Annex D

In this annex underlining indicates new text and striking through indicates deleted text.

The DFSA Rulebook

Prudential – Insurance Business Module

(PIN)

2 Management and control of risk

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~~**2.3.6** An Insurer must develop, implement and maintain a risk management system to identify and address Group risk, including but not limited to:~~

~~(a) risks associated with:~~

~~(i) its relationship with other members of its Group; and~~

~~(ii) the activities and adequacy of funding of other members of its Group; and~~

~~(b) risks associated with any Associates that the Insurer has.~~

~~**2.3.7** For the purposes of Rule 2.3.6, an Insurer may:~~

~~(a) take into account:~~

~~(i) its position within the Group,~~

~~(ii) the materiality of the risk to which it is exposed because of its membership of the Group, and~~

~~(iii) 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; and~~

~~(b) consider together Groups whose Holding Companies are all members of the same Group, except for any Group of which the Insurer is the Holding Company.~~

~~**Guidance**~~

~~The effect of Rule 2.3.7(b) is that, 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 Group as a whole for the purposes of this section. An Insurer that is a Holding Company is however still required to give specific consideration to the risks to which it is exposed as Holding Company.~~

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. ~~COB part 1 provides that Long-Term Insurance Business conducted by Insurers is limited to reinsurance.~~ COB Rule 2.2.2(1)(a) provides that Long-Term Insurance Business conducted by an Insurer in or from the DIFC is limited to reinsurance. However, this provision does not prevent a DIFC Incorporated Insurer from being able to effect or carry out Direct Long-Term Contracts of Insurance from an establishment outside the DIFC. Where an Insurer does so, it must comply with the requirements in this section relating to Direct Long-Term Insurance Business.

3. 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

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3.2.3

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Guidance

Because of the prohibition set out in COB part 1, Insurance ~~b~~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 not a DIFC Incorporated 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.

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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.

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

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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.

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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.

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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 4.5, in respect of Insurers carrying on Insurance Business of Class 7, 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.

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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~~3~~ 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.

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~~4.5 Insurers that undertake credit and surety insurance business~~

~~**4.5.1** This section applies only to Insurers that undertake Insurance Business in Class 7.~~

~~**4.5.2** An Insurer that undertakes Insurance Business in Class 7 must calculate a Class 7 Capital Requirement in respect of that business.~~

~~**4.5.3** An Insurer that is a Protected Cell Company that undertakes Insurance Business in Class 7 must calculate a Class 7 Capital Requirement in respect of every Cell to which such business is attributable.~~

~~**4.5.4** The Class 7 Capital Requirement must be calculated in accordance with principles notified to the Insurer by the DFSA.~~

~~**4.5.5** An Insurer intending to undertake Insurance Business in Class 7 must notify the DFSA in writing before commencing to undertake such business.~~

4.7 Availability of assets of insurers incorporated outside the DIFC

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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 amount determined by applying, in respect of any DIFC Insurance Business of the Insurer that is Class 7 Insurance Business, the principles referred to in Rule 4.5.4, taking no account of any reinsurance contracts entered into by the Insurer as cedant in respect of that business; and~~

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

5 MEASUREMENT OF ASSETS AND LIABILITIES OF INSURERS

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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**~~

~~GEN provides that Long-Term Insurance Business conducted by Insurers is limited to reinsurance.~~

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 ~~the premium on the underlying insurance contract is~~ they are due and receivable ~~by the cedant.~~

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 ~~the premium on the underlying insurance contract is due and receivable by the cedant~~ they are due and payable.

5.6.4 (1) Acquisition costs ~~Expenses~~ 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)~~(c)~~ 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);

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

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

~~(v)~~(vi) expenses, including commissions; and

~~(vi)~~(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.

5.7 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 ~~has an investment in an Authorised Firm or a Subsidiary or in an Associate that is subject to a regulatory requirement in the jurisdiction in which it is incorporated, obliging the Subsidiary or Associate to maintain a Minimum Capital Requirement or its equivalent,~~ is the Parent of a Financial Group, the value of the Insurer's investment in ~~the~~ any Subsidiary or Associate that is an Authorised Firm or a Financial Institution must be ~~reduced by the Insurer's proportionate share of the amount of that Minimum Capital Requirement or its equivalent~~ 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).

~~**5.7.3** In Rule 5.7.2, the Insurer's proportionate share of the Subsidiary's or Associate's Minimum Capital Requirement or equivalent means the amount of the Subsidiary's or Associate's Minimum Capital Requirement or equivalent, multiplied by the proportion of the Subsidiary's or Associate's total ownership rights that is held by the Insurer.~~

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.

6 FINANCIAL AND OTHER REPORTING BY INSURERS

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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 6.5.2 in the case of a report at the end of a reporting period; or

(b) the persons specified in Rule 6.5.5 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 PIN 17 in the Prudential Returns Module 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 at PRU 3.17 must be observed.

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

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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;

~~(a)~~(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;

~~(b)~~(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;

~~(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 Long-Term Insurance Liabilities as at the Reference Date;~~

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

~~(e) the assumptions used by the Actuary in the valuation process;~~

(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;

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

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

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

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

(j)(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.

8 CONSOLIDATED SUPERVISION

8.1 Introduction

8.1.1 This chapter applies to all Insurers, except for Rule 8.45.1 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. ~~An Insurer is exposed to risks through the relationships that it has with other insurance and non-insurance companies. This chapter requires an Insurer to provide the DFSA periodically with information relating to the structure and financial position of any Group of which it is a member, to assess significant related party transactions, and to notify certain transactions. Provisions in respect of management of Group risk are contained in chapter 2.~~

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

~~**8.1.2** In this chapter, the term '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.~~

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

8.2 Adequacy of capital resources of the group

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

8.2.2 An Insurer receiving a notice under Rule 8.2.1 shall have not less than three months to comply with the notice.

Guidance

An Insurer will normally be permitted to comply with a notice given under Rule 8.2.1 by presenting a copy of a statement, relating to the Group specified in the notice, made up in compliance with an equivalent or substantially equivalent regulatory requirement to which the Insurer or a Subsidiary or Associate of the Insurer is subject in a jurisdiction other than the DIFC. If that statement is not in English, the Insurer will be required to provide a certified translation of the statement into English.

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:

(i) its relationship with other members of its Group;

(ii) its membership in its Group; and

(iii) 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 described out in Rule A3.4.3(b) need not be made.

(3) For the purposes of (1)(b)(i) and (ii) 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~~3~~ Transactions within a group

8.4~~3~~.1 This section applies to all Insurers in respect of all transactions that are material.

Guidance

A single transaction or series of connected transactions that constitute a sale, purchase, exchange, loan or extension of credit, investment or guarantee involving one-half of one 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~~3~~.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.

8.54 Significant transactions other than group transactions

8.54.1 (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~~, as at the end of the reporting period immediately preceding 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~~, as at the end of the reporting period immediately preceding 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.

8.54.2 An Insurer must report to the DFSA all dividends and other distributions to shareholders within 15 business days following the declaration of the dividend or distribution.

8.54.3 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 15 business days of the date of declaration of the distribution.

8.54.4 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

9.4 Requirements for collateral for insurers in run-off

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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 ~~three~~ two amounts:

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

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

~~(iii) any Class 7 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 ~~three~~ two amounts:

(i) the Insurer's Insurance Liabilities; and

(ii) the Insurer's Minimum Capital Requirement; ~~and~~

~~(iii) any Class 7 Capital Requirement applicable to the Insurer;~~

(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).

App3 CALCULATION OF ADJUSTED CAPITAL RESOURCES

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A3.4 Adjusted equity

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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 Class 7 Capital Requirement to which the Insurer is subject;~~

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

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

App4 CALCULATION OF MINIMUM CAPITAL REQUIREMENT

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A4.2 Minimum capital requirement

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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, $ 100,000,000.~~

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

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A4.10 Underwriting risk component

A4.10.1

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(f) Classes 7(a) and 7(b)	90	90	140
(g~~f~~) Class 8	18	18	27

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A4.10.9

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~~**Guidance**~~
~~Provisions in respect of Class 7 are contained in section 4.5.~~

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A4.11 Reserving risk component

A4.11.1

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(f) Classes 7(a) and 7(b)	31.25	31.25	31.25
(gf) Class 87	28	28	28

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A4.11.5

~~**Guidance**~~
~~Provisions in respect of Class 7 are contained in section 4.5.~~

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. Because of the prohibition set out in COB Rule 2.2.2(1)(a)~~chapter 2~~, all Long-Term Insurance Business of an Insurer must be reinsurance, unless Direct Long-Term Insurance Business is carried on by a DIFC Incorporated Insurer from an establishment outside the DIFC.

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, ~~and~~ 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,~~ and~~ 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.

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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;

App5 CALCULATION OF ADJUSTED NON-CELLULAR CAPITAL RESOURCES AND ADJUSTED CELLULAR CAPITAL RESOURCES

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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 Class 7 Capital Requirement to which the Insurer is subject in respect of Class 7 Insurance Business of the Cell;~~

(j~~k~~) the amount of any operating assets, including inventories, plant and equipment, and vehicles, that are Cellular Assets; and

(k~~l~~) the amount of any other Cellular Assets that may not be applied to meet Cellular Liabilities of that Cell.

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App8 CALCULATION OF MINIMUM FUND CAPITAL REQUIREMENT

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A8.2.3 The Minimum Fund Capital Requirement in respect of a Long-Term Insurance Fund must always be equal to or higher than $~~10~~5,000,000.

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APP10 REPORTING TO THE DFSA

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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 of Directors referred to in section A10.5:

(a) Form 1: Statement of financial position;

(b) Form 2: Statement of capital adequacy;

(c) Form 3: Statement of financial performance;

(d) Form 4: Statement of premium revenue and reinsurance expense;

(e) Form 5: Statement of claims expense and recovery revenue;

(f) Form 6: Statement of movements in insurance provisions;

(g) Form 7: Statement of investment income;

(h) Form 8: Statement of acquisition expenses;

(i) Form 9: Reconciliation to financial statements.

(j) Form 11: Reconciliation of Direct to Total Long-Term Insurance Business;

(k) Form 12: Statement of Direct Long-Term Insurance Business;

(l) Form 13: Statement of Direct Long-Term Insurance Liabilities;

(m) Form 14: Statement of Assets Covering Direct Linked Long-Term Insurance Liabilities;

(n) Form 15: Statement of Assets Covering Direct Non-Linked Long-Term Insurance Liabilities and Minimum Capital Requirements;

(o) Form 16: Calculation of Direct Long-Term Insurance element of Long-Term Insurance Risk Component; and

(p) Form 17: Statement of Financial Group Capital Adequacy.

A10.3.2 The Quarterly Regulatory Return comprises the following forms, together with the Supplementary Notes pertaining to those forms and the Statement of Directors referred to in section A10.5:

(a) Form 1: Statement of financial position;

(b) Form 2: Statement of capital adequacy;

(c) Form 3: Statement of financial performance; and

(d) Form 10: Summary statement of operations

(e) Form 12: Statement of Direct Long-Term Insurance Business.

A10.3.3 The forms referred to in section A10.3.1 and section A10.3.2 must be prepared for each reporting unit for which an Insurer is required to complete an Annual Regulatory Return or a Quarterly Regulatory Return as applicable, except where:

(a) this appendix or the form 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.

A10.3.6 Where an item is described on the face of a form 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.

A10.4 General provisions relating to the completion of forms

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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.

....

A10.4.7 Where this appendix or the form requires information to be presented for different Classes of Business or for different types of insurance contract (~~that is~~ 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 section 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.