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DISCLOSURE DUTIES IN INSURANCE

BELGIAN REPORT*

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1. The Insured's Pre-Contractual Disclosure Duty

a. For reasons which should become clear from the answer to question 1, b (see hereafter), we have deemed it appropriate to answer this question 1, b) before turning to question 1, a.

b. Does your National Law impose upon the applicant/insured a duty to disclose information upon the applicant's own initiative?

1. In the well-known MAX-PLANCK comparative study on the insurance contract law of a number of European national systems (J. Basedow and T. Fock (eds.), *Europäisches Versicherungsrecht*, I, Mohr Siebeck, 2002) the authors could still maintain that "the spontaneous duty of declaration" was (at that time) the prevailing rule in a large number of EU Member States.

Things have changed. In an increasing number of national legislations the duty of spontaneous declaration has been abandoned and replaced by the method of the so-called "questionnaire", or at least has been softened, e.g. by putting upon the insurer a burden of proving the relevance of the information to be disclosed by the policyholder/insured (hereafter called "the applicant").

* For the purpose of the translation in English of the Belgian statutory texts on insurance contract law, the authors have gratefully made use of the translation of the Belgian Insurance Contract Act of 1992 (as amended by the Act of 16 March 1994), in *Commercial Laws of Europe*, 1994, I, pp. 55 ff.

The duty of disclosure was (and still is) based on the idea that there must be a balance between the premium and the risk. Under the traditional rule of spontaneous declaration, the (mistaken) assumption was that the applicant was best placed to know the risk and its relevant characteristics, and on the idea that the duty of good faith obliges the applicant to transmit a full and correct description of the risk to the insurer. In today's view such a system is deemed to put an unreasonable burden on the applicant, who most often is a layman in matters of risk, and in any event ill-placed to correctly assess the relevance of certain facts from the standpoint of the risk appreciation by the insurer.

2. However, the Belgian legislator remains faithful to the traditional rule, at least to its principle. He already did so at the time in the very first Insurance contract legislation of 11 June 1874 and, more remarkably, stuck to this view and principle when the insurance contract law – more exactly the law concerning non-marine insurance contracts – was fundamentally revised by the Non-marine Insurance Contract Act of 25 June 1992 (Loi sur les Contrats d'assurances terrestres).
Quite recently the Belgian legislator made an ambitious effort to set out a coordination and codification of a part of the insurance law, including the insurance contract law, in one global piece of legislation. The result is to be found in the Insurance Act of 4 April 2014 (hereafter cited as "Insurance Act of 2014") which in most of its provisions of Part 4 does not derogate from, but simply recasts, the corresponding articles of the Non-marine Insurance Contract Act of 1992. This Insurance Act of 2014 also recasts in its Part 5 the provisions of the Insurance Act of 1874 which still apply to marine and transport insurance contracts (with the exception of luggage insurance and moving insurance).
In the following answers, it is Part 4 of the Insurance Act of 2014 that will be referred to, unless stated otherwise.

3. The requirements of the duty to disclosure are now stated in Article 58 of the Insurance Act of 2014 (cfr. Article 5 of the Insurance Contract Act of 1992). The rule of this Article 58 is a general one and applies to all non-marine insurance contracts.

This general disclosure rule obliges the applicant *"to declare accurately, on conclusion of the contract, all circumstances known to him which he ought reasonably to consider as being material to the assessment of the risk by the insurer".*

However, Article 58 contains an (equally general) exception, stating in a short and categorical phrase, that *"genetic data shall not be disclosed"*. Belgian law indeed ranges among those countries which have taken a radical stand in this matter and the legislator has opted for a complete ban on the investigation, disclosure and communication of data relating to the genetic profile: insurers are not allowed to impose any genetic testing, nor are they allowed to ask for genetic data, or medical family history, and the applicants are not allowed to give such information, even when not asked for.

A second exception provides that the applicant *"need not to declare to the insurer circumstances already known to the latter or of which he ought reasonably to be aware"* (see answer to question 2).

This duty to disclosure is imposed only on the applicant/policyholder and not on the insured who is not the applicant/policyholder.

4. As regards work-related health insurance contracts, special rules apply to the situation where an insured individual loses the benefit of a preexisting (work-related) health insurance. Such person can, save in the case of fraud, require to be covered in a new health insurance contract (the so-called continuation of the existing policy) without having to undergo an additional medical examination, and without having to fill out a medical questionnaire (Article 208-211 of the Insurance Act of 2014). This is one of the rules which were introduced in 2007 to enhance the insurability of persons with a high(er) health risk profile and to organize a more redistributive solidarity in private health insurance.

a. Does your National Law impose a duty to answer questions put to the applicant/insured by the insurer?

The Insurance Act of 2014 obliges the applicant to spontaneously declare all relevant circumstances known to him (Article 58 Insurance Act of 2014, see answer on point b). Case law accepts that this obligation continues to exist, even when the insurer makes use of a questionnaire. In other words, the use of a questionnaire, even one which does not contain any default questions or open questions, does not relieve the applicant from declaring all the relevant information, even when not asked for. However, the inclusion of a question in the questionnaire is deemed to prove that the information that is asked for is considered by the insurer to be relevant to his risk assessment. This presumption implies that the applicant is thus obliged to answer all written questions. However, the Insurance Act of 2014 itself provides for an exception to the said presumption: where an applicant fails to answer a written question and the insurer proceeds nevertheless to the conclusion of the contract, the insurer may not subsequently rely on such omission, save in the case of fraud (Article 58, in fine, Insurance Act of 2014).

What happens when the answer to a written question is given by, or with the assistance of another person, like an insurance agent or a broker, his medical doctor or another "Hilfeperson"? In Belgium there is no explicit legal rule that deals with this question. Nonetheless, it is generally accepted that an insurance intermediary (broker or agent (!)) is not considered to be the representative of the insured except in the case where he is charged with a special mandate. Therefore it follows that the fact that a document has been filled in by a third person, does not relieve the policyholder from his own responsibility in carrying out his duty of disclosure. This is confirmed by the Belgian Cour de Cassation (Cass. 6 October 2011, Pasinomie 2011, 2145; RGAR 2012, 14881 in a case related to an insurance broker) and sustained by lower case law (see C. Van Schoubroeck, J. Amankwah, T. Meurs en N. Glibert, "Overzicht van rechtspraak Wet op de landverzekeringsovereenkomst (2004-2015)", *Tijdschrift voor Privaatrecht* 2016, 741-746).

2. Scope of the Applicant's Disclosure Duty – Subjective or Objective?

Is the applicant's disclosure duty limited to the applicant's actual knowledge or does it also include information which he or she should have been aware of?

As regards the scope of the applicant's duty of disclosure, we refer to the wording of Article 58 of the Insurance Act of 2014, cited above.
Three features of the scope of this duty appear from it and they deserve special attention.
Firstly, the applicant is only expected to give information about what he knows.
Under the earlier Insurance Act of 1874 a broader subjective scope was accepted. An authoritative older treatise expressed the rule as follows: *"Pour qu'il y ait réticence il faut donc que l'assuré connaisse le fait, ou tout au moins qu'il soit censé le connaître par lui-même ou par ses agents ou employés, c'est-à-dire, qu'on ne puisse lui faire grief de l'ignorer mais à condition cependant de ne point exiger de lui des recherches que l'on ne peut raisonnablement exiger"* (F. Monette, A. De Villé and R. André, *Traité des assurances terrestres*, Brussels, Bruylant, 1949, 444; H. COUSY and H. Claassens, "De verzwijging in verzekeringsovereenkomsten naar Belgisch recht", *Tijdschrift voor Privaatrecht*, 1984, 915, footnote 19).

It is generally accepted that this distinction between the actual knowledge and the subjective knowledge of what the policyholder should have been aware of, is not valid any more since the Insurance Contract Act of 1992 and under the current Article 58 of the Insurance Act of 214. Indeed, Article 58 clearly states that the applicant must only disclose what is known to him.

Secondly, the applicant has to disclose only those facts he ought reasonably to consider as constituting a basis for assessment of the risk by the insurer. The use of the term "reasonably" in Article 58 of the Insurance Act of 2014 indicates that an objective test must be applied: the question must be examined whether the average attentive and careful policyholder placed in the same circumstances would have considered that the (non- or false) disclosure would have an influence on the risk appreciation of the insurer. In some court cases it was for instance held that the applicant should be aware that his having constant pain should be of interest to the life insurer, or that his short length and high weight should be of interest to the health

insurer (possibly wanting to calculate the BMI), or that the identity of the usual driver of a car interests the motor vehicle liability insurer. As stated before, the fact that the insurer asks in a questionnaire for certain specific information creates an (almost) irrebuttable presumption that the information is relevant. In Belgium courts do not appear to attach special attention to moral factors like e.g. the past penal record of the policyholder. The disclosure of that kind of information is therefore subject to the general rules of relevancy, and such data must be disclosed if they ought reasonably to be considered as being relevant to the assessment of the risk to be insured, like for instance in case of a motor vehicle liability insurance, even if the insurer did not ask for it.

Thirdly, Article 58 of the Insurance Act of 2014 states expressly that the applicant need not declare to the insurer circumstances already known to the latter or of which the insure ought reasonably to be aware. The insurer is supposed to know all that common sense teaches us, but also the circumstances that the insurer is presumed to known in his capacity of a professional in judging matters of risk. An interesting question, to which so far no unanimous answer has been given, is whether the insurer can be supposed to know all the information that he could deduce from the applicant's file regarding a previous insurance contract or an insurance contract he concluded with the applicant with respect to a different insurance class. However, it is traditionally and generally accepted that all this does not imply that the insurer is expected to investigate the veracity and completeness of the applicant's declarations. The insurer must not verify the exactness of the declarations of the insured. But, in front of certain of these declarations, the insurer is expected to (re)act like a normal competent representative of his trade. It would however be excessive to expect any verification by the insurer.

3. The Insurer's Pre-Contractual Duties

a. Does your law impose on an insurer a pre-contractual duty to investigate the applicant's business in order to obtain the relevant information?

General comment

Under the impulse of changing EU regulation, the legislative and regulatory rules about the transfer of information, the publicity and transparency of documents and the (pre-

contractual) conduct of business by insurers and insurance intermediaries have been fundamentally changed and dramatically expanded.
The most striking change that has been operated by this new regulatory framework is a change in the direction of the information flow. Speaking in general terms, the flow of information was, under the traditional law, mainly one-directional, in the sense of moving from the policyholder/insured to the insurer. The new approach introduces information duties upon the insurance service providers (insurer and insurance intermediary), and also obliges them to take the initiative to obtain information from their clients. The role of the insurance service provider in gathering information becomes much more active, not to say proactive.

This development finds it ratio in the general tendency of economic law to better serve the interests of the consumer of professional services (penetration of the idea of consumer protection into the law of insurance), but also in a more general tendency of financial services law to impose upon the providers of such services more precisely a duty to serve the best interests of their clients, which implies the duty of information gathering and of information giving.

This evolution in financial services law has been highly accelerated by the financial crisis of 2008, which clearly revealed that customers, in particular with regard to investment services offered by banks and investment firms, were lacking sufficient and adequate information. Consequently, the European legislator introduced, modified and strengthened the information obligations and the rules of conduct of business imposed upon the services providers of those financial products, in particular in the so-called MiFID I and II Directives (Markets in Financial Instruments Directive) and the numerous delegated and implementing Acts.

Insurance providers do not fall under the scope of these MiFID-rules. The discussion whether and to what extent these rules that were originally conceived for the investment services market, had to be extended to insurance activities was settled at the EU level in the Regulation (EU) n° 1286/2014 of 26 November 2014 on key information documents for packaged retail and insurance-based investment products (PRIIPs), and the Insurance Distribution Directive of 20 January 2016 (IDD) (both of

which are and shall be further implemented by delegated and implementing Acts and Decisions).

With regard to Belgian law it must be highlighted that, with respect to the implementation of this EU legislation, Belgium has strived to be a good pupil in the class of the Member States, and has done so, either by making early, and even premature transposition of upcoming or proposed European legislation, and also by introducing into its national law rules and requirements that are further-reaching or more stringent than those imposed by EU law. It is for instance typical that the scope of application of these MiFID-rules is broader under Belgian law than it is under the EU rules, since indeed in Belgium they apply not only to non-life insurance but also to all the life insurance classes. Also, the process of "mifidisation of the insurance sector" was enacted in Belgium even before the EU legislator applied some MiFID-rules to certain insurance products. These further-reaching Belgian rules are referred to as "AssurMiFID" or "Twin Peaks II" [1]. It appears from the current parliamentary proceedings of transposition and implementation of the IDD into Belgian law (the deadline is 23 February 2018) that Belgian law will safeguard the "AssurMiFID"-*acquis* and thus remain also in the future more stringent than the present EU rules. This approach of the Belgian legislator, in particular his decision to extend the rules of conduct to non-life insurance, is criticized by the Belgian insurance sector (insurers and intermediaries).

a. Does your law impose on an insurer a pre-contractual duty to investigate the applicant's business in order to obtain the relevant information?

1. Being embedded in the view that the policyholder is under an obligation of spontaneous disclosure of the risk and that the insurer plays a passive role in the pre-contractual phase, the Belgian insurance contract law did so far not pay much attention to the pre-contractual investigation duties of the insurer.

[1] Belgian introduced the Twin Peaks supervision model in 2011 (referred to as Twin Peaks I). This implies that supervision of all the financial services providers (mainly insurance companies, banks and investment firms) is attributed to the National Bank of Belgium (prudential control) and the Financial Services and Markets Authority (FSMA) (conduct control and consumer protection); H. Cousy, "Le Secteur des Assurances sera-t-il mifidisé?", *Bulletin des Assurances*, 2009, 245-254.

However, since the beginning of the 21st century and under the influence of the developments in EU law, those more extensive pre-contractual investigation duties have been introduced in Belgian law via the new rules on insurance distribution. A distinction must be made according to the kind of insurance.

2. Regarding all insurance contracts.

Under these new rules the insurance intermediary but also the insurer who is distributing its products via direct selling, have to play a more active role in the gathering of information about the risk and about the applicant. They must make efforts to collect information about the applicant and about his needs and demands, and they are responsible for making sure that the product they offer or sell corresponds to these needs and demands (see b. hereafter).

This rule providing the obligation to collect information about the applicant and about his needs and demands was imposed by the EU Directive 2002/92/EC of 9 December 2002 on Insurance Mediation (IMD) (Article 12, 3-4). Recently, this rule has been recast in the recent Insurance Distribution Directive of 20 January 2016 (IDD). Where IDD differed from IMD is where the IDD enlarges its scope to all insurance distributors, i.e. intermediaries, but also direct selling by insurance companies (Articles 20, 1[2] and 22, 1 IDD). Since the IDD provides a minimum harmonisation, Member States can adopt stricter provisions regarding information requirements (Article 22, 2 IDD).

An interesting remark with regard to Belgian law is that already prior to the adoption of the IDD, Belgian law has imposed since 2006 this obligation to identify the demands and needs of the applicant also upon the insurance company distributing via direct selling and not only upon the insurance intermediary as was required by IMD (Article 12bis, §§3-4 of the Act of 27 March 1995; current Article 273, §3 Insurance Act of 2014), but also upon the insurer in case of direct selling (Article 12quinquies of the Act

[2] Article 20, 1 IDD: *"Prior to the conclusion of an insurance contract, the insurance distributor shall specify, on the basis of information obtained from the customer, the demands and the needs of that customer and shall provide the customer with objective information about the insurance product in a comprehensible form to allow that customer to make an informed decision. Any contract proposed shall be consistent with the customer's insurance demands and needs.*
Where advice is provided prior to the conclusion of any specific contract, the insurance distributor shall provide the customer with a personalised recommendation explaining why a particular product would best meet the customer's demands and needs".

of 27 March 1995; current article 276 Insurance Act of 2014). Be aware, however, that this obligation is (under EU as well as Belgian law) only mandatory in case the insurance contract concerned is covering mass risks and life insurance (Article 12, §4 IMD; Article 22, 1 IDD; Article 273, §4 Insurance Act of 2014 refer to "other than large risks").

This EU concept of mass risks encompasses non-life insurance risks which, because of their nature or because of the policyholder, are considered to be in need of special protection[3]. Insurance contracts concluded by consumers are in general considered to be mass risks, but also various insurance contracts concluded by small and medium sized companies (e.g. fire insurance, liability insurance, legal expenses insurance) fall under the scope of this concept. The underlying ratio of protection of consumers and small and medium sized companies is expressed in recitals 43 and 44 of the IDD.

3. Regarding savings and investment insurance products

Important for the subject of this paper is that when advice is given to non-professional clients about savings and investment insurance products, the intermediary or insurer in case of direct selling must obtain from his client or potential client information about the client's knowledge of the specific insurance product involved, about his financial situation, his savings and investment goals, in such a way as to enable the provider to offer a product that is suitable to the client. If the provider is unable to obtain the relevant information he should not give any recommendation.

If, in the same situation of insurance distribution concerning savings and investment insurances, no advice is given, the intermediary or insurer shall obtain at least information from the client about the client's knowledge and experience with the specific savings or investment insurance product, in such a way as to enable the

[3] With regard to non-life insurance classes, all risks which do not meet the criteria of a large risk are considered to be mass risks. To define a large risk, see Article 13, 27° EU Directive 2009/138/EC of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II): "a large risks means :
(a) risks classified under classes 4, 5, 6, 7, 11 and 12 in Part A of Annex I;
(b) risks classified under classes 14 and 15 in Part A of Annex I, where the policy holder is engaged professionally in an industrial or commercial activity or in one of the liberal professions and the risks relate to such activity;
(c) risks classified under classes 3, 8, 9, 10, 13 and 16 in Part A of Annex I in so far as the policy holder exceeds the limits of at least two of the following criteria:
(i) a balance-sheet total of EUR 6,2 million; (ii) a net turnover, within the meaning of Fourth Council Directive 78/660/EEC of 25 July 1978 based on Article 54(3)(g) of the Treaty on the annual accounts of certain types of companies (1), of EUR 12,8 million; (iii) an average number of 250 employees during the financial year". See Article 5, 39° of the Insurance Act of 2014.

provider to evaluate the appropriateness of the product for the client. If the product is inappropriate the provider shall warn his client and has to refuse to sell him a product when it is not appropriate considering the knowledge and understanding of the client. If the required information is lacking or inadequate, the provider shall warn the client that he cannot judge the appropriateness of the product for him.

These conduct of business rules on appropriateness and suitability were originally conceived for the investment services market. Now they also apply to savings and investment insurance products and they are added to the general duty of good care to act in accordance with the best interests of the client. The insurer and the insurance intermediary have with regard to those products the duty to provide the client with products that are suitable and appropriate to its needs, and the duty to acquire knowledge of the needs and objectives of the client (Articles 22, 1, 29 and 30 IDD; Article 277 Insurance Act of 2014; Article 27 of the Belgian Act of 2 August 2002 on the supervision of financial services; Article 4 Royal Decree of 21 February 2014 on the application of the articles 27 to 28bis of the Act of 2 August 2002).Currently those rules do in Belgium not apply to products to build up occupational pensions in the second pillar, but the legislative initiatives have been taken to enlarge the scope to these too.

b. Does your law impose on an insurer a duty to ascertain the insured's understanding of the scope of the insurance, and to draw the insured's attention to exclusions and limitations?

1. As was explained hereabove about the new regulatory (EU and Belgian) framework on insurance distribution, the insurers and the insurance intermediaries are responsible for making sure that the insurance contract they offer or sell corresponds to the needs and demands of the applicant, taking into account the information given by the client. In Belgium (and IMD and IDD), this obligation is only mandatory with respect to mass risks and life insurance.
In addition, if advice is provided prior to the conclusion of any specific contract, the insurance distributor shall provide the customer with a personalised recommendation explaining why a particular product would best meet the customer's demands and needs (Article 20, 1 and Article 22, 1; article 12bis, §§3-4 of the Act of 27 March 1995;

current Article 273, §3 Insurance Act of 2014 and Article 12quinquies of the Act of 27 March 1995; current article 276 Insurance Act of 2014) (see also point a). An “advice” is in this context understood as a recommendation concerning one or more insurance contracts, given either on demand of the client or on the provider’s own initiative. A “personalized advice” is one given to a person on the basis of this person’s personal characteristics.

2. With regard to savings and investment insurance products, special rules apply concerning the duties of the insurance distributors with respect to the appropriateness and suitability of these products (discussed supra under point a)).

3. Courts have occasionally referred to the general and unwritten principle of utmost good faith to impose on the insurer some warning and information duties. For example, in case the insurance contract provides certain specific precautionary measures (such as alarm devices in motor vehicles or fire sprinklers in buildings), some lower courts ruled that the insurer has to warn the insured of the sanction of forfeiture in case of a causal relation between the infringement of fulfilling the contractual measure and the theft or fire (see e.g. C. Van Schoubroeck, G. Jocqué, A. De Graeve, M. De Graeve, and H. Cousy, “Overzicht van rechtspraak. Wet op de landverzekeringsovereenkomst (1992-2003), *Tijdschrift voor Privaatrecht* 203,1867-1868; C. Van Schoubroeck, J. Amankwah, T. Meurs, N. Glibert, “Overzicht van rechtspraak. Wet op de landverzekeringsovereenkomst (2004-2015), *Tijdschrift voor Privaatrecht* 2016, 833).

4. At this point, it should be useful to remind the numerous and diverse rules on pre-contractual information duties.

4.1. General Belgian contract law requires that the applicant receives information on and has knowledge of the terms and conditions of the proposed insurance contract prior to the conclusion of the contract. This information is given to the applicant before the conclusion of the contract by the insurance intermediary or, in case of direct selling by the insurer, and is contained in the insurance proposal or in the draft general policy conditions submitted to the applicant. The insurer will not be allowed to invoke exclusion clauses or rights of recourse against his insured, unless he can prove that the policyholder had prior knowledge of, or that prior to acceptation, he had agreed

with the terms and conditions of the contract concerned. One exception to that rule is accepted by the Belgian Court de cassation with respect to motor vehicle liability insurance because in this class a model standard contract endorsed by Royal Decree exists, which contains the said terms and conditions (Royal Decree of 14 December of 1992) (see e.g. C. Van Schoubroeck, J. Amankwah, T. Meurs, N. Glibert, "Overzicht van rechtspraak. Wet op de landverzekeringsovereenkomst (2004-2015), *Tijdschrift voor Privaatrecht* 2016, 145-146).

4.2. Under the heading of "transparency prescriptions", the Insurance Act of 2014 contains a section on the legality and veracity of commercial publicity and other documents (Article 28). These rules are specified in the Royal Decree of 25 April 2014 on information requirements with respect to the commercialization of financial products to non-professional clients. Already in 2012 the Belgian insurers association and the federations of insurance brokers had adopted a code of conduct on the publicity, information and information sheets with respect to individual life insurance products (see, http://assuralia.be/images/docs/gedragsregels_reglesdeconduite/reclame-levensverzekering_publicite-assurance-vie/120309_NL_reclame-en-informatieverstrekking-leven.pdf), and in 2013 a sector code on the distribution of individual life insurance products (see, http://www.fvf.be/uploads/docs/Sectorcode-20130205.pdf) was established.

4.3. Under the heading of "transparency prescriptions", the Insurance Act of 2014 obliges the insurer to inform, as regards certain insurance contracts, his consumer clients, about the criteria of segmentation it uses with respect to acceptation, tarification and extent of cover, and of the reasons why he chooses such criteria in the particular contractual relationship (Articles 42-45).
Another section of the Act obliges the insurer to give information on his profit sharing policy and practice (Articles 47-53).

4.4. A specific section of the Insurance Act of 2014 is dedicated to the pre - and post-contractual information duties in life and non-life insurance policies (e.g. concerning the applicable contract law, the identification of supplier, basic data about cover and costs) (currently Articles 30 – 38 Insurance Act of 2014; Article 15 of the Royal Decree of 22 February 1991; also Royal Decree of 25 April 2014; see e.g. C. Van

Schoubroeck, “Onrechtmatige bedingen en transparantievoorschriften in Deel 3 van de Verzekeringswet” in Th. Vansweevelt and B. Weyts (eds.), *De Verzekeringswet 2014*, Reeks Interuniversitair Centrum voor Aansprakelijkheids – en verzekeringsrecht 2, Antwerpen, Intersentia, 2015, 1-25). Those provisions implement EU rules which were already provided in the Second generation of EU Insurance Directives of 1988 and 1990, and which were recently recast in the Articles 183 – 184 of the EU Directive 2009/138/EC of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II Directive). Notice that these rules do not specifically impose the obligation to draw the insured’s attention to exclusions and limitations

4.5. The most stringent rules regarding pre-contractual information duties are found in rules on insurance distribution and in specific rules of conduct of business.

The IDD provides the general rule that the insurance distributor shall provide the customer with the relevant information about the insurance product in a comprehensible form to allow the customer to make an informed decision, while taking into account the complexity of the insurance product and the type of customer (article 20, 4 IDD).

In the follow up of the financial crisis of 2008, the EU legislator has also focused on how this product information should be given, and introduced the use of specific product information documents.

With a view to creating a level playing field for all providers of investment services, the Regulation (EU) n° 1286/2014 of 26 November 2014 on key information documents for packaged retail and insurance-based investment products (PRIIPs) imposes rules on all PRIIP manufacturers and persons advising on, or selling PRIIPs. Those rules concern the format, the content and the use of the key information document to retail investors, with a view to enabling retail investors to understand and compare the key features and risks of the PRIIP.
This Regulation is directly applicable in each Member State of the EEA. It applies to all packaged retail investment products (Article 4, 1). These also includes “insurance-based investment products” (IBIPs), which are insurance products “which offer a

maturity or surrender value and where that maturity or surrender value is wholly or partially exposed, directly or indirectly, to market fluctuations" (Article 4, 2). The European Commission Delegated Regulation (EU) 2017/653 of 8 March 2017 lays down the regulatory technical standards with regard to the presentation, content, review and template of this standard "Key Information Document" (KID).

A lot of discussion has been going on as to whether specific product information rules and documents should also be imposed with respect to life insurance products which do not fall under the above cited definition of insurance-based investment products, as well as to non-life insurance products, such as fire, liability, legal expenses insurance. When adopting the IDD the European legislator decided to impose the obligation to use a standard document also with respect to the distribution of non-life insurance products. The information about these non-life insurance products shall be provided by way of a standardised insurance product information document (IPID or PID), to be drawn up by the manufacturer of the non-life insurance product (Article 20, 4-9 IDD). The European Commission Implementing Regulation (EU) 2017/1469 of 11 August 2017 on the format and content of the Insurance Product Information Document lays down the technical standards on the template for this insurance product information document.

With regard to Belgian law, it is interesting to observe that already prior to the adoption of the above cited EU rules, the Belgian legislator had opted for the use of a standard information sheet not only for all life insurance products in case these products are sold to non-professional clients, but also for non-life insurance products (see Royal Decree of 25 April 2014 on information requirements with respect to the commercialization of financial products to non-professional clients). However, these rules have not entered into force yet, since the Belgian legislator decided *in extremis* that it would be wise to assess their compatibility with the final texts of the Regulation (EU) PRIIPs and of the IDD.
However, brokers on the Belgian market have been using three model information sheets drawn up by the federation of insurance brokers in close cooperation with the association of insurance companies (see, model information sheets with regard to non-life insurance, life insurance other than savings - and investment products, and savings

– and investment life insurance products, see http://www.fvf.be/nl/profiel-van-de-makelaar/sectorale-documenten/informatieverplichting-verzekeringstussenpersonen).

4.6. The key rule of the abovementioned Belgian “AssurMiFID” is found in Article 277 of the Insurance Act of 2014, and in Article 27 of the Act of 2 August 2002. These provisions impose upon the insurance intermediaries and upon insurance companies the same general duty as is imposed on investment firms by the EU MiFID rules, in the following terms: “Insurance intermediaries and insurance companies must act honestly, fairly and professionally in accordance with the best interests of their client”. The Belgian legislator did indeed not wait for the outcome of the discussion at the EU level. By the Act of 30 July 2013 and three Royal Decrees of 21 February 2014 this “general MiFID-rule” and the specific rules of conduct that find their origin in the EU this legislation on investment firms and investment services were, subject to minor adaptations and exceptions, declared applicable to the insurance field. In all insurance distribution services (life insurance except occupational pensions, and non-life mass risks), the service provider must give information in a manner that is suitable to the client, concerning such items as the service provider, *the essential features of the insurance products*, about the remuneration obtained by the insurance provider, conflicts of interests, inducements, and costs. If the product is a savings or investment insurance, appropriate information and warnings must be given about the risks that are linked to certain of these savings and investment products and strategies.

In the final outcome of the discussion at EU level, the European legislator decided to extend, in the IDD, certain rules of conduct of the investment services to specific insurance operations and their providers, namely the insurance products which contain important elements of investment, or insurance products which can be considered as investment products in disguise (the so-called insurance-based investment products or IBIP’s). What had happened in the Belgian AssurMiFID legislation goes much further than IDD in the sense that in Belgium a number of conduct rules are now applicable to all insurance operations, including non-life insurance (e.g. costs and related charges, conflicts of interest, product oversight, inducements). It now appears that this Belgian AssurMiFID will remain in place, also after the implementation of IDD.
Under Belgian law, a special sanction of civil liability and a rebuttable presumption of a causal relationship applies in case of infringement of certain rules on conduct of

business (Article 30ter of the Act of 2 August 2002 and Royal Decree of 20 February 2014; see S. Illegems, Conduct of business rules in the Belgian insurance industry: the presumption of causation for civil liability, *European Journal of Commercial Contract Law*, 2015, 109-126).

4.7. It can also be added that information requirements regarding the key elements of the insurance contract are also imposed by consumer law with respect to insurance contracts concluded with consumers (see Book VI of the Belgian Code of economic law). Article VI.91, §1 of the Code of Economic Law also mentions the obligation to mention on the first page of the insurance policy that the contract is deemed to be tacitly renewed unless either party gives notice of objection.

4. The Insured's Post-Contractual Disclosure Duty

a. Does an insured have the duty to notify the insurer of a material change in risk? If so – what is the scope of the duty?

Whereas the PEICL (Principles of European Insurance Law)[4] leaves it to the parties to convene in the policy whether or not the insured has a duty of disclosure in situations where the risk is modified during the term of the contract, Belgian law does contain mandatory rules for this situation.

One will notice that the prescriptions of the Belgian Insurance Act of 2014 not only concern cases of "increase or aggravation" of the risk (Article 81), but also the case of "decrease" of the risk. In the latter case, (which will not be further developed here), Article 80 of the Insurance Act of 2014 prescribes that the insurer shall be required to grant a corresponding reduction of the premium from the date on which he became aware of the decrease of the risk. If the parties do not reach an agreement on the new premium, the policyholder may cancel the contract. Such legislation was asked for by consumers groups claiming that there must be equal treatment of insurer and insured.

In the case of increase or aggravation of the risk, the legal prescriptions are mutatis mutandis quite similar to the ones that apply to the disclosure duties of the applicant

[4] J. Basedow, J., Birds ,M. Clarke, H. Cousy, H. Heiss, L. Loacker (eds.), *Principles of European Insurance Contract Law (PEICL),* 2e expanded ed., Koln, Ottoschmidt, 2016, 921 pp. (hereafter cited as PEICL); H. Cousy, "The Principles of European Insurance Contract Law: The Duty of Disclosure and the Aggravation of Risk", European Contract Law, *ERA Forum Special Issues* 2008, 140.

at the time of the conclusion of the contract. Moreover, the regime of sanctions in case of violation of these duties is also largely similar to the sanctions that apply to non-disclosure situations at the outset of the contract.

The general rule to disclose increase of the risk, as stated in Article 81, §1 of the Insurance Act of 2014 (cf. Article 26 of the Insurance Contract Act of 1992), provides that: "*Save in relation to a life insurance, sickness insurance or credit insurance contract, the policyholder shall have an obligation during the term of the contract to declare, pursuant to Article 58, any new circumstances or changes in circumstances which are likely to entail an appreciable, permanent increase in the risk that the insured event will materialise".*

In case of a life insurance, sickness insurance and credit insurance, the insured has no obligation at all to disclose any increase or aggravation of the risk in the currency of the contract. With respect to life and sickness insurance, the underlying reasoning is that at the time of conclusion of these contracts the insurer should already in fixing the premium and the terms of the contract already take into account the statistical evidence that health deteriorates and the risk of premature death increases with age. Therefore, there is no reason for the premium to change if the insured's health deteriorates during the course of the contract

It has been observed that Article 81 of the Insurance Act of 2014 contains two definitions of what constitutes an increase: one definition concerning the increase (or aggravation) of risk that triggers the duty of the policyholder to declare, and the other concept of the increase of the risk, which gives the insurer the right to invoke the legally prescribed sanctions.

With regard to the policyholder's duty to disclose, the Insurance Act of 2014 prescribes that the policyholder must declare *"pursuant to Article 58, any new circumstances or changes in circumstances which are likely to entail an appreciable, permanent increase in the risk that the insured event will materialize".* The reference to Article 58 of the Insurance Act of 2014 means that the policyholder is only obliged to declare the circumstances that he knows of. The important words in Article 81 are "appreciable and permanent risk that the insured event will materialize". The words "appreciable"

("significant") and "permanent" ("durable nature") mean that minor changes of the risk or very temporary ones do not fall under the regime of aggravation of risk as referred to here.

As appears from the foregoing the Belgian legislation does not make use of the term "material change" in the risk, but rather of "decrease" and "increase" of the risk.

The second concept of aggravation or increase of risk, related to the possible reactions of the insurer, is more specific. Article 81, §1, second para states: "*If, in the performance of an insurance contract other than a life assurance, sickness insurance or credit insurance contract, the risk that the insured event will occur increases to such an extent that, if the increase had existed when the insurance was taken out, the insurer would have granted insurance only on other conditions he shall, within one month of the date on which he becomes aware of the increase, offer to amend the contract with retroactive effect to the date of the increase".*
The criterion here is whether or not the risk that the insured event will occur increases to such an extent that, if the increase had existed when the insurance was taken out, the insurer would have granted cover only on other conditions. As will be described in more detail hereafter, the insurer shall, within one month of the date on which he becomes aware of the increase, offer to amend the contract (see further answer to question 6).

b. What is defined in your jurisdiction as a material change?

See answer to question 4, a).

5. The Insurer's Post Contractual Duty

Does your law impose on an insurer disclosure duties after the occurrence of an insured event (such as the duty to provide coverage position in writing within a limited period, duty to disclose all reasons for declination etc.?)

1. As was announced hereabove, some of the information duties of the insurer (the Belgian legislator calls them "transparency prescriptions") extend well beyond the moment of conclusion of the contract (see, question 3, b, 4; also Royal Decree of 14

November 2003 on life insurance). In non-life insurance contracts the insurer must throughout the term of the contract keep the policyholder informed about changes in such data as name and place of headquarters, and the representative of the insurer. In life insurance, the updating also concerns other matters like insurance condition, name and legal form of the headquarters. When the insurer decides for reasons of changes of the risk to change his tariffs or cover conditions in the course of a (any) contract, he must inform the policyholder of his intention to do so in a detailed manner. The same applies when the insurer intends to cancel the policy for reason of change of the risk.
At the outset and in the course of the performance of the contract the policyholder must be informed about his right to participate in the profits and at least once a year he must get a report on the state of affairs.

2. If the notice of claim by the insured (or the third party in liability insurance) is given in good time, the limitation period shall be suspended until the date when the insurer informs in writing the insured or the third party of his decision to grant or refuse indemnity (Article 89, §3 Insurance Act of 2014; cf. Article 35, §3 Insurance Contract Act of 1992). The Cour de cassation and lower courts are quite severe in the application of this obligation and require that the decision of the insurer is understandable and unequivocally clear as to whether he will indemnify or not (see C. Van Schoubroeck, J. Amankwah, T. Meurs en N. Glibert, “Overzicht van rechtspraak Wet op de landverzekeringsovereenkomst (2004-2015)”, *Tijdschrift voor Privaatrecht* 2016, 911-912).

3. With regard to motor vehicle liability insurance the insurer is obliged to propose an indemnification or at least give an answer to the insured’s or the third party’s notice of claim within a statutory defined time period. In case of no or late reply, the insurer will have to pay a lump sum, or an interest on the paid sum (Articles 13-14 of the Act of 21 November 1989 on motor vehicle liability insurance).
Also with regard to fire insurance contract, mandatory rules require that the insurer pays out within certain strict time periods 5Article 121 Insurance Act of 2014).

6. Remedies in Case of Breach of the Insured's Disclosure Duties

a. What is the insurers' remedy in case an insured breached his/her precontractual disclosure duty ("all or nothing" rule or partial discharge)?

1. Under traditional insurance law the sanctions for violations of the disclosure duties were drastic and severe. The Insurance Act of 1874 adhered to the all or nothing principle ("Alles oder nichts Prinzip") under which a violation of the duty of disclosure led to the loss or forfeiture of the entire cover, even if the shortcoming was minor (e.g. without bad faith or non-intentional) and in spite of the absence of any correlation between the non- or ill-declared relevant circumstance on the one hand and the insured event on the other hand. The sanction took the form of the nullity of the insurance contract. Under this regime the violations of the duty of disclosure were indeed considered to lead to a defect that affects the consent of the parties, and thus the validity of the contract. This reference to the validity requirements explains why the remedy was sought in the sanction of the nullity of the contract, a radical sanction which implies the termination or cancellation of the contract and even the restitution of premiums and payments made under the contract.

The recent legislation, since the Insurance Contract Act of 1992, has abandoned this approach and opted for a more economically sound one, based on the idea of a certain equilibrium between the real risk and the amount of the premium. Except in cases of fraud (intentional omission or inaccuracy) where the sanction of nullity of the contract is maintained, the sanction (for unintentional violations) is conceived in such form as to enable the continuation of the contract, on the basis of a premium adapted by a new agreement between the parties.

The consequences of intentional and unintentional non-disclosure or misrepresentation are distinctly dealt with in the Articles 59 and 60 of the Insurance Act of 2014.

2. Article 59 provides that in case *"the intentional omission or inaccuracy in the declaration mislead the insurer as to the basis for assessment of the risk, the insurance contract shall be void. Premiums due up to the moment when the insurer had knowledge of the intentional omission or inaccuracy shall be payable to him"* (Article

59). The insurer has to prove that the policy holder has misled the insurer. Case law in general takes a severe stand as to the elements which in the concrete situation hold proof of the misleading intention of the policy holder see C. Van Schoubroeck, J. Amankwah, T. Meurs en N. Glibert, "Overzicht van rechtspraak Wet op de landverzekeringsovereenkomst (2004-2015)", *Tijdschrift voor Privaatrecht* 2016, 751-774).

3. In case of unintentional omission or inaccuracy Article 60 of the Insurance Act of 2014 applies the modern approach of modification of the insurance contract (§1), and, in case of a claim, the proportional reduction of the indemnity in case the omission is blameable (§§2 and 3)[5].

Article 60 distinguishes between an insurable risk and a non-insurable risk.
A risk is "non-insurable" when the insurer can prove that if he had known the truth, he would under no circumstances have insured the risk. Such proof allows the insurer to end the contract within one month of discovering the real situation.
If the insurer can only prove that if he had known the truth, he would not have covered the risk under the present terms, the insurer can propose a modification to the

[5] Article 60 provides**:**
"*§1 Where an omission or inaccuracy in the declaration is not intentional, the contract shall not be void.*
The insurer shall, within a period of one month of the date on which he became aware of the omission or inaccuracy, offer to amend the contract with effect from the date on which he became aware of the omission or inaccuracy.
If the insurer proves that he would under no circumstances have insured the risk, he may resile from the contract within the same period.
If the offer to amend the contract is refused by the policyholder or if it has not been accepted on the expiry of one month from receipt thereof, the insurer may resile from the contract within 15 days.
An insurer who fails to resile from the contract or offer to amend it within the periods fixed above may not rely in the future on facts known to him.
§2. If the policyholder cannot be blamed for the omission or incorrect declaration and if a claim arises before the amendment of cancellation of the contract takes effect, the insurer shall provide the agreed benefit.
3. If the policyholder can be blamed for the omission or incorrect declaration and if a claim arises before the amendment or cancellation of the contract takes effect, the insurer shall provide the agreed benefit only according to the ratio between the premium paid an the premium which the policyholder ought to have paid if he had duly declared the risk.
However if, on a claim, the insurer proves that he would under no circumstances have insured the risk the true nature of which is revealed by the claim, the benefit shall be limited to reimbursement of all the premiums paid.
§4. If a circumstance unknown to both parties on conclusion of the contract becomes known in the course of its performance, Article 80 or 81 shall be applied, depending on whether that circumstance constitutes a decrease or increase in the risk insured".

policyholder within one month. The latter is granted one month to answer. If he agrees, the contract is retroactively modified. If the policyholder refuses such offer or fails to react within the prescribed period, the insurer is entitled to cancel the contract within fifteen days.

When an insured event occurs before the insurer discovers the lack of information, or before the modification or cancellation of the contract has taken effect, the Belgian law makes still another distinction, this time distinguishing according to whether the policyholder's omission is blameable or not blameable.

If the policyholder cannot be blamed, that is if the policy holder did not commit any fault in failing to properly declare, the insurer will have to pay the full agreed indemnity or benefit.
If the policyholder is blameworthy the result will vary depending on whether the "real risk" is insurable or not. If the risk is "insurable" (i.e. if the insurer would have taken the risk), the insurer is entitled to a proportional reduction of the indemnity, in accordance with the ratio between the premium as paid and the right premium. Whereas, if the risk is "uninsurable", i.e. if the insurer proves that in the concrete situation he would under no circumstances have insured the risk, he will only have to reimburse to the maximum of the premiums paid.

To these rules of Article 60 of the Insurance Act of 2014, two exceptions apply.
First, as regards private health insurance contracts (which are not linked to any professional occupation), Article 205 of the Insurance Act of 2014 (originally introduced in 2007 in the Insurance Contract Act of 1992) operates a distinction. Unintentional violation of the disclosure duty cannot be sanctioned by the insurer in cases where the applicant did not disclose certain symptoms while the illness or affliction itself had not been diagnosed within a period of two years after the conclusion of the contract. Where, in the same cases of non-intentional violation, such manifestation had already taken place, and was diagnosed within two years after the conclusion of the contract, the insurer can invoke such violation and sanction the applicant according to the pre-stated rules in Article 60.

The second exception concerns life insurance contracts. Article 162 of the Insurance Act of 2014 maintains the (traditional) rule of the "incontestabilité" ("unchallengeability") of life insurance contracts in those cases where the violation of the disclosure duty was not intentional. The unintentional violation can only be invoked by the insurer during a limited time, and not later than one year after the conclusion of the contract (Article 10 of the Royal Decree of 14 November 2003).

b. What is the insurers' remedy in case an insured breached his/her post-contractual disclosure duty ("all or nothing" rule or partial discharge)?

As was noticed hereabove, the legislator applied a similar regime of sanctions to the case where the policyholder violated his disclosure duties at the moment of concluding the contract, as to the case where this violation took place in the course of the performance of the contract.
The same basic principles are applied here: continuation of the contract if possible, adaptation (in the sense of proportional reduction) of the premium if necessary.

The remedies in case of increase of the risk are provided in Article 81 of the Insurance Act of 2014[6].

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[6] Article 81 states: *"§1. (...)*
If the insurer adduces evidence that he would under no circumstances have insured the increased risk, he may cancel the contract within the same period.
If the offer to amend the insurance contract is refused by the policyholder, or if the offer is not accepted within one month of the date of receipt thereof, the insurer may cancel the contract within 15 days.
An insurer who fails to cancel the contract or offer to amend it within the periods indicated above may not plead the increase in risk in the future.
§2 If a claim is made before the amendment or cancellation takes effect and if the policyholder has fulfilled the obligation referred to in subsection (1) of this Article, the insurer shall provide the agreed benefit.
§3 If a claim is made and the policyholder has not fulfilled the obligation referred to in subsection (1) of this Article:
(a) the insurer shall provide the agreed benefit if the policyholder cannot be blamed for non-declaration;
(b) the insurer shall provide the benefit only according to the ratio between the premium paid and the premium which the policyholder ought to have paid if the increase had been taken into account, where the policyholder can be blamed for non-declaration.
However, if the insurer adduces evidence that he would under no circumstances have insured the increased risk, his liability in the event of a claim shall be limited to repayment of the total premiums paid;
(c) if the policyholder acts with fraudulent intent, the insurer may deny liability. Premiums due up to the date on which the insurer became aware of the fraud shall be payable by way of damages".

Here again Article 81 of the Insurance Act 2014 contains very detailed prescriptions about the possible remedies in case of increase of risk.
The initiative lies with the insurer who, having become aware of the increase of the risk, shall react within one month by offering to amend the contract with retroactive effect to the date of the increase (which will in most cases precede the moment where the insurer became aware of it). No need to say that the fixing of those two moments may give rise to dispute. Here again the insurer has two options: if he proves that he would not have insured the risk, the insurer may resile the contract, but if he offers an amendment, he may resile only if the policyholder refuses or fails to accept the offer. If the insurer remains passive he may not rely in the future on facts known to him.

And here again, as in the case of the sanctions for pre-contractual violations, detailed rules govern the situation where a claim arises before the amendment or cancellation of the contract takes effect. The same distinction is made according to whether the policyholder can or cannot be blamed for the violation. Only in case of proven fraudulent intent of the policyholder may the insurer deny liability.