# INSURANCE

Insurance, as defined by law in Italy, is a specific type of contract in which the protagonists are two parties, the insurer and the insured. By taking out an insurance policy, the insurer is obliged, subject to agreed limits, to reimburse the insured party for a loss it has suffered or to pay a sum or annuity when certain events and/or circumstances set out in the policy occur. On their part, the insured is obliged to pay a sum, called a premium, without which the insurance has no effect, as well as to take diligent steps to avoid accidents and to inform the insurer of the event within three days or in any case within the time limit defined in the agreement).
One can distinguish specific types of policies referring to different topics, events and circumstances. Below are the characteristics of the most common types off insurance.

### 1. Life insurance

A life insurance policy is a form of insurance that is triggered by the occurrence of an event pertaining to a person's life. This type of insurance can be a form of protection against the risks of illness or premature death or, otherwise, an investment opportunity.
In life insurance, four parties are involved: insurance company, policyholder, insured and beneficiary.

- The insurance company is the company that receives payment of the premium from the policyholder, possibly through an intermediary authorised by the latter do so, against a commitment to pay the insured benefit within the terms of the contract;
- The policyholder is the party that enters into the insurance contract, assumes the obligation to pay the premium vis-à-vis the insurance company and is entitled to exercise all the rights inherent in the contract;
- The insured party is the person on whose life the contract is concluded and the insured benefits are calculated; in other words, it is the person whose death, survival or other insured event gives rise to the insurer's obligation to pay the insured lump sum or annuity;
- The beneficiary is the person designated by the policyholder to receive the insured sums if the insured event occurs, i.e. the person entitled to the benefit paid by the insurance company. Depending on the type of contract, the figure can be distinguished and articulated according to the insured event, e.g. it may be foreseen that with reference to the insured benefit on contractual maturity, in the event of the survival of the insured party, the beneficiary is a subject X, whereas in the event of premature death the insured benefit is paid to the legal heirs of the same subject X.

The premium comprises the basic cost of coverage, charges (i.e. the cost of distributing and administering the policy) and ancillary costs for administrative charges and tax duties. The insurer may ask for a surcharge if the insured party's state of health poses greater risks than those considered 'ordinary', or if

the insured party engages in particularly risky professional or sporting activities. The premium may be: a single annual premium, paid at the start of the contract and valid for the entire duration of the policy; or a recurring premium, of a variable amount at the policyholder's discretion within the limits specified in the contract. It is possible to pay the premium via various methods, unless a specific method of payment is prescribed in the information documents issued by the Company. It is important to always read the documentation provided before signing the contract, which generally includes a summary sheet and an information note that enable the user to have both an overview of the product and to know its details.

At least one month before the expiry of the contract, the company must send the beneficiaries a notice reminding them of the approaching expiry date. In order to obtain payment, the beneficiary must submit a request for payment together with the documents stipulated in the contract. The policy conditions generally set a deadline of 30 days from receipt of all the necessary documentation to settle the insured lump sum or annuity. Even before the expiration date, however, the customer has the option of terminating the insurance relationship early and requesting the so-called surrender of the policy, i.e. to obtain a lump sum from the company. It is also possible to suspend the payment of annual premiums by keeping the contract in force until maturity for a proportionally reduced capital sum (reduction) and then resume the payment of amounts after the suspension period (reactivation). The above options (redemption, reduction and reactivation) are governed by the terms and conditions of the contract.

**The composite life policy**. It is a product that combines traditional life insurance policies, with a financial guarantee from the company, with unit-linked life insurance policies, where the investment risk falls on the policyholder. It is therefore important that you assess in detail the level of risk you are willing to take and the average annual percentage costs, pay particular attention to the terminology used in the information package, to the questions asked for client profiling, and to the possible presence of capital reallocation mechanisms between the two types.
Depending on the purpose for which the contract is concluded, there are different types of product to choose from.

### *1.1 Saving or investing*

Insurance aimed at savings and/or investment includes reappraised life products, reappraised annuity products and financial-insurance products. The different types can also be merged into a single product called "composite". These forms of insurance allow a sum or a payment plan to be used in a form of savings (reappraised life products and reappraised capital redemption policy) or in a supplementary annuity (reappraised life annuities) characterised by a guaranteed minimum return and, as a rule, by the consolidation of the returns obtained, i.e. without the possibility that the reappraised capital or the amount of the insured annuity may decrease. They are, therefore, suitable for users who do not wish

to take financial risks, who prefer low but guaranteed returns or who wish to ensure themselves or another person (e.g. their spouse or children in the case of a reversionary life annuity) an annuity instalment that will be paid out for life. Such products may therefore be suitable for intergenerational saving choices. Depending on the type preferred, savings insurance may guarantee the payment of the appreciated capital upon the policyholder's death, at the contract's maturity (with the possibility of choosing whether the payment should be made when the policyholder is still alive or when he/she has died) or at a pre-determined date, or the payment of a reappraised life annuity (effective immediately or starting from an agreed future date) against the payment of a premium by the customer. Insurance dedicated to investment, on the other hand, is linked to the performance of financial markets: the return on capital may be linked to the performance of investment funds or indices, and the customer may pay a single or annual premium, agreeing on the amount according to his or her needs, and, in agreement with the company, establishing the duration of the contract. Such products are suitable for those who prefer to invest their savings dynamically, identifying investment solutions best suited to their appetite for risk.

### *1.2 Protection*

These are forms of insurance designed to protect against the occurrence of certain risk situations: death, permanent disability, loss of self-sufficiency and serious illness. In return for the payment of a premium by the customer, the insurance company guarantees the payment of a benefit (usually a lump sum, in some cases an annuity), constant or decreasing, upon the occurrence of the insured event (claim) during the term of the contract.

Generally, the only benefit is to cover the insured risk, thus not providing for benefits such as repayment of the capital during the contract term (so-called surrender) or at maturity, when the contract expires.

The duration of the contract and the insured circumstance can be chosen by the customer or also determined according to the amount of debt the customer has incurred with a mortgage or loan, covered by the insurance in question. These forms of insurance usually cover risks such as death of the insured, permanent disability, loss of self-sufficiency and the onset of serious illness.

### *1.3 Supplementary pension schemes*

Supplementary pension forms provide that, once it has received the payments from the client, the insurance company allocates these same amounts to the accumulation of a certain sum which, once the retirement requirements have been fulfilled by the holder, will be converted into a supplementary pension. They are therefore suitable for those who consider it necessary to supplement their future pension: being tax-incentivised by the state, such pension forms can be an effective investment for a large number of citizens.

Supplementary pension schemes can take the form of Individual Pension Plans (IPPs) or open pension funds. IPPs, dedicated only to individual subscription, can receive the employee's contribution (for employees it is possible to allocate their severance indemnity fund for this purpose and receive the employer's contribution on a voluntary basis) and can be invested in separate insurance management schemes with a guaranteed minimum return or in units of investment funds of various types, also dividing the total amount of contributions among different components according to the age of the holder and the number of years remaining until being eligible for the pension. Open pension funds, on the other hand, are dedicated to both individual and collective memberships, thus in addition to the employee's voluntary contribution and severance indemnity fund, the employer's contribution as defined within the collective agreement. For this type of fund, it is possible to choose either more cautious investment lines, which therefore provide a minimum return guarantee, or riskier ones, depending on the age of the user or the duration of subscription.

## 2. Health insurance

Health insurance has peculiar characteristics compared to other insurance products, mainly due to the fact that unlike policies in which the subject of cover is a tangible asset, in respect of which known market values can be taken as a reference for determining the sum insured, the protected asset cannot be valued according to precise objective criteria, as the sum to be insured should correspond to the sum necessary to compensate for the decrease in income resulting from the diminished capacity to work. Considering, however, that a future income related to the pursuit of the profession is uncertain - since it can of course be estimated in the long term, but based on forecasts that can easily be disregarded and can also be influenced by numerous external variables - the determination of the value, hence of the sums insured, is left to the will of the parties. By taking out health insurance, one is covered for all illnesses, i.e. all changes to an individual's state of health, that present the characteristics of possibility and non-voluntariness. Generally, contracts also provide automatic coverage for the consequences of an accident, understood as "any event due to a violent and external fortuitous cause, which produces objectively ascertainable bodily injury".

The objectivity of the disease (resulting from examinations, diagnoses, medical examinations, consultations, etc.) and its 'evolutionary' state are also considered, that is, the pathway from simple onset (alteration in progress, but not yet evident through symptoms or through diagnosis made) to manifestation (occurring through symptoms or diagnosis), to the treatment phase and finally to that of convalescence and any after-effects. In order to constitute the subject matter of a contract, a future change must obviously take place, in the sense that it is certainly not possible to insure a disease that is already in place. Taking out a health insurance policy requires a specific risk assessment by both parties, insurer and insured, which is carried out by means of a specific health questionnaire attached

to the policy and aimed at describing the user's state of health as known by them: the questions relate to any previous illnesses, pathological situations, malformations, accidents, disability, use of drugs, results of diagnostic tests and hereditary factors. Following the results of the questionnaire, the insurance company allows full and total insurability (if there are no pathologies or in the case of pathologies that do not affect the policy, e.g. myopia) or, on the contrary, provide for exclusion of a pathology from the policy (in the case of pathologies with recurrences and consequences, e.g. cysts and polyps) or provide for a deductible or a limitation of indemnity (in the case of pathologies with possible recurrences, e.g. kidney stones) or an increase in the premium (in the case of pathologies that could entail a higher risk, e.g. diabetes and high blood pressure) or exclude the client's insurability altogether, e.g. in the case of very serious pathologies (e.g. cancer). On the part of the insured, it is then essential to examine in detail the timeframe set out in the contract for the policy to take effect. Generally speaking, the guarantee becomes operative according to the following timetable:

- For accidents: from the day on which the premium is paid;
- For illness occurring after subscription: after 30 days (60 days in the case of permanent disability);
- For illnesses related to unknown pathologies pre-existing to the contract or known and declared at the time of conclusion: after 120/180 days ;
- For childbirth: after 270/300 days;
- For miscarriage and pregnancy diseases: after 90/120 days for miscarriage.

The insured party must also scrupulously analyse the circumstances expressly excluded from the health policy, including pathologies pre-existing to the contract and deliberately concealed from the insurer, treatments required as a result of malicious behaviour on the part of the client, treatments to correct or eliminate physical defects or congenital malformations, treatment and/or consequences of alcoholism, drug addiction, use of narcotics and hallucinogens, dental and cosmetic treatment, injuries related to the performance of certain sporting activities, assisted fertilization procedures and/or operations and, in general, any event related to malicious conduct on the part of the insured party.
Even within the macro-category of health insurance, it is possible to distinguish certain subsets.

### *2.1 Insurance for the reimbursement of medical expenses*

Although each policy may have specific peculiarities, it is generally found that with respect to hospital and surgical expenses, reimbursement includes hospital fees, the costs of admission and the operating team, the costs of transporting the insured to the place of treatment, expenses before and after admission and/or surgery, and other extensions.

On the other hand, with regard to the reimbursement of specialist examinations and diagnostic tests, some policies cover specialist examinations - usually the most clinically demanding and financially

burdensome - as well as examinations and tests of a preventive nature, subject to certain conditions (e.g. no more than one examination per year).

### *2.2 Indemnity insurance*

It is aimed at compensating the loss of earnings resulting from the insured's absence from work as a result of illness and/or accident or also at providing lump-sum support for the increased costs of medical care and treatment. This is a policy of particular relevance for the self-employed or workers who are not employees, although of course it is not excluded that even employees, despite INPS and INAIL coverage, may in some circumstances need private insurance cover. The most common form of indemnity is hospitalisation indemnity, paid by the insurance company for each day of hospitalisation at an amount chosen by the user. It is possible that the contract provides for a deductible in terms of days of hospitalisation - in this case, the indemnity to the insured will correspond to the number of days of hospitalisation minus the deductible (generally the day of hospitalisation and the day of discharge are excluded) - and the application of surcharges for hospitalisation abroad or in the case of particularly serious or complex operations.

### *2.3 Critical illness insurance*

The protection offered by the insurance covers financial losses resulting from the onset of critical illnesses specifically provided for in the contract, as a result of which a predetermined sum is paid. Such policies almost always include stroke, cancer and myocardial infarction, to which coronary artery bypass surgery, kidney failure and organ transplantation are often added. Critical illness insurance may also be combined with temporary cover in the event of death. Critical illness policies always have an age limit, both minimum (18 years) and maximum (may range from 55 to 64 years), and generally exclude payment of benefits for claims arising from post-traumatic events, for illnesses arising before the contract is signed, and for death of the insured within 30 days of the first diagnosis of the critical illness. The insurance company may reserve the right not to proceed with payment of the insured sum in the event that the documentation supporting the claim was produced by a doctor practising in a country not included in a specific list provided for in the contract.

### *2.4 Long Term Care Insurance*

Long Term Care (LTC) policies, cover the loss of self-sufficiency in the independent performance of basic functions and activities of daily living - not necessarily due to illness or accident, but also to ageing - guaranteeing benefits in terms of services in kind or lump sum monetary amounts. Most insurances identify loss of self-sufficiency when the insured is unable to independently perform some basic activities of daily living (ADLs) such as dressing and undressing, getting around, maintaining good personal hygiene and feeding oneself. Loss of self-sufficiency is also recognised when the insured is diagnosed

with a nervous or mental disorder of organic origin, such as Alzheimer's disease or other incapacitating dementias leading to loss of mental capacity. An LTC policy provides for the payment of a life annuity in the event of continued Long Term Care. Again, there are specific age limits, normally 18 as the minimum age and 70 as the maximum age. In addition to not covering the insured's pre-existing or pre-diagnosed medical conditions, LTC policies generally contain exclusions similar to the ones specified for temporary death cover.

### 3. Motor Third Party Liability Insurance (TPL Car)

Motor Third Party Liability insurance is compulsory by law for all vehicles and covers the eventuality that a person causes personal injury or damage to property in a road accident; hence, when driving a vehicle. Vehicles parked on public roads or areas equivalent to public roads are also considered to be circulating; therefore, even if the car is parked on the street without being used, it is still subject to insurance. The obligation was introduced on the assumption that the driver is wholly or partially responsible for the damage and that there is a cause-and-effect relationship between the wrongful act (i.e. the action constituting a breach of the Highway Code) and the unjust damage caused. In the event of a collision between vehicles, it is further presumed that all drivers of the vehicles involved contributed equally to causing the damage, at least until proven otherwise; therefore, unless evidence to the contrary emerges, each driver is obliged to compensate, in part, the damage suffered by the other. Motor third party liability cover includes damage (physical and material) caused to indirectly involved non-transported third parties (excluding the owner, driver, lessee, usufructuary, buyer under hire purchase, limited liability partners if the insured is a company and relatives of the insured) , (bodily) damage to the passengers on board the insured vehicle, (material) damage to the passengers on board the non-liable insured vehicle. Compensation for damages may be partially reduced for the injured party in the event of they failed to wear a seat belt or helmet, or for contributory negligence on the part of the injured party. In the event of driving while intoxicated or under the influence of narcotics, transport that does not comply with the provisions of the vehicle registration certificate, or driving with no driving licence, the insurance company will compensate the injured third party in full, but will then claim against the insured.

### 4. Home and family insurance

Home and family insurance is a form of protection both for damage to the home and for the economic integrity of the entire household. Policies can be customised to the specific needs of the insured. You can therefore choose comprehensive cover with all the options of the multi-risk policy, partial cover with only those options for which you consider it necessary to take out insurance, or cover limited to basic cover only.

The contract, which runs for one year, is automatically renewed unless notice of termination is sent by

registered letter in advance, as stipulated in the contractual terms and conditions (generally 30 or 60 days before expiry). The parties agree on the amount and terms of payment as well as the type of risk to be insured: in order to establish these elements, the client must provide comprehensive and complete information on the risk in question, so that the severity and extent of the risk can be assessed. The cost of the premium is set by the insurance company on the basis of various factors, including the extent of the insured reimbursement limits (the maximum amount of the expense that the insurance company undertakes to indemnify), the limits of indemnity (deductibles and excess, i.e. the portion of the damage that remains the responsibility of the insured), the province of location (in particular for theft and catastrophic events), the replacement value of the house and the type of property (house or flat), and of course the risks covered.
In determining the premium, it is essential to first establish what the insured sum is, i.e. the amount for which the policy covers one or more assets against a certain category of risks. The first step in defining the sum insured is to choose the form of insurance, which in the context of multi-risk house policies is divided into three main types:

**A** - Full-value insurance covers all insured items, i.e. the sum insured must correspond to their full actual value. This means that in the event that the value of the insured goods increases over time compared to the value assumed at the time of conclusion, the client is obliged to change the sums insured; it is also advisable to make such an update in the event that the value of the insured goods instead decreases in order to avoid an unnecessary increase in the premium.

**B** - Absolute first-risk insurance provides cover for damage up to the stipulated sum, irrespective of the actual total value of the insured items.

**C** - Relative first-risk insurance relates only to the theft of property inside the home and, given that the damage is certainly less than the overall value of the property insured, the sum insured may be equal to the maximum damage that the customer believes he or she can suffer

When a claim occurs, the client must first prove that the event in question falls within the eventualities envisaged in the policy and, more generally, must comply with the obligations set forth in the Civil Code, including reporting the event to the judicial authorities and providing a detailed list of the stolen or damaged goods; once the checks have been carried out as to the actual coverage, the insurance company pays the compensation based precisely on what is indicated in the policy. For damage to contents of the home, acceptable-use policies provide compensation equal to the value of the item at the time of the damage, taking into account the loss of value due to use, while value-as-new policies provide compensation equal to the re-purchase value of the insured item without any depreciation,

less the residual value of the insured items only damaged. Compensation for damage to the building is estimated on the basis of the reconstruction value of the parts destroyed in a manner similar to that with which they were previously constructed, less the residual value of the parts that were only damaged.

Optional guarantees. This includes cases of fire, natural disasters (such as earthquakes and floods), theft and liability (for unintentional damage caused to third parties in connection with the ownership of the insured property and/or in connection with private life). There is also legal protection (i.e. covering certain legal costs), assistance (whereby the insured person has a home service available at all times for his or her home and family), and accidents (with compensation for the consequences of accidents that occur while the insured person is engaged in physical activity, while living in the home, during leisure time, or while travelling as a pedestrian, passenger or driver).

Both parties have the right to withdraw from the contract, exercising this right no later than 60 days after the payment of the indemnity or claim has been otherwise defined. If right to withdrawal is exercised by the company, the latter is obliged to give 30 days' notice of the decision and to pay a refund of the net premium not enjoyed, excluding taxes, on the sums insured that remain outstanding.