ISLE OF MAN
FINANCIAL SERVICES AUTHORITY

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Guidance Notes and Information

Concerning Insurance (Valuation and Solvency) Regulations

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INFORMATION

In this document, where the Isle of Man Financial Services Authority ("the Authority") indicates that it has exercised a power, this is not guidance but is information confirming that the power has been exercised as stated.

STATUS OF GUIDANCE

The Authority issues guidance for various purposes including to illustrate best practice, to assist regulated entities (in this case authorised insurers, permit holders and registered insurance managers (as applicable)) to comply with legislation and to provide examples or illustrations. Guidance is, by its nature, not law, however it is persuasive. Where a person follows guidance, this would tend to indicate compliance with the legislative provisions, and vice versa.

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Contents

1. Interpretation

In this document—

(a) "the Act" means the Insurance Act 2008;

(b) "the Authority" means the Isle of Man Financial Services Authority;

(c) "commercial non long-term business insurer" has the meaning given in the Guidance Notes and Information Concerning Various Insurance Regulations and the CGC;

(d) "Electronic Return", in relation to an authorised insurer, means the current version of the published regulatory return template on the Authority's website, specifically the: LTB_Return, NLT_Return_Classes_3-9&11 or NLT_Return_Class 12 (as applicable to the insurer) pursuant to regulation 17 of the Insurance Regulations 2021;

(e) "solvency coverage ratio" in relation to an authorised insurer means its eligible own-funds divided by its SCR and, for example in relation to a class 12 insurer, it is also the ratio of that name as set out in the NLT_Return_Class 12, "SCR Summary" Tab; and

(f) terms used in relation to the Insurance Regulations 2021, Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021 or Insurance (Long-Term Business Valuation and Solvency) Regulations 2021 (as the case may be) have the meaning (if any) as given in those documents or the Act (as appropriate).

2. Electronic Return clarifications

2.1 Participant Information tab: clarification on sign offs (all authorised insurers)

The Participant Information tab within an Electronic Return submitted to the Authority should simply provide the required details of the persons who have Signed Off the return under the Firm Declaration (physical signatures are not required for an Electronic Return.

The two signatories must be notified Controlled Function Role Holders of the insurer, unless the submission is in respect of an insurer that is managed by an insurance manager. In this case one signatory must be a Director of the insurer that is independent to the insurance manager, and the other signatory must be an appropriate person within the manager (who may or may not be a notified Control Function Role Holder).

2.2 Premium and Reserve Risk tab and Health Premium and Reserve Risk tab: clarification on premium volume measure (all non long-term business insurers only)

Appendix 4 includes additional information on how to complete the premium volume measures for use in the Premium and Reserve Risk tab, and Health Premium and Reserve Risk tab.

2.3 Change Analysis tab: clarification regarding previous period data (all authorised insurers)

(1) Sub-paragraphs (2) and (3) are subject to sub-paragraph (4), as applicable.

(2) Pursuant to regulation 17 of the Insurance Regulations 2021, in relation to an authorised insurer, an Electronic Return corresponding to its—

(a) annual return;

(b) first quarterly return of the year (subject to sub-paragraph (3)); or

(c) first bi-annual return of the year,

(as applicable) the Previous Period data must be that of the insurer's previous annual return.

(3) In relation to a first quarterly return, as referred to in sub-paragraph (2)(b), if the insurer's previous annual return data has not yet been submitted to the Authority, the Previous Period data must be that of the insurer's previous fourth quarterly return.

(4) In respect of the first instance of any of the returns referred to in sub-paragraph (2), and unless specified otherwise by the Authority, no Previous Period data is required to be included in the corresponding Change Analysis tab. This may arise for transitional purposes following the Insurance Regulations 2021 coming into effect on 30 June 2022, or following an insurer's initial authorisation. (To avoid any doubt, for transitional purposes, this sub-paragraph does not apply to long-term business.)

(5) Pursuant to Regulation 17 of the Insurance Regulations 2021, in relation to an authorised insurer, an Electronic Return corresponding to its—

(a) second, third or fourth quarterly return of the year; or

(b) second bi-annual return of the year,

(as applicable) the Previous Period data must be that of the insurer's last previous quarterly return or bi-annual return, as the case may be.

2.4 Helper Templates: clarification regarding submission (all authorised insurers)

Helper templates corresponding to an Electronic Return (as applicable) should not be submitted to the Authority with the Electronic Return unless specifically requested by the Authority.

2.5 Additional Balance Sheet Reconciliation (all non long-term business insurers):

Reference should be had to paragraph 5 of the Guidance Notes and Information Concerning Various Regulations and the CGC, as an authorised insurer must submit a reconciliation between its accounts and certain of its Electronic Return inputs as set out in that paragraph.

3. SCR/MCR treatment of assets subject to a security interest (all authorised insurers)

(1) In this paragraph (paragraph 3), "security interest" includes—

(a) a charge, mortgage, debenture, pledge, lien, encumbrance (or any other mechanism of the same or similar effect by whatever name or description); and

(b) any agreement to a contingent security interest.

(2) Subject to sub-paragraph (3), where an asset of an authorised insurer is subject to a security interest, the insurer must recognise the full extent to which that security interest might potentially be used for a purpose other than securing that the insurer's insurance business obligations are met. That recognition must be given effect by either—

(a) reducing the asset's value in accordance with (as applicable)—

(i) Regulation 14(4)(d) of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021; or

(ii) Regulation 13(4)(d) of the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021; or

(b) recognising a material contingent liability in accordance with (as applicable)—

(i) Regulation 14(9) of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021; or

(ii) Regulation 13(12) of the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021,

and, provided that such asset value reduction or contingent liability recognition, reflects the full extent to which that security interest might potentially be used for a purpose other than securing that the insurer's insurance business obligations are met, then no other such asset value reduction or contingent liability recognition is required in respect of the security interest in relation to the regulations referred to in sub-paragraphs (a) or (b).

(3) Subject to paragraphs (4) to (6), where an asset of an authorised insurer is subject to a security interest which is calculated to apply only in excess of a solvency coverage ratio of the insurer, then the fullest extent to which the security interest might potentially be used for a purpose other than securing that the insurer's insurance business obligations are met must be reflected via a reduction of eligible own-funds available in excess of that solvency coverage ratio (as these own-funds are encumbered and are no longer eligible) under Regulations (as applicable)—

(i) 72(1)(a) and 72(1)(d)(iii) of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021; or

(ii) 108(1)(a) and 108(1)(d)(iii) of the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021,

and, provided that such reduction of eligible own-funds available in excess of the solvency coverage ratio reflects the full extent to which that security interest might potentially be used for a purpose other than securing that the insurer's insurance business obligations are met, then no other such reduction of eligible own-funds available in excess of the solvency coverage ratio is required (and no additional asset reduction or contingent liability recognition is required in respect of the security interest in relation to the regulations referred to in sub-paragraphs (2)(a) or (2)(b)).

(4) A solvency coverage ratio, as referred to in sub-paragraph (3), should be—

(a) at least 100% to ensure compliance on an ongoing basis with its SCR, MCR, section 12A of the Act and Regulation 5 of the Insurance Regulations 2021; and

(b) in accordance with sub-paragraph (6).

(5) To avoid any doubt, a security interest cannot apply to any asset of the insurer required to meet any of its liabilities plus its SCR unless, and only insofar as, it is solely for the purpose of securing that the insurer's insurance business obligations are met.

(6) An authorised insurer must ensure that it does not agree to any security interest which prevents the insurer from complying on an ongoing basis with its capital adequacy requirement and liquidity adequacy requirement under the CGC.

4. Applications for approval of ancillary own-funds (all authorised insurers)

Pursuant to Regulation—

(a) 75(1) of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021; or

(b) 111(1) of the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021,

as applicable, Appendix 1 sets out information requirements relating to applications for approval of ancillary own-funds in respect of authorised insurers.

5. Applying proportionality (all non long-term business insurers)

Pursuant to Regulation 7 of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021, Appendix 2 sets out guidance in relation to applying proportionality in respect of the non long-term business of an authorised insurer.

6. Use of Regulation 18(2) (all non long-term business insurers)

(1) In this paragraph (paragraph 6) all references to a Regulation are references to the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021.

(2) For the purposes of Regulation 18(2), a commercial non long-term business insurer is not eligible to use Regulation 18(2).

(3) Subject to sub-paragraphs (4) (as applicable), in respect of an insurer that is eligible to use Regulation 18(2), where the insurer wishes to apply Regulation 18(2) and use its accounting provisions to determine its best estimate provisions, it must determine on a risk assessed basis that it is not proportionate (i.e. it is disproportionate) for it to determine its best estimate provisions in accordance with Regulation 18(1).

(4) In relation to proportionality as referred to in paragraph (3)—

(a) subject to sub-paragraphs (b) and (d), the Authority considers it proportionate for an insurer, under Regulations 18(2) and 7, to use its accounting provisions to determine its best estimate provisions;

(b) subject to sub-paragraph (c), sub-paragraph (a) does not apply to an insurer—

(i) where an insurer has reason to believe that its accounting provisions would be less than its best estimate provisions determined under Regulation 18(1) (an example of this would be where an insurer's accounting provisions are determined using a method which discounts the insurer's future cash-flows using a discount rate which is higher than the discount rate that would be applicable to the calculation required under Regulation 18(1));

(ii) which uses an accounting standard which, in respect of the insurer, does not recognise technical provisions (i.e. if the accounting standard does not recognise the insurer's contracts as insurance contracts); or

(iii) which has insurance contracts with contract boundaries (as determined under Regulation 17) greater than 12 months;

(c) paragraph (b)(iii) does not apply where the insurer's technical provisions have been recognised and valued in accordance with IFRS 17; and

(d) if paragraph (a) does not apply (because of paragraph (b)), and if the insurer wishes to use Regulation 18(2), then the insurer should seek approval from the Authority under Regulation 18(2).

7. Proportionate treatment of counterparty default risk exposures to parties on the approved entity list (all authorised insurers)

(1) The Authority considers it proportionate for an authorised insurer to use Regulation—

(a) 7 of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021

(b) 8 of the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021,

to exclude any counterparty default risk exposure it has in accordance with paragraph (2) from its Electronic Return counterparty default risk submodule, including any—

(i) direct exposure to such a counterparty; and

(ii) exposures to such a counterparty as a security provider in accordance with (as applicable)—

A. paragraph 7(7) of Schedule 2 to the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021; or

B. Regulation 61(9) of the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021.

(2) Paragraph (1), in relation to an authorised insurer, applies only to a counterparty default risk exposure of the insurer where the counterparty is on the approved entity list in (as applicable)—

(a) Schedule 4 to the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021; or

(b) Schedule 2 to the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021.

8. Board reports (all non long-term business insurers)

Pursuant to Regulation 8 of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021, Appendix 3 sets out guidance in relation to board reports in respect of an authorised non long-term business insurer.

APPENDIX 1 (Applications for approval of ancillary own-funds – relevant to all authorised insurers)

Regulation 75(1) of the Insurance (Non-Long-Term Valuation and Solvency) Regulations 2021 and Regulation 111(1) of the Insurance (Long-Term Business Valuation and Solvency) Regulations 2021 (in this appendix, as applicable, 'the Regulations') state that the classification of an eligible own-fund item as an ancillary own-fund item of an authorised insurer is subject to the approval of the Authority.

Under the same Regulations, in order for an ancillary own-fund item to be classified as Tier 2, it must display the features of a Tier 1 basic own-fund item if it were to be called up and paid in – otherwise it is classed as Tier 3.

The following applies to any authorised insurer seeking approval in respect of ancillary own-funds.

(1) The insurer must provide the following information to the Authority in respect of those funds and each counterparty involved—

(a) details of what tier the ancillary own-fund item is proposed to be classed as (including full details of how it meets the requirements of that tier in accordance with the Regulations);

(b) a breakdown of the insurer's existing eligible own-funds split between relevant tiers, both without the proposed ancillary own-funds being included and, assuming approval was to be given, with the approved ancillary own-funds included;

(c) the insurer's current SCR amount and solvency coverage ratio both without the proposed ancillary own-funds being included and, assuming approval was given, with the approved ancillary own-funds included;

(d) full details of the structure and contractual terms of the arrangement that the insurer has entered into (or intends to enter into) with the counterparty to provide funds;

(e) an opinion on the legal effectiveness and enforceability of the terms of corresponding commitments in all relevant jurisdictions;

(f) details of the status of the counterparties concerned in relation to their ability and willingness to make relevant payments;

(g) details of the recoverability of the ancillary own-fund item taking into account the legal form of the item as well as any conditions that would prevent the item from being successfully paid in or called up;

(h) details of the outcome of any past calls which the insurer has made for similar ancillary own-fund items, including the extent that information can be reliably used to assess the expected outcome of future calls (as applicable);

(i) details of the processes the insurer has in place to inform the Authority of any future changes which may have the effect of reducing the loss-absorbency of the ancillary own-fund item or might effect of any of the following (in each case as applicable): the—

(i) structure or contractual terms of the arrangement;

(ii) status of the counterparties concerned; and

(iii) recoverability of the ancillary own-fund item;

(j) where the insurer is seeking approval of a method by which to determine the amount of an ancillary own-fund item, details of the insurer's process for regularly validating that the method is appropriate to ensure that the results of the method reflect the loss-absorbency of the item on an ongoing basis; and

(k) any other information or confirmations as may be requested by the Authority in the course of considering an application for approval.

(2) Upon receipt of this information, the Authority will consider whether it will provide approval, and will notify the insurer of its decision in writing when made.

(3) In relation to any approval of ancillary own-funds in respect of an authorised insurer, the insurer will be required by the Authority to monitor the approved ancillary own-fund item in order to identify and notify the Authority of any changes to the basis on which the item was approved (e.g. change in value, structure, collateral, terms, counterparty security etc.). Following notification, and receipt of any other information that the Authority may require, the Authority will review its approval and may, for example, withdraw it, modify it or allow it to continue).

APPENDIX 2 (Applying proportionality in respect of non long-term business insurers)

(1) This guidance is in respect of Regulation 7 of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021 (in this appendix, as applicable, 'the Regulations'). Herein, any reference to a specific regulation is a reference to the Regulations.

(2) For ease of reference, regulation 7 is as follows:

"*7. Proportionality*

(1) *An insurer must apply these Regulations in a way that is proportionate to the nature, scale and complexity of the risks to which it is, or may be exposed.*

(2) *In determining whether the use of a method specified by these Regulations is proportionate, an insurer must carry out—*

(a) *an assessment of the nature, scale and complexity of the relevant risks underlying its insurance obligations; and*

(b) *an evaluation in qualitative or quantitative terms of the error introduced in the results of the method due to any deviation between —*

(i) the assumptions underlying the method in relation to the risks; and

(ii) the results of the assessment referred to in paragraph (a).

(3) *A method is considered to be disproportionate to the nature, scale and complexity of the risks if the error referred to in paragraph (2)(b) is material, unless —*

(a) *no other method with a smaller error is available and the method is not likely to result in an inadequate estimate of the risks in question; or*

(b) *the method results in estimates that are more prudent than the estimates that would result from using a proportionate method and the method does not lead to an inadequate estimate of the risks in question."*

(3) Regulation 7 enables an authorised insurer to replace a method prescribed by regulation, which is disproportionate, with an alternative method that is proportionate. To do so, the insurer must have demonstrated, on a risk assessed basis, that the prescribed approach is disproportionate to the nature, scale and complexity of the risks to which the insurer is exposed.

(4) The alternative method must be a good risk-based fit for the task at hand (i.e. an authorised insurer should use a method which provides an outcome that adequately reflects in financial terms the risks involved in the most reliable way available). Or, if preferred, the insurer can use a method with a more prudent outcome.

(5) To demonstrate the disproportionality of the prescribed method or the proportionate suitability of the alternative method (as the context requires), an

authorised insurer must complete the proportionality assessment required under Regulation 7(2). Material proportionality assessments should be documented in the insurer's board report as referred to in Regulation 8.

Proportionality Assessment

(6) A proportionality assessment under Regulation 7(2) requires an authorised insurer to thoroughly understand the risks relating to its insurance obligations (this is something the insurer should have available from carrying out its ongoing risk management function, including ORSA). Considering the risks involved, the insurer must then carry-out a qualitative or quantitative proportionality assessment to determine the impact of using the alternative method.

(7) A quantitative assessment would involve carrying out the prescribed method and the alternative method and determining the impact on the relevant component of the standard formula, whereas a qualitative assessment would involve documenting the reasons as to why the requirements of Regulation 7(2) and 7(3) are met. A qualitative assessment is useful where quantitative evidence is not required (i.e. it is clearly unnecessary) to assess the impact. An example of a qualitative assessment is provided below.

(8) An alternative method is deemed proportionate where the result of the assessment shows that the use of the alternative method has an immaterial impact compared to the prescribed method (or is more prudent than the prescribed method as referred to in paragraph (10)(b)).

(9) If not deemed proportionate, the alternative method is deemed disproportionate.

(10) Where an alternative method has been deemed disproportionate, it is still possible for that method to be used by an authorised insurer, but only in the circumstance where the alternative method is not likely to result in an inadequate assessment of the risks in question, and either—

(a) the insurer considers there to be no other proportionate method available which would provide for a smaller impact; or

(b) the result of the alternative method is more prudent than the use of the prescribed method.

(11) Proportionality assessments need to be carried out the first time a particular alternative method is applied. The assessment will then remain valid until the circumstances surrounding the use of that alternative method change in a way that might materially affect the reliability of the assumptions supporting the use of the alternative method.

(12) Upon review by the Authority (if and insofar as a review is carried out), there appears to be insufficient detail in the board report the Authority may require evidence that the proportionality assessment under Regulation 7(2) has been completed appropriately. The Authority may also require evidence of how the insurer's board has otherwise satisfied itself that that the proportionality assessment under Regulation 7(2) has been completed appropriately.

(13) In relation to the Auditor's Report under Regulation 17 of the Insurance Regulations 2021 (as applicable), audit firms may require sight of the completed

proportionality assessments where alternative methods have been used, to ensure that the requirements of Regulation 7 are being met. The Authority anticipates this to be straightforward where adequate and appropriate documentation has been included in the board report.

Example of a proportionate method

Use of homogenous data groupings in the counterparty default risk module

In this example an authorised insurer has a large number of single counterparty reinsurance exposures, which is making completion of the counterparty default risk module time-consuming and complex. The reinsurance exposures are to counterparties of the same credit quality step. Rather than use the prescribed approach (which is to determine the counterparty default SCR based on single counterparty exposures), the insurer instead wishes to use an alternative method where the single counterparty exposures would be assigned to homogeneous risk groups based on credit quality step (in which all of the counterparties included in a grouping have the same credit quality step that is assigned to the group).

The insurer must carry out a proportionality assessment. In this case the assessment may be quantitative and/or qualitative as follows—

(a) the insurer may use the default approach and carry out a quantitative proportionality assessment by determining the counterparty default risk SCR using the prescribed method and the alternative method. The alternative method in this case will always result in a larger SCR due to the loss of diversification the insurer would have benefited from had it allowed for the larger number of single counterparty exposures; or

(b) the insurer may instead (or also) have carried out a qualitative assessment, as a quantitative assessment wasn't required to evidence that using a smaller number of homogeneous risk groups would provide a lower diversification benefit and a larger (more prudent) SCR than would otherwise be the case (i.e. a quantitative assessment was clearly unnecessary to demonstrate the more prudent outcome).

Under both assessments, the alternative approach results in the risks in question still being adequately assessed and a more prudent counterparty default SCR, hence Regulation 7 has been complied with and the use of the proportionate method is allowable.

The results of the proportionality assessment should be documented in the board report, and a review process established setting out the criteria that would dictate a review of the proportionality assessment. For this particular alternative method, triggers for a review include a downgrading of a counterparty exposure, or a significant change in the number of exposures (such as the removal or addition of new reinsurance counterparties).

To avoid any doubt, single counterparty exposures assigned to a homogeneous risk group based on credit quality step may include counterparties which have a better credit quality step than that which is assigned to the group (for example, a homogeneous risk group with a credit quality step of 3, in addition to its constituent

credit quality step 3 single counterparty exposures, could also include single counterparty exposures of any or all of credit quality steps 2, 1 or 0).

APPENDIX 3 (Board reports in respect of non long-term business insurers)

(1) This guidance is in respect of Regulation 8 of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021 (in this appendix, as applicable, 'the Regulations'). Herein, any reference to a specific regulation is a reference to the Regulations.

(2) For board reports in respect of non long-term business insurers—

(a) for a commercial non long-term business insurer, as required by Regulation 8, its board report must be prepared by its actuarial function; and

(b) for a non-commercial non long-term business insurer, its board report should be prepared by its executive management (alternatively, if the insurer has a suitable actuarial function, it may elect for its board report to be prepared by that function, for example).

(3) Board reports, in relation to an authorised insurer should—

(a) be proportionate to the nature, scale and complexity of the risks to which the insurer is, or may be exposed; and

(b) provide for the information needs of its board,

and the board report may therefore need to evolve over time.

(4) Many of the matters referred to in this appendix for inclusion in the board report may have already been provided to the board in an alternative, documented form. Where this is the case, the board report may reference those documents. However, if cross referencing is used, it should be specific to the relevant parts of documents to allow the relevant information to be readily located by the board and the Authority.

(5) Where relevant, the board report of an authorised insurer should include the following information:

(a) Who has prepared the board report;

(b) A summary of the insurer's—

(i) technical provisions;

(ii) own-funds; and

(iii) SCR (broken down by risk module-components of the insurer's BSCR plus, where applicable, its operational risk module).

(c) An explanation of the key components of the insurer's own-funds, including—

(i) a breakdown by tier;

(ii) the identification of any ancillary own-funds that have been approved by the Authority; and

(iii) a reconciliation to the net asset position in the financial statements where this is different to the insurer's own-funds.

(d) An explanation of how the insurer's assets have been valued, along with details of the level of asset look-through that has been carried out.

(e) An explanation of (including rationale for) the methodology, key assumptions and expert judgements used to determine the best estimate provisions for each line of business. This should also include—

(i) commentary on the sufficiency and quality of data used in those calculations;

(ii) where the simplification under Regulation 18(2) has been used by an insurer to use its accounting provisions as its best estimate provisions, the board report should demonstrate to the board (as applicable) that guidance note 6 (above) is met; and

(iii) if Regulation 18(2) is being utilised by the insurer, justification should also be provided for any prudence removed from the accounting provisions.

(f) An explanation of (including rationale for) the methodology, key assumptions and expert judgements (including any application of proportionality) used to determine the risk margin. This should also include—

(i) where an insurer is using a simplified approach to calculate its risk margin, but is not using a prescribed method under Regulation 21(3), details of the simplified approach being used as well as expert judgements applied, such as appropriate run-off patterns; and

(ii) where a proportionate approach is used, justification as to why the approach has been deemed proportionate in accordance with Regulation 7 (to avoid any doubt, in respect of a non-commercial non long-term business insurer, use of Regulation 21(3)(a) may simply be justified by reference to paragraph 7; however, despite paragraph 7, any use of Regulation 21(3)(b) is required to be justified in accordance with Regulation 21(4)).

(g) An explanation of and rationale for the data, assumptions and expert judgements used when determining the inputs to the SCR risk modules. This should also include—

(i) an explanation of and rationale for any use of proportionality, including (as applicable) where—

A. the Regulations provide for the use of a proportionate approach (e.g. the use of a simplification such as under Regulation 38(13)); and

B. the insurer has decided itself in accordance with the Regulations to use an alternative simplification/proportionate approach (e.g. where groupings of exposures have been used in the concentration risk or counterparty default risk SCR, to provide for a simpler calculation); and

(ii) where a proportionate approach is used, justification as to why the approach has been deemed proportionate in accordance with Regulation 7.

(h) Appropriate general information to aid the board, for example—

(i) a detailed explanation of where any significant changes have occurred to methodologies, assumptions or expert judgements used since the previous board report;

(ii) an analysis of the movement in technical provisions, own-funds and SCR since the previous board report; and

(iii) a reconciliation of the results presented in the financial statements to the those presented in the Regulatory balance sheet, with an explanation for any items allowed for in the regulatory balance sheet that are not in the financial statements (and vice versa).

APPENDIX 4 (Determining Premium Volume Measure under Regulation 40 and Regulation 59)

Introduction

The premium volume measure under regulation 40 (Premium and Reserve Risk Capital Requirement) of the Insurance (Non-Long-term Business Valuation and Solvency) Regulations 2021 was amended in late 2022 to be consistent with the premium volume measure under Regulation 59 (NSLT Health Premium and Reserve Risk Capital Requirement). The amending provision is as follows:

3. Amendment to regulation 40 of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021

(1) Regulation 40 of the Insurance (Non Long-Term Business Valuation and Solvency) Regulations 2021 is amended as follows.

(2) For paragraph (5), substitute the following —

"(5) Unless the requirements of paragraph (7) are met, the premium volume measure for a particular segment is the sum of —

(a) the higher of the expected present value of premiums to be earned by an insurer in the 12 months after the valuation date and the premiums earned by an insurer in the 12 months before the valuation date;

(b) the expected present value of any remaining premiums to be earned by an insurer on existing contracts that aren't already included in sub-paragraph (a); and

(c) for contracts where the initial recognition date falls in the 12 months after the valuation date —

(i) for contracts whose initial term is one year or less, the expected present value of premiums to be earned by an insurer, excluding the premiums to be earned during the 12 months after the initial recognition date; or

(ii) for contracts whose initial term is more than one year, 30% of the expected present value of premiums to be earned by an insurer, after the 12 months following the valuation date."

How to determine your Premium Volume Measure

The premium volume measure under both regulations requires the following inputs:

Volume Measure	EPV of premium to be earned on existing and planned contracts in the following 12 months '000	Earned premium (previous 12 months)* '000	EPV of premium to be earned on existing contracts (not already included in column G) * '000	EPV of premium to be earned on planned single year contracts (not already included in column G) excluding premium to be earned in the 12 months after the IRD * '000	EPV of premium to be earned on planned multi-year contracts (not already included in column G)* '000
1 - Motor Vehicle Liability & 13 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
2 - Other Motor & 14 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
3 - Marine, Aviation & Transport (MAT) & 15 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
4 - Fire & Other Damage to Property & 16 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
5 - General Liability & 17 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
6 - Credit & Suretyship & 18 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
7 - Legal Expenses & 19 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
8 - Assistance & 20 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
9 - Miscellaneous Financial Loss & 21 Prop. Reins.	0.000	0.000	0.000	0.000	0.000
25 - Non-prop. reinsurance - Casualty	0.000	0.000	0.000	0.000	0.000
26 - Non-prop. reinsurance - MAT	0.000	0.000	0.000	0.000	0.000
27 - Non-prop. reinsurance - Property	0.000	0.000	0.000	0.000	0.000

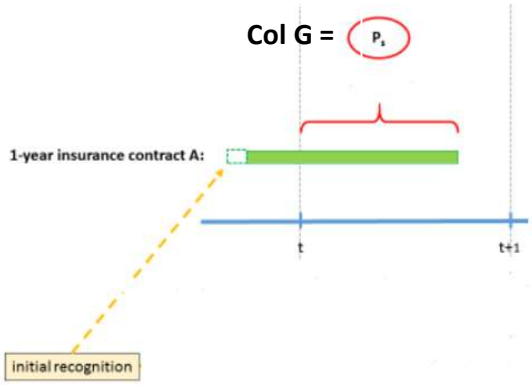
1: EPV of premium to be earned on existing and planned contracts in the following 12 months (Column G): This should include premiums to be earned on existing and planned contracts in the 12 months following the valuation date which could include:

- incepted contracts with coverage periods falling beyond the valuation date (see **Example 1**);
- contracts bound at the valuation date but not yet incepted (see **Example 3**); and
- planned/ in-pipeline contracts expected to be bound or incepted in the 12 months following the valuation date (see **Examples 3 and 4**).

The contracts within the first and second bullet point are existing contracts.

The contracts within the third bullet point are contracts that are planned/ in-pipeline. These should be determined based on current business plans. Where the inception date isn't known, this can be assumed to be half-way through the year.

Example 1: In the diagram P_s is the estimated premium to be earned on existing and planned contracts in the 12 months following the valuation date (Column G), t is the valuation date. This is an example of a single-year contract.



2. Earned premium previous 12 months (column I).

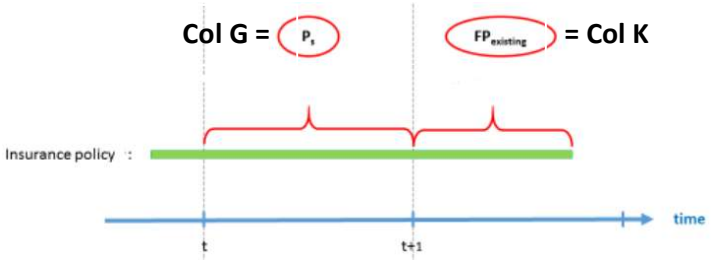
This should include all premiums that were earned in the 12 months before the valuation date.

3. EPV of premium to be earned on existing contracts (not already included in column G) (Column K). This should include premiums to be earned after the 12 months following the valuation date for existing contracts, i.e.:

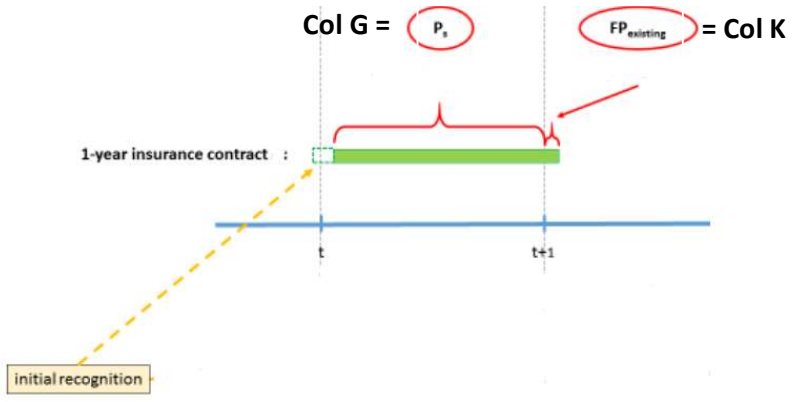
- premiums on multi-year contracts that were bound or incepted, on or before the valuation date (see **Example 2**); and
- premiums on single year contracts that were bound on or before the valuation date but incepted after, hence, extending the cover period beyond 12 months after the valuation date (see **Example 3**).

Premiums to be earned on planned contracts after the 12 months following the valuation date should go in columns M or O (see below).

Example 2: Note in the diagram P_s is the EPV of premium to be earned on existing and planned contracts in the following 12 months (Column G), $FP_{existing}$ is the EPV of premium to be earned on existing contracts (not already included in column G) (Column K) and t is the valuation date. This is an example of a 2-year contract.



Example 3: Note in the diagram P_s is the EPV of premium to be earned on existing and planned contracts in the following 12 months (Column G), $FP_{existing}$ is the EPV of premium to be earned on existing contracts (not already included in column G) (Column K) and t is the valuation date. This is an example of a single-year contract whose coverage period extends beyond 12 months following the valuation date.



4. EPV of premium to be earned on planned single year contracts (not already included in column G) excluding premium to be earned in the 12 months after the IRD[1] (Column M)

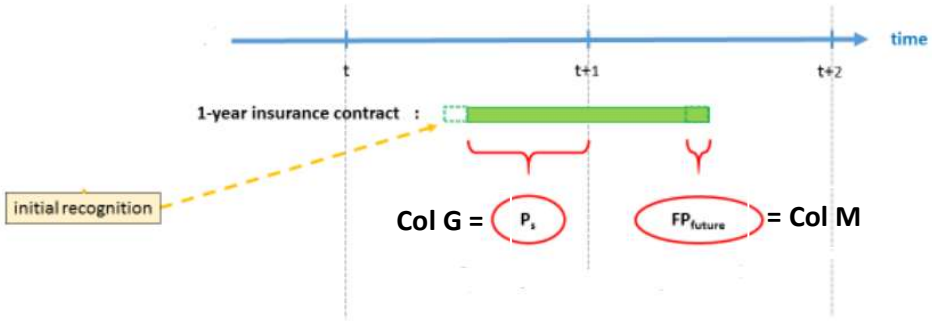
[1] IRD means initial recognition date which is the earlier of the date the contract was bound or incepted.

This should include premiums to be earned on single year contracts expected to be bound or incepted in the 12 months following the valuation date that have not already been included in column G (i.e. premiums earned in the 12 months following the valuation date) and should exclude premiums to be earned in the 12 months following the initial recognition date.

Hence, where cover is bound and incepted on the same day (i.e. the initial recognition date), the premiums expected to be earned in the 12 months after the initial recognition date are excluded and this column will be zero.

Column M will only be non-zero where the cover is bound before the inception date and the cover period extends beyond 12 months after the valuation date. For example, if you had a policy that incepted 6 months after it was bound, the last 6 months of that earned premium (i.e. the part falling after the 12 months after it was bound) should be included in column M (see **Examples 4 and 5**).

Example 4: Note in the diagram P_s is the EPV of premium to be earned on existing and planned contracts in the following 12 months (Column G) and FP_{future} is the EPV of premium to be earned on planned single year contracts (excluding premium to be earned in the 12 months after the IRD) (Column M). t is the valuation date.



The gap between P_s and FP_{future} reflects the exclusion of premium for single year planned contracts that would be earned in the 12 months following the initial recognition date.

Example 5: Note in the diagram FP_{future} is the EPV of premium to be earned on planned single year contracts (excluding premium to be earned in the 12 months after the IRD) (Column M). t is the valuation date.

The gap before FP_{future} reflects the exclusion of premium for planned contracts that would be earned in the 12 months following the initial recognition date.

5. EPV of premium to be earned on planned multi-year contracts (not already included in column G) (Column O)

This should include premiums to be earned on multi-year contracts expected to be bound or incepted in the 12 months following the valuation date that have not already been included in column G (i.e. premiums earned in the 12 months following the valuation date) (see example 6).

This premium measure component receives a 30% discount in the premium and reserve risk SCR calculation.

Example 6: Note in the diagram P_s is the EPV of premium to be earned on existing and planned contracts in the following 12 months (Column G) and FP_{future} is the EPV of premium to be earned on planned multi-year contracts (not included in column G) (Column O). t is the valuation date.