

ANNUAL
REPORT

2008

The Mediator

OF THE FRENCH FEDERATION OF INSURANCE COMPANIES

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introduction



insurance is an activity which is by its nature complex. As it is closely linked to human activity, it constitutes a reflection of society and societal changes, and has done so since its beginnings. There are numerous examples of this, whether it was a question initially of the coverage granted to great commercial expeditions, of the insurance linked to the extraordinary spread of the automobile during the last century, or, in greater proximity to us, the inexorable increase in the need to protect persons from the risks posed by everyday life, be such risks physical, moral or financial.

By its very nature mediation also reflects developments in the areas in which it is called upon to lend its assistance. One should not therefore be surprised that the financial crisis which developed in the second half of 2008, its consequences for the savings and pensions of individuals and the concerns caused by it, constitute the principal theme of this 15th annual report of the FFSA mediator, even if insurance of the person, along with the various and often recurrent difficulties to which such transactions can give rise, would have required that a significant portion of this year's report be devoted thereto.

The current structure of the annual report shall make it possible for the mediator, in light of the matters which have been submitted to him, to set out his expectations and his proposals, with the objective of making it easier to prevent disputes from arising.

This shall be the case in particular in the insurance of the person sector, but also in the non-life insurance sector, where for instance the diverging definitions of the concept of accident always constitute a significant source of problems.

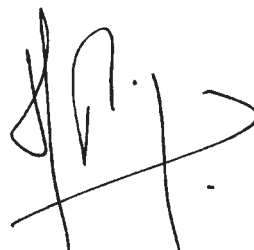
The section devoted to the index provides an opportunity, which is at all times based on specific cases, to recall certain fundamental rules which are for all that sometimes forgotten. It has been established, with the objective of harmonising the reality of the insurance contract with that which the public and sometimes even certain professionals believe it should constitute.

Before giving a statistical overview of insurance mediation, which this year shall be a more precise one, pursuant to the integration of all of the data provided to me by the

mediation services of companies which have elected to appoint a private mediator, I shall report increasing mediation activity at the international level. This international element of mediation would appear to be becoming more and more important. At this level it is the result of the spread of problems, in particular in the financial domain, and illustrates the universal nature of insurance and as a consequence the mediation associated therewith.

In conclusion, I shall, by way of recent initiatives and consultation which is underway in the field of class actions, broach the question of the role which can be played by mediation.

However, prior to this I would like, in light of certain judicial decisions, to share a thought on that which is covered by the concept of equity, which must be implemented by the Mediator, who is obliged by the Mediation Charter to stipulate that his opinions are prepared taking into account elements of the law and of equity.



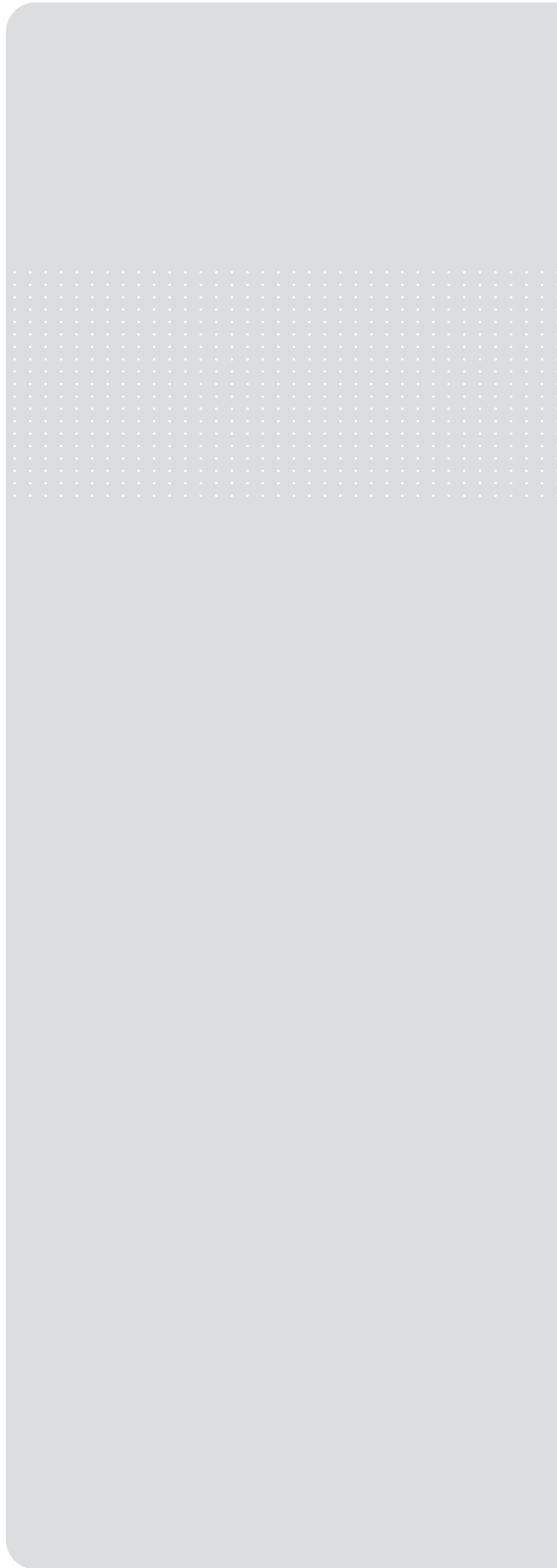
Francis Frizon

FFSA MEDIATOR



01

FIRST CHAPTER



Mediation: an equitable process

Article 8 of the FFSA Mediation Charter stipulates that

“In each opinion issued by the FFSA mediator, it shall be stipulated that such opinion has been drafted taking into account elements of the law and of equity, but also with the aim of achieving an amicable solution which does not correspond to the approach taken by a Court.”



This reference to equity is an element inherent to mediation and more generally to alternative modes of non-judicial dispute resolution in the economic context, wherever in Europe or the world such modes of dispute resolution are practiced. It gives a concrete form to the idea that each individual, in counterpoint to the creation of a market based on free exchange, must in the event of a dispute have easy access to a form of justice.

It is probably on the basis of this idea that we have now arrived at a point where we contrast the law and equity and, as a consequence, the decisions of a judge, who is bound by the rule of law, and the intervention of the mediator, who for his part is at liberty to appeal to equity.

To my mind there should be neither any ambiguity nor any conflict here. For the mediator it is not a question of ignoring at his own convenience the extensive body of legislative and regulatory texts which are applicable to insurance, with which he is bound to comply, like any citizen. Nor may the mediator ignore the interpretations and precisions of case law. The issue is rather the prevention of a straightforward application of legal rules leading in particular cases to unfair solutions.

In order to illustrate this process, insurance against theft constitutes a meaningful example.

On several occasions I have highlighted the difficult situations caused by insurers' strict application of the conditions applicable to proof contained in policies and to which the insurance coverage is subject. Thus, for instance, even when the fact of the theft is not disputed, when there is no evidence of a breaking into a building or vehicle, the insured victim is required to prove the use of copied keys by the burglars. Such proof is very difficult to adduce, taking into account the sophistication of the modus operandi of criminals. However, when the fact of the theft is not disputed and there is no trace of a break-in, there is necessarily a precise, serious and corroborating presumption that the burglar has made use of a stolen or copied key.

In these situations which require a proof which it is almost impossible to adduce – and in which good faith ought to prevail – the mediator is fortunately able to propose a solution in equity, which he is happy to note is accepted by the parties in almost all cases. It is apparent that, in similar cases, the Supreme Court (Cour de cassation), after some hesitation and in the face of conflicting decisions handed down by the lower judges adjudicating on the merits, is now confirming an inflexible interpretation of con-

tract law which, whilst rejecting the concept of freedom of proof, has the effect of depriving victims of insurance coverage on which they are legitimately entitled to rely.

A draconian application of the rule stipulated by Article L.113-8 of the Insurance Code, which holds that contracts are void in the event of a false statement being wilfully made by a policy-holder is another example thereof. Generally speaking, the Courts apply this provision strictly, which has particularly severe consequences.

As justified as such a sanction may be in the cases of proven fraudsters, it has unfair consequences when it is applied to beneficiaries who unknowingly commit a fraudulent act. This is sometimes the case with insurance in respect of death and, without derogating from the law, the mediator can in such particular cases recommend an equitable measure which, whilst acknowledging the cancellation of the contract, invites the insurer to waive its right to retain by way of damages the insurance premiums paid. It is clear that such a measure would be out of place in a court judgement.

The mediator is not expected to order sanctions or compensation and this is not his role. On the other hand, a fair solution which takes into account both the interests of the individual and those of all of the insured parties whose interests are represented by the insurer is expected from him. As the credibility of the mediator depends by its nature on his impartial position with regard to the parties, he must adopt a balanced position as between the parties and his recommendations, in order to be effective, must both comply with the law and be equitable.

I shall refrain from attempting to set out any particular definition of the law, of that which is just and of equity, save for citing the simple words of Jean-Etienne Portalis from his preparatory work on the Civil Code and, as far as equity is concerned, the thoughts of Aristotle.

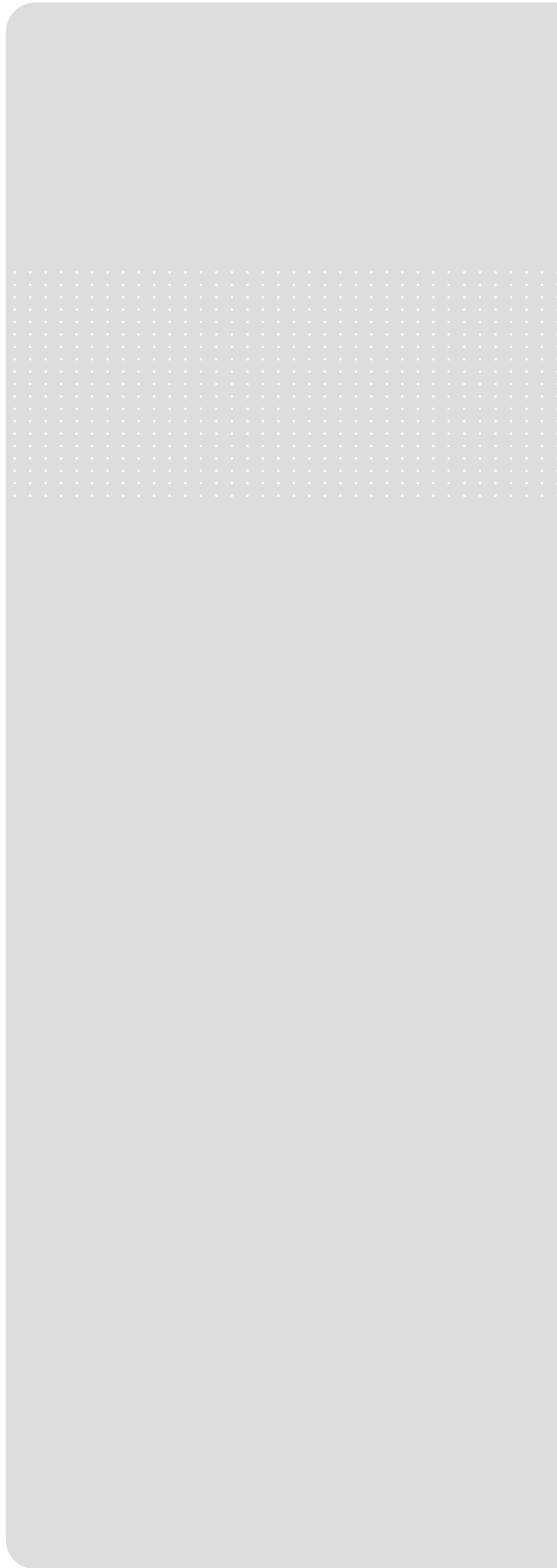
The former considered that “where the law is clear, it is necessary to follow it, but when it is obscure it is necessary to consider it in more detail, and if there is no relevant law, it is necessary to consult convention or equity. Equity constitutes a return to natural laws...”

Of equity Aristotle said that it “makes it possible to hope for true justice, as this is a justice tempered by love to the extent that equity makes it possible to add a human dimension to the inflexible coldness of the rule of law.”



02

SECOND CHAPTER



Mediation: a driving force

It is incumbent on the mediator to make recommendations of a general nature. Beyond the consideration of individual cases, his privileged position in terms of his monitoring and consultative powers makes it possible for him, by investigating the situations on which he is called to adjudicate, to propose the amendment of statutory or regulatory instruments, procedures or practices. In doing so, mediation functions preventively, whilst also contributing to improving the services provided by companies to individuals.

THE DUTY TO PROVIDE INFORMATION AND ADVICE

If there is one area in which the mediator has been called upon to make comments and recommendations, it is the area of provision of information to a policy-holder and the quality of the advice provided by professionals.

Several years ago now I was required, after having found on several occasions that certain contractual documents – which were not necessarily explicit in their presentation or drafting – were marked with a simple stamp stating “To be deemed notification”, to give the opinion in a report that such a practice did not contribute to the clarification of the required information. A debate has arisen in relation to the validity and the merits of the practice involving the issue of general contractual conditions “to be deemed an information sheet”, having regard to the formalities and the letter of Article L.132-5 –1 of the Insurance Code.

Court decisions on this point have handed down draconian sanctions against insurance companies and the legislator has intervened to amend Article L.132-5-2 of the Insurance Code, which now stipulates that the offer or the contract is “to be deemed notification” whenever the mandatory elements – stipulated by the Article of the Code itself – are set out there, in particular with the help of boxed text.

In this area, multiple interventions by both the Courts and the public authorities, to which the initiatives of professional insurance bodies are to be added, demonstrate a shared concern to take into account an essential aspect of the balance between the contractual parties. This is something to be satisfied with. Such satisfaction should be all the greater as it is accompanied by an amendment of the code of good conduct in relation to the marketing of insurance of the person stipulated by the Association Française de l'assurance [Association of French Insurers] and approved by the General Meeting of the FFSA and the Executive Commission of GEMA [Group of mutual insurance companies not member of the FFSA]

Thus, to cite but one example from insurance, namely borrower insurance policies – which has now been commented on by the mediator in his reports several years in a row – let us consider:

▣ alongside the confirmed case law of the Supreme Court (Cour de cassation) in relation to bankers and notaries who make available insurance coverage and according to which “the policy-holder of a group insurance

...
The evolution of practices and methods, a measuring stick for the improved provision of information to the insured.

policy is bound by a duty to advise and provide information to its members and the provision of an information sheet is not sufficient to discharge this obligation”, the consequence of which is that it is the bank or the notary who is marketing insurance and not the insurer, who is obliged to explain to the client the reasons why coverage is being denied, taking into account his age and personal situation;

▣ the finalisation, with the agreement of the FFSA, GEMA and the FBF [Fédération bancaire française (French banks federation)] under the aegis of the Minister for the Economy, of a standard information sheet to be provided to persons applying for a loan, relating to the insurance terms applicable to the loan and which must enter into force during 2009, which sheet constitutes real progress in that it is required to describe in detail by means of an example which is tailored to situation of the person applying for the loan, the various components of the insurance which shall guarantee the proper execution of the loan transaction;

The Code of Good Conduct of the Association Française de l'assurance [Association of French Insurers], which deals with important issues such as the duties of insurance advisers, the marketing of the Plan d'épargne retraite populaire [Retirement Scheme], the transformation of life insurance policies denominated in euros into policies based on units of account or also the advertising of life insurance policies, should not fail to limit the grounds for disputes which are submitted to mediation.

It is also necessary to warmly welcome the initiative of the Mediation Commission of the AERAS convention, which has been required to adjudicate on, as indeed I have been called upon to do on several occasions, the chaos which ensues when persons who wish to acquire a property are required to abandon their plans, when a bank rejects their mortgage application if insurance is refused. A very dim view – and rightly so – is taken of such situations, whenever the bank notifies the applicant tardily and orally in most cases that it has turned down the mortgage application, thereby not leaving any other option for the applicant, who as a result of such inefficiency is obliged to abandon his plans to purchase the property. In order to justify its position, the bank most often hides behind the delay in the insurer's notification of its decision, but such a delay is not always established. Whatever the case, it is not a normal state of affairs that applicants for a loan which is contingent on insurance cover are penalised by this method of processing their applications.

...
The common rules
of good conduct of
the industry.

...
The difficulty
encountered by
borrowers when
seeking insurance.

...
The AERAS
convention “S'Assurer
et Emprunter avec
un Risk Aggravé
de Santé”
[Obtaining insurance
and borrowing
with an aggravated
health risk]



...

The financial crisis and the effects of opportunism.

Thus, the modification of the notification procedure for insurance decisions, in the context of the AERAS convention, now requires the notification of negative outcomes in writing, sent directly by the insurer to the interested party, should constitute an improvement. For all that, all of the difficulties, in particular in connection with the adjournment of decisions and more importantly in connection with applications which are not processed in the context of the convention, which constitute the majority of applications, have not been dealt with.

Whilst congratulating ourselves on these realisations and on the significant progress made, the experience of the mediator obliges him to warn against excessive optimism. It has been seen that efforts must still be made in the area of borrower insurance and it is moreover sufficient to state that a number of claimants had quite clearly not read the information sheets provided to them and more generally that the provision of unfiltered and excessive information is not effective at the individual level.

Similarly it has to be stated that during times of crisis, when fears of the decimatisation of assets which are dependent on the fluctuations of stock exchanges are great, measures stipulating the advance blanket provision of information are insufficient to prevent attempts – which are more or less judicious, depending on the case, and which are very often opportunistic – to recover sums invested in better days from contracts based on units of account. Opportunism and a “deadweight” effect often come together.

PERSISTENT PROBLEMS IN INSURANCE OF THE PERSON

Irrespective of the appreciable efforts of professional insurance organisations in the area of codes of good conduct, there persists conduct to which attention must be drawn again, so very prejudicial is its nature to the image of the insurance industry, and which in addition conflicts with the efforts of the profession. **In this regard, three matters shall be referred to: contracts known as “in fine” contracts, a subject which has already been mentioned in a previous report, disputes resulting from the drafting of the beneficiary clause and, as demanded by the financial crisis, the difficulties inherent in the exercise of the right of relinquishment.**

Contracts known as “in fine” contracts

After my 2004 report, in which I referred to the question of speculative structures which, through a loan transaction which is “in fine” backed on an insurance contract based on units of account, can prove to be disastrous in the event of adverse stock market conditions, very few new matters were submitted to me. This is no longer the case, and over the past year I have noted a significant increase in the number of complaints relating to contracts of this type. This corresponds to the difficult times on the stock markets and certain requests for the intervention of the mediator, which should not be encouraged, are clearly opportunistic in nature.

The introduction of “unit-linked terms comprised of investment securities”, validated by the legislator in Article L.131-1 of the Insurance Code, has turned life insurance into an instrument of financial speculation which is within the reach of a clientèle made up of small investors, who are not averse to dabbling on the stock markets but who are not for all that ready to take great risks.

The intrusion of banks into such transactions has sometimes led to the putting in place of high-risk financial structures. For the bank, the structure consists of granting a loan – generally an in fine loan, under which the principal is to be repaid at the end of the loan – to a client responsible for simultaneously investing the loan in a life insurance policy denominated in units of account. The life insurance policy, which is provided by an insurance company which often belongs to the same group, is pledged to the bank as security for the loan. Basically the client hopes to make a reasonable profit from this transaction, without however having any personal funds at his disposal. This in fact constitutes a risky bet as it can happen – as is currently the case – that the value of the insurance contract given as security is insufficient to cover the loan.

The reactions of such speculators, who have been obliged to surrender the insurance policy by the bank which is the beneficiary of the pledge, are generally reserved for the insurance company, which, according to them, is guilty of a breach of its duty to provide advice.

However, as I stated in my 2004 report, whenever the lender and the insurance company belong to the same group and whenever it is the bank which, in the context of the same commercial transaction, drafts the loan agreement and the life insurance policy of which the purpose is to secure the proper completion of the transaction, whilst putting forward the insurance

...
 Stock markets,
 speculation, bank loans
 and insurance contracts:
 an explosive mixture.



policies offered by its subsidiary, it seems to me, at least in equity, that the bank should not be able to avoid having to deal with any possible shortfall in value on the expiry of the insurance policy given as security.

It is however important to establish precisely who in such circumstances - the bank or the insurer - proposed such speculative structures which it is entirely possible to refer to as risky, and indeed to whom such structures were proposed.

If such a structure is proposed to an inexperienced consumer, who has no financial skills, such a transaction would certainly engage the liability of the establishment which recommends it, as has been held on several occasions by the Supreme Court (Cour de cassation), which has ruled that a bank is in breach of its basic obligations to borrowers when it does not verify the level of their financial capacity and when it grants them a loan which is excessive, having regard to their ability to repay such loan.

Once again, it is to be hoped that the new measures which have been introduced to improve the conditions in accordance with which information and advice is provided by the professionals referred to above shall help to limit such practices which are prejudicial to the most vulnerable.

Beneficiary clauses

On several occasions during mediation proceedings I have been confronted with family disputes caused by the clause in the contract which stipulates as the beneficiaries of the life insurance policy “the spouse of the insured, and in the absence of such spouse his existing or future children, and in the absence of such children his heirs.”

Such a formulation, which is reproduced ad nauseam in the special terms and conditions of insurance of the person policies, gives rise to problems, in particular when one of the designated beneficiaries happens to predecease the insured, to the extent that such a standard designation has the consequence of depriving the children of the predeceased beneficiary of any entitlement to the insurance capital. In other words, if the “children” are designated as the beneficiaries of the policy and if one of them happens to predecease the policy-holder, no payment - save in the event that a wish to the contrary has been expressed - may devolve to his grand-children by way of representation.

...
The beneficiary
clause as a source of
family conflicts.

However, the French legal concept of “representation” (représentation) – which is provided for by Articles 751 to 755 of our Civil Code – is so enshrined in our culture that policy-holders don’t even begin to imagine that such a provision, which is unique to insurance of the person, could affect it.

In the face of such conflicts, which pit family members against each other, I am unable to intervene in any dispute and am able only to follow the disputed provision to the letter, even though in certain cases I find such a provision unfair.

However, the situation is likely to change when persons who are excluded from any distribution of guaranteed capital pursuant to the application of such a beneficiary clause invoke the liability of the insurance company, which, due to the fact that it included such a standard clause in the contract without having explained its consequences to the policy-holder, and without having established the true wishes of the policy-holder, deprives such persons of the chance of receiving that portion of the capital allocated to the predeceased beneficiary.

In such an event, the purpose of any action which may be instigated is not to claim that portion of the capital of which they consider themselves to have been unduly deprived, but rather to obtain equivalent damages. The risk for the insurance company, which fails to be diligent, is therefore that it will be required to pay out twice on the insurance policy.

Such a scenario is not a theoretical one, and the Paris Court of Appeal (Cour d’appel) has not failed to highlight that “it is incumbent on the insurer, in the case of life insurance policies subject to specific legislation derogating from general law, to inform the policy-holder that, contrary to the rules applicable to the devolution of an estate, the representation of predeceased children by their own children neither occurs pursuant to the law or automatically, in order to eliminate any likelihood of confusing a lay insured person,” and that as a consequence the clause designating as beneficiaries “the spouse, and in the absence of such spouse his existing or future children, and in the absence of such children his heirs” was “of a nature to mislead the policy-holder as to the identities of the second rank of beneficiaries.” Nor did the Judges fail in such decision to point out the incongruity of the expression “future children”, as the insured was 81 years old when she took out the policy ...

...
The necessary
amendment of the
standard beneficiary
clause.



In the face of such complex situations which arise again and again, I think it would be expedient to recommend that insurance companies and their proprietors discard the standard clause and inquire precisely what the actual testamentary intentions of their insured parties are. They might moreover take inspiration from the formula recommended by the Bureau commun des assurances collectives, which stipulates that payments are to be distributed to “the spouse or partner pursuant to a civil pact of solidarity (pacte civil de solidarité), and in the absence of such spouse or partner to the descendants in equal shares, with the share of any predeceased descendant devolving to his or her descendants, or to his or her brothers and sisters if the predeceased has no descendants, and in the absence of any sibling to the father and mother in equal shares or to the survivor in the event that one of them predeceases the other, and in the absence of parents to the heirs.”

Such a clause, which envisages the cases which are encountered most frequently, clearly appears to be of a nature to limit both the number of disputes and the risk that insurance companies will be required to pay out twice.

The waiver of the contract

Today no-one can dispute the correlation between number of matters submitted to mediation and the fall in the value of securities listed on the stock markets. Between periods of financial turbulence, applications to relinquish contracts from insured parties who feigned ignorance of stock exchange matters and who claim that they have been given inappropriate investment advice have tended to decrease, or even to stop altogether.

Paradoxically the current financial crisis has greatly facilitated the education of the public in financial matters, in that the media have been required by the crisis to explain, in detail and repeatedly, various products. Today no holder of a contract which is backed by shares can seriously claim to be unaware of the existence of risks linked to stock market fluctuations.

It remains nonetheless the case that one of the consequences of the depreciation of units of account has led to certain insured parties invoking – apart from the failure of professionals to comply with their obligation to provide proper advice – the right to relinquishment contained in Article L.132-5-1 of the Insurance Code.

...

The financial crisis and the temptation to relinquish the policy taken out.


This is the case with an insured who, prior to the fall in the value of his securities, intended to recoup his original investment, on the grounds that he had made successive supplementary payments, each of which he claimed conferred on him a right to relinquish. Another such insured, with the same objective, claimed not to have been able to exercise this right due to uncertainties in relation to the date on which the contract was concluded. And such insured intended to exercise his right to waive the policy, even when he had previously proceeded to surrender the said policy.

In all of these cases the mediator was able only to dismiss the claims, but not without having recalled that life insurance policies are by their very nature taken out for long periods of time and that any rushed intervention, which is solely motivated by stock market fluctuations which occur over such period, can prove to be prejudicial. At the same time, as far as the attitude of certain insurers is concerned, I have been obliged, in the context of a claim based on a failure to provide information in relation to the vesting of the right for the insured to relinquish the contract, to emphasise the good faith which must govern relations between insurers and the insured.

This particular case warrants a mention. An insured who had signed up for a collective life insurance policy with variable capital received a standard registered letter from the insurer explaining to him that “a recent change in life insurance regulations relating to the provision of information to insured persons requires [the insurer] to send to [the insured] an information sheet setting out the material provisions of [his] insurance contract.”

Some time later, having been warned of the consequences of such a formality by a similar letter sent to him by another insurer from which he had taken out another insurance policy, the insured sent to the first insurer a letter of relinquishment based on Article L.132-5-1 of the Insurance Code, requesting as a result the repayment in full of all sums paid by him, at the same time complaining of the insurance company’s failure to stipulate, as other companies had done, that the dispatch of the new information sheet entitled the insured to waive the contract.

The insurer rejected this claim on the basis that it was not made at the proper time, claiming on the one hand that a proper reading of this information sheet would have made it possible to exercise the right to waive the contract, to the extent that such information sheet sets out the provisions of the Insurance Code in relation to the policy-holder’s right to relinquish the policy, and on the other hand that even if other insurance companies did



...
Good faith in the
context of contractual
relations

expressly state that the dispatch of the new sheet conferred the right to relinquish the policy, each insurance company has its own particular practices. For the mediator, it was very clear that when the insurance company took the initiative to send to its policy-holders a new information sheet, it did not do so, as it claimed, in order to inform them of a recent change in the life insurance regulations relating to the provision of information to policy-holders, but did so in order to protect itself from the possible consequences of the case law of the Supreme Court (Cour de cassation). In fact, in its decisions dated 7 March 2006 the highest Court in France condemned the practice of “general conditions constituting an information sheet” as contrary to the provisions of Article L.132-5-1 of the Insurance Code in its version prior to the Law of 15 December 2005, with the result that the policy-holder was still able to exercise his right to relinquish the policy, as long as the insurer had not provided the policy-holder with any new information.

Granted, nothing formally obliged the insurer to inform its policy-holders of the effects of this new presentation of the contractual documents but I was required to find that by remaining silent in relation to this point, the insurer had not only committed a sin of omission but had also displayed a lack of good faith, as it was incumbent upon the insurer, as on other life insurance companies, to draw the attention of policy-holders to the rights which resulted from such harmonisation of their contractual documents with the case law of the Supreme Court (Cour de cassation).

Thus, in both the theory and practice of mediation, equity overlaps with the law.

ON THE EVERLASTING DISCUSSION OF THE CONCEPT OF AN ACCIDENT

Having dealt with this extensively in my preceding report, I shall not revisit in detail the difficulties encountered when claiming payment under policies known as GAV* policies. I would state that difficulties still persist, and are broadly similar in that they relate generally to the interpretation of the clause which defines the concept of an accident, frequently giving rise to differing interpretations.

I would cite by way of an example a claim brought by a person who was declared unable to work following an accident on a public road. This insured, who had claimed the daily compensation stipulated by his policy, was refused

**Garantie des accidents de la vie [insurance policies offering coverage for accidents causing physical injury].*

such payment on the ground that the illness which led to the declaration of occupational incapacity, and which resulted from the accident, was a consequence of a risk excluded from the cover provided by the policy.

After having found that the disputed clause was not drafted clearly and precisely enough to permit its proper comprehension by the insured and that therefore, in accordance with the provisions of Article L.132-2 of the Consumer Code, the clause had to be construed in the manner which was most favourable for the insured, the mediator has had to highlight the necessary distinction between the cause of the injury, which must be accidental, and the nature of the damage. In this case, the event which gave rise to the declaration of occupational incapacity was the accident and the pathology from which the insured suffered was nothing but the direct consequence thereof. To the extent that according to the contract, it was the occurrence of the accidental event which gave rise to the payment, I invited the insurer to make the payment of the stipulated daily payments.


I again can only insist on the necessity of drafting the material clauses of such so-called GAV policies with the greatest care and the greatest precision, and recommend that they are drafted in such a manner as to ensure their optimal readability, in order not to run the risk – at a time when every-day accidents cause 4.5 million injuries and around 20,000 deaths, namely 4.5 times the number of traffic accidents – that faith will be lost in an insurance product which is now acknowledged as constituting real progress in the provision of insurance coverage to our fellow citizens.

The concept of the accidental nature of an event to which the right to payment under an insurance policy is subject is quite clearly one which changes according to the individual but I have been required to adjudicate on a situation in non-life insurance which redefines the limits of audaciousness, as far the arguments put forward by certain insured parties are concerned.

For example, as his Alfa Romeo had become trapped in the sand whilst the insured was attempting to pull his boat off a beach, the vehicle, despite the efforts made, was submerged by the incoming tide. When it was retrieved at low tide, the vehicle was declared to be technically unsalvageable and the insurer refused payment on the ground that the accident did not present the accidental nature required by the policy, with the tide constituting neither a sudden nor an exceptional event.

The insured for his part maintained that the cause of the accident was the accidental immobilisation in the sand of the vehicle, which had led to its immersion by the tide. No clause of the contract, either a clause relating to

...
The imperative that
contractual clauses
are drafted clearly
and precisely.



...
Clauses must be
interpreted in good
faith.

the coverage provided or any exclusion clause, referred to the very specific case of the claimant, and it was necessary to refer to the definition of a covered accident as “a sudden, involuntary and unforeseen event.”

I recalled on such occasion that damage to property is the damage suffered by an asset which involves its deterioration or destruction and that such damage must be a direct, visible and tangible consequence of the damage to the asset. In this case, it was the action of seawater which caused the damage, with the immobilisation in the sand having only caused the immobilisation of the vehicle. If the vehicle had not been submerged by the tide, it would never have been damaged as a result of becoming trapped in the sand alone.

As the tide is a known natural and cyclical phenomenon, of which the insured, who stated that it was a significant coefficient on the day of the accident, was also aware, high tide could not be considered as “a sudden, involuntary and unforeseen event.”

ON THE PROPER USE OF MEDICAL CONFIDENTIALITY

The obligation incumbent on professionals to strictly observe confidentiality and in particular medical confidentiality, is based on the mandatory statutory provisions of the Criminal Code, of which Article 226-13 states that “the disclosure of secret information by a person entrusted with such a secret, either because of his position or profession, or because of a temporary function or mission, is punished by one year's imprisonment and a fine of ₺ 5,000” and of the Public Health Code, of which Article L.1110-4 stipulates that “any person cared for by a professional, an establishment, a health network or any other institution contributing to prevention of illness and the provision of care, shall be entitled to respect for his private life and the confidentiality of the information relating to him.” These absolute rules protect individuals. Their necessary rigour must not prejudice individuals.

The most sensitive area in which such provisions are applied is in the context of the borrower insurance. A number of applicants, who are unable for medical reasons to obtain insurance cover, have been refused loans by banks. Such a situation does not only affect the “aggravated risks” dealt with in the context of the AERAS convention, in relation to which the mediation com-

mission states that the great majority of claims relate to a failure to obtain disclosure of the medical reasons which led to the refusal to provide insurance. My intervention has on several occasions been sought following an insurer's refusal to inform the interested party of the medical grounds on which it has rejected the application for insurance, or on which, after the policy is taken out, it refuses to make payment.

Explaining such refusals, under the cloak of medical confidentiality, to the insured or the beneficiaries, in the even of the former's death, with an excessively concise sentence such as "It emerges from the evidence in our possession that our position is entirely justified and we regret that we are obliged to confirm to you that we reject liability" is somewhat brusque.

It is no more permissible to refuse, again under the cloak of medical confidentiality, to provide to the insured a copy of his own health declarations when he requests them for any reason whatsoever, be it on account of their loss or for any other reason. Nor is it justifiable to refuse, under the cloak of confidentiality, to provide to the heirs of the insured deceased the health declaration made by the latter and on which the insurer is relying. Confidentiality protects the private lives of individuals and it should not be used to protect a dead person to the prejudice of living persons.

I have intervened on a case by case basis with the companies concerned, recalling that it is essential to stipulate grounds for each decision, in order to ensure that the insured and beneficiaries are in a position to understand the reasons for the refusal and to take the necessary steps to possibly dispute the basis for such a refusal and to assert their rights.

If alive, it is a matter for the insured protected by confidentiality to decide if he wishes to disclose in support of his application, or claim, any medical information relating to his person.

In the event of the disappearance of the insured, the insurer must provide to his heirs the information on which it has based its refusal.

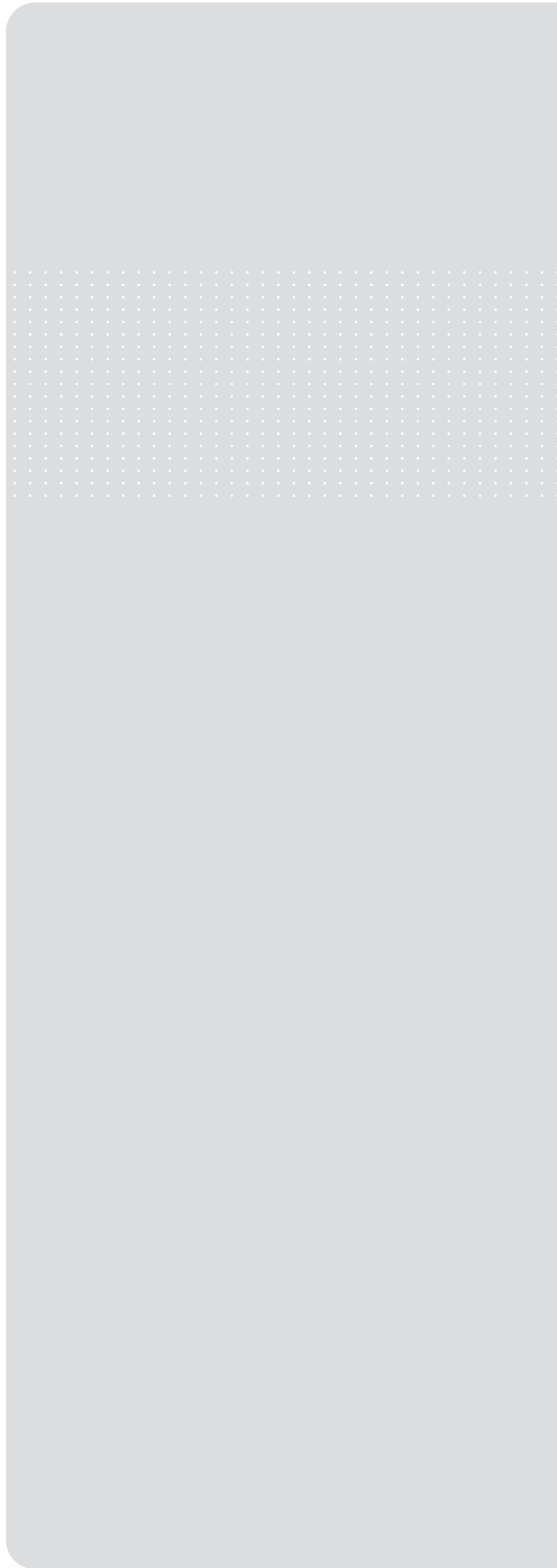
In the context of mediation, knowledge of the elements which constitute the respective positions of the insured and the insurer is indispensable. Compliance with the new procedures for the provision of information which have recently been put in place under the aegis of the Medical Commission of the FFSA should provide a solution which, whilst respecting the imperatives of medical confidentiality, makes it possible for all of the interested parties to assert their rights.

...
 Medical confidentiality must not be prejudicial to the insured which it purports to protect.



03

THIRD CHAPTER



An index for mediation

Very often simply recalling existing provisions is sufficient to settle disputes. Experience shows that a mere reading of the applicable rule suggests the solution. Being convinced that such a systematic recalling of the rules, which I instigated three years ago – whether these are rules stipulated by legislation, common sense or equity – is a useful tool in the prevention of disputes, it seems to me to be a good idea to supplement the index from year to year.



ARTICLE 1315 OF
THE CIVIL CODE:
"A person who claims the
performance of an obligation
must prove it. Reciprocally, a
person who claims to be released
from an obligation must
substantiate the payment or the
fact which has produced the
extinguishment of his obligation."

THE BURDEN OF PROOF

Taking into account the frequency of cases in which the applicant limits himself to claiming from the insurer compensation without stating the grounds for his claim, it is appropriate to recall that the burden of proof is incumbent on the party who intends to seek the performance or the extinction of an obligation.

An insured who intended to make a claim under his insurance policy providing coverage in respect of legal proceedings, in order to obtain compensation for the loss suffered by him, was refused payment on the grounds that he had not adduced any proof that he had actually suffered a loss. I recalled on this occasion that the enforcement of insurance policies is linked to the occurrence of an insured event which causes direct or indirect damage to the insured or any item of his property which is covered. It is therefore essential to establish and prove the existence of damage, prior to seeking the payment of compensation. Basing a claim on a hypothetical loss is insufficient.

The burden of proof is also incumbent on any insurer who wishes to withdraw from any one of its obligations. I have now stated on numerous occasions that insurers who intend to rely on the invalidity of a policy on account of a false statement pursuant to Article L.113-8 of the Insurance Code demonstrate only too rarely the intentional and fraudulent nature of the false statement, whereas such proof is indispensable to the application of a sanction which has particularly grave consequences for the insured.

It is necessary that such rules of proof, which reflect transparency and good faith throughout the term of the contract, are complied with by all parties.

THE DATE ON WHICH THE WAIVING PERIOD STARTS TO RUN

The right to relinquish an insurance contract is a provision which protects in particular the consumer and which is expressly provided for by the Insurance Code. It makes it possible for an insurance applicant to relinquish a life insurance policy or a capitalisation contract during a period of thirty (30) days from the date on which he is notified of the conclusion of the contract. Such a formulation is not as simple as it appears and on several occasions I have been required to adjudicate on disputes where the parties were contesting the date on which the relinquishment period began to run. It is furthermore regrettable that the "renunciation period" is sometimes referred to

in the insurance contract as a “retractation period,” with two designations for the same option not being conducive to clarity.

In a case submitted for my consideration, the insurer considered that the right to relinquish the policy vested once it had agreed to grant the policy and had received the funds. For his part, the insured considered that the relinquishment period did not begin to run until he had received his policy. In fact, there was a disparity between the various provisions in that one provision stipulated that the policy was concluded on receipt of the funds whereas others stipulated its entry into force once certain other conditions had been met.

In the spirit of new Article L.132-5-1 of the Insurance Code, it is imperative that the policy is concluded properly, in order for the insurer to be able to notify the insured and thus permit the relinquishment period to begin.

Thus, is it no longer sufficient to state for example that “the policy is concluded on the date of the encashment of the first payment”, in order for the policy to be actually concluded; it is necessary for all of the elements which constitute a final agreement between the parties to be in place. It is clear that as long as the applicant for a policy has not been provided with the documents stipulating his rights and obligations, such person is not in a position to give his consent. At this stage the contract has not been concluded. It is therefore not possible to claim that the contract was concluded as soon as the funds were en-cashed, as such a view ignores the fundamental rules applicable to the conclusion of contracts.

As a consequence, the right waive the contract can only exist once the insured has signed and returned the contractual documents which contain an express statement to the effect that the insurer has accepted the insurance application. It is not until this stage that the exchange of consent is formalised and the contract may be considered to have been duly concluded. The signature of an accession or subscription form therefore constitutes only a step prior to the conclusion of the contract, as it represents only the expression of the wish of the insurance applicant.

Thus it would appear expedient that from now on, on the one hand, one single term is used to designate the right of the policy-holder to review his decision to take out an insurance policy – I would propose that the term “renunciation” (in French: ‘renoncer’) retained by the Code be used – and on the other hand that the conditions applicable to the exercise of such a right of relinquishment are stipulated in minute detail in contracts in order to avoid any confusion.

ARTICLE L.132-5-1 OF THE
INSURANCE CODE
(EXCERPT):

“Any natural person who has signed a life insurance or capitalisation insurance offer or contract shall be entitled to withdraw therefrom (...) for a period of thirty calendar days from the date on which he is informed that the contract has been concluded...”



ARTICLE L.112-4 OF THE INSURANCE CODE makes the validity of clauses stipulating the forfeiture of contracts dependent on their being drafted in very clear terms.

FORFEITURE OF COVERAGE AND NULLITY

One source of confusion still exists, including on the part of professionals, between the concepts of forfeiture of coverage and nullity. In the context of insurance, the forfeiture of a policy reflects the withdrawal of the insured's right to receive payment under the policy when a breach of a contractual obligation, to which the policy-holder had however freely consented, is established. Thus, for instance, in the context of an all-risks home insurance policy, the insurer sometimes requests that its insured implement security measures which can take the form of reinforced doors, the installation of alarm systems or even window bars. If following the occurrence of an insured event, the expert happens to establish a breach of any one of such obligations stipulated by the policy, the insurer is entitled to declare the forfeiture of the insured's cover. Such a forfeiture has the effect of depriving the insured of the compensation payable pursuant to the insured event. For its part, nullity is not constituted by the withdrawal of any right from the insured but is the sanction for a defect affecting the conclusion of the contract, such as, for instance, the lack of capacity on the part of the policy-holder to enter into a contract, the cause of the contract or its purpose, which conflict with a legal obligation, or furthermore the lack of consent from one of the parties. Whilst the contract continues to exist and to produce its future effects after a forfeiture of coverage, nullity – which has much further-reaching consequences – involves the retroactive vitiation of the contract, which therefore places the parties in their respective positions prior to the conclusion of the contract. It is therefore particularly important that these concepts are used with the greatest of care, as their respective legal effects are entirely different and the consequences thereof are of a greater or lesser gravity for the insured.

THE NON-PAYMENT OF LIFE INSURANCE PREMIUMS

In the context of life insurance, the insurer cannot demand that premiums be paid. In the event that premiums or contributions cease to be paid by the insured, in accordance with the provisions set out in Article L.132-20 of the Insurance Code, the insurer is entitled, once a rigorous procedure has been completed, to reduce policies, or, whenever the surrender value is insufficient or insignificant, to simply terminate the contract whilst

retaining the previously paid premiums. If the surrender value makes reduction possible, the contract continues to produce its effects as between the parties but the commitments of the insurer are reduced pro rata the amount of the insurance premiums received and thus of the mathematical provision which has actually accumulated. The grant of this right to the insurer is subject to a rigorous procedure requiring the provision of information to the insured and compliance with strict time-periods. The application of these provisions may give rise to difficulties, and the insured do not readily understand why they cannot claim back all of the sums paid.

In one case, a person who had learned of the existence of a life insurance policy taken out by a deceased parent was astonished to find out from the insurer the low amount of capital available. The latter had therefore confused the reduction of the contract with its surrender. The intervention of the mediator, in the context of which it was explained to the claimant that, following the decision to suspend the payment of the insurance premiums, the contract had been reduced as consideration for less coverage, put an end to this claim.

In another case, it was more difficult to convince a claimant who had decided to suspend payments after only one year by so informing the company. As the insurer indicated that it had carried out a “partial termination”, the confusion caused was great, and all for a disputed sum of 305 euros.


In fact, the insurer had reduced the contract and could be reproached with nothing at the financial level. However, the procedure requiring the provision of information to the insured had not been followed, with no reminder letter in respect of payment having been sent and the insured not having been informed of the reduction of the contract within the statutory period of forty (40) days. I would emphasise again the importance of the provision of precise information in relation to the methods used for calculating surrender values or the reduction of policies. This would appear to be all the simpler as the procedures stipulated by the regulations are precise and make it possible to put a stop to claims which sometimes prove to be abusive, taking into account the sums in question.

ARTICLE L.132-20 OF THE
INSURANCE CODE
(EXCERPT)

stipulates: “An insurance or a capitalisation firm may not bring an action to demand payment of premiums. When a premium or part of a premium is not paid (...), [this] shall entail either the termination of the contract in the event of the absence or inadequacy of the surrender value or the reduction of the contract.”

FINANCIAL ARBITRAGE

Periods during which the value of securities on stock markets fall lead to an increase in the volume of financial arbitrage on multi-support type contracts, with a high number of insured then wishing to modify their financial exposure by moving their savings to funds in euros or by investing



FINANCIAL ARBITRAGE:
The option offered by
a multi-support life insurance
contract to transfer all or part of
the insured's savings from one
support to another.

in less exposed units of account. Life insurance contracts generally provide for the option for the insured to engage in arbitrage throughout the term of his policy, so that he is able to adjust the financial situation at any given time to the risk exposure sought by him.

I have on several occasions been required to adjudicate on the conditions in accordance with which such arbitrage is carried out and have found that the insured wishing to switch savings invested in units of account to funds in euros can see a significant decrease in the capital available in relation to the sum announced when they made the application to switch.

Generally the insurer explains that such a difference is due to the period inherent in the investment/disinvestment process for the units of account. Whenever an insured undertakes an arbitrage, this is sometimes not carried out until one week after instructions are provided and this period may be a period which is sensitive to a significant reduction in the amount of the investment which is ultimately available.

A certain period of time is obviously required to give effect to the arbitrage order. However, such a period is not always stipulated by the terms of the contract and it is necessary to have recourse to the information sheets for the units of account in question, which are not always available or provided. This only makes any disappointment greater and any disputes more bitter. This is why I would recommend that the terms which govern any financial arbitrage transactions, which must be carried in all transparency, be as comprehensible as possible and in any event do not provide for the attribution of liability for the disputed period by the insurer to the financial institution which manages the account, or vice versa.

THE LIMITATION PERIOD IN LIFE INSURANCE

ARTICLE L.114-1-2:
"The limitation [prescription] period shall be increased to ten years for life insurance contracts when the beneficiary is not the policyholder and in insurance contracts covering personal injury when the beneficiaries are the deceased insured's assigns ..."

According to the provisions of Article L.114-1 of the Insurance Code, all actions pursuant to the insurance contract are subject to a limitation period of two years from the date of the event which gives rise thereto. However, in the context of life insurance, the second section of this same Article stipulates that "the limitation [prescription] period shall be increased to ten years for life insurance contracts", subject however to the condition that the beneficiary of the contract is a person other than the policy-holder. This specific provision protects the interests of beneficiaries who do not dis-

cover the existence of a policy taken out for their benefit until it is too late. Such situations are not rare and this provision of the Insurance Code makes it possible to avoid disputes, or, as the case may be, to resolve such disputes easily, whenever the child designated as the beneficiary of a life insurance policy taken out by his father, for instance, does not become aware of such policy until several years after the death of his parent.

PERIODS: WAITING PERIODS (FRANCHISE) AND EXEMPTION PERIODS (CARENCE)

In insurance of the person, policies may stipulate a period during which the insurer shall not be obliged to perform its obligations. However the effects hereof vary, according to whether the contractual clause stipulates a waiting period (période de franchise) or an exemption period (délai de carence).

The waiting period which is generally provided for in health insurance contracts does not affect the coverage provided. It makes it possible for the insured to receive payments but only after the expiry of a period during which he suffers alone the consequences of the insured event. The period prior to the intervention of the insurer is generally between one and three months. Even if such a provision is generally well understood and accepted, difficulties can arise in the event of successive notifications of insured events, due for instance to relapses of an illness. In fact, as the waiting period applies to each new notification of an insured event, it can happen that the insured, due to the successive exemptions, does not receive any insurance payments. This situation is one which causes bad feeling.

The exemption period is a period during which no payments may be made under an insurance policy. Constituting a frequent provision in care insurance policies, it generally lasts between one (1) and three (3) years from the effective date of the contract. If, when such a provision is stipulated, the insured is declared to be in a state which requires care prior to the expiry of the period, the payments stipulated by the contract cannot be made. The contract is then terminated and the insurance premiums which are already been paid are reimbursed in full.

The purpose of this provision is to avoid assuming liability for situations which existed prior to the taking out of the insurance policy and in respect of which the insurance policy, in the absence of any caveat, can obviously not provide coverage.

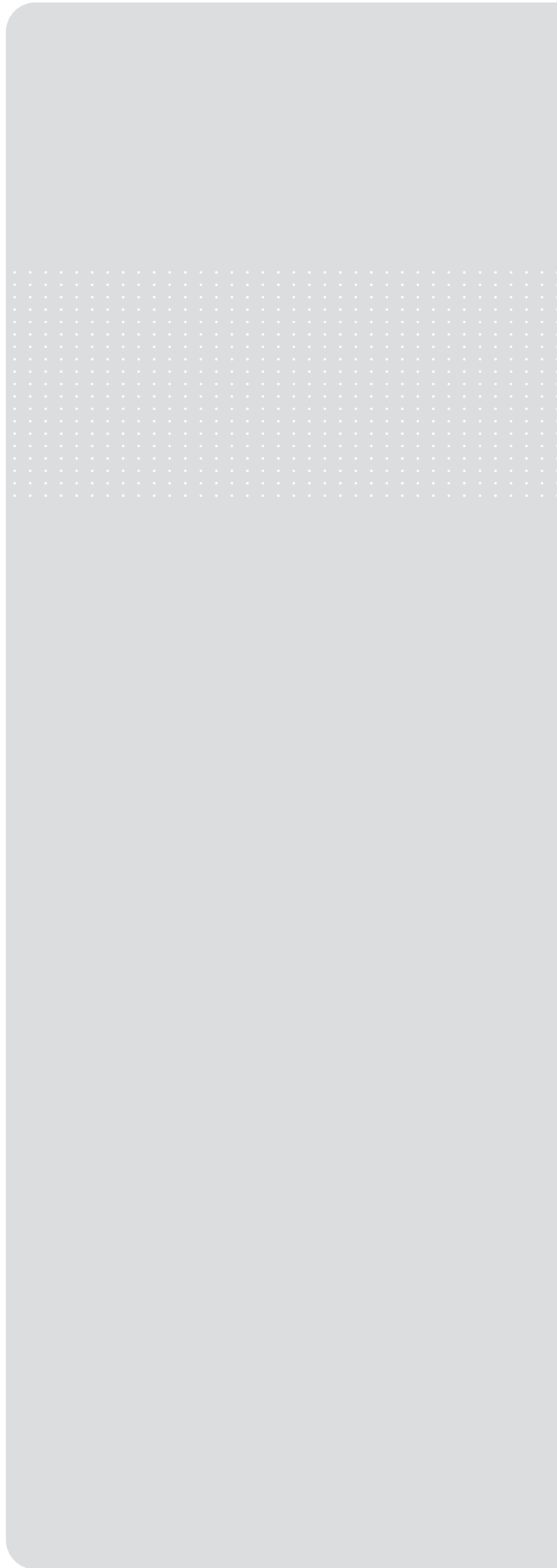
EXEMPTION PERIOD
(CARENCE)
The absence of goods or services.

WAITING PERIOD
(FRANCHISE)
The insured remains his own
insurer in respect of a designated
sum or for a designated period.



04

FOURTH CHAPTER



Mediation at the international level

Interest in out-of-court alternatives for the resolution of disputes between private parties is not decreasing and is definitely not decreasing at the international level. At the European level, recent years have been particularly rich in debate and initiatives surrounding the drafting of the Directive of 21 May 2008 relating to certain aspects of civil and commercial mediation.

The new Directive has caused a certain increase in interest in mediation, both at the level of the European Union and domestically, in connection with its implementation into French law. Co-operation between the different mediation systems has also increased, with an increase in contacts and the links within networks which bring together mediators and ombudsmen, be it a question of the European network FIN-NET or the International Network of Financial Services Ombudsmen schemes, INFO.

THE FIN-NET NETWORK

Protection of the consumer constitutes an integral part of the European project. In counterpoint to the single market, the European Commission is adopting an approach which facilitates and promotes alternative modes of out-of-court dispute resolution. In order to do so, it is relying on institutionalised networks, and in particular FIN-NET in connection with financial services and ECC-NET in connection with consumer disputes. These networks bring together the various bodies which specialise in out-of-court dispute resolution, which -- as they base their work on the principles and criteria, and particularly those of independence and transparency, set out in the Recommendations of the Commission dated March 1998 and April 2001 -- have been notified to the Commission by the authorities of the Member States. These networks constitute a forum for privileged exchanges which make it possible, through the active collaboration of their members, to devise solutions which are adapted to disputes between a national of one Member State with a company in another Member State.



Réseau pour la Résolution des Litiges Financiers

Network for Settling cross-border
Financial Disputes out of Court

The FFSA mediator has been a member since the inception of FIN-NET and I was called upon in 2008 to join its Steering Committee. I am regularly invited to collaborate on European Commission programmes in connection with the provision of information and assistance, which have as their purpose the promotion of alternative modes of dispute resolution within the European Union. I also maintain a relationship with the European Consumer Centres of the ECC-NET network (27 Centres throughout Europe), and in particular with the Franco-German European Consumer Centre in Kehl.

This year more than a dozen matters which are European in their dimensions have been submitted for my consideration. All of these cases are concerned with property or liability insurance and it has been possible to resolve them successfully. Since 2000 more than 80 matters have been processed by FFSA mediation with the assistance of European networks. I have also contributed to fulfilling the Commission's task of providing information by taking part in conferences in Member States, in order to explain and promote mediation.

On the occasion of the publication of the Directive on mediation and in the context of the deliberations of the European Courts on the actions brought by a consumers' group, I appeared with two of my colleagues from the Club of Public Service Mediators before the Consultative Group of European Consumers set up by the Commission.

THE INFO NETWORK



Created at an international conference for financial services ombudsman held in London in 2007, the International Network of Financial Services Ombudsman Schemes (INFO) brings together mediation systems in the financial arena, including systems of all sizes and horizons.

INFO has as its objective promoting the expertise of its members in the area of amicable dispute resolution and the exchange of experience and ideas. INFO organises an annual conference which constitutes a privileged occasion to augment collaboration between members through conferences and workshops. A monthly network newsletter is published on the internet.

INFO has today 34 mediation body members from 23 countries, with a significant majority of such members being from Anglo-Saxon countries. All five continents are represented.

The 2008 annual conference in New York made it possible for me to introduce the mediation of the FFSA, the originality and effectiveness of which were remarked upon. Following this conference, I was approached by the authorities of numerous countries, including Japan and Saudi Arabia, wanting more detail on the French mediation system.

I have also played host to a Chinese delegation interested in insurance mediation. A Japanese insurance company which had become aware of my report wished to meet me for the purpose of putting into place a mechanism to prevent disputes, particularly in the area of borrower insurance policies.



05

FIFTH CHAPTER

4,081
REQUESTS SENT TO
INSURANCE
MEDIATION
SERVICES IN 2008
INCLUDING...

1,411

> MATTERS REFERRED
FOR PROCESSING IN THE
CONTEXT OF INTERNAL
COMPLAINT PROCESSING
PROCEDURES

2,670
RECOMMENDATIONS,
INCLUDING...

297

> FORMALLY ISSUED
ADVICES FROM THE
MEDIATOR

Mediation in figures

It is not a simple matter to give an account of the statistical data representing all insurance mediation, as a result of the various practices and accounting methods employed, and according to whether there is recourse to company mediation or the FFSA mediator. The statistical data published in this report includes, in accordance with the new provisions of the Mediation Charter, the statistical data representing the mediation activities of companies which have elected to appoint a private mediator.* Significant variations which result from such integration render a comparison with the data published in the reports of the previous years irrelevant. However, it does now give a complete overview of insurance mediation, as the results of GEMA [Group of mutual companies not members of the FFSA] mediation have also been included.

Mediation complaints, claims and applications affecting insurance companies are sent to or pass through various bodies:

- The supervisory and regulatory authority for the profession is the natural recipient of complaints from the insured. Thus, ACAM – the Autorité de contrôle des assurances et des mutuelles [Regulatory authority for insurance and mutual undertakings] – which is charged with monitoring compliance with regulations by companies and their agents, received in 2008 3,227 claims, a slight decrease over the previous year. By inviting, in the context of its supervisory and regulatory task, the affected institutions to

comply with their regulatory obligations, ACAM naturally plays a role in the settlement of disputes, even if this is not its primary function.

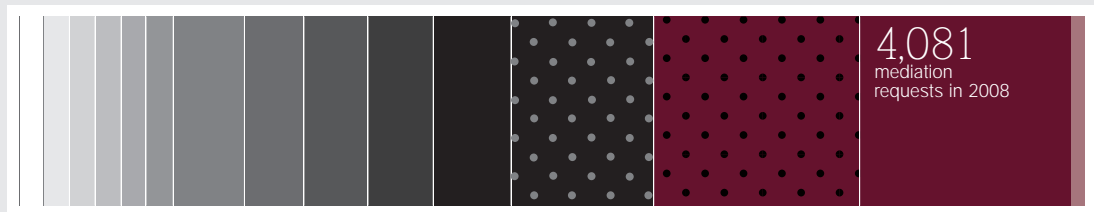
- The Centre de documentation and d'information de l'assurance [Centre for insurance documentation and information] disseminates practical information to the public. In 2008, amongst the correspondence sent to it, it received 839 letters of complaint, compared to 1,224 in 2005 and 846 in 2006, which is an indication of an improved awareness, on the part of the insured and third parties, of the avenues to be followed in the event of a dispute with an insurer.

- The task of the Boîte postale médiation assurance [Mediation insurance post box] is to forward the claims of private parties to the appropriate person or department within the insurance company in question, in order to instigate the processing of the complaint. It is incumbent on this internal department, should the dispute not be settled, to direct the claimant to the mediator. The Boîte postale received 1,876 letters in 2008, compared to 2,109 in 2007 and 2,270 in 2006.

The consistent fall in these figures also attests to an increase in knowledge of the mediation process on the part of private individuals. In 2008, 78.5% of claims directed to the Boîte postale related to a company which was a member of the FFSA and 11.2% of such claims involved a company which was a member of GEMA. The remaining 10.3% was made up of letters which did not make it possible to identify at all the insurer in question or which did not relate to mediation.

* AXA, CNP, GENERALI, MMA-GMF, GROUPAMA, NEUFLIZE Vie.

CHANGES IN THE NUMBER OF APPLICATIONS SINCE 1995

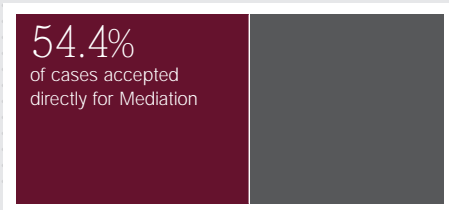


YEARS	NUMBER OF REQUESTS	YEARS	NUMBER OF REQUESTS	YEARS	NUMBER OF REQUESTS
1995	471	2000	534	2005	1,502
1996	509	2001	1,373	2006	2,761
1997	496	2002	1,154	2007	4,002
1998	498	2003	1,232	2008	4,081 + 269 (GEMA) = 4,350
1999	485	2004	1,273		

MEDIATION REQUESTS

Between 1 January and 31 December 2008, 4,081 applications were sent to insurance mediation services. I would once again draw attention to the fact that, as I have pointed out above, the report of the FFSA mediator, on the basis of the statements made to him by company mediators, deals with all insurance mediation activities. This figure therefore includes all mediation requests submitted, whether or not such requests were made to the departments of a company which has appointed a specific mediator, or to the FFSA mediator. In order to have a complete overview of insurance mediation, I have added to the figures for 2008 the 269 requests received by the GEMA mediator.

REASONS FOR THE REFERRAL OF MEDIATION APPLICATIONS



CASES ACCEPTED DIRECTLY FOR MEDIATION	●	54.4%
CASES RETURNED	●	45.6%
REFERRAL TO INTERNAL PROCEDURES		34.5%
NO JURISDICTION		6.9%
SENT BACK DUE TO INSUFFICIENT INFORMATION		4.2%

THE ORIGIN OF REQUESTS



APPLICANTS	●	76.9%
OTHER MEDIATORS	●	12.9%
LAWYERS	●	3.4%
PERSONS AROUND THE INSURED	●	3%
CONSUMER ASSOCIATIONS	●	2.3%
INSURANCE COMPANIES	●	0.9%
OTHERS (CONCILIATORS, ELECTED OFFICIALS ETC.)	○	0.6%

The admissibility of mediation requests

Out of the 4,081 requests received, only 280 matters did not fall within the jurisdiction of the insurance mediator. A break-down of the various reasons for submitting mediation requests confirms the public's improved awareness of how mediation functions. The consistency in the number of cases referred to the companies in question, in order to make it possible to implement or complete internal settlement procedures – of which there were 1,411 this year – makes it necessary to recall that prior to the application to the mediator, all measures, contractual or otherwise, which are likely to facilitate an internal settlement of the dispute, must be taken.

The origin of requests...

The majority of complaints are lodged directly by claimants. The proportion of complaints submitted through lawyers or with the assistance of a consumer organisation remains small. The low number complaints lodged with the assistance of a consumer organisation (2.3% of this year's complaints) is astonishing, given that they are privileged intermediaries and play a significant informative and advisory role for their members.

This situation should improve, to the extent that consumer associations and the Club of Public Service Mediators, which regularly organises consultative meetings, have just formalised their relationship in the context of these exchanges through a "Guide to the partnership between consumer associations and the Club of Public Service Mediators."

The proportion of complaints lodged through my fellow public service mediators, banks, and the Mediator of the Republic has been increasing steadily, which is a sign of the effectiveness of the collaboration between mediators, at both the national and European levels. The complaints lodged through another mediator amounted to 13% in 2008. They outnumber the aggregated number of complaints lodged through lawyers, which increased this year, consumer organisations and by the relatives of the complainant. Whenever the application is made by an insurance company, which amount to 0.9% of cases this year, I require the consent of the insured prior to commencing mediation.

BREAKDOWN OF THE DISPUTES SUBMITTED TO MEDIATION (EXCLUDING GEMA)



THE SUBJECT-MATTER OF DISPUTES

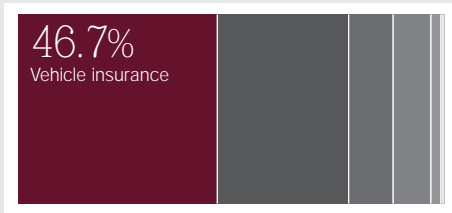
As already stated, the data set out herein now includes all mediation proceedings which have occurred in the insurance sector, apart from those which are subject to the jurisdiction of the GEMA mediator or the mediator of the Chambre syndicale des courtiers d'assurance [Trade Association of Insurance Brokers].

Presented in this way, the figures give a fuller overview than in previous years. Cases involving insurance of the person always constituted a significant majority of disputes. A global view, which would probably be even more detailed, would emerge from the integration of the figures broken down according to class of insurance for the mediation activities of the insurance mutual companies members of the GEMA (mainly non life insurance).

INSURANCE OF THE PERSON	58.6%
INDIVIDUAL INSURANCE OF THE PERSON	28%
COLLECTIVE INSURANCE OF THE PERSON	30.6%
PROPERTY AND LIABILITY INSURANCE	41.4%

Property and liability insurance	41.4%
Vehicle insurance	19.3%
Multi-risk home insurance	12.7%
General legal protection insurance	4.3%
Business risk and professional civil liability insurance	1.9%
Travel insurance	1%
Construction insurance	0.1%
Others	2.1%
Insurance of the person: individual policies	28%
Life insurance	23.8%
Health insurance	2.4%
Accident and GAV	1.6%
Others	0.2%
Insurance of the person: collective policies	30.6%
Borrower insurance	25.2%
Life insurance	3.4%
Health insurance	1.4%
Others	0.6%

NON-LIFE INSURANCE



VEHICLE INSURANCE	●	46.7%
MULTI-RISK HOME INSURANCE	●	30.7%
GENERAL LEGAL PROTECTION INSURANCE	●	10.5%
OTHER INSURANCES (CREDIT CARDS, MOBILE PHONES, ANIMALS, BOATS, ASSISTANCE)	●	8.8%
TRAVEL INSURANCE	●	2.5%
BUSINESS RISK AND CIVIL PROFESSIONAL LIABILITY	●	0.5%
CONSTRUCTION INSURANCE	●	0.3%

INSURANCE OF THE PERSON



COLLECTIVE POLICIES	●	52.3%
BORROWER INSURANCE		82.4%
LIFE INSURANCE		11.2%
HEALTH INSURANCE		4.7%
OTHERS		1.7%
INDIVIDUAL POLICIES	●	47.7%
LIFE INSURANCE		85.2%
HEALTH INSURANCE		8.7%
ACCIDENT AND GAV INSURANCE		5.7%
OTHERS		0.4%

Property and liability insurance

The mass-market classes of insurance, namely vehicle and home insurance, of course represent the great majority of cases. It should be noted that in the case of vehicle insurance, disputes relating to physical injury are an exception, which demonstrates the effectiveness of the specific legislative regime which was put in place several decades ago in an area where litigation was the rule rather than the exception.

Furthermore, an appreciable increase is to be noted in the number of claims pursuant to thefts of mobile telephones and credit cards.

Insurance of the person...

Individual life insurance policies and collective borrower policies give rise to most of these disputes. It should not be surprising that in this context almost all of the complaints received over the last quarter of 2008 related to insurance contracts based on units of account.

This situation shall certainly become critical throughout 2009.

Policies known as borrower insurance, which are either linked to a property loan or a consumer loan, make up 25.2% of all disputes submitted to insurance mediation.



THE AMOUNTS AT STAKE IN DISPUTES

There is widespread thinking to the effect that mediation could have as its basic objective the processing of “small” claims, namely those which involve only small amounts. There cannot however be two forms of justice, namely for those claims where the amounts at stake justify the involvement of a Court and other claims which are left to mediation to be processed. It is a fact that access to the justice of the Courts is complex and can cost amounts which may appear to be disproportionate when compared to the sums in question. Being able to have recourse to an alternative method of settling a dispute therefore constitutes an undeniable benefit.

I consider that this alternative must remain a free choice, whatever the amounts at stake, in order not, bluntly speaking, to surreptitiously create a two-tier form of justice, if one also considers the differences in the period of time necessary to process

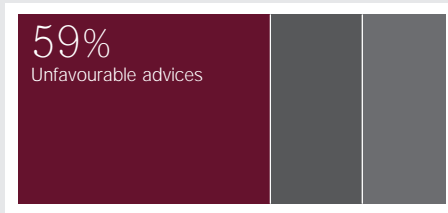
cases according to whether or not one has recourse to the judge or the mediator.

As far as both insurance of the person and product or liability insurance is concerned, I have been required to deal with cases where the amount in question was less than 15 euros in one case, but at the other extreme a case where the disputed sum was more than 250,000 euros.

I would repeat that beyond the financial considerations, the mediation request often represents a plea for an attentive ear and, furthermore, a plea for an acknowledgement at the very least that the problem exists.

It is not a rare occurrence for a case to be submitted to me without any sum of money being claimed, but rather “on principle” or simply so that the problem in question may be considered impartially.

THE NATURE OF OPINIONS



297 ADVICES ISSUED IN 2008 INCLUDING...

UNFAVOURABLE ADVICES	●	59%
ADVICES FAVOURABLE TO THE CLAIMANT	●	21.5%
PARTIALLY FAVOURABLE	●	19.5%

THE RESULTS OF MEDIATION

297 cases led to the issue by the mediator of a formal Advice sent to each of the parties in question. The GEMA mediator for his part issued 182 opinions in 2008. The vast majority of mediation proceedings, apart from cases where the formal issue of an Advice is necessary, vary in terms of their form, the exchange of correspondence, e-mails, telephone exchanges and meetings. Generally a letter from the company in question gives a concrete form to the agreement reached as a result of the submission of the matter to the mediator.

“Approximately 90% of disputes are resolved during the investigation of the matter following the submission of a complaint to the mediator, and this occurs before the mediator is obliged to formally issue an Advice which is served at the same time on both parties.”

The nature of the Advices...

Out of all of the Advices formally issued by the mediator in 2008, almost 41% were favourable or partially favourable to the claimant. This proportion represents an increase over previous years, when the number of opinions unfavourable to the applicant constituted a clear majority of the opinions issued. It is not possible to base one's opinions on a single year, but it will be necessary to be attentive to any indications of a tendency which may be noted over the coming financial years.

Following up on Advices

It emerges from the enquiries made by myself each year into the manner in which cases are followed up that 1.5% of the Advices were not complied with by the insurer or were complied with only partially. Article 6 of the FFSA Mediation Charter stipulates that: “The Advice handed down by the mediator shall not be binding on the parties, who as a consequence shall be free to act or not to act on his opinions.” This was for example the case with an insured who, after being unsuccessful with his complaint, applied to the Courts to ensure the judicial resolution of his dispute, or the case with an insurance company which did not wish to act in accordance with a formally issued Advice. Such cases remain rare, and no such case has yet arisen for the FFSA mediator in 2008. It is however necessary to cite the case where, when I had allowed the claim of the claimant and the insurer had decided to give effect to the formally issued Advice handed down by myself, the claimant instigated legal proceedings. I find it regrettable that a party can have recourse to mediation, only then to turn to the Courts, in order to attempt to obtain a more favourable resolution. The purpose of mediation is to prevent the parties becoming involved in legal proceedings, which marks a profound rupture in their relationship, when a more consensual process is available to them, which in most cases makes it possible for their relationship to continue.



PROCESSING PERIODS

For claimants the periods of time required to obtain a resolution are always too long.

The periods stipulated for mediation vary according to either the FFSA Mediation Charter (three (3) months) or the GEMA Protocol (six (6) months).

In all cases, the claimant considers that the period which is required by the mediator begins to run on the date of the first complaint and it is a matter of incomprehension that the mediator, once a complaint is submitted to him, does not propose a solution more quickly, or even immediately.

I would point out that clearly the mediator cannot hand down an opinion before he is in possession of all of the evidence, including evidence which is often missing and which it is necessary to request from the claimant himself during the investigation of the matter.

Thanks to an appreciable improvement in the processing of cases within companies and the new provision of the Mediation Charter, which requires companies to respond within a maximum period of six (6) weeks to my requests for information or documents, almost 86% of opinions are handed down within less than three (3) months.

Evidently in complex cases, which are ever more frequent, the period prior to receiving the opinion may be longer. By way of an example, in 2008 the processing of a case which had to contend with numerous unforeseen events required 321 days.

At the other extreme, one case was settled in 15 days.





conclusion

this year again I would like to extend my sincere and warmest thanks to everyone within companies and organisations who actively contribute to the success of mediation.

It is thanks to them, their trusting and focussed attention and their initiatives that the vast majority of the cases which are submitted to me are resolved before I am required to formally issue an Advice. Amongst such persons I would like to thank all company mediators and their departments for their collaboration and the support which they give to mediation.

Primarily I would like to extend my gratitude to employees within the mediation service of the FFSA, who, although they constitute a team which is limited in terms of its numbers, successfully guarantee on a day-to-day basis, in an economic context which is daily becoming more challenging and in an environment which is ever more conflict-riven, the quality and the proper functioning of insurance mediation as a result of their commitment, skills and efficiency.

Within a society whose ethos is based on free enterprise and competition, it is essential to encourage all actors to play an active role in maintaining balanced relationships based on good faith and reciprocal trust. Thus, when obligations

are not complied with, individuals must be able to have easy access, without making any assumptions in relation to the substance or otherwise of their claims, to as an out-of-court mechanism with which to settle disputes.

For fifteen years, the mediation of the FFSA, the characteristics of which have since the outset complied with the broad principles contained in the recent EU Directive, has been demonstrating its effectiveness in the resolution of disputes involving individuals and companies.

This is not the situation in all areas of the economy, nor in all countries, indeed far from it.

Thus thinking at both the national and European levels seeking to include in the law the option for consumers to take class actions have quite naturally emerged. The publication of the Green Book of the European Commission at the end of 2008 makes it possible to consult on a wide basis and to instigate a wide-ranging debate between stakeholders, but the question of the introduction into the law of this type of recourse has yet to be settled.

It is readily understandable that, in certain situations where the prejudice suffered by each individual within the collective in question is identical, such proceedings are possible. An industrial mass-market product which does not function or which proves to be dangerous must be replaced by the

producer irrespective of the capacity of its purchaser. The situation is clearly more complex in the financial services sector and even more complex in the insurance sector, where in essence it is necessary to take into account the situation of the co-contracting party, his level of skill and the information held by him, with each case proving to be a special case.

Without wishing to have recourse to caricatures, it would not be equitable to view in the same way the situation of an elderly person who is ignorant of stock markets and who has been induced to take out a policy based on units of account, which transpires to be a catastrophic choice, with the situation of a financial director who might nonetheless claim, profiting from the opportunism, to have been just as prejudiced by a similar policy.

Today opinion is divided.

There are certain persons who consider that disputes of the same nature should have a common solution and that mediation can be collective.

Other persons are of the opinion that mediation can only lead to a personalised response, taking into account the personal situation of each party, his knowledge and skills, and that as a consequence any solution cannot be collective.

As the volume of litigation before the Courts is

constantly increasing, as consumer associations have for a very long time been claiming the right to bring class actions and as such class actions are looked upon with favour by highly placed politicians, but also because they offer advantages in certain areas, the time for the introduction into our legal system of an overriding process has perhaps arrived.

I for my part remain convinced of the benefit, including within such a new framework, of promoting to the fullest extent possible the development of mediation, so as to make it so widely available that it constitutes a step which is taken prior to legal proceedings, whether such proceedings are individual or class actions. In the event of a class action which it is impossible to avoid, with liability acknowledged on the part of the professional in question, mediation should also have a role to play prior to the ultimate court decision.

It will then be important that the role of mediation, within parameters which must be defined precisely, is specifically provided for and organised.

There is no sector where mediation is incapable of playing a role. It is desirable that this thinking is pursued in order to reap all of the benefits from the advantages which mediation, a factor which contributes to social harmony, offers as a concrete and effective alternative to judicial action.



Appendices

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Mediation Charter

The companies of the FFSA have agreed to put in place a mechanism making it possible for the insured and third parties to benefit from a mediation process in order to settle their disputes. This mechanism is defined by the ten rules set out below:

>1

A FFSA mediator shall be appointed unanimously by a board made up of the Chairman of the Institut national de la consommation [National Consumer Institution], the Chairman of the Comité consultatif du secteur financier [Consultative Committee for the Financial Sector] and the Chairman of the Fédération française des sociétés d'assurance. The period of his appointment shall be three (3) years and shall be renewable.

>2

The FFSA mediator shall carry out his task completely independently.

>3

The mediator shall receive all of the assistance, funds and powers necessary to carry out his task. Companies shall have a maximum period of six (6) weeks to respond to requests for information or documents issued by the FFSA mediator.

>4

The task of the FFSA mediator shall be to investigate disputes in the insurance sector between an insured or a third party and an insurance company. Only disputes involving private individuals shall be subject to the jurisdiction of the FFSA mediator.

>5

A matter may be submitted to the FFSA mediator by the insured, by a third party, or with the consent of such parties, by the insurance company, after the internal dispute resolution procedures of such company have been exhausted. In such a case, the limitation period shall be suspended. No matter may be submitted to the FFSA mediator if litigation has been instigated or is underway.

>6

After having investigated the matter with the assistance of the parties, the FFSA mediator shall issue a motivated Advice within three (3) months. The Advice shall not be binding on the parties. The decision on whether or not to implement the opinion of the mediator must be taken by the directors of the company and notified to the FFSA mediator.

>7

The FFSA mediator shall inform the insured or the third party that they continue to be entitled to instigate proceedings before the Courts.

>8

It shall be stipulated in any Advice issued by the FFSA mediator that it has been prepared taking into account elements of law and equity but also with the aim of achieving an amicable solution which cannot correspond to a judicial approach.

>9

An insurance company may appoint a specific mediator as long as such person is an independent party, with whom the company may not have or have had any employment connection. Such company mediator shall then be substituted for the FFSA mediator; his intervention shall comply with the same formal conditions and time periods as the FFSA mediator, as defined in paragraphs 2, 3, 4, 5, 6, 7 and 8 above. The company mediator shall co-ordinate with the FFSA mediator and shall ensure with him the harmonisation of the opinions handed down and shall keep him informed of his activities.

>10

The FFSA mediator shall publish an annual report which shall provide an account of his activities and of the activities of the company mediators who shall for such purpose submit to him a report on their interventions.

Code of Good Conduct

Excerpt relating to the Mediation Charter

- This undertaking has been approved in principle by the General Meeting of 15 December 1992, with the latter having empowered the Executive Commission to stipulate the terms of its implementation. The text of this undertaking was adopted by the Executive Commission on 26 January 1993.

It should be noted that, by its purpose, this undertaking relates neither to reinsurance nor to professional risk insurance and that each of the companies in question has been individually invited to sign it.

This undertaking was ratified by the General Meeting of 24 June 2003. It was then extensively modified by the General Meeting of 16 December 2005.

The Commission consultative de l'assurance [Insurance Consultative Committee] commenced a consultation process in 1991 on the processing of complaints, a process which led to the publication by its Secretary-General in 1992 of a report recommending the promotion of mediation. The members of the Comité de liaison de l'assurance [Insurance Liaison Committee], which at the time brought together the FFSA, Groupama and GEMA, had approved the directions set out in such report and undertook to take the measures necessary to implement them.

It should be noted that since the adoption of this undertaking, Law No. 94-5 of 4 January 1994 inserted into the Insurance Code an Article L112-2, which requires the insurer to stipulate in the information documents provided to the policy-holder the conditions in accordance with which any complaints will be investigated, as well as the existence of a body responsible for such investigation and on which it shall be incumbent, should the dispute persist, to provide to the claimant the contact details of the mediator.

In 2005, the profession amended the Mediation Charter extensively, in order to impose on mediators appointed by companies rules identical to those applicable to the FFSA mediator and, furthermore, to adjust certain rules relating to periods and procedures in line with the expectations of certain professionals who had been consulted.

The full text of the Code is available on the website of the FFSA.

The Public Services Mediators' Charter

THE SIGNATORIES

- The mediator for the Caisse des dépôts et consignations
- The mediator for EDF
- The mediator for Education Nationale
- The mediator for the Fédération française des sociétés d'assurance
- The mediator for France 2 Télévision
- The mediator for France 3 Télévision
- The mediator for France Télévision programmes
- The mediator for Gaz de France
- The mediator for La Poste
- The mediator for the City of Paris
- The mediator for the Ministry of Economy, Finance and Industry
- The mediator for RATP
- The mediator for SNCF
- The mediator for the Mutualité sociale agricole
- The mediator for the Autorité des marchés financiers

Declaration of the Mediator of the Republic

“ *The Mediator of the Republic is an Independent Authority founded in 1973. Like his foreign colleagues, he may not be removed from office or dismissed, and his task consists of making recommendations, in particular on the basis of equity, in order to ensure the amicable settlement of disputes which arise between any natural or legal person and any*

body which carries out a public service mission. The evolution of our society and the aim of each public service to improve relations with its users has led to the creation of fora for mediation in several sectors. The Mediator of the Republic and the various public service mediators confirm their wish to work in concert in order to increase the efficiency

and the speed with which it is necessary to respond to the requests of our fellow citizens. The Mediator of the Republic approves the principles of this Charter which seeks to set out the elements of good practice for institutional mediation, in order to prevent such term from losing its value.”

The Club of Public Service Mediators which brings together *intuitu personae* mediators from bodies, public authorities or companies charged with the provision of a service to the public, has drafted and published a Charter setting out their shared values. Excerpts from this Charter, which was signed on 16 September 2004, are set out below.

The signatories of the Charter have a common concept of service to citizens, clients and users which promotes consultation, dialogue and the amicable resolution of disputes (...).

Institutional mediation is an alternative mode of dispute resolution. Like contractual mediation, it may be implemented in order to attempt to avoid legal proceedings and to settle specific and individual disputes between natural or legal persons and institutions or companies (...).

Institutional mediation is free, quick, readily accessible and occurs once all other internal modes of recourse have been exhausted (...). Institutional mediators are persons who have a key role to play, not only in the settlement of disputes between the institution and its public, but also in terms of prevention and acting as a catalyst for change within institutions or companies (...).

Public service mediators shall first of all ensure compliance with legal rules and they shall base their activities on the inherent values of mediation: the wish to facilitate the identification of amicable resolutions for disputes; equity; impartiality with regard to the complainant, the company, the authority; respect for the principle of adversarial process; the transparency of activities; confidentiality (...).

The particular status of institutional mediators is a guarantee of their impartiality in dispute resolution. They are independent of the structures of the institution or company (...).

Due to their position, their experience, their moral and professional authority, and due to the independence which they have within the institution, mediators (...) also have an overview of any problems detected, which helps them to better reveal the malfunctioning of the institution and makes it possible for them to propose changes (...) to the improvements proposed in the annual reports on their activities (...).

Texts

... Law No. 94-5 of 4 January 1994

Insurance Code - Article L112-2 (excerpt)

Paragraph 2

"The documents provided to the policyholder shall specify the law which governs the contract when French law does not apply, the procedures for investigating any claims which he may make under the contract, including in particular and if necessary, the authority in charge of such investigation, without prejudice to his right to bring a legal action, and the address of the head office and, if necessary, the address of the branch office offering the coverage."

... Recommendations of the Commission of the European Communities

Commission Recommendation of 4 April 2001 on the principles for out-of-court bodies involved in the consensual resolution of consumer disputes (notified under No. C (2001) 1016)

Commission Recommendation of 30 March 1998 on the principles applicable to the bodies responsible for out-of-court settlement of consumer disputes (notified under No. 98/257/EC).

... Directive 2008/52/EC of the European Parliament and of the Council of 21 May 2008 on certain aspects of mediation in civil and commercial matters

... PUBLICATIONS

Annual report on the activities of the Autorité de contrôle des assurances and mutuelles (ACAM)
www.ccamip.fr

Annual report on the activities of the Comité consultatif du secteur financier (CCSF)
www.banque-france.fr/ccsf

Report on financial mediation
www.ccsfin.fr

Annual report on the activities of Euro Info Conso
www.euroinfo-kehl.com

Association Française de l'assurance [Association of French Insurers] Code of good conduct in relation to the marketing of insurance of the person
www.assfass.fr

2008 report of the mediator of the mutual undertakings of GEMA
www.gema.fr

Mediation Commission of the AERAS Convention
2008 report on its activities
www.aeras-info.fr

GUIDE TO THE PARTNERSHIP between consumer associations and the Club of Public Service Mediators

MEDEF. Mediation and consumers
Practical guide for companies and professional associations
www.medef.fr

Banking Mediation Committee, 2007 Report
www.banque-france.fr

2008 report of the mediator of the Fédération bancaire française [French Banking Federation]
www.fbf.fr

... WEBSITES

Site of the Fédération française des sociétés d'assurance (FFSA)
www.ffa.fr

Website of the Institut national de la consommation (INC) [French National Consumer Association]
www.inc60.fr

FIN NET website
http://ec.europa.eu/internal_market/fin-net/how_fr.htm

INFO website
www.networkfso.org

For more information...

... USEFUL ADRESSES

Le Médiateur de la FFSA
[The French insurance Mediator]
BP 290
75425 Paris Cedex 09

Boite Postale Médiation Assurance
[Insurance Mediation Post box]
1, rue Jules Lefebvre
75431 Paris Cedex 09

Centre de Documentation
et d'Information
de l'Assurance (CDIA)
[Insurance information center]
26, boulevard Haussmann
75311 Paris Cedex 09

Le Médiateur des mutuelles
d'assurance du GEMA
[The Mediator for the mutual
insurance companies of GEMA]
9, rue de Saint Pétersbourg
75008 PARIS

... COMPANY MEDIATORS

AXA
Secrétariat de la Médiation
Terrasse 4
313, terrasse de l'Arche
92727 Nanterre Cedex

CNP ASSURANCES
Direction Médiation
4, place Raoul Dautry
75716 Paris cedex 15

GMF
Monsieur Le Médiateur
Association nationale des sociétaires de la Garantie
Mutuelle des Fonctionnaires
91, avenue de Villiers
75017 Paris

GROUPAMA
Secrétariat de la Médiation
5/7, rue du Centre
93199 Noisy le Grand Cedex

GENERALI
Secrétariat de la Médiation
7, boulevard Haussmann
75440 Paris Cedex 09

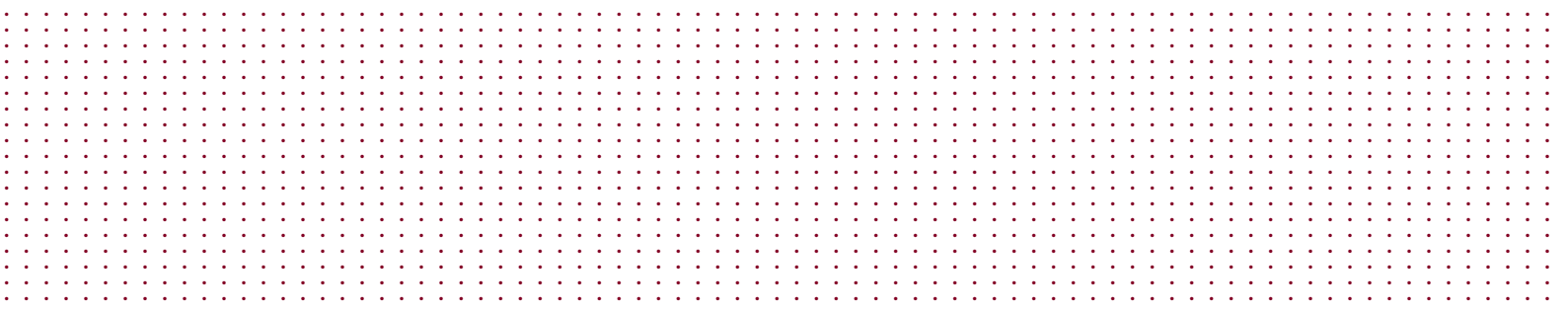
MMA
Service Clientèle et Médiation MMA
10, boulevard Alexandre Oyon
72030 Le Mans Cedex 9

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3, avenue Hoche
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