to another.

3. Factors that the Actuary should consider for the purposes of Rule 7.3.6(p) may include risks that may vary between the jurisdictions in which business is carried on, as well as generic risks. The former category might include the risk of political unrest, and the latter operational risks such as fraud.

4. The DFSA may specify additional information to be presented in the Actuary's report. Guidance to Rule 3.6.1 indicates that, where the DFSA permits an Insurer to carry on Direct Long-Term Insurance Business with features of a kind described in Rule 3.6.1(1), it may, as a condition of that permission, require additional information to be provided in the Actuary's report. That additional information could include, for example, detail on market-consistent valuations of guarantees or options, and the results of scenario testing.

7.3.7 Subject to Rule 7.3.8, where an Insurer carries on Direct Long-Term Insurance Business, the report referred to in Rule 7.3.5 must include the information set out in Rule 7.3.6 in respect of such business segregated by the jurisdiction in which it is carried on.

7.3.8 Where business in a jurisdiction is of limited significance, disclosures may, at the discretion of the Actuary, be aggregated for those jurisdictions.

7.4 Additional provisions relating to the report

7.4.1 When appointing an Actuary to prepare a report under section 7.2 or 7.3, an Insurer must ensure that there is an agreement in writing which legally binds the Actuary in accordance with the following provisions:

(a) the contract must require the Actuary to prepare his report in accordance with the provisions of section 7.2 or 7.3 as the case may be;

(b) the contract must require the Actuary to prepare the report using assumptions and methods that are, in the opinion of the Actuary, appropriate for the purposes of the report;

(c) the contract must require the Actuary to deliver the report to the Insurer's directors within such time as to give the directors a reasonable opportunity to consider and use the report in preparing the Insurer's Annual Regulatory Return for the reporting period ended on the reporting date;

(d) the contract must require and permit the Actuary to address the directors of the Insurer if the Actuary believes that there is a matter relating to the financial position or operations of the Insurer that should be brought to the attention of the directors; and

(e) the contract must require and permit the Actuary to address the DFSA if the Actuary believes that a matter brought to the attention of the directors of the Insurer is not adequately dealt with by bringing it to the attention of the directors.

7.4.2 An Insurer that has appointed an Actuary to provide a report under section 7.2 or 7.3 must make arrangements to enable the Actuary to undertake his functions, and in particular must:

(a) keep the Actuary informed of the Insurer's business and other plans;

(b) ensure that the Actuary is fully informed of the Rules in PIN applicable to the Insurer, as well as any other information that the DFSA has provided to the Insurer that may assist the Actuary in performing his duties; and

(c) ensure that the Actuary has access at appropriate times to all relevant data and people which the Actuary reasonably believes is necessary to fulfil his obligations to the Insurer in respect of this chapter.

7.4.3 The Insurer must submit the reports referred to in section 7.2 and section 7.3 to the DFSA, at the same time as it submits its Annual Regulatory Return for the reporting period ended on the reporting date.

7.4.4 Where an Insurer is not a DIFC Incorporated Insurer, a report prepared under section 7.2 or 7.3 must deal separately with the DIFC Insurance Business of the Insurer, and the Insurance Business of the Insurer as a whole.

7.4.5 Abbreviated details may be provided in a report prepared under the requirements of this chapter in respect of a Class of Business that is not material.

Guidance

For the purposes of Rule 7.4.5, a Class of Business that accounts for less than ten per cent of the Insurer's Net Written Premium in the reporting period ended on the reporting date and that accounts for less than ten per cent of the Insurer's Insurance Liabilities as at the reporting date, will normally be considered immaterial.

7.5 Qualifications of the actuary

7.5.1 An Actuary appointed to provide an actuarial report under this chapter must:

(a) have experience in the determination of liabilities in the Classes of Business dealt with in the actuarial report; and

(b) have the required skill and experience to perform his functions under the DIFC regulatory system.

Guidance

The Rules do not require an Insurer to use the same Actuary for all reports. An Insurer may provide separate reports, prepared by more than one Actuary, where the Insurer undertakes different Classes of Business, provided that each Actuary is appropriately qualified for the Classes of Business on which he reports. Similarly, an Insurer may appoint different Actuaries, each appropriately qualified, to provide reports in respect of Insurance Business conducted in or in respect of different geographical locations, for example DIFC Insurance Business and other Insurance Business.

7.5.2 An Insurer must notify the DFSA in writing of the name, professional qualifications and relevant experience of each person that the Insurer proposes to appoint to provide an actuarial report under this chapter.

7.5.3 The DFSA may, if it does not believe that the Actuary proposed by the Insurer possesses the qualifications set out in Rule 7.5.1, notify the Insurer in writing that another Actuary must be appointed.

7.5.4 An Insurer must notify the DFSA immediately on the termination or resignation of its Actuary, giving the reasons for such termination or resignation.

8 CONSOLIDATED SUPERVISION

8.1 Introduction

8.1.1 This chapter applies to all Insurers, except for Rule 8.5.1 which applies only to DIFC Incorporated Insurers.

Guidance

1. Group membership may be a source of both strength and weakness to an Insurer. The purpose of Group Risk requirements is to ensure that an Insurer takes proper account of the risks related to the Insurer's membership of a Group. The Group Risk requirements form a key part of the DFSA's overall approach to prudential supervision.

2. An Insurer is subject to separate reporting requirements in respect of changes in its Controllers. Those requirements are set out in chapter 11 of GEN. It may also be required to provide reports in respect of any Close Links it possesses.

8.1.2 (1) If an Insurer is a member of a Financial Group and the DFSA considers it necessary to extend the scope of the Financial Group to include entities outside of the Financial Group to ensure appropriate Financial Group supervision, an Insurer must also include in the scope of the Financial Group any entity the DFSA may direct the Insurer in writing to include.

(2) An Insurer may, for the purposes of this section, exclude from its Financial Group, any entity the inclusion of which would be misleading or inappropriate for the purposes of Financial Group supervision, provided the Insurer has obtained the DFSA's prior written approval to do so.

(3) An Insurer must provide to the DFSA, where requested, information regarding other Group entities, the Group structure and the systems and controls in place to manage Group Risk.

Guidance

If more than one member of the same Group is subject to an obligation to provide information in respect of a position of the Group, one or more of those Authorised Firms may make application to the DFSA for an appropriate waiver or modification of these Rules.

8.1.3 Deleted

8.2 Systems and controls requirements

8.2.1 If an Insurer is a member of a Group, it must establish and maintain systems and controls for the purpose of:

(a) monitoring the effect on the Insurer of:

a. its relationship with other members of its Group;

b. its membership in its Group; and

c. the activities of other members of its Group; and

(b) monitoring compliance with Financial Group supervision requirements below, including systems for the production of relevant data:

(i) monitoring funding within the Financial Group; and

(ii) monitoring compliance with Financial Group reporting requirements.

Guidance

1. For the purposes of the above requirement, an Insurer may take into account its position within its Group, the materiality of the risk to which it is exposed because of its membership of the Group, and the access that it has to the systems and controls of other members of its Group and any information produced by them or by Associates. For example, it would be reasonable for a small Insurer within a larger Group to place some reliance on its Parent to ensure that appropriate systems and controls are in place.

2. An Insurer may also consider together Groups whose Parents are all members of the same Group, except for any Group of which the Insurer is the Parent. An Insurer that is itself the Parent of a Group must give specific consideration to the risks to which it is exposed as the Parent. The DFSA will not otherwise however normally expect an Insurer to apply the provisions of this Rule to sub-Groups of a single Group.

8.3 Financial group capital requirements and financial group capital resources

8.3.1 (1) Section 8.3 does not apply to an Insurer if:

(a) the Insurer's Financial Group is already the subject of Financial Group prudential supervision by the DFSA as a result of the authorisation of another Financial Group member; or

(b) the DFSA has confirmed in writing, in response to an application from the Insurer, that it is satisfied that the Insurer's Group is the subject of consolidated prudential supervision by an appropriate regulator; or

(c) except where the DFSA has directed the inclusion of an entity pursuant to Rule 8.1.2(1), the percentage of total assets of Authorised Firms and Financial Institutions in the Financial Group is less than 40% of the total Financial Group assets.

(2) Where an Insurer has received confirmation in writing from the DFSA in accordance with (1)(b), it must immediately advise the DFSA in writing if the circumstances upon which the confirmation was based change.

8.3.2 Where a Financial Group contains both Insurers and Authorised Firms subject to the requirements in PIB Module, the DFSA shall determine which of the sectoral rules in section 8.3 and PIB section 7.3 shall apply in respect of the group.

Guidance

1. The objective of Rule 8.3.1(1)(a) is to avoid the necessity for multiple reporting of group capital adequacy.

2. Where a Financial Group includes both Insurers and entities subject to PIB, it is necessary to determine whether the Financial Group supervision applicable to the Financial Group should be that set out in PIN section 8.3 or PIB section 7.3. Normally, the DFSA will exercise its power under Rule 8.3.2 based on the relative size of the assets of the Financial Institutions undertaking Insurance Business (representing the insurance sector) and the assets of other Authorised Firms and Financial Institutions (representing a combined non-insurance sector). Pure holding companies will be excluded as being in neither sector. The Rules that will apply will be those of the sector with the larger total assets of the two. However, where the ratio of the assets of the two sectors differs by less than 1.5:1, the DFSA will consider a request from the Authorised Firms in the Financial Group to apply the sectoral rules applicable to the smaller of the two sectors.

8.3.3 An Insurer must ensure at all times that its Financial Group Capital Resources, as calculated in Rule 8.3.5, are equal to or in excess of its Financial Group Capital Requirement as calculated in Rule 8.3.4.

Guidance

If an Insurer breaches Rule 8.3.3, the DFSA will take into account the full circumstances of the case including any remedial steps taken by another regulator or the Authorised Firm, in determining what action it will take.

Financial group capital requirement

8.3.4 (1) An Insurer must calculate its Financial Group Capital Requirement as the sum of the entity requirements calculated in accordance with (2) and (3);

(2) Entity requirements for this purpose are:

(a) an Authorised Firm's Capital Requirement or Minimum Capital Requirement calculated in accordance with the requirements of whichever of the PIB or PIN Module applies to that Authorised Firm;

(b) in the case of regulated entities supervised by a regulator other than the DFSA, then, with the written agreement of the DFSA, the capital requirement of that entity; and

(c) for other entities in the Financial Group, a notional capital requirement calculated as directed by the DFSA .

(3) Where an Authorised Firm's Financial Group includes an entity under (c) of the definition of Financial Group in the GLO Module, that Financial Institution's capital requirement is included on a proportionate basis.

Financial group capital resources

8.3.5 (1) An Insurer must calculate its Financial Group Capital Resources by applying either of the following methods, excluding those amounts referred to in Rule 8.3.6:

(a) the accounting consolidation method which calculates the Adjusted Capital Resources of the Financial Group based on the Financial Group's consolidated financial statements; or

(b) the aggregation method, which is the sum of:

(i) the Adjusted Capital Resources of the Parent of the Financial Group;

(ii) subject to (3), the Adjusted Capital Resources calculated in accordance with the PIN Module, or the Capital Resources calculated in accordance with the PIB module, as may be appropriate, of Financial Institutions included in the Financial Group; and

(iii) subject to (3), the Financial Group's proportionate share of the Adjusted Capital Resources calculated in accordance with the PIN Module, or the Capital Resources calculated in accordance with the PIB Module, as may be appropriate, of Financial Institution participations included in the Financial Group.

(2) In calculating the Adjusted Capital Resources of a member of the Financial Group or of the Financial Group, an Insurer must follow the method of calculation set out in section A3.2, with the exception that the deduction set out in Rule A3.4.3(b) need not be made.

(3) For the purposes of (1)(b)(ii) and (iii) an investment by one Financial Group member in another must not be included.

Guidance

1. The calculation of Financial Group Capital Resources is subject to section 3.5 which limits the amount of hybrid capital (including subordinated debt) that may be included in Adjusted Capital Resources.

2. In the calculation of Capital Resources of Financial Institutions that are Financial Group members in accordance with the PIB Module, an Insurer applies to that member the deductions for illiquid assets and material holdings and Qualifying Holdings set out in the PIB Module.

3. The deduction set out at Rule 8.3.5(3) need not be made to the extent that the investment has already been excluded in whole or part by virtue of the application of the limits described in paragraphs 1 and 2 of this Guidance.

8.3.6 When calculating the Financial Group Capital Resources of a Financial Group, an Insurer must not include Capital Resources or Adjusted Capital Resources (as the case may be) of Subsidiaries or participations to the extent that those Capital Resources or Adjusted Capital Resources:

(a) exceed the entity requirement in respect of that Subsidiary or participation, calculated in accordance with Rule 8.3.4; and

(b) are not freely transferable within the Financial Group.

Guidance

1. Because the Financial Group Capital Requirement set out in Rule 8.3.4 includes capital requirements in respect of Group entities, capital resources may be included in the calculation of Financial Group Capital Resources to the extent of those requirements. Capital that is surplus to those requirements is however subject to an additional condition before it may be taken into account for the purposes of Financial Group capital adequacy.

2. In general, Capital Resources or Adjusted Capital Resources are considered not to be freely transferable if they are subject to a legal or constructive limitation on their transferability, whether that transfer would be made by dividend, return or capital or other form of distribution. Examples of relevant limitations might include obligations to maintain minimum capital requirements to meet domestic solvency requirements, or to comply with debt covenants.

8.4 Transactions within a group

8.4.1 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 percent (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.

8.4.2 Transactions entered into by an Insurer with Related entities must comply with the following conditions:

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

(b) 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.

8.5 Significant transactions other than group transactions

8.5.1 (1) A DIFC Incorporated Insurer must not enter into a transaction of the type described in this Rule unless the directors of the Insurer are 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 counterparty is a Person Related to the Insurer and the amount of the transaction equals or exceeds three per cent of the Insurer's surplus as at the end of the reporting period immediately preceding the transaction;

(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 equals or exceeds three per cent of the Insurer's surplus as at the end of the reporting period immediately preceding the transaction;

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

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

(2) For the purposes of (1), 'surplus' means:

(a) in the case of an Insurer that is not a Protected Cell Company, the Insurer's Adjusted Capital Resources; and

(b) in the case of an Insurer that is a Protected Cell Company, the Insurer's Adjusted Cellular Capital Resources in respect of the Cell to which the transaction relates, where the transaction relates to a Cell, and otherwise the Insurer's Adjusted Non-Cellular Capital Resources.

8.5.2 An Insurer must report to the DFSA all dividends and other distributions to shareholders within 21 days following the declaration of the dividend or distribution.

8.5.3 An Insurer that is a Takaful Insurer must report to the DFSA all distributions of profit or surplus (however called or described) to policyholders within 21 days of the date of declaration of the distribution.

8.5.4 An Insurer must notify the DFSA in writing within 30 days if the Insurer makes an investment in a body corporate to which it is Related, if the total investment in the Related body corporate by the Insurer and other bodies corporate to which the Insurer is Related exceeds ten per cent of the body corporate's paid-up capital or voting rights.

9 INSURERS IN RUN-OFF

9.1 Introduction

9.1.1 Subject to Rule 9.1.2, chapter applies to all Insurers.

9.1.2 In the case of an Insurer that is not a DIFC Incorporated Insurer, this chapter applies only in respect of Insurance Business carried on by the Insurer through an establishment in the DIFC.

Guidance

1. This chapter sets out prudential provisions applying to Insurers that cease to carry on Insurance Business, either wholly or in respect of a particular Class of Business. The provisions are also applicable to Cells and Long-Term Insurance Funds of Insurers, but do not (because of the effect of Rule 9.1.2) apply to non-DIFC Insurance Business of Insurers that are not DIFC Incorporated Insurers.

2. Sections 9.2 and 9.3 set out actions that an Insurer is required to take when it decides to cease to effect or carry out Contracts of Insurance. Sections 9.4, 9.5 and 9.6 give the DFSA specific powers relating to the supervision of such Insurers.

9.1.3 For the purposes of this chapter, in determining whether an Insurer is effecting Contracts of Insurance, or has ceased effecting Contracts of Insurance, including Contracts of Insurance effected through a Cell or a Long-Term Insurance Fund, Contracts of Insurance effected under a term of an existing Contract of Insurance must be ignored.

Guidance

The effect of Rule 9.1.3 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.

9.1.4 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 of its Insurance Business (or, in the case of an Insurer that is not a DIFC Incorporated Insurer, the whole of its Insurance Business carried on through an establishment in the DIFC), and a Cell 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 or a Long-Term Insurance Fund into run-off are construed accordingly.

9.2 Insurers ceasing to effect contracts of insurance in a class of business

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

(a) in a Class of Business in which the Insurer has previously carried on Insurance Business; or

(b) in respect of a Cell or a Long-Term Insurance Fund, in a Class of Business in which the Insurer has previously carried on Insurance Business through that Cell or Long-Term Insurance Fund.

9.2.2 An Insurer to which this section applies must, within 28 days of a decision to cease to effect new Contracts of Insurance in a Class of Business, notify the DFSA 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 Class of Business to which the decision relates; and

(c) where relevant, the Cell or Long-Term Insurance Fund to which the decision relates.

9.2.3 An Insurer which has provided a notice to the DFSA in accordance with Rule 9.2.2 must not effect any Contracts of Insurance in that Class of Business without the written permission of the DFSA. Where the notice referred to in Rule 9.2.2 relates to a Cell or Long-Term Insurance Fund of the Insurer, the restriction set out in this Rule applies only to that Cell or Long-Term Insurance Fund.

9.3 Run-off plans

9.3.1 This section applies to:

(a) Insurers that are in run-off or that maintain Cells or Long-Term Insurance Funds that are in run-off;

(b) Insurers that go into run-off or that place Cells or Long-Term Insurance Funds into run-off;

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

(d) Insurers whose permission to effect Contracts of Insurance in respect of their entire Insurance Business or in respect of the entire business of a Cell or Long-Term Insurance Fund is withdrawn by the DFSA.

9.3.2 If an Insurer takes a decision to go into run-off or to place a Cell or a Long-Term Insurance Fund into run-off, the Insurer must, at the same time as the notice referred to in Rule 9.2.2, provide the DFSA with a written run-off plan in respect of the Insurance Business being placed into run-off.

9.3.3 If the DFSA withdraws an Insurer's permission to effect Contracts of Insurance in respect of the Insurer's entire Insurance Business or the entire Insurance Business of a Cell or Long-Term Insurance Fund, the Insurer must, within 28 days of the written notice of withdrawal of permission (or, if later, the period specified in that notice), provide the DFSA with a written run-off plan in respect of that Insurance Business.

9.3.4 A run-off plan provided to the DFSA in accordance with this section must cover the period until all liabilities to policyholders relating to the Insurance Business in run-off are met and must include:

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

(b) an explanation of how, or to what extent, the Insurer will maintain its compliance with the requirements of chapter 4 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; and

(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.

9.3.5 Where an Insurer's Insurance Business in run-off relates to a Cell or a Long-Term Insurance Fund of that Insurer, the run-off plan must deal with the matters set out in Rule 9.3.4 so far as they relate to that Cell or Long-Term Insurance Fund.

9.3.6 An Insurer that has provided a written run-off plan to the DFSA must monitor the matters contained in the run-off plan and must notify the DFSA promptly and in writing of any significant departure from the run-off plan.

Guidance

An Insurer should decide whether a matter constitutes a significant departure from a run-off plan, having regard to the nature and size of the matter and its materiality relative to the size and complexity of the Insurer and, where relevant, the size and complexity of the Cell or Long-Term Insurance Fund concerned. The following matters will normally be considered as representing a significant departure from a run-off plan:

a. significant revision of the Insurer's strategy for managing risks, and in particular its strategy for the use of reinsurance;

b. a significant deterioration in the Insurer's claims experience, financial position or solvency position (the amount by which the Insurer's capital resources, determined in accordance with the provisions of chapter 4 relevant to that Insurer, exceed the applicable minimum capital requirements set out in that chapter); or

c. any other transaction or circumstance that is likely to have a material effect upon the Insurer's solvency position.

9.3.7 Where an Insurer has notified a matter to the DFSA in accordance with Rule 9.3.6, the DFSA 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.

9.4 Requirements for collateral for insurers in run-off

Guidance

This section contains provisions that enable the DFSA to require an Insurer that is in run-off or going into run-off to post collateral assets or make equivalent arrangements by letter of credit, to support the Insurance Liabilities and Minimum Capital Requirements applicable to the Insurer. In considering whether to exercise the powers in this section, the DFSA will have regard to the circumstances of the Insurer and the interests of policyholders.

9.4.1 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 or Long-Term Insurance Fund;

(b) has provided a notice to the DFSA in accordance with Rule 9.2.2 in respect of its entire Insurance Business or the entire Insurance Business of a Cell or Long-Term Insurance Fund; or

(c) has received a written notice from the DFSA 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 or Long-Term Insurance Fund.

9.4.2 The DFSA may, by written notice (referred to in this chapter as a 'collateral notice') require an Insurer to make available assets:

(a) of a type and in a manner described in Rule 9.4.6; and

(b) having a value, determined in accordance with the provisions of chapter 5, of the lower of:

(i) the amount, if any, specified in the notice; and

(ii) the amount determined in accordance with Rule 9.4.5.

9.4.3 An insurer must comply with the requirements of a collateral notice within the period (if any) specified in the notice, or within two months of the date of the notice, whichever is the longer.

9.4.4 The DFSA may at any time, by written notice to the Insurer, vary or revoke a collateral notice issued under Rule 9.4.2.

9.4.5 The amount referred to in Rule 9.4.2(b)(ii) is calculated as follows:

(a) in the case of an Insurer that is not a DIFC Incorporated Insurer, the amount of the assets that the Insurer is required by Rule 4.7.2 to make available;

(b) in the case of a Cell of an Insurer, the sum of the following two amounts:

(i) the Insurance Liabilities attributable to that Cell; and

(ii) the Minimum Cellular Capital Requirement applicable to that Cell.

(c) in the case of a Long-Term Insurance Fund, subject to (e) and (f), the sum of the following two amounts:

(i) the Insurance Liabilities attributable to that Long-Term Insurance Fund; and

(ii) the Minimum Fund Capital Requirement applicable to that Long-Term Insurance Fund;

(d) in the case of an Insurer that is a DIFC Incorporated Insurer and that is not a Protected Cell Company, the sum of the following two amounts:

(i) the Insurer's Insurance Liabilities; and

(ii) the Insurer's Minimum Capital Requirement.

(e) in the case of an Insurer to which (a) and (c) both apply, the amount set out in (a); and

(f) in the case of an Insurer to which (c) and (d) both apply, the amount set out in (d).

Guidance

Rule 9.4.5 describes the maximum amount of assets that the DFSA may require to be made available as collateral. The Rule includes provisions to avoid imposing multiple collateral requirements on the same Insurer in respect of the same Insurance Business in run-off.

9.4.6 The assets referred to in Rule 9.4.2 must be made available in one of the following two manners or in a combination of those two manners:

(a) assets of a type described in Rule 4.7.3 may be deposited with a custodian nominated or approved in writing by the DFSA; or

(b) a financial institution nominated or approved in writing by the DFSA may issue a confirmed letter of credit in favour of the DFSA, for the amount of the assets required to be made available.

9.4.7 The terms and conditions of a custody arrangement referred to in Rule 9.4.6(a) or a letter of credit referred to in Rule 9.4.6(b) and any change to those terms and conditions, must be notified to the DFSA, which may within two months of such notification require the Insurer to make any change to the terms and conditions of the arrangement or letter of credit.

Guidance

The terms and conditions of an arrangement or letter of credit will normally be expected to include provisions having the following effect:

a. the arrangement or letter of credit is not revocable or cancellable at the option of the Insurer, and contains no provision for automatic cancellation on the insolvency of the Insurer;

b. the DFSA has the right to apply assets deposited, or to draw upon the letter of credit, for the purpose of meeting Insurance Liabilities of the Insurer and any expenses incidental to that activity;

c. in the case of a custody arrangement, the Insurer is prohibited from applying, directly or indirectly, the assets deposited, except in the following manners:

i. in settlement of Insurance Liabilities of the Insurer that are in respect of the Insurance Business that is in run-off;

ii. in exchange for fair value, for other assets of a type described in Rule 4.7.3 and deposited with the same custodian under the same conditions;

iii. in consideration for the transfer to another Insurer of Insurance Liabilities of the Insurer that are in respect of the Insurance Business that is, or has been placed into, run-off;

iv. withdrawal from the custody of the custodian for deposit with a different custodian approved by the DFSA;

v. withdrawal from the custody of the custodian in accordance with Rule 9.4.12 ; or

vi. withdrawal from the custody of the custodian in accordance with a written notice issued by the DFSA revoking or varying the collateral notice; and

d. in the case of a letter of credit, the amount of the letter of credit may be reduced only:

i. in order to achieve, in accordance with Rule 9.4.12 a reduction in the amount of assets made available by the Insurer; or

ii. in accordance with a written notice issued by the DFSA revoking or varying the collateral notice.

9.4.8 The DFSA may, by written notice to an Insurer, require the Insurer to charge in favour of the DFSA part or all of any assets deposited with a custodian in accordance with Rule 9.4.6(a).

9.4.9 The Insurer must reassess, as at the end of March, June, September and December in each year, the amount of the assets that the Insurer is required by a collateral notice to make available, and the amount of assets made available by the Insurer.

9.4.10 The Insurer must report to the DFSA, within two months of the date as at which the reassessment referred to in Rule 9.4.9 is performed, the results of that reassessment and details of any action taken or proposed to be taken as a result of that assessment.

9.4.11 If the reassessment referred to in Rule 9.4.9 shows that the amount of assets made available is less than the amount that the insurer is required to make available, the insurer must, within two months of the effective date of the reassessment, make additional assets available so that the Insurer complies with the requirements of the collateral notice.

9.4.12 If the reassessment shows that the amount of assets made available is more than the amount that the insurer is required to make available, the Insurer may, with the written consent of the DFSA, remove assets from those made available provided that the Insurer complies with the requirements of the collateral notice after the assets have been removed.

9.5 Provisions in respect of contracts relating to insurance business in run-off

9.5.1 This section applies to any Insurer referred to in Rule 9.4.1.

9.5.2 An Insurer to which this section applies must inform the DFSA in writing of the existence and principal features of any contract which it enters into in respect of its Insurance Business in run-off, including Insurance Business carried on through a Cell or a Long-Term Insurance Fund that is in run-off, or that is in existence at the time the Insurer places that Insurance Business into run-off, and that is of any of the following types:

(a) contracts, other than Contracts of Insurance effected by the Insurer prior to going into run-off, with parties that are Related to the Insurer;

(b) contracts relating to the management of the Insurance Business in run-off, and any other contracts with the same counterparty or parties Related to that counterparty; or

(c) contracts for reinsurance of the Insurance Business that is in run-off, and any other contracts with the same counterparty or parties Related to that counterparty.

9.5.3 The DFSA may by written notice require an Insurer to provide additional information as specified in that notice in respect of any contract notified to the DFSA in accordance with Rule 9.5.2

9.6 Limitations on distributions by DIFC incorporated insurers in run-off

9.6.1 No DIFC Incorporated Insurer that is in run-off may make any distribution of profits or surplus however called or described, or return of capital, or any payment of management fees (other than fees payable under a contract notified to the DFSA in accordance with Rule 9.5.2), without the written consent of the DFSA. 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 DFSA.

10 INSURANCE SPECIAL PURPOSE VEHICLES

10.1 Application

10.1.1 This chapter applies only to Insurers that are Authorised ISPVs.

10.1.2 An Authorised ISPV must ensure that at all times its assets are equal to or greater than its liabilities.

Guidance

It is the policy of the DFSA that an Authorised ISPV should be fully funded. The DFSA considers that to be fully funded an ISPV must have actually received the proceeds of the debt issuance or other mechanism by which it is financed. The DFSA would not, for example, authorise an ISPV where part of the financing for its reinsurance liabilities was on a contingent basis, i.e. a stand by facility or letter of credit.

10.1.3 The assets of an Authorised ISPV must be held by, or on behalf of:

(i) the Authorised ISPV; or

(ii) the insurer which cedes to the Authorised ISPV the risks in respect of which the relevant assets are held.

10.1.4 An Authorised ISPV must develop, implement and maintain a risk management system to address all material risks to which it is subject. In particular, it must have regard to the Guidance on managing investment risk set out in section A.2.6.

Guidance

In developing, implementing and maintaining a risk management system as required under Rule 10.1.4 an Authorised ISPV should have proper regard to the Guidance on investment risk set out in section A2.6.

10.1.5 An Authorised ISPV must include in each of its contracts of reinsurance terms which ensure that its aggregate maximum liability at any time under those contracts of reinsurance does not exceed the amount of its assets at that time.

10.1.6 An Authorised ISPV must ensure that under the terms of any debt issuance or other financing arrangements used to fund its reinsurance liabilities the rights of the providers of that debt or other financing are fully subordinated to the claims of creditors under its contracts of reinsurance.

10.1.7 An Authorised ISPV must only enter into contracts or otherwise assume obligations which are necessary for it to give effect to the reinsurance arrangements which represent the special purpose for which it has been established.

10.1.8 Where the Authorised ISPV is a Protected Cell Company, Rules 10.1.2 to 10.1.7 should be read as applying to each Cell individually.

APP1 GUIDE TO THE APPENDICES

A1.1 Guide to the appendices

Guidance

1. In PIN, appendices have been used to present detailed material which would otherwise break up the flow of the main text.

2. App2 presents detailed guidance on systems and controls issues particularly relevant to Insurers.

3. The remaining appendices are all concerned with capital adequacy calculations and reporting.

4. A fundamental requirement of chapter 4 of the Rules is that an Insurer's capital resources should be at least equal to its capital requirement.

5. App3 contains the Rules for the calculation of an Insurer's capital resources, for a normally structured Insurer. App5 and App7 contain the corresponding rules for a Protected Cell Company and a segregated Long-Term Insurance Fund respectively.

6. App4 contains the Rules for the calculation of an Insurer's capital requirement, for a normally structured insurer. App6 and App8 contain the corresponding rules for a Protected Cell Company and a segregated Long-Term Insurance Fund respectively. They make frequent reference to App4.

7. App9 contains the rules for the calculation of the DIFC Business Risk Capital Requirement referred to in Rule 4.7.2(d). It is only applicable to Insurers incorporated outside the DIFC.

8. PRU and App10 contains financial reporting forms, and specifies how they must be completed.

APP2 MANAGEMENT AND CONTROL OF RISK

A2.1 Introduction

Guidance

1. This Guidance relates to the Rules on management and control of risk contained in chapter 2. It has been prepared to assist directors of Insurers, their Auditors, and others concerned in applying those Rules.

2. The Rules in chapter 2 require an Insurer to address specific areas of risk, as well as maintain a generally sound risk management system. Insurers have some flexibility in their approach to these requirements.

3. This appendix provides some general comment on the objectives of the Rules, risk management and control mechanisms. It also provides specific comment on the following selected aspects of the five broad areas of risk identified in section 2.3, that are considered to be of particular relevance to Insurers:

    a. Balance sheet and market risk components:

        i. reserving risk;

        ii. investment risk (including risks associated with the use of derivatives);

        iii. underwriting risk;

        iv. claims management risk;

        v. product design and pricing risk; and

        vi. liquidity management risk;

    b. Credit quality risk;

    c. Non-financial or operational risk components:

        i. business continuity planning risk; and

        ii. outsourcing risk;

    d. Reinsurance risk; and

    e. Group risk.

4. It is not the purpose of this appendix to provide guidance in areas that are common to all or many Authorised Firms other than Insurers. The principal objective is to address areas that are of specific relevance to Insurers.

5. The procedures set out in this appendix do not constitute a checklist of necessary procedures. An Insurer cannot assume that implementing all of the procedures set out in this appendix will guarantee that the Insurer complies with the requirements to which it is subject.

6. Since this appendix is not intended to be prescriptive or exhaustive, it cannot be regarded as a substitute for reading the Rules themselves and taking professional advice. An Insurer should contact the DFSA if there are any areas which it would like to discuss further.

A2.2 Objectives of the rules

Guidance

1. The objective of the Rules contained in chapter 2 is that Insurers should control their own risks through sound and prudent risk management systems, such as to minimise the likelihood that events, internal or external to the Insurer, cause the Insurer to fail financially or operationally.

2. The risk management systems required by the Rules should be integrated with the operational processes of a business. Insurers are expected to instil a strong risk control culture throughout their operations, so that material risks and potential problems that emerge can be identified, managed and promptly resolved in the normal course of business operations. The absence of such a control culture is likely to be taken as evidence that more specific control objectives are unlikely to be attained.

A2.3 Risk management systems

Guidance

1. The Rules require an Insurer to develop, implement and maintain sound and prudent risk management systems, appropriate to the size, business mix and complexity of the Insurer's operations. The responsibility for ensuring compliance lies with the Governing Body and senior management of the Insurer.

2. The nature and extent of the systems and controls which an Insurer will need to maintain will depend upon a variety of factors including:

   a. the nature, size and complexity of its business;

   b. the diversity of its operations, including geographical diversity;

   c. the volume and size of its transactions; and

   d. the degree of risk associated with each area of its operations.

3. To enable it to comply with its obligation to maintain appropriate systems and controls, an Insurer should regularly review its management of risk in the context of relevant environmental and operational factors and changes in those factors.

4. The Rules lay down certain minimum processes and procedures that must be maintained by Insurers. These include a written risk management strategy, risk management policies and procedures, and allocated responsibilities and controls.

5. The risk management strategy should cover not only the identification, assessment, control and monitoring of risks but also contingency plans to deal with the crystallisation of risks or adverse developments in important areas of risk. This will be assisted by stress and scenario testing tailored to the risk characteristics of the Insurer.

6. While the risk management systems of an Insurer must address all material risks, section 2.3 lays down specific requirements for an Insurer to maintain risk management systems in respect of the following areas:

   a. balance sheet and market risk;

   b. credit quality risk;

   c. non-financial or operational risk;

d. reinsurance risk; and

e. Group risk.

7. An Insurer should have regard to the need for adequate risk management systems at the level of any Group the Insurer is a member of (subject to exemptions for Groups that are intermediate Groups or Groups that are headed by Insurers, in which case the holding company is already subject to the risk management requirements in its own right). The Insurer bears a responsibility to take reasonable actions to ensure that the Group as a whole complies with the risk management requirements of the Rules. Although an Insurer may not be in a position to control the risk management systems of the Group, Group risk management systems are likely to have a material impact on the exposure of the Insurer to risks arising from its membership of the Group.

8. Further considerations in respect of Group risk generally are contained in section A2.5.

9. The Rules do not prohibit an Insurer from outsourcing its risk management systems. Where the Insurer is a member of a Group, it may be practicable for some processes to be performed on a Group-wide basis. An Insurer would not normally outsource risk management systems outside the Group. However the Insurer remains responsible under the Rules for the adequacy of its risk management systems, whether or not those processes are outsourced. Senior management cannot delegate their regulatory responsibility for ensuring that the Insurer's risk management systems are adequate. The fact that a system is partially or wholly outsourced would be a factor in the Insurer's assessment of whether the system was adequate. To decide whether any system is adequate, senior management would be expected to have assessed the design and operation of the system, including the design and the operations of controls over outsourcing decisions and monitoring. Because an Insurer must be in a position to demonstrate that it has complied with its regulatory requirements, adequate documentary evidence of these assessments should be maintained.

10. Further considerations in respect of outsourcing generally are contained in A2.13.

A2.4 Control mechanisms

Guidance

1. An Insurer should have appropriate control mechanisms in place to ensure that the policies and procedures established for risk management are adhered to at all times.

2. Control mechanisms would normally include:

a. clearly defined management responsibilities;

b. adequate segregation of duties;

c. a risk committee or audit function to establish and maintain the control processes;

d. a system of approvals, limits, authorisations and reporting lines;

e. policies to document the Insurer's procedural controls;

f. activity controls for each division or department;

g. verifications of activities such as underwriting, pricing and claims management, and reconciliations of relevant data;

h. reviews by Governing Body, senior management and internal audit; and

i. physical controls.

3. The directors should monitor the overall effectiveness of the Insurer's risk management systems. Depending on the size and complexity of operations of an Insurer, risk management systems may be monitored on an ongoing or periodic basis. At a minimum there should be periodic internal audits with results being reported directly to the Governing Body and senior management.

4. Where deficiencies are identified as part of the monitoring process or internal audit, these should be reported in a timely manner to the appropriate management and addressed. Material deficiencies should be reported to the Governing Body and senior management. A material deficiency can result not only from a single deficiency, but also from a number of small deficiencies that, when considered together, amount to a material deficiency.

A2.5 Reserving risk

Guidance

1. 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, reinsurance recoveries anticipated in respect of those liabilities are generally recognised as a separate asset. In the case of Long-Term Insurance, 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.

2. An Insurer's risk management system 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.

3. 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.

4. 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.

5. 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.

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

7. 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.

8. An Insurer is required by chapter 7 to obtain an annual report by an Actuary on the valuation of its Insurance Liabilities and associated assets. The Rules do not require the performance of an actuarial valuation at other times, however 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.

9. 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.

10. 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.

A2.6 Investment risk

Guidance

1. Investment risk refers to the possibility of an adverse movement in the value of an Insurer's on-balance sheet assets or certain off-balance sheet obligations. Investment risk derives from a number of sources including market risk (e.g. equity, interest rate and foreign exchange risk), credit quality risk (dealt with separately in this appendix), investment concentration risk and asset and liability mismatch risk (e.g. in terms of currency, maturity, and location). Associated risks include political risk, e.g. the risk of inability to realise assets in a particular location, and the risk of correlation such that a single event has adverse impacts on both assets and liabilities. Investment risk includes risk associated with the use of derivatives and other complex investment instruments, including asset backed securities, credit linked notes and insurance linked notes.

2. Suitable controls and management information systems should be in place to enable an Insurer to implement an appropriate investment strategy.

3. Appropriate procedures should be in place to enable an Insurer to monitor the interaction of its assets and liabilities so as to ensure that exposure to equity, interest rate and foreign exchange risk is contained within limits approved by the Insurer. Procedures should include testing of sensitivity to realistic scenarios that are relevant to the circumstances of the Insurer.

4. Appropriate procedures should be in place to enable an Insurer to monitor the location of its assets and liabilities, so as to ensure that risk of localisation mismatch is contained within limits approved by the Insurer. Procedures should include testing of sensitivity to realistic scenarios, including political risk scenarios that are relevant to the circumstances of the Insurer.

5. Insurers should remain alert to the need to consider asset and liability risks on an integrated basis. Systems should not consider only risks taken in isolation, but should consider how even when individual risks are addressed, combinations of circumstances may still expose an Insurer to loss. This is of particular relevance where a single outcome is exposed to more than one risk, for example where assets need to be available not only in a particular location but also in a specific currency.

6. Appropriate procedures should be in place for assessing the credit-worthiness of counterparties to whom the Insurer is significantly exposed. Further guidance in this area is provided in A2.11.

7. Appropriate procedures should be in place for setting prudent limits for the Insurer's aggregate exposure to certain categories of asset. Such limits should take account of the suitability of assets covering Insurance Liabilities. They may take account of the Insurer's other assets bearing in mind the possibility that such assets might in future be needed to meet Insurance Liabilities.

8. The investment strategy should be reflected in clear terms of reference from the Insurer to its investment managers, who should be qualified and competent to carry out their assigned task. The work of the investment managers should be monitored sufficiently closely by management to ensure that the Insurer's strategy is being followed and that the systems are effective.

9. Insurers should ensure that controls over derivatives and other complex investment instruments have been implemented and are adequate to ensure that risks are properly assessed, regularly reviewed in the light of changing market conditions and experience, and consistent with the overall investment strategy decided upon and approved by the Insurer. In particular senior management and directors of Insurers should:

   a. fully understand the nature of derivatives trading and trading in any other complex investment instruments being undertaken by the organisation and the related risks, and where relevant, are suitably qualified and competent to transact the range and type of transactions being undertaken and understand the nature of the exposures (including both counterparty and market risk) which their use will create;

   b. have documented clearly the objectives and policies for the use of derivatives contracts, and other complex investment instruments and monitor their use (including by way of compliance audits of investment managers) to ensure their use is in line with those objectives and policies. Insurers should ensure that policies are sufficiently clear and precise to ensure that new types of instrument are not dealt in without due prior consideration. They should also define any associated limits on exposures or volumes that are considered appropriate;

   c. have due regard to uncovered transactions in the context of the above controls so that in no circumstances is the Insurer's capital adequacy endangered. Systems should be adequate to prevent exposure to unacceptable, exceptionally volatile risks and to monitor transactions with a frequency commensurate with volatility and risk. The systems should trigger a hedge or close out a transaction whenever adverse movements or events threaten a significant worsening of the Insurer's capital adequacy position;

   d. have ensured that those who have responsibility for the control of investments in derivatives and other complex instruments, are sufficiently independent of the day-to-day operators to ensure effective control;

   e. be capable of analysing and monitoring the risk of all transactions undertaken by the Insurer individually and in aggregate (including interest rate risk, foreign exchange risk, fraud, error, unauthorised access to information and other operational risks);

   f. be provided regularly with appropriate statistics and information on the trading volumes of derivatives contracts by type of product including regular reports of all off-balance sheet transactions, contingencies and commitments;

   g. be satisfied that sufficient systems and controls relevant to derivative products and other complex investment instruments have been put in place, including independent agreement and reconciliation of positions, independent checking of prices, appropriate authorisation where dealing limits have been exceeded, etc; and

   h. have tested adequately and approved valuation models which are used to value open positions and derivative contracts, and other complex investment instruments, including controls preventing unauthorised programme amendments. Such models should

include appropriate testing of the robustness of the portfolio in changing investment conditions, using realistic scenarios relevant to the circumstances of the Insurer.

10. Stress and scenario testing should consider the impact of possible deteriorations in investment conditions, including where relevant the impact of simultaneous deteriorations in more than one market. It should also consider effects on liquidity, including where relevant those from an inability to repatriate assets from elsewhere. Where the insurance industry's holdings are large in relation to the turnover of the domestic market, scenario modelling should take account of the possible effect on the market of simultaneous liquidation of assets.

A2.7 Underwriting risk

Guidance

1. Underwriting is the process by which an Insurer determines whether and under what conditions to accept a risk. Weaknesses in the systems and controls surrounding the underwriting process can expose an Insurer to the risk of unexpected losses which may threaten the capital adequacy of the Insurer.

2. The risk management system for underwriting risk should normally include at least the following policies and procedures:

   a. clear identification and quantification of the Insurer's willingness and capacity to accept risk;

   b. clear identification of the classes and characteristics of insurance business that the Insurer is prepared to underwrite including:

      i. geographical areas;

      ii. the types of risk that may be underwritten; and

      iii. criteria for the use of policy exclusions and reinsurance;

   c. formal evaluation processes for the effective assessment of risks underwritten including:

      i. criteria for assessing risk;

      ii. methods for monitoring emerging experience; and

      iii. methods by which emerging experience is taken into account in updating the underwriting process;

   d. appropriate approval authorities and limits to those authorities that are definitive and specific (including controls surrounding any delegations that are given to intermediaries of the Insurer);

   e. concentration limits; and

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

      i. minimum standards of documentation;

      ii. internal audit;

      iii. peer review of policies underwritten;

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.

A2.8 Claims management risk

Guidance

1. Claims management is the process by which Insurers fulfil their contractual obligation to policyholders. An Insurer's duties when a claim is made under a Contract of Insurance may be summarised as:

   a. verify the contractual obligation to pay the claim;

   b. make an assessment of the amount and incidence of the claim liability, including loss adjustment expenses; and

   c. manage the claim settlement process.

2. The risk management system for claims management risk should normally include at least the following policies and procedures:

   a. clear definition and appropriate levels of delegations of authority;

   b. clear claim settlement procedures, including claim determination and investigation procedures and the criteria for accepting or rejecting claims;

   c. clear and objective loss estimation procedures (including estimation of reinsurance recoveries); and

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

      i. minimum documentation standards;

      ii. internal audit;

      iii. peer review of claims paid;

      vi. assessment of brokers' procedures and systems to ensure the quality of information provided to the Insurer is of a suitable standard; and

      vii. audits of ceding companies to ensure that the value of claims paid is in accordance with treaties in place.

3. In establishing and maintaining effective claims handling systems and procedures, senior management of Insurers should consider factors including the following:

   a. appropriate systems and controls should be in place to ensure that all liabilities or potential liabilities notified to the Insurer are recorded promptly and accurately. Accordingly, the systems and controls in place should ensure that a proper record is established for each notified claim;

   b. suitable systems should be in place to identify and quantify, for the key claims handling procedures, timeliness of processing, the effects of processing backlogs and the need for any corrective action;

c. suitable controls should be maintained to ensure that estimates for reported claims and additional estimates based on statistical evidence are appropriately made on a consistent basis and are properly categorised;

d. regular reviews of the actual outcome of the estimates made should be carried out to check for inconsistencies and to ensure that procedures remain appropriate. The reviews should include the use of statistical techniques to compare the estimates with the eventual cost of settling the claims, after deducting the amounts already paid at the time the estimates were made;

e. appropriate systems and procedures should be in place to ensure that claim files without activity are reviewed on a regular basis;

f. appropriate systems and procedures should be in place to assess the validity of notified claims by reference to the underlying Contracts of Insurance and reinsurance treaties;

g. suitable systems and procedures should be in place to accommodate the use of suitable experts such as loss adjusters, lawyers, actuaries, accountants etc. as and when appropriate, and to monitor their use; and

h. there should be suitable systems and procedures in place to identify and handle large or unusual claims, including systems to ensure that senior management are involved from the outset in the processing of claims that are significant because of their size or nature.

A2.9 Product design and pricing risk

Guidance

1. The pricing of an insurance product involves the estimation of claims and costs arising from that product and the estimation of investment income arising from the investment of premium income attaching to the product. An Insurer may be exposed to significant loss where the claims, costs or investment returns arising from the sale of a product are inaccurately calculated. This risk is particularly acute in the case of Long-Term Insurance, where the Insurer does not have the option to cancel an unprofitable policy, but is also relevant to General Insurance.

2. The risk management system for product design and pricing should normally include at least the following policies and procedures:

   a. minimum requirements for documentation of pricing and design decisions;

   b. clear identification of product lines that the Insurer is prepared to engage in or has chosen not to engage in;

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

   d. processes for assessing specific risks, including risks arising from:

      i. inflation;

      ii. anti-selection (the tendency of poorer risks in a population to seek insurance while better risks self-insure);

      iii. moral hazard (the tendency of insured persons to manage their own risk less effectively, in the knowledge that they are insured);

      iv. changes in mortality and morbidity patterns;

v. technology changes;

vi. catastrophes, natural or man-made;

vii. legal decisions;

viii. changes in government policy; and

ix. investment returns;

e. procedures for limiting risk through, for example, diversification, exclusions and reinsurance;

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

g. how emerging experience is to be reflected in price adjustments;

h. how the Insurer's product pricing responds to competitive pressures; and

i. methods for monitoring compliance with product design and pricing policies and procedures.

A2.10 Liquidity management risk

Guidance

1. An Insurer should have access to 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.

2. The risk management system for liquidity should normally include at least the following policies and procedures:

   a. procedures to identify and control the level of mismatch between expected asset and liability cash flows under normal and stressed operating conditions (using realistic scenarios relevant to the circumstances of the Insurer);

   b. procedures to monitor the liquidity and realisability of assets;

   c. procedures to identify and monitor commitments to meet liabilities including Insurance Liabilities;

   d. procedures to monitor the uncertainty of incidence, timing and magnitude of Insurance Liabilities;

   e. procedures to identify and monitor the level of liquid assets held by the Insurer; and

   f. procedures to identify and monitor other sources of funding including reinsurance, borrowing capacity, lines of credit and the availability of intra-group funding, and to identify the need for such sources to be made available.

3. When assessing its liquidity requirements an Insurer should also consider the currency in which the assets and liabilities are denominated, and the locations in which those assets and liabilities are situated or payable.

A2.11 Credit quality risk

Guidance

1. Credit exposures can increase the risk profile of an Insurer and adversely affect financial viability. Credit exposure includes both on-balance sheet and off-balance sheet exposures (including guarantees, derivative financial instruments and performance related obligations) to single and Related counterparties.

2. An Insurer's risk management system in respect of credit quality risk will normally be expected to include at least the following policies and procedures:

    a. limits (where relevant, at both an individual and consolidated level) for credit exposures to:

        i. single counterparties and groupings of counterparties that are related to each other;

        ii. entities to which the Insurer is Related;

        iii. single industries; and

        iv. single geographical locations;

    b. processes to monitor and control credit exposures against pre-approved limits;

    c. processes for identifying breaches of limits and for ensuring that breaches of limits are brought within the pre-approved limits within a set timeframe;

    d. processes for reducing or cancelling limits to a particular counterparty where the counterparty is known to be experiencing problems;

    e. processes for approving requests for temporary increases in limits;

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

    g. 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

    h. a process for reporting to the Governing Body and senior management:

        i. significant breaches of limits; and

        ii. large exposures and other credit risk concentrations.

3. Further guidance in respect of credit quality risk in respect of reinsurance counterparties is contained at A2.14.

A2.12 Business continuity planning risk

Guidance

1. Disruptions in an Insurer's business can lead to unexpected losses of both a financial and non-financial nature (e.g. data, premises, reputation etc). 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.

2. An Insurer's risk management system 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.

A2.13 Outsourcing risk

Guidance

1. 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. GEN Rule 5.3.requires an Authorised Firm to inform the DFSA about any material outsourcing arrangement.

2. 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.

3. 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. setting and monitoring of authority limits and referral requirements;

   b. the identification and assessment of performance targets;

   c. procedures for evaluation of performance against targets;

   d. provisions for remedial action;

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

   f. the ability of the Insurer and its risk management functions (for example, internal auditors), and its external auditors, to obtain access to the outsource contractors and their records;

   g. protection of intellectual property rights;

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

4. 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.

5. 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.

A2.14 Reinsurance risk

Guidance

1. Management of reinsurance risk relates to the selection, monitoring, review and control of reinsurance arrangements – that is, where some part of an Insurer's individual or aggregate insurance risks is ceded to other Insurers, whether by a direct Insurer to a reinsurer or by a reinsurer to other reinsurers.

2. An Insurer should inform the DFSA immediately if there is a likelihood of a problem arising with its reinsurance arrangements that is likely to materially detract from its current or future capacity to meet its obligations, and discuss with the DFSA its plans to redress this situation. Problems that might trigger such a situation could include the insolvency of a reinsurer with a significant share in the Insurer's programme, discovery of exposures without current reinsurance coverage, or exhaustion of reinsurance covers through multiple losses.

3. Each Insurer is required (by Rule 2.3.5) to maintain a written reinsurance management strategy which must be appropriate to the size and complexity of operations of the Insurer and must define and document the Insurer's objectives and strategy for reinsurance management.

4. An Insurer' s reinsurance management strategy should, at a minimum, include the following elements:

   a. systems for the selection of reinsurance brokers and other reinsurance advisers;

   b. systems for selecting and monitoring reinsurance programmes;

   c. clearly defined managerial responsibilities and controls;

   d. clear methodologies for determining all aspects of a reinsurance programme, including:

      i. identification and management of aggregations of risk exposure;

      ii. selection of maximum probable loss factors;

      iii. selection of realistic disaster scenarios, return periods and geographical aggregation areas; and

      iv. identification and management of vertical and horizontal coverage of the reinsurance programme;

   e. selection of participants on reinsurance contracts, including consideration of diversification and credit worthiness; and

   f. systems for identifying credit exposures (actual and potential) to individual reinsurers or Groups of connected reinsurers on programmes that are already in place.

5. Senior management should review an Insurer's reinsurance management systems on a regular basis. The review should cover:

   a. the identification and recording of policies underwritten to which reinsurance is attached;

   b. the identification of the dates when an obligation to pay reinsurance premiums arises;

   c. the identification of losses triggering recoveries under reinsurance contracts;

   d. management of the timing of payments to, and collections from, reinsurance counterparties;

   e. the credit standing and capacity of reinsurance counterparties to meet obligations to which they are subject as a result of claims incurred or to which they would become subject in the event of occurrence of losses;

   f. any concentration of reinsurance arrangements with reinsurance counterparties which would create large exposures or detract from diversification benefits in the event of occurrence of losses;

   g. the extent of reliance on reinsurance with related parties, and the accessibility of intra-group funding under a range of realistic conditions; and

   h. the impact of any adverse trends in estimated Insurance Liabilities on the adequacy of the Insurer's reinsurance arrangements, and any implications for the capacity of the Insurer to meet its future policyholder obligations.

6. Procedures for assessing the credit standing of reinsurance counterparties may include the following:

a. establishment of a security committee with a specific brief to undertake the procedures;

b. obtaining appropriate advice from reinsurance brokers;

c. review of ratings published by ratings agencies;

d. monitoring of key performance indicators in reinsurers' published reports; and

e. consideration of general conditions in the relevant reinsurance market.

A2.15 Group risk

Guidance

1. The senior management of an Insurer remain responsible for its regulatory compliance, including in any areas that are delegated or outsourced to other Group members.

2. 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.

3. 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.

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

5. 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 (for example, failures of control or compliance in other Group members).

6. The Insurer should have in place procedures to insulate the Insurer, so far as practicable, from potentially adverse effects of Group activities (for example, 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.

7. 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 DFSA is of appropriate quality.

APP3 CALCULATION OF ADJUSTED CAPITAL RESOURCES

A3.1 Purpose and general provisions

A3.1.1 This appendix applies to all Insurers to which section 4.3 applies.

Guidance

1. This appendix sets out the manner in which an Insurer that is not a Protected Cell Company is required to calculate its Adjusted Capital Resources. The equivalent provisions for Insurers that are Protected Cell Companies are set out in App5.

2. The Adjusted Capital Resources are calculated by making adjustments to the Insurer's equity as at the Solvency Reference Date.

A3.2 Adjusted capital resources

A3.2.1 An Insurer must calculate its Adjusted Capital Resources according to the formula:

ACR = AE – HCA

where:

ACR means the Insurer's Adjusted Capital Resources;

AE means the Insurer's adjusted equity; and

HCA means the Insurer's hybrid capital adjustment.

A3.2.2 Adjusted equity is calculated as set out in section A3.4. The hybrid capital adjustment is set out in section A3.5.

A3.3 Base capital

Guidance

The commencement point for calculating an Insurer's adjusted equity is the Insurer's base capital.

A3.3.1 Subject to Rules A3.3.2, A3.3.3 and A3.3.4, an Insurer's base capital consists of the following capital instruments and equity reserves of the Insurer:

(a) paid-up ordinary shares, except for shares referred to in Rule A3.5.1(d);

(b) general reserves;

(c) in the Insurance Fund of a Takaful Insurer, amounts provided from the Owners' Equity by loan to the Insurance Fund and not repaid as at the Solvency Reference Date;

(d) retained earnings;

(e) current year's earnings after tax; and

(f) hybrid capital, as defined in Rule A3.5.1.

A3.3.2 Where an Insurer is not a DIFC Incorporated Insurer, base capital may include capital instruments and equity reserves that are approved in writing by the DFSA as equivalent to the capital instruments and equity reserves described in Rule A3.3.1.

A3.3.3 Owner's Equity in a Takaful Insurer other than amounts referred to in Rule A3.3.1(c) must be classified as hybrid capital for the purposes of this section if:

(a) under the constitutional documents of the Insurer or the terms of insurance contracts or both, participation in the surpluses and losses of Takaful business is limited to the policyholders of the Insurer; and

(b) the Owners' Equity is available for loan to the Insurance Fund of the Insurer.

A3.3.4 Hybrid capital having a term to maturity of less than five years may only be included in base capital with the written consent of the DFSA.

A3.4 Adjusted equity

A3.4.1 An Insurer must calculate its adjusted equity by adding items to and deducting them from its base capital, as set out in this section.

Guidance

The purpose of these adjustments is to provide a consistent basis for the determination of the Insurer's Adjusted Capital Resources and to exclude from those resources assets that may not be readily realisable for the purposes of meeting Insurance Liabilities of the Insurer.

A3.4.2 The following items must be added to base capital, to the extent that the Insurer has excluded them in determining its base capital:

(a) any minority interests in companies that are Subsidiaries of the Insurer; and

(b) any amount in respect of dividends to be paid by the Insurer in the form of shares.

A3.4.3 The following items must be deducted from base capital, to the extent that the Insurer has not excluded them in determining its base capital, or has added them to base capital under Rule A3.4.2:

(a) any amounts in respect of appropriations to be made from profit in respect of the reporting period most recently ended, including dividends, distributions by Takaful Insurers of surplus, bonuses, pensions and welfare charges that are determined on the basis of the profit of that reporting period, whether or not the amounts have been approved by the Insurer for payment;

(b) Owners' Equity in a Takaful Insurer that does not, under the constitutional documents of the Insurer or the terms of insurance contracts or both, participate in the surpluses and losses of Takaful business;

(c) the amount of any investment by the Insurer or by a Subsidiary of the Insurer, in the Insurer's own shares;

(d) the amount of any tax liability that would be attributable to unrealised gains on investments, if those gains were realised;

(e) the amount of deferred acquisition costs;

(f) the amount of any deferred tax asset;

(g) the amount of any asset representing the value of in-force Long-Term Insurance Business of the Insurer;

(h) the amount of any goodwill, patents, service rights, brands and any other intangible items;

(i) the amount of any Zakah or charity fund of a Takaful Insurer;

(j) the amount of any operating assets, including inventories, plant and equipment, and vehicles; and

(k) the amount of any other assets that may not be applied to meet Insurance Liabilities of the Insurer.

A3.4.4 Rule A3.4.3(l) does not require an Insurer to exclude assets attributable to a Long-Term Insurance Fund maintained by the Insurer.

A3.5 Hybrid capital adjustment

Guidance

1. This section acts to limit hybrid capital to 15% of an Insurer's adjusted equity.

2. The purpose of the hybrid capital adjustment is to limit the extent to which an Insurer may rely for its Adjusted Capital Resources on instruments that do not or may not constitute permanent capital of the Insurer. Such instruments include share capital contributed by a Holding Company, where the Holding Company's investment is financed by debt rather than by its own capital.

A3.5.1 Hybrid capital includes the following items:

(a) subordinated debt;

(b) preference shares;

(c) Owners' Equity in a Takaful Insurer, of the type described in Rule A3.3.3; and

(d) ordinary shares issued by an Insurer to a Holding Company whose own paid-up ordinary share capital, taken together with its general reserves, is lower than that of the Insurer.

A3.5.2 Subject to Rule A3.5.3, an Insurer must calculate its hybrid capital adjustment as the amount by which the total amount of hybrid capital exceeds 15% of adjusted equity.

A3.5.3 The DFSA may at its discretion and on the application of an Insurer, permit that Insurer to apply Rule A3.5.2 as though the figure of 15% was replaced with a higher figure approved in writing by the DFSA. The approved figure may not be more than the actual percentage which the hybrid capital represents of adjusted equity, and may not in any case exceed 30%.

APP4 CALCULATION OF MINIMUM CAPITAL REQUIREMENT

A4.1 Purpose and general provisions

A4.1.1 This appendix applies to all Insurers to which section 4.3 applies.

Guidance

1. This appendix sets out the manner in which an Insurer that is not a Protected Cell Company is required to calculate its Minimum Capital Requirement. The equivalent provisions for Insurers that are Protected Cell Companies are set out in App6.

2. The Minimum Capital Requirement is calculated by determining individual components in respect of various specific risks that the Insurer is exposed to, and adding those components together to arrive at the Minimum Capital Requirement.

A4.2 Minimum capital requirement

A4.2.1 Subject to Rule A4.2.2, an Insurer must calculate its Minimum Capital Requirement according to the formula:

MCR = DRC + IVRC + OARC + OLRC + CRC + SFAC + URC + RRC + LIRC + AMRC

Where the following definitions apply:

Term	Definition
MCR	Insurer's Minimum Capital Requirement;
DRC	Insurer's default risk component;
IVRC	Insurer's investment volatility risk component;
OARC	Insurer's off-balance sheet asset risk component;
OLRC	Insurer's off-balance sheet liability risk component;
CRC	Insurer's concentration risk component;
SFAC	Insurer's size factor adjustment component;
URC	Insurer's underwriting risk component;
RRC	Insurer's reserving risk component;
LIRC	Insurer's Long-Term Insurance risk component; and
AMRC	Insurer's asset management risk component.

A4.2.2 The methods of calculation of the components referred to in Rule A4.2.1 are set out in sections A4.4, A4.5, A4.6, A4.7, A4.8, A4.9, A4.10, A4.11, A4.12 and A4.13.

A4.2.3 An Insurer's Minimum Capital Requirement must always be equal to or higher than:

(a) in the case of a Class 1 Captive Insurer, $ 150,000;

(b) in the case of a Class 2 Captive Insurer, $ 250,000;

(c) in the case of a Class 3 Captive Insurer, $ 1,000,000; and

(d) in the case of all other Insurers, $ 10,000,000.

A4.3 Applicability of components to assets of the insurer

A4.3.1 Subject to Rule A4.3.2, an Insurer must calculate those components of its Minimum Capital Requirement that are relevant to assets, in respect of every asset that is owned by the Insurer and that is available to meet the liabilities of the Insurer.

A4.3.2 Where an Insurer arranges its affairs such that its Invested Assets are held in a related entity, the Insurer may, with the written approval of the DFSA, calculate components of its Minimum Capital Requirement by reference to the Insurer's interest in the assets that are held by the related entity, instead of by reference to the interest that the Insurer has in that related entity. In that case this appendix shall be interpreted as though the assets (representing the Insurer's interest) held by the related entity were held directly by the Insurer.

Guidance

The effect of Rule A4.3.2 is to provide flexibility for Insurers whose investments are managed on a pooled basis within a Group, or which establish specialist Subsidiaries to manage their investments. While the Insurer's asset in such cases is a balance with, or investment in, a related entity, this Rule permits the Insurer to 'look through' the corporate arrangement and apply this appendix to the assets of the related entity as though they were the Insurer's own.

A4.4 Default risk component

Guidance

The purpose of the default risk component is to require an Insurer to set aside capital to cover the risk that amounts receivable from counterparties will not be received. The basic calculation model for this component, set out in A4.4.1, is modified by additional provisions that permit an Insurer to take account of the reduced default risk where an asset is covered by guarantees or collateral, and impose additional capital charges on assets that are encumbered. In addition, certain assets that are left out of account in calculating an Insurer's Adjusted Capital Resources are exempt from the default risk component calculation. Excluding these assets from Adjusted Capital Resources already effectively imposes a 100% capital requirement.

A4.4.1 An Insurer must calculate its default risk component as the sum of the amounts obtained by multiplying the value of each asset of the Insurer with the percentage applicable to that asset, as set out in the tables contained in this Rule and subject to the provisions of Rules A4.4.2, A4.4.5, A4.4.6 and A4.4.7.

(a) Assets that are Invested Assets

	Asset	%
(a)	Bonds Rated 'AAA', issued by a Government or Government agency	0.0
(b)	Bonds not included in (a), Rated 'A' or better	0.4
(c)	Bonds Rated 'BBB'	3.3
(d)	Bonds Rated 'BB'	7.5
(e)	Bonds Rated 'B'	13.7
(f)	Bonds Rated 'CCC'	20.2
(g)	Other Rated bonds	30.0
(h)	Secured loans – performing	2.0
(i)	Secured loans – Non-Performing	14.0
(j)	Loans to directors of the Insurer or to directors of Related parties, or to the dependent relatives of such directors	100.0
(k)	Unsecured loans to employees (except loans of less than $1,000)	100.0
(l)	Other bonds and loans	50.0

(b) Assets that are not Invested Assets

Asset			%
(a)	Reinsurance recoverable from:		
	(i)	reinsurers Rated 'AAA'	0.5
	(ii)	reinsurers Rated 'AA'	1.2
	(iii)	reinsurers Rated 'A'	1.9
	(iv)	reinsurers Rated 'BBB'	4.7
	(v)	reinsurers Rated 'BB'	9.6
	(vi)	reinsurers Rated 'B'	23.8
	(vii)	reinsurers Rated 'CCC'	49.7
	(viii)	reinsurers Rated 'R'	50.0
	(ix)	other reinsurers	25.0
(b)	Other assets		3.0

A4.4.2 Reinsurance recoverable includes amounts recoverable in respect of outstanding claims and in respect of Premium Liabilities. Insurers may make reasonable approximations where it is not possible to identify exactly the reinsurers to which amounts recoverable relate (for example, in the case of recoveries in respect of Premium Liabilities and in respect of claims incurred but not reported).

A4.4.3 Where an asset falls within more than one category in the table in Rules A4.4.1(a) or A4.4.1(b), the highest of the percentages applicable to that asset must be applied.

A4.4.4 Where an asset has been explicitly, unconditionally and irrevocably guaranteed for its remaining term, by a guarantor with a rating of 'A' or better who is not Related to the Insurer, the Insurer may at its option use, in place of the relevant percentage in the table in Rules A4.4.1(a) or A4.4.1(b), the percentage in those tables that would apply to a debt due from the guarantor.

A4.4.5 Where an Insurer holds collateral against an asset, and the collateral consists of a charge, mortgage or other security interest in cash or in debt securities whose issuer has a rating of 'A' or above, the Insurer may at its option use, in place of the relevant percentage in the table A4.4.1 (a) or in Rule A4.4.1(b), the percentage in those tables that would apply to the collateral.

A4.4.6 The provisions of Rules A4.4.4 and A4.4.5 apply only to so much of the asset that is covered by the guarantee or the collateral.

A4.4.7 Notwithstanding anything else in this section:

(a) the amount included in the default risk component in respect of any asset that is subject to a fixed or floating charge, mortgage or other encumbrance must be 100% of the value of the asset to the extent of that charge, mortgage or encumbrance. In the case of such assets, the percentages set out in the tables above must be applied only to the amount, if any, by which the value of the asset exceeds the amount of the charge, mortgage or encumbrance; and

(b) no amount must be included in the default risk component in respect of assets excluded from Adjusted Capital Resources in accordance with Rules A3.4.3(e), A3.4.3(f), A3.4.3(g), A3.4.3(h), A3.4.3(k) or A3.4.3(l).

A4.5 Investment volatility risk component

Guidance

The purpose of the investment volatility risk component is to require an Insurer to set aside capital to cover the risk of deterioration in the values 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.

A4.5.1 Subject to Rule A4.5.2, an Insurer must calculate its investment volatility risk component as the sum of the amounts obtained by multiplying the value of each Invested Asset with the relevant percentage applicable to that asset as set out in the following table.

Asset		%
(a)	All bonds up to 1 year to maturity	1.0
(b)	Bonds between 1 and 2 years to maturity	2.0
(c)	Bonds between 2 and 5 years to maturity	4.0
(d)	Bonds between 5 and 10 years to maturity	6.0
(e)	All other bonds	8.0
(f)	Equity investments*	15.0
(g)	Preference shares	6.0
(h)	Land and buildings	18.0
*Note: 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.		

A4.5.2 No amount must be included in the calculation of the investment volatility risk component in respect of:

(a) investments that are linked to liabilities of Investment-Linked Insurance contracts; or

(b) assets referred to in Rule A4.4.7(b).

A4.6 Off-balance sheet asset risk component

Guidance

The purpose of the off-balance sheet asset risk component is to require an Insurer to set aside capital to cover the risk of default and deterioration in value in respect of exposures that the Insurer has because it is a party to a derivative contract.

A4.6.1 An Insurer is required to calculate an off-balance sheet asset risk component, if the Insurer is, as at the Solvency Reference Date, a party to a derivative contract, including a forward, future, swap, option or other similar contract, but not including:

(a) a put option serving as a guarantee;

(b) a foreign exchange contract having an original maturity of 14 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.

A4.6.2 An Insurer must calculate its off-balance sheet asset risk component as the sum of the amounts obtained by applying the calculations set out in Rule A4.6.3 in respect of each derivative contract entered into by the Insurer that meets the description in Rule A4.6.1.

A4.6.3 The amount in respect of a derivative contract is obtained by calculating, for an asset equivalent amount as determined in Rule A4.6.4, a default risk component as set out in section A4.4 and an investment volatility risk component as set out in section A4.5, as though the asset equivalent amount were a debt obligation due from the derivative counterparty.

A4.6.4 The asset equivalent amount in respect of a derivative is calculated as the sum of the current mark-to-market exposure of the derivative (where this is positive) and the amount obtained by multiplying the notional principal amount of the derivative by the factors specified in the following table, according to the nature and residual maturity of the derivative.

Residual maturity	A	B	C	D	E
(a) Less than 1 year	NIL	1.0%	6.0%	7.0%	10.0%
(b) 1 year or more, but less than 5 years	0.5%	5.0%	8.0%	7.0%	12.0%
(c) 5 years or more	1.5%	7.0%	10.0%	8.0%	15.0%

Where:

A means interest rate contracts;

B means foreign exchange and gold contracts;

C means equity contracts;

D means precious metal contracts (other than gold); and

E means other contracts.

A4.7 Off-balance sheet liability risk component

Guidance

1. The purpose of the off-balance sheet liability risk component is to require an Insurer to set aside capital to cover the risk that it will be required to perform on a guarantee, letter of credit or other credit substitute that it has entered into. 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 that are Contracts of Insurance are excluded from the calculation of this component, as they are subject to a separate capital requirement under section 4.5.

A4.7.1 An Insurer must calculate an off-balance sheet liability risk component if the Insurer has issued guarantees, including put options serving as guarantees, letters of credit or any other credit substitute (other than an insurance contract) in favour of another party, so that the Insurer is exposed to the risk of having to make payment on those instruments should the guaranteed party default.

A4.7.2 An Insurer must calculate its off-balance sheet liability risk component as the sum of the amounts obtained by applying the calculations set out in Rule A4.7.3 in respect of each guarantee, letter of credit or other credit substitute.

A4.7.3 The amount in respect of a guarantee, letter of credit or other credit substitute (other than an insurance contract) is obtained by calculating, for the nominal amount of the guarantee, letter of credit or other credit substitute, a default risk component as set out in section A4.4 and an investment volatility risk component as set out in section A4.5, in respect of the obligation or asset over which the guarantee, letter of credit or other credit substitute is written, as though that obligation or asset were an obligation or asset of the Insurer.

A4.8 Concentration risk component

Guidance

The purpose of the concentration risk component is to require an Insurer to set aside 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. 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 size of that exposure relative to the Insurer's Adjusted Capital Resources. The total amount of the concentration risk component in respect of any asset is limited to 100% of the value of the asset, and certain assets that are left out of account in calculating an Insurer's Adjusted Capital Resources are excluded from the calculation.

A4.8.1 An Insurer must calculate a concentration risk component if the Insurer has, as at the Solvency Reference Date, 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 10% of the Insurer's Adjusted Capital Resources.

A4.8.2 For the purposes of the calculation referred to in Rule A4.8.1:

(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 A4.12.6 in respect of that counterparty or grouping of Related counterparties, but excluding any assets excluded from base capital by reason of any of the Rules referred to in Rule A4.4.7(2); and

(b) 'AAA'-Rated Governments and Government agencies are not counterparties.

A4.8.3 An Insurer must calculate its concentration risk component as the sum of the amounts obtained by applying to each investment exposure that exceeds 10% of the Insurer's Adjusted Capital Resources the relevant formula set out in the following table, subject to Rule A4.8.4.

Exposure expressed as a percentage of adjusted capital resources	Formula to determine concentration risk component
(a) Over 10 up to 25	20% of the amount by which the investment exposure exceeds 10% of Adjusted Capital Resources, up to a limit equivalent to 3% of Adjusted Capital Resources.
(b) Over 25 up to 50	3% of the amount of Adjusted Capital Resources, plus 40% of the amount by which the investment exposure exceeds 25% of Adjusted Capital Resources, up to a limit in total equivalent to 13% of Adjusted Capital Resources.
(c) Over 50 up to 75	13% of the amount of Adjusted Capital Resources, plus 60% of the amount by which the investment exposure exceeds 50% of Adjusted Capital Resources, up to a limit in total equivalent to 28% of Adjusted Capital Resources.
(d) Over 75 up to 100	28% of the amount of Adjusted Capital Resources, plus 80% of the amount by which the investment exposure exceeds 75% of Adjusted Capital Resources, up to a limit in total equivalent to 48% of Adjusted Capital Resources.
(e) Over 100	48% of the amount of Adjusted Capital Resources, plus 100% of the amount by which the investment exposure exceeds 100% of Adjusted Capital Resources.

A4.8.4 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 default risk component, investment 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.

A4.9 Size factor component

Guidance

The effect of the size factor component is to provide a relatively higher capital requirement in respect of Insurers with smaller portfolios of Invested Assets. The calculation adjusts the aggregate of the

default risk component, investment volatility risk component and concentration risk component in respect of Invested Assets, by a factor that varies according to the total size of Invested Assets.

A4.9.1 The base figure for the size factor component is determined by aggregating the following components:

(a) the default risk component determined in accordance with section A4.4, so far only as concerns the Insurer's Invested Assets;

(b) the investment volatility risk component determined in accordance with section A4.5; and

(c) the concentration risk component determined in accordance with section A4.8, so far only as concerns the Insurer's Invested Assets.

A4.9.2 An Insurer must calculate its size factor component by multiplying the base figure determined in accordance with Rule A4.9.1 by the factor derived by applying the following formula, where x represents the total Invested Assets expressed in millions of dollars:

(a) If $x \leq 100$, the factor is 1.5.

(b) If $100 < x \leq 200$, the factor is $(150 + 0.5(x-100))/x$.

(c) If $200 < x \leq 1{,}200$, the factor is $(200 – 0.2(x-200))/x$.

(d) If $x > 1{,}200$, the factor is zero.

A4.10 Underwriting risk component

Guidance

The purpose of the underwriting risk component of the Minimum Capital Requirement is to require an Insurer to set aside capital to address the risk that the cost of claims in respect of General Insurance Business will vary from the cost implicit in the premiums being charged. The basic calculation model set out in Rule A4.10.2 applies different factors to the premium in respect of different Classes of Business, based on the different perceived risk of variability associated with each. The model is modified by additional provisions dealing with certain Classes of Business. This section also restricts the extent to which reinsurance may be taken into account when calculating the underwriting risk component.

A4.10.1 Subject to the other provisions of this section, an Insurer must calculate its underwriting risk component as the sum of the amounts obtained by multiplying the Insurer's base premium, for each Class of Business, by the percentage factors set out in the following table.

Class of Business		Percentage factor		
		Direct insurance	Proportional reinsurance	Non-proportional and facultative reinsurance
(a)	Classes 1 and 2	18	18	27
(b)	Class 3	12	12	18
(c)	Class 4	17	17	26
(d)	Class 5	19	19	30
(e)	Class 6	27	27	29
(f)	Classes 7(a) and 7(b)	90	90	140
(g)	Class 8	18	18	27

A4.10.2 Where an Insurer underwrites Contracts of Insurance in Class 1 or Class 2, and those contracts constitute Long-Term Insurance contracts, the Insurer must not calculate an underwriting risk component in respect of those contracts but must instead calculate a Long-Term Insurance risk component as set out in section 4.12.

A4.10.3 The DFSA may, on written application by an Insurer undertaking business in Class 2, give consent in writing to the use of percentages other than those stated in item A4.10.1(a), if the DFSA 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 18% in the case of non-proportional or facultative reinsurance.

A4.10.4 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 A4.10.1 in respect of Class 5, 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 underwriting risk component.

A4.10.5 For the purposes of Rule A4.10.4, 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.

A4.10.6 For the purposes of this section, and subject to Rule A4.10.8, the Insurer's base premium means the higher of the two following amounts:

(a) the amount of the Insurer's Net Written Premium during the reference period; and

(b) 50% of the amount of the Insurer's Gross Written Premium during the reference period.

A4.10.7 In Rule A4.10.6, 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 A4.10.6 must be the forecast Net Written Premium and Gross Written Premium for that second reporting period.

A4.10.8 Where an Insurer enters, as Insurer or cedant, into a General Insurance contract of longer than twelve 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 DFSA.

A4.10.9 Where an Insurer enters as reinsurer into a finite risk reinsurance contract in respect of General Insurance Business, the underwriting risk component in respect of that contract, regardless of the Class of Business it relates to, must be 4% of the base premium on the contract.

Guidance

Deleted

A4.11 Reserving risk component

Guidance

The purpose of the reserving risk component of the Minimum Capital Requirement is to require an Insurer to set aside capital to address the risk that the cost of claims in respect of General Insurance Business will vary from the amounts recorded as liabilities in the Insurer's balance sheet. This calculation applies only to liabilities in respect of outstanding claims (the risk of deterioration in Premium Liability is addressed in the underwriting risk component in section A4.10). The principles of the calculation are similar to those in section A4.10.

A4.11.1 Subject to the other provisions of this section, an Insurer must calculate its reserving risk component as the sum of the amounts obtained by multiplying the Insurer's base claims reserve under Contracts of Insurance and reinsurance effected by it, for each Class of Business, by the percentage factors set out in the following table.

Class of business		Percentage factor		
		Direct insurance	Proportional reinsurance	Non-proportional and facultative reinsurance
(a)	Classes 1 and 2	28	28	28
(b)	Class 3	12	12	12
(c)	Class 4	16	16	16
(d)	Class 5	22	22	22
(e)	Class 6	10	10	10
(f)	Classes 7(a) and 7(b)	31.25	31.25	31.25
(g)	Class 8	28	28	28

A4.11.2 Where an Insurer underwrites Contracts of Insurance in Class 1 or Class 2, and those contracts constitute Long-Term Insurance contracts, the Insurer must not calculate a reserving risk component in respect of those contracts but must instead calculate a Long-Term Insurance risk component as set out in section A4.12.

A4.11.3 The DFSA may, on written application by an Insurer undertaking Insurance Business in Class 2, give consent in writing to the use of percentages other than those stated in Rule A4.11.1(a), if the DFSA 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 5%.

A4.11.4 For the purposes of Rule A4.11.1, the Insurer's base claims reserve 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; and

(b) 50% of the amount of the Insurer's provision for Gross Outstanding Claims.

A4.11.5 Where an Insurer has entered as reinsurer into a finite risk reinsurance contract, the reserving risk component in respect of that contract, regardless of the class of business it relates to, must be 6% of the base claims reserve on the contract.

Guidance

Deleted

A4.12 Long-term insurance risk component

Guidance

1. The purpose of the Long-Term Insurance risk component of the Minimum Capital Requirement 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.

2. The calculation model set out in Rule A4.12.1 deals separately with Direct Long-Term Insurance Business, with proportional and non-proportional reinsurance of Long-Term Insurance Business, and with finite risk reinsurance of Long-Term Insurance Business.

3. To determine the amount for proportional reinsurance business, the calculation model applies ratios to the Insurer's premium, to its liability and to the capital at risk in respect of such business. To determine the amount for non-proportional reinsurance, a ratio is applied to the Insurer's non-proportional reinsurance premium. To determine the amount for finite risk reinsurance, ratios are applied to the balance outstanding on contracts, depending on the rating of the Insurer and the term to completion. To determine the amount for Direct Long-Term Insurance Business, the calculation model applies ratios to the Insurer's liability and to its capital at risk in respect of such business. Additional or alternative charges are made in respect of particular Classes of Business.

A4.12.1 An Insurer must calculate its Long-Term Insurance risk component as the sum of the proportional reinsurance element determined in accordance with Rule A4.12.3, the non-proportional reinsurance element determined in accordance with Rule A4.12.4, the finite risk reinsurance element determined in accordance with Rule A4.12.5 and the Direct Long-Term Insurance element determined in accordance with Rule A4.12.8.

A4.12.2 In Rules A4.12.3, A4.12.4 and A4.12.8:

(a) contracts of finite risk reinsurance must be excluded from the calculation of the proportional reinsurance element and the non-proportional reinsurance element;

(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 contracts of Long-Term Insurance 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.

A4.12.3 The proportional reinsurance element is calculated as the sum of the following six amounts, so far only as they relate to proportional reinsurance business of the Insurer:

(a) 2% of the amount of the Insurer's Net Written Premium;

(b) 3% 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 Rule (5)
(a) less than $500 million	0.20% of the amount of capital at risk
(b) over $500 million up to $5 billion	0.13% of the amount of capital at risk, plus $350,000
(c) over $5 billion up to $25 billion	0.10% of the amount of capital at risk, plus $1,850,000
(d) over $25 billion	0.08% of the amount of capital at risk, plus $6,850,000.

A4.12.4 The non-proportional reinsurance element is calculated as 52% of the Insurer's Net Written Premium.

A4.12.5 The finite risk reinsurance element is determined as the sum of the following three amounts:

(a) subject to Rule A4.12.7, the sum of the amounts obtained by applying, to the amount outstanding in respect of each cedant, the percentages set out in Rule A4.4.1(a)(i) 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 A4.5.1, as though the amount outstanding were a bond; and

(c) 2.25% of the amount outstanding.

A4.12.6 In Rule A4.12.5, 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.

A4.12.7 For the purposes of Rule A4.12.5 (b), Rules A4.4.4, A4.4.5 and A4.4.6 apply mutatis mutandis to the amount outstanding.

A4.12.8 An Insurer who carries on Direct Long-Term Insurance Business through a branch located outside the DIFC must calculate the Direct Long-Term Insurance Business element of its Long-Term Insurance risk component as the aggregate of the following, in respect of those contracts:

(a) the following proportions of provisions in respect of Long-Term Insurance Business:

(i) in the case of Class I, Class II, and Class VI, 4%;

(ii) in the case of Class III and Class VII, where the Insurer bears investment risk, 4%; and

(iii) in the case of Class III, where the Insurer bears no investment risk but the allocation to cover management expenses is fixed for more than five years, 1%;

(b) in the case of all contracts where the Insurer bears a death risk under the contract, the following percentage of capital at risk, subject to a maximum reduction for reinsurance of 50%:

(i) where the contract is term assurance of not more than three years, 0.1%;

(ii) where the contract is term assurance of between three and five years, 0.15%; and

(iii) in all other cases, 0.3%;

(c) in the case of Class III, where the Insurer bears no investment risk and the allocation to cover management expenses is not fixed for more than five years, 25% of the Insurer's net administrative expenses in the past financial year pertaining to such business;

(d) in the case of Class IV, the higher of:

(i) 18% of Gross Written Premium, reducing to 16% for the amount of Gross Written Premium in excess of $50 million, and subject to a maximum reduction for reinsurance of 50%; and

(ii) 26% of the average gross claims incurred over the three preceding financial years, reducing to 23% for the amount of that average in excess of $35 million, and subject to a maximum reduction for reinsurance of 50%; and

(e) in the case of Class V, 1% of the assets of the tontine;

A4.13 Asset management risk component

Guidance

This section requires an Insurer to set aside capital in respect of assets that it manages. The circumstances under which an Insurer may conduct asset management activities are restricted by COB.

A4.13.1 An Insurer must calculate its asset management risk component as 0.5% of the market value of assets managed by it.

A4.13.2 Assets that are recognised as assets of the Insurer in accordance with generally accepted accounting principles are not assets managed by it.

APP5 CALCULATION OF ADJUSTED NON-CELLULAR CAPITAL RESOURCES AND ADJUSTED CELLULAR CAPITAL RESOURCES

A5.1 Purpose and general provisions

A5.1.1 This appendix applies to all Insurers to which section 4.4 applies.

Guidance

1. This appendix sets out the manner in which an Insurer that is a Protected Cell Company is required to calculate its Adjusted Non-Cellular Capital Resources and the Adjusted Cellular Capital Resources applicable to each Cell. The calculation is in each case analogous to that applicable to Insurers that are not Protected Cell Companies, so that (except where changes are necessary to reflect structural differences) the capital of each Cell, and of the non-cellular portion of the Insurer, is determined as though it was an Insurer subject to App3.

2. The Adjusted Non-Cellular Capital Resources and Adjusted Cellular Capital Resources are calculated by making adjustments to the non-cellular equity of the Insurer or cellular equity of the Cell, as at the Solvency Reference Date.

3. Provisions in respect of adjusted non-cellular capital resources are set out in sections A5.2 to A5.5. Provisions in respect of adjusted cellular capital resources are set out in sections A5.6 to A5.10.

A5.2 Adjusted non-cellular capital resources

A5.2.1 An Insurer must calculate its Adjusted Non-Cellular Capital Resources according to the formula:

ANCR = ANE – HNCA

where:

ANCR means the Insurer's Adjusted Non-Cellular Capital Resources;

ANE means the Insurer's adjusted non-cellular equity; and

HNCA means the Insurer's hybrid non-cellular capital adjustment.

A5.2.2 Adjusted non-cellular equity is calculated as set out in section A5.4. The hybrid non-cellular capital adjustment is set out in section A5.5

A5.3 Base non-cellular capital

Guidance

The commencement point for calculating an Insurer's adjusted non-cellular equity is the Insurer's base non-cellular capital.

A5.3.1 Subject to Rules A5.3.2 and A5.3.3, an Insurer's base non-cellular capital consists of the following capital instruments and equity reserves of the Insurer:

(a) paid-up ordinary shares, except for shares referred to in Rule A5.5.1(3);

(b) general reserves;

(c) retained earnings;

(d) current year's earnings after tax; and

(e) hybrid non-cellular capital (as defined in Rule A5.5.1).

A5.3.2 All Cell Share Capital and any capital instruments or equity reserves of the Insurer that are attributable to a Cell must be excluded from base non-cellular capital.

A5.3.3 Hybrid non-cellular capital having a term to maturity of less than five years may only be included in base non-cellular capital with the written consent of the DFSA.

A5.4 Adjusted non-cellular equity

A5.4.1 An Insurer must calculate its adjusted non-cellular equity by adding items to and deducting them from its base non-cellular capital, as set out in this section.

Guidance

1. The purpose of these adjustments is to provide a consistent basis for the determination of the Insurer's Adjusted Non-Cellular Capital Resources and to exclude from those resources assets that may not be readily realisable for the purposes of meeting any Non-Cellular Liabilities of the Insurer.

2. A Takaful Insurer may not count as non-cellular capital amounts loaned to Insurance Funds that are attributable to Cells, as those amounts will be counted towards base cellular capital of the Cells concerned.

A5.4.2 The following items must be added to base non-cellular capital, to the extent that the Insurer has excluded them in determining its base non-cellular capital:

(a) any minority interests in companies that are Subsidiaries of the Insurer, where the Insurer's interest in those companies constitutes a Non-Cellular Asset of the Insurer; and

(b) any amount in respect of dividends to be paid by the Insurer in the form of shares other than Cell Shares.

A5.4.3 The following items must be deducted from base non-cellular capital, to the extent that the Insurer has not excluded them in determining its base non-cellular capital, or has added them to base non-cellular capital under Rule A5.4.2:

(a) any amounts in respect of appropriations to be made from profit in respect of the reporting period most recently ended, including dividends, bonuses, pensions and welfare charges that are determined on the basis of the profit of that reporting period, whether or not the amounts have been approved by the Insurer for payment;

(b) Owners' Equity in a Takaful Insurer that does not, under the constitutional documents of the Insurer or the terms of insurance contracts or both, participate in the surpluses and losses of Takaful business;

(c) the amount of any investment by the Insurer or by a Subsidiary of the Insurer, in the Insurer's own shares;

(d) the amount of any tax liability that would be attributable to unrealised gains on investments, if those gains were realised;

(e) the amount of any deferred tax asset;

(f) the amount of any goodwill, patents, service rights, brands and any other intangible items;

(g) in a Takaful Insurer, the amount of any loan made from the Owners' Equity to an Insurance Fund that is attributable to a Cell, that has not been repaid as at the Solvency Reference Date;

(h) the amount of any Zakah or charity fund of a Takaful Insurer;

(i) the amount of any operating assets, including inventories, plant and equipment, and vehicles; and

(j) the amount of any other assets that may not be applied to meet Non-Cellular Liabilities of the Insurer.

A5.5 Hybrid non-cellular capital adjustment

Guidance

1. This section acts to limit hybrid non-cellular capital to 15% of an Insurer's adjusted non-cellular equity.

2. The purpose of the hybrid non-cellular capital adjustment is to limit the extent to which an Insurer may rely for its Adjusted Non-Cellular Capital Resources on instruments that do not or may not constitute permanent capital of the Insurer. Such instruments include share capital contributed by a Holding Company, where the Holding Company's investment is financed by debt rather than by its own capital.

A5.5.1 Subject to Rule A5.5.2, hybrid non-cellular capital includes the following items:

(a) subordinated debt;

(b) preference shares; and

(c) ordinary shares issued by an Insurer to a Holding Company whose own paid-up ordinary share capital, taken together with its general reserves, is lower than that of the Insurer.

A5.5.2 Hybrid non-cellular capital excludes any instrument that is attributable to a Cell.

A5.5.3 Subject to Rule A5.5.4, an Insurer must calculate its hybrid non-cellular capital adjustment as the amount by which the total amount of hybrid non-cellular capital exceeds 15% of adjusted non-cellular equity.

A5.5.4 The DFSA may at its discretion and on the application of an Insurer, permit that Insurer to apply Rule A5.5.3 as though the figure of 15% was replaced with a higher figure approved in writing by the DFSA. The approved figure may not be more than the actual percentage which the hybrid non-cellular capital represents of adjusted non-cellular equity, and may not in any case exceed 30%.

A5.6 Adjusted cellular capital resources

A5.6.1 An Insurer must calculate the Adjusted Cellular Capital Resources in respect of a Cell according to the formula:

ACCR = ACE +CCA – HCCA

where, in respect of that Cell:

ACCR means the Adjusted Cellular Capital Resources;

ACE means the adjusted cellular equity

CCA means the non-cellular capital adjustment; and

HCCA means the hybrid cellular capital adjustment.

A5.6.2 Adjusted cellular equity is calculated as set out in section A5.8. The non-cellular capital adjustment is determined as set out in section A5.9. The hybrid non-cellular capital adjustment is set out in section A5.10.

A5.7 Base cellular capital

Guidance

The commencement point for calculating the adjusted cellular equity in respect of a Cell is the base cellular capital in respect of that Cell.

A5.7.1 Subject to Rules A5.7.3 and A5.7.4, the base cellular capital in respect of a Cell consists of the following capital instruments and equity reserves that are attributable to that Cell:

(a) paid-up Cell Shares, except for shares referred to in Rule A5.10.1(d);

(b) general reserves;

(c) in the Insurance Fund of a Takaful Insurer, where the Insurance Fund is attributable to the Cell, amounts provided from the Owners' Equity by loan to the Insurance Fund and not repaid as at the Solvency Reference Date;

(d) retained earnings;

(e) current year's earnings after tax; and

(f) hybrid cellular capital (as defined in Rule A5.10.1).

A5.7.2 Owners' Equity in a Takaful Insurer other than amounts referred to in Rule A5.7.1(c) must be classified as hybrid capital for the purposes of this section if:

(a) under the constitutional documents of the Insurer or the terms of insurance contracts or both, participation in the surpluses and losses of Takaful business is limited to the policyholders of the Insurer; and

(b) the Owners' Equity is available for loan to the Insurance Fund of the Insurer.

A5.7.3 Hybrid cellular capital having a term to maturity of less than five years may only be included in base cellular capital with the consent of the DFSA.

A5.8 Adjusted cellular equity

A5.8.1 An Insurer must calculate its adjusted cellular equity in respect of each Cell by adding items to and deducting them from the base cellular capital of that Cell, as set out in this section.

Guidance

The purpose of these adjustments is to provide a consistent basis for the determination of the Adjusted Cellular Capital Resources in respect of a Cell and to exclude from those resources assets that may not be readily realisable for the purposes of meeting any Cellular Liabilities of that Cell.

A5.8.2 The following items must be added to base cellular capital, to the extent that the Insurer has excluded them in determining base cellular capital:

(a) any minority interests in companies that are Subsidiaries of the Insurer, where the Insurer's interest in those companies constitutes a Cellular Asset of that Cell; and

(b) any amount in respect of dividends to be paid by the Insurer in the form of Cell Shares of that Cell.

A5.8.3 The following items must be deducted from base cellular capital, to the extent that the Insurer has not excluded them in determining base cellular capital, or has added them to base cellular capital under Rule A5.8.2:

(a) any amounts in respect of appropriations to be made from profit of the Cell in respect of the reporting period most recently ended, including dividends, bonuses, pensions and welfare charges that are determined on the basis of the profit of that reporting period, whether or not the amounts have been approved by the Insurer for payment;

(b) Owners' Equity in a Takaful Insurer that does not, under the constitutional documents of the Insurer or the terms of insurance contracts or both, participate in the surpluses and losses of Takaful business;

(c) the amount of any investment by the Insurer or by a Subsidiary of the Insurer, in the Insurer's own shares, where that investment or the Subsidiary concerned is a Cellular Asset;

(d) the amount of any tax liability that would be attributable to unrealised gains on investments that are Cellular Assets, if those gains were realised;

(e) the amount of deferred acquisition costs that are Cellular Assets;

(f) the amount of any deferred tax asset that is a Cellular Asset;

(g) the amount of any Cellular Asset representing the value of in-force Long-Term Insurance Business of the Insurer;

(h) the amount of any goodwill, patents, service rights, brands and any other intangible items that are Cellular Assets;

(i) the amount of any Zakah or charity fund of a Takaful Insurer;

(j) the amount of any operating assets, including inventories, plant and equipment, and vehicles, that are Cellular Assets; and

(k) the amount of any other Cellular Assets that may not be applied to meet Cellular Liabilities of that Cell.

A5.8.4 Rule A5.8.3(l) does not require an Insurer to exclude Cellular Assets attributable to a Long-Term Insurance Fund maintained by the Insurer.

A5.9 Non-cellular capital adjustment

A5.9.1 Where an Insurer that is a Protected Cell Company is organised such that Non-Cellular Assets may be used to meet Cellular Liabilities of a Cell, the Insurer may determine a non-cellular capital adjustment in respect of that Cell.

Guidance

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

A5.9.2 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 Adjusted Non-Cellular Capital Resources; 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 Adjusted Non-Cellular Capital Resources.

A5.10 Hybrid cellular capital adjustment

Guidance

1. This section acts to limit hybrid cellular capital to 15% of an Insurer's adjusted cellular equity in respect of a Cell.

2. The purpose of the hybrid cellular capital adjustment is to limit the extent to which an Insurer may rely for its Adjusted Cellular Capital Resources in respect of a Cell on instruments that do not or may not constitute permanent capital of that Cell. Such instruments include share capital contributed by an investor where the investor's investment in the Cell is financed by debt rather than by the investor's own capital.

A5.10.1 Subject to Rule A5.10.2, hybrid cellular capital includes the following items:

(a) subordinated debt;

(b) preference shares;

(c) Owners' Equity in a Takaful Insurer, of the type described in Rule A5.7.2; and

(d) Cell shares issued by a Cell to an investor who stands in the position of a Holding Company in relation to the Cell, and whose own paid-up ordinary share capital, taken together with its general reserves, is lower than that of the Cell.

A5.10.2 Hybrid cellular capital excludes any instrument that is not attributable to a Cell.

A5.10.3 Subject to Rule A5.10.4, an Insurer must calculate the hybrid cellular capital adjustment in respect of a Cell as the amount by which the total amount of hybrid cellular capital exceeds 15% of adjusted non-cellular equity.

A5.10.4 The DFSA may at its discretion and on the application of an Insurer, permit that Insurer to apply Rule A5.10.3 as though the figure of 15% was replaced with a higher figure approved in writing by the DFSA. The approved figure may not be more than the actual percentage which the hybrid cellular capital represents of adjusted cellular equity, and may not in any case exceed 30%.

APP6 CALCULATION OF MINIMUM NON-CELLULAR CAPITAL REQUIREMENT AND MINIMUM CELLULAR CAPITAL REQUIREMENT

A6.1 Purpose and general provisions

A6.1.1 This appendix applies to all Insurers to which section 4.4 applies.

A6.1.2 In this appendix, the term 'segment' includes both:

(a) a Cell of a Protected Cell Company; and

(b) the portion of a Protected Cell Company that is not a Cell; and the term 'segmental' is construed accordingly.

Guidance

1. This appendix sets out how an Insurer that is a Protected Cell Company is required to calculate its Minimum Non-Cellular Capital Requirement and the Minimum Cellular Capital Requirement applicable to each Cell.

2. The Minimum Non-Cellular Capital Requirement and the Minimum Cellular Capital Requirement are calculated on a basis that is analogous to the basis of calculation of the Minimum Capital Requirement for Insurers that are not Protected Cell Companies, as set out in App4. This appendix therefore incorporates references to the provisions of App4.

3. The calculation of the Minimum Non-Cellular Capital Requirement takes into account only Non-Cellular Assets and Non-Cellular liabilities, while the Minimum Cellular Capital Requirement in respect of a Cell takes into account only Cellular Assets of that Cell and Cellular Liabilities of the same Cell.

4. The methods of calculation for the Minimum Non-Cellular Capital Requirement and the Minimum Cellular Capital Requirement in respect of a Cell are identical, so the term Minimum Segmental Capital Requirement is used to refer to both. Similarly, the term 'segment' is used in this appendix to refer to both a Cell and the non-cellular part of an Insurer.

A6.2 Minimum segmental capital requirement

A6.2.1 Every Insurer must calculate its Minimum Non-Cellular Capital Requirement and the Minimum Cellular Capital Requirement applicable to each Cell, in accordance with this appendix.

A6.2.2 Subject to Rules A6.2.4, A6.2.5, and A6.2.6, an Insurer must calculate its Minimum Segmental Capital Requirement according to the formula:

MSCR = DRC + IVRC + OARC + OLRC + CRC + SFAC + URC + RRC + LIRC + AMRC

where:

Term	Definition
MSCR	Insurer's Minimum Segmental Capital Requirement;
DRC	Insurer's default risk component in respect of that segment;
IVRC	Insurer's investment volatility risk component in respect of that segment;
OARC	Insurer's off-balance sheet asset risk component in respect of that segment;
OLRC	Insurer's off-balance sheet liability risk component in respect of that segment;
CRC	Insurer's concentration risk component in respect of that segment;
SFAC	Insurer's size factor adjustment component in respect of that segment;
URC	Insurer's underwriting risk component in respect of that segment;
RRC	Insurer's reserving risk component in respect of that segment;
LIRC	Insurer's Long-Term Insurance risk component in respect of that segment;
AMRC	Insurer's asset management risk component in respect of that segment.

Guidance

Because of the provision in chapter 1 that all Insurance Business of an Insurer that is a Protected Cell Company must be conducted through its Cells, the URC, RRC and LIRC components will apply only to Cells.

A6.2.3 The methods of calculation of the components referred to in Rule A6.2.2 are set out in sections A6.4, A6.5, A6.6, A6.7, A6.8, A6.9, A6.10, A6.11, A6.12 and A6.13.

A6.2.4 An Insurer's Minimum Non-Cellular Capital Requirement must always be equal to or higher than US$ 50,000.

A6.2.5 The Minimum Cellular Capital Requirement in respect of a Cell must always be equal to or higher than US$ 50,000.

A6.2.6 Where the aggregate of the Minimum Segmental Capital Requirements of the segments of an Insurer, calculated in accordance with the formula set out in Rule A6.2.2 is less than US$ 250,000, the difference between that aggregate and US$ 250,000 must be added to the Minimum Non-Cellular Capital Requirement.

A6.3 Applicability of components to assets of the insurer

A6.3.1 Subject to Rules A6.3.2 and A6.3.3, an Insurer must calculate those components of a Minimum Segmental Capital Requirement that are relevant to assets, in respect of every asset that is attributable to that segment and that is available to meet liabilities attributable to that segment.

A6.3.2 Where an Insurer arranges its affairs such that Invested Assets attributable to a segment are held in a Related entity, the Insurer may, with the written approval of the DFSA, calculate components of the relevant Minimum Segmental Capital Requirement by reference to the Insurer's interest in the assets that are held by the Related entity, instead of by reference to the interest that the Insurer has in that Related entity. In that case this appendix shall be interpreted as though the assets (representing the Insurer's interest) held by the Related entity were held directly by the Insurer.

Guidance

The effect of Rule A6.3.2 is to provide flexibility for Insurers whose investments are managed on a pooled basis within a Group, or which establish specialist Subsidiaries to manage their investments. While the Insurer's asset in such cases is a balance with, or investment in, a Related entity, this Rule permits the Insurer to 'look through' the corporate arrangement and apply this appendix to the assets of the Related entity as though they were the Insurer's own.

A6.3.3 Where an Insurer that is a Protected Cell Company arranges its affairs such that the Invested Assets of a segment are held in another segment of the same Insurer, the Insurer may, with the written approval of the DFSA, calculate relevant components of its Minimum Segmental Capital Requirement in respect of the first segment, by reference to the segment's interest in the assets that are held by the second segment, instead of by reference to the interest that the first segment has in the second segment. In that case this appendix shall be interpreted as though the assets (representing the first segment's interest) held by the second segment were held directly by the first segment.

Guidance

1. The effect of Rule A6.3.3 is to extend the flexibility given by A6.3.2 to cover situations where one segment of an Insurer uses another segment of the same Insurer as a specialist investment entity.

2. Where Rule A6.3.3 is applied, the Insurer still needs to calculate the Minimum Segmental Capital Requirement for the specialist investment segment, in respect of the Invested Assets which the specialist investment segment owns. Two segments would therefore be required to hold capital in respect of those Invested Assets.

A6.4 Default risk component

Guidance

The purpose of the default risk component is to require an Insurer to set aside capital to cover the risk that amounts receivable from counterparties will not be received. The basic calculation model for this component, as it applies to Insurers that are not Protected Cell Companies, is set out in section A4.4. The provisions in this section apply this basic model to the segments of a Protected Cell Company.

A6.4.1 An Insurer must calculate the default risk component in respect of a segment as the sum of the amounts obtained by multiplying the value of each asset of the segment with the relevant percentage, in accordance with the following tables and subject to the provisions of Rules A6.4.2 and A6.4.3:

(a) assets that are Invested Assets: the table set out in Rule A4.4.1(a); and

(b) assets that are not Invested Assets: the table set out in Rule A4.4.1(b).

A6.4.2 The provisions of Rules A4.4.2, A4.4.3, A4.4.4, A4.4.5, and A4.4.6 must be applied, mutatis mutandis, to assets of a segment as though references in those Rules to an Insurer were instead references to a segment.

A6.4.3 Notwithstanding anything else in this section:

(a) the default risk component in respect of any asset that is subject to a fixed or floating charge, mortgage or other encumbrance must be 100% of the value of the asset to the extent of that charge, mortgage or encumbrance. In the case of such assets, the percentages set out in the tables referred to above must be applied only to the amount, if any, by which the value of the asset exceeds the amount of the charge, mortgage or encumbrance; and

(b) no default risk component must be calculated in respect of assets excluded from Adjusted Cellular Capital Resources or Adjusted Non-Cellular Capital Resources in accordance with Rules A5.4.3(e), A5.4.3(f), A5.4.3(i), A5.4.3(j), A5.8.3(e), A5.8.3(f), A5.8.3(g), A5.8.3(h), A5.8.3(k) or A5.8.3(l).

A6.5 Investment volatility risk component

Guidance

The purpose of the investment volatility risk component is to require an Insurer to set aside capital to cover the risk of deterioration in the values of Invested Assets. The basic calculation model for this component, as it applies to Insurers that are not Protected Cell Companies, is set out in section A4.5. The provisions in this section apply this basic model to the segments of a Protected Cell Company.

A6.5.1 An Insurer must calculate the investment volatility risk component in respect of a segment as the sum of the amounts obtained by multiplying the value of each Invested Asset attributable to the segment with the relevant percentage, in accordance with the table set out in Rule A4.5.1, but subject to the provisions of Rule A4.5.2.

A6.6 Off-balance sheet asset risk component

Guidance

The purpose of the off-balance sheet asset risk component is to require an Insurer to set aside capital to cover the risk of default and deterioration in value in respect of exposures that the Insurer has because it is a party to a derivative contract. The provisions in this section apply the basic provisions of section A4.6 to the segments of a Protected Cell Company.

A6.6.1 An Insurer is required to calculate an off-balance sheet asset risk component, if the Insurer is, as at the Solvency Reference Date, a party to a derivative contract, including a forward, future, swap, option or other similar contract, but not including:

(a) a put option serving as a guarantee;

(b) a foreign exchange contract having an original maturity of 14 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.

A6.6.2 An Insurer must calculate the off-balance sheet asset risk component in respect of a segment as the sum of the amounts obtained by applying the calculations set out in Rule A6.6.3 in respect of each derivative contract entered into by the Insurer in respect of that segment that meets the description in Rule A6.6.1.

A6.6.3 The amount in respect of a derivative contract is obtained by calculating, for an asset equivalent amount as determined in Rule A6.6.4, a default risk component as set out in section A6.4 and an investment volatility risk component as set out in section A6.5, as though the asset equivalent amount were a debt obligation due from the derivative counterparty.

A6.6.4 The asset equivalent amount in respect of a derivative is calculated as the sum of the current mark-to-market exposure of the derivative (where this is positive) and the amount obtained by multiplying the notional principal amount of the derivative by the factors specified in the table set out in Rule A4.6.4, according to the nature and residual maturity of the derivative.

A6.7 Off-balance sheet liability risk component

Guidance

1. The purpose of the off-balance sheet liability risk component is to require an Insurer to set aside capital to cover the risk that it will be required to perform on a guarantee, letter of credit or other credit substitute that it has entered into. 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. The provisions in this section apply the relevant provisions of section A4.7 to the segments of a Protected Cell Company.

2. Credit substitutes that are Contracts of Insurance are excluded from the calculation of this component, as they are subject to a separate capital requirement under section 4.5.

A6.7.1 An Insurer must calculate an off-balance sheet liability risk component in respect of a segment if the Insurer has issued guarantees, including put options serving as guarantees, letters of credit or any other credit substitute (other than an insurance contract) in favour of another party, so that the segment is exposed to the risk of having to make payment on those instruments should the guaranteed party default.

A6.7.2 An Insurer must calculate its off-balance sheet risk component as the sum of the amounts obtained by applying the calculations set out in Rule A6.7.3 in respect of each guarantee, letter of credit or other credit substitute.

A6.7.3 The amount in respect of a guarantee, letter of credit or other credit substitute (other than an insurance contract) is obtained by calculating, for the nominal amount of the guarantee, letter of credit or other credit substitute, a default risk component as set out in section A6.4 and an investment volatility risk component as set out in section A6.5 in respect of the obligation or asset over which the guarantee, letter of credit or other credit substitute is written, as though that obligation or asset were an obligation or asset of the Insurer.

A6.8 Concentration risk component

Guidance

The purpose of the concentration risk component is to require an Insurer to set aside 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 provisions in this section apply the relevant provisions of section A4.8 to the segments of a Protected Cell Company.

A6.8.1 An Insurer is required to calculate a concentration risk component in respect of a segment if the segment has, as at the Solvency Reference Date, an investment exposure to a single counterparty or group of Related counterparties, or to a single property, that exceeds 10% of the adjusted segmental capital resources.

A6.8.2 For the purposes of the calculation referred to in Rule A6.8.1:

(a) 'investment exposure' means the aggregate value of all equity, bond or other investments in or in respect of the counterparty or group of Related parties or property in question, together with off-balance sheet exposures to the same counterparty or group 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, but excluding any assets excluded from base cellular capital or base non-cellular capital by reason of any of the Rules referred to in Rule A6.4.3(b);

(b) 'adjusted segmental capital resources' in respect of a segment means Adjusted Cellular Capital Resources in respect of that segment (where the segment is a Cell) or the Insurer's Adjusted Non-Cellular Capital Resources (where the segment is not a Cell); and

(c) 'AAA'-Rated Governments and Government agencies are not counterparties.

A6.8.3 An Insurer must calculate its concentration risk component in respect of a segment as the sum of the amounts obtained by multiplying each investment exposure of that segment that exceeds 10% of the adjusted segmental capital resources, by the relevant factor percentage set out in the table set out in Rule A4.8.3, reading that table as though all references to Adjusted Capital Resources were references to adjusted segmental capital resources, and subject to Rule A6.8.4.

A6.8.4 If the concentration risk component in respect of an investment exposure of a segment, aggregated with the sum of the default risk, investment volatility risk and off-balance sheet asset risk components (so far as concerns that segment), 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.

A6.9 Size factor component

Guidance

The effect of the size factor component is to provide a relatively higher capital requirement in respect of segments with smaller portfolios of Invested Assets. The provisions in this section apply the relevant provisions of section A4.9 to the segments of a Protected Cell Company.

A6.9.1 The base figure for the size factor component is determined by aggregating the following components, for the segment:

(a) the aggregate of the default components determined in accordance with section A6.4, in respect of Invested Assets;

(b) the investment volatility risk component determined in accordance with section A6.5; and

(c) the concentration risk component determined in accordance with section A6.8.

A6.9.2 An Insurer must calculate the size factor component in respect of a segment by multiplying the base figure for that segment as determined in accordance with Rule A6.9.1 by the factor derived by applying the following formula, where x represents the total Invested Assets of the segment, expressed in millions of dollars:

(a) if $x \leq 100$, the factor is 1.5;

(b) if $100 < x \leq 200$, the factor is $(150 + 0.5(x-100))/x$;

(c) if $200 < x \leq 1{,}200$, the factor is $(200 – 0.2(x-200))/x$; and

(d) if $x > 1{,}200$, the factor is zero.

A6.10 Underwriting risk component

Guidance

1. The purpose of the underwriting risk component is to require an Insurer to set aside capital to address the risk that the cost of claims will vary from the cost implicit in the premiums being charged. The provisions in this section apply the relevant provisions of section A4.10 to the segments of a Protected Cell Company.

2. As Insurance Business in Protected Cell Companies may only be carried on through Cells, every Insurer will have an underwriting risk component of zero in respect of its Minimum Non-Cellular Capital Requirement.

A6.10.1 An Insurer must calculate the underwriting risk component in respect of a segment according to the method set out in section A4.10, applied as though all references in that section to an Insurer were instead references to that segment.

A6.11 Reserving risk component

Guidance

1. The purpose of the reserving risk component is to require an Insurer to set aside capital to address the risk that the cost of claims will vary from the amounts recorded as liabilities in the Insurer's balance sheet. This calculation applies only to liabilities in respect of outstanding claims (the risk of deterioration in Premium Liability is addressed in the underwriting risk component in section A6.10). The provisions in this section apply the relevant provisions of section A4.11 to the segments of a Protected Cell Company.

2. As Insurance Business in Protected Cell Companies may only be carried on through Cells, every Insurer will have a reserving risk component of zero in respect of its Minimum Non-Cellular Capital Requirement.

A6.11.1 An Insurer must calculate the reserving risk component in respect of a segment according to the method set out in section A4.11, applied as though all references in that section to an Insurer were instead references to that segment.

A6.12 Long-term insurance risk component

Guidance

1. 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. The provisions in this section apply the relevant provisions of section A4.12 to the segments of a Protected Cell Company.

2. As Insurance Business in Protected Cell Companies may only be carried on through Cells, every Insurer will have a Long-Term Insurance risk component of zero in respect of its Minimum Non-Cellular Capital Requirement.

A6.12.1 An Insurer must calculate the Long-Term Insurance risk component in respect of a segment according to the method set out in section A4.12, applied as though all references in that section to an Insurer were instead references to that segment.

A6.13 Asset management risk component

Guidance

This section requires an Insurer to set aside capital in respect of assets that it manages. This section applies the relevant provisions of section A4.13 to the segments of a Protected Cell Company.

A6.13.1 An Insurer must calculate the asset management risk component in respect of a segment according to the method set out in section A4.13, applied as though all references in that section to an Insurer were instead references to that segment.

APP7 CALCULATION OF ADJUSTED FUND CAPITAL RESOURCES

A7.1 Purpose and general provisions

A7.1.1 This appendix applies to all Insurers to which section 4.6 applies.

Guidance

1. This appendix sets out the manner in which an Insurer is required to calculate the Adjusted Fund Capital Resources in respect of each Long-Term Insurance Fund it maintains. The calculation is analogous to that applicable to Insurers other than Protected Cell Companies, so that (except where changes are necessary to reflect structural differences) the capital of a Long-Term Insurance Fund is determined as though it was an Insurer subject to App3.

2. The Adjusted Fund Capital Resources are calculated by making adjustments to the equity of the fund, as at the Solvency Reference Date.

A7.2 Adjusted fund capital resources

A7.2.1 An Insurer must calculate the Adjusted Fund Capital Resources in respect of each Long-Term Insurance Fund maintained by it, according to the formula:

AFCR = AFE – FHCA

where:

AFCR means the Adjusted Fund Capital Resources in respect of the fund;

AFE means the adjusted fund equity in respect of that fund; and

FHCA means the fund hybrid capital adjustment in respect of that fund.

A7.2.2 Adjusted fund equity is calculated as set out in section A7.4. The fund hybrid capital adjustment is set out in section A7.5.

A7.3 Base fund capital

A7.3.1 The commencement point for calculating the adjusted fund equity in respect of a Long-Term Insurance Fund maintained by an Insurer is the base fund capital.

A7.3.2 Subject to Rules A7.3.3, A7.3.4 and A7.3.5, the base fund capital in respect of a Long-Term Insurance Fund must consist of the following capital instruments and equity reserves of the Insurer, that are classified as capital instruments and equity reserves of the fund:

(a) general reserves;

(b) retained earnings;

(c) amounts attributed to the Long-Term Insurance Fund by the Insurer in accordance with Rule 3.4.2;

(d) in the case of a Takaful Insurer, amounts provided from the Owners' Equity by loan to the Insurance Fund and not repaid as at the Solvency Reference Date;

(e) current year's earnings after tax; and

(f) hybrid capital (as defined in Rule A7.5.1).

A7.3.3 Where an Insurer is not a DIFC Incorporated Insurer, base capital may include capital instruments and equity reserves that are approved in writing by the DFSA as equivalent to the capital instruments and equity reserves described in Rule A7.3.2.

A7.3.4 Owners' Equity in a Takaful Insurer, that has not been transferred to the Insurance Fund, must be classified as hybrid capital for the purposes of this section if:

(a) under the constitutional documents of the Insurer or the terms of insurance contracts or both, the owners do not participate in the surpluses and losses of Insurance Business; and

(b) the Owners' Equity is available for loan to the Insurance Fund maintained within the Long-Term Insurance Fund of the Insurer.

A7.3.5 Hybrid capital having a term to maturity of less than five years may only be included in base fund capital with the written consent of the DFSA.

A7.4 Adjusted fund equity

A7.4.1 An Insurer must calculate its adjusted fund equity in respect of each Long-Term Insurance Fund as set out in this section.

Guidance

The purpose of these adjustments is to provide a consistent basis for the determination of the Insurer's Adjusted Fund Capital Resources and to exclude from those resources assets that may not be readily realisable for the purposes of meeting Insurance Liabilities of the Long-Term Insurance Fund.

A7.4.2 The following items must be deducted from base fund capital, to the extent that the Insurer has not excluded them in determining its base fund capital:

(a) any amounts in respect of appropriations to be made from the Long-Term Insurance Fund in respect of the current year, including dividends, distributions by Takaful Insurers of surplus, bonuses, pensions and welfare charges that are determined on the basis of the current year's profit, whether or not the amounts have been approved by the Insurer for payment;

(b) the amount of any investment by the Long-Term Insurance Fund or by a Subsidiary of the Long-Term Insurance Fund, in the Insurer's own capital;

(c) the amount of any tax liability that would be attributable to unrealised gains on investments, if those gains were realised;

(d) the amount of deferred acquisition costs;

(e) the amount of any deferred tax asset;

(f) the amount of any goodwill, patents, service rights, brands and any other intangible items;

(g) the amount of any Zakah or charity fund of a Takaful Insurer, maintained within the Long-Term Insurance Fund;

(h) the amount of any operating assets, including inventories, plant and equipment, and vehicles; and

(i) the amount of any assets that may not be applied to meet Insurance Liabilities attributable to the Long-Term Insurance Fund (for example, assets that are subject to fixed or floating charges, mortgages or other security).

A7.5 Fund hybrid capital adjustment

Guidance

1. This section acts to limit hybrid capital to 15% of the adjusted fund equity in respect of a fund.

2. The purpose of the fund hybrid capital adjustment is to limit the extent to which an Insurer may rely for its Adjusted Fund Capital Resources in respect of any Long-Term Insurance Fund on instruments that do not or may not constitute permanent capital of that fund.

A7.5.1 Fund hybrid capital includes the following items:

(a) subordinated debt attributable to the fund; and

(b) Owners' Equity in a Takaful Insurer of the type described in Rule A7.3.4.

A7.5.2 Subject to Rule A7.5.3, an Insurer must calculate its fund hybrid capital adjustment as the amount by which the total amount of hybrid capital exceeds 15% of adjusted fund equity.

A7.5.3 The DFSA may at its discretion permit an Insurer to apply Rule A7.5.2 as though the figure of 15% was replaced with a higher figure approved in writing by the DFSA. The approved figure may not be more than the actual percentage which the fund hybrid capital represents of adjusted fund equity, and may not in any case exceed 30%.

APP8 CALCULATION OF MINIMUM FUND CAPITAL REQUIREMENT

A8.1 Purpose and general provisions

A8.1.1 This appendix applies to all Insurers to which section 4.6 applies.

Guidance

1. This appendix sets out the manner in which an Insurer that conducts Long-Term Insurance Business through a Long-Term Insurance Fund is required to calculate the Minimum Fund Capital Requirement in respect of each Long-Term Insurance Fund.

2. The Minimum Fund Capital Requirement is calculated on a basis that is analogous to the basis of calculation of the Minimum Capital Requirement for Insurers other than Protected Cell Companies, as set out in App4.

3. The effect therefore is as though each Long-Term Insurance Fund maintained by an Insurer were itself an Insurer that had to calculate a Minimum Capital Requirement in accordance with App4. Consequently, this appendix incorporates references to the provisions of App4.

A8.2 Minimum fund capital requirement

A8.2.1 Subject to Rule A8.2.3, an Insurer must calculate the Minimum Fund Capital Requirement in respect of each Long-Term Insurance Fund maintained by it, according to the formula:

MFCR = DRC + IVRC + OARC + OLRC + CRC + SFAC + LIRC + AMRC

where:

Term	Definition
MFCR	Minimum Fund Capital Requirement in respect of the fund;
DRC	Default risk component in respect of that fund;
IVRC	Investment volatility risk component in respect of the fund;
OARC	Off-balance sheet asset risk component in respect of the fund;
OLRC	Off-balance sheet liability risk component in respect of the fund;
CRC	Concentration risk component in respect of the fund;
SFAC	Size Factor Adjustment Component in respect of the fund;
LIRC	Long-Term Insurance risk component in respect of the fund; and
AMRC	Asset management risk component in respect of the fund.

A8.2.2 The methods of calculation of the components referred to in Rule A8.2.1 are set out in sections A8.4, A8.5, A8.6, A8.7, A8.8, A8.9, A8.10 and A8.11.

A8.2.3 The Minimum Fund Capital Requirement in respect of a Long-Term Insurance Fund must always be equal to or higher than $5,000,000.

A8.3 Applicability of components to assets of the fund

A8.3.1 Subject to Rule A8.3.2, an Insurer must calculate those components of the Minimum Fund Capital Requirement in respect of a Long-Term Insurance Fund, that are relevant to assets, in respect of every asset that is attributable to the Long-Term Insurance Fund.

A8.3.2 Where an Insurer arranges its affairs such that Invested Assets attributable to a Long-Term Insurance Fund are held in a Related entity, the Insurer may, with the written approval of the DFSA, calculate components of the Minimum Fund Capital Requirement by reference to the interest of the Long-Term Insurance Fund in the assets that are held by the Related entity, instead of by reference to the interest that the Long-Term Insurance Fund has in that Related entity. In that case this appendix shall be interpreted as though the assets (representing the Long-Term Insurance Fund's interest) held by the Related entity were held directly by the Long-Term Insurance Fund.

Guidance

The effect of Rule A8.3.2 is to provide flexibility for Insurers whose investments are managed on a pooled basis within a Group, or which establish specialist Subsidiaries to manage their investments. While the Insurer's asset in such cases is a balance with, or investment in, a Related entity, this Rule permits the Insurer to 'look through' the corporate arrangement and apply this appendix to the assets of the Related entity as though they were the Insurer's own. This flexibility extends to Invested Assets attributable to Long-Term Insurance Funds, though this provision does not provide any exemption from section 3.4 in respect of segregation of assets.

A8.4 Default risk component

Guidance

The purpose of the default risk component is to require an Insurer to set aside capital to cover the risk that amounts receivable from counterparties will not be received. The basic calculation model for this component, as it applies to Insurers that are not Protected Cell Companies, is set out in section A4.4. The provisions in this section apply the relevant provisions of section A4.4 to each Long-Term Insurance Fund that an Insurer maintains.

A8.4.1 An Insurer must calculate the default risk component in respect of a Long-Term Insurance Fund as the sum of the amounts obtained by multiplying the value of each asset attributed to the fund with the relevant percentage, in accordance with the following tables and subject to the provisions of Rules A8.4.2 and A8.4.3:

(a) assets that are Invested Assets: the table set out in Rule A4.4.1(a); and

(b) assets that are not Invested Assets: the table set out in Rule A4.4.1(b).

A8.4.2 The provisions of Rules A4.4.2, A4.4.3, A.4.4.4, A4.4.5 and A4.4.6 must be applied, mutatis mutandis, to assets attributed to a Long-Term Insurance Fund as though references in those Rules to an Insurer were instead references to a Long-Term Insurance Fund.

A8.4.3 Notwithstanding anything else in this section:

(a) the default risk component in respect of any asset that is subject to a fixed or floating charge, mortgage or other encumbrance must be 100% of the value of the asset to the extent of that charge, mortgage or encumbrance. In the case of such assets, the percentages set out in the tables referred to above must be applied only to the amount, if any, by which the value of the asset exceeds the amount of the charge, mortgage or encumbrance; and

(b) no default risk component must be calculated in respect of assets excluded from Adjusted Fund Capital Resources in accordance with Rules A7.4.2(d), A7.4.2(e), A7.4.2(f), A7.4.2(h), or A7.4.2(i).

A8.5 Investment volatility risk component

Guidance

The purpose of the investment volatility risk component is to require an Insurer to set aside capital to cover the risk of deterioration in the values of Invested Assets. The basic calculation model for this component, as it applies to Insurers that are not Protected Cell Companies, is set out in section A4.5. The provisions in this section apply the relevant provisions of section A4.5 to each Long-Term Insurance Fund that an Insurer maintains.

A8.5.1 An Insurer must calculate the investment volatility risk component in respect of a Long-Term Insurance Fund as the sum of the amounts obtained by multiplying the value of each Invested Asset attributable to the fund with the relevant percentage, in accordance with the table set out in Rule A4.5.1, but subject to the provisions of Rule A4.5.2.

A8.6 Off-balance sheet asset risk component

Guidance

The purpose of the off-balance sheet asset risk component is to require an Insurer to set aside capital to cover the risk of default and deterioration in value in respect of exposures that the Insurer has because it is a party to a derivative contract. The provisions in this section apply the relevant provisions of section A4.6 to each Long-Term Insurance Fund that an Insurer maintains.

A8.6.1 An Insurer is required to calculate an off-balance sheet asset risk component in respect of a Long-Term Insurance Fund, if the Insurer is, as at the Solvency Reference Date, a party to a derivative contract attributable to that fund, including a forward, future, swap, option or other similar contract, but not including:

(a) a put option serving as a guarantee;

(b) a foreign exchange contract having an original maturity of 14 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.

A8.6.2 An Insurer must calculate the off-balance sheet asset risk component in respect of a Long-Term Insurance Fund as the sum of the amounts obtained by applying the calculations set out in Rule A8.6.3 in respect of each derivative contract entered into by the Insurer and attributable to that fund, that meets the description in Rule A8.6.1.

A8.6.3 The amount in respect of a derivative contract is obtained by calculating, for an asset equivalent amount as determined in Rule A8.6.4, a default risk component as set out in section A8.4 and an investment volatility risk component as set out in section A8.5, as though the asset equivalent amount were a debt obligation due from the derivative counterparty.

A8.6.4 The asset equivalent amount in respect of a derivative is calculated as the sum of the current mark-to-market exposure of the derivative (where this is positive) and the amount obtained by multiplying the notional principal amount of the derivative by the factors specified in the table set out in Rule A4.6.4 according to the nature and residual maturity of the derivative.

A8.7 Off-balance sheet liability risk component

Guidance

The purpose of the off-balance sheet liability risk component is to require an Insurer to set aside capital to cover the risk that it will be required to perform on a guarantee, letter of credit or other credit substitute that it has entered into. 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. The provisions in this section apply the relevant provisions of section A4.7 to each Long-Term Insurance Fund that an Insurer maintains.

A8.7.1 An Insurer must calculate an off-balance sheet liability risk component in respect of a Long-Term Insurance Fund if the Insurer has issued guarantees, including put options serving as guarantees, letters of credit or any other credit substitute in favour of another party, so that the Long-Term Insurance Fund is exposed to the risk of having to make payment on those instruments should the guaranteed party default.

A8.7.2 An Insurer must calculate its off-balance sheet risk component as the sum of the amounts obtained by applying the calculations set out in Rule A8.7.3 in respect of each guarantee, letter of credit or other credit substitute.

A8.7.3 The amount in respect of a guarantee, letter of credit or other credit substitute is obtained by calculating, for the nominal amount of the guarantee, letter of credit or other credit substitute, a default risk component as set out in section A8.4 and an investment volatility risk component as set out in section A8.5 in respect of the obligation or asset over which the guarantee, letter of credit or other credit substitute is written, as though that obligation or asset were an obligation or asset of the Insurer.

A8.8 Concentration risk component

Guidance

The purpose of the concentration risk component is to require an Insurer to set aside 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 provisions in this section apply the relevant provisions of section A4.8 to each Long-Term Insurance Fund that an Insurer maintains.

A8.8.1 An Insurer is required to calculate a concentration risk component in respect of a Long-Term Insurance Fund if that fund has, as at the Solvency Reference Date, an investment exposure to a single counterparty or group of Related counterparties, or to a single property, that exceeds 10% of the Adjusted Fund Capital Resources.

A8.8.2 For the purposes of the calculation referred to in Rule A8.8.1:

(a) 'investment exposure' means the aggregate value of all equity, bond or other investments in or in respect of the counterparty or group of Related parties or property in question, together with off-balance sheet exposures to the same counterparty or group of Related counterparties or property that that fund has because the Insurer has issued guarantees, letters of credit or other credit substitutes (other than insurance contracts), or because it has entered into derivative contracts, but excluding any assets excluded from base fund capital in accordance with any of the Rules referred to in Rule A8.4.3(b); and

(b) 'AAA'-Rated Governments and Government agencies are not counterparties.

A8.8.3 An Insurer must calculate its concentration risk component in respect of a Long-Term Insurance Fund as the sum of the amounts obtained by multiplying each investment exposure of that fund that exceeds 10% of the adjusted segmental capital resources, by the relevant factor percentage set out in the table set out in Rule A4.8.3, reading that table as though all references to Adjusted Capital Resources were references to Adjusted Fund Capital Resources, and subject to Rule A8.8.4

A8.8.4 If the concentration risk component in respect of an investment exposure of a Long-Term Insurance Fund, aggregated with the sum of the default risk component, investment volatility risk component and off-balance sheet asset risk component (so far as concerns that fund), 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 three components in respect of that investment exposure is equal to 100% of that investment exposure.

A8.9 Size factor component

Guidance

The effect of the size factor component is to provide a relatively higher capital requirement in respect of Long-Term Insurance Funds with smaller portfolios of Invested Assets. The provisions in this section apply the relevant provisions of section A 4.9 to each Long-Term Insurance Fund that an Insurer maintains.

A8.9.1 The base figure for the size factor component is determined by aggregating the following components, for the Long-Term Insurance Fund:

(a) the aggregate of the default components determined in accordance with section A 8.4, in respect of Invested Assets;

(b) the investment volatility risk component determined in accordance with section A8.5; and

(c) the concentration risk component determined in accordance with section A 8.8.

A8.9.2 An Insurer must calculate the size factor component in respect of Long-Term Insurance Fund by multiplying the base figure for that fund as determined in accordance with Rule A8.9.1 by the factor derived by applying the following formula, where x represents the total Invested Assets attributable to that fund, expressed in millions of dollars:

(a) if $x \leq 100$, the factor is 1.5;

(b) if $100 < x \leq 200$, the factor is $(150 + 0.5(x-100))/x$;

(c) if $200 < x \leq 1{,}200$, the factor is $(200 – 0.2(x-200))/x$; and

(d) if $x > 1{,}200$, the factor is zero.

A8.10 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. The provisions in this section apply the relevant provisions of section A4.12 to each Long-Term Insurance Fund that an Insurer maintains.

A8.10.1 An Insurer must calculate the Long-Term Insurance risk component in respect of a Long-Term Insurance Fund according to the method set out in section A4.12, applied as though all references in that section to an Insurer were instead references to that fund.

A8.11 Asset management risk component

Guidance

This section requires an Insurer to set aside capital in respect of assets that it manages. The provisions in this section apply the relevant provisions of section A4.13 to each Long-Term Insurance Fund that an Insurer maintains.

A8.11.1 An Insurer must calculate the asset management risk component in respect of a Long-Term Insurance Fund according to the method set out in section A4.13, applied as though all references in that section to an Insurer were instead references to that fund.

APP9 CALCULATION OF DIFC BUSINESS RISK CAPITAL REQUIREMENT

A9.1 Purpose and general provisions

A9.1.1 This appendix applies to all Insurers to which section 4.7 applies.

Guidance

1. This appendix sets out the manner in which an Insurer that is not a DIFC Incorporated Insurer is required to calculate its DIFC Business Risk Capital Requirement. The basis of calculation is analogous to the basis of calculation of elements of the Minimum Capital Requirement for Insurers that are not Protected Cell Companies, as set out in App4.

2. The DIFC Business Risk Capital Requirement is calculated with reference to the insurance activities of the Insurer, carried out through its establishment in the DIFC, without deduction for reinsurances.

A9.2 DIFC business risk capital requirement

A9.2.1 An Insurer must calculate its DIFC Business Risk Capital Requirement as the sum of the Insurer's DIFC underwriting risk component, the Insurer's DIFC reserving risk component and the Insurer's DIFC Long-Term Insurance risk component.

A9.2.2 In calculating the DIFC Business Risk Capital Requirement:

(a) no account must be taken of Contracts of Insurance effected by the Insurer, other than through an establishment in the DIFC; and

(b) no account must be taken of contracts of reinsurance entered into by the Insurer as cedant, regardless of where those contracts of reinsurance were entered into.

A9.3 DIFC underwriting risk component

Guidance

The DIFC underwriting risk component requires an Insurer to demonstrate the availability of capital to address the risk that the cost of claims on Contracts of Insurance entered into as Insurer through an establishment in the DIFC will vary from the cost implicit in the premiums being charged.

A9.3.1 An Insurer must calculate its DIFC underwriting risk component according to the method set out in section A4.10, subject to the modifications set out in Rules A9.2.2(a) and (b).

A9.4 DIFC reserving risk component

Guidance

The DIFC reserving risk component requires an Insurer to demonstrate the availability of capital to address the risk that the cost of claims in respect of contracts entered into as Insurer through an establishment in the DIFC will vary from the amounts recorded as liabilities in the Insurer's balance sheet.

A9.4.1 An Insurer must calculate its DIFC reserving risk component according to the method set out in section A4.11, subject to the modifications set out in Rules 9.2.2(a) and (b).

A9.5 DIFC long-term insurance risk component

A9.5.1 An Insurer must calculate its DIFC Long-Term Insurance risk component according to the method set out in section A4.12, subject to the modifications set out in Rules 9.2.2(a) and (b).

APP10 REPORTING TO THE DFSA

A10.1 Purpose and general provisions

A10.1.1 This appendix applies to all Insurers.

A10.1.2 In this appendix and the forms, unless the term 'Annual Regulatory Return' or 'Quarterly Regulatory Return' is used, the term 'Return' includes both of those Returns.

Guidance

1. The form and content of the Returns differs according to the characteristics of the Insurer.
2. General requirements relating to the recognition and measurement of assets and liabilities are dealt with in PIN chapter 5.
3. The Returns are provided in PRU.
4. This appendix sets out some matters relating to content and presentation of the information contained in the Returns. Further guidance in relation to the preparation and submission of the Returns is provided in PRU and the DFSA's electronic prudential reporting system.

A10.2 Completion of forms for global, cell, fund and DIFC business reporting units

Guidance

Separate Returns are completed for Insurers' entire business, and for those parts of the business that are subject to separate capital adequacy requirements, namely Cells, Long-Term Insurance Funds, and DIFC business. These parts, and the entire business, are described as 'reporting units' because a Return is required for each. An Insurer may therefore have to submit more than one set of Returns.

A10.2.1 A Return must be completed in respect of each of the reporting units set out in this section that applies to the Insurer.

A10.2.2 There are four types of reporting units in respect of which an Insurer may be required to submit a Return. These are referred to in this appendix and the forms as the global reporting unit, the Cell reporting unit, the fund reporting unit and the DIFC business reporting unit. The Returns in respect of these reporting units are referred to respectively in this appendix and the forms as the Global Return, the Cell Return, the Fund Return and the DIFC Business Return.

A10.2.3 Every Insurer that is required by PIN chapter 6 to complete a Return must complete a Global Return. A Global Return has the following characteristics:

(a) Subject to (b), a Global Return includes all of the assets, liabilities, equity, revenues and expenses of the Insurer, regardless of the residency status or location of the Insurer, of the customer or of any asset or liability.

(b) The Global Return of a Protected Cell Company does not include any assets, liabilities, equity, revenues or expenses that are attributable to a Cell.

A10.2.4 Except as provided otherwise in this appendix, an Insurer that is a Protected Cell Company must complete a Cell Return in respect of each Cell that it maintains. A Cell Return includes all of the assets, liabilities, equity, revenues and expenses attributable to the Cell, regardless of the residency status or location of the customer or of any asset or liability. An Insurer to which this Rule applies is not required to complete a Quarterly Regulatory Return in respect of any Cells maintained by it that are Captive Cells.

A10.2.5 Except as provided otherwise in this appendix, an Insurer that maintains a Long-Term Insurance Fund must complete a Fund Return in respect of each Long-Term Insurance Fund that it maintains. A Fund Return includes all of the assets, liabilities, revenues and expenses attributable to the Fund, regardless of the residency status or location of the customer or of any asset or liability. An Insurer to which this Rule applies is not required to complete a Fund Return in the following cases:

(a) where the Insurer is deemed to constitute a single, Long-Term Insurance Fund, such that the information contained in the Fund Return would be identical to that in the Global Return; and

(b) where a Cell of the Insurer is deemed to constitute a single, Long-Term Insurance Fund, such that the information contained in the Fund Return would be identical to that in the Cell Return.

Guidance

A10.2.5 operates to prevent the preparation of duplicate Returns. However, where under this section an Insurer or a Cell is exempt from the requirement to prepare a Quarterly Regulatory Return because of its captive status, the Fund Quarterly Regulatory Return would not be identical and must still be prepared.

A10.2.6 An Insurer that is not a DIFC Incorporated Insurer must complete a DIFC Business Return. A DIFC Business Return has the following characteristics:

(a) it includes only liabilities that are Insurance Liabilities of the Insurer in respect of its DIFC Insurance Business and assets that are associated with those Insurance Liabilities; and

(b) revenues and expenses must be included only to the extent that they are attributable to the Insurer's DIFC Insurance Business.

Guidance

The assets that are associated with Insurance Liabilities normally include only reinsurance and other recoveries in respect of claims, whether or not incurred, included in Insurance Liabilities. The DIFC Business Return does not include assets such as investments, fixed assets, or receivables other than reinsurance recoveries in respect of Insurance Liabilities.

A10.3 Content of Returns

A10.3.1 The Annual Regulatory Return comprises the following forms, together with the Supplementary Notes pertaining to those forms and the Statement by Directors referred to in Rule A10.5:

(a) Form IN 10 (Statement of financial position);

(b) Form IN 20 (Statement of capital adequacy);

(c) Form IN 30 (Statement of financial performance);

(d) Form IN 40 (Statement of premium revenue and reinsurance expense);

(e) Form IN 50 (Statement of claims expense and recovery revenue);

(f) Form IN 60 (Statement of movements in insurance provisions);

(g) Form IN 70 (Statement of investment income);

(h) Form IN 80 (Statement of acquisition expenses);

(i) Form IN 90 (Reconciliation to financial statements);

(j) Form IN 100 (Summary statement of operations);

(k) Form IN 110 (Reconciliation of direct to total long-term insurance business);

(l) Form IN 120 (Statement of direct long-term insurance business);

(m) Form PIN 130 (Statement of direct long-term insurance liabilities);

(n) Form IN 140 (Statement of assets covering direct linked long-term insurance liabilities);

(o) Form IN 150 (Statement of assets covering direct non-linked long-term insurance liabilities and minimum capital requirements); and

(p) Form IN 160 (Calculation of direct long-term insurance element of long-term insurance risk component).

A10.3.2 The Quarterly Regulatory Return comprises the following forms, together with the Supplementary Notes pertaining to those forms and the Statement by Directors referred to in Rule A10.5:

(a) Form IN 10 (Statement of financial position);

(b) Form IN 20 (Statement of capital adequacy);

(c) Form IN 30 (Statement of financial performance); and

(d) Form IN 100 (Summary statement of operations).

A10.3.3 The forms referred to in Rule A10.3.1 and Rule A10.3.2 must be prepared for each reporting unit for which an Insurer is required to submit an Annual Regulatory Return or a Quarterly Regulatory Return as applicable, except where:

(a) this appendix, the instructional guidelines to the form set out in PRU or the DFSA's electronic prudential reporting system states that the form is not required for that reporting unit, or for that Insurer; or

(b) the form would contain no information, in which case the Insurer may omit the form and present a Supplementary Note stating that the form has not been prepared for that reason.

A10.3.4 The forms comprising the Returns are set out in PRU and the DFSA's electronic prudential reporting system.

A10.3.5 Items must be disclosed in the Returns in accordance with the instructional guidelines set out in PRU and the DFSA's electronic prudential reporting system, subject to the effects of other provisions of this appendix.

A10.3.6 Where an item is described in a Return as the result of a mathematical calculation, that mathematical calculation must be used to determine that item except where these Rules or the relevant instructional guidelines require otherwise.

Guidance

The Returns and instruction guidelines are provided in App10, PRU and the DFSA's electronic prudential reporting system.

A10.4 General provisions relating to the completion of forms

Guidance

Annual Regulatory Returns follow the cycle of the Insurer's normal statutory reporting, under the Companies Law 2004 in the DIFC and under equivalent legislation elsewhere. Quarterly Regulatory Returns are presented on a year to date basis at specified dates.

A10.4.1 Supplementary Notes must be presented in accordance with any instructions provided through the DFSA's electronic prudential reporting system or specified in PRU. Each Supplementary Note must identify the form to which it relates.

A10.4.2 Returns must be presented in the English language.

A10.4.3 A Return must be presented in United States currency, rounded to thousands of dollars, with no decimal place except where these Rules or the relevant instructional guidelines require otherwise.

A10.4.4 Where the format of a form requires the presentation of comparative information, the comparative information shall be presented according to the following principles:

(a) In the case of a form forming part of the Annual Regulatory Return, the comparative information shall be that presented in the Annual Regulatory Return for the previous reporting period.

(b) In the case of a form forming part of the Quarterly Regulatory Return, the comparative information shall be that presented in the Quarterly Regulatory Return for the corresponding quarter in the previous calendar year.

(c) Comparative information shall be presented unless:

(i) the Insurer did not exist at any time during the comparative period (whether or not it was an Insurer);

(ii) in the case of a Cell Return or a Fund Return, the Cell or Long-Term Insurance Fund to which the Return relates did not exist at any time during the comparative period; or

(iii) so far only as concerns the DIFC Business Return, in the case of an Insurer that is not a DIFC Incorporated Insurer, the Insurer was not at any time an Insurer during the comparative period.

(d) An Insurer that is required to present comparative information in a Return, and that was not required to prepare a Return in respect of the comparative period, must present comparative information that would have been presented in the Return covering the comparative period, if the Insurer had been required to prepare that Return.

(e) Comparative information shall not be changed from the time it was first presented, unless re-presentation is necessary for the interpretation of the Return. Where comparative information is changed, the Insurer must include in the Return a Supplementary Note showing the nature of the change and the reason for it.

A10.4.5 The Annual Regulatory Return, including the Statement by Directors, is subject to audit, except where this appendix or the form instruction guidelines states that a form is not subject to audit.

A10.4.6 Each page of the Statement by Directors must show:

(a) the words 'Annual Regulatory Return' or 'Quarterly Regulatory Return', as applicable;

(b) Deleted

(c) the Insurer's licence number;

(d) the Insurer's name;

(e) the reporting period to which the Return relates;

(f) whether the Return is a Global, Cell, Fund or DIFC Business Return; and

(g) where the return relates to a Cell or a Long-term Insurance Fund, sufficient information to identify the Cell or Long-term Insurance Fund in question.

A10.4.7 Where this appendix or the form requires information to be presented for different Classes of Business or for different types of insurance contract (for example, direct insurance, facultative reinsurance, proportional reinsurance treaty and non-proportional reinsurance treaty), an Insurer required to complete the form must present the relevant information in respect of all Classes of Business and types of contract, except under the following circumstances so far as concerns businesses other than Direct Long Term Insurance Business of a DIFC Incorporated Insurer:

(a) Where an item of numerical information in respect of a Class of Business for a type of insurance contract is less than two per cent of the total such numerical information in respect of all Classes of Business for that type of insurance contract, the Insurer may aggregate that numerical information for that Class of Business for that type of insurance contract with the same

item of information for the Class of Business for that type of contract in which that item of information is the largest.

(b) Where an item of numerical information in respect of a type of insurance contract for a Class of Business is less than two per cent of the total such numerical information in respect of all types of insurance contract for that Class of Business, the Insurer may aggregate that numerical information for that type of insurance contract for that Class of Business with the same item of information for the type of insurance contract for that Class of Business in which that item of information is the largest.

Guidance

This Rule establishes de minimis limits for an Insurer in respect of detailed numerical information presented by Class of Business or by type of insurance contract. These de minimis limits do not apply for Direct Long-Term Insurance Business carried on by a DIFC Incorporated Insurer. Amounts below the de minimis limits may be aggregated together with other items of information in the same line or column of a form. Insurers are not required to apply the sub-sections in the order that they are set out. However, Insurers should ensure that the Returns continue to comply with both sub-sections after applying either. It is possible that applying the second sub-section to be applied could affect compliance with the first.

A10.4.8 Where an Insurer arranges its affairs such that a Cell or Long-Term Insurance Fund maintained by it pays or receives income in the form of interest, dividends, rental, recharge of management expenses or other investment income, from another reporting unit of the Insurer, that income must be shown gross as an expense in the reporting unit bearing the expense, and as income in the reporting unit receiving the income. Where, however, the same reporting unit records the income and the expense, the two must be netted.

Guidance

This Rule establishes accounting policy in respect of transactions between reporting units. Internal recharges within an Insurer should be shown as such where they are external to a reporting unit of that Insurer. However, where a reporting unit (for example, the Global Return of an Insurer that is not a Protected Cell Company, and that maintains one or more Long-Term Insurance Funds) includes both 'sides' of the internal transaction, the internal transaction must be eliminated by netting the income and expense.

A10.5 Statement by directors

Guidance

1. The Statement by Directors forms a part of the Annual Regulatory Return or the Quarterly Regulatory Return. By providing these statements, the directors confirm that the Returns have been properly prepared and that the Insurer complies with applicable prudential rules.

2. The Statement by Directors is set out as statements that must be made, but circumstances may arise when a statement cannot be made because it would be untrue to do so. Under such circumstances this section provides for the directors to provide an explanation in place of the omitted statement.

A10.5.1 Every Return must include a Statement by Directors, in accordance with this section.

A10.5.2 The Statement by Directors forming part of the Annual Regulatory Return must state that:

(a) the Annual Regulatory Return has been prepared in accordance with the provisions of PIN chapter 6, this appendix, PRU chapter 3 and the DFSA's electronic prudential reporting system;

(b) proper Accounting Records have been maintained and adequate information obtained by the Insurer;

(c) appropriate systems and controls have been established and maintained by the Insurer over its transactions and records;

(d) the Insurer has complied with the provisions of PIN chapter 4 throughout the reporting period; and

(e) the Insurer complies, as at the date of the statement, with those provisions of PIN that are applicable to it.

A10.5.3 The Statement by Directors forming part of the Quarterly Regulatory Return must state that:

(a) the Quarterly Regulatory Return has been prepared in accordance with the provisions of PIN chapter 6, this appendix, PRU chapter 3 and the DFSA's electronic prudential reporting system; and

(b) the Insurer complies, as at the date of the statement, with those provisions of PIN that are applicable to it.

A10.5.4 If in the opinion of the directors it would be untrue to make one or more of the statements referred to in Rule A10.5.2 and Rule A10.5.3 the statements concerned must be omitted and the Insurer must instead state in a Supplementary Note that the directors are unable to make the statements in question, and must give the reasons for that inability.