INSURANCE

Hang Chuon Naron

The front page photo is Preah Vihear—the Khmer Temple built in 11th-12th century by Suryavarman I and Suryavarman II in Banteay Srey style dedicated to Shiva. It is situated atop of the a 525-meter cliff in the Dangrek Mountains in Cambodian province of Preah Vihear.

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INTRODUCTION

TO

INSURANCE

Hang Chuon Naron, Ph.D., AMII

Phnom Penh, May 2008

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I dedicate this book to my father, HANG CHUON,

Who dedicated his life to develop and protect

Cambodian arts and culture

To my mother, MEN SA OUN,

Who always cares for the children,

To my wife, PEN VIMUOL

And

To my children,

HANG VIRAKRIDH and HANG VIMUOLEA

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Preface

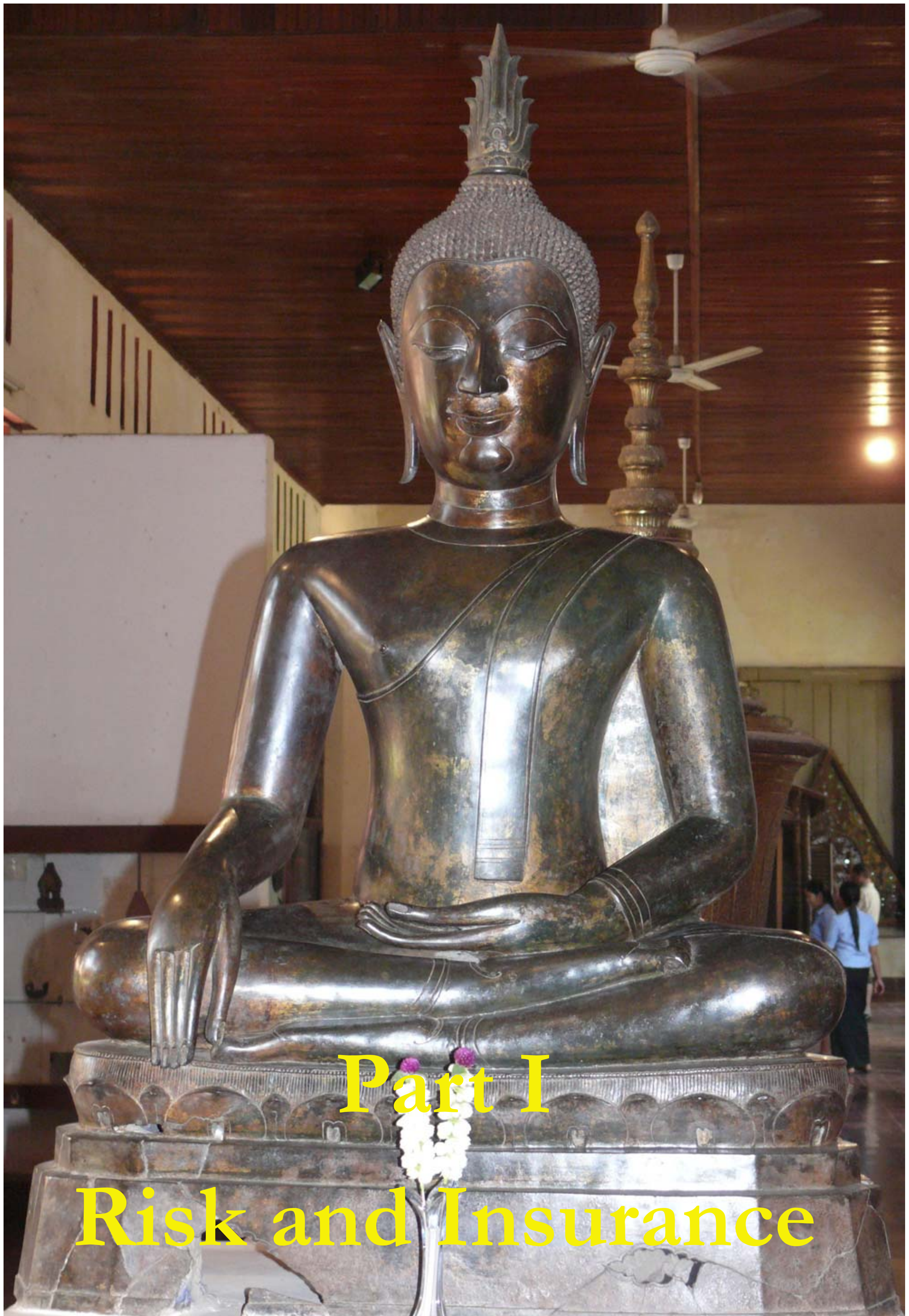
Cambodia has made tremendous efforts to develop its financial sector, especially the insurance sector. Although the first insurance company was established here in 1993, real development of the insurance industry in Cambodia started only in 2000, when the Law on Insurance was enacted. In 2001, the Royal Government of Cambodia, with the technical assistance of the Asian Development Bank, prepared and adopted the Financial Sector Blueprint for 2001-2010, which provided a roadmap for the development of the insurance sector in Cambodia. In 2003 the government issued license insurance companies.

I have ventured into this previously unknown to me specialized area of finance, when I was assigned by the management of the Ministry of Economy and Finance to establish and operationalize the national reinsurance company, Cambodia Re. I felt that insurance was too technical and without good knowledge about insurance, it would be hard to manage Cambodia Re. I therefore decided to explore the techniques of insurance.

The paper contains seven sets of technical notes covering fundamental areas of insurance. These notes were taken during my preparation for eight insurance examinations for the Advanced Diploma on Insurance, leading to the Associate of the Malaysian Insurance Institute and eventually the Chartered Insurance Institute in the United Kingdom.

It was felt that these notes could be useful to those who wants to gain insight into insurance or who also wants to take examination on insurance. I therefore decided to publish these notes in the form of a manual entitled "An Introduction into Insurance". I would like to express my profound gratitude to my family for their understanding and to all my friends for their support during the last two years, 2006-2007, when I prepared for the insurance examinations. I wish all those who want to sit for insurance exams a great success.

Hang Chuon Naron, Ph.D., AMII



Part I
Risk and Insurance

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Part I

Risk and Insurance

1. The Nature of Risk

Risk is different from chance. Risk implies some form of uncertainty about an outcome, which is not favorable; risk implies both doubt about the future and the outcome leaves us in a worse position. Chance also implies some doubt about the outcome, which is favorable: chance of passing an examination.

Risk implies some form of uncertainty about an unfavorable outcome or the future, which could leave us in a worse position than at the moment. For example, the risk of being in an accident or the risk of a fire. Risk consists of three components:

- Firstly, there is the idea of uncertainty, which is at the core of the concept of risk. It implies that there is some doubt as to whether the event will occur or not, as a result of imperfect information about the future, leading to doubt, hence uncertainty about the future;

- Secondly, there is the implication that there are differing degrees of risk. Thus, risk is a combination of the likelihood of an event and the severity of the damage caused should the event occur, such as the frequency of damage by flooding and the severity of damage.

- Thirdly, there is the idea of a result having been brought about by a cause or causes.

Chance also implies some doubt about the outcome, which is favorable: the chance of winning a bet or the chance of passing an examination.

1.1. The Meaning of Risk

Risk implies some form of uncertainty about an unfavorable outcome or the future, which could leave us in a worse position than at the moment, such as the risk of being in an accident or the risk of a fire. Risk consists of the following components:

Uncertainty: there is the idea of uncertainty, which is at the core of the concept of risk. It implies that there is some doubt as to whether the event will occur or not, as a result of imperfect information about the future, leading to doubt, hence uncertainty about the future;

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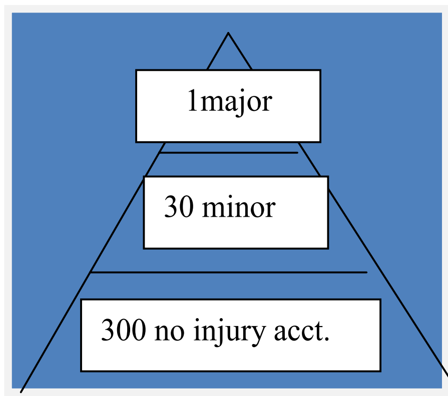
1.1.1. Level of Risk

There are differing degrees of risk. Risk is a combination of the likelihood of an event and the severity of the damage caused should the event occur, such as the frequency of damage by flooding and the severity of damage. One way to look upon the actual level of risk is to compare perception against the known or real risk. But there is a tendency to overestimate low frequency events and to underestimate high frequency events.

A. Frequency and Severity

The distinction between the frequency and severity of risk is important from an insurance point of view. There are risks that are characterized by high frequency and low severity, such as there are a large number of small fires and few large ones. There are risks with low frequency and high severity, such as accidents involving ships and planes.

Figure 1.1. The Heinrich Triangle



The Heinrich Triangle shows that for every one major injury at work, there are thirty minor injuries and three hundred non-injury accidents. The triangle was the result of looking at several thousand incidents at work. The construction industry has a very narrow Heinrich Triangle – This means that in the construction industry, accidents in general cause minor and major injuries and there are less non-injury accidents than in other industries.

1.1.2. Peril and Hazard

The peril is the prime cause. It is what will give rise to the loss. For example, flood is

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the peril and the proximity of the house to the river is the hazard. Storm, fire, theft, motor accident and explosion are perils. Hazards are factors that may influence the outcome. Theses hazards are not themselves the cause of the loss, but they can increase or decrease the effect should the peril operate. The underwriter has the task of assessing the hazards.

Hazards can be physical or moral:

- **Physical hazard** relates to the physical characteristics of the risk, such as the nature of the construction of a building, i.e. wooden house, security protection of a shop or factory, or the proximity to a river bank.

- **Moral hazard** concerns the human aspects, which may influence the outcome. This refers to the attitude of the insured person: (i) lack of care on the part of the insured; (ii) regular claimant or people who look at insurance as investment; and (iii) dishonest insured, dishonest claimant.

1.2. Classification of Risks

Risk can be classified as follows:

- **Financial and non-financial risks—**This approach relates to the outcome rather than the nature of risk itself. **Financial risk** is the risk with the outcome can be measured in monetary terms and where it is possible to place some value on the outcome. For example, it is possible to measure in financial terms the loss related to the damage to property, theft of property or lost business profit following a fire. **Non-financial risk** is the risk where the outcome cannot be measured in financial terms. For example, the selection of a career, the choice of marriage partner or having children can be classified as non-financial risks, as the outcome is not measurable financially.

- **Pure and speculative risks—**The second approach to risk classification also concerns the outcome, but where there is only the possibility of loss and gain. **Pure risks** involve a loss or, at best, a break-even situation. The outcome can only be unfavorable or leave us in the same position. The risks of a motor accident, fire, theft or injury, storm, explosion, malicious damage, liability, machinery breakdown are pure risks with no element of gain. **Speculative risk** involves a situation where there is the chance of gain. Investing money in shares, pricing the products, making marketing decisions and providing credit to customers can be classified as speculative risks. These actions may result in a loss or a break even situation or a

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prospect of a gain. Speculative risk involves a situation where there is the chance of gain. Investing money in shares can be classified as speculative risks. These actions may result in a loss or a break even situation or a prospect of a gain. Speculative risks are usually uninsurable. Insurance is not normally available for those risks where the outcome can be a gain. Speculative risks are entered into in the hope that there will be gain. There would be little incentive to work towards achieving this gain if it was known that an insurance company would pay up, regardless of the effort of the individual and there is very high risk or moral hazard. However, the pure division between pure and speculative risks has also evolved. For example, there is insurance for a credit risk, which is classified as a speculative risk, to meet some of the consequences of a default debtor.

- **Examples of speculative risks:** (i) Investing money in shares – this kind of investment can result in a gain when the share prices go up or in a break-even situation when the share price remains the same or in a big loss during the stock market crash; (ii) Pricing of products – a wrong price may either make the products uncompetitive or not yield a sufficient high return to the company; (iii) Marketing decisions – incorrect interpretation of market needs may cause a loss, but a correct decision could be very profitable; (iv) Providing credit to customers can be a risky business. If the customers are not in the position to pay back the loan, there will be a loss.

Fundamental and particular risks—The third classification relates to both the cause and effect of risk. **Fundamental risks** are those which arise from causes outside the control of any individual or group of individuals. Their effects are felt by many people: earthquakes, floods, famine, volcanoes and other natural disasters. Social change, political intervention and war are capable of being interpreted as fundamental risks. **Particular risks** are much more personal both in causes and effects: fire, theft, work injury and motor accident. All these risks arise from individual causes and affect individuals in their consequences. **Fundamental risks**, such as earthquakes, floods, famine, volcanoes and other natural disasters, arise from causes outside the control of any individual or group of individuals, with their effects being felt by many people. This is contrasted with the particular risks, which are much more personal both in causes and effects and arise from individual causes and affect individuals in their consequences.

Because of that different nature of risks, particular risks, such as fire, theft, work injury and motor accident are insurable, as these risks arise from individual causes and affect individuals in their consequences. At the same time, fundamental risks, such as earthquakes, floods, famine, volcanoes or social changes and political intervention,

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which will affect many people, are not insurable.

However, it is difficult to generalize this statement, as the insurance market place has changed from time to time. For example, earthquakes and floods, which are regarded as fundamental and not insurable in many parts of the world, are insurable in the United Kingdom. The ADB and the World Bank provide political risk insurance for projects in developing countries.

1.3. Risk Management

The three main elements of risk management are as follows:

- **Risk identification**—how can the assets or earning capacity of the enterprise be threatened? Ways in which an organization may be impeded from achieving its objectives;
- **Risk analysis**—measure the potential impact of risk on organization; gathering information; analysis of past experience; frequency and severity of risk to the organization; and
- **Risk control** - physical risk control: pre-loss risk reduction – advice on safety and recommendations to industry; Post-loss risk control: use of automatic fire sprinkler system; and financial risk control: risk retention – risk transfer, ie. insurance.

There are positive aspects of risk, within the business environment: (i) Risk creates hope for profit. Entrepreneurs are encouraged to take risks in the hope that reward will be higher; (ii) Risk is a bar to entry into the market place for ventures which are unsound or short-lived. When the cost of risk is viewed as too high potential players will look elsewhere; and (iii) Risk encourages a safety culture, which includes employees, consumers, the public and the environment.

2. Insurance

2.1. The Functions of Insurance

Insurance fulfill the following functions:

- **Risk transfer**: the primary function of insurance is to act as a risk transfer mechanism. A Telecommunication company can transfer the financial consequences of the risks, such as fire, lightning, loss of profit following fire, theft

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and other perils to an insurance company in return for paying a premium. In so doing, the company can exchange the uncertainty for a loss for certainty. This risk transfer mechanism allows the Chief Executive Officer of the company to concentrate on developing and expanding the business in order to increase the company's profit.

- **Creation of the common pool**: By accepting premiums from a large number of the insureds, the insurance company creates a pool to provide insurance protection. The losses of the few insured are met by the contribution in the form of premiums of the many. The pool will operate only when there will be only a few losses in any one year and the premiums of the insured will be sufficient to pay any claim and cover the cost of operating the pool and the profit of the insurer; and

- **Equitable premiums:** the insurer has to ensure that a fair premium is charged which reflects the degree of risks, i.e. the hazard and the value which people bring to the pool. Thus, the risks of similar type that are brought together in a common pool do not all represent the same degree of risk to the pool itself. However, the premium must also be competitive. Charging too much the insurer will loose the business to the competitors, but charging too little the insurer will not be able to get sufficient funds to pay claims.

From the above definition, it is clear that insurance would not be an effective risk transfer mechanism without the common pool and equitable premium principles. However, in real life, this principle may not be working perfectly. Indeed, a common pool of each class of business and the critical mass of the insured is critical for the law of large numbers to operate. For that reason, at a global level, international insurance and reinsurance companies are striving to get global business by taking about 5% of the business from each country in order to limit their exposure as part of risk management. However, at the national level, especially at the business line level, in a small country where insurance market is still underdeveloped, the pool concept may not be working well. For that reason, sometimes profit from one class of business will be used to pay the loss from the others.

As to the equitable premium principle, this may not be possible at all time. Competition and fluctuations of the insurance markets make it difficult to charge equitable premiums. The insurance market has gone through ups and downs. In a good year, premiums go up and in the bad year premiums drop as a result of increase in competition. Moreover, insurance company is divided into two sections: insurance and fund investment. Revenue generated from fund investment can be used to compensate for losses in the insurance business.

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2.2. The Benefits of Insurance

Insurance can bring benefits to both individuals and the economy of a country. Following are the benefits that insurance can bring to people, businesses and the country:

- **Peace of mind:** insurance exists to meet the financial consequences of certain risks. Buying insurance allows entrepreneur to transfer some risks to an insurer. Insurance also acts as a stimulus to the activity of businesses which are already in existence through the release of funds for investment in productive side of the business. Because of the common pool, the business is able to purchase insurance at a premium which is less than the fund that the company itself would have to retain.

- **Loss control:** insurers do have an interest in reducing the frequency and severity of losses, not only to enhance their own profitability but also to contribute to a general reduction in economic waste in the country as a whole. Surveyor provides recommendations on loss prevention and safety (sprinklers and how to store stocks). Loss adjusters reduce after-fire losses.

- **Social benefit:** when the owner of business has fund to recover from a loss people will keep their job and continue to contribute to the national economy.

- **Investment of funds:** time gap between receipt of premiums and payment of claims allows for investment of funds. Life insurance creates possibility for development of government bonds. Thus, insurance contributes to the promotion of economic activities and the development of the capital markets.

- **Invisible earnings:** insurance transactions across borders bring large volume of premium inflows, which are classified as invisible earnings or service transfer for the balance of payments.

2.3. Nature of Insurable Risks

The insurable risks have the following nature:

- ***Fortuitous:*** happening of event must be entirely fortuitous. It is not possible to insure against an event which will definitely occur;

- ***Financial value***: insurance does not remove the risk, but endeavor to provide financial protection against the consequences. The risk to be insured must result in a loss which is capable of being measured in financial terms;

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- ***Insurable interest***: relationship between the insured and the financial loss;

- ***Homogeneous exposures***: insurer looks for homogeneous exposures in order to enjoy the benefits from the law of large numbers. In the absence of large number of homogeneous exposures, the benefits of the law of large numbers disappear and the calculation of required premiums becomes more of a guesstimate;

- ***Particular risks*** are much more personal both in causes and effects, such as fire, theft, work injury and motor accident;

- ***Pure risks***, which involve a loss or, at best, a break-even situation. The outcome can only be unfavorable or leave us in the same position. The risks of a motor accident, fire, theft or injury, storm, explosion, malicious damage, liability, machinery breakdown are pure risks with no element of gain.

- ***Public policy***: it is common principle in the law that contracts must not be contrary to what society would consider to be the right and moral thing to do.

2.4. The Development of Insurance

2.4.1. Marine Insurance

A. Edward Lloyd's Coffee Shop

Edward Lloyd's Coffee Shop was in existence by 1688, although the original date of opening is uncertain. Edward Lloyd encouraged the merchants or underwriter, who brought more business to his shop. He provided them with shipping information and published a news sheet in 1696, called 'Lloyd's News'.

Edward Lloyd's Coffee Shop encouraged the development of marine insurance and made London the world centre of marine insurance. With the expansion of the insurance business, Lloyd's Coffee Shop was moved to new premises in 1769 and a committee was formed. Then the coffee shop was transformed into the insurance fraternity. In 1871, by Act of Parliament the modern Corporation of Lloyd's was formed.

B. Chartered Companies Monopoly

In 1720, the London Assurance and the Royal Exchange were granted Royal Charters to transact marine insurance. The Act which provided for the incorporation of these

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two companies, giving monopoly rights. As only individuals could provide marine insurance could provide marine insurance, the activities in Edward Lloyd's coffee house prospered. The monopoly was terminated in 1824, when the Alliance Marine Insurance Company was allowed to provide marine insurance.

C. Marine Insurance Act 1906

The case law was accumulated over the years, some 2,000 cases, was incorporated in the Marine Insurance Act 1906.The Act formed the basis for the operation of marine insurance.

D. Aviation Insurance Development

In 1919 the first regular civil aviation service started, but it was until 1923 that the British Aviation Insurance Group began offering aviation insurance.

2.4.2. Loss or Damage to Property

A. Fire Insurance

The industrial revolution changed the face of British industries and increased the number of items to be insured. Big new factories were constructed, housing sophisticated machinery and equipment. The demand for fire insurance increased tremendously commensurably with the growth of the industries, as more goods were produced and transported around the country and shipped overseas.

As a result of the industrial revolution, by the beginning of the 19th century there were many insurance companies offering fire insurance. However, these companies did not form any association to coordinate their business. As fire insurance was increasing, there was a need to pool expertise, establish common criteria to classify risks and establish tariffs. Concerted actions in fire fighting were also needed. Only in 1860 an insurance association was formed and in 1868 it became known as the Fire Offices' Committee.

On 22 June 1861 a fire broke out in wharves and warehouses along the banks of the Thames, near the centre of London. This fire was known as the Tooley Street fire, which wrecked havoc and cost the fire insurance companies £1 million. The immediate response to this fire was a drastic increase in the premiums charged for this type of property. More importantly the consequences of the Tooley Street fire were as follows:

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The new London Wharf and Warehouse Committee decided on the tariffs for insurance of wharves and warehouses. Differential rates of charges were adopted in an effort to encourage owners to think about fire precautions: bad risks were penalized and good ones rewarded. A fire service for London was established and run by the city under the Metropolitan Fire Brigade Act 1865 in order to provide adequate facilities to the fire fighting forces. Two new companies were established: the Commercial Union and the Mercantile, and later the North British and Mercantile.

B. Theft Insurance

It was until 1887 that the first fire policy was extended to include theft cover. The Mercantile Accident and Guarantee Insurance Company began issuing theft policies in 1889, although the term used was burglary. The use of the word theft followed on from the Theft Act 1968, when the legal definition of theft was given.

C. Engineering

The change brought about by the Industrial revolution brought with them many problems, such as the risk of damage or injury, related to the operation of machine.

The public opinion grew to such extent that in 1882 the Boiler Explosion Act was passed, by which severe penalties could be imposed if the explosion of a boiler was found to have been the fault of the owner.

2.4.3. Life, Personal Accident and Health

A. Ordinary Life Assurance

The first evidence of life assurance dated back to 1583, when a policy was taken out on 18 June on the life of William Gibbons.

B. Actuarial Principles

The intention of the mortality tables was to be able to state in mathematical terms the likelihood of persons of a given age dying. It was described by Halley: '...that the pricing of insurance on lives might be regulated by the age of the persons on whose life the insurance is made.'

The Life Assurance Act 1774 was passed: 'An act for regulating insurances upon lives and prohibiting all such insurances except in cases where persons insuring shall have an

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interest on the life or death of the person insured.

C. Industrial Life Assurance

The changing structure of society brought about by the Industrial Revolution produced the beginnings of industrial classes. But they were not protected against infirmity and old age.

D. Personal Accident and Health Insurance

In 1848 the Railway Passengers Assurance Company began offering policies aimed at providing compensation in the event of an accident. In 885 the Sickness and Accident Insurance Association started issuing policies that provided compensation payments in the event of certain sickness. The policies became permanent.

2.4.4. Liability

A. Employer's Liability

Industrialization attracted many people to come and work in the cities and resulted in appalling conditions and a disregard for safety, causing many injuries. However, ordinary employees found it difficult to win any claim. Moreover, the law allowed employers to avoid any liability for injury.

In 1880, the Employers' Liability Act placed certain employees in a much better legal position. They could sue their employers with a slightly higher chance of success, but many obstacles remained. The most notable development was the establishment of the Employers' Liability Assurance Corporation.

However, the passing of the Workmen's Compensation Act in 1897 provided scale benefits on death and half earnings during disablement, regardless of proving fault.

B. Public Liability

The earliest policies at the end of the 19th century related to horse drawn caches and later developed into motor vehicle insurance.

C. Motor Insurance

Motor insurance was developed later than other forms of insurance, as the increase use

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and development of cars became a mass phenomenon only in the 1920s. To address the problems associated with motor accidents the first Road Traffic Act was enacted in 1930. The intention was to ensure that funds would be available to compensate innocent victims of motor accidents. Insurance against legal liability was introduced to pay damages to injured persons. The insurance requirement applied to all users of motor vehicles, except where some special legal requirement is in force. The 1930 Road Traffic Act promoted the motor insurance by creating requirement for insurance against legal liability.

D. Surety, Credit and Loss of Profits

Suretyship or fidelity guarantee insurance caters for the risk of losing money by the fraud of dishonesty of some other person. In 1840 the Guarantee Society was formed to provide surety by the means of a policy of insurance.

In 1893 another form of pecuniary insurance began to be transacted by the Excess Insurance Company. This attempted to meet the risk that a person might sell goods and the purchaser may not pay for them. This became known as credit insurance and by 1918 a specialist company was formed.

Loss of profits or business interruption insurance is the third form of cover began to appear at the start of the 20th century. These policies endeavored to relieve the hardship associated with consequential loss following fire.

2.4.5. Common Features of Development

Following are the common features of insurance development:

- **Firstly**, each class of insurance developed in response to a demand for protection, such as in the case of fire, life and liability classes of insurance. To protect the people against the eventuality of risks, such as to protect the employees or the member of the public against motor accident, the Parliament passed the legislation to make employers' liability and motor insurance compulsory.

- **Secondly**, the development of various forms of insurance was accompanied by a measure of government supervision. Effective supervision is designed to prevent the failure of insurance companies and to provide protection of the consumers.

- **Thirdly**, insurance companies started off as specialist companies offering protection in one or two types of insurance only. These specialist companies have

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expanded the forms of cover they write. At present, there are very few specialist companies other than life and pensions companies. The majority offer many different forms of insurance.

- **Fourthly**, insurance companies have joined together over the years to pool resources. The association of insurance companies has classified the risks, pooled statistics and come up with common policy wordings and rates.

- **Fifthly**, one of the main feature of the insurance industry is the growth of reinsurance, as insurance companies themselves have sought financial protection. The development of reinsurance, i.e. insurance bought by insurance companies, has become an essential part of the insurance market place.

2.5. Class of Insurance

2.5.1. Ordinary Life Insurance

Term assurance: payment of sum assured on death, provided death occurs within a specified term. Should the life assured survive to the end of the term then the cover ceases and no money is payable;

Decreasing term assurance: to cover the outstanding balance of a monthly repayment building society mortgage. As borrower repays the capital sum, the sum assured diminishes year by year until exhausted at the end of the mortgage period;

Convertible term assurance: allows life assured to convert the policy into an endowment or whole life contract at normal rates.

Family income benefits: benefit on death paid out to family by installments every months to replace income;

Whole life assurance: sum assured is payable on the death. Premiums are payable either through the life of the assured or cease at certain age, often 80;

Endowment assurance: sum assured is payable in the event of death within a specified period of 15, 20, 30 years.

Assurances for children: policy is effected on the life of a parent with an option date (18 or 21 years), child can continue the policy in his own name.

Group life assurances: sum assured payable in the event of death of an employee;

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Annuities: a person can receive a yearly sum in return for payment to an insurance company of a sum of money.

Features: premium payments – level amounts throughout the period of the policy; participation in profits; surrender values; paid-up policies – the premium ceases but policy continues, but on maturity a smaller sum will be due;

A. Annuity

An annuity is a method by which a person can receive a yearly sum, an annuity, in return for payment to an insurance company of a sum of money. When a person has a reasonably large sum of money and wants to provide an income for himself after he retires or at some other time, he can buy an annuity with a life insurance company. Annuity is not life assurance, but it is based on actuarial principles.

Annuity has different forms:

- Immediate annuity – the annuity may start at once;
- Deferred annuity – the annuity may start at some date in the future;
- Annuity certain – it may be payable irrespective of death for a certain period;
- Guaranteed annuity – it provides the annuity for a guaranteed period or until the annuitant dies;
- Reversionary annuity – it provides for payment to annuitant, the wife, on the death of another named person, the husband;
- The joint and last survivor annuity – it is payable while two people, husband and wife, are alive and on the death of one will continue at the same or smaller rate on the life of the survivor.

B. Special Features of Life Insurance

Premium payments—Life insurance premiums are payable by level amounts throughout the period of policy. This means that each person pays the same amount throughout, that amount being determined by his age on effecting the policy. Premiums can be paid annually, half-yearly, quarterly or monthly.

Participation in profits—Life insurance companies value their assets and liabilities at

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regular intervals, some every year and others every three years. This valuation allows them to determine if any surplus exists after calculating all future liabilities and other contingencies. Should such a surplus exist it is distributed among those policyholders who have 'participating' policies. Such policies allow the policyholder to participate in any profits the company makes.

The policyholder pays an additional amount for the privilege of participating in profits and the bonuses are added to the sum assured and payable at maturity date.

Surrender values—When a person no longer wants his policy or cannot continue the premiums he can ask for the surrender value. He ceases payment and received a portion of the premiums. Not all policies allow a surrender value. Surrender within a few years will not produce any amount, as it needs to cover the costs.

Paid-up policies—Some policies provide the policy to become paid-up, rather than for a surrender value to be available. In this case the premiums cease and the policy continues, but on maturity a smaller sum than would be originally have been paid will be due to the policy holder. Depending on the policy and the company concerned these paid-up policies may or may not continue to participate in profit.

2.5.2. Industrial Life Insurance

Industrial life insurance: the function is to bring life assurance to the workers. They are of the lower income class; collection of premiums at the home of policyholders.

2.5.3. Personal Accident Insurance

Personal accident insurance: provide compensation in the event of an accident causing death or injury. Policy is extended to include a weekly benefit for up to 104 weeks or compensation if the insured is temporarily totally disabled due to an accident, and a reduced weekly benefit if he is temporarily only partially disabled from carrying out his normal duty.

In the event of permanent total disablement (other than loss of eyes or limbs) an annuity is paid.

Personal accident and sickness policies are renewable annually and if a claim has occurred which could be of a recurring nature, the cover may be restricted at renewal or in severe cases renewal may not be offered.

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2.5.4. Motor Insurance

An 'Act only' policy covers the minimum required by the law (Road Traffic Act 1988) and similar to 'Third Party only' policy, i.e. to provide insurance in respect of legal liability to pay damages arising out of injury caused to any person, unlimited in amount, and damages to the property of other people subject to certain limits and exceptions.

A 'Third Party and Theft' policy would satisfy the minimum legal requirements plus cover for damage to the car itself from fire and theft.

A 'Comprehensive policy' adds accidental loss of or damage to vehicle to the TP and T cover.

2.5.5. Marine and Transport Insurance

A. Professional and Indemnity Clubs

Marine underwriters limit their cover to ship-owners to three quarters of the liability in respect of liability to another ship, in order to prevent negligent navigation. In order to provide indemnity for the remaining quarter of this liability, the ship-owners established their own Professional and Indemnity Club (P&I) Club, which is a mutual insurance association. The functions of the P&I Club are the following:

- Cover the balance not covered by the three quarters running down clause relating to ship-owner's liability for damage done to another vessel or its cargo as a result of negligent navigation;
- His liability for loss of life or personal injury;
- His liability for damage done to immobile objects such as buoys, quays, dock walls, and other property on land;
- His liability for cargo resulting from faulty stowage, short-delivery and non-delivery;
- His liability as an employer to his employees for vocational accidents;
- Payments for sickness and repatriation of crew members;
- Other miscellaneous contingencies.

B. Marine Cover

The marine policy provides cover for: hull, cargo and freight.

Time policy for fixed period 12 months;

Voyage policy for the period of voyage from warehouse to warehouse;

Mixed policies: time and voyage;

Building risk: construction of marine vessels;

Floating policy: provides policyholder a large reserve of cover for cargo. After each shipment the value of shipment is deducted from the outstanding.

Marine cargo: on a warehouse to warehouse basis and frequently covering all risks.

C. Marine Open Cover

The marine open cover is the most common form of cargo insurance. Its purpose is to pre-establish an automatic facility tailored to anticipate the permutations of a client's future insurance needs over the full range of his on-going trading operations, whatever the variations in interests, voyages, conditions or rates. Once arranged, the insured is guaranteed protection on the agreed basis for all shipments falling within its provisions, subject to declaration of full shipment details of each dispatch.

The client is relieved of the necessity to negotiate the insurance of every shipment individually, while the insurer obtains prospective continuity of interest in the client's global activities.

D. Aviation Insurance

Most policies are issued on an 'all risks' basis subject to restrictions. Usually a comprehensive policy is issued covering the aircraft, the liabilities to passengers and the liabilities to others. Liabilities to passengers are governed by international agreements: (i) The Warsaw Convention 1929 made signatories liable to passengers without negligence, but subject to certain maximum amounts; (ii) The Hague Protocol 1955 raised some of the above limits. The national laws may place higher limits on domestic flights.

The two international agreements also place limits on liability for goods carried by air.

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Unless of special risk or value, cargo is usually insured 'all risks' in the marine or general markets rather than the aviation market.

2.5.6. Fire and Other Property Damage Insurance

A. Fire Insurance

A standard fire policy covers the following perils:

- fire;
- lightning; and
- explosion: of boilers; and of gas used for domestic purposes only.

The policy covers fire but excluding loss destruction or damage caused by:

- explosion resulting from fire (such as gas explosion);
- earthquake or subterranean fire: (i) its own spontaneous fermentation or heating, or (ii) Its undergoing any heating process or any process involving the application of heat.

Other circumstances in which the loss is closely associated with the fire that it is regarded as covered by the policy include:

- Property damage by water or other extinguishing agents used for extinguishment purposes;
- Damage done by the fire brigade in the execution of its duties, including for gaining access to a fire;
- Property blown up to prevent a fire spreading;
- Damage occasioned by falling walls or parts of a building in which a fire takes place;
- Loss of or damage to property removed from a burning buildings caused by rain, theft, or damage during removal, provided that the removal was justified and that the insured take steps as soon as possible to protect the removed property from further damage.

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A standard fire policy excludes subsidence, flood, impact damage, and strike, riot and civil commotion, which are considered as special perils. Strike, riot and civil commotion and impact damage can be provided as extensions for additional premium income.

B. Theft Insurance

Theft policies intend to provide compensation to the insured in the event of the loss of property insured. The theft policy will show a more detailed definition of stock. The insurers charge more for stock, which is attractive to thieves. Theft is defined as forced and violent breaking into or out of the premises of the insured. Shoplifting is uninsurable.

C. All Risks Insurance

All Risks Insurance provides cover for the following:

Personal Effects: All risks policies provide cover for individuals who seek a wider protection than that afforded by the policies available to cover household effects. The all risks policy can be taken out on expensive items: jewellery, cameras and fur coats for a lump sum for accidental loss or damage.

Business all risks: to protect machinery, desk top equipment, computers etc.

Goods-in-transit: Goods-in-transit insurance covers property against loss or damage while it is in transit from one place to another or being stored during a journey. Policies often specify the means of transport to be used.

If goods are shipped by sea then marine insurance is effected. This also includes the transit of cargo over land at each end of the voyage.

The cover for the goods in transit policies is practically "all risks". The insured will be indemnified for loss of or damage to by fire, accident, theft or pilferage while being loaded on, carried by, or unloaded from the motor vehicles and while temporarily garaged during transit.

The insured and insurer will need to agree on how much the goods are valued at.

There are two types of cover:

- **Old-for-new** - items are replaced at their current market value;

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- **Indemnity cover** – the insurance company will take into account general depreciation.

The goods in transit policies fall into two categories:

- On goods on insured's own vehicles, with a sum insured for each vehicle;

- On all goods dispatched by the insured, by own vehicles, by road haulier, rail and post, subject to a limit any one consignment.

Contractors' all risks: the over provided for new buildings or civil engineering projects, such as highways or bridges. The policy provides compensation to the contractor in the event of damage to the construction works from many perils.

Money insurance: provides compensation to the insured in the event of money being stolen either from his business premises, his own home or money in transit to or from bank. The policy also provide compensation to employees injured during robbery.

D. Glass

Cover is also available against accidental breakage of plate glass in windows and doors. In the case of shops this is often extended to include damage done to shop window contents.

E. Engineering

The cover is to provide compensation to the insured in the event of the plant (boilers, lifts, cranes, electrical equipment, engines and computers) being damaged by extraneous cause of its own breakdown.

The engineering cover:

- Damage to or breakdown of plants and machinery;

- Inspection services;

- Costs of repair of own surrounding property due to (a);

- Legal liability for injury caused by (a);

- Legal liability for damage to property of others caused by (a);

2.5.7. Liability Insurance

There are the following forms of liability insurance:

Employers' liability: Under the Employers' Liability (Compulsory Insurance) Act, every employer shall insure with an authorized insurer against liability for bodily injury or disease sustained by his employees and arising out of and in the course of their employment. The policy will also pay certain expenses such as lawyers' fees or doctor's expenses where the injured person has made medical check. The policy indemnifies the insured in respect of his legal liability. The policy does not apply where property of an employee is damaged. Actions involving personal injury must normally be started within three years of the date of accident. However, to resolve the difficulty of untraced policies, some insurers are now prepared to issue a policy which will offer cover on a 'claims made' basis for claims made during the currency of a policy even if the events may have occurred many years previously.

Public liability: members of public may suffer injury or damage to property due to activities of someone else. The insurer will indemnify the insured against legal liability to pay compensation and claimants' costs and expenses in respect of accidental:

- Bodily injury to any person;
- Loss of or damage to material property. *When the chemicals damaged the shoes and the briefcase of the factory's inspector, the insurer will pay the cost of repairing the damage. They may be also responsible for the cost of hiring another car while the third party's car is being repaired.*
- Nuisance, trespass, obstruction or interference with any rights of way, light, air or water resulting in financial loss occurring within the electrical kettle factory during the period of insurance in connection with the business.

Product liability: the liability of the manufacturer arising out of goods sold. The use of faulty material or incorrect assembly of an electrical kettle can result in injury to the person who had bought it. If the buyer can show that the kettle manufacturer was to blame, he or she will succeed in a claim for damage. The scope of the cover is limited to the insured's legal liability for bodily injury to persons, or loss of or damage to material property caused by the electrical kettle. A combined public/ product liability policy may be issued, with a single operative clause or the public liability policy may be extended by endorsement to cover products liability risks.

Professional liability: liability arising out of professional negligence: lawyers,

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accountants, doctors and insurance brokers.

Directors' and Officers' liability: Liability may arise out of lack of care and skill in the performance of a director's duties, such as negligent advice or misstatement, especially in the context of a merger or takeover when failure to understand economic trends results in a poor forecast of the company's performance; any act which goes beyond the limits of the company's constitution, unauthorized payments, failure to disclose the full extent of their interests, a failure to comply with requirements or the failure to arrange proper insurance. The Directors and Officers Liability policy may consist of two parts. The first is to indemnify the company in respect of costs it has incurred indemnifying a director against the successful defense of a claim. The second part indemnifies the director from the company because he has not been successful in the defense of a claim.

2.5.8. Credit and Suretyship Insurance

Credit insurance: provide protection to traders, who can sustain losses or default on the part of the buyers of the goods.

Suretyship or fidelity guarantee insurances: provide insurance against loss by reason of the dishonesty of persons holding the position of trust, or loss caused by mistake (a liquidator maladministers the affairs of the company being wound-up; accountants working in the company.

2.5.9. General (and others) Insurance

Insurance of rent: a building has been damaged until repair, but the person occupying the building may still be paying rent to the owner.

Interruption insurance: loss of profits or consequential loss following from: a fire and special perils; engineering breakdown risks; computer damage and breakdown risks; Certain overhead costs will remain, even sales are reduced; Net profit will be reduced; Increase in costs to keep the business going;

Legal expenses insurance: cover provided to private individuals and organizations facing possibility of legal actions, such as trade union and professional bodies.

2.5.10. Combined and Comprehensive Policies

Combined insurances mean that a number of insured perils or policies are combined

into one policy. For example, a householder will require fire, special perils, loss of rent, theft, glass, money and liability insurances. These classes of insurance can be combined into a single household policy. These combined policies are very suitable for a large number of business insureds. Another example is that the holiday and travel insurance policy provide all risks cover, combined with personal accident, medical expenses and loss of deposits.

The advantages of the combined insurances are: (i) less costly; (ii) one premium and one renewal date; (iii) less chance of overlooking one form of cover; (iv) easier to market as one product.

2.5.11. Space risks

A number of risks can be covered in the marine market, such as material damage during testing or launch, as well as while in orbit and loss of revenue.

3. Risk Assessment

3.1. Human Assessment of Risks

There are two ways of defining the actual level of risk:

- Firstly, one way to look upon the actual level of risk is to compare perception against the known or real risk. But there is a tendency to overestimate low frequency events and to underestimate high frequency events;

- The second way to look at actual risk is to see there is some way we could objectively arrive at a measure of risk through mathematical or rational measure of risk. This method relies on the standard gamble.

There are four reasons why the perceived level of risk often differs from the real level of risk. A great deal of research has shown that the perceived level of risk often differs from the real level of risk, due to the following actors:

- **Firstly, familiarity:** people are influenced in their perception of risk, depending upon their level of familiarity with the risky event: personal experience, media intervention, which makes the event easy to recall. This tends to overstate the real level of risk;

- **Secondly, control**: people would generally understate the level of risk where they

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feel in control of events. People often feel uneasy about air travel, although there is much larger probability of car accidents;

- **Thirdly, personal and societal effect**: we may understate the risk to society, while overestimate our own personal risk;

- **Fourthly, frequency and severity**: there is evidence to suggest that some people are concerned more by the likelihood of the event, regardless of its potential severity, while another group of people ignore the frequency of the events and concentrate on the effect. For example, the probability of major nuclear events is low, but people are more concerned that, should there be an event, the effect will be a disaster.

3.1.1. Actual and Perceived Risk

There are reasons why an individual's perception of risk might differ from the actual risk:

- The differences between real and perceived risk can be accounted for in a number of ways:

- Familiarity: people are influenced in their perception of risk, depending upon their level of familiarity with the risky event: personal experience, media intervention (overstate the real level of risk);

- Control: people understate the level of risk where they feel in control of events (air travel vs. car driving);

- Personal and societal effect: understate the risk to society, while overestimate our own personal risk;

- Frequency and severity: there are those who are guided by the likelihood of the event, regardless of its potential severity, and others who almost ignore the chance and concentrate on the effect (the probability of major nuclear events is low, but people are more concerned that, should there be an event, the effect will be a disaster.

3.1.2. Utility Theory

In 1738 Daniel Bernoulli proposed a theory for the measurement of risk. He suggested

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that a given amount of money was not of equal importance to individuals possessing different amount of wealth. Satisfaction or utility a person derived from having money, tended to increase at a decreasing rate. A person experienced a reduction in marginal satisfaction for larger and larger quantities of the commodity.

Below is the objective value of a gamble where, on the throw of a single die, it is possible to win 30 if a 1 or 6 is thrown or 0 if a 2, 3, 4 or 5 is thrown.

$30 (0.33) + $30 (0) = 10$

There are two factors affect in expected utility:

- Firstly, most people exhibit a difference between the actual risk and their own perception of the risk (difference between perceived risk and either the real or objective value of the risk);

- Secondly, a given amount of money was not of equal importance to individuals possessing different amounts of wealth. The satisfaction or utility a person derived from having money tended to increase at a decreasing rate. Decreasing marginal utility, where a person experienced a reduction in marginal satisfaction for larger and larger quantities of the commodity.

3.2. Risk Identification

There are the following identification techniques:

Organization charts—it takes a broad view of risk; it helps risk identifier to become familiar with the structure of the company; it encourages others to think about risk; it highlight concentration of risk; but it is too simplistic;

Physical Inspections—the person who inspects do not have to rely on others; it allows the person carrying out inspection to build a good relationship with the people at the site; it can be done at short notice. But it is time consuming; it gives impression that the person who inspects is the only one who identify the risk.

Check Lists—A check list is designed to address the problem of time-consuming nature of physical inspections. By using the check list method of collecting data we need only to send a pro-forma to the site to be completed by the people at the time. In so doing, we reduce the time and the costs. Physical inspections are good when the premises are new. A check list is good for regular internal control. It acts as the source of information about all the retail outlets of the fast food restaurants located all over the

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country.

More importantly, the reason why the check list is used is that it is useful when there is repetition of similar types of exposure to risk for all the 30 retail outlet of the chain of fast food restaurants. Each outlet is quite similar and a check list can be prepared for completion by the manager at each of the 30 retail outlet.

There are at least two styles of preparing a check list. The first style is to prepare a check list, which simply lists a number of points, which relates to particular risks. The respondent has to make sure that all items have been looked at and he is satisfied that they are in order, before returning the form.

The second style of preparing the check list is to give a similar list, but ask for a definite response. This could be by way of a 'yes' or 'no' answer. This kind of style may encourage more attention to the details of the form.

While preparing a check list the following points should be kept in mind:

- The check list should be simple to understand and complete. We should not ask complex questions or use complicated language or jargon;
- The check list should not have ambiguity, which can confuse the person who completes it. For that reason, we should prepare drafts of check lists and then test them out before using them;
- The check list should be short, as it would safe time of the person who will complete it;
- The check list should not be threatening. The intention of the check list is to find out about risk and not to punish people once the risk is found.

The advantages and disadvantages of using the check list for risk identification:

The advantages of the check list for risk identification are as follows:

- They can be a quick and effective means for risk identification;
- The costs are low, as the main work is being done by people on the site;
- They allow for easy risk comparison by year or by unit;

- They can be adapted easily to changes in the make up of business;
- They encourage others to get involved in the job of risk identification.

However, a check list approach also has the following disadvantages:

- The information which comes to the risk identifier is second-hand (you don't see the risk yourself);
- There can be low response rate. People might think that the form is not so important;
- The forms can contain ambiguities and the results will be less worthwhile;
- There is no guarantee that the form will be completed with care and attention to details. Some people might complete the form in a hurried and less than accurate manner.

Four factors which should be kept in mind when compiling a check list:

- Simple to understand and complete;
- Free from ambiguity (not to confuse);
- Short;
- Should not be threatening;

Flow chart— (i) Production flow—where raw materials come in at one end of a process and a finished product emerges at the other end; (ii) Service flow—the business may depend on services; (iii) Money flow—in the case of a bank or insurance company.

- Step one: understand the flow;
- Step 2: representing the flow;
- Step 3: the risk flow chart;
- Step 4: structured analysis of the chart.

The flow chart is more detailed analysis and qualitative. But its disadvantages are: time-consuming to construct, too simplistic; and risks identified are general.

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Hazard and Operability Studies

The Hazard and Operability Studies (HAZOP) is an extremely detailed examination of a plant or process which is used in the process industries, in particular the chemical industry. There are four main steps involved:

- Working out the intention of the plant or a part of it;
- Deciding on deviations from this intention;
- Listing the causes of these possible deviations;
- Calculating the consequences of the deviations.

The main difference between the flow chart and HAZOP methods of risk identification:

- In Flow charts risks identified are general;
- No measure of the likelihood of events;
- HAZOP is extremely detailed and the most comprehensive risk identification method;
- Time-consuming, expensive and a team should be involved;
- Widely used in high risk industries;

Fault Trees—This technique is used during the early days of the American space programme. There are so many possible faults in the complicated business of launching a space craft. The advantages of the fault three approach to risk identification

- Reduce complicated events into their component parts;
- Give structure to the identification;
- Allow for calculation of likelihood;

Disadvantage: very numerical and probabilities are often not available.

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4. Risk Data

4.1. Characteristics of Risk Data

The following is a typical risk profile for household insurance covering loss due to fire or theft.

The concept of risk involves two special features: the frequency with which events occur and the severity of each event. Most fires are relatively small. In a domestic context, there will be thousands of small household fires which cause little damage and occasionally destroy a house.

The profile of fire losses can be summarized as high frequency and low severity. There are a large number of small losses and few large losses. High frequency is associated with low costs, and high cost incidents have a low frequency: there are thousands of small fires for every one large total loss. In the case of manufacturing company: industrial injury risk, the accidental damage risk on their motor fleet, the risk of thefts and fires. *However, losses at sea, particularly involving the hull of ships. There are few losses involving scratches and dents, the bulk of losses at sea turn out to be serious. The same is aviation risk.*

The profile for household insurance covering loss due to fire or theft can be described as high frequency and low severity: there are a large number of small losses and few large losses associated with fire or theft. This can be explained by the fact that there can be thousands of small fires for every one large, resulting in total loss. The same is true with the theft risk. There are many small thefts for one large theft. We can summarize household insurance covering loss due to fire or theft risks as risks with high frequency associated with low costs; predictable and has little potential for catastrophe.

The risk profile for ships and planes are opposite to the profile for household insurance covering loss due to fire or theft. There bulk of accidents involving ships and planes are usually very serious, with total loss. There are few marine hull and aviation losses involving scratches and dents.

A large company should adopt the following approach with regard to risks:

High Frequency/ Low Severity Risk—These losses happen frequently but each one has low severity. As they happen frequently it is predictable. A firm can make accurate estimates of the cost of these losses and decide on funding mechanisms. Some may involve insurance, but some may involve self-insurance, in case that the firm is of sufficient size and financial strength to carry potential losses.

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Low Frequency/ High Severity Risk—The low frequency and high severity losses have the potential to cause extremely serious damage to the firm. It involves high costs. It is difficult to predict and has catastrophe potential. The firm should buy insurance to protect.

Database—is a way of describing the raw material or raw data of statistics. Data can be used to describe what has happened in the past. Data on motor accidents describe relationship between the age of driver and cost, the time of the year of the accident. Raw data can also be used as the basis for forecast, decision or judgment. We use this to calculate premium rate, such as claim data.

There are two ways of categorizing the variables contained in a data base. The two ways are: using the existing data base and creating new data base. An insurance company has data on policy information, risk profile, number of insurance policy, claims data, types of losses, sum insured divided into different business lines, investments, staff numbers, assets, provisions.

4.2. Data Collection Methods

In order to create a data base we can gather data or use published data base. The published data can be drawn from government and the Association of British Insurers (ABI). Methods of collecting data:

- **Direct observation**: to observe a phenomenon with your own eye: how many people fail to use pedestrian crossings, wear seat-belts, drive foreign cars and exceed speed limits. This method is reliable.

- **Interviews**: are you happy with the service you have received from your branch office. This method has a problem as the respondent can interpret the question.

There are a number of methods for collecting data: (i) **direct observation**: to observe a phenomenon with one own eye; (ii) **interviews**: talking to people to get the information needed; (iii) **experiment:** to test out a new technique; and (iv) **questionnaire**: sending out forms to be completed the people, who then returned them back. In some cases, it is necessary to use a combination of methods to get data.

Interview – The interview method can be carried out by sending staff members to go and ask questions about the services provided the branch office of an insurance company. The interviewers prepare the same basic structure of the interviews, which will be conducted with a number of respondents. To improve the result of the interviews, the samples of respondents or people to be interviewed should be identified.

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A sample is a number of objects or people selected from the population, i.e. the full set of objects and people. To get good data, the sample should represent the whole set of populations. To avoid any possibility of bias, the samples should be selected at random. In this case, the samples can be selected from among the main customers of the company, representing firms, households, government offices, local authorities etc. The results of the interviews can be then aggregated. The problem with the interview method is that the respondent might interpret the questions and provide a long-winded response. Therefore, the question should be accurately worded.

Experiment: in use a loss control mechanism, development of new fire-fighting equipment.

Questionnaire – a form should be designed and then sent to a group of people, who were selected at random to represent the population of clients of the insurance company. The questions to be asked should be brief, simple and without ambiguity. We should avoid asking leading or personal questions. To avoid the bias, we should make sure that the sample to which the questionnaire will be sent are representative. To this end, we should divide the respondents into different categories, then select one or two representative from each category. Alternatively, we can select the sample at random. By using the sample we can get more reliable data.

A questionnaire is one of the most common methods for collecting raw data. A questionnaire is a form, which is sent to people for their completion. The person completes the form and returns it. The questionnaire has the advantage of speed and cost. A person doest not have to accompany the questionnaire and so forms can be sent very quickly for completion. The questionnaire therefore has the advantage of saving time and costs.

However, the disadvantage of a questionnaire is poor response rate, i.e. a very low percentage of questionnaires are ever returned. Moreover, these returned forms are often incomplete or wrongly completed. Nevertheless, questionnaire is a very popular method of collecting data and the advantages probably outweigh the disadvantages.

Questionnaire should not include leading questions. L**eading question** is a question that suggests the answer or contains the information the person who prepares the questionnaire is looking for. Leading questions will generally be answerable with a yes or no, while non-leading questions are open-ended. Therefore, the questionnaire should not include leading questions, as the results that we get would not reflect the thinking of the respondent. Thus, leading questions would not help the person who prepared the question to get the information on the real situation or the objective answer to the

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question. The example of leading question is as follows:

- Responsible people always insure their cars, do you insure your car?
- Life insurance has been very popular among company's managers, have you purchased your life insurance policy?
- What do you think about a comprehensive motor policy? Many people prefer just to buy a Third Party motor policy.

Pointers should be kept in mind when compiling a questionnaire: Brevity, simplicity, ambiguity, leading questions, personal questions and the nature of response.

When considering a sample from a population, we want to avoid: The population is the full set or number of objects, people or circumstances, which is to be the subject of the study. We could have populations of motor claims, fires, insured people, houses, factories.

Samples are drawn from population as population is too large to use. Thus, a smaller sample is useful. **The problem to avoid is the bias in the sample, that is the sample is not representative.**

Stratified sampling: have the number of the sample divided into different categories;

Random sampling – more reliable.

4.3. Presentation of Risk Data

Five key factors that must be considered when choosing a method of presentation. There are different methods of presenting company reports, advertisements or publications. When choosing any method of presentation, the following five key factors must be considered:

- Firstly, the method helps our understanding of what information is contained in the raw data and not to inhibit it.
- Secondly, the selected method is concise in its representation. The table, graph or drawing should represent the data in a concise and accurate manner. They should not be less precise than the raw data.
- Thirdly, the whole presentation should be neat. The neatness of the table or

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drawing would improve the presentation.

- Fourthly, the end product of the work is accurate. The data must be transposed accurately into whatever method of presentation.
- Fifthly, the table, graph or drawing should be freestanding, i.e. they can be interpreted without the need to refer to any other documentation.

4.3.1. Tables

The table has a heading, which should be explicit to describe the main contents. The table should contain information on:

- general type of business, motor;
- particular classes of motor business: private car and commercial;
- cover: comprehensive and TPL;
- the region;
- total; and
- percentage.

Feature that can distort our interpretation of a set of figures includes effect of mix change: the possibility of a change in the make-up or mix of a set of figures. The table we produce can lead to wrong conclusions if they conceal certain vital pieces of information. In order to get useful information, we must look at the component or the mix of the data and the change in the data.

4.3.2. Graphs

Single line graph (number of policies – year), i.e. one variable vs. year; multiple line graphs (number of policies in different regions – year), i.e. many variables vs. year and X-Y graphs (claims – policy sold), i.e. variable vs. variable.

The following data show the number of hours studied for the MII exam and the marks received in the exam.

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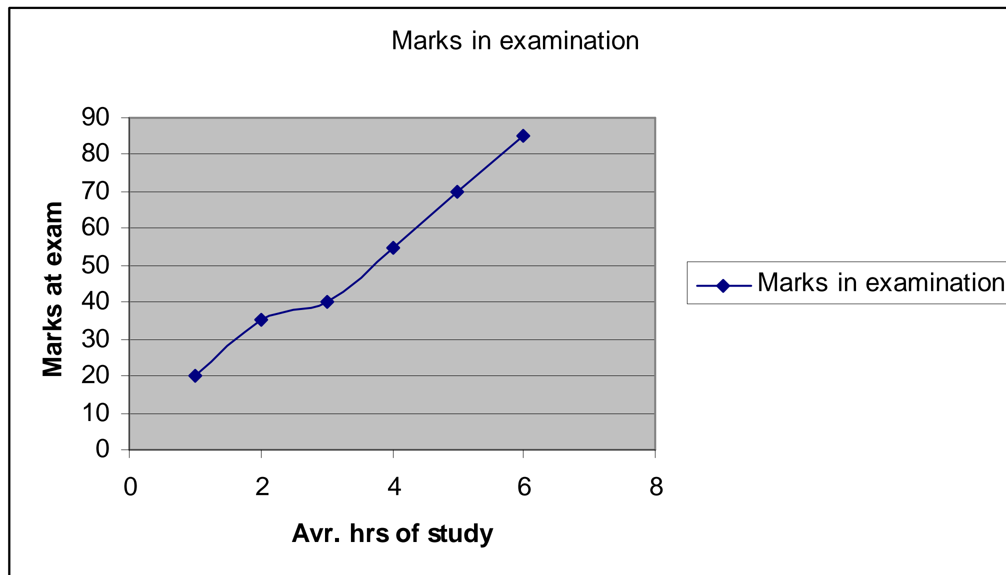
Average hours of study per week	Marks in examination
1	20
2	35
3	40
4	55
5	70
6	85

These figures can be represented on a x-y graph.



We can see that there is a very strong correlation between the average hours of study per week and the marks received at the MII exam. As the number of hours of study per week rises, the marks at the exam also increase. Except for the additional third hour of study, an additional hour of study would allow a student to get 15 marks higher at the MII exam. During the third additional hour of study, a student will get only 5 marks higher.

Multiple Line Graphs—carry information on more than one variables at a time.

X-Y Graphs—which shows that one variable may be related to another variable, such as between premium income and commission paid; between sales and staff costs;

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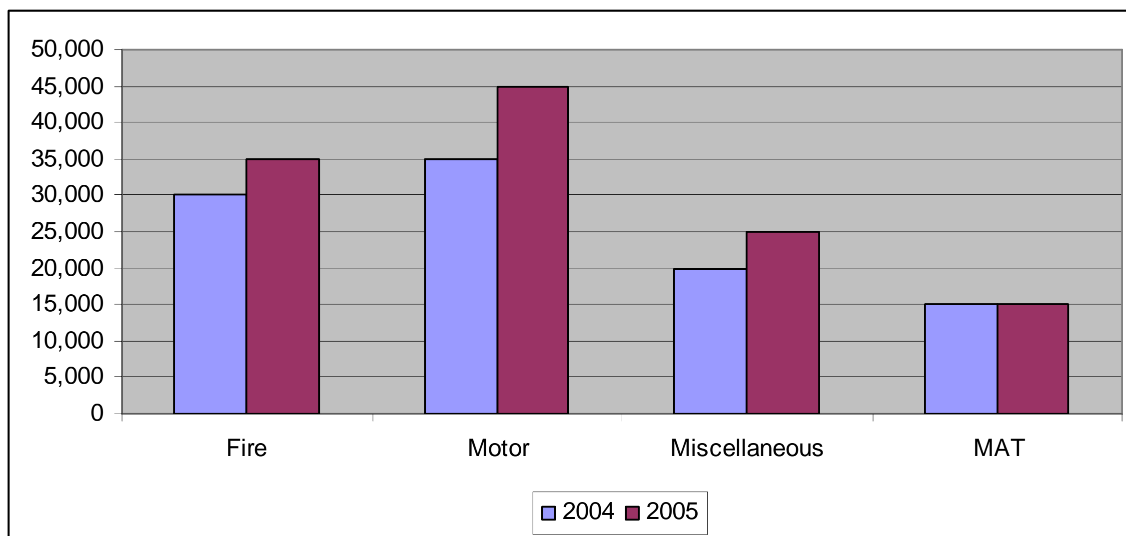
between claims and the number of policies.

C. Bar Charts

Simple bar chart: sum insured divided into different lines (fire, motor, marine)

Multiple bar chart: sum insured divided into different lines in 2-3 years)

Component bar chart: divided different class of business into direct, broker, agent.



D. Pie Chart

A retail electronic company has locations in Malaysia, Thailand and Cambodia. Sales figures for 2005 were as follows:

Country	Sales
Malaysia	14.5
Thailand	5.0
Cambodia	3.5
Total	23

These figures can be represented on a bar chart and a pie chart.

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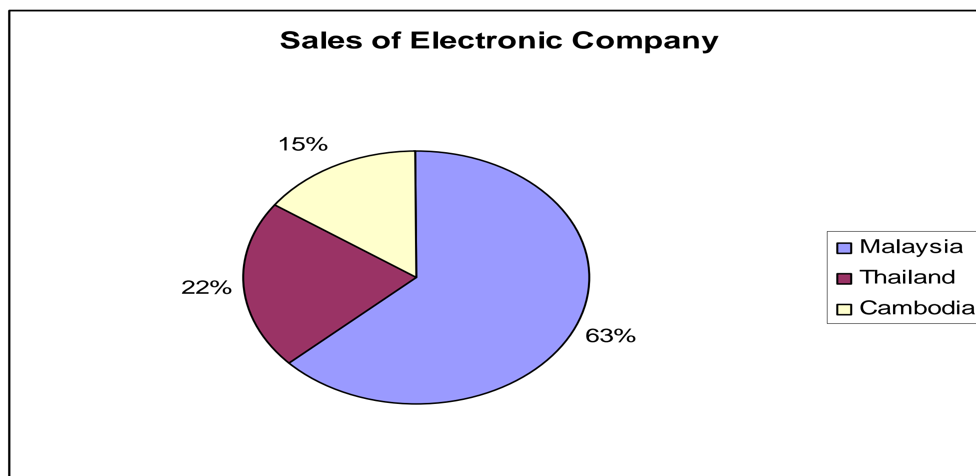

D. Frequency Distribution

Discrete variables are those which can only be a whole number. Continuous variables are those which need not to be whole number and which could be any fraction of an integer.

Frequency distribution is a method of presenting data into classes or groups, counting the number of times that values were observed to fall within each class or group. There are 5 classes of equal size.

500	25	210	120	153
35	400	20	700	69
90	390	80	174	60
68	80	210	40	159
310	30	80	470	160
610	210	445	50	70
35	74	80	35	280
160	80	550	390	150

Construct a group frequency table. (Use five classes, each with a class width of 150.)

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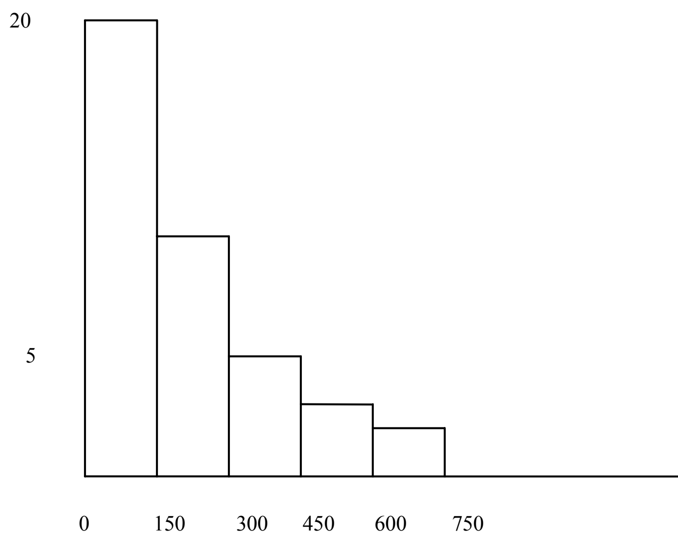
CLAIMS	FREQUENCY
0 < 150	20
150 < 300	10
300 < 450	5
450 < 600	3
600 < 750	2
	40



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5. The Measurement of Risks

5.1. Statistical Measurement of Risk Data

The three aspects of the data which we want to measure are:

- **Location** – where the data is located in the whole span of the variable – claim costs from zero to million or the whole spectrum of ages;
- **Dispersion** – the extent to which the data is tightly grouped or spread out – claim costs between 1$ to 1 million $ or are ages tightly grouped around some central figures; and
- **Skew** – the measurement which will enable us to identify clustering of data. Are most of the people in the study young? did the majority of claims cost a substantial amount?

5.1.1. Main Measures of Location

A. The Average:

Arithmetic mean – all values are added and the total is divided by the number of values.

Geometric mean – is used where relative changes in some variables are being averaged.

B. The Median

The median– is the value halfway through a list of values which have been arranged in ascending order. For odd-numbered arrays of values – the value half way; for even-numbered arrays – the mean of the two middle value. The median splits the distribution into two equal parts, but often we refer to the top 25% - quartiles, the bottom – 10% - deciles, and percentiles

C. The Mode

The Mode– the most commonly occurring value. Modal time taken to qualify;

Mode = mean – 3 (mean – media);

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For continuous data – the mode marks the area where the greatest degree of cluster takes place. For discrete data, the mode will be an actual individual value and will therefore avoid fictitious value such as 4.2 branch offices. The mode, like median, cannot be used for further mathematical processing.

C. Dispersion

Dispersion measures the extent to which the data is spread out or tightly grouped, around the measure of location.

Range is the simplest method of measuring dispersion – the distance between the smallest and largest values of the variable. A claims distribution which had a smallest claim of 30$ and a largest of 500$ would have a range of 470$.

Quartile deviation is to concentrate between the first and the third quartiles. The first quartile is the value below which lies 25% of all values and the third quartile is the point beyond which lies 25% of values. The extreme values can be cut off if we concentrate on the centre portion of values in the distribution.

$$\frac{Q3 - Q1}{2}$$

Standard deviation measures the extent to which each one of the variables in a distribution varies from the mean.

In order to compare dispersions, we must relate the standard deviation to the mean by using the coefficient of variation.

Skew is the measure of the extent to which the values in a distribution were grouped, or bunched, at one end of the distribution or the other.

$$\text{Skew} = \frac{\text{mean} - \text{mode}}{\text{standard deviation}}$$

$$\text{Pearson's coefficient of skew} = \frac{3\ (\text{mean} - \text{media})}{\text{standard deviation}}$$

In aviation claims experience distribution, there are few small claims. The bulk of the

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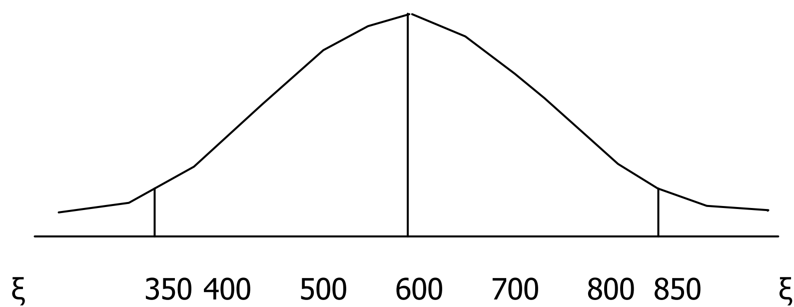
aviation claims involves large claims. Thus, the values of the aviation claims are grouped at the higher end of the distribution. This pulls the mean down lower than the median. As a result, the Pearson's coefficient of skew, represented by the formula – [3 (mean – median)/standard deviation] – is negative.

Standard Deviation—The claims costs under the travel policies are normally distributed with the following parameters:

Mean claims cost: $600

Standard deviation: $100



The mean claims cost is $600 and the standard deviation is $100. All claims costs are embraced by the curve and what we want to find is the area under the curve which is bounded by the points $350 and $850. This can be found from the formula:

$$z = \frac{x - \mu}{\sigma} = \frac{850 - 600}{100} = 2.5$$

Z value of 2.5 above the mean embraces 41.55% of all values. Therefore, the required probability is 0.4155.

5.1.2. Probability

There are three methods of deriving probabilities:

- **1. The *a priori* method** caters for those occasions when all the possible outcomes in an event are known before, or prior to, the event occurring and all of the outcomes are equally likely.

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desired outcome

all possible outcomes

The major drawback with the a priori method is its stipulation that all possible outcomes are known beforehand. In the real world this is rarely so.

- **2. Relative frequency –** look back at the relative frequency with which the event in question occurred in the past and the estimate will hold good for the future. The drawback of this method is when there is a lack of historical data.

- **3. Subjective probability** - is used when dealing with unique events, or events which have only occurred a few times and about which there is little data, i.e. expression to the degree of belief that an event will occur. Subjective probability - is used when dealing with unique events, or events which have only occurred a few times and about which there is little data, i.e. expression to the degree of belief that an event will occur.

If events A and B are mutually exclusive, what are the probabilities of:

A and B occurring?

P(A and B) = P(A).P(B)

A or B occurring?

P(A or B) = P(A) + P(B)

If events A and B are not mutually exclusive:

P(A or B) = P(A) + P(B)

For events A and B, what is the probability of events A and B both occurring:

if the events are independent?

P(A and P) = P(A).P(B)

if the events are not independent?

P(A and B) = P(A). P(B/A)

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If the factories were close, then the fires at A and at B, i.e. the events were not independent.

5.2. Probability Distribution

The two major features are: frequency and severity.

Frequency with which losses occur is a discrete number. Severity of a loss normally means its monetary value. Severity is a continuous variable, it need not be a whole number.

$\sum P(x).x$

- x is the mid-point loss and P(x) is the probability of loss.

This is a base for estimating what we expect to pay out in the long run.

5.2.1. The 'Expected Value'

The expected value is a form of future average in the long run. The expected value is found by multiplying the outcome by the probability that the outcome will occur and then add all these products.

$\sum P(x).x$

Number of thefts	P(x)	$\sum P(x).x$
0	0.7	0
1	0.2	0.2
2	0.06	0.12
3	0.03	0.09
4	0.01	0.04
	1.00	0.45

The expected number of thefts per shop is 0.45.

The expected value is a form of future average in the long run. The expected number of claims per policy is found by multiplying the outcome by the probability that the outcome will occur and then add all these products.

$\sum P(x).x$

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Suppose that these 10 losses had a severity distribution as follows:

Cost (US$)	Mid-point	P(x)	P(x).x
0 < 300	150	0.7	105
300 < 600	450	0.2	90
600 < 900	750	0.06	45
900 < 1,200	1,050	0.03	31.5
1,200 < 1,500	1,350	0.01	13.5
		------	--------
		1.00	285

The expected value of theft loss per policy is US$285.

5.3. Theoretical Probability Distribution

5.3.1. Normal Distribution

Normal distribution is a theoretical distribution, but is a close approximation in a large number of actual cases if empirical distributions were to be drawn. The height of people is a good illustration of this feature. The bulk of people are all roughly the same height, with only a few very small people and few very large ones. It is symmetrical. The mean lies at the point under the peak of the curve. The two tails of the curve theoretically never touch the horizontal axis. It is used in much of the statistical work concerned with sampling. In specific areas under the curve lie certain standard deviations above and below the mean.

For example, the claims costs under the travel policies are normally distributed with the following parameters:

Mean claims cost: $600

Standard deviation: $100

The mean claims cost is $600 and the standard deviation is $100. All claims costs are

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embraced by the curve and what we want to find is the area under the curve which is bounded by the points $350 and $850. This can be found from the formula:

$$z = \frac{x - \mu}{\sigma} = \frac{850 - 600}{100} = 2.5$$

Z value of 2.5 above the mean embraces 41.55% of all values. Therefore, the required probability is 0.4155.

The two parameters which determine the shape and position of a normal distribution is the mean, μ , and standard deviation, σ.

5.3.2. Relationships

It is possible to look at the relationship between the costs of motor claims and the age of the drivers; the frequency of house thefts and the geographical location of the property; the gross profit of an insurer and the level of premium income. Thus, one variable depends on the other.

- Firstly, if we understand the relationship it may be possible to predict the value of the dependent variable based on the value of the independent variable. [We may be able to predict the costs of claims based on the age of the driver].
- Secondly, an understanding the relationship between two variables would enable us to say how strong the relationship was. For example a strong or weak relationship between the costs of claims and the age of the driver. This knowledge would help us to decide which independent variables are important and should be included into the calculation.

Simple regression and correlation is to study the relationship between two variables: one dependent and the other independent variable, as opposed to multiple.

5.3.3. Regression

Regression is defined as the mathematical expression of the relationship between the dependent and independent variable. Linear regression and correlation is to study the relationship by means of a straight line. The line found can then be used to predict the value of "y" for a given value for "x" – but what limitation must be borne in mind?

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The equation of a straight line is the form: $y = a + bx$

y – is the dependent variable;

a – is where the straight line will cross the y – axis;

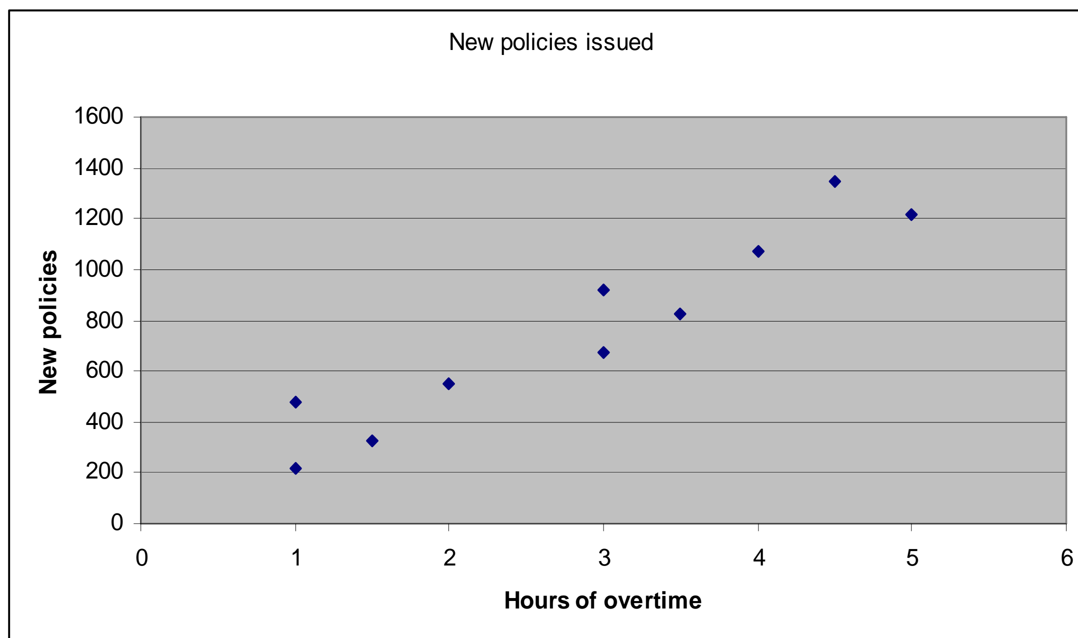
b – is the gradient of the line;

x – is the independent variable.

5.3.4. Scatter Diagrams

We are studying the relationship between the hours of overtime and new policies issued. The hour of overtime is the independent variable, while the number of new policies issued constituting the dependent variables. We are trying to explain the relationships between independent and depending variables by means of linear regression, i.e. by studying a straight line through the following scatter diagram.

Figure 1.6: Scatter diagram



We have seen that there is a direct, positive relationship between additional hours of overtime and the new insurance policies issued. As hours of overtime spent increase, we would expect the number of policies issued increases. Moreover, the scattered points align themselves in a pattern of straight line, which indicate the close relationships

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between variables. Next, we would look at these relationships more closely.

5.3.5. The Regression Equation

The relationship between the hour of overtime and the number of new policies issued can be expressed by a mathematical equation, which will allow us to make predictions about the dependent variables.

As we will limit our study to linear regression, the equation would take the form of a straight line: $y = a + bx$;

where -**y** is the dependent variable, i.e. the number of issued policies;

-**a** is where the straight line will cross the y-axis;

-**b** is the gradient of the line; and

-**x** is the independent variable.

Using this straight line, we wish to fit the straight line to the dots in the scatter diagram. As the straight line cannot go through all the 10 dots, we will try to place a **line of best fit** through the dots.

To draw the line, we have adopted the approach of least squares regression. Each dot will be a certain distance from the line and the least squares find that line where the distance between all the dots and the line is kept to a minimum. In order to draw the line, we need to find the value of the constants 'a' and 'b'.

The 'b' constant can be calculated based on the following formula:

$$b = \frac{\Sigma xy - n\bar{x}\bar{y}}{\Sigma x^2 - n\bar{x}^2}$$

Therefore, we must find out the values for Σxy, $\bar{x}$, $\bar{y}$, Σx^2 and $\bar{x}^2$.

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X	Y	XY	X^2	Y^2
3.5	**825**	**2,887.5**	**12.25**	**680,625**
28.5	**7,620**	**26,370**	**99.75**	**7,104,300**

$$b = \frac{26,370 - 10\,(2.85)\,(762)}{99.75 - 10\,(2.85)^2} = \frac{26,370 - 21,717}{99.75 - 81.225} = \frac{4,653}{18.525} = 251.17$$

The formula for 'a' is:

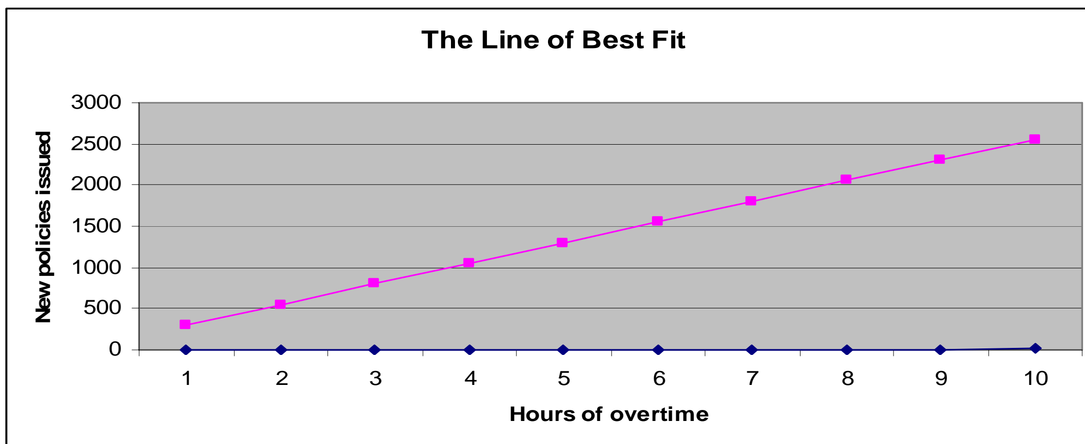
$$a = \frac{\Sigma y - b\Sigma x}{n} = \frac{7,620 - 251.17\,(28.5)}{10} = \frac{7,620 - 7,158.35}{10} = 46.16$$

The least squares regression line is:

$y^1 = 46.16 + 251.17\,x$

Now we try to plot our theoretical graph based on the above y^1formula, by replacing x with the number from 1 to 10. Then we will obtain the following results:

Week	1	2	3	4	5	6	7	8	9	10
Hours of	1	2	3	4	5	6	7	8	9	10
New	297.33	548.5	799.67	1,050.84	1,302	1,553	1804.35	2055.52	2306.69	2557.86



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5.3.6. The Coefficient of Determination

We have seen that our theoretical diagram presents the regression line, along which fall the value of 'y^1' upon 'x'. All of the variation of actual y^1s from the mean of all y^1s is explained by the regression line.

The purpose of calculating the coefficient of determination, r^2, is to measure the variation in the number of policies issued from the mean is explained or determined by the regression of policies issued on the hours of overtime, i.e. the ratio of explained variation to the total variation.

$$r^2 = \frac{a\Sigma y + b\Sigma xy - n\tilde{y}^2}{\Sigma y^2 - n\tilde{y}^2} = \frac{(46.16)(7{,}620) + (251.17)(26{,}370) - 10(762)^2}{(762)^2 - 10(762)^2} =$$

$$= \frac{351{,}739.2 + 6{,}623{,}352.9 - 5{,}806{,}440}{7{,}104{,}300 - 10(580{,}644)} = \frac{1{,}168{,}652.1}{1{,}297{,}860} = 0.9004$$

Thus, the coefficient of determination equals 90%. This means that 90% of the variation in the new policies issued from the mean is explained or determined by the regression of the new policies issued on the hours of overtime. Only 10% remains unexplained by this relationship.

Four 'unexplained' factors that could be relevant

The expression $\Sigma (y - y^1)^2$ is called 'the unexplained variations', because they behave in a random or unpredictable manner. We have the following equation.

$y^1 = 46.16 + 251.17\ x$

The line can be used as a predicting equation. The value of 'y' can be predicted for any value of 'x'. The line should be used to predict values of 'y' for values of 'x' which lie within the limits of the values of 'x' which were used to derive the equation itself. In this case, the values of 'x' varies from 1 to 5. Our line has only described what has happened between the overtime of 1 and 5 hours. What happens outside these limits is not explained by the line.

Suppose $x = .5$; $y = 171.74$;

$x = 6$; $y = 1{,}553.18$;

x = 7;   y = 1,804.35;

x = 8   y = 2,055.52;

6. The Insurance Market Place

6.1. The General Structure of the Market Place

The three general classes of participants in the insurance market are:

- The sellers – insurance companies and Lloyd's under-writer members;
- The buyers – general public, industry and commerce;
- The intermediaries – insurance brokers and agents;

The Intermediaries consist of the insurance broker. The insured can obtain independent advice on insurance matters from a broker without the cost to himself, on the following issues: insurance needs; best type of cover and its restriction; best market; claim procedure; and obligations placed on the insured by policy conditions.

Broker advices on insurance needs, best type of cover and its restrictions, best market, claim procedure, obligations placed on the insured by policy conditions and updates the information as time goes by to take account of market changes.

6.1.1. Lloyd's Brokers

The Lloyd's broker carries out the same functions as an ordinary insurance broker, but if one wishes to insure at Lloyd's the business must normally be placed there by a Lloyd's broker or other intermediary through Lloyd's brokers. Special direct dealing arrangements exist where a non-Lloyd's broker may deal direct with a syndicate. Managing agents may set up service companies to deal direct with the public for personal lines and commercial motor business without any Lloyd's broker involvement.

Lloyd's broker operates at all time in the interests of his client and must understand his requirements and advise on the best way to meet them. It is the broker's duty to advice on insurance needs, to obtain the best possible terms for his clients, best type of cover and its restrictions, best market, claim procedure, obligations placed on the insured by policy conditions and updates the information as time goes by to take account of market changes. Should there be a claim the broker negotiates, arrange settlement,

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collects the money from underwriters via the central accounting system and pays it to his client.

The Council of Lloyd's registers broking firms to act as Lloyd's brokers. They are required to satisfy the Council as to their expertise, integrity and financial standing. After being appointed, they can display the words 'and at Lloyd's' on their letter heading and name plates. The Lloyd's broker represents the insured in the transactions with the underwriter.

Other intermediaries are:

- The agents – agents have to register under the law.
- The Insurance Consultants – a person who can act as intermediaries without registration.

6.1.2. The Sellers or Suppliers

A. Lloyd's

In 1871,the Lloyd's Act created the Corporation of Lloyd's. The 1982 Act created the Council of Lloyd's, which has overall responsibility and control of affairs at Lloyd's, including the rule-making and discipline. The Council consists of 18 members: 6 working, 6 external and 6 nominated members. The Committee of Lloyd's comprises working members of the Council and is concerned with day-to-day running of the affairs at Lloyd's.

The capital behind the underwriting of insurances at Lloyd's is supplied by investors called Names or underwriting members. The underwriting members are not insurance professionals. Some members are Working Names. They are people who are engaged in the work of the insurance market. They have to satisfy strict requirements as to knowledge of the market.

B. Membership of Lloyd's

Now there are mostly corporate names and some individual members, grouped into syndicates. Corporate membership was introduced in 1994. Each syndicate appoints an underwriting agent to manage its affairs and this underwriting agent appoints professional underwriters. In view of unlimited liability, there is strict regulation of underwriting member. There are three forms of membership of Lloyd's:

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- Vocational name – people who have worked in Lloyd's for at least five years and passed Introductory Test; do not have to show means;
- Connected or associated name – Employees or principals of firms trading in the Lloyd's market who do not meet the requirements of vocational names.
- Other names – external members, not in the two categories.

6.1.3. Insurance Companies

A. Proprietary Insurance Companies

The majority of insurance companies have been created by registration under the Companies Acts. The majority of these companies come are limited liability companies with shareholders as proprietors.

Proprietary companies have an authorized and issued share capital to which the original shareholders subscribed, and it is the shareholders that any profits belong after provision for expenses, reserves and, in the case of life business, with-profit policyholders' bonuses. The shareholders' liability is limited to the nominal value of their shares, but the company is liable for its debts and if the solvency margin cannot be met the company will go into liquidation.

B. Mutual insurance company

Mutual companies are owned by policyholders, who share profits made. The policyholder owner may enjoy lower premiums or higher life assurance bonuses than would be the case.

C. Mutual Indemnity Association

Mutual indemnity associations differ from mutual companies in that the companies will accept business from the public at large. The true mutual indemnity associations grew out of trade associations and are common pools into which members of a particular trade contribute and from which they can make claim when necessary. The associations were formed because members considered that the cost of commercial insurance was too high, compared to claims or their need was not met by the market.

Contributions were made to the fund on the basis of tonnage or value. In bad years, the members would be called upon to make additional contributions to keep the fund

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solvent. Most of these associations have been taken over by the normal insurance market.

6.2. Self Insurance

The five advantages of self-insurance are as follows:

- Premiums should be lower as there are no costs in respect of broker's commission, insurers' administration and profit margins;
- Interest and profit of the investment of the fund belongs to the insured and can be used to increase the fund or to reduce future premium contributions;
- There is a direct incentive to reduce and control the risk of loss;
- The insured's premium costs are not increased due to the adverse claims experienced of other firms;
- No disputes will arise with insurers over claims.

The five disadvantages of self-insurance are as follows:

- A catastrophic loss could occur, wiping out the fund and perhaps forcing the organization into liquidation;
- Capital has to be tied up in short-term, easily realizable, investments which may not provide as good a yield as the wider spread of investments available to an insurance company;
- The technical advice of insurers on risk prevention would be lost and since the insurance surveyors would have a wide experience over many firms and different trades, this knowledge could be advantageous to the insured;
- There may be criticism from shareholders and other departments:
- at the transfer of large amounts of capital to create fund and at the cost to dividends that year; and
- at the low yield on the investment of the fund compared with the yield obtainable if that amount of capital were invested in the production side of the organizations.

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- The basic principle of insurance, that of spreading the risk, is defeated.

Self-insurance can be considered as an alternative risk transfer (ART) mechanism, whereby the first layer or proportion of our risks is not insured in the commercial market. For that reason we will set aside funds to meet eventual insurable losses for the first layer.

The reasons that we would self-insure the first layer are the following:

- The commercial rate for the first layer of risk is very high;
- Our company is strong financially to carry such losses, as the cost to us is still lower than the commercial premium level of transferring the whole risks to commercial insurance;
- Our risks are predictable, with high frequency and low severity;
- We can save from the cost which suppose to cover the insurer's administration cost and profit;

For the above reason, our company can establish a fund, which will be used to meet the eventual cost. The advantages of such self-insurance scheme are as follows:

- Premiums should be lower as there is no costs related to broker's commission, insurers' administration and profit margins;
- Interest of the investment of the funds belongs to our company. This can be used to increase the volume of the self-insurance fund;
- The premium costs are not increased, due to the deterioration of claim experience of other firms;
- There is a direct incentive for our company to reduce and control the risk of loss;
- No disputes will arise over claims;

However, self-insurance has the following disadvantages:

- A catastrophic loss could occur, which could wipe out the fund. For that reason we should purchase insurance to cover our large exposure against big claims;'
- The aggregate effect of several losses in one year could have the same effect as one

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catastrophic loss;

- Capital has to be tied up in short term, easily realisable investments which may not provide as good as yield as the better spread of investment's available to an insurance company;

- We should increase the number of insurance staff employed at an extra cost;

- We will not be able to benefit from the technical advice of insurers on risk prevention, as their surveyors have wide experience on loss control;

- There may be criticism from shareholders, as we will have to transfer large amounts of capital to create the fund at the cost to dividends. Moreover, the yield on the investment of the fund is low, compared to production investment;

- In time of financial pressure, there may be temptation to borrow money from the fund, compromising the security which it had created;

- Pressure may be brought to bear *ex gratia* payments;

- The basic principle of spreading the risks is defeated;

- The contribution made to the fund does not qualify as a charge against corporation tax, whereas premium payments are allowable.

6.3. Transactions of Business at Lloyd's

THE ROOM – Underwriters and their staffs sit at 'boxes' each with a number and the Lloyd's brokers negotiate their contracts. The Room at Lloyd's is the only place in the country where there is recognized insurance market.

TRANSACTION OF BUSINESS – Only Lloyd's brokers may place insurance at Lloyd's. Lloyd's broker will prepare a slip. Risks may be placed electronically.

The slip – The slip will show: Details of insured; Period of cover required; Inception date of cover; Perils or type of cover required; Property to be insured; Sums insured or limits of liability; Special conditions to be incorporated; Expected premium.

Lloyd's underwriters – The broker will take the slip to an underwriter who specializes in this class of business, with a view to him accepting the lead or first proportion of the risk. Discussions on other aspects of the risk, such as the claims experience, will take

place and the underwriter may feel obliged to amend some of the terms on the slip before he can accept the rate of premium or the conditions.

Once agreement on terms has been reached, the underwriter will stamp and initial the slip for the proportion which he is prepared to accept for his syndicate. The broker will proceed to other underwriters until 100% is underwritten. Each underwriter will record details of the risk underwritten for his own records.

Lloyd's Policy Signing Office – When the slip is complete, the broker returns to his office and has the policy prepared in accordance with the slip. The policy and slip are then submitted to Lloyd's Policy Signing Office (LPSO), where the policy is checked with the slip and signed on behalf of all syndicates. Brokers will send accounting and settlement details electronically to LPSO. Accounts are prepared for the syndicates and brokers from the data recorded at the Policy Signing Office.

Lloyd's Claim Office – The Lloyd's broker also provides a service to his client in the settlement of claims. He negotiates with the staff of the Lloyd's Claim Office (LCO). Once the broker has been informed of a casualty or potential loss he will advise the leading underwriter and LCO of the details and obtain any relevant details and enter the appropriate information into the claims office computer system.

6.4. Organizational Structure of an Insurance Company

The Board of Directors – formulate the overall plan of operation.

General manager – is the CEO of the company, responsible for implementing the policy laid down by the Board.

Company secretary – administration of the company to ensure compliance with the law.

Management services –Department of specialists, such organization and methods staff, statisticians and economists to advise on any changes in plan.

Personnel – in charge of recruiting new staff members of the correct type; ensure training and remuneration.

Accounts – provide reporting of insurance accounts.

Investment – is responsible for investing the reserves of the company.

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A. Geographical Organization:

The geographical organization of a company can includes: the Executive head office; Administrative head office; Regional offices; and Main branches.

B. The centralized operational system

When a company is centralized, all underwriting claims, policy drafting, renewals and accounts work is handled from head office with the branches merely being sales outlets.

The advantages of the centralized operational system are as follows: Uniformity of policy, practice and routine; Most economic use of merchanised methods; Fewer experts are required with a resultant saving in salaries; Branches are relieved form routine work and can concentrate on selling.

However, this system has the following disadvantages: The system is often run from an area of high salary, building and rating costs; Poor service can result from the administration being remote from the customers; Excessive power resides in a few hands. Dictatorial attitudes can develop in underwriting to the detriment of the company; Lack of promotion prospects for most of the staff.

C. Decentralization

With decentralization – the main branch is responsible for its own underwriting, policy drafting and claims. The advantages of decentralization are: Local officials will be best understand local conditions; Good local service responsible; Branch staff became knowledgeable and makes decision; Underwriting policy is democratic; Better staff morale – chances of promotion;

However, the disadvantages are: Many experts are required, with higher staff bills; Branches inundated with routine work; Effort wasted in making traffic branches expert in everything;

Regional system – the country is divided into regions and the principal branch became the regional office. It took over the underwriting, policy drafting and claims work from head office or the branches depending upon the system in force before. In late 1970s the tendency was to remove some of the authority from main branches to regional offices and from regional offices to head office, due to ICT.

7. Transacting Insurance

7.1. Publicity

The insurer has embraced modern concepts in marketing and advertisements using billboards, television or brochures and sport sponsorship to promote products available from insurance company.

The insurer has adopted a modern approach to insurance advertising, such as "We won't make a drama out of a crisis"; "I want to be ..."

The nature of insurance products, i.e. the proposer cannot see or touch the product; there is no possibility of testing the product and in many cases the proposer hopes that he will never have to use the service of the insurer.

Proposal form is often the only printed publicity material. Now insurers distribute a leaflet, which provides information on motor insurance: total loss of the car, authorising repairs, range of cover.

7.2. Proposal Forms

The proposal form is the mechanism by which the insurer receives information about the risks to be insured. In most classes of insurance a proposal form is completed by the proposer and submitted to the insurer.

However, there are certain classes of insurance for which proposal forms are not required, such as fire and marine insurance. In the case of fire insurance the details of risk are so complex, thus the insurer cannot rely on a proposal form. The insurer uses their own risk surveyor to inspect the property to be insured and discuss the risks with the insured. Sometimes a broker can prepare full details of a risk for an insurer. In marine insurance, a broker, acting for a proposer, provides the description of the risk and take the 'slip' containing the details of the risk to the underwriter at Lloyd's.

The proposal from differs depending on the class of insurance. In general it should include the name and address of the proposer, his occupation and age; details of past claims; description of trade; period of cover required; basis for premium calculation.The proposal form is the common mechanism by which the insurer receives information about risks to be insured. In most classes of insurance a proposal form is completed by the proposer and submitted to the insurer.

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The classes of insurance for which proposal forms are not required are fire and marine insurance. In the case of fire insurance, the actual details of the risk are complex that it would be impossible to confine them to a proposal form. For example, it is impossible to describe a large manufacturing plant on a proposal form. For this, the insurer use the risk surveyors to visit the premises or to discuss the risks with proposer. Brokers play an important part in this process by preparing full details of a risk for an insurer.

In marine insurance, a broker, acting on behalf of a proposer, would describe the risk and take the slip containing the details of the risks to the underwriter at Lloyd's.

Risk specific questions relate to the form of risk for which cover is sought. They assist the underwriter in determining whether or not he will accept the risk and on what terms and price.

On the motor proposal, details of the drivers required. The underwriter wants to know who will be driving the car as it influences the price of the insurance.

On the household proposal, questions concerning the level of physical protection at the house; intruders alarms used; neighborhood watch schemes;

On the life proposal, questions concerning the health of the proposer;

There are two features appear on all proposal forms:

- Declaration – appears at the end of the form – confirms that the information which has been supplied is true to the best of the proposer's knowledge and belief.
- Warnings or important notes about what facts should be disclosed and the dangers of all material facts are not disclosed. This has the effect of allowing insurers to avoid liability under the policy if a fact emerged which had not been declared.

7.2.1. Proposal form for private motor insurance

The proposal form is the most common mechanism by which the insurer receives information about risks to be insured. The following are five risk specific questions on a proposal form for private motor insurance.

- Firstly, details of the proposer: the name and address of the proposer, occupation and age of the driver;
- Secondly, specific questions about the driver: will the car be driven by anyone under

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the age of 25; whether he or she have been convicted in connection with motor vehicle (fines, penalty, date and reasons for disqualification); whether he or she has been disqualified from holding or obtaining a driving licence; had a proposal for any motor insurance declined, had a policy cancelled or had renewal of a policy refused; accidents or losses suffered by those who drive the car for the past three years.

- Thirdly, details about the vehicles: full details of make of vehicle and model; whether the car has been modified to increase performance; where the car is kept;

- Fourthly, cover and options: type of cover: comprehensive; third party, fire and theft or third party only;

- Fifthly, declaration: (i) the car is in good conditions and repair; (ii) all information supplied is true and complete and nothing materially affecting the risk has been concealed.

7.3. The Policy

Each policy have a heading which includes the name of the insurer, the address and company logo. Then come the preamble. The proposal form is the basis of the contract and is incorporated in it. The insured has to particularly careful when completing the proposal form. The premium has been paid or there is an agreement that the insured will pay. There can only be a valid contract when the insured has paid the premium. The insurer will provide cover detailed in the policy, subject to its terms and conditions. Then the signature.

Under the preamble, or close to it, will be the signature of an official from the company.

7.3.1. Operative clause

The operative clause indicates the actual cover provided under the policy is outlined. The insurer is stating clearly what it is agreeing to do, what benefits it will pay. These rules should be read in conjunction with the policy schedule.

7.3.2. Exceptions

Exceptions are the consequence of having a scheduled type of policy. Exceptions are what are not covered under the policy. In the policy there are a number of general exceptions, which apply to all sections of the policy. For example, exceptions dealing

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with war risks and nuclear contamination.

7.3.3. Conditions

A condition stating that the insured will comply with all the terms of the policy. The requirement that the insured notify the insurer of any changes in the risk. The condition relates to the procedure is to followed in the event of a claim or the effect of fraud:

- The insured has to take reasonable care to minimize the risk of loss or damage;
- A condition about arbitration;
- A condition which outlines what is to happen if there are other policies in force covering the some loss;
- Condition that allows the insurer to cancel the policy and how this can be done.

There are express conditions and implied conditions. Express conditions are those that appear on the printed policy. Implied conditions are those which are not appear on the policy.

Other kinds of conditions are:

- Conditions impose an obligation on the insured and can be classified:
- Conditions precedent to the contract – the policy will be void or not come into effect if the insured fails to comply with the term (for life insurance – premium is paid until the policy come into effect; in motor – the insured must maintain the vehicle in a roadworthy condition at all time); Conditions precedent to the contract are those conditions which must be fulfilled prior to the formation of the contract itself. If not fulfilled the contract is not valid. The implied conditions fall into this category, such as:

Firstly, the subject matter of insurance actually exists and can be identified;

Secondly, the insured has insurable interest, i.e. the insured has financial relationship with the subject matter of insurance. He stands to benefit if it is not lost or damaged and will suffer in the event of any loss or liability;

Thirdly, the respect of the principle of utmost good faith in negotiations leading up to the formation of the contract. This is the duty of disclosure of all facts which may be

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material in the forming of the insurance contract;

Fourthly, the policy will be void or not come into effect if the insured fails to comply with the term (for life insurance – premium is paid until the policy come into effect; in motor – the insured must maintain the vehicle in a roadworthy condition at all time);

- Conditions subsequent to the contract – these conditions which have to be complied with once the contract is in force, such as adjustment of the premiums or notification of alterations to the risk. Conditions subsequent to the contract – that must be complied with once the contract is in force, such as condition relating to the adjustment of the premiums, notification of alterations of the risk.

- Conditions precedent to liability – these conditions relate to claims and must be complied with if there is to be a valid claim, such as prompt notification of claims in the proper manner. This allows insurers to avoid liability for a particular loss if the term is broken, but not avoid the contract as a whole (prompt advice of a loss); Condition precedent to liability – conditions related to claims and must be complied with if there is to be a valid claim.

7.3.4. Main components of an insurance policy

Heading – each policy has a heading which includes the name of the insurer, address, company logo;

Preamble – makes mention of the premium and the cover provided by the insurer, subject to its terms and conditions.

Signature – under the preamble will be the signature of an official from the company;

Operative clause – the most important section of the policy, i.e. actual cover is outlined. The company will ... pay certain benefits, rules etc.

Exclusions – what is excluded;

Conditions – the insured will comply with all the terms of the policy; notify the insurer of any change to the risk; procedure for claims; effect of fraud; care to minimize the risk of loss or damage; arbitration;

Policy schedule – information on the insured; address; nature of business; period of insurance; premiums; sum insured; policy number

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7.3.5. The policy schedule

The policy schedule is made personal to the insured. The policy schedule usually contains the following information: The insured; The address of the insured; The nature of the business; The period of insurance; Premiums; The limits of liability; The policy number; Reference to any special exclusions, conditions or aspects of cover.

7.3.6.Cover note

A cover note is issued to provide confirmation of a cover, as it is not always possible to issue an actual policy as soon as the terms of the contract have been agreed. It is a summary of terms and conditions of the insurance that has been placed, as well as details that the insurers have accepted. The cover note is widely used in motor insurance. The cover note is temporary and will be super-ceded once the policy is issued. It could take the form of a letter from the insurer to the insured. The motor cover is in force once the cover note is issued and the premium may still have to be paid.

The policy is the evidence of the contract and contains all the details of cover, exceptions, conditions, period of cover, premiums and other information. It is not possible to issue policy as soon as the terms of contract have been agreed. But there is need to proof that the cover is in force. The COVER NOTE is a temporary document to state that insurance is in force and give brief details of the cover. It will be superceded once the policy is issued. Confirmation that cover is in force need not always be in the form of a pre-printed cover note. It could take the form of a letter from the insurer to the insured.

A different situation exists in life insurance. Once the proposer has sent his completed proposal form to the insurer he will receive a letter of acceptance. This letter of acceptance is an offer to the proposer, which is accepted once the premium has been paid. The life assurance policy will only come into effect once the premium has been paid. The motor cover is in force once the cover note is issued and the premium may still have to be paid.

7.3.7. Certificates of insurance

Where insurance is compulsory, the law also requires that certificate is issued to prove that a policy is in force. Certificate makes it easier for law enforcement agencies to quickly identify that the insured has complied with the law and has a valid policy, as it is

not practical to carry insurance policy at all time. As in some countries both motor insurance and employers' liability insurance are compulsory, insurers are required to issue a small certificate of insurance for both classes of insurance business to proof that the cover is in force.

In case of the motor insurance, the information contained in the certificate includes the name of the policyholder, the registration number of the car, the period of insurance, persons entitled to drive and limitations as to use.

The employers' liability certificate contains a notice that the certificate must be displayed at all places of business, including outdoor sites.

7.3.8. 'Days of grace'

Non-payment of a premium implies that the contract is not to be renewed and it will lapse on the renewal date. However, there may be cases where the premium has not been paid by the renewal date even though there was still an intention to renew.

Days of grace extend to 15 or 30 days after the renewal date, during which time the insured can pay the premium. Days of grace are not an extension of cover. Once premium is paid the cover applies from the renewal date.

In motor insurance the premium must be paid by the renewal date and days of grace do not apply. If the premium is not paid then the policy ceases. But insurer can issue a certificate which provides the minimum cover.

7.3.9. Renewal notice

Before the expiration of the insurance policy, which generally provides a cover for a twelve-month period, the insurer issues a renewal notice to the insured to inform that the insurance period will end soon and proposes to renew the policy by offering the premium to renew the policy. The renewal notice is to remind the insured and to secure renewal of the policy. If the insured wants to renew the policy, he sends the premium to the insurer and will receive a confirmation of renewal. However, to facilitate the insured, the insurer offers days of grace of fifteen or thirty days after the renewal date during which time the insured can pay the premium. This was used when there is intention to renew, but the premium was not paid by the renewal date. However, in motor insurance, the days of grace do not apply and the insured must pay the premium by the renewal date.

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7.3.10. Long term agreement

In order to retain business in a strong competition environment, the insurer offers the insureds a discount of five percent from the premium if the insureds offer the business to the insurer at each renewal date for three years. Thus, both the insurer and the insured will benefit form this long term agreement.

8. Underwriting

The task of an underwriter is to manage the insurance pool as effectively and profitably as he can. This pool, which is created by the premium contributions of many people will be used to pay for the losses of the few insureds. The role of the underwriter is to: (i) Assess the risk which people bring to the pool; (ii) Decide whether or not to accept the risk or how much to accept; (iii) Determine the terms, conditions and scope of cover to be offered; (iv) Calculate a suitable premium.

8.1. Hazard

Hazards are factors that may influence the outcome. Theses hazards are not themselves the cause of the loss, but they can increase or decrease the effect should the peril operate.

The peril is the prime cause. It is what will give rise to the loss. For example, flood is the peril and the proximity of the house to the river is the hazard. Storm, fire, theft, motor accident and explosion are perils. Flood is the peril and the proximity of the house to the river is the hazard. The peril is the prime cause, it is what will give rise to the loss. Storm, fire, theft, motor accident and explosion are perils. Hazards are factors that may influence the outcome. They are not the cause of the loss, but they can increase or decrease the effect. Hazard can be physical or moral. Physical hazard relates to the physical characteristics of the risk, such as wooden house, security protection of a shop or factory, or the proximity to a river bank. Moral hazard refers to the attitude of the insured person.

The underwriter has the task of assessing the hazard. Hazard can be physical or moral. Physical hazard relates to the physical characteristics of the risk, such as the nature of the construction of a building, i.e. wooden house, security protection of a shop or factory, or the proximity to a river bank.

- **Property loss or damage**: construction of a building would be an aspect of physical hazard. Buildings of wooden construction would present higher level of

physical hazard than ones built of bricks. The provision of automatic fire sprinklers and fire fighting equipment would represent a good physical feature;

- **Liability:** The presence of dangerous chemicals; the absence of guards on machinery, excessive noise or dust;
- **Motor:** People who have a high mileage such as salesmen, young people have higher hazard. The place where the car is garaged or used (commercial vehicle) has impact on physical hazard;
- **Life assurance**: people with certain, potentially dangerous occupations, a person who has recurring illness.

Moral hazard concerns the human aspects, which may influence the outcome. This refers to the attitude of the insured person: (i) Lack of care on the part of the insured; (ii) Regular claimant or people who look at insurance as investment; (iii) Dishonest insured, dishonest claimant.

8.2. The Underwriting Process

Personal insurance – The main source of information about a risk is the proposal form and if there is anything the proposer wants to know, he will write to the proposer.

Delegation of underwriting – travel insurance policy is sold by travel agent or airline. For household insurance, broker has authority to issue policies with an upper monetary limit.

Commercial business insurances – The underwriting of commercial business insurance is very complicated task. The subject of insurance ranges from small shops and factories to large multinational corporations. The underwriter has to evaluate the hazard associated with the risk which is being proposed. In small cases he may be able to do this from reading a proposal form and communicating with the proposer.

In large cases, a broker may be able to help by preparing plans and reports on the risks. These reports will be passed to the underwriter to negotiate on the terms, conditions, the cover and the premium. However, the underwriter will engage a specialist risk surveyor to inspect different area of risk such as fire, security, liability and business interruption. The surveyor prepares a report, which consists of the following features:

- A full description of the risk: plan of the premises, the process and details of the insured;

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- An assessment of the level of risk: relevant hazard factors, both moral and physical, idea of the degree of risk; comments on surrounding property;

1. A measure of the maximum probable loss (MPL);
2. Recommendations on loss prevention;
3. The view on the adequacy of the insurance requested.

The role of the risk surveyor – The risk surveyor is a person who acts as the eyes and ears of the underwriter. Insurance companies employ specialist risk surveyors to prepare a report for the underwriter and in the case of property risks the risk surveyor will also draw a plan. Sometimes the insurer hires a professional surveyor to survey the risk. In some cases, the broker can help the insurer to survey the risk.

8.2.1. The main features of a survey report

The survey report should contain the following:

- A full description of the risk – the plan of the premises in case of a property risk, the process being carried on at the premises, details of the insured;
- An assessment of the level of risk – the relevant hazard factors, both moral and physical, idea of the degree of risk, comments on the surrounding property;
- A measure of the maximum probable loss (MPL) – the maximum the surveyor believes will be the subject of a loss;
- Recommendations on loss prevention – steps should be taken to protect the risk or requirements which the insured must implement if cover is to be granted;
- The surveyor's view on the adequacy of the insurance – the surveyor provides his view on the sum insured or the limit of liability to make sure that the insured is not under-insuring the risk.

8.3. Reinsurance

A contract of reinsurance is one by which a direct insurer procures a third party to insure him against loss or liability by reason of such original policy. There are elements of reinsurance that are particular. Reinsurance is a distinct and separate contract from the original insurance, and itself takes the form of a contract of insurance. Reinsurance

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need not cover the reinsured's entire obligation under the original contract of insurance, either in terms of the sums payable or in terms of the perils covered. However, reinsurance cannot provide a wider cover than that originally insured. The reinsurance contract must cover the same risk as the original insurance. The insurance contract and the reinsurance contract must exist at the same time with the insurance contract preceding the reinsurance contract.

The direct insurer can get the following benefits from reinsurance:

- Enable the insurance company to grant cover for amounts of liabilities that would otherwise be beyond the capacity of their financial resources;

- Event out fluctuations in underwriting results due to exceptionally large individual losses, or catastrophes over a wider area; example, windstorm or earthquake losses and riots owing to disorder where accumulation is high. In short, it stabilizes the loss trend for the primary insurers;

- To protect against the accumulation, known or unknown, of net retention of a specified portfolio. By this manner, it can also increase the capacities of a linked proportional program (Risk or Working excess of loss reinsurance).

- To protect against an increase in the unexpected loss frequency of a specified portfolio (Cat excess of loss reinsurance).

- Lead to spreading of risks over a much greater number of insurers and reinsurers with consequent deductions of individual financial commitment.

- In the case of facultative excess of loss, it enables the primary insurers to control the commercial business without the necessity of co-insurance or dependent on facultative arrangement that in both ways, will subject to loss of confidentiality in terms of rating.

- By the creation of capacities, primary insurers will continue to be able to compete.

8.3.1. Reasons to Buy Reinsurance

Security – the insured wants to be relieved from the uncertainty of loss. Buying insurance provide peace of mind.

Stability – by purchasing reinsurance, the insurer can avoid fluctuation in claims costs from year to year and within a year, due to exceptionally large individual losses, or

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catastrophes over a wider area. In short, it stabilizes the loss trend for the primary insurers;

Capacity – the insurer can increase the capacity it has to accept the business, as he may have financial limit on the size of risk which it can accept. This enables insurance companies to grant cover for amounts of liabilities that would otherwise be beyond the capacity of their financial resources;

Catastrophe – the insurer can transfer much of the risk to the reinsurer, thus it can reduce the possibility of a complete catastrophe, which could cause serious financial problems;

'Macro' benefits – the cost of risk is spread around the market place and the world. By placing reinsurances with many companies, the impact of risk does not fall solely on one economy.

8.3.2. The Reinsurance Market

The players in the reinsurance market are as follows:

A. The buyers:

Direct insurers: ordinary insurers who transact insurance with the general public. Insurers purchase reinsurance to increase capacity and provide protection.

Captive insurance companies: the companies owned by a non-insurance parent and transact insurance for their parent companies. The captives may retain a fixed proportion and reinsure the balance.

Lloyd's syndicates: Reinsurance protection is to limit the extent of the personal loss they might suffer.

Reinsurers: individual reinsurers seek protection to secure financial stability in their account by purchasing reinsurance.

B. Intermediaries

Reinsurance brokers: they have a specialist knowledge of reinsurance and world insurance markets. They can assist in arranging the correct covers and selecting the most appropriate reinsurers.

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Management companies: They offer a management service to organizations who have captives. One management company will handle several captives and the management of captive will often include the placing of reinsurance.

C. Sellers

Reinsurers: They specialize in reinsurance and do not write any direct business. They are usually international companies, transacting reinsurance in many parts of the world;

Direct insurers: They may be asked to provide reinsurance for other direct insurers or for reinsurers. Thus, they can be both sellers and buryers.

Captive insurance companies: They can be a supplier of reinsurance where it writes business from a source other than its parent company. The captive can be a buyer and seller of reinsurance.

Pools: The pools are established to provide protection. Contributions to the pool will be assessed by an underwriter. The pool can also provide reinsurance.

Lloyd's syndicates: They are both buyers and sellers in the same market. A large proportion of the business written by syndicates is reinsurance.

8.3.3. Transacting Reinsurance

A. Proportional treaties

Proportional treaties– concern with proportions of the values at risk, the direct office decides what proportion of the risk he wants to retain and cede the balance to reinsurers. Premiums and losses are shared in the same proportions.

Quota share treaty—A quota share treaty protects the insurer's gross retention. The mechanics of a QS are the purest form of proportional reinsurance. The insurer agrees to cede a stated percentage amount of all business within its gross retained account, irrespective of the class of risk and individual retention chosen. QS would be used for new insurers, or developing a new line or class of business, or for experimental or special classes. It is used to reduce net retained income in order to improve or protect solvency requirements; and to balance a surplus treaty which has poor results.

Advantages are as follows:

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- Reinsurer follows the fortune of the insurer almost identically;
- The account and reporting of business is simple;
- Flexibility exists in increasing or decreasing the amount of QS ceded;
- Unlimited cover is provided for aggregation of risk losses in a single loss event.

The disadvantages are as follows:

- The insurer agrees to cede a stated percentage amount of all business within his gross retained account, irrespective of the class of risk and individual retention chosen.
- Since a stated percentage of the retention is ceded away, there is no choice of selecting the risks. Insurer has to cede both good and bad risks to reinsurer.
- The quota share treaty is inflexible: no choice of selecting a retention exists;
- Large amounts of premium income are ceded away and this might be to the detriment of the insurer;

If your company has a 60% quota share treaty and you have just accepted a risk of $800,000 with a premium of $2,000, calculate your own retention and the amount that you will cede to the treaty reinsurers in terms of sum insured and premium respectively.

If my company has a 60% QS treaty, then it would cede the remaining 40% of all risks to the reinsurers and retain 60% of all risks. The company will also retain 60% of the premium and cede 40% of the premium to the reinsurers.

When the company accepted a risk of $800,000 with a premium of $2,000, it will retain $480,000 of the risk and cedes $320,000. The company will retain the premium of $1,200 and cedes $800 to the reinsurer.

Surplus treaty – how much of each risk it wants to retain for its own account. Risks are divided into lines, the direct office retain one line, i.e. retention, and cede the remaining lines to the insurer.

B. Non-Proportional Reinsurance

Non-proportional reinsurance – are based on the losses, rather than the sums insured.

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The insurer agree to pay an amount over and above, or in excess of, an amount which the direct office agrees to pay or retain. The following are the forms of non-proportional treaties:

Excess of loss – the ceding office pays the first $x of losses arising from an event and the reinsurer pays $y in excess of $x.

Stop loss (excess of loss ratio) – provides protection for an entire portfolio of risk, rather than for individual losses. The loss ratio is claims expressed as a percentage of premiums.

C. Types of treaty reinsurance for Various Purposes

Excess of loss reinsurance is the standard form of reinsurance bought to protect liability insurance, including public liability. This can be done for each liability class separately or for all classes as a whole for smaller-sized accounts. Excess of loss cover can be given on an each and every loss basis or on an each and every risk basis either within, or excess of, a risk.

For public liability insurance, companies in a start-up position or those wishing to maximize their line size could purchase proportional reinsurance, either quota share or a surplus treaty. Otherwise, excess of loss would be the usual treaty for public liability insurance, sometimes in combination with other liability classes. Cover is on a 'losses occurring' basis up to the limit of indemnity with an upper layer to cover 'clash' of one or more policies and costs in addition.

Stop loss can be purchased for liability account. Stop loss is expressed as A% loss ratio/ percentage of premium income or $X amount in the aggregate whichever is the lower in excess of B% loss ratio/ percentage of premium income or $Y amount in the aggregate whichever is the greater.

Facultative reinsurance can be purchased for peak exposures excluded from the main treaties, either because of large limits of indemnity, a territorial scope outside the main treaties or because they fall under a special exclusion. Facultative reinsurance would usually be on an excess of loss basis. A facultative obligatory cover may be arranged in the reinsured frequently needs facultative cover.

Protecting an entire portfolio of risk—For insurers in a start-up position, who wish to write sizeable lines but do not have the spread of business or adequate capital in order to comfortably assume a significant amount of risk for their own account, a quota share

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or surplus treaty or a combined quota share and surplus treaty can be purchased to protect an entire portfolio or risk.

The surplus treaty would enable the reinsured to cede large lines on more exposed risks to their reinsurers whiles keeping smaller standard business entirely for themselves. It allows the insurer to vary its retention upon a particular risk or line of business, provide automatic capacity available upon a particular class and size of risk.

A quota share treaty protects the insurer's gross retention. The insurer cedes a stated percentage amount of all business within its gross retained account, irrespective of the class of risk and individual retention chosen. This kind of treaty is used when the insurer is not sure about the risk and is mainly used by new companies or companies writing new classes of business.

When the insurer is sure about underwriting management and the spread of risks, it can shift to a non-proportional treaty. Treaty excess of loss is available in a variety of forms: Risk excess of loss, catastrophe excess of loss and stop loss.

Risk Excess of Loss is a cover that protects within a reinsured's retention. The purpose is to limit the reinsured's liability in respect of individual risks or accidents or events. Such classes are motor vehicle third party liability, employer's liability and general third party liability. The common use of this cover for property class is to increase the original net retention. It enhances the capacity under the proportional program. It reduces the number of cession and retains large volume of the premium for its own account.

8.4. Premiums

When calculating insurance premiums, underwriters must consider both risk factors and external commercial factors. The risk factors include the risk profile, an assessment of the level of risk, a measure of the Maximum Probable Loss (MPL) or Estimated Maximum Loss (EPL), the surveyor's view on the adequacy of the insurance being requested, the claim experiences etc. At the same time, the underwriters must take into consideration the following external commercial factors:

- **The effect of inflation**: the underwriters must be aware of the changing value of money. Claims will be met in the future, out of premiums received today. The cost of settling a claim may arise, due to inflation. This is an important factor which the underwriters should take into account when calculating the premium;

- **Currency fluctuations:** exchange rate risk also presents a challenge to underwriters when calculating the premiums. In general, premiums are collected in national

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currencies. For a multinational company receiving businesses from many countries, currency fluctuations can seriously affect the level of reserves for claim payment. Therefore, exchange rate will be another factor that underwriters should consider when calculating the premium.

- **Interest rates:** insurance business is divided into two parts: pure insurance business and investment of funds. These funds may generate substantial income for an insurance company. Thus, the variability in the interest rates should be taken into consideration by the underwriters in premium calculation.

- **Competition:** in the world of tough competition, long-term relationship between the insured and the insurer is critical for the insurance business. While rating the risk both factors – competition and long-term relationship – should be taken into account by the underwriters.

The insurance premiums must cover the following financial items: Cover expected claims – estimates of claims; Create an estimate for outstanding claims – claims to be settled, especially in personal injury; Provide a reserve – contingencies beyond their control; catastrophic reserve; Meet all expenses – salaries, office costs, advertising; commission; Provide for profit – a surplus; Inflation; Interest rates; Exchange rates; Competition.

8.4.1. Premiums Calculation

Premiums are arrived at by applying a premium rate to a premium base. The sum insured is a suitable premium base for property insurance. The rate reflects the hazard which the insured brings to the pool. The insurer adjusts the rate taking into account good risks or bad risks. Office places or apartments will get low premium, while garment factories or wooden houses will require higher premium. In motor insurance, the age of the driver, type of vehicle – commercial vehicle or taxi;

Adjustable premiums – at the beginning of the year only estimate of the total wage bill is provided. At the end of the year the insured provide an actual wage paid. At this point the premium will be adjusted up or down, depending on the wages figure;

Flat premiums – is applied to motor insurance.

8.4.2. The 'Application of Average'

The application of average is used in under-insurance. If the cost of replacement is

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lower than the sum insured, the insured will not get the total claim. If the sum insured is 75% of the value of the property, in case of total loss or partial loss, the insured will get only 75% of the claim.

8.5. Claims

The notification of a claim is the responsibility of the insured. The conditions of the policies are speedy notification of the claim, with time limits within which a claim should be notified. The insurer wants to take statements from witness. In the case of theft, the claim should be intimated to the policy to allow the maximum opportunity to recover stolen property. In the case of damage to property, speedy notification is required to take remedial or loss reduction action. In some cases, brokers can have delegated authority to handle claims. The claim is usually handled by the claim department.

8.5.1. Claim Handling

In the event of a claim, the insurer requires that the insured provides prompt notification of a claim. The conditions of the policies are speedy notification of the claim, with time limits within which a claim should be notified. The insurer wants to take statements from witness. In the case of theft, the claim should be intimated to the police to allow the maximum opportunity to recover stolen property. In the case of damage to property, speedy notification is required to take remedial or loss reduction action. In some cases, brokers can have delegated authority to handle claims. The claim is usually handled by the claim department.

When a claim occurs, the insurer has to ensure that: the cover was in force at the time of the loss; the insured is the correct insured; the peril is covered by the policy; the insured has taken reasonable steps to minimize the loss; conditions have all been complied with; no exceptions are appropriate; the value of the loss is reasonable.

In fulfilling the above functions, the insurer calls upon the loss adjusters to conduct investigations. The loss adjuster is an expert in processing claims from start to finish. This will involve ensuring that all the interests of the insurer are preserved, in checking that the cover was in force and was adequate at the time of the loss. The adjuster will also act to minimize the extent of the loss and is in a position to use his considerable experience to bring about a swift settlement of the claim.

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8.5.2. The Loss Adjuster

In case of a large or detailed claim, the insurer calls upon the loss adjusters to conduct investigations about the claim, notably in fulfilling the above functions. The loss adjuster is an expert in processing claims from start to finish. This will involve ensuring that all the interests of the insurer are preserved, in checking that the cover was in force and was adequate at the time of the loss. The adjuster will also act to minimize the extent of the loss and is in a position to use his considerable experience to bring about a swift settlement of the claim. The loss adjuster prepares a detailed report of the claims, listing all the points and the photographs of the damaged property. The final report would give details of what the actual loss amounted to. Based on the loss adjuster's report, the insurer will pay claim to the insured.

8.5.3. Factors in Property Claim Settlement

In the final stage of claim settlement – the actual monetary settlement – the eventual cost of the claim will depend on the nature of the cover: indemnity or reinstatement.

- **Indemnity** is one of the basic doctrines of insurance, i.e. an insured is to be placed in the same financial position after a loss as he enjoyed before the loss. The measure of indemnity would be the replacement cost less an amount for wear and tear. In the case of partial damage, indemnity would be the repair cost les wear and tear.

- **Reinstatement** is a form of 'new for old' policy, it avoids the difficulty in ascertaining the value of a loss under an indemnity contract. Reinstatement may take place in the following circumstances:

- By the insurers under the terms of the policy: The operative clause of the policy gives the insurer the option to reinstate. Unless and until the insurers decide to reinstate, the contract remains one to pay money. The reinsured cannot refuse to accept a money payment, and demand reinstatement. He cannot refuse to accept reinstatement if the insurers elect to reinstate. Insurers may be required to cause the insurance money to be expended in rebuilding, reinstating, in the following circumstances:

- When there is reason to believe that the reinsured or any person acting on his behalf has fraudulently set fire to the property with the object of obtaining the insurance money;

- When requested to do so by any person interested in or entitled to the property, such as owners and purchasers; lessors or lessees; mortgagors or mortgagees; tenants from

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year to year.

There are several factors which may limit the insured's entitlement to a full indemnity:

- *The sum insured or limit of liability* – the maximum amount recoverable under many policies is limited by sum insured or the limit of indemnity (or limit of liability). The insured cannot recover more than this amount even where the loss, measured by the indemnity principle, is a higher amount. However, the UK Road Traffic Act requires motor insurers to grant unlimited cover for liability in respect of death or bodily injury.

- *Other policy limits* – within the overall sum insured or limit of indemnity, there may be further separate limits for particular types of loss or particular types of property. For example, a household contents policy will restrict cover on individual 'valuable' to 5% of the total sum insured.

- *Underinsurance and average clauses* – where there is underinsurance, the policyholder is not paying their fair share into the pool. Therefore an average clause is applied and the claim payment for any loss will be scaled down proportionately.

- *Excess or deductible* – a clause which provides that the insured must bear the first amount of any loss, expressed either as a sum of money or a percentage of the loss.

- *A franchise* – similar to an excess in that there is no liability for any loss which is less than the franchise figure. Once the franchise has been exceeded, the loss is payable in full.

9. Government Supervision

9.1. The Insurance Company Act 1982

The following are the main items in the Insurance Company Act 1982:

- **Restriction on carrying on insurance business:** defining classes of business and the requirements to be met;

- **Regulations of insurance companies:** financial matters, such as accounts, actuarial investigation, winding-up and other matters;

- **Conduct of insurance business:** insurance advertisements, 'cooling-off' notices for life insurance and the disclosure for intermediaries;

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- **Special classes of insurers:** Lloyd's, industrial life assurance and companies established outside the UK;
- **Supplementary:** criminal proceedings which would follow any breach of the Act.

9.2. Groups of insurance business

9.2.1. Long Term

Class I Life and annuity

Class II	Marriage and birth

Class III	Linked long term

Class IV	Permanent health

Class V	Tontines

Class VI	Capital redemption

Class VII	Pension fund management

9.2.2. General

Class 1 Accident

Class	Sickness

Class	Land vehicles

9.3. Forms of company

UK companies:

Community companies: companies with head office in member states, but have branch offices in UK;

External companies: Companies with head office outside EC, but having branch agency in UK.

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9.4. Solvency Margin

Solvency margin is defined as assets over liabilities by %. If the minimum solvency margin is not maintained then the Secretary of State has the power to intervene. The purpose is to ensure that insurance companies can meet their liabilities.

The Solvency Margin (surplus capital) of an insurance company is the surplus of assets over liabilities, both evaluated in such a way as to satisfy insurance regulatory authorities that the company is in a position to meet its liabilities. The domestic legislation defines methods of valuation of assets and liabilities that can be included in the solvency margin.

According to the legislation of some countries, a margin of solvency is defined as some percentage of assets over liabilities. However, some countries have shifted toward risk-based capital in defining solvency margin. Thus, the actual value of the solvency margin, in monetary terms, varies from company to company, reflecting its size, the volume of business and the degree of risky business that they underwrite.

An insurance company is solvent if it is able to fulfill its obligations under all contracts under all reasonably foreseeable circumstances.

If the minimum solvency margin is not maintained the domestic legislation would require remedial action. If the liabilities of an insurance company exceed its assets, the company is technically bankrupt. To protect policyholders and maintain the stability of the insurance industry, insurance regulators use the solvency margin as one of the instruments to monitor and regulate insurance companies.

9.4.1. Bases for calculating the solvency margin

The solvency margin is determined by taking the greater of two sums resulting from the application of two sets of calculations called respectively the premium basis and claims basis.

Gross premiums received are transferred into ECU. The company calculates 18% of the first 10 million ECU and 16% of any balance over and above 10 million. Then adjusted for reinsurance.

Claim basis – The total gross claims paid during the preceding 3 years, converted into ECU and the average taken. 26% is calculated of the first 7 million ECU and 23% of any excess over 7 million ECU.

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The basis framework of solvency margin for life business is the same as for general. But the main difference is that calculations are based on actuarial liabilities. In life business, claims are long-term and their actuarial value is calculated.

9.2. The Financial Service Act 1986

The Act was approved to provide a framework for protecting investors. To ensure that investors can place their money with confidence with any investment business.

The main objective of state regulation of insurance is to protect the public and to take socially desired measures. The state regulation can be explained as follows:

Maintain solvency – The Solvency Margin (surplus capital) of an insurance company is the surplus of assets over liabilities, both evaluated in such a way as to satisfy insurance regulatory authorities that the company is in a position to meet its liabilities. An insurance company is solvent if it is able to fulfill its obligations under all contracts under all reasonably foreseeable circumstances;

Equity – State regulation is designed to protect policyholders and maintain the stability of the insurance industry. Insurance regulators use the solvency margin as one of the instruments to monitor and regulate insurance companies;

Insurable interest – this doctrine of insurance was introduced into the legislation in order to prevent gambling, i.e. it is not acceptable that a person would benefit by effecting insurance policy where he or she had no financial interest in the potential loss other than the profit to be made if it occurs;

Provision of certain form of insurance – the State has made intervention by requiring that some forms of cover should be made compulsory, such as employers' liability and motor insurance;

National insurance – for some areas of social risks, the government's intervention has been total and it has assumed the responsibility for providing cover, such as unemployment, sickness and window's benefits under the national insurance scheme.

9.2.1. Supervision of Intermediaries

The supervision of intermediaries prior to and following the Insurance Brokers Registration Act 1977 (UK)

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Before the adoption of the Insurance Brokers Registration Act 1977, anyone could call themselves an insurance broker regardless of their knowledge about insurance. For that reason there were about 9,000 firms calling themselves brokers in the 1970s. In January 1976, the British Insurance Brokers' Council was established by four broker associations to prepare a proposal for the registration and regulation of insurance brokers. Based on this proposal an Insurance Brokers (Registration) Act was adopted in July 1977.

After the adoption of the Act a person who does not qualify for registration or does not seek registration cannot refer to himself a broker. Instead they will be called an insurance consultant or adviser. Brokers have to comply with a set of strict operating conditions.

9.2.2. Compulsory Insurance

A. Reasons for compulsory insurance

Provision of funds: the enactment of compulsory insurance ensures that funds will be available when damages are awarded;

Eases the State's burden: the State would not allow people injured at work to go without compensation. If the responsible party did not have sufficient funds, the State would provide money. The existence of compulsory insurance eliminates this possibility;

The response to national concern: the concern over accidents was so high that legislation was introduced to ensure the provision of insurance, such as in case of injury or damage;

Protection: insurance allows the insured to have access to all the expertise available from insurers, which may improve the risk and thus assist in protecting people.

B. Forms of compulsory insurance

Motor insurance – third party risks are death of, or bodily injury to any person and damage to third party property.

Employers' liability insurance – every employer has to insure against liability for bodily injury or disease sustained by employees and arising from their employment.

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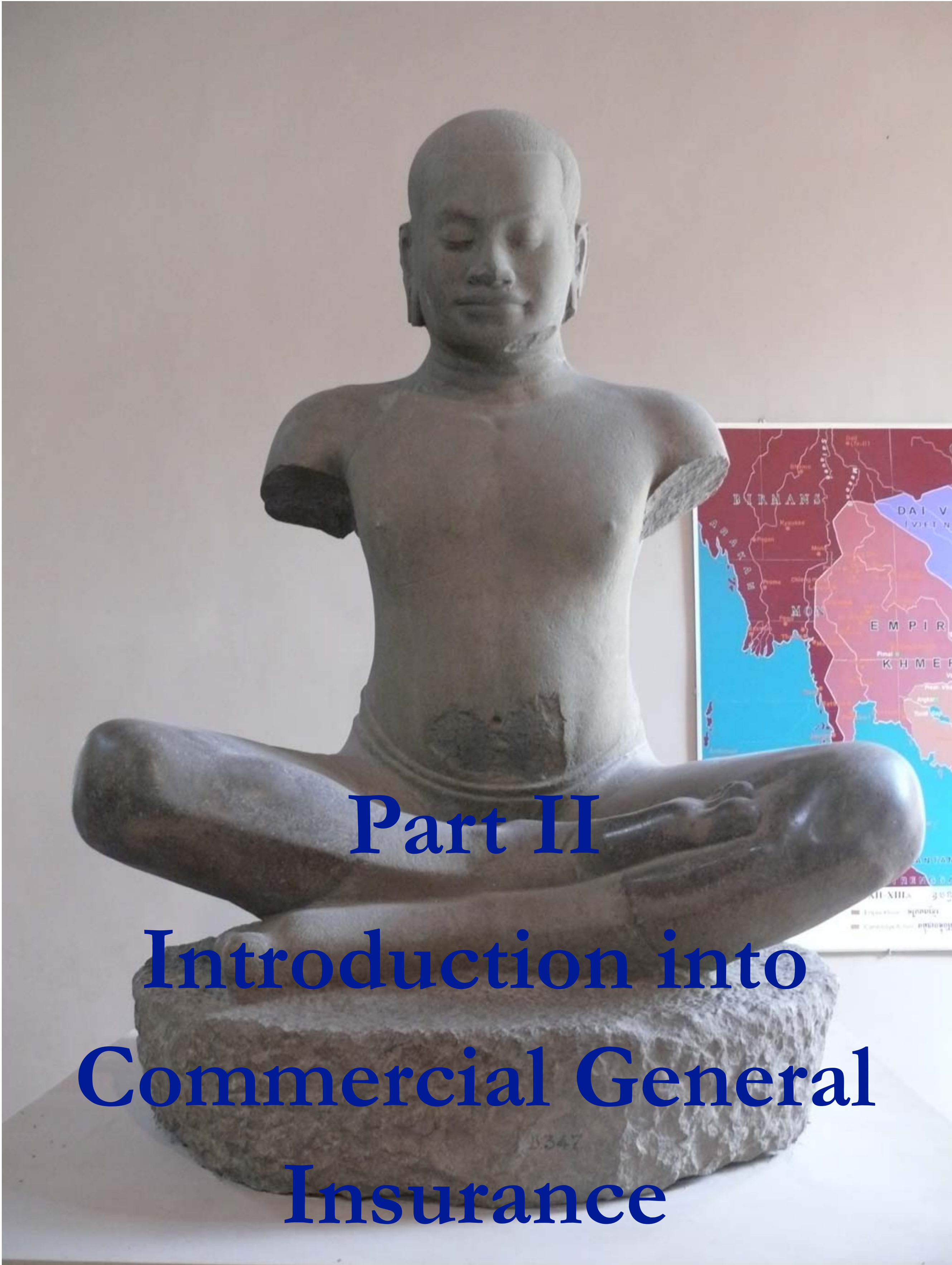
Compulsory insurance provides funds, eases the state's burden, respond to national concern and provides protection.

C. Nationalization of the insurance industry

Reasons for nationalization: Government control of funds would be to the benefit of society at large; It would be possible to introduce uniformity in wordings and practice; Statistics could be pooled; Premium rates could be reduced in the absence of the profit motive; The cost exercise of making the statutory returns would be eliminated;

Reasons against nationalization: It is difficult to nationalize the international companies. It could be that some overseas countries would not trade with government-owned insurance industry; Insurance has grown and developed in private hands for many centuries and there is no reason to think that any better service would result from State ownership; Experience of certain nationalized industries is one of overloaded bureaucracy; Competition encourages efficiency and innovation; The large scale nature of any State insurance organization may lead to a strictness in practice and interpretation that would not benefit the public.



Part II
Introduction into Commercial General Insurance

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Part II

An Introduction into Commercial General Insurance

1. Risk Improvement and Loss Prevention

The primary duty of a surveyor is to examine each building in detail in order to discover all the features which affect the hazards of the building, such as "common hazards" such as those arising from construction, lighting, heating and power, but also "particular hazard"

1.1. Fire Waste

Fire waste is the absolute economic loss of the wealth of the community caused by fire. Fire results in the wastage of materials and financial resources. The wealth of the community is reduced commensurably with the property damaged by fire. Trade and business, as well as employment will also suffer from fire. Therefore, everybody will benefit from the reduction of the fire wastage. Two parties can take measures to reduce fire waste: the community (that is the State) and the insurers.

The State can take measures to reduce both physical hazard and moral hazard related to fire waste. The State can adopt legislations and regulations to prevent fire; improve the efficiency of the fire brigades; enact construction standards; raise awareness of the community about fire risks; provide budget for the functioning of the fire brigades.

Insurers use the system of rating to eradicate the causes of fire and to reduce its scope. The basic rate is loaded for bad features and reduced where the risk is lessened by such factors as fire-resisting construction or the provision of fire extinguishing appliances. This rating encourages the insured to improve the standard of construction, install automatic sprinklers, with the result that fire wastage will be reduced.

Moreover, industrial premises are periodically inspected by surveyors who make recommendations to reduce fire hazard. These recommendations usually include warranty to sweep up factory at the close of each working day or prohibition of storage of highly flammable materials etc. The insured are required to follow up such recommendations to get the cover. Insurers are able to put their knowledge and expertise at the disposal of the insured to reduce to minimum the fire hazard.

Salvage—can cover many activities aimed at reducing damage caused by the fire itself and by the firefighting measures. This includes removing water used for firefighting

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from the building, covering stock with waterproof sheets to keep it dry or moving stock out of the way of the water, waterproof sheets may be fixed over damaged roofs to protect against the weather.

1.2. Theft

The rating of theft risks is based on the attractiveness of the property and on its location, with higher rates being applied to target items, such as cigarettes, spirits, clothing and jewellery, and to areas more prone to burglary, such as some of the urban areas.

Thus the following factors will determine the rating of a theft risk, such as the nature and value of the property, construction of the building, the quality of construction, its location and the character of the neighborhood, physical protection (type of door or window, nature of fastening, description of safes), alarm protection, the security is operated, for example, whether locks are used, keys are kept in custody of the keyholders, whether cash is locked in the safe out of working hours. Moreover, standards of protection should be improving from time to time. The presence of adverse features, such as weakness in security, the activity of criminals and vandals looking for easy pickings.

1.3. Motor

Risk improvement in motor insurance includes: excesses; premium loadings; reduction in policy cover; no claims discount; specially reduced premiums for proven good drivers.

1.4. Engineering

Inspection service is crucial for both insurer and insured to improve risk by detecting faults and arranging for their correction before they develop far enough to cause breakdowns. Preliminary survey is carried out to assess the risk and hazard, followed by a periodical inspection service for as long as the policy is in force.

1.5. Fidelity Guarantee

The enquiries made by the insurer into the system of check and methods of supervision and into the business and domestic history of any employee whose fidelity is to be guaranteed are designed to improve risks.

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1.6. Accident Prevention

Accident prevention is important for both insurers and the nation in order to reduce accident waste. Insurers play an important role in accident prevention, as they build up useful knowledge. Accident prevention is also in the interests of the policyholders, who want to maintain good record.

2. The Application of Insurance Principles

2.1. Utmost Good Faith

In the English law of contract, the general rule is that a contracting party is under no duty to disclose material facts known to him but not to the other party. The legal doctrine of ***caveat emptor*** (let the buyer beware) applies, which means that it is the duty of the buyer to make himself acquainted with the defects, if any, of the goods he is purchasing, and he has no remedy against the seller, except in case of misrepresentation or fraud.

A contract of insurance is, however, an exception to the general rule of caveat emptor, and requires both the insured and the insurer to exercise ***the utmost good faith*** (*uberrima fides*) in their negotiation*: "It is the duty of the assured, the man who desires to have a policy, to make full disclosure to the underwriters without being asked of all the material circumstances, because the underwriter knows nothing and the assured knows everything."*

2.1.1. Duty of Disclosure

It is an implied condition in all contracts of insurance that the proposer shall make full and complete disclosure to the insurer of all the material facts relating to the risk to be insured. If he conceals anything he knows to be a material fact, that is fraud; and therefore the policy is void.

2.11. Material Facts

A material fact is a fact which would influence the mind of a prudent insurer in deciding whether to accept a risk for insurance and on what terms, i.e. fixing the premium. This information includes: Information about previous fire in the vicinity of insured property; Any fact about previous loss by theft; the premises are not secure; Previous accidents and record of accidents of any driver; Conviction of sale managers for smuggling; Excessive over-valuation of the subject matter of the insurance for the

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purpose of a valued policy; The refusal by another insurer to renew fire insurance.

2.1.2. Duration of Duty of Disclosure

The duty of disclosure operates up to the moment when the negotiations for the contract of insurance are completed. If after proposing for an insurance, but before the proposal has been accepted, the proposer learns of further material facts, he is bound to disclose them.

2.1.3. Warranties

The word Warranty denotes term of the contract which must be strictly complied with and upon any breach of which, the insurer is entitled to repudiate the policy.: Warranted that no woodworking be done in the premises; Warranted that all fire-break doors will be kept closed except during working hours and will be maintained in efficient working order; Warranted that the intruder alarm will be operational at all times when the premises are unoccupied.

2.1.4. The Rehabilitation of Offenders Act 1974

The duty of disclosure has been modified by the Rehabilitation of Offenders Act 1974. Certain criminal convictions are deemed to be spent after a period of time (the rehabilitation period) which varies according to the severity of the sentence. Thus, the person convicted becomes entitled to speak and act, after rehabilitation period, as if he neither committed the crime nor been convicted of it.

The following is the rehabilitation period for various motor offences: A fine: rehabilitation period five years; A license endorsement: rehabilitation period four years, but with drink offences – the rehabilitation period is eleven years; A driving suspension – driver rehabilitated after the suspension period.

Under the Rehabilitation of Offenders Act 1974, if the proposer has a spent conviction he is under no obligation to disclose it. The insurer cannot seek information in an indirect way in order to discover whether there are any spent convictions. In this regard, the insurer cannot refuse liability when discovering this. A broker who has knowledge of a spent conviction cannot pass on the information to the insurers because if he discloses any information forbidden by the Act he will be guilty of defamation and will be liable in damages to the defamed person.

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2.1.5. The Application of the Principles of Disclosure

Both parties to the insurance contract, i.e. the insured and the insurer, should be of utmost good faith in negotiating and executing the insurance contract. Under this doctrine of utmost good faith (*uberrima fides*), it is an implied condition that the proposer who desires to have an insurance policy is required to make full and complete disclosure to the underwriters all the material facts, because this legal doctrine presumes that the underwriter knows nothing and the assured knows everything about the proposed risk.

The implied condition means that such condition is necessary to the efficacy of the insurance contract and it is a custom or a usage that the proposer should tell the underwriter the information he knows about the risk so that the later can make decision.

The proposer should provide full and complete discloser, meaning that he should tell the insurer all material facts about the proposed risks, so that the underwriter would use them as a basis for accepting or not accepting a risk for insurance, determining the rate and setting the terms for the policy. If the proposer fails to disclose or conceals material facts, the policy would be void and this action would be considered as a fraud, with legal consequences for both the proposer and the insurer.

Good faith prohibits either the proposer or the insurer from concealing what he privately knows in an attempt to persuade the other party to conclude an insurance contract because he is ignorant of that fact. For example, the proposer should provide information about any previous fire near the insured property so that the underwriter is aware about that risk. The proposer should tell the underwriter the fact about previous losses or about the fact that the premises are not secure when negotiating theft insurance. In case of motor insurance, the proposer should give information regarding previous accidents and record of accidents of the driver. All this information is considered as material facts, as the underwriter can be prudent enough to consider all these material circumstances before accepting the risk and set adequate premium.

2.2. Indemnity

Indemnity is compensation for a loss or injury sustained, and all contracts of property or pecuniary insurance are contracts of indemnity but contracts of life insurance are not. On the happening of an event insured against, the insured will be placed by the insurer in the same pecuniary position that he occupied immediately before the event, subject to any limitations. The insured is not entitled to receive anything in excess of the monetary extent of his loss and he will receive less if any limitation in the policy

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operates.

Franchise: A policy of insurance is still a contract of indemnity even if it contains a "valued policy" providing for payment of a specified sum on the happening of a particular event. The effect of the valuation is to prove the value of the property at the time of the loss, and is the measure of the indemnity payable in the event of a total loss.

2.3. Insurable Interest

One of the consequences of the principle of indemnity is that the insured can claim to be indemnified only for the loss he sustains, and in order to suffer a loss he must have an interest in the subject matter of the insurance. That is he must stand in some relationship to the subject matter, by reason of which he will benefit by its continued safety or be prejudiced by its loss. An insurable interest in property may arise through ownership, possession or contract, and in certain cases it may be created or modified by statute as already shown.

2.4. Subrogation

The principle of subrogation is an integral part of the principle of indemnity. It is the right of the insurer who has granted an indemnity to receive, after payment of a loss, the advantages of every right of the insured, arising previously or in the future, including the rights in contract or tort, which may diminish the insured's loss.

The term is used to include indemnification which means the duty of the insured to account to the insurers for any benefit or payment received by him from another source, in diminution of his loss, whether before or after the insurers pay his claim.

The principle of subrogation is an integral part of the principle of indemnity. It is the right of the insurer who has granted an indemnity to receive, after payment of a loss, the advantages of every right of the insured, arising previously or in the future, including the rights in contract or tort, which may diminish the insured's loss.

The term is used to include indemnification, which means the duty of the insured to account to the insurers for any benefit or payment received by him from another source, in diminution of his loss, whether before or after the insurers pay his claim. The only exception to this duty is a gift of a charitable nature intended to benefit the insured exclusively.

The doctrine of subrogation has been adopted solely for the purpose of preventing the insured from recovering more than a true indemnity. The express subrogation

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condition usually inserted in policies of indemnity differs from the basic equitable principle by empowering insurers to exercise subrogation rights even before settlement of the insured's claim has been made. However, in the case of marine insurance the insurer must have paid the claim before the right of subrogation accrues and it is not possible to provide otherwise by a specific policy condition.

Subrogation rights apply only where there is legal liability and do not apply in respect of a gift of a charitable nature which is clearly expressed to benefit the insured exclusively. If the insurers make an ex gratia payment they are deprived of any subrogation rights to which they would otherwise have been entitled. Rights to subrogation may accrue to the insurers as a result of tort or of contract or of the provisions of a statute.

2.5. Contribution

Although an insured may effect more than one policy to cover the same property or interest, he cannot recover in total more than a full indemnity. The principle of contribution is concerned with the apportionment of liability as between insurers in the event of double insurance. A man who insures his interest in property against loss by fire cannot recover from the insurer a greater amount than he has lost.

Where the insured has more than one policy under which he might claim for particular loss, in the absence of a specific condition, nothing to prevent him from claiming the whole of this loss under any one of these policies, assuming the sum insured under the policy he chooses is adequate to cover his losses. The insurers under the policy cannot resist liability on the ground that there are other policies in existence which the insured might equally have enforced; ***but when they have paid the loss they are entitled to call upon the insurers of the other policies to bear their share of the loss and pay their proportion of the amount already paid under the first policy.*** This is the **"rights of contribution"**, and it arises not from any contract but from the principles of equity.

The right of contribution arises only when all the policies concerned: Cover the same peril; Cover the same subject-matter; and are effected by or on behalf of the same insured.

2.6. Arbitration

Arbitration is an alternative to litigation. If parties so agree, the dispute may be heard by and adjudicated upon by a single arbitrator, but if they fail to agree on who should so act, then it is provided that each party shall appoint his own arbitrator, in which event

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an independent umpire will also be appointed. It is the task of the umpire to deal with any point on which the two arbitrators fail to agree.

2.7. Proximate Cause

Proximate cause is an initial act can trigger an event or a sequence of events. Without the initial act which produces the event, no event, thus no claim would have occurred. However, we have seen sometimes that every event is the result of a chain of previous events. But the chain of causes can be broken by a new or independent cause. This immediate or effective cause, not necessarily that closest in time to the event, is called the proximate cause. Thus, the doctrine of proximate cause states that the immediate and not the remote cause of the event should be considered as the cause that results in a claim.

If there is a claim, firstly the insurer should look at whether the loss was caused by the peril covered by the policy. Secondly, if the peril is covered, the insurer should establish a direct relationship of cause and effect. The cause, as stated earlier, must be proximate in efficiency, i.e. the effective cause that pushed the event to happen.

We have seen that usually the connection between the insured peril and the loss is clear. However, sometimes the chain of causation is not so clear and it is difficult to identify the proximate cause of the loss. An insurer has to trace the effective cause of the loss so as to certify that the loss was caused by the peril covered by the policy.

For example, a fire policy also covers smoke damage, in the sense that the smoke caused by fire. The fire policy would pick up the smoke damage caused by fire. The insurer will not be liable for the damage caused by smoke from a badly adjusted paraffin heater. Here the proximate cause is the smoke damage caused by fire.

Another example, when there is a strong fire, water pipe can get burst. A fire policy covers water damage caused by fire. But the fire policy would not pay water damage caused by other factors, such as frost because water damage caused by frost is not the proximate cause in the sense of a fire policy.

4. Property Insurance

4.1. Sum Insured

Premium is the price charged by the insurer for the risk he undertakes. If the insurer is to receive a premium commensurate with the risk, the sum insured should represent the

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full value at the time of effecting the insurance. If the sum insured is less than the full value of the property, there is under-insurance. When a loss occurs under property insurance policies, the sum insured is reduced by the amount paid in settlement, from the time of the loss until the next renewal date. If the amount is to be restored to the normal figure, the policy must be endorsed and an appropriate additional premium paid.

4.2. The Value of the Subject Matter of Insurance

The value of the subject matter of insurance is its value: at the time of the loss and at the place of the loss. The cost of reinstatement is the basis of reinstatement for buildings; for other property is the market value. The sum payable in the event of a claim can be calculated as follows:

Buildings—The normal basis for building is the cost of repair or reinstatement. If extensive work is required, an architect will compile a specification and a bill of quantities with detailed measurements will be drawn up. The bill will be subject to tender or presented to the loss adjusters. Adjustment may be made to compensate for "betterment": (i) additions or improvements; or (ii) new for old. In this regard, the insured must contribute to this cost.

For obsolete building, the basis of valuation is: (i) the cost of purchasing a similar building plus allowance for removal of debris; or (ii) the cost of erecting a modern building providing comparable facilities to the insured building plus an allowance for professional fees, removal of debris and additional expenditures.

For a builder engaged on a specific contract for the erection of a factory complex, the value of the subject matter of the insurance is its value at the time of loss and at the place of loss. So regardless of the fluctuation of the property's value during the insurance period, for buildings the cost of reinstatement is the basis for settlement, while for other property the market value will be serve as our guide.

The basis for settlement need not always be the cost of reinstatement of a serious or total loss. The basis of valuation is:

- The cost of purchasing a building and an allowance for removal of debris costs; or
- The cost of erecting a modern building providing comparable facilities to the insured building plus, if insured, an allowance for professional fees, removal of debris costs and the additional expenditure which might arise out of local authorities' requirements.

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Machinery—For the machinery, if the repair of machinery is possible, the basis of indemnity is the cost of restoring it to its previous condition. If the machinery is damaged beyond repair, the recompense is the cost of replacing it by second-hand machinery of the same age, type, capacity and condition. However, new machine must be bought for practical reason. Thus, deduction will be made because:

- Better machinery;
- Replacement of new for old machine.

Computers and Computer Records—Computers should be insured under a special form of policy which covers loss or damage resulting from any external cause such as fire, explosion, theft, storm or flood, as well as covers the risk of any form of electrical or mechanical breakdown while the equipment is in use. Cover is also provided under the material damage section for the complete cost of repair or replacement of the computer and its related equipment at current prices.

Retailers' Stock—A small trade whose stock are subject to seasonal increase:

- For retailer's stock indemnity is based on wholesale price paid by the insured, i.e. excluding profit and not the selling price. The wholesale price can be taken from the wholesaler's invoices. Discounts will be deducted from the wholesale prices, as the insured will get the discounts when the goods are replaced by new stock.
- Deduction may have to be made for depreciation of stock through age, and especially for goods which have become old-fashioned.
- As indicated earlier, since the value of the stock can fluctuate during the period of insurance, the wholesale price at the time of replacement might be higher than that originally paid by the insured. Therefore, to ensure equity between the insurer and the insured, we have to make sure that the sum insured is adequate.

Farm Produce—For growing crops the basis is the price at the nearest market less the cost of cutting and threshing and transport.

Manufacturers Stock—In the case of goods manufactured but unsold at the time of a fire or insured damage, the claim is based on the cost of production which includes the costs of raw materials, labor, factory overheads and administrative on-costs but excludes profit. If the total exceeds market value of the goods, then the market value is the true indemnity.

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Farm Implements—The measure of indemnity for farm implements is the value at the time of loss or damage based on the cost of replacement less an allowance for wear and tear.

Livestock—The basis of settlement is the market value at the place where, and the time when, loss occurred. The claims should be supported by veterinary surgeons' certificates which show the cause of injury or death and the value of the animal. If there is any residual value in a carcase or hide a suitable allowance must be made for it.

Engineering—for the boiler policy the sum must cover not only the value of the boiler and installation costs but also the cost of possible damage to surrounding property, both belonging to the insured and belonging to other people.

4.3. Reinstatement

Reinstatement means the restoration of the property insured to the condition in which it was immediately before the fire. In the event of a total loss it is effected by rebuilding the premises or replacing the goods by similar goods; in case of partial loss, reinstatement is made by making the repairs.

4.3.1. The Reinstatement Memorandum

The Reinstatement Memorandum—is a policy extension which may be granted at the request of the insured. In certain cases, the insurers will bear the cost of reinstatement in full without any deduction for wear and tear. The reinstatement may be applied to insurance covering buildings, machinery and other property but not stock. Under the reinstatement memorandum, the payment to be made is the cost of reinstatement to a condition equal to, but not better or more extensive than the property when it was new, on the same or another site, provided the liability of the insurer is not increased.

The following limitations apply:

- The cost of reinstatement must have been incurred if the benefit of the extension is to be obtained;
- The work of reinstatement must be carried out with reasonable dispatch;
- Where there is partial destruction only, the maximum liability of the insurer is the estimated cost of reinstatement if the whole of the property insured had been

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destroyed;

- Average applies if the sum insured is less than 85 percent of the full reinstatement value of the insured property at the time of reinstatement.

4.3.2. Options for Reinstatement

Insurers have option to pay cash, repair, replace or reinstate. Reinstatement may take place in the following circumstances:

- By the insurers under the terms of the policy: The operative clause of the policy gives the insurer the option to reinstate. This clause gives the reinsurers the right to exercise this option. Unless and until the insurers decide to reinstate, the contract remains one to pay money. The reinsured cannot refuse to accept a money payment, and demand reinstatement. He cannot refuse to accept reinstatement if the insurers elect to reinstate.

- By the insurers under statute: The Fires Prevention Act 1774 applies to houses and buildings only. Insurers may be required to cause the insurance money to be expended in rebuilding, reinstating, or repairing such premises in the following circumstances:

- When there is reason to believe that the reinsured or any person acting on his behalf has fraudulently set fire to the property with the object of obtaining the insurance money;

- When requested to do so by any person interested in or entitled to the property, such as owners and purchasers; lessors or lessees; mortgagors or mortgagees; tenants from year to year.

- By the insurers under statute or contract: The 1774 Act does not compel the insurers themselves to reinstate. It requires that the money be laid out in reinstatement. In the normal way the insurers pay cash to their insured and then have no interest in whether he reinstates or not. If the Act invoked, the insurers must withhold payment until reinstatement is carried out. An insured may be compelled to reinstate in the following circumstances:

- Where he has entered into a contract to do so;

- Where reinstatement is imposed on him by statute, in a trust or settlement or in a mortgage.

4.4. Average Conditions

In case of under-insurance, average is applied. Average makes the insured a co-insurer when under-insurance exists. Average only operates when the policy contains a clause specifically stating that the sum insured is 'subject to average' or of one of the three following conditions:

Pro-Rata Conditions of Average—the insurers pay only that proportion of a loss which is commensurate with the premium they have received.

Special Condition of Average—also known as the 75 per cent condition of average and applies only to agricultural produce at farms. This condition comes into operation only if the sum insured is less than 75% of the value, in which case pro rata average comes into play and the insurers are liable only for that proportion of the loss.

The Two Conditions of Average—This condition is used in a policy covering "mercantile risks", i.e. goods at docks or at public wharves or warehouse; or in a policy where there are specific items covering the contents of individual buildings and a floating item covering contents in all buildings.

4.5. Valued Policy

A 'valued policy' provides that in the case of total loss, the amount payable shall be the sum insured which was agreed between insurer and insured at the time of effecting the policy. It is not necessary for the insured to prove the extent of the loss; he must merely prove that the loss has occurred. Valued policies are issued for items such as paintings, sculptures, works of art, antiques or items of jewellery.

4.6. First Loss Insurance

The first loss policies are effected when the insurer feels that any loss that will occur from a certain peril cannot amount to more than a fraction of the value at risk. When a loss occurs the insurer will pay up to the sum insured without consideration of the total value at risk. The sum insured is deliberately restricted, in agreement with the insurer, to a figure less than the full value of the property. First loss policies are common in theft insurance.

4.7. Loss Settlements and Adjustment

Small claims are negotiated and settled by claims staff of the insurance company. In the

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case of large claims, settlement is placed in the hands of a qualified loss adjuster who has the experience and expertise necessary to carry out detailed investigations. A loss adjuster must: (i) recognize the responsibility by striving to maintain a high standard in all aspects of his work; (ii) not seek to obtain any advantage in the conduct of his business otherwise than by his professional ability; and (iii) at all times preserve impartiality.

5. Fire and Perils Insurance

5.1. The Standard Fire Policy

A standard fire policy covers the following perils: fire; lightning; and explosion (of boilers; of gas used for domestic purposes only). Fire implies the actual ignition of something which ought not to be on fire, and it must be accidental or fortuitous. The policy covers fire but excluding loss destruction or damage caused by: (i) explosion resulting from fire (such as gas explosion); (ii) earthquake or subterranean fire; (iii) (a) its own spontaneous fermentation or heating, or (b) Its undergoing any heating process or any process involving the application of heat.

Other circumstances in which the loss is closely associated with the fire that it is regarded as covered by the policy include: (i) Property damage by water or other extinguishing agents used for extinguishment purposes; (ii) Damage done by the fire brigade in the execution of its duties, including for gaining access to a fire; (iii) Property blown up to prevent a fire spreading; (iv) Damage occasioned by falling walls or parts of a building in which a fire takes place; (v) Loss of or damage to property removed from a burning buildings caused by rain, theft, or damage during removal, provided that the removal was justified and that the insured take steps as soon as possible to protect the removed property from further damage.

5.1.1. General Exclusions

- Damage occasioned by riot, civil commotion, war, invasion act of foreign enemy hostilities (whether war be declared or not), civil war, rebellion, revolution or usurped power;
- Radioactive contamination;
- Pollution and contamination;
- Marine exclusion clause (to exclude liability for damage to property that is or could

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be covered by a marine policy;

- Consequential loss or damage;

5.1.2. General Conditions

Policy voidable—the policy shall be voidable in the event of misrepresentation, misdescription or non-disclosure in any material particular;

Alteration—This policy shall be avoided with respect to any of the Property Insured in regard to which there be any alteration after the commencement of this insurance;

Reasonable precaution—The insured shall take all reasonable precautions to prevent damage.

5.1.3. Sprinkler Leakage

The extension on sprinkler leakage covers accidental escape from any automatic sprinkler installation. Common causes of leakage include:

- Damage to a sprinkler head or other part of the installation by impact from some object;
- Heat from some source other than fire as understood by a fire policy such as a portable heating appliance or portable plant which involves the application of heat;
- Excessive heat from a boiler flue;
- Mechanical defect in the installation (unless due to the insured's failure to carry out his responsibility to maintain it in an efficient condition); or
- Freezing of water followed by bursting of the pipes.

5.1.4. Subsidence and Landslide

A standard fire policy excludes subsidence, flood, impact damage, and strike, riot and civil commotion, which are considered as special perils. Strike, riot and civil commotion and impact damage can be provided as extensions for additional premium income.

Because there is a huge drain at the side of the factory and at the back of the factory

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there are lime hills, the probability of flood and subsidence is very high. Therefore, extensions should not be provided for subsidence. As to flood, full flood cover should not be provided. At best, flood cover may be provided with hour clause (72 hours) and event limit (say $4 million) for very high API.

5.2. Special Perils

The 'special perils' were employed to describe those risks normally excluded from the ordinary or standard fire policy but which insurers are prepared to cover on certain conditions and at an additional premium. These special perils are: Fire, Lightning and Explosion; Aircraft; Riot, civil commotion and malicious damage; Earthquake; Subterranean fire; Spontaneous fermentation; Storm; Flood; Escape of Water from any tank, apparatus or pipe; Impact; and Sprinkler Leakage.

6. Other Property Insurance

6.1. Theft Policy

A theft policy does not operate under the following three circumstances:

Firstly, loss or damage by fire however caused (this is the function of a fire policy);

Secondly, loss or damage occasioned by any person lawfully in the premises or directly or indirectly caused by any person with connivance of any inmate or member of the insured's household or business staff or any servant of the insured;

Thirdly, loss or damage to money, securities, coins, medals, stamps, precious stones, or articles composed of any of them; documents, business books, manuscripts, computer systems, records, curios, sculptures, rare books, plans, patterns, moulds, models of designs, tobacco, cigars or cigarettes;

The above conditions are either difficult to value, are attractive to thieves or are covered by other form of insurance.

6.2. Goods-In-Transit

Goods-in-transit insurance covers property against loss or damage while it is in transit from one place to another or being stored during a journey. Policies often specify the means of transport to be used. Shipping goods by sea involves taking out marine insurance. This also includes the transit of cargo over land at each end of the voyage.

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A goods-in-transit policy will protect the insureds from: Theft (while in transit); Loss (while in transit); Damage caused by accidents during transit; Damage caused during transit; The consequences of any untoward delay (in some cases); How much the goods are valued at.

There are two types of cover: (i) Old-for-new - items are replaced at their current market value; and (ii) Indemnity cover – the insurance company will take into account general depreciation.

Some policies have special features. These can include built-in legal expenses, cover for possessions in your vehicle, food spoilage in freezers, garage cover, outbuildings cover, etc. The cost of goods-in-transit insurance depends on the level of risk. If a company has a record of losing goods then it is likely to find the premiums getting more expensive. If there is such a record then the recommendation is to take measures to increase the level of security.

The goods in transit policies fall into two categories: (i) On goods on insured's own vehicles, with a sum insured for each vehicle; (ii) On all goods dispatched by the insured, by own vehicles, by road haulier, rail and post, subject to a limit any one consignment.

The underwriters should consider the following factors: (i) Nature of goods, how susceptible to damage and theft; (ii) The methods of transit to be employed; (iii) Security devices fitted to own vehicles; (iv) Limit any one load or consignment; (v) Experience, which will reflect the above considerations, and quality of drivers and standard of management.

The cover for the goods in transit policies is practically "all risks". The insured will be indemnified for loss of or damage to by fire, accident, theft or pilferage while being loaded on, carried by, or unloaded from the motor vehicles and while temporarily garaged during transit.

The exclusions of the goods in transit policies are: Radioactive contamination and explosive nuclear assemblies clause; War, riot and civil commotion, earthquake or subterranean fire; Moth, vermin, insects, damp, mildew or rust; Delay, loss of market, consequential loss of any kind, deterioration and changes by natural causes; Theft or pilferage assisted, brought about or connived at by the insured's employees; Goods accompanying commercial travelers.

Moreover, the following property are exclude: explosives, acids, goods of a dangerous nature, bullion, cash, bank and currency notes, deeds, bonds, securities, jewellery,

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precious stones, clocks, watches and articles of a like nature, curios, antiques, business books, models, moulds, patterns, designs, and livestock.

6.3. All Risks Insurance

"All Risks insurance" is the widest form of cover available for property. "All Risks Policy" means that instead of cover being provided for a list of happenings, e.g. fire, storm, etc., it is provided against "all risks" – though some exclusions are made. It covers accidental loss, damage or destruction from any cause, including fire unless the cause is specifically excluded. The usual exclusions, apart from war risks, radioactive contamination and 'sonic bangs', are:

- Loss or damage occurring outside the UK consequent upon riot, civil commotion, earthquake or volcanic eruption;
- Loss by delay, confiscation or detention by customs or other official bodies or authorities;'
- Loss or damage arising from wear and tear depreciation, gradual deterioration, moth, vermin or from any process of cleaning, dyeing or restoring any article;
- Damage (other than by fire or thieves) to china, glass or other brittle substances;
- Loss or damage resulting from electrical or mechanical defect, breakdown or derangement.
- These exclusions are either traditionally uninsurable or it would be against public policy to insure them.

Industrial All Risks—The cover goes far beyond a fire policy extended to include the 'Special Perils'.

6.4. Money Insurance

The cover is against all risks and includes money: in transit, being carried by the insured or his representative; on the insured's premises during business hours; in a bank night safe; in a locked safe or strongroom out of business hours; on the insured's premises out of business hours not in safe or strongroom; in the private residence; in the custody of collectors or travelers.

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6.5. Contractors' All Risks Insurance

This policy provides all risks cover in respect of both temporary and permanent works while in course of construction and until handed over by the contractor to his employer. Cover also includes the unfixed materials or equipment on site for incorporation in the works, and all items of constructional plant, equipment and tools.

7. Engineering Insurance

The Factories Act 1961 provides statutory requirements for periodic inspections by a 'competent person'. The 'competent person' is the person who should have such practical and theoretical knowledge and experience of the type of machinery or plant in order to detect its defects or weakness and to assess their importance in relation to the strength and functions of the machine or plant. The competent person must be able not only to discover defects but also to tell what effect they are likely to have. The objective of the periodic inspection is to prevent the boiler explosions and accidents by detecting incipient faults and arranging for their correction before they develop far enough to cause breakdown.

7.1. Boilers and Pressure Plant

The boiler explosion policy provides property indemnity against damage to the boiler or other insured item and damage to other property of the insured directly due to explosion or collapse of the insured item.

After each examination, reports are issued on prescribed forms giving full details of the condition of the plant, together with any useful observations affecting its maintenance and efficiency. It involves close scrutiny of all parts of the plant and various fittings are examined to ensure that they are maintained in a satisfactory condition.

Boilers and Pressure Plant can be divided into five groups according to the design and construction and work done. Name these five groups. Boilers and Pressure Plant includes steam boilers, steam receivers, economizers, superheaters, steam pipes, hot water heating and supply installations, bakers' ovens, air receivers, steam jacketed pans, calorifiers, sterilizers, vulcanisers, presses and ironing machines and any other pressure vessels.

According to design and work done, they are divided into five groups: Steam generating boilers; Low pressure hot water heating boilers; Low pressure steam heating boilers; Domestic supply boilers; High pressure hot water boilers.

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7.2. Machinery Breakdown

An engine plant includes steam engines, gas and oil engines, diesel engines, air compressors, pumps, hydro-extractors, fans, gas producer plants, large refrigerating plants, and other miscellaneous plant subject to mechanical breakdown. Serious breakdown of an engine plant may be avoided by the periodical inspection service. It is possible that a defect may develop so gradually that an employee may not notice it. A trained surveyor who examines the engine at intervals of a few months can detect the default. This can prevent serious breakdown.

The main causes of a breakdown of a steam engine are as follows: Careless operation or bad maintenance of engines may lead to parts working loose, and parts that are allowed to become unduly worn may break and slip from position; The use of steam carrying impurities can cause seizure of the piston valves and sometimes of the pistons themselves; Repeated shock by reason of worn bearings or through the flywheel key becoming loose may mean a fracture of the crankshaft, crankpin, or crankweb, and the misalignment of parts; Overspeeding through the failure of the governor or its unsatisfactory operation may cause failure of moving parts through the stress; Water allowed to get into the cylinders from improperly drained steam pipes, condensing system or exhaust pipes; Engine set on a weak or faulty foundation or weak or faulty design of the engine.

7.3. Gas Plant Policy and a Boiler Policy

The Boiler Policy is used for steam boilers, steam receivers, economizers, superheaters, steam pipes, hot water heating and supply installations, bakers' ovens, air receivers, steam jacketed pans, calorifiers, sterilizers, vulcanisers, presses and ironing machines and any other pressure vessels.

The standard boiler policy provides property indemnity against damage to the boiler or other insured item and damage to other property of the insured directly due to explosion or collapse of the insured item. Explosion means the sudden and violent rendering of the plant by force of internal steam or other fluid pressure. Collapse means sudden and dangerous distortion of any part of the plant caused by crushing stress by force of steam or other fluid pressure.

Gas Plant Policy is used to insure gas producer plant. The cover of the gas plant policy is almost the same as under a boiler policy. The principal risk is explosion but it is an explosion caused by the ignition of gas not by internal pressure as in a boiler. The gas engine, being an internal combustion engine, is more extensive used than any other and

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it is necessary to consider it apart from the steam engine.

7.4. Crane Policy and Lift Policy

The lifting machinery is insured under two principal policies, crane policy and lift policy. In addition to a periodical inspection service, the crane policy covers the property as follows: Indemnity against mechanical breakdown; Damage by extraneous causes.

Damage by breakdown excludes damage to any boiler pressure vessel and/or fittings unless such damage is caused by breakdown of any other part of the machine. This serves to exclude from the policy cover explosion of a boiler where a crane is steam-engine driven or of an air receiver where such item is used for starting an internal combustion engine. Either the boiler or the air receiver could be insured against explosion under the normal boiler policy.

Cover under the lift policy is similar to the crane policy, but damage by extraneous causes is omitted because this risk does not occur so much with lifts as it does with cranes.

Crane and lift policies may be extended to cover such additional risks as damage to goods being lifted, and damage to own property. Sometimes a special policy is used for excavators, but the crane policy can be used.

8. Business Interruption Insurance

8.1. Gross Profit

Gross profit is the maximum loss that the insured can incur consequent upon the interruption of the business and is represented by the total of net profit and the fixed standing charges. A business interruption policy is designed to protect this gross profit. Gross profit can be calculated by using two common methods: The addition basis method and difference basis method.

Under the addition basis method, gross profit is calculated by adding net profit to the standing charges. Standing charges include the rent and business rate payable in respect of the premises occupied for the business, the interest payable on debentures, mortgages, bank overdrafts, loans, bank charges, the costs for light, heat and power etc. If no net profit is being earned by a business but a net loss is being sustained, the gross profit insured will be the amount of the standing charges less such net loss. However,

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calculating gross profit using the addition basis method is cumbersome, as it requires constant upkeep of the list of insured standing charges in the policy.

For that reason, the calculation of gross profit by using the 'Difference basis' method is preferable. Under this method, gross profit is calculated by deducting the total of the variable charges from the amount of the turnover.

Variable charges—the cost of buying raw material, the cost of packing materials for finished goods and payments to carriers for the carriage and delivery to customers of such goods.

Standing charges—rent and business rate payable in respect of the premises occupied for the business, the interest payable on debentures, mortgages, bank overdrafts and loans, together with bank charges, the costs for light, heat and power.

8.2. Consequential Loss Policy

The task of underwriting of a consequential loss policy is a challenging one. When rating this policy, the following factors should be taken into account:

Firstly, the physical risk, which determines the rate. For example, average fire rate on buildings gives a more accurate indication of the consequential loss risk and the sum insured on buildings is taken into account in the calculation of the basis rate for the consequential loss policy.

Secondly, the indemnity period is the second factor to be taken into account and the basis rate should be adjusted accordingly: 6 months' indemnity period: 110% of the basis rate; 12 months' indemnity period: 150% of the basis rate; 18 months' indemnity period: 140% of the basis rate; 24 months' indemnity period: 125% of the basis rate. The rate so produced is the profits rate;

Thirdly, the interruption risk, which is used to indicate specially adverse or favorable features which might hinder or speed the resumption of normal business activities by an insured peril. This includes the difficulty of replacing specialized machinery, the possibility of obtaining temporary accommodation or the nature of the local market which might result in the permanent loss of customers to competitors.

Not all losses are covered by the policy. The following are the losses that are not covered by consequential loss policy: Under-insurance against material damage; Difference between the value of stock or plant at the time if suffered insured damage and its value at the time of its subsequent replacement; Deterioration of undamaged

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stock after damage has occurred to the premises by fire or other insured perils; The cost of preparing fire and business interruption claims; Litigation costs connected with insurance claims; Fines, damages or penalties under contracts arising from breach of contract in consequence of damage.

9. Liability Insurance

9.1. Employers' Liability

Under the Employers' Liability (Compulsory Insurance) Act 1969, every employer carrying on any business in Great Britain shall insure with an authorized insurer against liability for bodily injury or disease sustained by his employees and arising out of and in the course of their employment in Great Britain.

Territorial limits generally apply to the Employers' Liability policy. It is usual to stipulate that the bodily injury or disease must be sustained. In Great Britain, Northern Ireland, the Isle of Man, or the Channel Islands. (There may be a specific mention of offshore installations with the Continental shelf around those countries); or While temporarily outside these territories.

Jurisdiction clause—Coupled with a territorial restriction there may be a jurisdiction clause which provides that where an overseas extension is given, claims must be brought against the insured in Great Britain, Northern Ireland, the Isle of Man, or the Channel Island. This provides that any claim by an insured's employee will be handled on the basis of English law and with an English scale of damages. This is designed to prevent a plaintiff shopping around in the courts of the world in order to establish the one most favorable to his claim.

Retroactive Cover—Actions involving personal injury must normally be started within there years of the date of accident. Some diseases, however, develop over a period of time and may not become apparent until some years after the policy has lapsed. Difficulties may arise if the insured cannot trace his insurers many years ago. To resolve the difficulty of untraced policies or policies which may have had restrictive endorsements, some insurers are now prepared to issue a policy which will offer cover on a 'claims made' basis for claims made during the currency of a policy even if the events may have occurred many years previously. This would apply particularly to claims for cancer, pneumo-coniosis, or noice induced deafness. The retroactive policy would exclude any risk for which a more specific insurance was in force, and where an indemnity under a previous policy was not available because of a breach of policy conditions, non-disclosure or misrepresentation.

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9.2. Directors and Officers Liability

Directors and officers owe duties to a company. If there is a breach of duty on their part which causes damage to the company they can be sued and held liable for heavy award of damages. Company's shareholders will sue them in the name of the company.

Liability may arise out of lack of care and skill in the performance of a director's duties, such as negligent advice or mis-statement, especially in the context of a merger or takeover when failure to understand economic trends results in a poor forecast of the company's performance; any act which goes beyond the limits of the company's constitution, unauthorized payments, failure to disclose the full extent of their interests, a failure to comply with requirements or the failure to arrange proper insurance.

The Directors and Officers Liability policy may consist of two parts. The first is to indemnify the company in respect of costs it has incurred indemnifying a director against the successful defense of a claim. The second part indemnifies the director from the company because he has not been successful in the defense of a claim. The policy is generally issued on a claims made basis.

The exclusions are on the following lines: Claims for bodily injury or property damage; Actions brought against an individual director as a result of his own dishonest, fraudulent or malicious conduct; Claims arising from any improper personal gain, profit or advantage; Breach of professional duty may be excluded.

10. Commercial Vehicles

The commercial vehicle motor policy has two sections: third party section and 'own damage' section. The present trend is to put the third party section of the policy first and the 'own damage' section second. According to the amendment of the UK Road Traffic Act as from 1 January 1989, under the third party section, a policy must provide: Unlimited indemnity in respect of the death of or bodily injury to, any person, and Indemnity up to a minimum of £250,000 in respect of loss of, or damage to, someone else's property.

A few insurers provide unlimited indemnity in respect of damage to the property of third parties, but the majority imposes a limit on the amount which they will pay. The indemnity is for any one event or occurrence. The insurer could be called upon to pay this amount more than once in the course of the year if the policyholder's vehicle were involved in more than one accidents.

The third party indemnities apply not only to accidents caused by the vehicle but also to the loading and unloading. Motor insurer therefore imposes a limit on the extent of their cover. They cover any accident which occurs on the carriageway. The policyholder is the party indemnified. As claims are not necessarily made against the policyholder but may be against other parties, insurers include the following indemnities in their policies:

Indemnity to driver: Anyone may drive on the order or with the permission of the policyholder. The driver is normally an employee, but he could be someone unconnected with the business;

Indemnity to user: The policyholder may allow someone to use the vehicle for social, domestic and pleasure purposes, and the user in turn may get someone to drive for him. This is provided that the user is in the vehicle;

Indemnity to passenger: In contrast to the private car policy, insurers do not include as part of the standard cover indemnity for a passenger who causes an accident.

10.1. Hire Car Business

Hire car is one of the different types of commercial vehicle risks. Hire car covers three types of car hire business: Private hire is the hiring of a car plus driver from the operator's premises; Public hire is the plying of a car plus driver on the streets for business. Public hire taxis also use recognized stands such as railway stations; Hire and drive or self-drive hire is the hiring of vehicle by an individual, who drives it himself. Most of hire and drive business is concerned with private cars, but a number of firms also hire out small vans, larger and more specialized commercial vehicles to serve businesses.

Insurers are not keen about hire and drive business because people who hire car temporarily and drive themselves vary so much. They have two methods of handling hire and drive:

Insurers issue a hire car policy with the following covers: comprehensive, third party fire and theft or third party only. They require the operator to obtain an application form from each potential hirer. Applicant's driving history should be submitted and the operator should check the hirer's driving license. If the record is poor, the operator must refer this to the insurer before allowing the hirer to take a car. The certificate of motor insurance issued to the operator covers the driving of his cars by hirers for their business and for social, domestic and pleasure purposes.

Issue of short period policy to individual hirer: Insurers authorize hire and drive

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operators to issue short period policies on their behalf with certain conditions and the business operator must refer any cases outside these conditions to his insurers. They may refuse to insure inexperienced drivers. Insurers provide hire and driver operators with a short period scale of charges to cover periods from one day to one month.

10.2. Agricultural Motor vehicles.

The own damage section of the Agricultural Motor Vehicle policy covers loss of or damage to the vehicle and its spare parts and accessories while they are on it. The insurer has the option of repairing or replacing the vehicle or making a cash payment. The exclusions to the own damage section of Agricultural Motor Vehicle are: Loss of use, depreciation, wear and tear, mechanical or electrical breakdowns, failures or breakages; Damage to tyres by application of brakes or by punctures, cuts or bursts; Damage directly occasioned by pressure waves caused by aircraft and other aerial devices traveling at sonic or supersonic speeds; Loss or damage caused by earthquakes, riot, or civil commotion.

10.3. Motor Trade policies

Motor trade policies are concerned with dealers, repairers and others whose main line of business is handling of motor vehicles in some way. For this reason, they will not be able to effect insurance in the same way as a private proposer. A motor dealer can have many cars in his possession and they can change car rapidly. Thus, the intention is to arrange insurance without unduly cumbersome. There are three main kinds of motor trade policies: (i) Road risks insurance: This is designed to cover vehicles in the custody or control of the motor trade while on a road or temporarily garaged during the course of a journey. It does not provide cover on the insured's own premises. There are three basic kinds of policy; (ii) Named driver policy: the cover is limited to particular named individuals; (iii) Trade plate basis: There are strict regulations governing the use of trade plates and it is not possible to include social, domestic and pleasure use; (iv) Points basis: A number of points are allocated for different aspects of the risk which show some measure of the amount of risk. Once the total points have been arrived at, premiums are calculated per 100 points; (v) Internal risks insurance: The cover provided relates to vehicles which are on the garage premises and two types of cover are possible; (vi) Third party only cover, which relates to liability to third parties for bodily injury and damage to property; (vii) Damage to third party cover which provides in addition to the cover above, liability for damage to customers' vehicles and cover for damage to the insured's own vehicles; (viii) Comprehensive road and garage risks: This policy combines in one document the cover provided under the road risks policy and the internal risks. The most significant of these are that theft of vehicles on the insured's

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premises is covered, as is pleasure use by partners, directors or spouses.

10.4. Special Types Policy

Special type policies cover:

- Ambulances—Flat premiums are charged in respect of ambulances and few insurers have significant amount of ambulance business, as the majority of local authorities prefer to reinsure;
- Dumpers—Dumpers are rated according to use. Some will be used exclusively on the insured's premises, others elsewhere. The policy will cover hire and provide an indemnity to the hirer, but the premium payable will be lower if no hiring is involved;
- Hearses—This type of vehicle presents low risks. Comparatively low premium rates are applied according to the district of use and the value of the vehicle;
- Mechanical navies and other mobile plant —This includes mechanical navies, shovels, grabs and excavators. The policies issued will normally cover hire, driving by the hirer's driver, indemnity to hirer and also damage to vehicle while in use as a tool of trade. Third party working risks will be excluded unless an additional premium is paid and the additional premium will depend upon whether the cover in respect of damage to cables and pipes is provided;
- Shovels which do not dig below their own wheelbase level may be rated as site clearing and leveling plant;
- Mobile canteens, fish fryers, ice cream vans, shops, surgeries and libraries—These vehicles are rated according to the district of use and special consideration has to be given to the risks which are ancillary to the pure motor risks. The motor policy can be extended for an additional premium to cover fixtures, fittings and utensils;
- Tippers—These vehicles present an extra risk when the tipping mechanism is operated and the vehicle is not standing level or is on soft ground. An additional premium for comprehensive cover based on its value or plated weight is often charged.

11. Reinsurance

A contract of reinsurance is one by which a direct insurer procures a third party to

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insure him against loss or liability by reason of such original policy. The purpose of reinsurance by direct insurer is: For limiting oscillation of losses on a specified insurance portfolio. Insurers are able to base their calculations on items that are reasonably stable (Excess of loss reinsurance); To protect against individual losses which are relatively large in comparison with the size of a specified portfolio (Personal accident excess of loss reinsurance); To protect against the accumulation, known or unknown, of net retention of a specified portfolio. By this manner, it can also increase the capacities of a linked proportional program (Risk or Working excess of loss reinsurance); To protect against an increase in the unexpected loss frequency of a specified portfolio (Cat excess of loss reinsurance).

The insurer has accepted a greater pecuniary responsibility in respect of a specified risk, or a number of risks, than it considers prudent to retain in full (Facultative excess of loss reinsurance). Reinsurance also: Leads to spreading of risks over a much greater number of insurers and reinsurers with consequent deductions of individual financial commitment; In the case of facultative excess of loss, it enables the primary insurers to control the commercial business without the necessity of co-insurance or dependent on facultative arrangement that in both ways, will subject to loss of confidentiality in terms of rating; By the creation of capacities, primary insurers will continue to be able to compete; Enables insurance companies to grant cover for amounts of liabilities that would otherwise be beyond the capacity of their financial resources; Events out fluctuations in underwriting results due to exceptionally large individual losses, or catastrophes over a wider area; example, windstorm or earthquake losses and riots owing to disorder where accumulation is high. In short, it stabilizes the loss trend for the primary insurers.

11.1. Facultative Reinsurance

Facultative reinsurance could be used: where treaty capacity has been filled and the insurer requires capacity beyond its treaty; the risk if outside the terms of the treaty and where no treaty protection is available; to reinsure risks which the insurer does not wish to cede to its treaties; to reinsure unusual risks, such as hazardous or complicated risks, including 'target' risks; for unique commercial, financial or strategic reasons.

Under the facultative reinsurance, each risk is reinsured separately and each party is free to decide whether to reinsurer or not and whether to accept the reinsurance or not. Thus, risks are considered individually. The reinsurer has freedom of choice in how much of the risk to insure and at what premium and commission rate. However, there are disadvantages of facultative reinsurance: the insurer cannot rely on successful placement of risk; the administration involved is labor intensive and expensive; risks

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offered for facultative reinsurance are likely to be heavier by way of extra hazards and will be of high value; full risk details and loss information have to be disclosed; 'error factor' exists in hasty facultative placements; there is low commission reimbursement to the insurer – if the insurer arranges surveys, reinsurers might be obtaining business at improved terms; cover cannot be confirmed until reinsurance placement is effected or completed.

11.2. Types of Reinsurance

11.2.1. Property

Proportional forms of reinsurance are most common in the property fields. There is a fixed sum insured upon which a proportion can be calculated. Surplus and quota share treaties are used widely in the property market, with facultative catering for risks excepted by the treaty reinsurers or for catastrophe cover. Excess of loss reinsurance is, however, now becoming more common in the property field as a result of the American influence.

11.2.2. Liability

Excess of loss reinsurance is used almost exclusively by liability insurers as it relies on the value of claims as opposed to a proportion or risk. The excess of loss for of reinsurance can also be applied to the liability sections of other policies, e.g. motor.

11.2.3. Marine and Aviation

Marine and aviation risks are really a combination of property and liability insurances. Therefore insurers are arranging reinsurances to suit such needs. Facultative reinsurance is still common in the marine market with quota share and excess of loss also being employed. Insurers also use catastrophe reinsurance to address the nature of catastrophe risks and also use the pooling method to manage the risks.

11.2.4. Life and Personal Accident

The reinsurance arrangements for life and personal accident contracts are slightly different from the non-life business. The long tail life business requires long term reinsurance.

For ordinary life assurance risks, reassurance may be arranged on a facultative or treaty

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basis. The difference between reassurance and reinsurance lies in the basis upon which reassurance is provided.

Two options are available: 'original terms' and 'risk premium basis'. In the former, the reassurer divides the total premium and sum assured in a given portion, with the reassurer following all the terms and conditions of the direct office's policy.

In the first year or two of the life policy, the reassurance sum insured will be the full difference between the retention and the sum assured. After two years the life company will be able to build a reserve fund against a potential death claim. The risk which has to be reassured is the mortality risk above the level of retention, which is technically known as the 'death strain'. As the reserve accumulates, it will exceed the retention and then only the difference between the reserve and the sum assured needs to be reassured. The reassurance cover will eventually reduce to nil, while the rate to be applied to it will be the risk rate for the life assured's age each year. This rate will therefore increase.

The premium effect is that initially the premium will rise each year since the risk (difference between direct sum assured and the retention) will be reducing while the mortality rate will increase as the life assured grows older. As the reserve fund builds up beyond the retention level, the rate of increase in the reserve will be greater than the increase in the mortality rate. The overall effect is that the premium will rise in the early stages of the reinsurance and reduction in the later stages.

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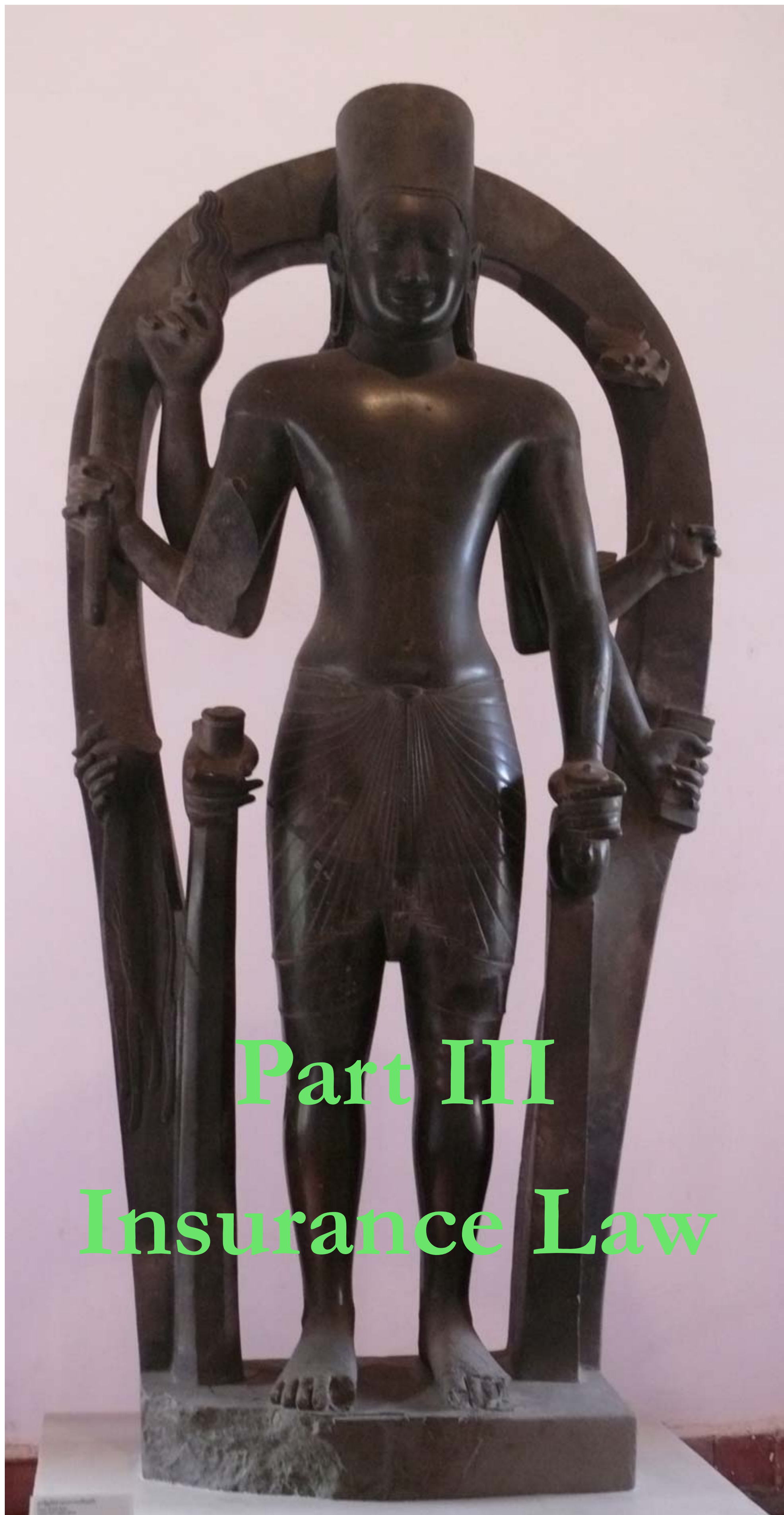

Part III

Insurance Law

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Part III

Insurance Law

1. Law and Legal System

1.1. Classification of law

Law can be classified as common law and Civil or Roman law; public and private law.

Public law – legal structure of the State and relationships between the State and individual member of the community: constitutional law, administrative law and criminal law.

Private law – law of contract, law of torts, law of trusts, law of property, family law and law of succession.

The Rule of law includes: The powers exercised by politicians and officials must have a proper foundation and be based on an authority given to them by law; The law generally should be reasonably certain and predictable; People should be treated equally by law, which should not allow unfair discrimination; No one should be punished or deprived of their property, stutus or other rights unless they are given a fair hearing by an impartial court or tribunal; and Every person should have a right of access to the courts, which will defend the liberties and freedoms of the individual.

1.2. Development of English law

1.2.1. Common Law

The process whereby local customs were developed into a system of rules which was common to the whole country. The unified system of law developed from the legal customs. Unwritten law as whole is contained in decisions of the courts (i.e. case law) rather than in statute law (i.e. Acts of Parliament and written rules and regulations); Contrasted with equity; English law.

1.2.2. Equity

Equity is a supplement to the common law and is described as a collection of rules which were developed to remedy some shortcomings of the common law. The main

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defects of the common laws were as follows:

System of writs – in order to begin proceedings in the common law courts, a claimant needed to obtain an original writ from the main Royal office, the Chancery. The writ had two main functions: it ordered the sheriff of the county to make sure that the defendant was at the trial; and it outlined the cause of action;

Limited remedies – the only remedy which the common law courts could give was an award of damages;

Procedure – there were elaborate rules governing the procedure which had to be followed in bringing a case. Any technical breach of the rules might leave the claimant without redress;

Corruption – the rich and the powerful were often able to escape justice by bribery of witnesses and juries.

Those were dissatisfied with the common law addressed petitions to the Chancellor. In 1474, a Court of Chancery was formally established and was presided over the Lord of Chancellor. The system of rules which was developed and applied in the Court of Chancery became known as equity. Equity means fairness and reflects the original role of the Chancellor as a moral and spiritual leader.

Because equity was based on morality or conscience, its rules tended to be too flexible, often leading to uncertainty. Ultimately equity and common law operated alongside each other as two separate systems administered in different courts. A claimant who lost their case in the common law courts might have to start action all over again in the Court of Chancery.

Under the Judicature Acts 1873-75, the common law courts and Court of Chancery were amalgamated in a single system, the Supreme Court of Judicature. The principle that equity should prevail in the case of a conflict with common law was also restated.

Legal writers disagree as to whether the common law and equity are now completely fused into one set of rules and principles. Equity, unlike common law, cannot stand alone. Common law is a complete system of law, whereas equity is merely a supplement which offers an alternative solution to some legal problems.

Equity has given the legal system the following principles and remedies:

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1.2.3. The law of trusts

Specific performance, a court order compelling a person to carry out a promise which they have given to another; and Injunction, a court order compelling a person to do something or prohibiting them from doing something.

The following examples also derive from equity: Promissory estoppel; Subrogation; and Contribution.

1.3. Source of English law

The English law has developed to reflect social, economic and technological changes. There are two main sources of the new English law:

Legislation – legislation is law which has been created in a formal way and set down in writing. Only the Parliament which has the power of making law. Sometimes the Parliament delegates its law-making power to the cabinet, which can create regulations or decrees, to government ministries, which can create ministerial circulars, and to local authorities.

The principal form of Parliamentary legislation is the Act of Parliament or statutes. Acts of Parliament may create entirely new law, overrule what already exists, and modify or extend existing principles of common law or equity. They may repeal or modify existing statute law.

However, Acts of Parliament often lay down only a general framework of rules, leaving the detail to be filled in by the cabinet and government ministries. Detailed rules of this sort cannot be made unless the Parliament has given the power to make law. Therefore, the Acts of Parliament often confer on the cabinet or the government ministries the power to make detailed rules and regulations for the purpose of implementing the Act. These Acts are called Enabling Acts or Parent Acts and the rules made under the authority of these Acts are known as delegated or subordinate legislation.

The most important forms of delegated legislation are as follows:

Statutory instruments – departmental regulations or orders adopted by government ministries;

Orders in council – drafted by a Minister and come into force when approved by a meeting of the Privy Council;

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By-laws – prepared by local authorities for local application. They require the approval of the appropriate Minister.

Judicial Precedent or Case Law – a decision in a previous legal case where the facts are similar to the case before the court. Precedent is the major source of new law today. The doctrine of binding precedent requires a judge to base their decisions on the law established in earlier cases where the facts were the same.

In addition the two main sources, there are two minor sources of European law:

Local customs – local custom is a minor source of law. English common law was originally based on customs adopted throughout the country. This process was completed many centuries ago. However, a long-established local custom may give a group of people or people living in a particular area the rights which the law supports. A number of conditions must be fulfilled before a custom is recognized by the courts as legally binding:

- Immemorial existence – the custom must have existed since the beginning of 'legal memory' which arbitrarily fixed as the year 1189;
- Continuity – there must be proof that the custom has been observed continuously;
- Reasonableness – the court will decide that the custom must not be unreasonable;
- Certainty – the custom must be certain with regard to the nature of the activity, the right, the persons who will benefit from it and the locality to which it applies;
- Peaceful user – the custom must have been exercised peaceably and openly;
- Compulsory – the people affected by the custom must recognize it as binding upon all of them.
- Not contrary to statute – statute law is supreme and will overrule any custom which is inconsistent with it.

1.4. Precedent and case law

The doctrine of binding precedent requires a judge to base their decisions on the principle established in earlier cases where the facts were the same.

Ratio decidendi Principle is based on: The material facts of the case; The decision on the

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judge; and The reason for the decisions.

Advantages—Certainty in the law; Possibility of development and growth, flexibility in the law; Wealth of detailed decisions and rulings.

Disadvantages—Rigidity in the system – binding; change can be made by Parliament;

1.5. European Community law

The main sources of European Community Law are:

The Treaties – especially the Treaty of Rome (the EC Treaty), best regarded as the 'Constitution' of Europe, setting out the basic framework and fundamental principles of European law (such as the right to free movement of goods, people, services and capital);

Regulations – laws made by the Council or Commission which have general application. They are automatically binding in their entirety on all Member States without any action by national governments or legislatures;

Directives – directives of the Council or Commission are binding on Member States to which they are addressed as to the result which is to be achieved. However, the method of implementing the law contained in the Directive is left to each Member State. Although the European Directives are not 'self-enacting' and have to be converted into national law, the European Court of Justice has ruled that a Member State which fails to implement a Directive can be sued for damages by an individual who suffers loss as a result of the failure to implement.

Decisions – decisions do not have general application and are binding only upon those to whom they are addressed. They may be addressed to a particular Member State or a particular organization.

Recommendations and opinions have no binding force and are advisory only.

2. Legal Personality

2.1. Various classes of persons

Persons are divided into natural persons and juristic persons or corporations. The Crown is a legal entity is more or less equal to Government. Natural persons – all human beings. Minors, persons of unsound mind, bankrupts and aliens.

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2.1.1. Corporations

Corporations are divided into: corporation sole and corporations aggregate.

Corporations sole – a legal person representing an official position which will be occupied by a series of different people: the Queen, the bishops and Public Trustee. Corporations sole can only be created by statute.

Corporate aggregate – a legal person consisting of a number of people. It may be created by:

- By Royal Charter (chartered corporation) – CII, Chartered Institute of Loss Adjusters and the Institute of Charted Accountants; BBC and Bank of England.

- By Private Act of Parliament (statutory corporations) – British Railways, British Gas or

- By Registration under the Companies Acts (registered corporations).

Corporation is a separate legal personality. Corporations are subject to the general law. The corporation must not act ultra vires. Corporation have perpetual succession.

There are two types of registered company – public limited companies or private companies.

Public limited companies – must be limited and have share capital; shares are freely transferable and listed on stock exchange. At least two members and two directors.

Private companies – prohibited from inviting the general public to subscribe for their shares or securities. At least two members and one director.

2.1.2. Limited Companies

All public companies are limited companies. Companies generally may be limited by shares or by guarantee. A company is limited by shares means that the liability of a shareholder is limited to the nominal value of their shares. Shares may be fully or partially paid. If the company goes into liquidation, the liability of the shareholders is limited to the value of their shares. They have no further responsibility for the debts of the company.

A company is limited by guarantee means that each member undertakes that on the

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winding up of the company, they will contribute towards the debts fo the company to a certain, modest amount, called the guarantee.

2.1.3. Unlimited Companies

Private companies may be limited or unlimited. The liability of the shareholders is unlimited. If an unlimited company (which must be a private company) goes into liquidation, there is no limit on the liability of the shareholders to contribute to the assets of the company to pay the company's debts. This means that the liability of a shareholder include both the nominal value of their shares and their wealth as well.

2.2. Memorandum of Association

A Memorandum of Association – contains the following:

The name clause – the name of a company should not mislead members of the public or cause them to confuse the company with another operating in a similar sphere. The name must not be one prohibited by statute; it must not undesirable; it must include public limited company (abbreviated plc) in the case of public companies.

The registered office clause – this states the location of the registered office of the company.

The objects clause – it sets out the purpose for which the company was formed and the aims and type of business which it intends to pursue. The company must not act *ultra vires*, i.e. outside the scope of activities set out in this clause.

The unlimited liability clause – it should indicate that whether the company is limited by shares or by guarantee, thus a clause must state that the liability is limited.

The guarantee clause – in the case of a limited company with a share capital, there must be a clause stating the amount of the share capital describing the division of the capital into shares of fixed amount.

The association clause and subscription – at least two persons in the case of a public company and at least one in the case of a private company must subscribe their names to the memorandum.

2.3. Unincorporated associations

Unincorporated associations include: Social clubs and voluntary organizations; Trade

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unions – quasi-corporations; Member who orders goods or supplies for club is personally liable to pay for them; Club property to be held by trustees for the benefit of the association.

2.4. Partnerships

Definition – the relationship which subsists between persons carrying on a business in common with a view of profit; A profit making business enterprise; No special formalities for formation – can be created orally or by implied conduct of members; All partners are treated as agents of the partnership firm; A contract made by one partner will bind on the others; A wrong committed by one partner will make all partners liable; The relationship of partners is a fiduciary one based on duties of good faith to each other; The death of a partner automatically dissolve the partnership; Personal liability that partners have for the firm's debts and liabilities.

3. Law of Torts

3.1. Nature of Tort

Tort means 'wrong'. Tortious liability arises form the breach of duty fixed by law; such duty is towards persons generally and its breach is redressable by an action for unliquidated damage (unspecified, not fixed in advance but decided by the court.

The law of torts is part of civil law. The purpose of an action in tort is to provide compensation or reparation for the victim. Actions in tort are brought by the victim themselves (the claimant), whereas criminal prosecutions are brought in the name of the Crown by the police or a public prosecutor.

3.2.1. Classification of Torts

Torts can be classified as follows: Defamation (libel and slander): protects a person's interest in their reputation; Trespass to the person: protects a person against deliberate physical harm; Private nuisance, trespass to land: protects a person's interest in the land they occupy; Breach of copyright or patent design: protects a person's interest in 'intellectual property'; Action in tort will succeed where claimant has suffered injury, damage or loss; some time actionable per se (without proof of damage); Wrongful behavior: Intentional act on the part of the defendant; Negligence;

Strict liabilities – a person may be held liable even though their actions are neither intentional nor negligence.

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Malice in the legal sense meaning is not just personal spite or ill-will but any improper motive.

3.2.2. Trespass

Trespass has the following characteristics: The act of the defendant must be direct; The act of the defendant must be intentional; The tort is actionable per se.

Trespass takes three main forms: (i) Trespass to the person: Assault – act of the defendant which causes the claimant to fear an attack on their person (to point a loaded gun; wave a stick or threatening gesture); Battery – application by the defendant of physical force (shooting or hitting with stick); False imprisonment – the defendant imposes total bodily restraint on the claimant (locking a person in a room); (ii) Trespass to goods – defendant directly and intentionally interferes with goods in the possession of another (moving from one place to another, cut down trees): Conversion – stealing or selling borrowed goods; (iii) Trespass to land – direct interference with land of other people; actionable per se; and takes three forms: Unlawful entry into the land of another; Unlawful remaining; Unlawful placing or throwing any material object (rubbish or litter);

3.2.3. Negligence

In the judgment in *Blyth v. Birmingham Waterworks Company (1856)*, negligence was defined as follows: *"…the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."*

Negligence is a failure to take care in circumstances where the law demands that care should be taken, giving rise to a claim for damages by the person who suffers as a result.

For an action in negligence to succeed, there are three essentials: (i) A duty of care owed by the defendant to the claimant – a duty of care is owed to the claimant if it is reasonably foreseeable that they will be affected by the defendant's acts or omissions; (ii) A breach of that duty by the defendant – a breach of duty occurs when the defendant fails to do what a 'reasonable man' would have done in the circumstances, or does what a reasonable man would not have done. Alternatively, a breach occurs when the defendant fails to take reasonable precautions; (iii) Damage suffered by the claimant as a result of the breach – damage may take a number of forms, including death, bodily injury and damage to property. The law releases the defendant from liability where the

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damage is too remote.

Negligence misstatement – negligent word or negligent advice. Liability for negligent advice could arise only where there was a contract between the parties. Liability under Hedley Byrne rule arises where:

There is special relationship between the parties (but not a contract) where it is reasonable for the claimant to rely on the advice given. The giver of advice can reasonably foresee that the advice is likely to be acted upon and that the recipient is likely to suffer if it is inaccurate. The advice is acted upon causing loss to the claimant.

3.2.4. Nuisance

Nuisance takes two forms:

Public nuisance – carrying on of an activity which causes inconvenience or annoyance to the public or interference with a right common to all. Public nuisance is treated as a crime because it affects the public at large. However, an individual who suffers 'special damage',i.e. loss or inconvenience more than public may bring a civil action.

Private nuisance – unlawful interference with a person's use or enjoyment of their land. Damage must result and interference must be 'unreasonable'. It takes two forms: Wrongfully allowing harmful things to escape from their own property (noise, smells, vibration, damp or vermin); or Wrongful interference with servitudes or rights attaching to claimant's land (rights of way, rights to light or rights of support to land or building).

Majority of liability claims are founded on negligence. Claims based on nuisance are rare.

Rule in Rylands v. Fletcher

The rule in Rylands v. Fletcher relates to strict liability, i.e. liability that can arise even where there is no fault or negligence.

For the rule to operate there must be an escape of the damage-causing 'thing' from the defendant's land and there must be a non-natural use of land.

Although the rule in Rylands v. Fletcher imposes strict liability, a number of defences are available: Consent of the claimant; Act of God; Unexpected act of a stranger;

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Statutory authority; and General principles governing remoteness of damage.

3.2.5. Breach of Statutory Duty

To succeed in an action for breach of statutory duty the claimant must establish: That the statute was intended by Parliament to allow a civil remedy; The statute must impose a duty on the defendant and not merely on a power; The claimant must prove that the statutory duty was owed to him; There must be a breach of the duty by the defendant; The damage suffered by the claimant must be caused by the breach and be of a kind which was contemplated by the statute.

Employers' liability—An employer must take reasonable care vis-à-vis their employees as follows: To select competent staff; To provide and maintain proper plant, premises and equipment; To provide a safe system of work.

The above duties are best regarded as a distinct branch of the tort of negligence. The employer's duty at common law is not strict but rather a duty to take reasonable care for the safety of their employees. The standard of care demanded of employers by the law is high.

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Vicarious liability – an employer is vicariously liable for the torts committed by an employee in the course of their employment.

Liability for defective or dangerous premises—People are injured when visiting unsafe premises. They may come into contact with unexpected hazards, such as dangerous machinery, vicious animals or toxic materials.

Under the Occupiers' Liability Act 1957 a 'common duty of care' is: "… a duty to take such care as in all the circumstances of the case is reasonable to see that the visitor will be reasonably safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there."

Under English law liability for defective premises is placed on occupier rather than on owner of premises.

Liability for defective products—Defective product is common source of injury and damage. If the victim was the buyer of the goods they will be able to sue the seller for breach of contract. An action in tort may be based either on negligence or the Consumer Protection Act 1987.

Consumer Protection Act 1987—Negligence arises from a failure to take reasonable care. A person who suffers injury from a defective product should be entitled to damages without the need to establish fault. A producer is liable for personal injury or damage in excess of £275; the product must be intended for private use.

3.2.6. Defamation

Defamation is a false statement about a person which causes injury to that person's reputation. Where the defamatory statement is in a permanent form the tort takes the form of libel and where the statement is in non-permanent form the tort is slander.

Libel – libelous statement is contained in writing, picture or drawings. A defamatory radio or television broadcast is also libel. Libel can be a crime as well as a tort if it is serious. Libel has always been actionable per se.

Slander – defamatory speech or defamatory gesture. Slander is a civil wrong only. Slander is not actionable per se and damage must be proved, except in four cases where damage is assumed to have occurred, that the claimant: Is guilty of a crime punishable by imprisonment; Is suffering form certain infectious or contagious diseases; Is unfit to carry out their profession, trade or business; In case of a woman, is guilty of sexual immorality.

Essentials of defamation – four an action in defamation to succeed the following elements must be present:

A defamatory statement—Reference (of the statement) to the claimant; Publication (of the defamatory statement); Damage (in cases of slander not actionable per se). A number of special defences are available in defamation: Justification; Fair comment on matter of public interest or concern; Privilege – the need to protect free speech takes priority over the need to protect people's reputations.

Innocent defamation – it was published unintentionally and not through any lack of

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reasonable care.

General defences in tort: Self defence – the law allows people to use reasonable force for self defence; Necessity – the tort was carried out to avoid a greater evil; Statutory authority – the law allowing aircraft to fly over land;

Act of God: Consent and *volenti non fit injuria* – the claimant agrees to deliberate act (boxing, football) and 'no legal wrong is done to a person who consents'; Contributory negligence – claimant is partly to blame for injuries.

Limitation of actions—Three years where the claim is in respect of personal injuries or for libel or slander; Six years for most other tort actions (property damage)

Remedies in tort—Damages – compensate the claimant by paying for the loss; Injunctions – a court order commanding the defendant to do or refrain from doing thing.

4. Law of Contract

4.1. Types of contract

A contract under seal – a formal contract in writing and is witnessed; Simple contract (informal) can be in any form (oral and in writing);

Unilateral and bilateral – under a unilateral contract only one of them is legally bound (a promise); bilateral contract – both are legally bound;

Void, voidable and unenforceable contracts – a void contract has no binding effect on either party; voidable contract is binding but one of the parties will have the right to set it aside; an unenforceable contract is valid, but it cannot be enforced in a court if one party refuses to keep to the agreement.

4.2. Formation of a contract

The following are essentials for the formation of a valid contract: There must be an agreement, shown by offer and acceptance; There must be the intention to create legal relations; There must be consideration (in the case of simple contract); The agreement must be in the form required by law; The parties must have capacity to contract.

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4.2.1. Agreement or an offer

An offer may be terminated in the following ways:

A time limit or a 'reasonable time' – an offer will lapse if the offeror imposes a time limit for acceptance and the other party does not accept within that time.

Death – the death of either party before acceptance will usually terminate the offer. Death after acceptance will not affect most contracts.

Acceptance – acceptance of an offer will complete the contract and bring the offer to an end.

Revocation – the offeror may widthdraw their offer at any time before acceptance.

Rejection or counter-offer – if the offeree rejects the offer it then terminates.

4.2.2. Acceptance

A contract will come into existence when the offer is accepted, provided all essential terms are agreed. Acceptance may be through words, written or spoken, or may be implied by conduct.

Positive act of acceptance – there must be some positive act of acceptance: an offer cannot be accepted by silence or by doing nothing;

Communication of acceptance – acceptance is not effective until it is communicated by the offeree or by an agent;

Where the 'posting rule' applies – a letter of acceptance is effective the moment it is posted and not when it is received as in the case of an offer;

Intention to create legal relations – even an agreement is reached, there may be no contract if they did not intend their arrangement to be legally binding.

Consideration – either a 'profit or benefit to the promisor' or a 'detriment to the promisee'. Rules of consideration: Consideration must be real or genuine; Consideration need not be adequate; Consideration must not be past; Consideration must move from the promise; Consideration must not be something which the promisee is already bound to do.

Promissory estoppel – although a promise made without consideration cannot be enforced and will not complete a contract, it may be used as a defence. The defendant will not be allowed to claim relief unless they have acted fairly.

4.3. Form of contracts

The law requires a contract to be in a particular form; some type of written documentation. Most contracts can be made without any writing or other formality and only a limited number of contracts are subject to formal rules. There are four categories: Contracts which must be under seal (by deed) – signed, sealed and delivered; a lease for more than 3 years must be by deed; Contracts which must be in writing – bills of exchange, cheques and promissory notes, the transfer of shares, consumer credit transactions, and marine insurance; Contracts which must be evidenced in writing by a 'note or memorandum' – contracts of guarantee; Contracts where one party must give certain written particulars to the other – employment contract, lease.

4.3.1. Contractual capacity

Minor

Under English law a minor is a person below the age of 18. The main purpose of the special legal rules which govern contracts made by minors is to protect them from their own inexperience, which may lead them into agreements which are disadvantageous to them.

Contracts made by minors fall into three categories: (i) **Contract which are binding** – a minor is bound by contracts for 'necessaries', i.e. basic products and services of everyday life, and by beneficial contracts of employment or of a similar character; (ii) **Contracts which are binding unless they are repudiated** – certain contracts of a continuing nature are binding on both parties but the minor can avoid liability by repudiating the contract. For example, a lease, a partnership and the holding of shares in a company; (iii) **Contracts which are not binding on the minor** – all contracts other than those in the two sections above. They include contracts to buy goods which are not necessaries and contracts to borrow money.

4.3.2. Terms of a contract

The terms of a contract must be certain and no contract is formed if a vital term is missing or if the meaning of an essential term is uncertain.

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Classification of terms: **Express terms** – based on words spoken by the parties or written down by them. An express term will override any implied term; **Implied terms**: Terms implied in fact; Terms implied by customs or usage; Terms implied in law; Standard terms and exemption clauses.

4.3.3. Unfair Contract Terms Act 1977

Conditions and warranties – warranty is a term that affects only minor aspect of the agreement, if broken the injured party has a right to claim damages, but not to avoid the contract; a condition goes to the root, if broken the contract can be avoided.

Defective contracts—The defect, that may destroy the validity of the contract, arises from: (i) **Illegality**: Contracts which are contrary to law – contracts involving the commission of a crime or tort (to forge banknotes, steal property or kill or injure people; contracts forbidden by law, such as no insurable interest); Contracts which are contrary to public policy (tending to sexual immorality – prostitution; affecting the freedom of marriage; contracts of trade with an enemy; contracts to break the law of a friendly country; contracts to corrupt public life; contracts to pervert the course of justice); (ii) **Improper pressure**: **Duress** – a contract achieved through force or threats of force; threats to the claimant's property or business; **Undue influence** – the concept of undue influence is a product of equity which recognized more subtle form of persuasion. Undue influence occurs when one party holds a dominant position over the other or is able to take advantage of a relationship of trust and confidence between them, such as: Parent and child; Doctor and patient; Solicitor and client; Religious leader and follower (but not husband and wife or banker and customer). If such a relationship exists, the person seeking to have the contract set aside need only show that the contract was manifestly to their disadvantage; (iii) **Mistake**: Mistake concerning the subject matter of the contract; Mistake as to the identity of the other party; Mistaken signing of written document; Mistakes in recording agreements – rectification. (iv) **Misrepresentation** – a false statement of fact which induces the other party to enter into the contract. Remedies are: rescission (cancellation); damages; refusal of further performance; affirmation. It may be fraudulent (knows that it is false), innocent (believe to be true) or negligent: The misrepresentation must be one of fact (contrasted with statements of law and statements of opinion); The misrepresentation must be made by a party to the contract; The misrepresentation must be material (to influence a reasonable person to accept the contract); The misrepresentation must induce the contract; The claimant must suffer damage as a result of the misrepresentation; (v) **Non -disclosure** – parties to a contract are under no positive duty of disclosure.

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4.3.4. Discharge of contracts

A contract may be discharged: **By performance** – each party has carried out their side of the bargain; failure to perform is a breach; **By breach** – breach by failure to perform and anticipatory breach (breach before performance); **Frustration** – unexpected turn of events after the contract was made, such as change in law or operation of law, destruction of a thing necessary for performance of the contract, non-occurrence of an event on which the contract depends, commercial purpose of the contract frustrated, death or personal incapacity; **Discharge by agreement** – waiver; **Discharge by operation of law** – merger, death or bankruptcy.

4.3.5. Remedies in contract

The main remedies are: **Rescission** – for misrepresentation and for breach of contract; **an action for damages** – award of damages is a remedy for breach of contract; **an action for specific performance** – remedies which compel the defendant to honor their promise; an action for an injunction: prohibitory injunction – a promise not to work for another person; mandatory injunction – to do something positive to end a wrongful state of affairs.

4.3.6. Privity of contract

Privity of contract is a doctrine which restricts the rights and duties created by a contract to the persons who originally made it. A contract between A and B cannot confer any legally enforceable benefit on a third party and cannot impose any duties on the third party. 'Only a person who is a party to a contract can sue upon it'.

Assignment—An original party to the contract may assign their rights under the contract to another who then stands in their place. If A owe B $100, B may assign the right to receive $100 to C. A is not party to the assignment and its consent is not needed. The assignment must: be absolute; be in writing and signed by the assignor; written notice must be given to the debtor. Personal contracts cannot be assigned.

Rights can often be assigned, a person cannot transfer their obligations under a contract to another without the consent of the other party and the assignee.

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5. Agency

5.1. Law of agency

An agent is a person who has the authority or power to act on behalf of another person, the principal. The task of the agent is to bring about a contract between their principal and a third party.

An agency can be created: By agreement (or consent) – the agency relationship is created through an agreement between the agent and the principal; By express agreement (in writing or in oral); By implied agreement – conduct of the parties; By ratification – actions commenced, ratification later on; Agency by necessity – arises where a person is entrusted with goods belonging to another and an emergency makes it necessary;

5.2. Duties of an Agent

An agent has the following duties: To obey the principal's instruction – provided they are lawful and reasonable; liable in damages for failure; To exercise proper care and skill – level of care and skill depend on the circumstances; To perform duties personally – an agent may not delegate duties to sub-agent.

Delegation may be allowed: To act in good faith towards the principal; To account for monies received on behalf of the principal.

Remedies for breach of duty

For breach of duty of the agent, the principal can have recourse to the following remedies: Sue the agent for damages for breach of contract; In certain cases, sue the agent in tort, where the agent has refused to return the principal's property; For serious breach (such as taking bribes), dismiss the agent without notice or compensation; Sue the agent or the donor to recover a bribe paid to the agent; If the breach is fraudulent, repeal any contract made through the agent and refuse commission; and Sue for an account if the agent fails to disclose full financial details of his agency dealings.

5.3. Rights of agents

The agents have the rights to: Remuneration; Indemnity – when incur expenses; Lien – the right to retain goods of another as security for payment of debt.

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Authority of agents: **Actual authority** – real, right to act on behalf of the principal; **Express actual authority** - instruction; **Implied actual authority**; **Apparent (ostensible) authority** – the agent has no real authority to do the act; this arises when the principal has restricted the authority, the apparent agent has never been appointed; the authority of the agent has been terminated.

5.1.3. Contract made by the agent

Disclosed principal – existence is known to the third party; and Undisclosed principal –

5.4. Termination of agency

Agency can be terminated: By agreement between the parties; By performance; Lapse of time; Withdrawal of authority; Renunciation by agent; Death of either principal or agent; Bankruptcy; Insanity; Frustration.

Agency by ratification is meant that the relationship of principal and agent was created retrospectively, i.e. after the agent has carried out his task in favor of the principal. Only then the principal accepted the agreement as binding. However, a number of conditions must be satisfied for ratification is considered to be valid: The agent doing the act must aim to do it on the principal's behalf and not on the agent's own behalf; The principal must be the person whom the agent had in mind at the time of the act; At the time of ratification, the principal must have full knowledge of the circumstances relevant to the act, or must have waived further inquiry; The principal must have existed and have had the contractual capacity to do the act at the time it was done; Ratification must take place within a reasonable time; Void or illegal acts cannot be ratified; The whole contract must be ratified.

6. Making the Contract

6.1. Formation of an insurance contract – general principles

The rules of offer and acceptance apply to insurance in the same way as they do to other contracts. An insurance contract will come into existence once the offer made by one party is unconditionally accepted by the other. A prospectus published by insurance company which contains details of cover and standard rates of premium is an invitation to treat.

Following are the conditions:

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- The proposal form submitted to the insurer will be the offer and the insurer will accept it by confirming the cover or issuing the policy. The insurer may quote premium based on the proposal form, which the proposer may accept or decline.
- An acceptance of an offer must be communicated to the other party.
- An acceptance will be effective only if the parties are agreed on:
- The nature of risk and the subject matter of insurance;
- The duration of the contract;
- The amount of the premium.

When an insurance contract is renewed, a fresh contract is formed on the same basis as old one. Fresh offer and acceptance are required. An insurance contract will come into existence once an offer is accepted, the cover may not operate immediately.

No legally binding contract is formed unless the parties intended to be legally bound. A promise is not legally binding unless it is supported by consideration, i.e. something of value is given in exchange for it. A promise to pay is as good consideration as payment itself.

Formal requirements of insurance contracts: Contracts by deed; Insurance contracts which must be in writing – marine policy; Insurance contracts which must be evidenced in writing – contracts of guarantee; Insurance contracts where written documentation is required – motor, life insurance.

Capacity to contract: Insurance contracts made by minors – an insurer who grants cover to minor is fully liable to meet all valid claims under the policy. The minors themselves are only fully bound by contracts for necessities and beneficial contracts (employment); other contracts either do not bind them or are voidable by them; Insurable interest. The legal right to insure arising out of a financial relationship recognized at law, between the insured and the subject matter of insurance. The insurance contract may fail if the policyholder has no valid interest which he can insure. Insurable interest is the legal right to insure arising out of a financial relationship recognized at law, between the insured and the subject matter of insurance.

6.2. Insurable Interests

The key elements of insurable interests are the following: **A subject matter of**

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insurance – the insurable interest is the interest which a person has in property which they own, such as a house, a car or other goods. The owner has an interest because the destruction of or damage to the property will cause the owner loss. In many cases, the subject matter of the insurance is something other than material property; it may be human life or something intangible such as a debt.

The policyholder must have economic or financial interest in the subject matter of insurance. The doctrine of insurable interest requires there to be a relationship between the insured and the subject matter of insurance whereby the insured will suffer a financial loss if the insured event occurs.

The interest must be a current interest, not merely an 'expectancy'. English law requires that a person has a current interest in the subject matter of insurance. A mere hope or expectation of acquiring an interest in the future is not enough. The interest must be a legal interest, that is one that the law recognizes and will support.

Table 6.1. Differences between Insurance Contracts and Wagering Contract

Insurance contract	**Wagering contract**
The insured is required to have a financial interest in the subject matter of the contract.	The interest are limited to the stake to be won or lost.
The object is to protect the insured against loss and their identity is known	Either party may win or lose and the loser cannot be identified until after the
Full disclosure on the part of both parties is required under the doctrine of utmost good faith	Full disclosure is not required of either party
In most cases payment is made only by way of indemnity – i.e. for a loss which	The stakes are not paid by way of indemnity. Payment is made without suffering
The contract is enforceable at law.	Neither party can enforce the contract in court.

There are two main reasons why the law requires insurable interest: To reduce moral hazard – behavior leading to loss; To discourage wagering.

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In the past insurance policies were often used as a 'cloak' for gambling. It was this irresponsible use of insurance as a means of betting on the lives and property of others that led the Parliament of the U.K. to discourage the practice by imposing a need for insurable interest. Apart from insurable interest, the key difference between an insurance contract and a wagering contract are shown in the above Table 6.1.

6.3. Development of the law on insurable interest

Where there is no insurable interest, the contract is generally void. Both sides cannot enforce the contract in court.

6.3.1. Creation of insurable interest

There are a number of ways in which insurable interest may arise:

Common law – every person has unlimited interest in their own life; ownership of a car carries the right to insure;

Contract – the landlord is liable for maintenance of property; the lease often contains a condition which makes the tenant responsible for maintenance or repair. This creates financial interest in the property.

Statute – Act of Parliament creates insurable interest where none exists under common law (Industrial Insurance and Friendly Societies Act gave a child a limited insurable interest in the life of their parents).

6.3.2. Time when interest is required

Life insurance – insurable interest is required at the time when the contract is made; there is no requirement to prove when claim arises on death or maturity;

Marine insurance – the insured must be interested in the subject matter insured at the time of the loss. There is no requirement of insurable interest when the contract is made (the cargo changes ownership often);

Other insurances – pecuniary and liability insurances; insurable interest is required at the time of the loss; indemnity insurance that pay out only when the insured suffers a loss.

Waiver of insurable interest – for policies on goods, insurable interest can be waived.

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6.3.3. Application of insurable interest

1. Life insurance:

Family relationships – precise financial interest difficult to establish, but insurable interest is: Own life; Spouses – husband and wife have unlimited insurable interest in the life of each other; Other family relationships – no other family relationship gives rise to an insurable interest. A parent cannot legally insure his or her own child.

Business relationships – financial interest in the life of another arises from a commercial contract or business dealing: **Partners** – have an insured interest in each other's lives up to the amount of any loss or expense that might arise from the death of a partner; **Employer and employee** – an employee can insure the life of this employer, but limited to a sum representing his wage for the minimum period of notice under his contract of employment. An employer has an insurable interest in the life of his employees (sum representing value of work); **Creditor and debtor** – a creditor ahs an insurable interest in the life of his debtor. A debtor has no corresponding insurable interest in the life of his creditor.

2. Property insurance

Persons who have an insurable interest in property: Outright owners of property; Part or joint owners; Mortgagees and mortgagors – a mortgage involves a lender (bank or mortgagee) and a purchaser – mortgagor; Executors and trustees; Landlord and tenant; Bailees – who has legal possession of goods belonging to another; People living together; Finders and people in possession;

7. Utmost Good Faith

7.1.Misrepresentation

Misrepresentation is a false statement of fact that induces the other party to enter into the contract. To take effect a misrepresentation shall require the following:

- The misrepresentation must be one of fact – statements of existing fact are to be contrasted with statements of law and statements of opinion or belief. A misstatement as to the state of a man's mind is a misstatement of fact.

- The misrepresentation must be made by a party to the contract – a statement by a third party is not actionable;

- The misrepresentation must be material – the misrepresentation must concern something which would influence a reasonable person in deciding whether to proceed with the contract or what terms to accept. The requirement of materiality does not apply if the misrepresentation is fraudulent.

- The misrepresentation must induce the contract – the claimant must have relied and acted upon the statement in question.

- The claimant must suffer damage as a result of the misrepresentation – if the misrepresentation does not cause any loss or disadvantage to the claimant, it will not affect the contract.

- When a person makes a false statement with the deliberate intention of misleading another and putting them in a disadvantage there is a fraudulent misrepresentation (right to claim damage).

- If the statement is false, but there is no intention to mislead the other party it is innocent misrepresentation.

- Negligent misrepresentation – where the statement is false because the person making it did not take sufficient care to check that it was correct.

Misrepresentation in insurance – a proposer for theft insurance says that the premises are protected by a burglar alarm when they are not; a proposer for motor insurance declares that their car has not been modified in any way when it has; a proposer for life insurance gives their age as 25 when he is aged 35.

Non-disclosure and misrepresentation – the dividing line between misrepresentation (making false statement) and non-disclosure (failing to disclose the whole truth) is a very fine one. Misrepresentation and non-disclosure tend to be regarded as aspects of a more general duty to act in good faith.

7.2. Duty of disclosure

The parties to an insurance contract are dealing with a product that is intangible. The insurance policy cannot be tested by the proposer before it is bought. The proposer will have to trust that the insurers will pay their claims properly when the time comes. The proposer will not know the details of the cover that they are to receive unless the insurers make the information available to them. The proposer is the only one who has full knowledge about the subject matter of insurance. "Insurer will not be able discover the full facts about a risk unless the proposer volunteers the necessary information. For

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these reasons, in insurance there is a positive duty of disclosure going beyond a mere duty no misrepresent matters which are disclosed.

7.2.1. Reciprocal duty

The duty is reciprocal. The requirement on the part of the insurer will be to provide full and accurate information about the cover that is being offered. Insurers should make clear that the cover is in accordance with its usual form of policy and make a copy of the document available on request, full disclosure will be deemed to have been made.

7.2.2. Material facts

The essential duty is to disclose material facts,i.e. "every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk. This is what a reasonable underwriter want to know about when forming his opinion of the risk. If insurers discover an actionable breach of good faith at any time they can avoid the contract.

7.2.3. Matters which must be disclosed

Matters to be disclosed are divided into two:

- **Physical hazard** – an adequate description of the subject matter of insurance and details of any unusual features of the subject matter; **Fire insurance** – the construction of the building, the nature of its use, fire detection and fire fighting equipment; **Theft insurance** – the nature of stock, its value and the nature of security precautions; **Motor insurance** – the type of car, details of regular drivers; **Marine cargo** – the type of cargo, the terms of sale, how the cargo is carried, its destination, containerized; **Life insurance** – age, previous medical history.

- **Moral hazard** – behavior of the insured: Identify of the insured and their general background; occupation; Criminal acts – a history of criminal activity; Previous losses and claims under other policies; Any other adverse insurance history – another policy in place.

2.3.4. Matters which need not be disclosed

The parties to an insurance contract are dealing with a product that is intangible. Thus, it is a reciprocal duty for both proposer and insurer to make full disclosure. It is

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presumed that as the underwriter knows nothing and the proposer knows everything, it is the duty of the insured to make full disclosure to the underwriter without being asked of all the material circumstances.

However, there are matters which a proposer need not disclose: **Matters of law** – everyone is deemed to know the law; **Factors which lessen the risk** – such as installation of an alarm system for a theft risk or automatic sprinklers for a fire risk; **Facts known by the insurers** – there is no need to tell insurers what they know already; **Facts which the insurers ought to know** – things that are in the public domain and normal trade practices; **Information that is waived by insurers**; **Facts covered by the terms of policy**, for example matters which are the subject of an expressed or implied warranty in the policy; **Facts which the proposer does not know**.

2.3.5. Duration of the duty

At common law, the duty of disclosure begins at the commencement of negotiations for an insurance contract and ends when the contract is formed. It is formed at the point where there is offer and unqualified acceptance. There is no general duty to disclose new material facts that arise during the currency of the contract. This is a sensible rule, as insurers calculate the premium on the basis of the risk as it appears at inception and agree to run the risk for an agreed period of time. The insured has no right to a reduction in premium if the risk should improve in the course of the policy term.

If the insurers invite renewal of the contract the duty of disclosure is revived. The insured will have the duty to declare any changes in the risk or new material circumstances that have arisen during the current period of insurance. If the insured makes no such declaration he will be taken to have affirmed that the facts relating to the risk stand unchanged.

In the case of long term insurances, such as life insurance and certain associated classes, the position is different. The insurer is obliged to accept the renewal premium if the insured wishes to continue the contract. There is no fresh duty of disclosure. The long-term contracts do not cease at the end of the year. A person who had been insured under a life policy for many years is not required to inform insurers, should he was told by a doctor that he was suffering from a terminal illness.

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2.4. Breach of good faith

A breach of good faith may occur on the part of the insured or, more rarely, on the part of the insurer. A breach of good faith may take the form of: **Misrepresentation**, which may be either innocent or fraudulent; **Non-disclosure**, which may be innocent or fraudulent. If fraudulent – concealment.

Regardless of whether there is fraud or not, the insurers have the right to avoid the contract '*ab initio*' (from the beginning). The effect is that the contract is cancelled retrospectively, so that the insurers are not liable for any claims arising between the making of the contract and the time when it is avoided. In the case of misrepresentation (but not non-disclosure, unless it is fraudulent), insurers may have a right to claim damages as an alternative to avoiding the policy. **Breach by the insurer** – if the insurers are in breach of their duty of good faith, the insured will be entitled to avoid the contract. An insurer might be deprived of the right to avoid a policy because of its own lack of good faith.

The Statement of General Insurance Practice provides an insurer with the right to avoid policy for breach of good faith. The Statement stipulates that the proposer should not be required to guarantee the absolute truth of the answers that they give on the proposal form, but should merely promise that they are true to the best knowledge and belief. Moreover, the use of 'basis of the contract' clauses is severely limited so that they will not have the effect of creating warranties. The Statement of General Insurance Practice prevents insurers from refusing a claim on the grounds of breach of warranty unless the breach did cause or contribute to the loss.

8. Warrants and Other Terms, Void and Illegal Contracts, Joint and Composite Insurance

8.1. Warranties and other terms

A breach of a term of the contract may lead to termination, the right to repudiate a claim and to pay damages. The terms of a contract are contained in a written document, but may be oral or implied by law. The terms of an insurance contract cover all sorts of things including payment of premium, rights of cancellation and application of arbitration.

8.1.1. Warranties

A warranty in an insurance contract is a term which, if broken, allowed the insurers to

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repudiate the contract as a whole. A warranty is a promise made by the insured relating to facts or to something which they agree to do. A warranty may relate to past or present facts or it may be a continuing warranty.

Continuing warranties are applied by insurers to ensure that some aspect of good management is observed. Alternatively, the function of the warranty may be to ensure that certain high risk practices or activities are not introduced without the insurer's knowledge.

Exact compliance – a warranty must be exactly complied with. If it is broken, cover terminates even if the breach did not cause a loss. Termination arises from the date of breach.

Warranties can arise in insurance contracts in three ways: **As express warranties** – warranties may be expressly stated in the policy itself. Any clause to the effect that the policy will be void or of no effect if something is not done is a warranty; **As implied warranties** – a marine insurance policy includes the implied warranty of seaworthiness. However, a warranty cannot be implied in a non-marine insurance policy; and **From a 'Basis of the Contract' clause** – warranties may arise from the answers that the insured gives to the questions on the proposal, and the declaration that they sign at the foot of the form.

8.1.2. Conditions

Conditions impose an obligation on the insured and can be classified: **Conditions precedent to the contract** – the policy will be void or not come into effect if the insured fails to comply with the term (for life insurance – premium is paid until the policy come into effect; in motor – the insured must maintain the vehicle in a roadworthy condition at all time); **Conditions precedent to liability** – allows insurers to avoid liability for a particular loss if the term is broken, but not avoid the contract as a whole (prompt advice of a loss); and **Collateral conditions** – not being part of the main agreement to insure, but concerned only with a side issue, such as adjustment of the premium. If condition is broken the insurers will not able to avoid the policy or avoid the claim.

8.1.3. Exception clauses (exclusions)

A fire policy may exclude fire caused by earthquake and a theft policy may exclude theft of money or theft involving collusion by an employee of the insured. 'Suspensive conditions' or 'clauses describing the risk' –

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8.1.4. Breach of warranty or condition

Breach of warranty: Cover terminates automatically; in effect the contract ends; Cover terminates from the time of the breach; The insurers do not have to prove a connection between the breach and any loss that has occurred; The insurers cannot avoid a particular claim and allow the contract to continue. They must either allow the contract to terminate, or waive the breach.

Breach of condition precedent to the contract: If a condition precedent is never fulfilled the contract is void ab initio; If the condition imposes a continuing obligation the effect is similar to a breach of warranty, but cover may terminate only if there is a casual connection between the breach and the loss.

Breach of condition precedent to liability: The insurers may avoid the particular claim; The policy as a whole is not avoided and remains in force.

Breach of collateral (or 'mere') condition: The insurers may not avoid the policy or the claim, but may claim damages.

Breach of a 'suspensive condition' or 'clause describing the risk' - Cover is suspended for as long as the insured fails to comply with the condition, but resumes if and when he starts to comply with it again.

A breach of warranty terminates cover from the date of the breach. There need be no casual connection between the breach and the loss. A single insurance contract is divisible, with one part being valid and the other not.

Waiver of breach of warranty – insurers could waive the breach by allowing the policy to stand, i.e. by refraining from avoiding it.

'Waiver by estoppel' – an insured who has broken a warranty cannot enforce the contract unless they can prove that knowing of the breach, the insurers: Issued or renewed the policy; Accepted further premiums; Advised the insured about future loss prevention; Resisted the claim on grounds other than breach of warranty; Gave the insured 30 days notice of cancellation under a cancellation clause instead of treating the contract as having ended automatically.

8.2. Void and Illegal Insurance Contracts

An insurance contract is void if: (i) **Mistake** – a contract will be void if there is a fundamental mistake that 'goes to the root of the contract'. Mistake when the life

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insured is dead or when the insurer and insured are at cross-purpose; (ii) **Illegality—** Contracts that are illegal or against public policy are void and the court will not assist a party to the contracts. The contracts therefore cannot be enforced and money or goods delivered under it cannot usually be recovered by an action in court.

Contracts which are contrary to the law, for example, contracts involving the commission of a crime or tort, such as contracts to forge banknotes, steal property are illegal, thus void. A contract may not involve the commission of a legal wrong or forbidden by statute, but may bring about results which are harmful to the public or socially undesirable. This kind of contract is void and unenforceable. The same is true in the case of insurance contracts.

Illegality can arise in a number of ways:

1. No insurable interest:

An insurance contract may be illegal and void because the would-be insured lacks the insurable interest required by statute, but there is no criminal penalty.

For example, the U.K. Life Insurance Act 1774 states that 'no insurance shall be made' by a person who has no insurable interest in the life or event in question. A marine insurance policy which lacks the insurable interest required by the Marine Insurance Act 1906 shall be void.

2. Purpose of contract illegal

The contract is void when its purpose is illegal or contrary to public policy. Contracts of insurance with enemies or on enemy property may fall in this category. The example to this effect was ***Keller v. Le Mesurier (1803)***.

3. Unlawful use of insured property

If insured property is used unlawfully the contract may be illegal. In marine insurance law there are decisions which state that policies of insurance on illegal adventures are illegal.

4. Close connection with a crime

Where there is close connection between the loss and a criminal act, the policy may be void. First, there is a requirement in insurance that losses should be fortuitous, thus the

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insured will not be able to claim from his own 'willful misconduct'. Second, public policy prevents the insured from carrying out activities that break the law.

For example, in ***Beresford v. Royal Insurance Co. Ltd (1938)***, the insured committed suicide in order to use policy money to pay off his death. Although the policy did cover suicide and extended to cover acts of 'willful misconduct', the court held that public policy prevented a claim being made.

In ***Geismar v. Sun Alliance (1977)***, the insured had smuggled the insured property into the UK. The court held that the claimant could not recover for the theft under his insurance as this would allow him to benefit from his criminal act. Contracts that are illegal or against public policy are void and the court will not assist a party to the contracts. The contracts therefore cannot be enforced and money or goods delivered under it cannot usually be recovered by an action in court.

8.3. Joint and composite insurance

Two or more persons are often insured under a single policy (co-insurance):

A joint policy is indivisible – the insured persons share a common interest in the subject matter (joint owners of property) – a breach by one insured (a breach of utmost good faith) may cause the whole policy to fail;

Under a composite policy – interests are different (lessor and lessee), a breach by one insured may invalidate their own cover without affecting the right of other insured persons to claim, provided the latter are innocent of the breach. A composite policy is a bundle of separate contracts between the insurers and various insured.

9. Assignment and Agency in Insurance

9.1. Assignment and Insurance

Assignment is concerned with the transfer to another person of the rights and duties under the contract. Three types of assignments:

Assignment of the subject matter – a motor policy holder sells his car to another; the insured under household buildings policy sells the house. It does not carry with it automatic assignment of the policy; if the insured sell the subject matter, the contract will end.

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Assignment of the benefit of the contract – the right to recover money under an insurance contract can be assigned to another person. The entire contract is not assigned, but only the benefit of it. There is no change in the subject matter or in any other aspect of the risk; the insurance money is payable on exactly the same event. An insured might assign the benefit of his household policy to a builder as a means of paying for the repair of storm damage covered by the policy. The arrangement could be made before damage.

Assignment of contract itself – is subject to some limiting factors:

a. 'Personal' contracts are not freely assignable – many insurance contracts are of a 'personal character', i.e. the terms of the contract will depend on the insured's own personal characteristics. For example, the terms of a motor policy cover are based on the age, occupation, experience and driving record of the insured and the driver. Most property insurance is also personal in a sense that risk survey looks at the management of the property. The change in the management tends to increase or reduce the standards for property control. In liability insurance, most claims arise from the conduct of the insured. For the above reason, the insurance policy cannot be assigned without the consent fo the insurer. Insurer would require that a new contract be formed if there is a change in the subject matter of insurance.

b. Assignment must take place at the time when property is transferred – the policy is lapsed automatically if the subject matter of insurance is sold. Therefore if a policy is assigned when the property it covers is sold, the assignment must take place at the same time.

c. Marine insurance – few insurance contracts are freely assignable. But marine cargo policies are an exception. The ownership of cargo may change several times in the course of voyage, thus it is convenient if the insurance cover can be easily transferred at the same time.

d. Assignment of life policy – life insurance provides a means of investment and a source of protection. Life policies are freely assignable because, provided the identity of the life insured does not change on assignment, there is no change in risk. Thus, life policies are not personal contracts. The assignment of life policy may be irrevocable or conditional. For example, the life policy is assigned as security for a loan but the mortgage can be redeemed and the policy recovered once the debt is repaid.

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9.2. Insurance Contracts Formed through an Agent

Insurance agent makes a mistake or careless in carrying out his duties:

- The intermediary may grant cover to a client on behalf of an insurer, in doing so, disobey the insurer's instructions or exceed the authority given;
- The intermediary may fail to pass on to the insurers important information about the risk given to him by a proposer. The insurers might avoid the policy for non-disclosure.
- The principal is liable for his agent's deeds and can be bound in contract by agent, i.e. what is done by an agent is deemed to have been done by his principal.

In insurance, one of agent's main duties is to pass on information. An insurance broker will be required to pass on information about a risk to insurers. Any knowledge which an agent posses is imputed to the principal.

In insurance an intermediary may, at different time, act on behalf of both the proposer/ insured and the insurer:

- *The agent is an agent of the proposer*—When an agent advises the proposer about the sort of insurance he needs and recommends a general type of policy; If no authority is given by the insurers and the only recognition he receives from the insurers is the payment of commission; When he fills in or adds to the answer in proposal from, and the proposer knows this; When he complete a form on the proposer's behalf and the form incorporates a wording to the effect that if the form is completed by someone other than the proposer, that person is deemed to be the agent of the proposer; When he and the proposer are in collusion to defraud the insurers; When the agent gives the insured advice about how to formulate his claim.
- *The agent is agent of the insurer*—When he has expressed authority from the insurer to receive and handle proposal forms; When he handles the forms according to a previous course of business with the insurers and within an implied authority that has arisen; When he is instructed by the insurers to ask questions and fill in the answers on a proposal form – he is then the insurer's agent even when the proposal contains a declaration to the contrary; When he surveys and describes the property on the insurer's behalf; When he acts without express authority, and the company either ratifies his action or has ratified such action in the past; When he has express or implied authority to collect premium.

9.3. Duties and Rights of Insurance Agents

The duty of an insurance agent to the principal: Obedience – an agent must carry out all lawful instructions; Reasonable care and skill; Personal performance - one of the duties of an agent to the principal is to perform his duties personally. Generally, an agent may not delegate duties to a 'sub-agent'. However, delegation may be allowed in the following circumstances: Where the principal expressly authorizes the agent to delegate all or some of their duties; Where the authority to delegate can be implied from the circumstances, such as delegation of routine clerical and administrative tasks to employees; Where the delegation is in accordance with trade customs; and In case of necessity; Where delegation is necessary for the proper performance of the agent's duties. When delegation takes place the sub-agent acts on behalf of the agent, not the principal. The agent is liable to the principal for any fault of the sub-agent.

Good faith – the agent must act in good faith when dealin with principal. He must: not conceal any relevant information from then principal; Maintain confidentiality; Not accept secret commissions; Generally act in the principals' best interest and not his own at all times. Duty to account – an agent must account to the principal for all monies received on his behalf.

Duties of the principal to an insurance agent: To pay the agreed remuneration; To indemnify the agent.

10. Making the Claims

10.1. Who Can Claim an Insurance Policy

The doctrine of privity of contract confines the rights and duties under a contract to the persons who originally made it. If this doctrine were strictly applied it would mean that the only person who could claim on an insurance contract would be the policyholder. However, the Contracts Act 1999 provides that a third party can enforce a contractual term if: (i) the contract provides that they may do so; or (ii) the contract purports to confer a benefit on the third party.

Assignment – the benefit of contract can be assigned to third party. The assignee can enforce the contract in their own name, whereas in the case of equitable assignment the assignee must join the assignor in the action.

Agency – a third party can gain the right to claim on an insurance policy under the rules of agency. The doctrine of undisclosed principal can be applied in insurance.

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Trust – a person who insures is deemed to have established a trust for the benefit of a third party, who can enforce the policy. This arises frequently in the field of life insurance where a person insures their own life, but does so expressly for the benefit of another.

Road Traffic Act 1988 – Motor insurance policies often cover persons other than the policyholder including, various named drivers, any person who drivers the insured vehicle with the policyholder's permission.

Third Parties (Rights Against Insurers) Act 1930 – A problem can arise for an accident victim if the wrongdoer becomes bankrupt. The injured party ranks with other ordinary creditors in competition for the assets that are available.

Law of Property Act 1925 – the benefit of any insurance effected by the vendor fo real property is automatically assigned to the purchaser if, after exchange of contracts, the property is damaged or destroyed.

Fire Prevention Act 1774 – this act allows a person who has a legal or equitable interest in buildings (such as lessee, mortgagee) to compel the owner or their insurers to reinstate (rebuild) the property if it is damaged or destroyed by fire.

Policies with 'additional insureds' – insurance policies, especially liability insurance contracts, often grant an indemnity (protection) to persons other than the main insured, which is usually a company (any principal that employs the insured (firm) to do work for them; owners of plants hired by the insured);

'Noting the interests' of third parties – property insurance policies often have the interest of various persons other than the policyholder 'noted' in them. The interest of a mortgagee (lender with security over the property) is often noted.

10.2. Notice of proof of loss

When a loss occurs the insured is required to give notice of the loss within a time limit (such as 15 or 30 days).

The burden of proof—The burden of proving the loss remains with the insured and it is in their best interests to complete the claim form. To discharge the burden of proof, the insured must be able to establish two things: **That the loss was caused by the operation of an insured peril** – the insured must prove that an insured peril was the proximate cause of the loss. In the case of fire insurance the insured must prove that the property has been burned or in the case of theft insurance, that it has been stolen.

Once the insured has established *prima facie* loss by an insured peril the burden shifts to the insurers; and **The amount of his loss** – the insured must provide good evidence of value to support the amount claimed.

The two things must be established by the insured 'on the balance of probability'. The loss must be fortuitous – whatever the peril, the law requires that the loss must be accidental or fortuitous and must not caused deliberately by the insured or by his own willful misconduct. Intentional damage by members of the insured's family or their employees will be covered provided that the insured has no involvement in their actions. In theory, insurers can extend their policies to cover deliberate loss if they wish.

Insurers often seek to avoid liability for losses caused by excessive carelessness by including a 'reasonable precautions' clause in the contract.

10.3. Construction of insurance contract

The cover provided under an insurance contract must be precisely defined, stating clearly the perils against which cover is being provided and define clearly the perils that are to be excluded. Dispute about the meaning of the words used in insurance contracts occur form time to time. In some countries the wording of insurance policies is tightly regulated. Policy wordings have to be specifically approved by a government regulator.

10.3.1. EC Directive on Unfair Terms

The EC Directive on Unfair Terms in Consumer Contracts includes:

- **Fairness** – a contract term that is 'unfair' is unenforceable. Unfair terms if they have not been individually negotiated and they cause 'significant imbalance in the parties' rights and obligations arising under the contract, to the detriment of the consumer'. The terms should be expressed in 'plain intelligible language' to meet the 'fairness' test, if they are 'core terms which relate to the definition of the main subject matter of the contract.

- **Intelligibility** – ambiguous terms are likely to be construed against the insurer by virtue of the *contra proferentem* rule.

10.3.2. Common law rules for the interpretation of insurance policies

Ordinary meaning – the court will assume that the parties intended the words in question to bear their ordinary meaning.

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Technical or legal meaning – words are intended to bear their common meaning may not apply if the word has a clearly established technical meaning.

The importance of context – the meaning of a word depends on its context where it is used.

Inconsistencies – insurance policies, like other written documents, sometimes contain inconsistencies or contradictions, so that one part of the document appears to conflict with another.

Where printed words conflict with words that are hand-written or typed, the latter take precedence. An endorsement overrules anything in the printed policy that appears to conflict with it; An express term of the contract will overrule any implied term.

11. Causation

Named perils policy include: (1) insured perils, e.g. fire; (2) excluded perils e.g. fire caused by earthquake, or war risks, or nuclear risks; and (3) uninsured perils e.g. loss by theft.

'All risks' policy (e.g. personal 'all risks') includes: (1) excluded perils e.g. wear and tear, gradual deterioration; (2) insured perils, any form of loss other than (1).

11.1. Proximate Cause

The doctrine of ***proximate cause*** states that the proximate cause is the main and most powerful cause in bringing about the loss (although it has recently been accepted that there might be more than one proximate cause). The choice of the real or efficient cause from out of the whole complex of the facts must be made by applying common-sense standards. Causes which play only a small part in bringing about the loss are remote causes.

In theory, where there is a 'chain of events' the insurers are liable where the loss flows in an unbroken chain directly fro an insured perils. There is no liability if the loss flows directly from an excluded peril.

11.1.1. 'Chain in events'

For example, in ***Leyland Shipping v. Norwich Fire Insurance Ltd (1918)***, the Ikara ship was hit by an enemy torpedo and was brought to the port Le Havre for repair.

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When a storm blew up the harbour master ordered the ship to an outer berth and the ship sank after she left the port. Insurance policy covered perils of the seas, but excluded war risks. The court held that the torpedo was the proximate cause of the loss because the damage it caused had been effective throughout. The 'chain of event' had not been broken.

The chain of event will be unbroken only where each event is the natural and probable result of what happened. If the chain of event is broken by some new intervening cause the position will be different. In ***Marsden v. City and County Insurance (1865)*** a fire caused a mob to gather, and glass was broken when a riot developed and the mob took to plunder. The policy covered breakage of glass but excluded breakage by fire. The riot and not the fire was held to be the proximate cause and the loss was covered.

In reality very few losses are the result of a simple 'chain of events' and the comparison with a 'chain' may often be rather misleading. The comparison with a chain, with each link, or event, finishing where the next one begins, may not reflect the complexity of the situation. Ultimately it is the most 'efficient' or powerful cause that is the proximate cause, irrespective of how it connects with other events.

11.1.2. Concurrent Causes

Occasionally, two or more perils operate concurrently to bring about a loss. A building might be damaged by a fire that was raging and a storm that was battering it at the same time. Where the perils are independent (in the sense that one did not lead to the other) and either one would have caused some loss without the other, the insurers are simply liable for that part of the loss attributable to whichever peril is insured.

In other cases the perils may be not only independent (i.e. *one did not lead to the other*) but also interdependent (*neither one led to the other*), in the sense that neither peril would have caused damage on its own. Thus, it is impossible to attribute part of the damage to one peril and part to the other, because all the damage is caused by the two working together and none would have been caused by either peril working separately.

A. Insured peril combined with excepted peril

If one peril is an insured peril and the other is an excluded peril, the exception prevails and the insurers have to liability at all.

B. Insured peril combined with uninsured peril

If one of the perils is an insured peril and the other is an uninsured peril (i.e. not

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specifically excluded) the position is different. In this case the insurers are liable for the whole of the loss.

11.1.3. Modification of the Doctrine of Proximate Cause

The doctrine of proximate cause can be excluded or modified by the particular words used in the policy. Insurers may wish to exclude some risks (such as war risks) absolutely and be in a position to refuse payment even there the peril operates as a remote cause.

To achieve this, insurers sometimes exclude loss caused 'directly or indirectly' by the peril in question. Provided the clause is upheld, the effect will be to exclude any loss in which the peril operates, even though it does so only as a remote cause. In ***Coxe v. Employers' Liability Insurance Corporation Ltd. (1916)*** the insured was killed in the darkness by a train while inspecting sentries guarding a railway, the lights having been extinguished under wartime regulations. War was excluded as an indirect as well as a direct cause and the insurers were not liable, even though war was only a remote cause of the accident.

12. Measuring the Loss: The Principles of Indemnity

The principle of indemnity requires that the insured should be fully compensated for their loss, but not over-compensated.

Indemnity insurance – insurers agree to pay only when the insured suffers a loss and only for the amount of the loss. Most of non-life insurances are indemnity contracts, i.e. all property, pecuniary and liability insurance, including motor, marine and aviation;

Non-indemnity (contingency) insurances – insurers agree to pay a specified sum when a particular defined event occurs. The insured does not have to prove that they have suffered a loss. Life insurance, accident and health insurances (though can sometimes operate as a contract of indemnity).

Indemnity means to save from loss or harm or protection or security against damage or loss. Insurance policies as contracts of indemnity are intended to provide financial compensation for a loss which the insured has suffered and put them in the same position after the loss as they enjoyed immediately before it. Parties may agree that the policy will pay less than a full indemnity in the event of a loss or more than a full indemnity.

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12.1. Measure of indemnity

Property insurance – the measure of indemnity for the loss of property is determined not by its cost, but by its value at the date of loss and at the place of loss. If the value has increased, the insured is entitled to an indemnity based on increased value, subject to the adequacy of the sum insured.

Building – cost of repair or reconstruction at the time of loss with a deduction for betterment.

Machinery and equipment – the cost of repair less an allowance for wear and tear; or the cost of replacement (second hand or new equipment less betterment), less wear and tear.

Manufacturers' stock (raw materials, work in progress and finished stock) – for raw materials, replacement cost including delivery to site; for other stock – raw material costs plus labor costs and other costs.

Wholesale and retail stock – cost at the time of loss of replacing the stock including transport and handling costs to the insured's premises.

Farming stock – for livestock and produce – local market price.

Pecuniary insurance – cover financial loss, such as business interruption insurances and credit insurances which cover bad debts arising from the insolvency or default of the insured's trading partners. For bad debt – the amount of bad debt less recoveries.

Liability insurance – court award or 'out of court' settlement plus cost of claim (lawyers fees, court fees, medical report, expert witnesses).

Marine insurance – valued and unvalued policy. For unvalued marine policy is the 'insurable value' for total loss. For partial loss – for a ship, the reasonable cost of repairs.

12.1.1. Variation in the principle of indemnity

Less than a full indemnity—Indemnity is a contractual principle which can be contractually varied. Parties may agree that the policy will provide either more or less than a strict indemnity. There are several factors which may limit the insured's entitlement to a full indemnity:

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The sum insured or limit of liability – the maximum amount recoverable under many policies is limited by sum insured or the limit of indemnity (or limit of liability). The insured cannot recover more than this amount even where the loss, measured by the indemnity principle, is a higher amount. However, the UK Road Traffic Act requires motor insurers to grant unlimited cover for liability in respect of death or bodily injury.

Other policy limits – within the overall sum insured or limit of indemnity, there may be further separate limits for particular types of loss or particular types of property. For example, a household contents policy will restrict cover on individual 'valuable' to 5% of the total sum insured.

Underinsurance and average clauses – where there is underinsurance, the policyholder is not paying their fair share into the pool. Therefore an average clause is applied and the claim payment for any loss will be scaled down proportionately.

Excess or deductible – a clause which provides that the insured must bear the first amount of any loss, expressed either as a sum of money or a percentage of the loss.

A franchise – similar to an excess in that there is no liability for any loss which is less than the franchise figure. Once the franchise has been exceeded, the loss is payable in full.

12.1.2. Extensions in the Operation of Indemnity

There are a number of instances where the insured may, depending on the precise circumstances, recover more than a strict indemnity. **Indemnity** is a contractual principle of insurance and not a statutory one, i.e. it can be varied if the parties to the insurance contract wish to vary it. Parties may agree that the policy will pay more than a full indemnity, according to the following circumstances:

Reinstatement cover – in the event of loss, the insurers will pay a sum equivalent to the cost of rebuilding or replacing the property to a condition 'equivalent to or substantially the same as but not better or more extensive than its conditions when new'. No deduction is made for wear and tear and the insurance pay for the full cost of rebuilding 'as new'. It is possible to insure against extra costs which might be incurred by the insured. Reinstatement is more expensive than a simple indemnity insurance because the sum insured will need to be higher to cover the cost of rebuilding 'as new'. (applied to buildings, plant, machinery and contents.)

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'New for old' cover – cover on reinstatement is 'new for old' on buildings and machinery. The term 'new for old' is associated with household goods and personal possessions, including household contents and personal 'all risks' policies. The insurers will pay full replacement cost of any insured item with no deduction for wear, tear or depreciation. The sum insured need to reflect the total replacement cost.

Agreed value cover – the parties agree that in the event of a loss a particular sum, fixed at the outset of the insurance, will be paid, regardless of the actual value of the property at the time. The objective is to avoid disputes as to the value of the property at the time of the loss, where the property is unique or there is a limited market. The insurers must pay the agreed value regardless of the actual value at the time of the loss. Therefore, the insured may receive more than a full indemnity, if the value declines.

Partial loss under valued policies – in the case of partial loss, the rule established in ***Elcock v. Thomson (1949)*** may be applied. In this case, a large house was insured under a fire policy for an agreed value of £106,850 although its actual value was only £12,600 at the time of fire, a reduction of £32,055. Under this rule the insured is entitled to a proportion of the agreed value which is equivalent to the degree of depreciation in actual value cause by the loss.

12.2. Method of providing indemnity

When a claim occurs there are several methods to provide indemnity:

Payment of money – an insurance contract is essentially a contract to pay money. If there is no clause in the policy, the insured has a legal right to insist on money payment.

Reinstatement – the insurers choose to settle the claim by actually rebuilding the property that has been damaged instead of paying money to the insured. The choice of rebuilding the property instead of paying money is given in the operative clause of most fire policies and other property insurance. Insurers rarely exercise this option, because they will be responsible for problems arising in the reconstruction process. Insurers may use the insurance money for rebuilding or reinstating building: (i) if they suspect fraud or arson; (ii) upon request of any person interested in the building.

Repair – insurers make extensive use of repairs as a method of providing indemnity (motor). Some have acquired ownership of garages.

Replacement – the most common situation where insurers choose to settle claims by replacing the insured property.

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12.3. Salvage and Abandonment

Marine insurance – there is a long established principle that, where the insured has been paid for a total loss, the insurer is entitled to claim for their own benefit anything that remains of the insured subject matter. The action of giving up the subject matter to the insurer is referred to as **abandonment** and the right of the insurer to take over the subject matter is known as **salvage**.

Constructive total loss – the subject matter is not destroyed but the insured is deprived of the possession of their ship or goods. Where there is an actual total loss under a marine policy, abandonment is automatic. In the case of a constructive total loss, the insured must serve a notice of abandonment.

Non-marine insurance – the concept of a constructive total loss is not recognized. Losses are either actual total losses or partial losses. When insurers pay an (actual) total loss under a non-marine policy, the doctrine of abandonment and salvage will apply. It supports the principle of indemnity and prevents the insured from making profit from his loss.

12.4. Effect of Claim Payments on Policy Cover

Successive partial losses – where a policy grants a fixed amount of cover, the cover reduces by the amount of any claim payment. Unless the sum insured is restored by the insured paying an extra reinstatement premium, the policy will lapse once the cover is used up.

Total losses: (i) **Termination of the policy by payment** – in some cases, such as life insurance, payment of the full sum insured will end the contract; and **Termination by destruction of the subject matter** – cover may cease automatically if there is a total loss, because the subject matter no longer exists.

13. Subrogation and Contribution

13.1. Subrogation

The principle of **subrogation** supports the principle of indemnity. Subrogation can be defined as the right of an insurer who has indemnified an insured in respect of a particular loss (i.e. paid a claim) to recover all or part of the claim payment by taking over any alternative right to indemnity which the insured possesses.

Subrogation will arise only where the insured has suffered a loss and has another means of recovering for it, i.e. a claim on their insurance policy and a legal right or claim against some other person for the same loss.

Firstly, the main purpose of subrogation is to prevent 'unjust enrichment' of the insured – in other words to prevent him from unfairly profiting from his loss and so to preserve the principle of indemnity. Thus subrogation is a doctrine in favor of insurers in order to prevent the insured from recovering more than a full indemnity.

Secondly, subrogation prevents the 'guilty' party from being 'let off the hook', and ensures that he does not escape his financial responsibilities simply because the other party has arranged insurance.

In ***Napier v. Hunter (1993)***, the House of Lords held that the subrogation implied that: (i) A duty on the part of the insured to start proceedings against a third party in order to reduce his loss; (ii) A promise by the insured to account to the insurer for moneys received from the third party; (iii) A promise by the insured to permit the insurer to exercise his right of action against the third party should the insured fail to do so himself; (iv) A promise by the insured to act in good faith when proceeding against the third party.

13.2. Operation of subrogation

The principle of subrogation can operate in two ways:

First, the insured may have actually succeeded in 'recovering for the same loss twice', i.e. collected a claim payment from his insurers and also recovered compensation for the same loss from another source.

Second, where the insured has not received compensation from another source, insurers who have indemnified the insured in respect of the loss may themselves bring an action against the third party who is legally responsible for it.

At common law the insurers must indemnify the insured (pay claim) before they can exercise subrogation rights. Insurer always includes an express subrogation clause in non-marine policies. This allows the insurers to begin proceedings against a third party before they have settled the insured's own claim.

Sharing the recovery – any recovery from a third party is shared between the insured and the insurers, depends on two factors: The amount of the recovery in relations to the loss; and Whether the insurance covers the loss in full.

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Source of abrogation rights – the doctrine of subrogation is to pass to the insurer a rights to recover from third party who is legally responsible for the loss suffered by the insured. It may arise:

Tort – subrogation rights most frequently arise in tort. The third party will have negligently damaged property belonging to the insured which is covered under the latter's property insurance. A lorry driver might negligently drive his vehicle into a building, causing damage. If the owners of the building claim for the impact damage under their property insurance, the insurer will be able to exercise subrogation rights against the lorry driver in the name of the insured.

Contract – subrogation right may exist in contract. If the insured has an alternative contractual right of recovery, in addition to that provided by his own insurance, the insurers will be able to enforce this right for their own benefit. Property insurers who pay a claim for damage to buildings may have rights of recovery against a tenant of the insured, who is legally responsible for the damage under the terms of the lease.

Statute – a recovery by way of subrogation may be founded on a statutory right belonging to the insured. The statutory right of property owners to recover damages from the police authority if their property is damaged in the course of a riot.

Subrogation gives the insurer the right to pursue a claim against a third party for the loss of the subject matter whereas abandonment and salvage confer rights only over the subject matter itself.

13.3. Modification or Denial of Subrogation Rights

Sometimes insurers agree not to enforce their subrogation right and on other occasions they are prevented by law from exercising rights of subrogation.

Market agreements – subrogation rights are often affected by general agreements between insurance companies. Insurers agree among themselves to waive their rights of subrogation against third parties. This is common where the third party himself is insured. The most well known is in the motor insurance.

Contractual waiver of obligation – insurers agree with a particular insured that they will not exercise subrogation rights against certain other parties who are associated with the insured by including in the policy a 'subrogation waiver clause'.

Co-insurance cases – two or more persons can be insured under the same policy and

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that the policy can be joint or composite. A question arises as to whether an insurance company, having indemnified one co-insured for a loss covered by the policy, can exercise subrogation rights against another co-insured who was legally responsible for the loss. In some cases there may be an express 'waiver of subrogation' clause to the effect no subrogation rights will be exercised against a co-insured.

13.4. Contribution

Contribution is corollary of the principle of indemnity which prevents the insured from '*making a profit from his loss'*. Contribution is concerned with the sharing of losses between insurers when there is double insurance. This derives from the principle that the insured cannot recover for the same loss twice and that the insurers should share the loss in a fair way.

Contribution can be defined as: "Contribution is the right of an insurer to call upon others similarly, but not necessarily equally liable to the same insured to share the cost of an indemnity payment."

Under the common law rules, the following conditions must be satisfied for contribution to arise:

- Two or more policies of indemnity exist – that is there should be two or more policies and the policies in question must be indemnity contracts. Contribution does not apply in the case of life or other non-indemnity insurances.

- Each insures the subject matter of the loss – a person may have one policy covering goods in a particular warehouse only and another policy covering goods in all warehouses. Liability policies or pecuniary insurances may be drawn into contribution where each policy covers the source of legal liability or financial loss in question.

- Each insures the peril which brings about the loss – the range of perils need not be identical, provided there is overlap between the two. An 'all risks' policy may be drawn into contribution with a fire policy where the source of loss is fire.

- Each insures the same interest in the subject matter – different interests in the same property may exist in the case of landlord and tenant, mortgagor and mortgagee or seller and purchaser of a building. If each takes out policy which cover his own interest only there will be no double insurance, therefore no contribution.

- Each policy is liable for the loss – contribution will arise only where both insurers

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can be called upon to pay under their policies. This may not be the case if one insurer has the right to avoid the contract for breach of condition.

13.4.1. Operation of contribution at common law

'**Escape**' clause – is a condition that forbids the insured from taking out another policy without the consent of the insurers. It does this by providing that the insurance will be avoided if the insured takes out any further insurance on the same risk without notifying the insurers and obtaining their consent.

Other non-contribution clause – it may not prohibit other insurances arranged without consent by simply state that there will be no liability for any loss which is insured by another policy.

'More specific insurance' clause – where a loss is covered by another more specific insurance, the policy will respond only when the cover provided by the more specific insurance has been exhausted. In other words, the policy operates like an excess of loss policy, but only where the 'primary' cover is more specific.

'Rateable proportion' clause – included in virtually all indemnity insurances. The insurers will be liable for a 'rateable proportion' only of any loss that is also insured by another policy. "If at the time of any loss, damage or liability there is any other insurance covering such incidents we will pay only our rateable proportion."

Basis of contribution – there are two main methods of calculating the ratio of contribution: (i) **Maximum liability method**: loss is shared by the insurers in proportion to the maximum amount of cover that is available under each policy (proportional method). Property is insured for $10,000 with A and $20,000 with B. In case of loss, A will pay 1/3 and B will pay 2/3; and **Independent liability method** – the liability of each insurer for the particular loss is assessed as though its policy were only one in force. The figure that results in each case represents the independent liability of the insurer for the loss. The loss is then shared in proportion to the independent liabilities of the two insurers.

Policy A	sum insured	$10,000
Policy B	sum insured	$20,000
Loss		$6,000

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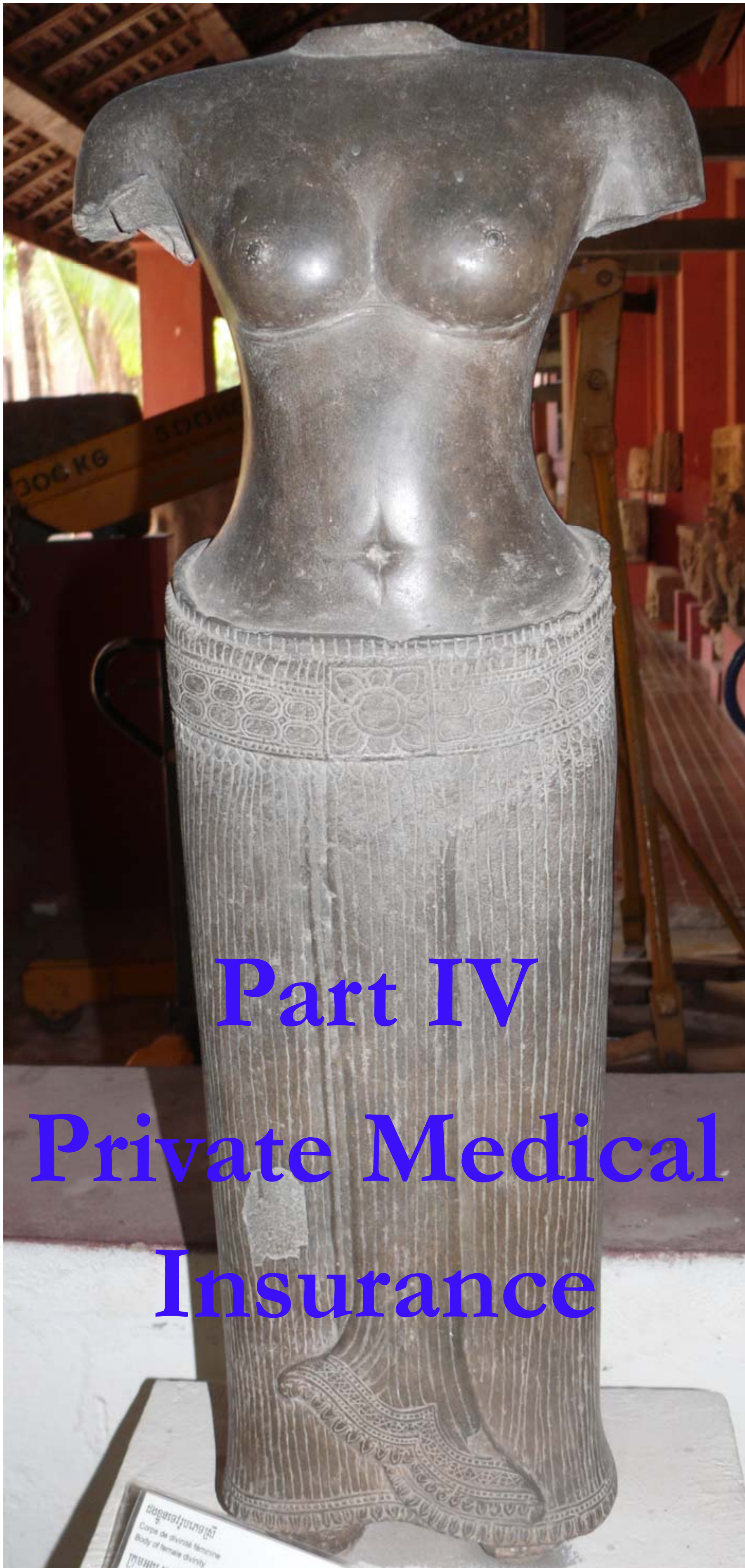

Part IV Private Medical Insurance

Part IV

Private Medical Insurance

1. Healthcare in the United Kingdom

1.1. The National Health Services (NHS)

The National Health Services (NHS) implemented in 1948. The NHS Plan 2000 sets out ten core principles for the NHS: (i)- The NHS will provide a universal service for all based on clinical need, not ability to pay; (ii) The NHS will provide a comprehensive range of services; (iii) The NHS will shape its services around the needs and preferences of individual patients, their families and cares; (iv) The NHS will respond to the different needs of different populations; (v) The NHS will work continuously to improve quality services and to minimize errors; (vi) The NHS will support and value its staff; (vii) Public funds for healthcare will be devoted solely to NHS patients; (viii) The NHS will work together with others to ensure a seamless service for patients; (ix) The NHS will help keep people healthy and work to reduce health inequalities; and (x) The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

But there are problems with the NHS: Over a million people in the UK are waiting for hospital treatment at any time; In many places it is virtually impossible to find an NHS dentist (dentistry has been largely privatized since the early 1950s); The NHS workforce is growing at 5% a year- if current trends continue, and assuming the total UK workforce remains the same size, every working person in the UK will be employed by the NHS within the next 60 years; Central management of such a large organization is virtually impossible; The population is growing older, bringing with it new challenges; Providing healthcare free at point of use may result in artificially high demands being placed on the NHS; Staff turnover is a major issue- the NHS spends £ 1.5 billion a year on replacing the 270, 000 staff that leave; The NHS is heavily reliant on recruiting medical staff from abroad; Patients are becoming more demanding and more informed (encouraged by the wide availability of health information on the internet); Reform is required, but fear of change is a significant slowing factor; and Preventative health has also played a relatively minor role, leading to higher than necessary demands for certain services. For example, obesity is a growing problem while tobacco and alcohol use can result in high levels of demand that might otherwise be avoided.

The NHS is, and will remain, an essential element in most people's lives in the UK.

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Increasingly though, the private sector will be used to deliver healthcare (as has already happened in dentistry, pharmacy and alternative therapies, for example). It does so through: Self-pay hospital treatment and operations; Long term care (although this may be funded partly or wholly by local authorities and some elements are means tested); Pharmacy (although GP surgeries and hospital also dispense prescriptions and many people qualify for free prescriptions); Private dentistry; Private GP services (although just 1 % of people have a private GP); Alternative therapies; Treatments not approved by the National Institute of Health and Clinical Excellence (NICE) (see section C2); and Medical and dental insurance and other health-related insurance policies.

1.1.1. Before the NHS

By the early twentieth century, a varied network of trade unions, friendly societies and other self-help groups provided insurance against medical risks. This was even before the first moves were made towards the establishment of State provision for the finance of public healthcare.

Lloyd George's **National Insurance Act 1911** built on these friendly society foundations to create a comprehensive scheme to provide national insurance against a range of risks for working people. In medical terms, the Act covered sickness and disability benefits, treatment by doctors in general practice and means-tested funding of hospital treatments. This cover was available to all manual and low-paid, non-manual employees for less than four old pence (approximately one new penny) per week. However, for those who better placed financially, private insurance against health risks continued alongside the **National Insurance (NI) scheme.**

In 1942 liberal politician **William Beveridge** was commissioned to head a committee to undertake a study and to produce a report on a possible national health and welfare system. This was published in 1942 as the **Beveridge Report : Social Insurance and Allied Services.** The concept was not universally supported, which was why Beveridge's name alone appeared on what was actually a committee report, but it captured the public imagination: in the first month alone, 100, 000 copies of the report were published. The NHS was established by Aneurin Bevan's **National Health Service Act 1946** and came into effect on **5 July 1948.**

1.1.2. The NHS: Its Operation and Organization

The NHS provides a comprehensive level of care. This includes: **Primary care** through GPs, opticians, dentists and other healthcare professionals; **Secondary care** through hospitals and ambulance services; and **Tertiary care** though specialist hospitals treating

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particular types of illness such as cancer.

A- Primary care

Only one out of ten patients receives their medical attention in a hospital setting, which is why the general practitioners (GP) can be regarded as the cornerstone of the NHS. Not only do GPs provide essential primary care, they also act as 'gatekeepers' to the rest of the service, referring patients, where appropriate, on to hospital or specialist treatment. In addition to GPs, a variety of other health professionals also provide a range of primary care services: Dentists; Opticians; Pharmacists; health visitors; midwives; community nurses; physiotherapists; chiropodists; occupational therapists; and speed therapists.

The key professionals in relation to private medical insurance are: General practitioners (GPs); Consultants; and other healthcare practitioners.

B- Secondary care

Some 280 major district general hospitals in the UK provide a wide range of services; from accident and emergency to maternity. These hospitals are now run as self-governing NHS trust and, increasingly, will be run as foundation trusts with greater autonomy. Traditionally, hospitals were often measured by the total number of beds. Today, however, other more relevant measures concerning the volume and quality of treatments are being taken into account.

The DH also now ranks hospitals, adopting a star based system to give patients and referring doctors and indication of the qualify of service that the hospital provides. Such table are not an absolute indicator of quality, and such data needs to be treated with caution. Patients needing surgery are now given a choice of care providers, so more information on hospitals will becomes increasingly important to patients and their families.

C- Tertiary care

In addition to the general hospitals, there are numerous centers of excellent. For example, the Christie Hospital in Manchester is one the foremost cancer hospitals in Manchester is one of the foremost cancer hospitals in the UK. Major centers in London include the Institute of Psychiatry at the Maudsley Hospital and Great Ormond Street Hospital, which is renowned for its care of sick children.

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D- Community care

The responsibility for providing long-term care for people with physical disabilities or for vulnerable members of society, such as those who are elderly, mentally ill or have learning difficulties, is shared between the NHS and local authority social services departments. While a wide range of support is in place, from residential and nursing homes to day centers, the aim is to help vulnerable people live as independently as possible in the community rather than in institutions. The NHS funds some residential care home costs and pays nursing costs on a sliding scale, but only pays the full costs where the primary need is medical. Otherwise, means testing is used to determine which patients will qualify for local authority funded care.

1.1.3. Diagnosis and Treatment

The scope of the treatment offered by the NHS, includes the treatment of both acute and chronic illnesses. The Association of British Insurers (ABI- the trade body which represents most UK insurers) defines and acute condition as: "**A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery".**

The ABI definition of a chronic condition is: "**A disease, illness or injury which has at least one of the following characteristics; It continues indefinitely and has no known cure; It comes back or is likely to come back; It is permanent; You need to be rehabilitated or specially trained to cope with it; It needs long-term monitoring, consultations, check ups, examinations or tests."**

1.2. The NHS Plan 2000

In July 2000 the Government published a White Paper called the NHS Plan setting out a programme of investment and reform for the NHS. The investment (totaling some £20 billion extra over the next three financial years) had previously been announced in the March 2000 Budget Statement by the Chancellor of the Exchequer, and was intended to bring health spending in the UK closer to the EU average.

Much of the extra investment is intended to provide more services and staff over the next decade as follows: 7,000 extra hospital beds; 100+ new hospitals; 20,000 extra nurses and 6,500 extra therapists; and 7,500 more consultants and 2,000 more GPs.

The key elements of the reform are: new contracts for consultants and GPs; new

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national standards set by the Department of Health; establishment of a Modernization Agency; maximum waiting times; free nursing care in nursing homes, greater partnership al all levels including between the NHS and Social Security staff, including the establishment of Care Trusts to commission health and social care; and greater responsibilities for nurses.

1.3. Private Healthcare and the NHS

The principal differences that define the split between the public and private sectors are: The time spent waiting for treatment (the NHS has waiting lists); Choice of facilities (usually referring to ' hotel facilities' rather than medical treatment), Choice of specialist and treatment by a specialist, not under the guidance of a specialist; Treatments using techniques or technology that may not be available though the NHS; and The availability of intensive carte back-up technology, which may not be available at certain private hospitals.

Differences often arise due to the type of treatment that is required. Such treatments include the followings:

- Emergencies—These will be sudden or unexpected illnesses or injuries that need immediate hospital attention at the accident and emergency department.
- This facility is usually provided under the NHS. Some medical insurance policies specially exclude this type of treatment, which is not widely available privately.
- Complementary or 'alternative' medicine. This includes therapies outside of 'traditional' medicine, for example acupuncture, osteopathy, chiropractic and homeopathy. These may or may not be offered by the NHS and may or may not be covered by a medical insurance policy.
- Cosmetic surgery. This is non-essential surgery that will change a person's appearance, for example, a breast implant or face lift. This will usually have to be paid for privately and is usually excluded under medical insurance polices.

2. PMI Market and Products

The main purpose of PMI is to pay the costs associated with the acute conditions of secondary care received outside the NHS; i.e. as a private patient. It usually in a hospital of their choice, at a time which is suitable for them, their families and, in many cases, their employer. They have the option of occupying a private room, which offers a

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greater degree of comfort and privacy than an NHS hospital ward and are able to choose the consultant who will provide the private medical treatment.

2.1. An Overview

The PMI market is divided into: Personal, or individually paid; Commercial, corporate or company-paid (group schemes); and Voluntary/employee-paid, or organized through a company but paid for by the individual employee.

2.1.1. Individual Products

These products cater for the individual customer who takes responsibility for arranging their own PMI cover and paying their own premiums. Cover will usually be arranged on a single, married, one parent with child/ children or family basis. The customer will usually be offered the choice of annual, quarterly and monthly payment periods, with the following range of payment methods: cash/cheque; credit card; variable direct debit; standing order (in some case). Most insurers will offer a discount of between 5 and 7.5% for annual payment in advance and some will only accept direct debit payments.

The rang of personal PMI products is roughly divided into: comprehensive; standard; budget; international.

2.1.2. Company and Corporate Products

These products cater for those employers wishing to provide all or some of their staff with PMI cover. They are generally referred to as group schemes or company-paid schemes. Usually, the employer will be offered the choice of annual, quarterly and monthly payment periods, with the following range of payment methods: cheque; variable direct debit; and standing order (in some cases). Most of the insurers will offer a discount for annual payment.

Insures generally find it convenient to divide this market into: small group schemes; and large group or corporate schemes.

2.1.3. Voluntary/ Employee-Paid Market

Voluntary schemes fall between individual and company paid products whereby an association/organization or employer whishes to offer PMI to its members or employees but does not want to pay the premiums. The members or employees will be

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responsible for paying the premiums but will normally receive a discount dependent on the size and/ or claims experience of the scheme. Invariably, the benefits offered are based on those found in the individual market, with a few minor alteration, negotiated between the insurer and the employer, or association / organization, sponsoring the scheme.

2.2. Types of PMI Products

PMI policies are generally based on the principle of indemnifying, or reimbursing, a customer or member for the costs of private medical treatment, and / or services, which they have received. This basic framework is adapted to meet the requirements of the market for which a policy is being developed and according to the needs of the customer within that market.

Many PMI insures include one, or more, health cash schemes within their product portfolios, as an alternative to the traditional indemnity policies. Health cash schemes generally provide the member with a predetermined, monetary lump sum for each day spent as a hospital impatient or day cost patient. These polices often also include payment for private outpatient treatment, dental , optical treatment and prescriptions.

2.2.1. PMI Products in the Individual Market

A- Comprehensive Policies

Comprehensive policies are invariably the 'flagship' product within a PMI insurer's product portfolio. They are sometimes referred to as 'full cost', or 'full refund' policies. They are the most expensive to purchase because they offer the widest range of benefits and services to members. In additional to covering the cost of private inpatient, outpatient and day case treatment of eligible medical conditions, they frequently include the following benefits: Treatment of mental and addictive illnesses (with the exception of alcohol and/ or drug abuse); Repatriation to the UK in the event of a medical emergency; Alternative, or complementary medicine; Dental treatment provided by a specialist (up to a specified annual amount). These are often referred to as oro-surgical operations; Optical care (up to a specified annual amount); A per night /day cash benefit if treatment is received as an NHS patient rather than taking treatment as a private patient; Provision of a guest room, for a parent to a accompany a child during a hospital stay; Home nursing services; and Private ambulance services.

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B- Standard Polices

Structurally, standard policies are similar to and offer many of the benefits available from comprehensive policies. However, certain benefits are reduced, or excluded completely, in order to contain treatment costs and to reduce premiums.

Standard polices may require patients to receive treatment in a pre-specified hospital, with which the insurer has negotiated favorable rates for accommodation and services. Outpatient benefits may be made available only which the course of treatment is directly related to an inpatient stay or day case episode.

C- Budget Policies

Budget policies enable customers to purchase a certain amount of PMI cover, for a low premium. Some budget polices are six-week schemes, so called, because the indemnity cover for the cost of eligible private treatment only becomes available when the waiting list is longer than six weeks for NHS treatment. The customer may decide to receive treatment as an NHS patient, in which care the PMI insurer may pay a cash benefit. Six week schemes can be difficult to understand because waiting list vary from area to area and even by hospital or individual consultant.

In addition to six-week schemes, limited benefit policies also come under the ' budget' heading. Such policies offer customers the opportunity to buy cover for only the more important and/or expensive types of treatment; for example, inpatient and day case costs. In order to qualify for benefit payment, treatment must usually, depending on the insurer, be received at one of a network of hospitals with which the insurer has negotiated preferable rates.

Cost are reduced by the severe limitation, or total exclusion by most insurers, of benefits such as outpatient treatment and treatment for psychiatric and addictive disorders.

The current trend in budget policies is to offer **modular** or **menu policies**. These allow customers to choose which benefits to cover. For example, a customer in budget policies is to offer **modular** or **menu policies.** These allow customers to choose which benefits to cover. For example, a customer may exclude out-patient treatment (arguing that costs are often low and so can be afforded)or exclude heart and cancer treatments, arguing that such treatments are now covered very well by the NHS, which has prioritize them in recent years.

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D- Senior Polices

The intention behind senior policies was to encourage elderly people, who are more likely to require medical treatment, to reduce the burden on the NHS by insuring themselves against the costs of private treatment. Also, senior polices were a means of encouraging retired groups scheme members, from the company paid market, to retain their PMI cover on an individual basis.

PMI contracts are usually annually and automatically renewable, provided that premiums have been paid. Some policies are age restricted, although an insurer may not refuse to renew existing cover on grounds of age. Premiums usually rise with age to reflect extra costs and increased claims.

E- International Policies

International policies provide cover against the cost of treatment required by UK expatriates or other third country national living and working abroad. In order to provide effective and reasonably priced cover, insurers may negotiate agreements with foreign hospitals to provide accommodation at guaranteed rates. Also, facilities are arranged to enable the insurer to pay claims directly to providers in their local currency.

Whilst UK PMI policies often exclude benefit payment for any form of privately obtained primary care, international polices often provide some cover (albeit often with an annual maximum entitlement) for such treatment. This is due to differences in structure and operation in may foreign countries which do not emulate the NHS/ private sector relationship which exists in the UK. Instead patients are often expected to contribute to their treatment costs. Evacuation and repatriation back to the UK or another country may also be covered, as may normal pregnancy.

2.3. PMI Products in the Company Paid Market

2.3.1. Large Group Scheme Policies

These schemes are generally intended to cover at least 50 members. Because of the nature of their composition, it is common for large group schemes to include cover for pre-existing conditions. Premiums are calculated according to the group's claims experience (called **experience rating**) over the previous twelve month period, or longer, rather than a collection of individual tabular ratings. In some cases **' cost plus' rating** applies- the premium is the cost of claims expected to be paid, plus an administration charge. Where the insurer charges a premium for each member,

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regardless of age or gender, this is called **community pricing.**

There is an extensive choice of PMI benefits and services available to the employer who is sponsoring a large group scheme. The standard PMI benefits apply; for example, full cover of inpatient and day case treatment costs. However, the employer can also take advantage of the greater flexibility of benefits structure which is available within this market and may opt to purchase cover for treatments and conditions which are normally totally excluded under the terms and conditions of PMI policy. For example, the employer may want to include the cost of treating mental and addictive conditions, the provision of personalized managed care facilities and dedicated helplines. These are all examined later on in this text.

2.3.2. Small Group Scheme Policies

These schemes generally cater for groups of less than 50 members and may also be described as **SME plans** (covering small and medium sized enterprises). The policies are usually underwritten and administered in the same way as those sold in the individual market, with the main difference being the discount structure. The amount of discount offered to the employer will depend on the size of the group and its claims history.

Underwriting is the process whereby an insurer qualifies whether a pre-existing condition affects the risk for which cover is being sought. Normally, for PMI contracts, this means that the condition, or any related condition, is totally excluded and not covered by payment of an additional extra premium.

Because of the nature of the small group scheme market, the flexibility of benefit structures and range of additional services to choose from are greatly reduced in comparison to those on offer to large group schemes.

2.3.3. Health, Healthcare or Medical Trust Policies

Insurance premium tax (IPT) increases the overall cost of PMI, particularly for large group schemes where the annual premiums often run into several thousands of pounds. In order to try and minimize the impact of IPT on large group schemes, insurers and third party administrators (TPAs) have developed complex health trust arrangements which enable employers to provide staff with PMI cover, without incurring the cost of IPT.

Instead of paying premiums to an insurer, the employer appoints trustees to whom it

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pays a sum of money. The trustees hold the money on trust and use it to provide healthcare benefits for the employees. The trustees are responsible for the trust's administration, as well as handling and paying claims. The cost of IPT is avoided because the trustees are not considered to be conducting insurance business.

As the employer is ultimately responsible for funding the trust, the trustees may decide to purchase stop loss insurance, the purpose of which is to meet the cost of treatment over and above that for which the employer is prepared to pay during any twelve month period. By this arrangement, the insurer agrees to meet all the eligible costs of private treatment which during a twelve month period exceeds the previously agreed amount.

As IPT is payable on the stop loss premium, a health trust would normally only be an advantage to a large group scheme, as the smaller the trust, the greater the relative cost of stop loss cover and setting up and administering the trust.

2.3.4. PMI Products in the Voluntary/Employee-Paid Market

Voluntary, or employee-paid policies, enable an employer, or association/organization, to offer PMI cover to groups of employees (or, in the case of an association/ organization, its membership) and their dependants, without having to take responsibility for paying premiums. Members of such groups generally pay their own premiums, by payroll deduction, via the employer. For employers, in particular, voluntary schemes are the means of providing PMI to those members of staff who do not qualify for membership of a company-paid scheme.

Because the policies found in this market are sponsored by employers or associations/ organizations, the premiums are usually subject to discounting. The amount of the discount will depend on the size of the group's membership and/or its claims experience.

2.4. General Terms and Conditions of PMI Products

The terms and conditions (or scheme rules) provide the framework on which the contract is constructed, administered, funded, renewed and terminated. The terms and conditions generally follow a similar pattern and format, regardless of which PMI market they are written for.

Contracts normally comprise the following: Terms and conditions; Table of benefits; Application form; and Policies documents, including any individual exclusion of

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benefits applied by underwriters. In the case of large group schemes, the standard terms and conditions are usually supported by a supplement, or schedule.

2.4.1. Regulation/Legislation Affecting Terms and Conditions

A- European Union (EU) Unfair Terms in Consumer Contracts Directive

On 1 July 1995 the European Union's (EU) Unfair Terms in Consumer Contracts Directive came into force and, unlikely the **Unfair Contract Terms Act 19977,** The financial services industry (including PMI) is included in its provision. Essentially, the EU Directive requires PMI insurers to issue terms and conditions that are written in plain, straightforward language and which do not put the customer in a disadvantageous position. The ABI Code of Practice, mentioned above, also seeks to reinforce this.

B- OFT's Health Insurance Reports

The Office of Fair Trading (OFT) report on health insurance published in July 1996, looked at for main areas: PMI; PHI/income protection; Critical illness insurance; and Long-term care insurance.

The recommendations for PMI were: PMI plans should be presented in a common format, and- like other contracts- in clearly understandable language, and an approach should be developed to enable a ready comparison to be drawn between plans, possibly based on **common core benefits;** PMI providers should abandon the moratoria approach to underwriting; There should be a warning about likely increases in PMI premiums; All protocols of care practices should be drawn up within a common framework, guided by an industry body and the Department of Health. NHS trusts and insurers should publicize their protocols on best practices.

In May 1998, the OFT published a second reporting giving the industry just for months to act on the recommendations in its earlier report. This has included: An ABI guide for consumers. The guide must be given to clients before they make their final decision to buy; PMI product outlines, which enable products to be compared more easily; PMI providers offering moratorium underwriting must now offer full medical underwriting as an alternative; a new draft statement of practice on selling PMI is being developed to replace the exiting code of practice on general insurance.

C- Disability Discrimination Act 1995

The Disability Discrimination Act 1995 is wide ranging in its scope and gives disabled

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people new rights in the following areas: Employment; Access to goods, facilities and services (including insurance); Buying or renting land or property. The underlying principles of the Act are: disabled people should not be treated less favorably than those whom are not disabled; employers, providers of services, property landlords etc. must be able to justify discrimination against a disabled person, if and when this occurs.

The regulations recognize the need for insurers to be able to distinguish between individuals on the basis of the risk they are seeking to insure. Therefore, insurers will be able to justify less favorable treatment of a disabled person if their action is based on relevant: actuarial data; statistical data; other information on which it is reasonable to rely (e.g. medical reports).

According to the Act, an individual is disabled if they have a physical or mental impairment having an effect which is substantial (not just trivial or minor), long-term and adverse to their ability to carry out one of the following normal day to day activities: mobility; manual dexterity; physical co-ordination; continence; ability to lift, carry or otherwise mover everyday objects; speech, hearing or eyesight; memory, or ability to concentrate, learn or understand; perception of the risk of physical danger.

The following conditions are excluded from the provisions of the act: addiction to, or dependency on, alcohol, nicotine, or any other substance (unless medically prescribed); seasonal allergic rhinitis, except where it aggravates the effect of another impairment; tendency to set fires; tendency to steal; tendency to physical/sexual abuse of others; disfigurements due to tattoos, body piercing etc; and voyeurism.

2.4.2. Key Stages of a Contract

A- Enrolment

This section will cover the following: the criteria and processes for qualifying as a member (including cover for dependants); the contractual position concerning addition of dependants to an existing contract, including coverage of a newly born child; the 'cooling –off period' (i.e. the time a policyholder has between signing the contract and deciding to terminate without incurring any penalty). This is sometimes included in the marketing literature. Under English law the 'cooling-off period' must be at least 124 days.

B- Renewal

This section will cover the following: How the contract should be renewed; The

frequency of renewal (this is usually annually); The minimum amount of notice a policyholder will be given of the approaching renewal; The consequences of the policy not being renewed (i.e. membership will cease).

C- Premiums

This section will cover the following: When the premium should be paid; By what method; and the frequency.

D- Termination will cover the following:

This explains how the policyholder, or the insurers, may terminate the contract and any penalties that may be incurred for doing so by the party instigating the termination. Some of the reasons for an insurer terminating the contract may be due to the policyholder: Misleading the insurer regarding any material information relevant to the extent of cover purchased (e.g. not disclosing pre-existing medical conditions at the time of applying for cover); Falling to pay premiums on, or before their due date; and Falling to renew membership.

E- General Rules on Benefits

This section explains the contractual position relating to the provision of PMI benefits and will normally cover such issues as: Benefits being conditional on the patient being referred for specialist treatment, on the recommendation of their General Practitioner; Settlement of accounts directly with the medical provider concerned; and The effect of any excesses applied to the policy.

F- Exclusions

The most conditions are treatment excluded by PMI terms and conditions are:

- Pre-existing conditions (i.e.. An illness or physical condition already diagnosed or treated prior to PMI cover commencing). The pre-existing condition clause is intended to ensure that all members receive cover on an equitable basis;
- Mental and addictive conditions and disorders. Most insurers will make provision for benefits to be paid on a discretionary basis;
- Pregnancy and childbirth. Some insurers will cover delivery by caesarean section and/ or defined 'complications of pregnancy', providing it is medically necessary

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and occurs more than twelve months after the mother's PMI cover commenced;

- Mental and addictive conditions and disorders. Most insurers will make provision for benefits to be paid on a discretionary basis, albeit in certain, closely monitored situations. Treatment will invariably need to be pre-authorized with the insurer and, if agreed, will only be payable for a specified period;

- Treatment for illness or injury resulting from nuclear or chemical contamination, war, invasion, acts of foreign enemies, hostilities (whether war be declare or not), civil war, rebellion, revolution, insurrection or military or usurped power.

- Renal dialysis. Some insurers qualify this exclusion by stating that renal dialysis will be covered in situations where it is needed for the immediate purpose of kidney transplant or in connection with immediate management of acute secondary renal failure.

- Treatment intended to relieve conditions associated with bodily change which arise from physiological or natural causes, such as Hormone Replacement Thereby (HRT) linked to the female menopause, ageing, puberty etc;

- Treatment provided by an individual who is not recognized as a specialist by the insurer;

- Dental or oral surgery;

- Treatment of chronic conditions (other than acute episodes).

G- Claims

The contractual arrangements for making and paying claims are laid down. Normally this section will address the following issues: The claimant providing original accounts and receipts in support of a claim; The claim being made on the insurer's prescribed form; and The need for premiums to be paid to date before claims are assessed.

H- Alterations to the Contract

Typical examples of possible alterations to the contract are: The insurer changing, for commercial and/ or legislative reasons, the terms and conditions (including premium rates); and Policyholder wishing to transfer cover to another PMI product offered by the same insurers, or wishing to change their scale of cover.

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2.5. Serving the Customer

2.5.1. Membership Helplines

There have been many innovations in the area of helplines namely: Customer helplines; Specific helplines; and Medical helplines.

A- Customer Helplines

The helpline service has generally been extended where most PMI insurers offer a national telephone number which enables any body to call the helpline from any where in the UK and only pay local charging rates for the cost of the call.

B- Specific Help or Equivalent Lines

Larger commercial schemes may be provided with a specific helpline with an 0800 or equivalent prefix that provides an entirely free call from anywhere in the UK except from some mobile the incoming number displayed on their consuls and answer with a personalized greeting or customized message.

C- Medical Helplines

Some insurers provide access to 'personal health advisors' who are able to provide advice to members on health-related issues or guide them through procedures for receiving treatment of making claim. These services may be extended to 24-hour medical helplines providing access to medically qualified staff. The concept has now been adopted by the Government through the NHS Direct service, which will also allow primary care appointments to be booked. It is likely that insurer led helplines will differentiate themselves from NHS Direct by for example, giving more in-dept advice and information on medical conditions.

2.5.2. Customer Services and Technology

The installation of sophisticated computerized telephone switchboards such as Automatic Call Distribution (ACD) together with telephone services offered with in-house computer systems and functions, sometimes deferred to as Computerized Telephony Integration (CTI), is a fast developing are of technology and many PMI insurers are making substantial investments in these areas in order to gain competitive advantage, raise standards of customer service whilst also aiming to lower costs.

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A- Automatic Call Distribution (ACD)

ACD equipment is a computerized telephone switchboard that offers an enhanced range of services over conventional equipment. Most organizations of any size will now have an ACD switchboard. They provide for the automatic re-routing of calls to an area where resource is available to respond to calls.

Comprehensive status checks and individual staff productivity figures would be maintained by the ACD equipment together with data on the incidence, frequency and duration of calls answered together with data on calls lost where all lines may have been engaged or all available staff occupied. Priority queuing and call answering is another feature with callers provided with information as to their place in the answering queue.

B- Computerized Telephony Integration (CTI)

CTI builds on the facilities of ACD equipment and is an area where rapid advances are being made in the harnessing of technology to further improve customer services. For example, in the area of predictive dialing which is particularly useful in areas such as telesales or for activating such as welcoming calls. Predictive dialing enables a computer linked to a switchboard to be programmed with a database of numbers to call. The system would automatically dial the number and only when a human answer is obtained would the cal then be directed to an operator for the conservation to start. An operator in this context is sometimes referred to as an 'agent'.

The use of CTI improves staff productivity as it avoids misdialing and connection to remote answer phones. It also enables each call to be directed to the next available agent. The system may be able to display on the console details of the person being called to assist the agent during conversation

2.5.3. Continual Focus on Customer Service Level

Some insurers have worked hard to achieve the internationally recognized British Standard European Number International Standards Organization (BS EN ISO 9002: 1994). Its purpose is to provide a total quality management system to ensure delivery of a 'quality product' to prospective customers. The accreditation was originally designed for manufacturing purposes. However, over the past eight years. Companies from the sectors have adopted ISO procedures and applied for quality accreditation.

BS EN ISO 9002:1994 requires the implementation of quality procedures and guidelines, as part of the total quality management system. Procedures and guidelines

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are open to audit and an external assessor will look for most of the '20 quality system requirements' which include: Management responsibility; Internal quality audits; Training; Statistical techniques.

2.6. Arbitration

2.6.1. Internal Procedures

Each insurer will have its own internal procedures for handling disputers. This will normally be a named official (often the chief executive officer) to whom any compliant may be addressed. That individual will then arrange for the complaint to be investigated and for a formal reply to be sent to the complainant. The complainant will then be advised of any further right that they may have. This now includes the right to complain to the Financial Ombudsman Service if the complaint cannot be satisfactorily concluded.

The FOS adopted the best practices of the previous eight separate ombudsmen and complaints handling schemes. The key features of the service are as follows: Complaints may be heard from individuals or small firms (with up to £1m turnover); A complaint must be made within six months of the date by which the firm advises the complainant that they may refer their complaint to the FOS. The compliant must usually be made within six years of the event upon which the compliant to the FOS. The must usually be make within six years of the event upon which the compliant is founded; The maximum award the FOS may make is £100,000; FOS findings are binding on insurers but not on complaints, who still have the right to go to the law; FOS ombudsmen are not bound by the law only. An award may be made even where the complaint has no case in law. A key element of the FOS scheme is that ombudsmen can make decisions in favor of a customer, even where they may have no legal case. The aim is to ensure that customers are treated fairly and that the law is not used as an excuse to avoid paying fair claims.

The FOS Scheme is funded in two ways: a general levy paid by all firms conducting general insurance activities, based on their relevant gross premium income; and a case fee payable by the firm to which the complaint relates.

3. Benefit Design and Structure

3.1. Relationship between PMI Insurers and the NHS

PMI products are intended to supplement and complement NHS provisions, not to replace them in entirety. The structure of products reflects this interdependence and

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offers coverage which supplements the NHS. PMI benefits provide access to both medical and surgical treatment, concentrating on a number of areas where NHS provision is considered to be lacking: Waiting times for non-urgent (elective) operations/condition (e.g. hip replacement, hernia repairs, varicose veins); Choice of consultant; Choice of admission date; Choice of hospital; 'hotel' accommodation offered by private hospitals (e.g. private rooms, often with en suite bathroom, television, telephone etc.); and Peace of mind

The main scope of PMI cover is treatment of non-life threatening conditions where are long waiting times for NHS treatment. However, PMI also provides cover for other areas, e.g. cancer treatment (oncology), cardiac surgery and strokes. There has also been an increase in the complexity of procedures carried out. The NHS remains the main providers of accident and emergency treatment (A&E).

PMI benefit often exclude a number of conditions and this means that NHS treatment is essential for those people who cannot afford to pay for private treatment. Common exclusion are: Pregnancy and childbirth (where complications are not experienced); Cosmetic surgery (where surgery is performed to enhance, rather to restore, a person's appearance); Routine dental treatment; Long-term conditions (sometimes referred to as 'chronic conditions'); and Treatment for mental and/ or addictive conditions.

3.1.1. Purpose of PMI

The benefits reflect the underlying purpose of PMI which is to provide cover against the cost of non-emergency secondary healthcare. PMI does not cover primary care provided by dentist or General Practitioners (GP) or the functions which support them (e.g. practice nurses). Most people with PMI have an NHS GP, and their access to private treatment is usually only a available via this GP. Although dentistry is also NHS GP, many people now pay for dentistry privately or through a dental insurance or capitation scheme.

PMI aims to provide cover for '' acute' illness, or injury, which requires relatively short-term treatment which, in turn, leads to recovery.

A- Definitions of Eligible Treatment

Acute condition—A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness of injury, or which leads to you full recovery.

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Chronic condition—A disease, illness or injury which has at least one of the following characteristics: It continues indefinitely and has no known cure; It comes back or is likely to come back; It is permanent; You need to be rehabilitated or specially trained to cope with it; or It needs long-term monitoring, consultations, check ups, examinations or tests.

Day-patient treatment—Treatment which, for medical reasons, means you have to go into a hospital or day-patient unit because you need a period of clinically-supervised recovery but do not have to stay overnight.

Diagnostic tests—Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

In-patient treatment—Treatment which, for medical reasons, means that you have to stay in hospital overnight or longer.

Out-patient treatment—Treatment given at a hospital consulting room or out-patient clinic where you do not go in for a day-patient or in-patient treatment.

Pre-existing condition—Any disease, illness or injury for which: You have received medication, advice or treatment; or You have experienced symptoms; Whether the condition has been diagnosed or not in the xx years before the start of your cover (the same period is not common to all insurers).

Treatment—Surgical or medical services (include diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.

3.2. Key Elements of PMI Benefit Design

The core PMI benefits comprise the following:

3.2.1. Hospital Charges

This benefit makes provision for paying hospital charges made in respect of private inpatient and day case treatment, the key elements being: Accommodation and nursing; Theater fees; Diagnostics (x-ray and pathology); Drugs and dressings; and Prostheses.

3.2.2. Hospital Networks

The concept has been developed to become generally known as a hospital network and

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offers the following advantages: Insurers can often negotiate more attractive pricing and fixed cost treatment, especially where one hospital has the prospect of treatment patients who might otherwise be treated in a competitor hospital; Insurers may be able to negotiate upgraded facilities for their patients; Insurers can influence the over-supply of beds by choosing to support only the most efficient hospitals; Insurers may seek to improve quality standards by only including hospitals on their network that meet strict quality standards; Policy holders benefit from any cost savings that the insurer can achieve, in the form of lower premiums or smaller premium increases in future; Less efficient hospitals; Those operated by small charities that may be unable to raise funds to pay for expensive modernization or equipment; and Those that lose out to similar hospitals nearby being unable or unwilling to compete with them on price.

3.2.3. Surgeon and Anesthetist Fees for Surgical Procedures

Two of the most significant elements of any surgical treatment are the fees charged by the surgeon and anesthetist for carrying out the operation (commonly referred to as the 'surgical procedure'). Some insurers classify each operation according to its complexity, normally using the following categories of classification: Minor (e.g. remove of a skin lesion); Intermediate (e.g. removal of the impacted, buried or unerupted teeth); Major (e.g. hysterectomy); Major plus (e.g. total hip replacement); and Complex major (e.g. heart valve replacement).

There are a number of ways in which surgeon and anesthetist fees are reimbursed and these are:

- **Full refund of all fees considered 'reasonable and customary' -** The insurer guarantees to cover, in full, the fees charged by the surgeon and anesthetist, provided that these are within a range that the insurer considers to be 'reasonable and customary', it will either shortfall the claim, or negotiate an acceptable level of reimbursement with the surgeon or anesthetist.

- **Specified benefits level for the combined surgeon and anesthesia fees—**The insurer specified the amount that they will pay for the surgeon and anesthetist individually, based on the classification of the procedure;

- **Surgeons' and anesthetists' fee paid as part of an overall single price—** insurers will negotiate a single price for a procedure with a hospital. This will include all costs, regardless of how long the patient spends in hospital. In such case, the hospital will either employ the surgeon and anesthetist direct or agree a fixed fee with them.

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3.2.4. Consultant Networks

At least one major PMI provider now operates a consultant network. However, the aim is to encourage consultants to agree to certain rules, rather than to adopt a restricted list of consultants. Primarily, those rules are likely to include the consultant agreeing to: Charge fees within the insurer's normal maxima; Engage in clinical audit and continuing medical education; Adopt a good practice; Summit claims direct to the insurer, not the patient; Participate in clinical governance initiatives; and Adopt the highest professional standards.

3.2.5. Physicians' Fees for Medical Care

Insurers will either provide a full refund of 'reasonable and customary' fees, or specify a maximum benefit limit, usually calculated on a daily, or weekly basis. As for surgeon and anesthetist fees, one or two insurers offer a full refund with no qualification.

Insurers may sometimes consider making an additional payment to physicians who are involved in treating PMI members suffering from major medical illnesses which require the physician to attend the patient frequently (e.g. heart attack and pneumonia).

3.2.6. Outpatient Charges

This benefit makes provision for paying charges made in respect of private outpatient treatment, the key elements being: consultations/surgical procedures/diagnostics; MRI/CT scants/radiotherapy/chemotherapy; and Physiotherapy and other therapies.

Outpatient charges are one of the most variable areas of PMI benefit. It is often used by insurers as a means of differentiating between comprehensive and budget products.

3.2.7. Cancer Treatment (Oncology)

This benefit makes provision for paying charges made in respect of private cancer treatment, the key elements being: Drugs; and Specialist fees. Oncology may be incorporated into the standard benefits offered by the insurer and, as a result, will be covered. However, some insurers have developed a separate benefit or oncology to cover the costs of chemotherapy and radiotherapy. Normally, a full refund of the cost of any cancer (cytotoxic) drugs and tests associated with the chemotherapy and radiotherapy, will be met in full. The fees charged by the specialist is subject to a benefit maximum, per course of treatment. The insurer defines what is meant by a course of

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treatment (e.g. The number of radiotherapy sessions provided over a specified period of time).

3.3. PMI Coverage of Long-Term and Incurable Conditions

3.3.1. Acute Appendicitis

A patient has severe pain, requires admission to hospital, undergoes a surgical procedure from which the recovery period is a number of weeks after which the patient is restored to previous health. This acute episode of illness would be covered by PMI.

3.3.2. Osteoarthritis

Osteoarthritis causes a person to become increasingly disabled and may require at its most severe for example, a hip replacement. The insurer would regard the severity of the disease, at the time a hip replacement is required, to be an acute episode and the costs of surgery would be covered.

3.3.3. Diabetes

Diabetes is controlled either by dietary management, or daily administration of insulin. This management can often be carried out under the supervision of a GP. However, acute episodes may arise during the course of long-term/chronic debates. For example, the patient's condition may deteriorate to the extent threat admission to hospital is necessary. In this situation, the admission would be covered by the insurer, but once the patient's condition was stabilized to a level at which they were able to return home no further benefit would be paid.

3.3.4. Alzheimer's disease

Alzheimer's disease is a degenerative disease of the brain leading to dementia and for which there is currently no cure. Care of the patient would normally be custodial, i.e. general nursing care and establishing medication. This condition is not normally covered by PMI.

3.3.5. Cancer

Dependent upon the stage at which cancer is diagnosed, it may be considered to be an acute illness (curable in may cases) or terminal (incurable). PMI covers the acute

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treatment of cancer as described under' oncology', and would also cover surgical interventions to treatment cancer. Active treatment of the cancer will continue until a terminal diagnosis has been given. The terminal phase of cancer can vary in duration. Therefore, insurers will often manage these case on an individual basis. Many insurers will allow benefit towards a period of terminal care.

3.4. Flexibility of Benefit Packages

In an increasingly competitive market, the benefits offered by an insurer are an essential factor in differentiating one company's products from another's. The comprehensiveness of benefits offered on PMI policy are a key differentiator when compared with the price charge for cover. The ability of the insurer to provide flexibility to meet the needs of the customer is also a very important factor.

Another means of differentiation is the quality of service and administration that the insurer provides. It is becoming increasingly common within the commercial market for the insurer to: Produce personalized literature; Provide dedicated helplines; Provide access to nurses for medical advise; and Define and agree service levels relating to handling questions and timely settlement of claims.

Typical examples of the flexibility offered to commercial clients are as follows:

- **Nomination of single preferred hospital**—Employer who may be located at one site, or have several large offices/factories in a limited number of sites, may choose to nominate a single, local hospital for use by employees at each site. This guaranteed volume of business then enables the insurer to negotiate a preferential rate for the hospital costs of any treatment;

- **Pre-authorization—**In order to help control their PMI costs, clients may choose to have all claims pre-authorized by the insurer. This intervention, usually by a team of nurses, is an example of how the principles of managed care are used to help control costs;

- **Co-payments—**Some commercial and individual costumers choose co-payments whereby the insured person is required to pay a percentage of the costs of any claim. This may be a specified limit, for example, 10% of all costs up to an annual maximum of £2,000 per person.

- **Overseas cover—**PMI benefits are designed to cover the cost of treatment received within the UK and as such may be inadequate to cover overseas treatment. International PMI products exist which are more appropriate.

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- **Complementary medicine—**Customers may choose to cover complementary medicines such as acupuncture, chiropractic, homeopathy and osteopathy.

- **Full refund of all costs—**For the most senior of its executives, an employer may select, and pay appropriate premiums for, a full refund of all costs, even if the insurer does not usually offer this as one of their standard products options.

- **Discretionary benefit option (DBO) -** DBOs offer the employer the opportunity to provide its employees with a full refund on a discretionary basis. For an increased premium, an employer can supplement the standard benefit package. On each occasion when a claim is not being paid in full by the insured, the employer can decide whether they wish to pay the shortfall themselves.

- **Employee assistance programmes (EAP) -** Employers can now offer an EAP as part of the menu of benefits available to employees. An EAP officers employees access to services including a confidential counseling service for a range of issues such as: dept and financial worries; family and domestic issues; mental and addictive illness; and legal advice.

3.4.1. Flex Schemes

Flexible benefits or flex schemes aim to offer employees maximum choice on their employee benefits package so as to take account of their personal circumstances and wants. Typically a flex scheme will include a range of core benefits which every employee gets. To that a menu of other benefits will be offered. Those additional benefits may be paid for from a pool of money available to the employee or by paying for them direct fro their salary. Once a year, or more frequently, the employee may choose to change their benefits package, e.g. on marriage or having a child.

The range of employee benefits that may be included within a flex scheme could incorporate: PMI; Income protection; Additional pension benefits; Life assurance; Critical illness cover; Health cash plan; Dental insurance; Holiday entitlement; Company car; and Salary (what is not spent on benefits may be taken as salary instead).

3.4.2. Benefits for Services Other Than Medical Treatment

- Home nursing—Benefits are available for nursing provided at the patient's home, normally following inpatient or day case care. There is usually an annual benefit maximum applied and /or a limited number of visits allowed.

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- Maternity grants—Cover is not usually provided for normal pregnancy or childbirth although some top of the range plans include a significant contribution towards private maternity costs. However, a number of insurers have introduced a maternity grant where a cash sum is paid on the birth of a child, which can be used in any way.

- NHS cash benefit—Some members may prefer to receive NHS treatment (e.g. where no waiting list applies). This benefit provides the member with a cash payment for each night (and in some cases each day) that the member receives NHS treatment as an inpatient.

- Ambulance cover—Cover may be provided for the use of road ambulances where this is medically necessary, either from home to hospital, between hospitals, or from hospital to home.

- Overseas cover—Many insures will also allow benefits for emergency treatment overseas. Repatriation and evacuation benefit may also be linked to this.

- Complementary medicine—Acupuncture; Chiropractic; Homeopathy; and Osteopathy.

- Health Screening—Increasing public awareness of health-related issues has resulted in an annual, or bi-annual, health screening being offered by many insurers. Other insurers may not cover the cost of a health screen, but may offer discounted rates instead.

- Travel insurance—The logic for including travel insurance is that it pays for emergency medical and dental treatment abroad.

- Dental and optical cash benefits—A number of products offering cash benefits towards a variety of medical expenses have been in the market place for some time. Alternatively, a health cash plan scheme may operate.

- Psychiatric cover—Some of the more comprehensive plans offer cover for the diagnosis and treatment of such conditions as depression. Treatment in hospital may be limited in duration and must be agreed between the insurer and specialist before treatment commences.

- Critical illness cover—Although many serous acute conditions can be treated, there are often lengthy periods of convalescence (in some instances the patient may never return to work). Such circumstances may well be accompanied by financial problems for the client and whilst it is possible to cover such eventualities by means

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of other insurance arrangements such as income protection and critical illness (CI). These plans pay a defended benefit in the form of a tax free lump sum (usually £10,000) should the insured life be alive 28 days following the diagnosis of a defined level of a named critical condition. These conditions are cancer, heart attack, kidney failure, dementia, motor neuron disease, multiple sclerosis, total paralysis, Parkinson's disease, stroke and acceptance o to the official NHS waiting list for a major organ transplant.

4. Risk Assessment

4.1. Assessment

Risk Assessment – consists of underwriting and pricing factors. **Underwriting** consists of reducing the differences of members by excluding impairment. It is designed to put all members on equal footing with the insurer at the start; **Pricing factors** – certain members have higher risk, due to: age, medical history; occupation; product; smoking; scale of hospital; no claims discount; loyalty discount; individual pricing;

Insurance pricing – premiums consist of : Risk premium; and Expense loading – added to the claims cost to cover administrative charges by: load factor (+20%) or flat load ($100). Expense loading include: (a) acquisition and maintenance costs; (b) return on capital; (c) protection against statistical fluctuations; (d) taxation and regulatory costs.

Actuary – determines appropriate premiums for sub-groups of members. Risk will vary depending on demographic (sex, occupation), lifestyle and medical factors.

Underwriter – (i) responsible for assessing and classifying the risk according to medical history; and (ii) ensuring conformity between the actual claims experience and the claims estimated by the actuary.

Pricing principles and practice – there are two methods of pricing: (i) strategic pricing driven by financial plan and profit target; and (ii) pricing differentials related to various prices for different members of the groups (tactical decision).

Pricing analysis – combination of ratios and testing significance of new pricing factors and the independent effects of pricing factors. The more paid out of the claims on particular risk, the higher the premium.

Differential pricing – the process of deciding the differential prices involves the combination of data, the analysis and judgment.

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Competitive comparisons – when compared the prices of competitor's products, it is distorted by discounts; new entrants are more competitively priced, as new business is more profitable. Competitor's published prices are different from the prices quoted to clients.

Product development (prototyping) – for development of new products. It includes anticipated volumes, recommended premiums, claims projections, estimated expense, competitor analysis and balance between good and bad risks. Insurer should consider the methods of distribution, administration, marketing and product specification.

4.2. Pricing Commercial Business

Three main elements of pricing commercial business are: **Business strategy** – forecasts of changes in market trends, anticipated competitor, product to be sold and how, profit margins and annual operating plans; **Pure pricing model** – investigation of risk factors and making adjustments; and **Making the process** – identify the limits of authority and discretion associated with pricing.

Pricing mechanism – premium quoted for new business based on: who will be covered; age profile of the group or age specific pricing; sale of cover; claims experience; method of payment; area of cover; which hospital can be excluded; additional risk factors.

Pricing formula – a margin will be built into calculation: **Administrative costs (marketing, customer services, claims)**; **FSA levies**; **Risk premiums**; **IPT**; and **Profit**.

There are two methods: Explicit calculation ($10 per policy); and Target loss ratio (TLR); margin = claim fund x (1 – TLR/TLR);

Claims fund can be calculated based on: current claims history; weight the historical claims; predict the claims funds (claims fund = claims to date x conversion factor, i.e. n x 12/n + [1+inflation])

Other risk premium or pricing adjustments include benefits; stop loss factors; profit share; long-term contract; cost plus; co-funding.

4.3. Dental Insurance

Dental insurance offers more flexibility in that you get to choose your dentist. You can claim for treatment whether you use a NHS dentist or go private. Generally, you will

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pay the dentist for your treatment and claim the money back from your insurer. Premiums are based on your age and can vary widely, so shop around.

Dental policies often will not pay for the full cost of your treatment. Most policies set maximum payouts in any 12-month period and some will only pay 75% of the treatment with an annual maximum cap.

Dental insurance will pay for general treatment such as **crowns, root canal work, bridges, dentures and other laboratory work up to the maximum annual limits**.

Exclusions: include cosmetic work and orthodontic treatment such as braces and implants. Treatment of oral cancer, surgical removal of roots, treatments on salivary glands and serious dental abscesses are excluded.

Capitation schemes—These schemes allow you to pay on a monthly basis instead of settling a bill each time. The premium is determined after you have consulted a dentist. It covers regular treatment, including check-ups and can also cover fillings, X-rays and extractions. They are ideal if your teeth are in good health and you just need them to be maintained.

Underwriting—The underwriting function attempts to reduce differences in groups of members by excluding cover for impairments which the member already has. This puts all members on a consistent footing at the start of their relationship with an insurer.

Pricing factors—Insurers will be aware that some groups of members will be a higher risk than others. For example, members purchasing products with high cover limits, i.e. the more expensive products, or those of higher age are more likely to make a claim.

5. Underwriting PMI

5.1. Application of Medical Underwriting in PMI

Details of previous and existing medical conditions, with the associate likelihood of further treatment and expense, are relevant to the insurer in determining the terms on which the applicant will be accepted (e.g. will benefit be excluded for treatment of any condition disclosed at the time of application?) Applicants who have a history of ill-health, or a pre-existing medical condition, are more likely to require treatment in the future this incurring costs to the insurer.

Insurers can detect non-disclosure through their claims systems which compare the length of membership of the scheme with the condition for which treatment is being claimed. If a member claims early in the PMI membership, the insurer will often

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investigate to establish whether it may be a pre-exiting condition and therefore non-disclosure.

5.1.1. Detection of Non-Disclosure at Point of Claim

Claims for medical conditions that usually involve protracted periods of onset and development are usually rejected, or suspended, by claims systems. The enables manual review of the claims where the full circumstances are investigated. This involves through research to establish the date of onset of the medical condition which is the subject of the claim. This process involves a second review of the application form to determine whether the condition was declared by the applicant, but the risk accepted by the underwriter. In these circumstances, the insurer will usually accept liability for the claim.

5.1.2. Obtaining Medical Information from GPs

Where the medical condition was not declared on the application form enquiries will be made of the claimant's GP, to determine when the doctor was first consulting by the claimant in relation to the condition in question. This information will be sought in accordance with the Access to Medical Reports Act 1988 and the Access to Health Records Act 1990. These Acts state that application forms should include a statement confirming the confidential nature of the information which has been declared by the customer and the need for the insurer to obtain the customer's written consent to contact their GP, or other medical practitioner, for further information.

A further statement explains that non-disclosure of a material fact many nullify the policy and a paragraph is usually included stating that the member has read and understands the rules of the policy. GPs are bound under their professional code of conduct to respond truthfully and accurately to any requests for information.

In the event that further medical evidence is required the insurer would write to the client advising the requirement and requesting written permission to approach the GP and advising the client of their rights under the Medical Reports Act.

The client has the right to withhold consent in which case it is unlikely that the insurer would proceed with the application. The client is able to see the report before the GP issues it. In this case the insurer will advise the GP and the client has 21 days in which to contact the doctor to examine and discuss the report and give permission for it to be issued to the insurer. If the client feels that the report is incorrect or misleading, the client can request that their GP amends the content. In the event that the GP declines

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this request, then a statement of the disputed content would be sent to the insurer which would influence the underwriting decision.

If the client fails to meet the 21 day deadline, the GP will forward the report to the insurer. If the client does not wish to see the report, no delays are encountered. However, if the client subsequently wished to examine the report (usually as a result of the underwriting decision), they have the right to see the content up to six months from the date of the issue of the original report. The doctor has the right to withhold the content to the report from their client if they believe that the detail would cause their client harm either physically or mentally.

5.2. Principal Methods of Underwriting

Although there are a number of alternative methods of understanding in the PMI sector, there are some common features. The principal underwriting methods are as follows: Use of standard, or general exclusions; Moratoria underwriting; Declared medical history; Switch underwriting; Personal underwriting.

5.2.1. Use of Standard Exclusions

The following standard exclusions apply to most types of PMI polices: Pre-existing conditions; Pregnancy or childbirth including termination; Attributable to Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS); Alcohol, solvent or drug abuse; Cosmetic surgery, Drugs and dressings other than those prescribed by the specialist during inpatient/day case treatment; War invasion or civil riot; and Private GP treatment.

5.2.2. Moratoria Underwriting

Moratoria underwriting (often referred to as 'point of claim underwriting') enables the PMI policy to be purchased with a minimum of formality. The costs of treatment for pre-existing conditions are excluded. The applicant does not have to declare their medical history at the time of joining the scheme. Moratoria underwriting lends itself to direct selling, as applicants may be covered immediately rather than being subject to underwriting of their declared medical history.

For the insurer, it is administratively easy, as underwriting a new application is not required at the point of joining. Insurers that offer moratoria underwriting must now offer new applicants the choice of either moratoria underwriting, or full medical history declaration.

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Whilst ease of administration is an attraction for the insurer there are also disadvantages. It is not always clear what is covered under the policy and the limitations that apply to pre-existing conditions may lead to disputes at the point of claim when costs may already have been incurred by the member. To assist moratoria underwriting, insurers encourage members to seek authorization of claims prior to treatment being received.

5.2.3. Medical History Declaration

When using the medical history declaration, full medical history information and current state of health are obtained from the applicant, usually as part of the application form. The questions asked seek to determine the severity of any pre-existing medical conditions, and although they may differ between insurers will generally include the following:

- 'Have you or any of your dependants to be included in the policy, any physical defect, infirmity or medical condition?'
- 'Have you, or any of your dependants to be included in the policy, been admitted to a hospital or nursing home or consulted a specialist during the last five years?'
- 'During the last twelve months have you, or any of your dependants to be included in the policy, consulted a GP? Please include details of any repeat prescriptions.'
- 'Have you, or any of your dependants to be included in the policy, any foreseeable need for treatment or for consulting any medical practitioner?'

The underwriter will usually also consider other factors such as: Age; Gender; Start date of illness, duration and severity; Frequency of symptoms; Nature and effectiveness of treatment received; and Present state of health.

5.2.4. Switch Underwriting

People who already have PMI may find it worthwhile switching to another insurer, especially if it will save them money or offer them more attractive benefits. Some insurers now offer switch underwriting. If the customer is able to answer 'yes' to a small number of questions, the new policy will not impose any more exclusions than their existing policy. However, all current exclusions will carry forward onto the new policy.

Such questions may include: Whether they made a claim in, say, the last two years;

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Whether they are currently undergoing any medical treatment; and Whether they have had medical treatment in, say, the past two years.

5.2.5. Personal Underwriting

This takes into account various risk factors and allows the insurer to price based on the individual risk. In some cases, the insurer may then apply an increased premium to cover pre-existing conditions. Where the individual has positive risk factors- such as a healthy lifestyle, good body mass index and few past health problems, the insurer may offer a lower premium than standard.

5.3. Underwriting for Employer-Paid Business

To avoid selection against the insurer through provision of cover for a disproportionately large number of people in ill-health, employer-paid group schemes are normally required to cover all employees within a given category; clearly defined by age, employee status grade and length of service.

The overall premium will be lower than if each employee joined as an individual personal member because: the volume of business results in a greater spread of risk; and the administration cost is lower as only one invoice needs to be issued to the employer, rather than individual invoices to each member.

5.3.1. Small Schemes

Risk is managed by pricing the premiums according to the claims history of all employees within the small- schemes portfolio. Further factors determining price will include: number of eligible employees (group size); type of industry; geographical location of the company; and occupations.

All small schemes are underwritten to ensure that the terms and conditions and price of membership are set at levels that maintain profitability, and which accurately reflect the degree of risk; with all members being treated equally.

The high levels of competition within the commercial market mean that insurers are keen to secure business from their competitors by quoting keener rates. Employers use this situation in order to obtain lower premiums for the highest level of cover.

This may lead to insurers offering 'no worse terms' to employers transferring their business from another PMI insurer (it may also be referred to as 'no further

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underwriting'). 'No worse terms' means the scheme transfers to the new insurer on the same medical underwriting terms as those provided by the previous insurer. Before offering or agreeing to 'no worse terms' an insurer will usually investigate all, or some of the following: size of the scheme; when the scheme was last underwritten; loss ratio with existing insurer; whether cover has altered from that provided by the previous insurer; and whether the categories of employees to be covered has altered.

'No further underwriting' means that the new insurer may be exposed to conditions where treatment is already being given or a medical condition is just starting to emerge. Difficulties can also arise when the benefits provided by the new insurer are different or inferior from those previously provided.

5.3.2. Large Group Schemes

Risk is managed by pricing premiums according to the employer's claims history from the previous policy year. The majority of large group schemes are not underwritten. However, for reasons of cost containment, some may opt for individual underwriting, or for exclusions relating to particular conditions, for example, mental and/or addictive illnesses.

Schemes or individual members that transfer from a large scheme to a small scheme, or vice versa, will normally be underwritten to ensure that the correct premium is calculated in respect of the revised risk, for example, where a large scheme wishes to transfer to a small scheme costing basis, but at a higher scale of cover. Cover for pre-existing conditions will also be underwritten to restrict cover to the previous risk exposure

5.3.3. Competition within the Employer-Paid Market

Insurers have underwriting procedures which need to be followed when underwriting business from competitors. Whilst these are sound and endeavor to limit the insurer's exposure to unnecessary risk, a rigid adherence to the procedures is not always possible. Some flexibility is warranted if the insurer wishes to maintain or increase their business portfolio. Deviations from procedure may be made where the underwriter decides that a less rigid approach may be possible based on the circumstances, or claims history, of a particular scheme.

It is crucial that these decisions are made by skilled underwriters who have the authority and commercial experience to understand the nature of the exposure and the consequences of their decisions. Where there is a difference of opinion with the sales

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function (whose main focus is to acquire business from all possible sources), the commercial judgment of the underwriter must prevail.

5.3.4. Addition of Newly Born Children to an Existing Policy

Normally, newly born children may be added to existing policies from their date of birth, without underwriting, as long as details are notified to the insurer within a defined period (usually three months). This is usually subject to the proviso that the mother has been a member, with continuous cover for a set period of time. Treatment for congenital birth defects may either be included or excluded.

5.3.5. Disadvantages of Underwriting from a Medical History Declaration

Although use of a medical history declaration and the exclusion of cover for known conditions is one of the most commonly used methods of underwriting, it does have a major disadvantage. Members who wish to obtain comprehensive cover regardless of cost, would have excluded any treatment for pre-existing or related conditions. This means that members have a choice of relying on the NHS for treatment, or they must pay the full cost from their own resources.

5.4. Future of Underwriting

What is the future of underwriting PMI? Some insurers believe that there is a need for more sophistication in terms of accurate underwriting which reflects the true risk being insured. To implement this type of change, some insurers now use expert underwriting systems and premium loading which will permit cover for pre-existing medical conditions, rather than excluding them completely.

Tele-underwriting (where an underwriter phones the customer to ask the underwriting questions rather than requiring a form to be completed) allows underwriters to ask more tailored questions of customers — so keeping application forms short, while obtaining more information about factors that may affect the risk.

However, other insurers argue that simplicity reduces costs, increases certainty for potential customers and does not require a change of culture for the insurer.

5.4.1. Premium Loading as an Alternative to Exclusions

Some PMI insurers now offer products that incorporate innovative ways of covering

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pre-existing conditions. Where an applicant declares an existing medical condition, it may be necessary for the insurer to obtain further information from that person's GP and/or consultant, in order for the correct premium loading to be calculated. The calculation may also need to take account of most of the following:

- ***Gender.*** Incidence of some medical conditions may be confined to a single gender, e.g. breast cancer is much more common in women while prostate cancer can only affect men.

- ***Smoking.*** Smokers represent a higher risk and, amongst other conditions, have an increased propensity to respiratory and heart disease.

- ***Occupation.*** Sedentary workers are generally less healthy than active workers.

- ***Weight and height.*** Whether the weight is within an acceptb1e proportion to the height. The body mass index (BMI) is often used to determine this.

- ***Alcohol consumption.*** Units of alcohol consumed over a period of time (normally weekly). At older ages especially, moderate consumption may be a positive factor, whereas heavy consumption or binge drinking may be a negative factor. In extreme cases it may not be possible to offer terms at all.

- ***Exercise patterns.*** Whether any exercise is undertaken and if so, the duration and regularity.

5.4.2. Genetic Testing

A genetic test is defined by the ABI as 'an examination of the chromosome, DNA or RNA to find out if there is an otherwise undetectable disease related genotype, which may indicate an increased chance of that individual developing a specific disease in the future'. The *Oxford Medical Dictionary* defines genetics as 'the science of ingeritance'. In other words it is defined as the study of inherited diseases and conditions..

This can be important, as some diseases are a direct result of, or are aggravated by, a familial trait that may be able to be identified through laboratory testing of genetic material before any symptoms are apparent. Certain conditions such as Huntington's disease can already be traced to a specific gene and considerable work is under way to establish markers for other diseases.

A test cannot determine when a disease is likely to occur, and the person concerned may still live to a very advanced age, particularly if steps are taken to reduce risks. This

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topic is likely to remain a contentious issue in the insurance industry for many years to come.

The concordat requires that predictive genetics tests may only be considered for certain types of long-term insurance. They should not be used by PMI insurers.

There are two situations where a genetic test could be considered by a PMI underwriter: where the insured person voluntarily provides the test result — usually this will be where the test result is negative; and where the test is diagnostic rather than predictive.

6. Claims

6.1. Pre-Authorization of Claims

Pre-authorization is the process of obtaining authorization from an insurer that the treatment is medically necessary and clinically appropriate, and covered by the policy. The claimant is required to contact a telephone helpline, usually run by qualified nurses. These individuals have the necessary medical and insurance skills to determine whether a claim is likely to be covered or excluded, or whether further information is required before a claim can be considered. Failure to obtain authorization may mean that the insurer will not pay any treatment costs or may not pay all the costs.

There are a number of reasons for carrying out pre-authorization: to promote day case surgery; to manage psychiatry and addictions; to ensure appropriateness of procedures; to manage high cost case; to ensure appropriateness of treatment: from inpatient to day case; from day case to outpatient; to obtain information about claims; and to manage hospitals and consultants.

6.2. Structure of PMI Benefits

6.2.1. Relationships with Hospitals

Hospital costs account for approximately 60% of the claims expense and insurers therefore invest considerable time in negotiation of contracts with hospitals. Contracting with hospitals started to become common during the early 1980s when agreements on both price and the direct payment of bills to the hospital began to feature in discussions between the larger insurers and hospitals. Such contracts are now standard procedure within the industry.

Insurers use a number of different methods to contract with hospitals. The contracts will normally be for a period of one year and may include one or more of the following

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methods of contracting:

- **Per diem rate –** a single charge per day in hospital regardless of the actual costs (accommodations; drugs and dressing);
- **Procedure pricing –** a fixed price for carrying out procedure covering inpatient and day case patient costs; does not include pre-admission test, outpatient treatment or specialist fees;
- **Episode pricing –** a fixed price for carrying out procedure covering all hospital and consultant costs for the entire period of care (including pre-admission and post-admission test and consultations);
- **Per case rate –** for unusual cases, the price will be negotiated on an individual basis.

The contract includes service level agreements: pre-authorize certain admission or provide medical reports for long stay claims.

"Hold Harmless" Clause in hospital contract – the hospital agrees not to pass any additional costs that are not covered to the member. An exception – services not covered by PMI policy (telephone calls).

6.2.2. Relationships With Consultants

Consultants are effectively self-employed professionals who agree to treat individual patients on a private basis and form a contract with each patient. The patient accepts liability for payment of the consultant's fee, with the insurer acting as a third party in this relationship.

The main issue that affects an insurer's relationship with a consultant is the level of reimbursement that the insurer offers towards the consultant's fees. Surgeons and anesthetists may be paid: a full refund of all 'reasonable and customary' fees; specified combined fees for the surgeon and anesthetist; specified individual fees for the surgeon and anesthetist; or through a combined fee to the hospital, which then separately pays the surgeon and the anesthetist.

Reimbursement levels are usually governed by the various schedules of procedures that insurers publish to the medical profession. There are usually five main classifications of procedure, with some insurers dividing, each into a further five sub-categories. Two common standard medical coding mechanisms:

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- **'International Classification of Disease' (ICD)** – codes published by the WHO used for diagnosis or impairment codes.

- **Clinical Classification and Schedule Development (CCSD) or Office of Population, Censuses and Surveys (OPCS) codes** – used for surgical procedures; published by insurer in the schedule of surgical procedure (classification of the procedure and the level of benefit).

6.3. Payment of Claims

The **Access to Medical Reports Act 1988** requires the insurer to obtain a member's consent before asking for a medical report relating to the treatment. This declaration is usually included on the claim form to avoid the insurer having to contact the member again.

For group schemes, the claim form may also need to be signed by an authorized signatory of the employer (e.g. the Company Secretary), to confirm that the patient is covered by the scheme. The **Data Protection** Act **1998** states that the employer does not have the right to receive details of the treatment and the claim form may, therefore, be signed prior to treatment taking place.

It is necessary to submit the original invoices and/or receipt to the insurer to minimize fraudulent claims. The member must also declare any other policy from which the medical expenses may be claimed (e.g. motor insurance policy in the event of a car crash).

6.3.1. Claims Assessment Policy

The objective is to ensure that the: Treatment received is covered; costs are within the benefits specified; charges comply with the contract that exists between the insurer and the hospital. Where pre-authorization applies, the patient should contact their insurer as soon as their GP tells them that a consultation with a specialist is necessary. Typical procedure private medical insurance claims assessors use in the payment of treatment invoice: Claims process:

- **Visit GP** – consultation with specialist; treatment needed?

- **Specialist determines treatment required** – if inpatient required – admit patient to hospital. Undertake treatment;

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- **Submit claim form and accounts to insurer –** (may be via EDI);
- **Insurer –** process claim against benefit entitlement;
- **Send remittance to medical provider** – notify member of payment.

Six eligibility checks for claims process: Is the patient covered under the policy; Is the treatment covered under the policy; Do premiums paid cover the dates of treatment; Is the hospital covered by the policy; Is the consultant or therapist accepted by the insurer? Is the condition pre-existing

6.3.2. Direct Payment

The major insurers have direct settlement agreements with hospitals and consultants. As claims are approved for payment, these will be held against the provider's record and will be incorporated into the next periodic payment to the provider. This may be on a daily, weekly, fortnightly or monthly basis.

The Advantages are: Member did not concerned about arranging payments; Hospitals and consultant are guaranteed reimbursement; Insurer can exert influence on hospitals to reduce costs.

However, there are disadvantages for the consultant: Erosion of relationships between consultant and patient; Did not suit accounting method; Administrative burden.

6.3.3. Electronic Data Interchange

Electronic data exchange – is designed to exchange data between the insurers and hospitals and consultants. Hospitals and consultants enter the details of claims, costs and fees on the computer terminal at their own premises. The advantages of EDI are that the whole process is speedier, some data checks may be incorporated at point of entry to reduce mistakes and improve data quality and paperwork is eliminated.

6.3.4. Provider Help Lines

Most insurers have some form of helpline that providers can use to: confirm benefits available for treatment; discuss details of a particular case; enquire about settlement of claims; discuss shortfalls which the consultant (or more commonly their secretary) or hospital wish to clarify; and discuss cases where the patient has already settled the bill and the insurer should have reimbursed the member rather than the provider.

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6.3.5. Patient Help Lines

As well as using help lines to pre-authorize claims, many insurers now operate help lines to assist customers with a range of medical needs. The helpline will usually take the form of either: pre-recorded tapes giving information about particular medical conditions; access to a qualified medical person — usually a nurse—who can give generic and specific advice relating to conditions affecting the customer or members of their family. For example a parent can be given advice about a crying baby or whether to contact a GP or hospital about say a sprained wrist or ankle; or access to a third party helpline service. Such help lines may cover legal issues, stress, bereavement, domestic problems (e.g. where to find a plumber) as well as health and medical issues. GP help lines, giving access to a private GP are also becoming popular.

6.3.5. Incurable Conditions

PMI covers acute conditions where treatment is given with a view to curing the condition. In some cases conditions may be incurable, either at outset or ultimately.

Where the condition is treatable, but may become untreatable — say cancer treatment — the initial treatment is likely to be covered under the policy. There may come a time when the condition is no longer judged to be treatable (i.e. it is no longer an acute chronic condition but has become chronic) and a decision has to be taken to discontinue paying for treatment.

Incurable conditions are not always life threatening. For example, both diabetes and asthma are incurable yet sufferers may have a reasonably normal life expectancy. In some cases where an acute flare up occurs or where say arthritis may be treated by installing a prosthesis (e.g. a hip or knee replacement) such events are covered under the policy even though other treatment is likely to be excluded. Initial diagnosis of chronic conditions is usually also covered if the policy covers consultations.

6.5. Managed Care

Managed care originated in the United States of America (USA), and is now common within the UK healthcare market. By using managed care techniques, the insurer or third party administrator intervenes in the decisions surrounding the medical care given. This is to ensure that procedures are necessary and alternative, less expensive treatments are also considered.

Managed care – is to ensure that procedures are necessary and alternative, less

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expensive treatments are also considered. It is concerned with three aspects of healthcare: clinical appropriateness of healthcare intervention; the price of healthcare; and the quality of healthcare.

Some products are concerned not only with reimbursing the costs of healthcare, but also maintaining the health of their members and promoting preventive health and health education to members.

The four elements of managed care: Utilization reviews; Hospital networks; Consultant networks; Guidelines and protocols.

Utilization review consists of pre-authorization, case management and concurrent review.

Pre-authorization – a process of obtaining an authorization of treatment from the insurer to ensure that the treatment is covered by the policy, is necessary and appropriate.

Case management – concentrate on high cost of complex intervention (transplant and cancer) to make sure that the treatment is cost-effective.

Concurrent review – the case is reviewed to ensure that the patient still needs to be in hospital or needs to return home.

7. Alternatives to Medical Insurance

7.1. Self-Pay

The simplest alternative to medical insurance is self pay. **Self-pay –** the advantage is cost saving. However, the disadvantages are: the treatment may cost more; the sufficient fund may not be available; more than one member may need treatment; more than one course of treatment may be needed.

7.2. Fixed Price Surgery

Fixed price surgery – the advantage is that the price is fixed regardless of an extra night. Fixed price deals cover inpatient accommodation, specialists' fees for the surgeon and anesthetist, theatre fees and post operative drugs. The hospital will build some margin into the price in case of complications. The costs of fixed price surgery are generally lower than for the equivalent treatment given to a patient insured under a PMI

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policy, as treatments received under fixed price deals are priced on the profit margin.

Consequently, patients treated under these fixed price deals may receive less priority than a PMI patient. Claims payment under fixed price surgery differs from claims for settlement under a conventional PMI policy. Under fixed price arrangements, the payment for the whole episode of treatment is normally made, in total, to the hospital which then remits the appropriate amounts to the surgeon and anesthetist.

7.3. Treatment Centers

The NHS has been a regular customer of fixed price surgery. This may be cheaper than the cost of providing similar treatment within the NHS and also avoids having to build up permanent facilities to meet short term needs. Many of these will take place at treatment centers. A treatment centre is a specialist facility that will typically only carry out certain procedures. For example, the NHS may contract with a private supplier to carry out 10,000 cataract operations a year.

The provider will be responsible for meeting NHS quality requirements, setting up appropriate facilities and recruiting suitable staff. In some cases, medical staff may be brought in from other countries to carry out the work. Some medical staff may be recruited from abroad, and low cost air fares mean that some may work part-time in the UK, as well as at their local hospital abroad.

7.4. Major Medical Expenses (MME)

Unlike PMI, MME or major medex products may not indemnify claimants for the costs incurred when they receive private medical treatment. These products were originally intended to provide a lump sum payment when the claimant undergoes an operation which is medically essential, and which also requires a general anesthetic.

This is known as a 'qualifying operation'. The lump sum would be paid regardless of whether treatment was received as an NHS or private patient and may be spent in any way the claimant chooses. However, some MME contracts will reduce the lump sum payable if the claimant opts to have their treatment under the NHS.

MME products will usually impose a three month waiting period before the member is deemed eligible to receive benefit. The waiting period will not apply to a member who undergoes a qualifying operation as a result of an accident which occurs during the first three months of the cover.

Each policy is underwritten and any pre-existing conditions are generally excluded.

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Some insurers will cover pre-existing conditions once the member has had a treatment-free period of one or two years. A number of standard exclusions also apply to MME policies; for example, self-inflicted injuries, and treatment for AIDS and related conditions.

The amount of benefit is normally enough to cover the following costs: surgeons' fees; anesthetists' fees; hospital accommodation; drugs and dressings. This is particularly true if treatment is undertaken at an NHS hospital where costs will often be a fraction of those at a private hospital.

7.5. Health Trusts

A health trust (sometimes also known as a healthcare or medical trust) is established by an employer to provide similar benefits to PMI, without being an insurance (which among other things, may avoid the need to pay insurance premiums tax). The benefits available to the individual members (trust beneficiaries) are administered according to the trust's provisions and are subject to trust legislation. A trust is a legal entity and its purpose, scope and function must be embodied in a trust deed. Creating a trust can be a legally complex process.

A trust is administered by trustees appointed by the employer and their responsibilities are defined in the trust deed, together with procedures for appointing trustees. The trustees may contract with an insurer to provide a 'stop loss' policy. Claims made under a health trust are not referred to as 'claims', nor are people making claims referred to as 'claimants'. Instead, a claim is known as a 'request for benefit' which is made by a 'trust beneficiary'.

A major benefit of health trusts is that they avoid liability for insurance premium tax (IPT) as benefits are not considered to have been received under a contract of insurance. IPT is currently (as at August 2006) calculated at 5% of gross premiums, which is a cost which would have to be borne by the employer.

The more employees covered on PMI, the greater the cost of IPT, therefore a health trust will be seen as a viable means of providing PMI to a large number of employees without bearing the additional cost of IPT. It was also argued that setting up a health trust may give greater flexibility in designing benefit schedules to suit members, although once established it may be harder to change benefits in a trust than in a PMI scheme.

Under PMI policies, benefits are guaranteed. Under trust law, benefits are paid at the

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discretion of the trustees. In practice, this will not cause any problems. However, the change from 'absolute' to 'discretionary' rights must be communicated to all employees who are entitled to membership of the group, and their acceptance must be obtained.

7.6. Reinsuring PMI business

The three main types of reinsurance coverage available for medical expense insurance are as follows:

7.6.1. Quota Share

This method can relieve any financial strain that solvency margins may impose on an insurer (e.g. if premium income is projected at a higher level than available surplus can support). A constant percentage of each policy is reinsured. Therefore, if a policy is 20% reinsured, 20% of all claims under the policy will be paid by the reinsurer.

The quota share percentage is usually set according to the surplus required by the solvency margin. This surplus will, therefore, be the percentage of the retained premium.

7.6.2- Specific Stop Toss

This method is also known as 'excess of loss' and can be used by an insurer to limit their liability on each individual claim over a defined period (normally twelve months and defined as either a calendar or policy year). This coverage reduces the risk of a large variability in medical claim costs to an insurer without having to reduce specific limits in the policy. The reinsurer pays the benefit that exceeds the excess amount on each individual provided the claims are incurred in the defined period.

The coverage is called specific stop loss as it restricts the loss the insurer can incur on any specific policy at the agreed amount.

7.6.3. Aggregate Stop Toss

This cover is usually sold to insurers when a specific stop loss agreement is already in place, and will protect against a large volume of claims by number in a set period of time. It is usually purchased on a yearly basis. For example, when aggregate claims in a given benefit period exceed the overall amount limit, the reinsurer will pay the excess

claims. The claims included in the aggregate stop loss coverage are only those up to the specific stop loss limit, as amounts in excess of this specific stop loss limit are already paid by the reinsurer.

8. Taxation

8.1. PMI as a Taxation Benefit

A higher paid individual will pay tax at their highest rate, on the notional PMI premium their employer has paid to secure benefits for them; including other family members where covered under the PMI scheme. However, the Finance Act 1995 provides that employees shall not be subject to tax on a benefit-in-kind where their employer pays premiums on items such as directors' and officers' liability insurance or a professional indemnity insurance policy. Group income protection and group critical illness policies, where the benefit is paid to the employer, are not taxed as a benefit-in-kind. In addition, this 1995 Act provides that payment of an employee's uninsured liabilities will not give rise to a benefit-in-kind, provided they arise from the employee's work.

8.2. Taxation of Benefits to Individuals

8.2.1. Insurance Premium Tax (IPT)

Insurance premium tax (IPT) is payable at the rate of 5% on all annual premium insurance policies, including PMI. It is also payable on long-term private medical insurance premiums, as an anti-avoidance measure. IPT is collected by the insurer as part of the premium charged to their client and is not usually charged as a separate item.

Where PMI is taken out by or for an employee outside the UK, IPT is not payable. International PMI policies are therefore not usually subject to IPT.

8.2.2. Value Added Tax (VAT)

Value added tax (VAT) is payable on most goods and services, usually at the rate of 17.5%. Where an individual or company is registered for VAT, they may reclaim VAT paid on goods and services that they have bought so that VAT is only effectively paid on the value added to a good or service — as well as in full by those who are not VAT registered. Insurance premiums are not subject to VAT.

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8.2.3. Employers' Tax Relief on PMI Policies

Where a company takes out a PMI policy to provide benefits for its employees, it may offset the premiums paid against its trading profits, as they are a legitimate expense of the business.

If a private company with turnover of £180,000 a year and taxable profits of £100,000 a year. As its profits are below £1.3 million a year it pays the small companies' tax rate of 19% on its profits in the 2006/2007 tax year. Its tax bill is therefore:

£100,000 x 19% =19,000

If it takes out a group PMI policy with an annual premium of £10,000, its pre-tax profit will fall from £100,000 to £90,000. Therefore, its tax bill will be:

£ 90,000x19%=17,100

8.3. Health Trusts

Equity introduced numerous new concepts, one of which is **the trust.** Indeed, in his great book on equity, Maitland describes the trust as the greatest contribution of equity to English law.

A trust is established by the settler for the benefit of **beneficiaries.** To ensure that the trust is administered properly, the settler appoints one or more trustees who then use the trust money for the maximum benefit of the beneficiaries. If the trustees do not administer the trust properly, they will be liable for the serious offence of a breach of trust.

8.3.1. Health Trust Policies

Health trust policies (also called healthcare or medical trusts) are becoming increasingly popular since the introduction of insurance premium tax (IPT). This was increased to 5% from July 1999 and could increase further in the future.

Consequently, health trusts have been inaugurated and developed to enable employers to provide medical insurance for their employees without incurring the extra cost of IPT. Naturally, there is some expense attached to initiating and administering the trust, but for larger schemes this is less onerous than the IPT.

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Under a health trust arrangement, the employer appoints a number of trustees. The employer then transfers a sum of money to the trustees who hold it on trust for the benefit of the employees. There is trust documentation supplied known as the **trust deed** which confirms the powers, duties and responsibilities of the trustees. They must act in accordance with these provisions and must use the trust money for the benefit of the employees. In this context, they would pay money to provide healthcare benefits to the employees. The trustees may protect against exceptional costs arising by taking out stop loss insurance, which would be subject to IPT.

The relationship between the employer and the trustees is subject to the law of trusts and not to insurance law and this means that the costs of the imposition of IPT are avoided. However, unlike under an insurance policy, the benefits under the trust are not guaranteed. In practice, the additional costs of setting up and administering a health trust means that only larger schemes (typically more than 500 members) are likely to see cost savings, despite not having to pay IPT.

A potential disadvantage of the health trust arrangement is that it is an open-ended risk to the settler (e.g. an employer). This is because the employer must provide all of the funds for the trust. To eliminate the effects of this problem, the trust could be advised to purchase stop loss insurance, which, as its name suggests, has the consequence of stopping the loss experienced by the settler exceeding a certain figure.

9. Legislation and Regulation

9.1. Access to Medical Reports Act 1988

This Act establishes a right of access by individuals to reports relating to themselves, as provided by medical practitioners for employment or insurance purposes, and to make provision for related matters.

A person shall not apply to a medical practitioner for a medical report relating to any individual to be supplied to them for employment or insurance purposes unless: the applicant has notified the individual that they propose to make the application; and the individual has notified the applicant that they consent to the making of the application.

Where an individual has been given access to a report, the report shall not be supplied in response to the application in question unless the individual has notified the medical practitioner that they consent to it being so supplied.

The individual shall be entitled, before giving their consent, to request the medical

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practitioner to amend any part of the report which the individual considers to be incorrect or misleading; and, if the individual does so, the practitioner: shall amend the part accordingly if they are to any extent prepared to accede to the individual's request; shall attach a statement to the report if they are to any extent not prepared to accede to it but the individual requests them to attach a statement of their views in respect of any part of the report which the medical practitioner is declining to amend.

9.2. Access to Health Records Act 1990

9.2.1. Right of Access to Health Records

An application for access to a health record, or to any part of a health record, may be made to the holder of the record by any of the following: the patient; a person authorized in writing to make the application on the patient's behalf; where the patient is a child, a person having parental responsibility for them; where the patient is incapable of managing their own affairs, any person appointed by a court to manage those affairs; where the patient has died, the patient's personal representative and any person who may have a claim arising out of the patient's death.

9.2.2. Correction of Inaccurate Health Records

Where a person considers that any information contained in a health record, or any part of a health record, to which they have been given access is inaccurate, they may apply to the holder of the record for the necessary correction to be made.

9.3. Data Protection Act 1998

The 1998 Act makes new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. It confirms that an individual is entitled:

- to be informed by any data controller whether personal data of which that individual is the data subject are being processed by or on behalf of that data controller;

- if that is the case, to be given by the data controller a description of: the personal data of which that individual is the data subject, the purposes for which they are to be processed, and the recipients or classes of recipients to whom they are or may be disclosed;

- to have communicated to them in an intelligible form: the information constituting any personal data of which that individual is the data subject, and any information available to the data controller as to the source of these data, and where the processing by automatic means of personal data of which that individual is the data subject.

9.4. Disability Discrimination Act 1995

The purpose of this legislation is to prohibit discrimination against the disabled. It covers many aspects of life, notably transport, employment, studying and leisure. Under this legislation, disability is defined as a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to -day activities.

It is unlawful to refuse to provide or deliberately not to provide a disabled person with a service which is provided to other members of the public. Similarly, it is unlawful to offer a disabled person a lower standard of service

Special regulations permit insurers to treat the disabled less favorably than other people, but this is only permitted if insurers can justify their action on the basis of actuarial or other statistical information; or on other information on which it is reasonable to rely.

Should a disabled person be able to show that they have received less favorable treatment, the insurer has to prove that there is an increased risk associated with the disabled person due to their disability. Should the insurer be unable to do this, they must compensate them for financial loss and/or any inconvenience caused.

9.5. Financial Services and Markets Act 2000

The key elements of regulation of healthcare insurance from 14 January 2005 are: it applies to all classes of insurance and investment products; there is one regulator for the whole market — the FSA; and intermediaries may choose to be regulated directly by the FSA or to become an appointed representative of an authorized firm — known as a 'principal'.

The stages in becoming authorized are: registration with the FSA; making an application to become authorized; assessment by the FSA; and authorization. The FSA has four key objectives, to: maintain market confidence in the UK financial system; promote public awareness and understanding of the financial system; secure an appropriate degree of protection for consumers; and contribute to the reduction of financial crime.

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To meet these objectives, the FSA undertakes three key roles as follows: the direct authorization and regulation of the UK financial services system; monitoring the activities of the various recognized bodies such as the Stock Exchange and designated professional bodies such as the Law Society: and policing the financial services system.

The FSA has published a set of principles that authorized firms must follow to be regarded as 'fit and proper'. Under the FSA principles a firm must: Conduct its business with integrity; Conduct business with due skill, care and diligence; Take reasonable care to organize and control its affairs responsibly and effectively, with adequate risk management systems; Maintain adequate financial resources; Observe proper standards of market conduct; Pay due regard to the interests of its customers and treat them fairly.; Pay due regard to the information needs of its clients and communicate information to them in a way that is clear, fair and not misleading; Manage conflicts of interest fairly, both between itself and its customers and between a customer and another client; Take reasonable care to ensure the suitability of advice and discretionary decisions for any customer who is entitled to rely on its judgment; Arrange adequate protection for clients' assets when it is responsible for them; Deal with its regulators in an open and co-operative way, and disclose to the FSA anything relating to the firm of which the FSA would reasonably expect notice.

10. Marketing and Sales

Throughout much of the 1990s, sales of PMI remained relatively flat although the group market showed growth towards the end of the decade. There are a number of factors that led to this situation: Prices have consistently risen faster than general inflation; Younger people have not been attracted to PMI (this group traditionally cross -subsidized older members); PMI is still seen by some as queue jumping or being disloyal to the NHS; Consumers expect more from their PMI plan; Claims incidence has risen; New medical treatments have increased costs; Over-supply of beds has driven up prices.

10.1. Buyers of PMI

Buyers of PMI may be broken down into three main categories: Private individuals who buy PMI either for themselves or for their family; Voluntary groups — members of groups who use their combined market power to secure better terms; and Companies — employees may either be given or may choose to have PMI cover.

10.1.1. Private Individuals

Private individuals make up around one-quarter of all people who have PMI cover, but

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their combined premiums make up almost half the total. PMI sells mainly to higher socio-economic groups. There are two reasons for this: **Cost; Attitudinal reasons**. In areas such as education and housing the tradition of private provision is better established.

Older people (65+) are less likely to have PMI because: many would have been covered by their employer prior to retirement; PMI is significantly more expensive for older people, reflecting the greater likelihood of their needing treatment and the cost of such treatment.

Other factors that may be important to consumers include the following: **Choice of when to have treatment; Choice of** hospital; **Hospital cleanliness**. Hospital/ healthcare acquired infections (HCls) including MRSA (methicilin resistant staphylococcus aurous) affect around one in ten hospital patients a year. Most of these, but not all, are in NHS hospitals. The risk of acquiring an HCI is less in an independent hospital; **Choice of consultant; Better 'hotel' benefits; Other benefits**. PMI products may include a wide range of additional benefits, from paying a cash allowance for each night spent in hospital to worldwide travel insurance.

10.1.2. Voluntary Groups

Voluntary groups encompass a wide range of people from those who are members of an affinity group (such as a sports club) to members of a company scheme where the employee pays most or all of the premium.

Of these, the main groups that may be regarded as voluntary schemes are the following:

Affinity groups. An affinity group is any group of people who have an affinity such as membership of a particular organization or a shared interest. Affinity groups can use their combined buying power to secure lower rates or special terms from PMI insurers.

Other voluntary groups. These may include groups of employees outside a company scheme or clients of a particular intermediary.

Company — employee paid. Some employers are happy to set up and possibly administer a group scheme but may require the employee to pay the premiums.

10.1.3. Companies

A company scheme may cover from as few as one individual up to many thousands of

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employees. The 'company' may be a sole proprietor, a partnership or a company.

The key element of a company scheme is that it is taken out by a business rather than by an individual — even though benefits will be paid to or for the benefit of individuals, not the business. Companies may pay for part or all of the costs of PMI for their employees and may be classed in three groups:

Company — part **employee paid.** In some instances, the company only pays part of the premium. For example, it may pay for basic benefits only, with the employee paying for any additional benefits.

Company — employee pays for dependants only. In this case, the company pays for their employee while the employee pays for their spouse/partner and/or children.

Company — employer paid. Here the company pays the whole PMI premium or subscription.

Reasons for buying PMI: get back to work quickly; keep benefits package competitive; ensure staff are well cared for; reduce sickness/ absence costs.

10.2. Marketing techniques

10.2.1. Right Product at the Right Price

Market segmentation techniques to develop a package of benefits to appeal to a particular market segment:

- **by age** – plan targeted at young people or old people';
- **by gender** – plan targeted women should give benefits for pregnancy and extra cover for women;
- **by geography** – plan for London or Scotland;
- **by affinity group** – plan for members of the sports or health clubs whose member value cover for physiotherapy or health screen;
- **by family status** – plan for single person; for couples or for single parent with children;
- **by price level** – some people value wide cover, regardless of premium,

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some value less cover to keep the premium low;

10.2.2. Getting Product Proposition to the Customer

The choice of distribution channels is strategic; products are designed for sales on Internet and telesales. Advertisement is designed to build brand name or to support a product; advertisement intends to build brand's value of the product in the mind of the customer.

10.2.3. Product Proposition and its Presentation – (brochure)

Literature plays a key role and used to create impression; PMI is valuable; selling the PMI benefits, technical details about products and choices.

10.2.4. Follow Up

Once the sale has been made the next marketing process is to ensure the customers that they have made a right choice. The speed and quality of issuing policy is key; a welcoming letter; information about how to claim. Insurers should give incentives to the customers to provide details to other people.

10.2.5. Intermediary Sales Process

Where an intermediary is involved, the PMI sales process is likely to consist of the following stages:

Prospecting. This is the term used for the methods of finding new potential customers or prospects. It may involve the use of advertising to generate leads or name awareness, sending letters and mail shots, telephone canvassing and referrals from existing customers. There are a number of other ways in which prospects may be found.

Initial contact. This may involve setting up a meeting to discuss the client's needs. In some cases, information about the company or a specific product may be sent to the client in advance of the meeting. However, in others meetings are replaced by all communications being carried out electronically or by post.

Meeting. The purpose of the meeting is to establish rapport, ascertain the client's needs and determine the best solution to those needs. A direct sales person may have only one product to offer, although most PMI providers offer a range of policies to suit individual needs. A broker may wish to offer the client a choice of contracts. Data

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gathering may vary considerably between types of intermediary, as follows:

— A PMI specialist may use a computerized point of sale track which can help illustrate the need for PMI, perhaps using statistics and pictures to build up an understanding of the need for the product. The sales track may also include a quotation facility and may even print out an application form.

— An IFA is more likely to use the fact find that they use for their regulated (life assurance, pensions and investment) business, both for consistency and to ensure compliance with the complex regulations that apply to regulated business, especially where both regulated and unregulated business is being discussed with a client. Even here, a quotations package may be used to illustrate cost and benefits. This may be a package devised by a particular provider or a commercially available package covering a number of providers.

— Online underwriting may also be available.

Follow-up and servicing meetings. After any initial meeting, a follow-up meeting may be arranged to make a presentation or a servicing meeting may be arranged to discuss any future or other needs. Again, this will vary considerably between advisers. Servicing meetings will usually be carried out at least annually, shortly before renewal. This is the best time to consider changes to the plan or, in appropriate cases, a switch to another provider.

10.4. Product Marketing

The role of a product marketing department is to manage a particular product area to achieve the optimal business outcomes. The role will vary between providers, some having large specialist departments while others may concentrate on market segmentation and have a much smaller team to manage individual product areas. In some cases this may be just one individual — the product manager or product champion.

10.4.1. Researching the Needs of Customers

There are 2 types of market research: (i) quantitative analysis – counting response to a particular question (eg. how long people have to wait to get treatment); (ii) qualitative analysis – in-depth survey of people's view (how they think about NHS);

10.4.2. Analyzing Sales

To help forecasting and identify trends. Declining sales indicate non-competitive product;

10.4.3. Competitor Analysis

What they are doing and how their products compared with ours;

10.4.4. Pricing

Pricing levels to optimize sales and profitability targets by using price models and analyzing competitor pricing;

10.4.5. Product Design

A multi-disciplinary process with collective responsibility to avoid battles (finance department wants to set highest prices to minimize unit profitability, while sale department wants to get lowest prices to maximize sales;

10.4.6. Product Promotion

Advertising; product literature – brochures, application forms, sale aids; training salesmen; launching product to the press; launching products to intermediaries; launching products to representatives of hospital groups.

10.5. Distribution Channels

PMI can be sold through a number of distribution channels. The two main types are direct business and independent intermediaries. In practice, most insurers use a combination of distribution channels to give a balance of benefits and costs. By so doing they are able to vary the support given to each area from time to time in order to meet specific business objectives.

10.5.1. Direct Business

A- Direct Sales Force

The majority of PMI business is sold through direct sales forces set up by PMI insurers.

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The sales force may get leads from advertising and from enquiries and/or may prospect for business. The main advantages of a direct sales force are as follows:

Control. The PMI insurer has control of the channel and may direct effort towards or away from particular market segments. They may do this positively, by rewarding business from a sector; or negatively, by penalizing business from that sector, perhaps by paying a lower rate of bonus or by direction.

Differentiation. The insurer can differentiate their service proposition from that of their competitors.

Training. Training is under the direct control of the insurer, helping to ensure the right quality and compliance with internal and external sales rules.

Expertise. Individuals only have to learn one insurer's products and are therefore able to build up a high level of expertise.

Control of business levels. Business levels may be controlled to a large extent by expanding or contracting the size of the sales force.

Feedback. The insurer is better able to get feedback about their products and the needs and views of their customers.

Expertise. While managing a direct sales force is straightforward in principle, in practice few insurers have been able to do so successfully and consistently.

Costs. The costs, especially start-up costs, may be prohibitive. Where salespeople are paid a salary, this may have to be paid regardless of sales and while they are undergoing training.

Lack of competitive challenge. Over-reliance on a direct sales force can result in too little attention being paid to what competitors are doing until it is too late.

Infrastructure costs. These include management overheads, property costs, training and administration. Invariably many of these costs are incurred before any new business is received.

B- Advertising

Whilst much advertising is designed to generate leads for a direct salesperson to follow up, it is possible to include a full application form in a newspaper advertisement. Extra

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business written in this way has to be balanced against the extra space (and therefore cost) of including an application form. Many consumers may have additional questions that they want answers to before committing themselves to buy or they may be put off by the complexity of the application form. If so, that negates the advantage of having an application form.

C- Telesales

Telesales is the use of salespeople to sell PMI over the phone. Potential clients may be called as a follow up to a response or cold called. The telesales process may be used to set up an appointment for an intermediary to visit the prospect or to sell direct.

The telesales operative will explain the purpose of the call and then ask appropriate questions in order to determine whether the prospect would be suitable to take out PMI.

Telesales work is highly demanding, requiring well-trained staff with a positive disposition and a good knowledge of their company's procedures and products. In order to monitor standards companies may record calls and, if so, this must be disclosed to the prospect. Calls also act as proof of what was said in the event of any subsequent dispute.

Telesales usually operate in specially set-up call centers. These may be situated in any geographical area and use technology to assist, monitor and control workflow.

D- Internet

This new technology enables insurers to offer a menu of information so that consumers may choose how much or how little information they have, subject to any regulatory constraints. It is also now possible for insurers to go on risk and to issue terms and a policy document, online.

10.5.2. Independent Intermediaries

There are four main types of independent intermediary.

A- Brokers

Until April 2001, only those firms registered, under the Insurance Brokers (Registration) Act 1977, with the Insurance Brokers' Registration Council could call themselves

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insurance brokers. Since then, the term may now be used by any intermediary. Individuals who hold an Associateship or Fellowship of the Chartered Insurance Institute (ACIIs and FCIIs) may now apply to the CII for a Chartered Insurance Broker title.

B- Other intermediaries

These include many firms that specialize in selling PMI. The advantage of specialization is that it enables the business and its sales staff to build up higher levels of expertise. Their higher levels of business may enable them to secure better terms from insurers.

C. Independent Financial Advisers

Independent financial advisers (IFA5) specialise in giving financial advice. PMI business may make up only a small part of some firms' business. Many IFAs may apply the same business rules to PMI as they apply to selling investment products. This helps to ensure consistency as well as meeting the high selling standards to which IFAs are subject.

Since June 2005, the term IFA may only be used by intermediaries who advise from the whole market and who offer the option of being paid by fee, rather than receiving commission from the product provider.

D Employee Benefits Consultants

Such firms usually restrict their activities to giving advice to large corporate customers. Selling PMI may make up only a small proportion of their business. Most will be paid a fee by the client, although some may take commission from the product provider and this may be offset against any fee payable.

The range of services offered may include: claims monitoring; product design; negotiations with insurers; legal advice (e.g. in setting up a health trust); third party administration; negotiations with hospitals and other healthcare providers; administration systems and salary payroll systems to enable clients to run their PMI schemes effectively and cost efficiently.

The main advantage of securing business from independent intermediaries is that costs are mainly linked to the amount of business received — this is what commission is based on. However, it is still necessary to set up a sales support infrastructure and business levels are outside the direct control of the insurer.

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10.6. The Role of Third Party Administrators

Third part administrators (TPAs) have grown considerably in influence over recent years. The role of the TPA may include: administering claims; underwriting; customer service; product design; negotiating pricing with hospitals; advice, information and management feedback.

TPA5 are primarily used by companies that wish to split the various functions normally included within a PMI policy. A large corporate client may decide to use a health trust, coupled with stop loss insurance and a TPA to handle all administration. The TPA aims to provide the same or a better level of service than an insurer but at a lower price. They seek to achieve this partly through economies of scale, managing a number of separate accounts often from the same office.

TPA5 may also be used by insurers that wish to concentrate on underwriting risks and marketing rather than on administration. This can enable with little knowledge of PMI to have a PMI product within their product range. If desired, underwriting the risk can also be outsourced, leaving the insurer with just the commercial risks of the business.

So far as the PMI customer is concerned, the divide between insurer and TPA is seamless. Phone calls and letters will be answered in the name of the insurer, usually under delegated powers, and the TPA will have power to settle all claims up to a pre-agreed limit. Where a TPA has a number of client schemes, they are able to provide benchmarks enabling different schemes to be compared with others.

10.6.1. Insurer/Provider Relations and Product Marketing

The relationship between insurers and providers of healthcare services is a symbiotic one — both rely on each other for the success of their business. Whilst much of this relationship is to do with pricing and service levels, hospitals and other healthcare providers make up an important part of the marketing mix too.

The product marketing department will want to ensure that hospitals and, if possible, individual specialists are: aware of the product; favorably disposed towards the insurer; not likely to cause difficulties for the customer; in a position to support the customer's buying decision positively; able to influence potential customers positively towards the product.

10.6.2. Transfers of Business

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If an insurer decides to pull out of the PMI market it may transfer its business to another insurer. A number of options may be available to the new insurer: the new insurer may simply take over the underwriting and may acquire the name from the previous insurer, which means it will take over all the responsibilities and liabilities of the existing insurer; the new insurer may offer new terms that are identical to the old ones, at the same or a different premium; the new insurer may offer a no worse terms switch to an equivalent but not identical policy; or the new insurer may offer a switch, but apply new underwriting terms.

The new insurer will need to consider: the value of adding new customers; how many of them are likely to switch; how profitable the business is likely to be; and whether any payment is required either way.

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Part V

Insurance Practice

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Part V

Insurance Practice

1. Risk

1.1. The Meaning of Risk

Risk consists of the following components:

Uncertainty: there is the idea of uncertainty, which is at the core of the concept of risk. It implies that there is some doubt as to whether the event will occur or not, as a result of imperfect information about the future, leading to uncertainty about the future;

Level of risk: there are differing degrees of risk. Thus, risk is a combination of the frequency and likelihood of an event and the severity of the damage caused should the event occur, such as the frequency of damage by flooding and the severity of damage. But there is a tendency to overestimate low frequency events and to underestimate high frequency events; and

Peril and hazard: The peril is the prime cause. It is what will give rise to the loss. For example, flood is the peril and the proximity of the house to the river is the hazard. Storm, fire, theft, motor accident and explosion are perils.

Hazards are factors that may influence the outcome. Theses hazards are not themselves the cause of the loss, but they can increase or decrease the effect should the peril operate. The underwriter has the task of assessing the hazards. Hazards can be physical or moral:

- **Physical hazard** relates to the physical characteristics of the risk, such as the nature of the construction of a building, i.e. wooden house, security protection of a shop or factory, or the proximity to a river bank.

- **Moral hazard** concerns the human aspects, which may influence the outcome. This refers to the attitude of the insured person: Lack of care on the part of the insured; Regular claimant or people who look at insurance as investment; Dishonest insured, dishonest claimant.

The Heinrich Triangle shows that for every one major injury at work, there are thirty minor injuries and three hundred non-injury accidents. The triangle was the result of

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looking at several thousand incidents at work.

The construction industry has a very narrow Heinrich Triangle – This means that in the construction industry, accidents in general cause minor and major injuries and there are less non-injury accidents than in other industries.

1.2. Classification of Risks

1.2.1. Financial and Non-Financial Risks

Financial risk is the risk with the outcome can be measured in monetary terms and where it is possible to place some value on the outcome. For example, it is possible to measure in financial terms the loss related to the damage to property, theft of property or lost business profit following a fire.

Non-financial risk is the risk where the outcome cannot be measured in financial terms. For example, the selection of a career, the choice of marriage partner or having children can be classified as non-financial risks, as the outcome is not measurable financially.

1.2.2. Pure and Speculative Risks

Pure risks involve a loss or, at best, a break-even situation. The outcome can only be unfavorable or leave us in the same position. The risks of a motor accident, fire, theft or injury, storm, explosion, malicious damage, liability, machinery breakdown are pure risks with no element of gain.

Speculative Risks involves a situation where there is the chance of gain. Investing money in shares can be classified as speculative risks. These actions may result in a loss or a break even situation or a prospect of a gain. Speculative risks are usually uninsurable. Insurance is not normally available for those risks where the outcome can be a gain. Speculative risks are entered into in the hope that there will be gain. There would be little incentive to work towards achieving this gain if it was known that an insurance company would pay up, regardless of the effort of the individual and there is very high risk or moral hazard. However, the pure division between pure and speculative risks has also evolved. For example, there is insurance for a credit risk, which is classified as a speculative risk, to meet some of the consequences of a default debtor.

Examples of speculative risks: (i) Investing money in shares – this kind of investment can result in a gain when the share prices go up or in a break-even situation when the

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share price remains the same or in a big loss during the stock market crash; (ii) Pricing of products – a wrong price may either make the products uncompetitive or not yield a sufficient high return to the company; (iii) Marketing decisions – incorrect interpretation of market needs may cause a loss, but a correct decision could be very profitable; (iv) Providing credit to customers can be a risky business. If the customers are not in the position to pay back the loan, there will be a loss.

1.2.3. Fundamental and Particular Risks

The third classification relates to both the cause and effect of risk. **Fundamental risks** are those which arise from causes outside the control of any individual or group of individuals. Their effects are felt by many people: earthquakes, floods, famine, volcanoes and other natural disasters. Social change, political intervention and war are capable of being interpreted as fundamental risks.

Particular risks are much more personal both in causes and effects: fire, theft, work injury and motor accident. All these risks arise from individual causes and affect individuals in their consequences.

Because of that different nature of risks, particular risks, such as fire, theft, work injury and motor accident are insurable, as these risks arise from individual causes and affect individuals in their consequences. At the same time, fundamental risks, such as earthquakes, floods, famine, volcanoes or social changes and political intervention, which will affect many people, are not insurable.

However, it is difficult to generalize this statement, as the insurance market place has changed from time to time. For example, earthquakes and floods, which are regarded as fundamental and not insurable in many parts of the world, are insurable in the United Kingdom. The ADB and the World Bank provide political risk insurance for projects in developing countries.

2. Insurance

2.1. The Functions of Insurance

Risk transfer: the primary function of insurance is to act as a risk transfer mechanism. A Telecommunication company can transfer the financial consequences of the risks, such as fire, lightning, loss of profit following fire, theft and other perils to an insurance company in return for paying a premium. In so doing, the company can exchange the uncertainty for a loss for certainty. This risk transfer mechanism allows the Chief

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Executive Officer of the company to concentrate on developing and expanding the business in order to increase the company's profit.

Creation of the common pool: By accepting premiums from a large number of the insureds, the insurance company creates a pool to provide insurance protection. The losses of the few insured are met by the contribution in the form of premiums of the many. The pool will operate only when there will be only a few losses in any one year and the premiums of the insured will be sufficient to pay any claim and cover the cost of operating the pool and the profit of the insurer.

Equitable premiums: the insurer has to ensure that a fair premium is charged which reflects the degree of risks, i.e. the hazard and the value which people bring to the pool. Thus, the risks of similar type that are brought together in a common pool do not all represent the same degree of risk to the pool itself. However, the premium must also be competitive. Charging too much the insurer will loose the business to the competitors, but charging too little the insurer will not be able to get sufficient funds to pay claims.

From the above definition, it is clear that insurance would not be an effective risk transfer mechanism without the common pool and equitable premium principles. However, in real life, this principle may not be working perfectly.

Indeed, a common pool of each class of business and the critical mass of the insured is critical for the law of large numbers to operate. For that reason, at a global level, international insurance and reinsurance companies are striving to get global business by taking about 5% of the business from each country in order to limit their exposure as part of risk management.

Moreover, insurance company is divided into two sections: insurance and fund investment. Revenue generated from fund investment can be used to compensate for losses in the insurance business.

2.2. The Benefits of Insurance

Insurance can bring benefits to both individuals and the economy of a country. Following are the benefits that insurance can bring to people, businesses and the country:

Peace of mind: insurance exists to meet the financial consequences of certain risks. Buying insurance allows entrepreneur to transfer some risks to an insurer. Insurance also acts as a stimulus to the activity of businesses.

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Loss control: insurers do have an interest in reducing the frequency and severity of losses, not only to enhance their own profitability but also to contribute to a general reduction in economic waste in the country as a whole. Surveyor provides recommendations on loss prevention and safety (sprinklers and how to store stocks). Loss adjusters reduce after-fire losses.

Social benefit: when the owner of business has fund to recover from a loss people will keep their job and continue to contribute to the national economy.

Investment of funds: time gap between receipt of premiums and payment of claims allows for investment of funds. Life insurance creates possibility for development of government bonds. Thus, insurance contributes to the promotion of economic activities and the development of the capital markets.

Invisible earnings: insurance transactions across borders bring large volume of premium inflows, which are classified as invisible earnings or service transfer for the balance of payments.

2.3. Nature of Insurable Risks

Fortuitous: happening of event must be entirely fortuitous. It is not possible to insure against an event which will definitely occur.

Financial value: The risk to be insured must result in a loss which is capable of being measured in financial terms.

Insurable interest: relationship between the insured and the financial loss.

Homogeneous exposures: insurer looks for homogeneous exposures in order to enjoy the benefits from the law of large numbers.

Particular risks are much more personal both in causes and effects, such as fire, theft, work injury and motor accident;

Pure risks, which involve a loss or, at best, a break-even situation. The outcome can only be unfavorable or leave us in the same position. The risks of a motor accident, fire, theft or injury, storm, explosion, malicious damage, liability, machinery breakdown are pure risks with no element of gain.

Public policy: it is common principle in the law that contracts must not be contrary to what society would consider to be the right and moral thing to do.

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3. Development of Insurance

3.1. Marine and Aviation

3.1.1. Edward Lloyd's Coffee Shop

Edward Lloyd's Coffee Shop was in existence by 1688, although the original date of opening is uncertain. Edward Lloyd encouraged the merchants or underwriter, who brought more business to his shop. He provided them with shipping information and published a news sheet in 1696, called 'Lloyd's News'.

Edward Lloyd's Coffee Shop encouraged the development of marine insurance and made London the world centre of marine insurance. With the expansion of the insurance business, Lloyd's Coffee Shop was moved to new premises in 1769 and a committee was formed. Then the coffee shop was transformed into the insurance fraternity. In 1871, by Act of Parliament the modern Corporation of Lloyd's was formed.

3.1.2. Chartered Companies Monopoly

In 1720, the London Assurance and the Royal Exchange were granted Royal Charters to transact marine insurance. The Act which provided for the incorporation of these two companies, giving monopoly rights. As only individuals could provide marine insurance could provide marine insurance, the activities in Edward Lloyd's coffee house prospered. The monopoly was terminated in 1824, when the Alliance Marine Insurance Company was allowed to provide marine insurance.

3.1.3. Marine Insurance Act 1906

The case law was accumulated over the years, some 2,000 cases, was incorporated in the Marine Insurance Act 1906.The Act formed the basis for the operation of marine insurance.

3.1.4. Aviation Insurance Development

In 1919 the first regular civil aviation service started, but it was until 1923 that the British Aviation Insurance Group began offering aviation insurance.

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3.2. Loss or Damage to Property

3.2.1. Fire Insurance

The industrial revolution changed the face of British industries and increased the number of items to be insured. Big new factories were constructed, housing sophisticated machinery and equipment. The demand for fire insurance increased tremendously commensurably with the growth of the industries, as more goods were produced and transported around the country and shipped overseas.

As a result of the industrial revolution, by the beginning of the 19th century there were many insurance companies offering fire insurance. However, these companies did not form any association to coordinate their business. As fire insurance was increasing, there was a need to pool expertise, establish common criteria to classify risks and establish tariffs. Concerted actions in fire fighting were also needed. Only in 1860 an insurance association was formed and in 1868 it became known as the Fire Offices' Committee.

On 22 June 1861 a fire broke out in wharves and warehouses along the banks of the Thames, near the centre of London. This fire was known as the Tooley Street fire, which wrecked havoc and cost the fire insurance companies £1 million. The immediate response to this fire was a drastic increase in the premiums charged for this type of property. More importantly the consequences of the Tooley Street fire were as follows:

The new London Wharf and Warehouse Committee decided on the tariffs for insurance of wharves and warehouses; Differential rates of charges were adopted in an effort to encourage owners to think about fire precautions: bad risks were penalized and good ones rewarded. A fire service for London was established and run by the city under the Metropolitan Fire Brigade Act 1865 in order to provide adequate facilities to the fire fighting forces. Two new companies were established: the Commercial Union and the Mercantile, and later the North British and Mercantile.

3.2.1. Theft Insurance

It was until 1887 that the first fire policy was extended to include theft cover. The Mercantile Accident and Guarantee Insurance Company began issuing theft policies in 1889, although the term used was burglary. The use of the word theft followed on from the Theft Act 1968, when the legal definition of theft was given.

3.3.2. Engineering

The change brought about by the Industrial revolution brought with them many problems, such as the risk of damage or injury, related to the operation of machine.

The public opinion grew to such extent that in 1882 the Boiler Explosion Act was passed, by which severe penalties could be imposed if the explosion of a boiler was found to have been the fault of the owner.

3.4. Life, Personal Accident and Health

3.4.1. Ordinary Life Assurance

The first evidence of life assurance dated back to 1583, when a policy was taken out on 18 June on the life of William Gibbons.

Actuarial Principles—The intention of the mortality tables was to be able to state in mathematical terms the likelihood of persons of a given age dying. It was described by Halley: '...that the pricing of insurance on lives might be regulated by the age of the persons on whose life the insurance is made.'

The Life Assurance Act 1774 was passed: 'An act for regulating insurances upon lives and prohibiting all such insurances except in cases where persons insuring shall have an interest on the life or death of the person insured.

3.4.2. Industrial Life Assurance

The changing structure of society brought about by the Industrial Revolution produced the beginnings of industrial classes. But they were not protected against infirmity and old age.

3.4.3. Personal Accident and Health Insurance

In 1848 the Railway Passengers Assurance Company began offering policies aimed at providing compensation in the event of an accident. In 885 the Sickness and Accident Insurance Association started issuing policies that provided compensation payments in the event of certain sickness. The policies became permanent.

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3.5. Liability

3.5.1. Employers' Liability

Industrialization attracted many people to come and work in the cities and resulted in appalling conditions and a disregard for safety, causing many injuries. However, ordinary employees found it difficult to win any claim. Moreover, the law allowed employers to avoid any liability for injury.

In 1880, the Employers' Liability Act placed certain employees in a much better legal position. They could sue their employers with a slightly higher chance of success, but many obstacles remained. The most notable development was the establishment of the Employers' Liability Assurance Corporation.

However, the passing of the Workmen's Compensation Act in 1897 provided scale benefits on death and half earnings during disablement, regardless of proving fault.

3.5.2. Public Liability

The earliest policies at the end of the 19th century related to horse drawn caches and later developed into motor vehicle insurance.

3.5.3. Motor Insurance

Motor insurance was developed later than other forms of insurance, as the increase use and development of cars became a mass phenomenon only in the 1920s. To address the problems associated with motor accidents the first Road Traffic Act was enacted in 1930. The intention was to ensure that funds would be available to compensate innocent victims of motor accidents. Insurance against legal liability was introduced to pay damages to injured persons. The insurance requirement applied to all users of motor vehicles, except where some special legal requirement is in force. The 1930 Road Traffic Act promoted the motor insurance by creating requirement for insurance against legal liability.

3.5.4. Surety, Credit, Loss of Profits

Suretyship or fidelity guarantee insurance caters for the risk of losing money by the fraud of dishonesty of some other person. In 1840 the Guarantee Society was formed to provide surety by the means of a policy of insurance.

In 1893 another form of pecuniary insurance began to be transacted by the Excess Insurance Company. This attempted to meet the risk that a person might sell goods and the purchaser may not pay for them. This became known as credit insurance and by 1918 a specialist company was formed.

Loss of profits or business interruption insurance is the third form of cover began to appear at the start of the 20th century. These policies endeavored to relieve the hardship associated with consequential loss following fire.

3.6. Common Features of Development

Firstly, each class of insurance developed in response to a demand for protection, such as in the case of fire, life and liability classes of insurance. To protect the people against the eventuality of risks, such as to protect the employees or the member of the public against motor accident, the Parliament passed the legislation to make employers' liability and motor insurance compulsory.

Secondly, the development of various forms of insurance was accompanied by a measure of government supervision. Effective supervision is designed to prevent the failure of insurance companies and to provide protection of the consumers.

Thirdly, insurance companies started off as specialist companies offering protection in one or two types of insurance only. These specialist companies have expanded the forms of cover they write. At present, there are very few specialist companies other than life and pensions companies. The majority offer many different forms of insurance.

Fourthly, insurance companies have joined together over the years to pool resources. The association of insurance companies has classified the risks, pooled statistics and come up with common policy wordings and rates.

Fifthly, one of the main feature of the insurance industry is the growth of reinsurance, as insurance companies themselves have sought financial protection. The development of reinsurance, i.e. insurance bought by insurance companies, has become an essential part of the insurance market place.

4. The Classes of Insurance

4.1. Ordinary Life Insurance

Term assurance: payment of sum assured on death, provided death occurs within a

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specified term. Should the life assured survive to the end of the term then the cover ceases and no money is payable;

Decreasing term assurance: to cover the outstanding balance of a monthly repayment building society mortgage. As borrower repays the capital sum, the sum assured diminishes year by year until exhausted at the end of the mortgage period;

Convertible term assurance: allows life assured to convert the policy into an endowment or whole life contract at normal rates.

Family income benefits: benefit on death paid out to family by installments every months to replace income;

Whole life assurance: sum assured is payable on the death. Premiums are payable either through the life of the assured or cease at certain age, often 80;

Endowment assurance: sum assured is payable in the event of death within a specified period of 15, 20, 30 years.

Assurances for children: policy is effected on the life of a parent with an option date (18 or 21 years), child can continue the policy in his own name.

Group life assurances: sum assured payable in the event of death of an employee;

Annuities: a person can receive a yearly sum in return for payment to an insurance company of a sum of money.

Features: premium payments – level amounts throughout the period of the policy; participation in profits; surrender values; paid-up policies – the premium ceases but policy continues, but on maturity a smaller sum will be due;

4.1.1. Annuity

An annuity is a method by which a person can receive a yearly sum, an annuity, in return for payment to an insurance company of a sum of money. When a person has a reasonably large sum of money and wants to provide an income for himself after he retires or at some other time, he can buy an annuity with a life insurance company. Annuity is not life assurance, but it is based on actuarial principles.

Annuity has different forms: Immediate annuity – the annuity may start at once; Deferred annuity – the annuity may start at some date in the future; Annuity certain – it

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may be payable irrespective of death for a certain period; Guaranteed annuity – it provides the annuity for a guaranteed period or until the annuitant dies; Reversionary annuity – it provides for payment to annuitant, the wife, on the death of another named person, the husband; The joint and last survivor annuity – it is payable while two people, husband and wife, are alive and on the death of one will continue at the same or smaller rate on the life of the survivor.

4.1.2. Special Features of Life Assurance

A. Premium Payments

Life insurance premiums are payable by level amounts throughout the period of policy. This means that each person pays the same amount throughout, that amount being determined by his age on effecting the policy. Premiums can be paid annually, half-yearly, quarterly or monthly.

B. Participation in Profits

Life insurance companies value their assets and liabilities at regular intervals, some every year and others every three years. This valuation allows them to determine if any surplus exists after calculating all future liabilities and other contingencies. Should such a surplus exist it is distributed among those policyholders who have 'participating' policies. Such policies allow the policyholder to participate in any profits the company makes. The policyholder pays an additional amount for the privilege of participating in profits and the bonuses are added to the sum assured and payable at maturity date.

C. Surrender Values

When a person no longer wants his policy or cannot continue the premiums he can ask for the surrender value. He ceases payment and received a portion of the premiums. Not all policies allow a surrender value. Surrender within a few years will not produce any amount, as it needs to cover the costs.

D. Paid-up Policies

Some policies provide the policy to become paid-up, rather than for a surrender value to be available. In this case the premiums cease and the policy continues, but on maturity a smaller sum than would be originally have been paid will be due to the policy holder. Depending on the policy and the company concerned these paid-up policies

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may or may not continue to participate in profit.

4.2. Industrial Life Assurance

Industrial life insurance: the function is to bring life assurance to the workers. They are of the lower income class; collection of premiums at the home of policyholders;

4.3. Personal Accident Insurance

Personal accident insurance: provide compensation in the event of an accident causing death or injury. Policy is extended to include a weekly benefit for up to 104 weeks or compensation if the insured is temporarily totally disabled due to an accident, and a reduced weekly benefit if he is temporarily only partially disabled from carrying out his normal duty. In the event of permanent total disablement (other than loss of eyes or limbs) an annuity is paid. Personal accident and sickness policies are renewable annually and if a claim has occurred which could be of a recurring nature, the cover may be restricted at renewal or in severe cases renewal may not be offered.

4.4. Motor Insurance

An 'Act only' policy covers the minimum required by the law (Road Traffic Act 1988) and similar to 'Third Party only' policy, i.e. to provide insurance in respect of legal liability to pay damages arising out of injury caused to any person, unlimited in amount, and damages to the property of other people subject to certain limits and exceptions. A 'Third Party and Theft' policy would satisfy the minimum legal requirements plus cover for damage to the car itself from fire and theft. A 'Comprehensive policy' adds accidental loss of or damage to vehicle to the TP and T cover.

4.5. Marine and Transport Insurance

4.5.1. Professional and Indemnity Clubs

Marine underwriters limit their cover to ship-owners to three quarters of the liability in respect of liability to another ship, in order to prevent negligent navigation. In order to provide indemnity for the remaining quarter of this liability, the ship-owners established their own Professional and Indemnity Club (P&I) Club, which is a mutual insurance association. The functions of the P&I Club are the following: cover the balance not covered by the three quarters running down clause relating to ship-owner's liability for damage done to another vessel or its cargo as a result of negligent navigation; his liability for loss of life or personal injury; his liability for damage done to immobile

objects such as buoys, quays, dock walls, and other property on land; his liability for cargo resulting from faulty stowage, short-delivery and non-delivery; his liability as an employer to his employees for vocational accidents; payments for sickness and repatriation of crew members; other miscellaneous contingencies.

4.5.2. Marine Cover

The marine policy provide cover for the following risks: hull, cargo and freight. There are different kinds of marine policies:

- **Time policy** for fixed period 12 months;
- **Voyage policy** for the period of voyage from warehouse to warehouse;
- **Mixed policies**: time and voyage;
- **Building risk:** construction of marine vessels;
- **Floating policy:** provides policyholder a large reserve of cover for cargo. After each shipment the value of shipment is deducted from the outstanding.
- **Marine cargo:** on a warehouse to warehouse basis and frequently covering all risks.

4.5.3. Marine Open Cover

The marine open cover is the most common form of cargo insurance. Its purpose is to pre-establish an automatic facility tailored to anticipate the permutations of a client's future insurance needs over the full range of his on-going trading operations, whatever the variations in interests, voyages, conditions or rates. Once arranged, the insured is guaranteed protection on the agreed basis for all shipments falling within its provisions, subject to declaration of full shipment details of each dispatch.

The client is relieved of the necessity to negotiate the insurance of every shipment individually, while the insurer obtains prospective continuity of interest in the client's global activities.

4.6. Aviation Insurance

Most policies are issued on an 'all risks' basis subject to restrictions. Usually a comprehensive policy is issued covering the aircraft, the liabilities to passengers and the

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liabilities to others. Liabilities to passengers are governed by international agreements: (i) The Warsaw Convention 1929 made signatories liable to passengers without negligence, but subject to certain maximum amounts; (ii) The Hague Protocol 1955 raised some of the above limits. The national laws may place higher limits on domestic flights.

The two international agreements also place limits on liability for goods carried by air. Unless of special risk or value, cargo is usually insured 'all risks' in the marine or general markets rather than the aviation market.

4.7. Fire and Other Property Damage Insurance

4.7.1. Fire, Theft, Engineering, All Risks, Glass

A. Fire Insurance

A standard fire policy covers the following perils: fire; lightning; and explosion: of boilers; of gas used for domestic purposes only.

The policy covers fire but excluding loss destruction or damage caused by: explosion resulting from fire (such as gas explosion); earthquake or subterranean fire; (i) its own spontaneous fermentation or heating, or its undergoing any heating process or any process involving the application of heat.

Other circumstances in which the loss is closely associated with the fire that it is regarded as covered by the policy include: property damage by water or other extinguishing agents used for extinguishment purposes; damage done by the fire brigade in the execution of its duties, including for gaining access to a fire; property blown up to prevent a fire spreading; damage occasioned by falling walls or parts of a building in which a fire takes place; loss of or damage to property removed from a burning buildings caused by rain, theft, or damage during removal, provided that the removal was justified and that the insured take steps as soon as possible to protect the removed property from further damage.

A standard fire policy excludes subsidence, flood, impact damage, and strike, riot and civil commotion, which are considered as special perils. Strike, riot and civil commotion and impact damage can be provided as extensions for additional premium income.

B. Theft Insurance

Theft policies intend to provide compensation to the insured in the event of the loss of property insured. The theft policy will show a more detailed definition of stock. The insurers charge more for stock, which is attractive to thieves. Theft is defined as forced and violent breaking into or out of the premises of the insured. Shoplifting is uninsurable.

C. All Risks Insurance

Personal Effects: All risks policies provide cover for individuals who seek a wider protection than that afforded by the policies available to cover household effects. The all risks policy can be taken out on expensive items: jewellery, cameras and fur coats for a lump sum for accidental loss or damage.

Business all risks: to protect machinery, desk top equipment, computers etc.

Goods-in-transit: Goods-in-transit insurance covers property against loss or damage while it is in transit from one place to another or being stored during a journey. Policies often specify the means of transport to be used. If goods are shipped by sea then marine insurance is effected. This also includes the transit of cargo over land at each end of the voyage. The cover for the goods in transit policies is practically "all risks". The insured will be indemnified for loss of or damage to by fire, accident, theft or pilferage while being loaded on, carried by, or unloaded from the motor vehicles and while temporarily garaged during transit. The insured and insurer will need to agree on how much the goods are valued at.

There are two types of cover: **old-for-new** - items are replaced at their current market value; and **indemnity cover** – the insurance company will take into account general depreciation.

The goods in transit policies fall into two categories: on goods on insured's own vehicles, with a sum insured for each vehicle; and on all goods dispatched by the insured, by own vehicles, by road haulier, rail and post, subject to a limit any one consignment.

Contractors' all risks: the over provided for new buildings or civil engineering projects, such as highways or bridges. The policy provides compensation to the contractor in the event of damage to the construction works from many perils.

Money insurance: provides compensation to the insured in the event of money being

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stolen either from his business premises, his own home or money in transit to or from bank. The policy also provide compensation to employees injured during robbery.

Glass: Cover is also available against accidental breakage of plate glass in windows and doors. In the case of shops this is often extended to include damage done to shop window contents.

D. Engineering

The cover is to provide compensation to the insured in the event of the plant (boilers, lifts, cranes, electrical equipment, engines and computers) being damaged by extraneous cause of its own breakdown. The engineering policy covers: damage to or breakdown of plants and machinery; inspection services; costs of repair of own surrounding property due to (a); legal liability for injury caused by (a); and legal liability for damage to property of others caused by (a).

E. Liability Insurances

Employers' liability: Under the Employers' Liability (Compulsory Insurance) Act, every employer shall insure with an authorized insurer against liability for bodily injury or disease sustained by his employees and arising out of and in the course of their employment. The policy will also pay certain expenses such as lawyers' fees or doctor's expenses where the injured person has made medical check. The policy indemnifies the insured in respect of his legal liability. The policy does not apply where property of an employee is damaged. Actions involving personal injury must normally be started within three years of the date of accident. However, to resolve the difficulty of untraced policies, some insurers are now prepared to issue a policy which will offer cover on a 'claims made' basis for claims made during the currency of a policy even if the events may have occurred many years previously.

Public liability: members of public may suffer injury or damage to property due to activities of someone else. The insurer will indemnify the insured against legal liability to pay compensation and claimants' costs and expenses in respect of accidental: bodily injury to any person; loss of or damage to material property. *When the chemicals damaged the shoes and the briefcase of the factory's inspector, the insurer will pay the cost of repairing the damage. They may be also responsible for the cost of hiring another car while the third party's car is being repaired.*

Nuisance, trespass, obstruction or interference with any rights of way, light, air or water resulting in financial loss occurring within the electrical kettle factory during the period

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of insurance in connection with the business.

Product liability: the liability of the manufacturer arising out of goods sold. The use of faulty material or incorrect assembly of an electrical kettle can result in injury to the person who had bought it. If the buyer can show that the kettle manufacturer was to blame, he or she will succeed in a claim for damage. The scope of the cover is limited to the insured's legal liability for bodily injury to persons, or loss of or damage to material property caused by the electrical kettle. A combined public/ product liability policy may be issued, with a single operative clause or the public liability policy may be extended by endorsement to cover products liability risks.

Professional liability: liability arising out of professional negligence: lawyers, accountants, doctors and insurance brokers.

Directors' and Officers' liability: Liability may arise out of lack of care and skill in the performance of a director's duties, such as negligent advice or misstatement, especially in the context of a merger or takeover when failure to understand economic trends results in a poor forecast of the company's performance; any act which goes beyond the limits of the company's constitution, unauthorized payments, failure to disclose the full extent of their interests, a failure to comply with requirements or the failure to arrange proper insurance. The Directors and Officers Liability policy may consist of two parts. The first is to indemnify the company in respect of costs it has incurred indemnifying a director against the successful defense of a claim. The second part indemnifies the director from the company because he has not been successful in the defense of a claim.

F. Credit and Suretyship Insurances

Credit insurance: provide protection to traders, who can sustain losses or default on the part of the buyers of the goods.

Suretyship or fidelity guarantee insurances: provide insurance against loss by reason of the dishonesty of persons holding the position of trust, or loss caused by mistake (a liquidator maladministers the affairs of the company being wound-up; accountants working in the company.

G. General (Other) Insurance

Insurance of rent: a building has been damaged until repair, but the person occupying the building may still be paying rent to the owner.

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Interruption insurance: loss of profits or consequential loss following from: a fire and special perils; engineering breakdown risks; computer damage and breakdown risks; certain overhead costs will remain, even sales are reduced; net profit will be reduced; increase in costs to keep the business going;

Legal expenses insurance: cover provided to private individuals and organizations facing possibility of legal actions, such as trade union and professional bodies.

H. Combined and Comprehensive Policies

Combined insurances mean that a number of insured perils or policies are combined into one policy. For example, a householder will require fire, special perils, loss of rent, theft, glass, money and liability insurances. These classes of insurance can be combined into a single household policy. These combined policies are very suitable for a large number of business insureds. Another example is that the holiday and travel insurance policy provide all risks cover, combined with personal accident, medical expenses and loss of deposits.

The advantages of the combined insurances are: (i) less costly; (ii) one premium and one renewal date; (iii) less chance of overlooking one form of cover; (iv) easier to market as one product.

Space risks: a number of risks can be covered in the marine market, such as material damage during testing or launch, as well as while in orbit and loss of revenue.

5. The Insurance Market Place

5.1. The General Structure of the Market Place

The three general classes of participants in the insurance market are:

5.1.1. The Buyers

The general public is the buyers of personal insurance, private car insurance, household insurance and life assurance. However, commercial and industrial insurance bought by industry and commerce makes up the largest share of insurance markets.

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5.1.2. The Intermediaries

A. The Insurance Broker

The insured can obtain independent advice on insurance matters from a broker without the cost to himself, on the following issues: insurance needs; best type of cover and its restriction; best market; claim procedure; and obligations placed on the insured by policy conditions.

Broker advices on insurance needs, best type of cover and its restrictions, best market, claim procedure, obligations placed on the insured by policy conditions and updates the information as time goes by to take account of market changes.

B. Lloyd's Brokers

The Lloyd's broker carries out the same functions as an ordinary insurance broker, but if one wishes to insure at Lloyd's the business must normally be placed there by a Lloyd's broker or other intermediary through Lloyd's brokers. Special direct dealing arrangements exist where a non-Lloyd's broker may deal direct with a syndicate. Managing agents may set up service companies to deal direct with the public for personal lines and commercial motor business without any Lloyd's broker involvement.

Lloyd's broker operates at all time in the interests of his client and must understand his requirements and advise on the best way to meet them. It is the broker's duty to advice on insurance needs, to obtain the best possible terms for his clients, best type of cover and its restrictions, best market, claim procedure, obligations placed on the insured by policy conditions and updates the information as time goes by to take account of market changes. Should there be a claim the broker negotiates, arrange settlement, collects the money from underwriters via the central accounting system and pays it to his client.

The Council of Lloyd's registers broking firms to act as Lloyd's brokers. They are required to satisfy the Council as to their expertise, integrity and financial standing. After being appointed, they can display the words 'and at Lloyd's' on their letter heading and name plates. The Lloyd's broker represents the insured in the transactions with the underwriter.

C. The Agents

Agents have to register under the law.

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D. The Insurance Consultants

The insurance consultant is a person who can act as intermediaries without registration.

5.1.3. The Sellers or Suppliers

A. Lloyd's

In 1871,the Lloyd's Act created the Corporation of Lloyd's. The 1982 Act created the Council of Lloyd's, which has overall responsibility and control of affairs at Lloyd's, including the rule-making and discipline. The Council consists of 18 members: 6 working, 6 external and 6 nominated members.

The Committee of Lloyd's comprises working members of the Council and is concerned with day-to-day running of the affairs at Lloyd's.

The capital behind the underwriting of insurances at Lloyd's is supplied by investors called Names or underwriting members. The underwriting members are not insurance professionals. Some members are Working Names. They are people who are engaged in the work of the insurance market. They have to satisfy strict requirements as to knowledge of the market.

Now the Lloyd's members are mostly corporate names and some individual members, grouped into syndicates. Corporate membership was introduced in 1994. Each syndicate appoints an underwriting agent to manage its affairs and this underwriting agent appoints professional underwriters. In view of unlimited liability, there is strict regulation of underwriting member.

There are three forms of membership of Lloyd's:

Vocational name – people who have worked in Lloyd's for at least five years and passed Introductory Test; do not have to show means;

Connected or associated name – Employees or principals of firms trading in the Lloyd's market who do not meet the requirements of vocational names.

Other names – external members, not in the two categories.

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B. Insurance Companies

Proprietary Insurance Companies

The majority of insurance companies have been created by registration under the Companies Acts. The majority of these companies come are limited liability companies with shareholders as proprietors.

Proprietary companies have an authorized and issued share capital to which the original shareholders subscribed, and it is the shareholders that any profits belong after provision for expenses, reserves and, in the case of life business, with-profit policyholders' bonuses. The shareholders' liability is limited to the nominal value of their shares, but the company is liable for its debts and if the solvency margin cannot be met the company will go into liquidation.

Mutual insurance company

Mutual companies are owned by policyholders, who share profits made. The policyholder owner may enjoy lower premiums or higher life assurance bonuses than would be the case.

Mutual Indemnity Association

Mutual indemnity associations differ from mutual companies in that the companies will accept business from the public at large. The true mutual indemnity associations grew out of trade associations and are common pools into which members of a particular trade contribute and from which they can make claim when necessary. The associations were formed because members considered that the cost of commercial insurance was too high, compared to claims or their need was not met by the market.

Contributions were made to the fund on the basis of tonnage or value. In bad years, the members would be called upon to make additional contributions to keep the fund solvent. Most of these associations have been taken over by the normal insurance market.

Self-Insurance

The five advantages of self-insurance are as follows:

- Premiums should be lower as there are no costs in respect of broker's commission, insurers' administration and profit margins;

- Interest and profit of the investment of the fund belongs to the insured and can be used to increase the fund or to reduce future premium contributions;

- There is a direct incentive to reduce and control the risk of loss;

- The insured's premium costs are not increased due to the adverse claims experienced of other firms;

- No disputes will arise with insurers over claims.

The five disadvantages of self-insurance are as follows:

- A catastrophic loss could occur, wiping out the fund and perhaps forcing the organization into liquidation;

- Capital has to be tied up in short-term, easily realizable, investments which may not provide as good a yield as the wider spread of investments available to an insurance company;

- The technical advice of insurers on risk prevention would be lost and since the insurance surveyors would have a wide experience over many firms and different trades, this knowledge could be advantageous to the insured;

- There may be criticism from shareholders and other departments: at the transfer of large amounts of capital to create fund and at the cost to dividends that year; and at the low yield on the investment of the fund compared with the yield obtainable if that amount of capital were invested in the production side of the organizations.

- The basic principle of insurance, that of spreading the risk, is defeated.

5.2. Transaction of Business at Lloyd's

The room – underwriters and their staffs sit at 'boxes' each with a number and the Lloyd's brokers negotiate their contracts. The Room at Lloyd's is the only place in the country where there is recognized insurance market.

Transaction of business – Only Lloyd's brokers may place insurance at Lloyd's. Lloyd's broker will prepare a slip. Risks may be placed electronically.

The slip – The slip will show: details of insured; period of cover required; inception date of cover; perils or type of cover required; property to be insured; sums insured or limits of liability; special conditions to be incorporated; expected premium.

Lloyd's underwriters – The broker will take the slip to an underwriter who specializes

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in this class of business, with a view to him accepting the lead or first proportion of the risk. Discussions on other aspects of the risk, such as the claims experience, will take place and the underwriter may feel obliged to amend some of the terms on the slip before he can accept the rate of premium or the conditions.

Once agreement on terms has been reached, the underwriter will stamp and initial the slip for the proportion which he is prepared to accept for his syndicate. The broker will proceed to other underwriters until 100% is underwritten. Each underwriter will record details of the risk underwritten for his own records.

Lloyd's Policy Signing Office – When the slip is complete, the broker returns to his office and has the policy prepared in accordance with the slip. The policy and slip are then submitted to Lloyd's Policy Signing Office (LPSO), where the policy is checked with the slip and signed on behalf of all syndicates. Brokers will send accounting and settlement details electronically to LPSO. Accounts are prepared for the syndicates and brokers from the data recorded at the Policy Signing Office.

Lloyd's Claim Office – The Lloyd's broker also provides a service to his client in the settlement of claims. He negotiates with the staff of the Lloyd's Claim Office (LCO). Once the broker has been informed of a casualty or potential loss he will advise the leading underwriter and LCO of the details and obtain any relevant details and enter the appropriate information into the claims office computer system.

5.3. Organizational Structure of Insurance Companies

5.3.1. The centralized operational system

When a company is centralized, all underwriting claims, policy drafting, renewals and accounts work is handled from head office with the branches merely being sales outlets. The advantages of the centralized operational system are as follows: Uniformity of policy, practice and routine; Most economic use of merchanised methods; Fewer experts are required with a resultant saving in salaries; Branches are relieved form routine work and can concentrate on selling.

However, this system has the following disadvantages: The system is often run from an area of high salary, building and rating costs; Poor service can result from the administration being remote from the customers; Excessive power resides in a few hands. Dictatorial attitudes can develop in underwriting to the detriment of the company; Lack of promotion prospects for most of the staff.

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5.3.2. The Decentralized Operational System

Decentralization – the main branch is responsible for its own underwriting, policy drafting and claims. Decentralization has the following advantages: Local officials will be best understand local conditions; Good local service responsible; Branch staff became knowledgeable and makes decision; Underwriting policy is democratic; Better staff morale – chances of promotion.

However, decentralization has the following disadvantages: Many experts are required, with higher staff bills; Branches inundated with routine work; Effort wasted in making traffic branches expert in everything.

Regional system – the country is divided into regions and the principal branch became the regional office. It took over the underwriting, policy drafting and claims work from head office or the branches depending upon the system in force before. In late 1970s the tendency was to remove some of the authority from main branches to regional offices and from regional offices to head office, due to ICT.

6. Transacting Insurance: Proposals and Policies

6.1. Publicity

The insurer has embraced modern concepts in marketing and advertisements using billboards, television or brochures and sport sponsorship to promote products available from insurance company. The insurer has adopted a modern approach to insurance advertising, such as "We won't make a drama out of a crisis"; "I want to be ..."

The nature of insurance products, i.e. the proposer cannot see or touch the product; there is no possibility of testing the product and in many cases the proposer hopes that he will never have to use the service of the insurer.

Proposal form is often the only printed publicity material. Now insurers distribute a leaflet, which provides information on motor insurance: total loss of the car, authorising repairs, range of cover.

6.2. Proposal Form

The proposal form is the mechanism by which the insurer receives information about the risks to be insured. In most classes of insurance a proposal form is completed by the proposer and submitted to the insurer. The proposal from differs depending on the

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class of insurance. In general it should include the name and address of the proposer, his occupation and age; details of past claims; description of trade; period of cover required; basis for premium calculation.

The classes of insurance for which proposal forms are not required are fire and marine insurance. In the case of fire insurance, the actual details of the risk are complex that it would be impossible to confine them to a proposal form. For example, it is impossible to describe a large manufacturing plant on a proposal form. For this, the insurer use the risk surveyors to visit the premises or to discuss the risks with proposer. Brokers play an important part in this process by preparing full details of a risk for an insurer.

In marine insurance, a broker, acting on behalf of a proposer, would describe the risk and take the slip containing the details of the risks to the underwriter at Lloyd's.

A. Risk Specific Question in a Proposal Form

Risk specific questions relate to the form of risk for which cover is sought. They assist the underwriter in determining whether or not he will accept the risk and on what terms and price.

On the motor proposal, details of the drivers required. The underwriter wants to know who will be driving the car as it influences the price of the insurance.

On the household proposal, questions concerning the level of physical protection at the house; intruders alarms used; neighborhood watch schemes;

On the life proposal, questions concerning the health of the proposer;

B. Features that Appear on Proposal Forms

Declaration – appears at the end of the form – confirms that the information which has been supplied is true to the best of the proposer's knowledge and belief.

Warnings or important notes about what facts should be disclosed and the dangers of all material facts are not disclosed. This has the effect of allowing insurers to avoid liability under the policy if a fact emerged which had not been declared.

C. Proposal Form for Private Motor Insurance

The proposal form is the most common mechanism by which the insurer receives information about risks to be insured. The following are five risk specific questions on a

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proposal form for private motor insurance.

Firstly, details of the proposer: the name and address of the proposer, occupation and age of the driver;

Secondly, specific questions about the driver: will the car be driven by anyone under the age of 25; whether he or she have been convicted in connection with motor vehicle (fines, penalty, date and reasons for disqualification); whether he or she has been disqualified from holding or obtaining a driving licence; had a proposal for any motor insurance declined, had a policy cancelled or had renewal of a policy refused; accidents or losses suffered by those who drive the car for the past three years.

Thirdly, details about the vehicles: full details of make of vehicle and model; whether the car has been modified to increase performance; where the car is kept;

Fourthly, cover and options: type of cover: comprehensive; third party, fire and theft or third party only;

Fifthly, declaration: (i) the car is in good conditions and repair; (ii) all information supplied is true and complete and nothing materially affecting the risk has been concealed.

6.3. The Policy

6.3.1. The Heading

Each policy have a heading which includes the name of the insurer, the address and company logo.

6.3.2. Preamble

The proposal form is the basis of the contract and is incorporated in it. The insured has to particularly careful when completing the proposal form. The premium has been paid or there is an agreement that the insured will pay. There can only be a valid contract when the insured has paid the premium. The insurer will provide cover detailed in the policy, subject to its terms and conditions.

6.3.3. Signature

Under the preamble, or close to it, will be the signature of an official from the

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company.

6.3.4. Operative Clause

The operative clause indicates the actual cover provided under the policy is outlined. The insurer is stating clearly what it is agreeing to do, what benefits it will pay. These rules should be read in conjunction with the policy schedule.

6.3.5. Exceptions

Exceptions are the consequence of having a scheduled type of policy. Exceptions are what are not covered under the policy. In the policy there are a number of general exceptions, which apply to all sections of the policy. For example, exceptions dealing with war risks and nuclear contamination.

6.3.6. Conditions

The policy contains conditions, stating that the insured will comply with all the terms of the policy. The following are the conditions in a typical policy: the requirement that the insured notify the insurer of any changes in the risk; what procedure is to followed in the event of a claim; the effect of fraud; the insured has to take reasonable care to minimize the risk of loss or damage; a condition about arbitration; a condition which outlines what is to happen if there are other policies in force covering the some loss; condition that allows the insurer to cancel the policy and how this can be done.

There are express conditions and implied conditions. Express conditions are those that appear on the printed policy. Implied conditions are those which are not appear on the policy. Conditions impose an obligation on the insured and can be classified:

Conditions precedent to the contract – the policy will be void or not come into effect if the insured fails to comply with the term (for life insurance – premium is paid until the policy come into effect; in motor – the insured must maintain the vehicle in a roadworthy condition at all time);

Conditions subsequent to the contract – these conditions which have to be complied with once the contract is in force, such as adjustment of the premiums or notification of alterations to the risk. Conditions precedent to the contract are those conditions which must be fulfilled prior to the formation of the contract itself. If not fulfilled the contract is not valid. The implied conditions fall into this category, such as:

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Firstly, the subject matter of insurance actually exists and can be identified;

Secondly, the insured has insurable interest, i.e. the insured has financial relationship with the subject matter of insurance. He stands to benefit if it is not lost or damaged and will suffer in the event of any loss or liability;

Thirdly, the respect of the principle of utmost good faith in negotiations leading up to the formation of the contract. This is the duty of disclosure of all facts which may be material in the forming of the insurance contract;

Fourthly, the policy will be void or not come into effect if the insured fails to comply with the term (for life insurance – premium is paid until the policy come into effect; in motor – the insured must maintain the vehicle in a roadworthy condition at all time);

Conditions precedent to liability – these conditions relate to claims and must be complied with if there is to be a valid claim, such as prompt notification of claims in the proper manner. This allows insurers to avoid liability for a particular loss if the term is broken, but not avoid the contract as a whole (prompt advice of a loss);

Conditions subsequent to the contract – that must be complied with once the contract is in force, such as condition relating to the adjustment of the premiums, notification of alterations of the risk.

6.3.7. Main Components of an Insurance Policy

Heading – each policy has a heading which includes the name of the insurer, address, company logo;

Preamble – makes mention of the premium and the cover provided by the insurer, subject to its terms and conditions.

Signature – under the preamble will be the signature of an official from the company;

Operative clause – the most important section of the policy, i.e. actual cover is outlined. The company will ... pay certain benefits, rules etc.

Exclusions – what is excluded;

Conditions – the insured will comply with all the terms of the policy; notify the insurer of any change to the risk; procedure for claims; effect of fraud; care to minimize the risk of loss or damage; arbitration;

Policy schedule – information on the insured; address; nature of business; period of insurance; premiums; sum insured; policy number.

6.3.8. The Policy Schedule

The policy schedule is made personal to the insured. The policy schedule usually contains the following information: The insured; The address of the insured; The nature of the business; The period of insurance; Premiums; The limits of liability; The policy number; Reference to any special exclusions, conditions or aspects of cover.

6.3.9. Cover Note

A cover note is issued to provide confirmation of a cover, as it is not always possible to issue an actual policy as soon as the terms of the contract have been agreed. It is a summary of terms and conditions of the insurance that has been placed, as well as details that the insurers have accepted. The cover note is widely used in motor insurance. The cover note is temporary and will be super-ceded once the policy is issued. It could take the form of a letter from the insurer to the insured. The motor cover is in force once the cover note is issued and the premium may still have to be paid.

The Difference between a Cover Note (non life) and a Letter of Acceptance (life insurance)

The policy is the evidence of the contract and contains all the details of cover, exceptions, conditions, period of cover, premiums and other information.

It is not possible to issue policy as soon as the terms of contract have been agreed. But there is need to proof that the cover is in force. The **COVER NOTE** is a temporary document to state that insurance is in force and give brief details of the cover. It will be superceded once the policy is issued. Confirmation that cover is in force need not always be in the form of a pre-printed cover note. It could take the form of a letter from the insurer to the insured.

A different situation exists in life insurance. Once the proposer has sent his completed proposal form to the insurer he will receive **a letter of acceptance**. This letter of acceptance is an offer to the proposer, which is accepted once the premium has been paid.

The life assurance policy will only come into effect once the premium has been paid.

The motor cover is in force once the cover note is issued and the premium may still have to be paid.

6.3.9. Certificates of Insurance

Where insurance is compulsory, the law also requires that certificate is issued to prove that a policy is in force. Certificate makes it easier for law enforcement agencies to quickly identify that the insured has complied with the law and has a valid policy, as it is not practical to carry insurance policy at all time. As in some countries both motor insurance and employers' liability insurance are compulsory, insurers are required to issue a small certificate of insurance for both classes of insurance business to proof that the cover is in force.

In case of the motor insurance, the information contained in the certificate includes the name of the policyholder, the registration number of the car, the period of insurance, persons entitled to drive and limitations as to use. The employers' liability certificate contains a notice that the certificate must be displayed at all places of business, including outdoor sites.

6.3.10. 'Days of Grace'

Non-payment of a premium implies that the contract is not to be renewed and it will lapse on the renewal date. However, there may be cases where the premium has not been paid by the renewal date even though there was still an intention to renew.

Days of grace extend to 15 or 30 days after the renewal date, during which time the insured can pay the premium. Days of grace are not an extension of cover. Once premium is paid the cover applies from the renewal date.

In motor insurance the premium must be paid by the renewal date and days of grace do not apply. If the premium is not paid then the policy ceases. But insurer can issue a certificate which provides the minimum cover.

6.3.11. Renewal Notice

Before the expiration of the insurance policy, which generally provides a cover for a twelve-month period, the insurer issues a renewal notice to the insured to inform that the insurance period will end soon and proposes to renew the policy by offering the premium to renew the policy. The renewal notice is to remind the insured and to secure renewal of the policy. If the insured wants to renew the policy, he sends the premium to

the insurer and will receive a confirmation of renewal. However, to facilitate the insured, the insurer offers days of grace of fifteen or thirty days after the renewal date during which time the insured can pay the premium. This was used when there is intention to renew, but the premium was not paid by the renewal date. However, in motor insurance, the days of grace do not apply and the insured must pay the premium by the renewal date.

7. Transacting Insurance: Underwriting and Claims

7.1. Underwriting

The task of an underwriter is to manage the insurance pool as effectively and profitably as he can. This pool, which is created by the premium contributions of many people will be used to pay for the losses of the few insureds. The role of the underwriter is to: Assess the risk which people bring to the pool; Decide whether or not to accept the risk or how much to accept; Determine the terms, conditions and scope of cover to be offered; Calculate a suitable premium.

7.1.1. Hazard

The peril is the prime cause. It is what will give rise to the loss. For example, flood is the peril and the proximity of the house to the river is the hazard. Storm, fire, theft, motor accident and explosion are perils. Flood is the peril and the proximity of the house to the river is the hazard. The peril is the prime cause, it is what will give rise to the loss. Storm, fire, theft, motor accident and explosion are perils.

Hazards are factors that may influence the outcome. Theses hazards are not themselves the cause of the loss, but they can increase or decrease the effect should the peril operate.

The underwriter has the task of assessing the hazard. Hazard can be physical or moral:

Physical hazard relates to the physical characteristics of the risk, such as the nature of the construction of a building, i.e. wooden house, security protection of a shop or factory, or the proximity to a river bank.

Property loss or damage: construction of a building would be an aspect of physical hazard. Buildings of wooden construction would present higher level of physical hazard than ones built of bricks. The provision of automatic fire sprinklers and fire fighting equipment would represent a good physical feature;

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Liability: The presence of dangerous chemicals; the absence of guards on machinery, excessive noise or dust.

Motor: People who have a high mileage such as salesmen, young people have higher hazard. The place where the car is garaged or used (commercial vehicle) has impact on physical hazard.

Life assurance: people with certain, potentially dangerous occupations, a person who has recurring illness.

Moral hazard concerns the human aspects, which may influence the outcome. This refers to the attitude of the insured person: Lack of care on the part of the insured; Regular claimant or people who look at insurance as investment; Dishonest insured, dishonest claimant.

7.1.2. The Underwriting Process

Personal insurance – The main source of information about a risk is the proposal form and if there is anything the proposer wants to know, he will write to the proposer.

Delegation of underwriting – travel insurance policy is sold by travel agent or airline. For household insurance, broker has authority to issue policies with an upper monetary limit.

Commercial business insurances – The underwriting of commercial business insurance is very complicated task. The subject of insurance ranges from small shops and factories to large multinational corporations. The underwriter has to evaluate the hazard associated with the risk which is being proposed. In small cases he may be able to do this from reading a proposal form and communicating with the proposer.

In large cases, a broker may be able to help by preparing plans and reports on the risks. These reports will be passed to the underwriter to negotiate on the terms, conditions, the cover and the premium. However, the underwriter will engage a specialist risk surveyor to inspect different area of risk such as fire, security, liability and business interruption.

The surveyor prepares a report, which consists of the following features: A full description of the risk: plan of the premises, the process and details of the insured; An assessment of the level of risk: relevant hazard factors, both moral and physical, idea of the degree of risk; comments on surrounding property; A measure of the maximum

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probable loss (MPL); Recommendations on loss prevention; The view on the adequacy of the insurance requested.

7.1.3. Risk Surveyor

The role of the risk surveyor – The risk surveyor is a person who acts as the eyes and ears of the underwriter. Insurance companies employ specialist risk surveyors to prepare a report for the underwriter and in the case of property risks the risk surveyor will also draw a plan. Sometimes the insurer hires a professional surveyor to survey the risk. In some cases, the broker can help the insurer to survey the risk.

A survey report should have the following features:

A full description of the risk – the plan of the premises in case of a property risk, the process being carried on at the premises, details of the insured;

An assessment of the level of risk – the relevant hazard factors, both moral and physical, idea of the degree of risk, comments on the surrounding property;

A measure of the maximum probable loss (MPL) – the maximum the surveyor believes will be the subject of a loss;

Recommendations on loss prevention – steps should be taken to protect the risk or requirements which the insured must implement if cover is to be granted;

The surveyor's view on the adequacy of the insurance – the surveyor provides his view on the sum insured or the limit of liability to make sure that the insured is not under-insuring the risk.

7.2. Reinsurance

A contract of reinsurance is one by which a direct insurer procures a third party to insure him against loss or liability by reason of such original policy. There are elements of reinsurance that are particular:

- Reinsurance is a distinct and separate contract from the original insurance, and itself takes the form of a contract of insurance.
- Reinsurance need not cover the reinsured's entire obligation under the original contract of insurance, either in terms of the sums payable or in terms of the perils covered. However, reinsurance cannot provide a wider cover than that originally

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insured.

- The reinsurance contract must cover the same risk as the original insurance.
- The insurance contract and the reinsurance contract must exist at the same time with the insurance contract preceding the reinsurance contract.

7.2.1. The Benefits of Reinsurance

The direct insurer can get the following benefits from reinsurance:

- Enable the insurance company to grant cover for amounts of liabilities that would otherwise be beyond the capacity of their financial resources;
- Event out fluctuations in underwriting results due to exceptionally large individual losses, or catastrophes over a wider area; example, windstorm or earthquake losses and riots owing to disorder where accumulation is high. In short, it stabilizes the loss trend for the primary insurers;
- To protect against the accumulation, known or unknown, of net retention of a specified portfolio. By this manner, it can also increase the capacities of a linked proportional program (Risk or Working excess of loss reinsurance).
- To protect against an increase in the unexpected loss frequency of a specified portfolio (Cat excess of loss reinsurance).
- Lead to spreading of risks over a much greater number of insurers and reinsurers with consequent deductions of individual financial commitment.
- In the case of facultative excess of loss, it enables the primary insurers to control the commercial business without the necessity of co-insurance or dependent on facultative arrangement that in both ways, will subject to loss of confidentiality in terms of rating.
- By the creation of capacities, primary insurers will continue to be able to compete.

7.2.2. The Reasons to Buy Reinsurance

Security – the insured wants to be relieved from the uncertainty of loss. Buying insurance provide peace of mind.

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Stability – by purchasing reinsurance, the insurer can avoid fluctuation in claims costs from year to year and within a year, due to exceptionally large individual losses, or catastrophes over a wider area. In short, it stabilizes the loss trend for the primary insurers;

Capacity – the insurer can increase the capacity it has to accept the business, as he may have financial limit on the size of risk which it can accept. This enables insurance companies to grant cover for amounts of liabilities that would otherwise be beyond the capacity of their financial resources;

Catastrophe – the insurer can transfer much of the risk to the reinsurer, thus it can reduce the possibility of a complete catastrophe, which could cause serious financial problems;

'Macro' benefits – the cost of risk is spread around the market place and the world. By placing reinsurances with many companies, the impact of risk does not fall solely on one economy.

7.2.3. The Reinsurance Market

The players in the reinsurance market are as follows:

A. The buyers

Direct insurers: ordinary insurers who transact insurance with the general public. Insurers purchase reinsurance to increase capacity and provide protection.

Captive insurance companies: the companies owned by a non-insurance parent and transact insurance for their parent companies. The captives may retain a fixed proportion and reinsure the balance.

Lloyd's syndicates: Reinsurance protection is to limit the extent of the personal loss they might suffer.

Reinsurers: individual reinsurers seek protection to secure financial stability in their account by purchasing reinsurance.

B. The Intermediaries

Reinsurance brokers: they have a specialist knowledge of reinsurance and world

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insurance markets. They can assist in arranging the correct covers and selecting the most appropriate reinsurers.

Management companies: They offer a management service to organizations who have captives. One management company will handle several captives and the management of captive will often include the placing of reinsurance.

C. The Sellers

Reinsurers: They specialize in reinsurance and do not write any direct business. They are usually international companies, transacting reinsurance in many parts of the world;

Direct insurers: They may be asked to provide reinsurance for other direct insurers or for reinsurers. Thus, they can be both sellers and buryers.

Captive insurance companies: They can be a supplier of reinsurance where it writes business from a source other than its parent company. The captive can be a buyer and seller of reinsurance.

Pools: The pools are established to provide protection. Contributions to the pool will be assessed by an underwriter. The pool can also provide reinsurance.

Lloyd's syndicates: They are both buyers and sellers in the same market. A large proportion of the business written by syndicates is reinsurance.

7.2.4. The Reinsurance Market

A. Proportional Treaties

Proportional treaties – concern with proportions of the values at risk, the direct office decides what proportion of the risk he wants to retain and cede the balance to reinsurers. Premiums and losses are shared in the same proportions.

Quota share treaty—A quota share treaty protects the insurer's gross retention. The mechanics of a QS are the purest form of proportional reinsurance. The insurer agrees to cede a stated percentage amount of all business within its gross retained account, irrespective of the class of risk and individual retention chosen.

QS would be used for new insurers, or developing a new line or class of business, or for experimental or special classes. It is used to reduce net retained income in order to

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improve or protect solvency requirements; and to balance a surplus treaty which has poor results.

The advantages of a QS treaty are: Reinsurer follows the fortune of the insurer almost identically; The account and reporting of business is simple; Flexibility exists in increasing or decreasing the amount of QS ceded; Unlimited cover is provided for aggregation of risk losses in a single loss event.

However, the disadvantages of the QS are: the insurer agrees to cede a stated percentage amount of all business within his gross retained account, irrespective of the class of risk and individual retention chosen; since a stated percentage of the retention is ceded away, there is no choice of selecting the risks. Insurer has to cede both good and bad risks to reinsurer; the quota share treaty is inflexible: no choice of selecting a retention exists; large amounts of premium income are ceded away and this might be to the detriment of the insurer.

B. Non-Proportional Treaties

Non-proportional reinsurance – are based on the losses, rather than the sums insured. The insurer agree to pay an amount over and above, or in excess of, an amount which the direct office agrees to pay or retain.

Risk Excess of Loss is a cover that protects within a reinsured's retention. The purpose is to limit the reinsured's liability in respect of individual risks or accidents or events. Such classes are motor vehicle third party liability, employer's liability and general third party liability. The common use of this cover for property class is to increase the original net retention. It enhances the capacity under the proportional program. It reduces the number of cession and retains large volume of the premium for its own account. The ceding office pays the first $x of losses arising from an event and the reinsurer pays $y in excess of $x.

Stop loss (excess of loss ratio) – provides protection for an entire portfolio of risk, rather than for individual losses. The loss ratio is claims expressed as a percentage of premiums.

C. Types of Reinsurance Treaty for Certain Class of Business

Liability insurance e.g. public liability

Excess of loss reinsurance is the standard form of reinsurance bought to protect liability

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insurance, including public liability. This can be done for each liability class separately or for all classes as a whole for smaller-sized accounts. Excess of loss cover can be given on an each and every loss basis or on an each and every risk basis either within, or excess of, a risk.

For public liability insurance, companies in a start-up position or those wishing to maximize their line size could purchase proportional reinsurance, either quota share or a surplus treaty. Otherwise, excess of loss would be the usual treaty for public liability insurance, sometimes in combination with other liability classes. Cover is on a 'losses occurring' basis up to the limit of indemnity with an upper layer to cover 'clash' of one or more policies and costs in addition.

Stop loss can be purchased for liability account. Stop loss is expressed as A% loss ratio/ percentage of premium income or $X amount in the aggregate whichever is the lower in excess of B% loss ratio/ percentage of premium income or $Y amount in the aggregate whichever is the greater.

Facultative reinsurance can be purchased for peak exposures excluded from the main treaties, either because of large limits of indemnity, a territorial scope outside the main treaties or because they fall under a special exclusion. Facultative reinsurance would usually be on an excess of loss basis. A facultative obligatory cover may be arranged in the reinsured frequently needs facultative cover.

Protecting an entire portfolio of risk—For insurers in a start-up position, who wish to write sizeable lines but do not have the spread of business or adequate capital in order to comfortably assume a significant amount of risk for their own account, a quota share or surplus treaty or a combined quota share and surplus treaty can be purchased to protect an entire portfolio or risk.

The surplus treaty would enable the reinsured to cede large lines on more exposed risks to their reinsurers whiles keeping smaller standard business entirely for themselves. It allows the insurer to vary its retention upon a particular risk or line of business, provide automatic capacity available upon a particular class and size of risk.

A quota share treaty protects the insurer's gross retention. The insurer cedes a stated percentage amount of all business within its gross retained account, irrespective of the class of risk and individual retention chosen. This kind of treaty is used when the insurer is not sure about the risk and is mainly used by new companies or companies writing new classes of business.

When the insurer is sure about underwriting management and the spread of risks, it can

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shift to a non-proportional treaty. Treaty excess of loss is available in a variety of forms: Risk excess of loss, catastrophe excess of loss and stop loss.

7.3. The Premiums

When calculating insurance premiums, underwriters must consider both risk factors and external commercial factors. The risk factors include the risk profile, an assessment of the level of risk, a measure of the Maximum Probable Loss (MPL) or Estimated Maximum Loss (EPL), the surveyor's view on the adequacy of the insurance being requested, the claim experiences etc.

At the same time, the underwriters must take into consideration the following external commercial factors:

The effect of inflation: the underwriters must be aware of the changing value of money. Claims will be met in the future, out of premiums received today. The cost of settling a claim may arise, due to inflation. This is an important factor which the underwriters should take into account when calculating the premium;

Currency fluctuations: exchange rate risk also presents a challenge to underwriters when calculating the premiums. In general, premiums are collected in national currencies. For a multinational company receiving businesses from many countries, currency fluctuations can seriously affect the level of reserves for claim payment. Therefore, exchange rate will be another factor that underwriters should consider when calculating the premium.

Interest rates: insurance business is divided into two parts: pure insurance business and investment of funds. These funds may generate substantial income for an insurance company. Thus, the variability in the interest rates should be taken into consideration by the underwriters in premium calculation.

Competition: in the world of tough competition, long-term relationship between the insured and the insurer is critical for the insurance business. While rating the risk both factors – competition and long-term relationship – should be taken into account by the underwriters.

The financial items that must be covered by insurance premiums:

Cover expected claims – estimates of claims;

Create an estimate for outstanding claims – claims to be settled, especially in

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personal injury;

Provide a reserve – contingencies beyond their control; catastrophic reserve;

Meet all expenses – salaries, office costs, advertising; commission;

Provide for profit – a surplus;

Inflation;

Interest rates;

Exchange rates;

Competition.

Premiums are arrived at by applying a premium rate to a premium base. The sum insured is a suitable premium base for property insurance. The rate reflects the hazard which the insured brings to the pool. The insurer adjusts the rate taking into account good risks or bad risks. Office places or apartments will get low premium, while garment factories or wooden houses will require higher premium. In motor insurance, the age of the driver, type of vehicle – commercial vehicle or taxi:

Adjustable premiums – at the beginning of the year only estimate of the total wage bill is provided. At the end of the year the insured provide an actual wage paid. At this point the premium will be adjusted up or down, depending on the wages figure;

Flat premiums – is applied to motor insurance.

The 'application of average' on an insurance claim

The application of average is used in under-insurance. If the cost of replacement is lower than the sum insured, the insured will not get the total claim. If the sum insured is 75% of the value of the property, in case of total loss or partial loss, the insured will get only 75% of the claim.

7.4. Claims

The notification of a claim is the responsibility of the insured. The conditions of the policies are speedy notification of the claim, with time limits within which a claim should be notified. The insurer wants to take statements from witness. In the case of

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theft, the claim should be intimated to the policy to allow the maximum opportunity to recover stolen property. In the case of damage to property, speedy notification is required to take remedial or loss reduction action.

In some cases, brokers can have delegated authority to handle claims. The claim is usually handled by the claim department.

7.4.1. Claim Handling

In the event of a claim, the insurer requires that the insured provides prompt notification of a claim. The conditions of the policies are speedy notification of the claim, with time limits within which a claim should be notified. The insurer wants to take statements from witness. In the case of theft, the claim should be intimated to the police to allow the maximum opportunity to recover stolen property. In the case of damage to property, speedy notification is required to take remedial or loss reduction action.

In some cases, brokers can have delegated authority to handle claims. The claim is usually handled by the claim department. When a claim occurs, the insurer has to ensure that: the cover was in force at the time of the loss; the insured is the correct insured; the peril is covered by the policy; the insured has taken reasonable steps to minimize the loss; conditions have all been complied with; no exceptions are appropriate; the value of the loss is reasonable.

In fulfilling the above functions, the insurer calls upon the loss adjusters to conduct investigations. The loss adjuster is an expert in processing claims from start to finish. This will involve ensuring that all the interests of the insurer are preserved, in checking that the cover was in force and was adequate at the time of the loss. The adjuster will also act to minimize the extent of the loss and is in a position to use his considerable experience to bring about a swift settlement of the claim.

7.4.2. The Loss Adjuster

In case of a large or detailed claim, the insurer calls upon the loss adjusters to conduct investigations about the claim, notably in fulfilling the above functions. The loss adjuster is an expert in processing claims from start to finish. This will involve ensuring that all the interests of the insurer are preserved, in checking that the cover was in force and was adequate at the time of the loss. The adjuster will also act to minimize the extent of the loss and is in a position to use his considerable experience to bring about a swift settlement of the claim. The loss adjuster prepares a detailed report of the claims,

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listing all the points and the photographs of the damaged property. The final report would give details of what the actual loss amounted to. Based on the loss adjuster's report, the insurer will pay claim to the insured.

7.4.3. Amount Payable in Property Claim Settlement

In the final stage of claim settlement – the actual monetary settlement – the eventual cost of the claim will depend on the nature of the cover: indemnity or reinstatement.

Indemnity is one of the basic doctrines of insurance, i.e. an insured is to be placed in the same financial position after a loss as he enjoyed before the loss. The measure of indemnity would be the replacement cost less an amount for wear and tear. In the case of partial damage, indemnity would be the repair cost les wear and tear.

Reinstatement is a form of 'new for old' policy, it avoids the difficulty in ascertaining the value of a loss under an indemnity contract. Reinstatement may take place in the following circumstances:

By the insurers under the terms of the policy: The operative clause of the policy gives the insurer the option to reinstate. Unless and until the insurers decide to reinstate, the contract remains one to pay money. The reinsured cannot refuse to accept a money payment, and demand reinstatement. He cannot refuse to accept reinstatement if the insurers elect to reinstate.

Insurers may be required to cause the insurance money to be expended in rebuilding, reinstating, in the following circumstances:

- When there is reason to believe that the reinsured or any person acting on his behalf has fraudulently set fire to the property with the object of obtaining the insurance money;

- When requested to do so by any person interested in or entitled to the property, such as owners and purchasers; lessors or lessees; mortgagors or mortgagees; tenants from year to year.

There are several factors which may limit the insured's entitlement to a full indemnity:

The sum insured or limit of liability – the maximum amount recoverable under many policies is limited by sum insured or the limit of indemnity (or limit of liability). The insured cannot recover more than this amount even where the loss, measured by the indemnity principle, is a higher amount. However, the UK Road Traffic Act

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requires motor insurers to grant unlimited cover for liability in respect of death or bodily injury.

Other policy limits – within the overall sum insured or limit of indemnity, there may be further separate limits for particular types of loss or particular types of property. For example, a household contents policy will restrict cover on individual 'valuable' to 5% of the total sum insured.

Underinsurance and average clauses – where there is underinsurance, the policyholder is not paying their fair share into the pool. Therefore an average clause is applied and the claim payment for any loss will be scaled down proportionately.

Excess or deductible – a clause which provides that the insured must bear the first amount of any loss, expressed either as a sum of money or a percentage of the loss.

A franchise – similar to an excess in that there is no liability for any loss which is less than the franchise figure. Once the franchise has been exceeded, the loss is payable in full.

8. Supervision of Insurance

8.1. The Insurance Companies Act 1982

The main parts of the Insurance Companies Act 1982:

Restriction on carrying on insurance business: defining classes of business and the requirements to be met;

Regulations of insurance companies: financial matters, such as accounts, actuarial investigation, winding-up and other matters;

Conduct of insurance business: insurance advertisements, 'cooling-off' notices for life insurance and the disclosure for intermediaries;

Special classes of insurers: Lloyd's, industrial life assurance and companies established outside the UK;

Supplementary: criminal proceedings which would follow any breach of the Act.

8.2. Solvency Margin

The Solvency Margin (surplus capital) of an insurance company is the surplus of assets

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over liabilities, both evaluated in such a way as to satisfy insurance regulatory authorities that the company is in a position to meet its liabilities. The domestic legislation defines methods of valuation of assets and liabilities that can be included in the solvency margin. The purpose is to ensure that insurance companies can meet their liabilities.

However, some countries have shifted toward risk-based capital in defining solvency margin. Thus, the actual value of the solvency margin, in monetary terms, varies from company to company, reflecting its size, the volume of business and the degree of risky business that they underwrite. An insurance company is solvent if it is able to fulfill its obligations under all contracts under all reasonably foreseeable circumstances.

If the minimum solvency margin is not maintained the domestic legislation would require remedial action. If the liabilities of an insurance company exceed its assets, the company is technically bankrupt. To protect policyholders and maintain the stability of the insurance industry, insurance regulators use the solvency margin as one of the instruments to monitor and regulate insurance companies.

The solvency margin is determined by taking the greater of two sums resulting from the application of two sets of calculations called respectively the premium basis and claims basis.

Gross premiums received are transferred into ECU. The company calculates 18% of the first 10 million ECU and 16% of any balance over and above 10 million. Then adjusted for reinsurance.

Claim basis – The total gross claims paid during the preceding 3 years, converted into ECU and the average taken. 26% is calculated of the first 7 million ECU and 23% of any excess over 7 million ECU.

The difference between the solvency margin for general business and for long term business: The basis framework of solvency margin for life business is the same as for general. But the main difference is that calculations are based on actuarial liabilities. In life business, claims are long-term and their actuarial value is calculated.

8.3. The Financial Service Act 1986

The Act was approved to provide a framework for protecting investors. To ensure that investors can place their money with confidence with any investment business.

The main objective of state regulation of insurance is to protect the public and to take socially desired measures. The state regulation can be explained as follows:

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Maintain solvency – The Solvency Margin (surplus capital) of an insurance company is the surplus of assets over liabilities, both evaluated in such a way as to satisfy insurance regulatory authorities that the company is in a position to meet its liabilities. An insurance company is solvent if it is able to fulfill its obligations under all contracts under all reasonably foreseeable circumstances;

Equity – State regulation is designed to protect policyholders and maintain the stability of the insurance industry. Insurance regulators use the solvency margin as one of the instruments to monitor and regulate insurance companies;

Insurable interest – this doctrine of insurance was introduced into the legislation in order to prevent gambling, i.e. it is not acceptable that a person would benefit by effecting insurance policy where he or she had no financial interest in the potential loss other than the profit to be made if it occurs;

Provision of certain form of insurance – the State has made intervention by requiring that some forms of cover should be made compulsory, such as employers' liability and motor insurance;

National insurance – for some areas of social risks, the government's intervention has been total and it has assumed the responsibility for providing cover, such as unemployment, sickness and window's benefits under the national insurance scheme.

8.4. Supervision of Intermediaries

Before the adoption of the Insurance Brokers Registration Act 1977, anyone could call themselves an insurance broker regardless of their knowledge about insurance. For that reason there were about 9,000 firms calling themselves brokers in the 1970s. In January 1976, the British Insurance Brokers' Council was established by four broker associations to prepare a proposal for the registration and regulation of insurance brokers. Based on this proposal an Insurance Brokers (Registration) Act was adopted in July 1977.

After the adoption of the Act a person who does not qualify for registration or does not seek registration cannot refer to himself a broker. Instead they will be called an insurance consultant or adviser. Brokers have to comply with a set of strict operating conditions.

8.5. Compulsory Insurance

Provision of funds: the enactment of compulsory insurance ensures that funds will be

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available when damages are awarded;

Eases the State's burden: the State would not allow people injured at work to go without compensation. If the responsible party did not have sufficient funds, the State would provide money. The existence of compulsory insurance eliminates this possibility;

The response to national concern: the concern over accidents was so high that legislation was introduced to ensure the provision of insurance, such as in case of injury or damage;

Protection: insurance allows the insured to have access to all the expertise available from insurers, which may improve the risk and thus assist in protecting people.

8.5.1. Forms of Compulsory Insurance

Motor insurance – third party risks are death of, or bodily injury to any person and damage to third party property.

Employers' liability insurance – every employer has to insure against liability for bodily injury or disease sustained by employees and arising from their employment.

Compulsory insurance provides funds, eases the state's burden, respond to national concern and provides protection.

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Part VI
Reinsurance

Part VI

Reinsurance

1. The Main Forms of Reinsurance

1.1. Definition of Reinsurance

A contract of reinsurance is one by which an insurer procures a third party to insure him against loss or liability by reason of such original policy. There are elements of reinsurance that are particular:

- Reinsurance is a distinct and separate contract from the original insurance, and itself takes the form of a contract of insurance.
- Reinsurance need not cover the reinsured's entire obligation under the original contract of insurance, either in terms of the sums payable or in terms of the perils covered. However, reinsurance cannot provide a wider cover than that originally insured.
- The reinsurance contract must cover the same risk as the original insurance.
- The insurance contract and the reinsurance contract must exist at the same time with the insurance contract preceding the reinsurance contract.

1.1.1. The Purpose of Reinsurance

Reinsurance is a technical and financial device:

- For limiting oscillation of losses on a specified insurance portfolio. Losses must be in a lateral movement. Insurers are able to base their calculations on items that are reasonably stable (Excess of loss reinsurance).
- To protect against individual losses which are relatively large in comparison with the size of a specified portfolio (Personal accident excess of loss reinsurance).
- To protect against the accumulation, known or unknown, of net retention of a specified portfolio. By this manner, it can also increase the capacities of a linked proportional program (Risk or Working excess of loss reinsurance).

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- To protect against an increase in the unexpected loss frequency of a specified portfolio (Cat excess of loss reinsurance).
- The insurer has accepted a greater pecuniary responsibility in respect of a specified risk, or a number of risks, than it considers prudent to retain in full (Facultative excess of loss reinsurance).

1.1.2. The Result of Reinsurance

Reinsurance:

- Enables insurance companies to grant cover for amounts of liabilities that would otherwise be beyond the capacity of their financial resources;
- Events out fluctuations in underwriting results due to exceptionally large individual losses, or catastrophes over a wider area; example, windstorm or earthquake losses and riots owing to disorder where accumulation is high. In short, it stabilizes the loss trend for the primary insurers;
- Leads to spreading of risks over a much greater number of insurers and reinsurers with consequent deductions of individual financial commitment.
- In the case of facultative excess of loss, it enables the primary insurers to control the commercial business without the necessity of co-insurance or dependent on facultative arrangement that in both ways, will subject to loss of confidentiality in terms of rating.
- By the creation of capacities, primary insurers will continue to be able to compete.

1.2. Types and Methods of Reinsurance

The main methods of reinsurance are proportional (pro-rata or participating) and non-proportional (excess of loss). Both can be transacted on a treaty/contract or a facultative basis. There are three main types of proportional reinsurance: Facultative; Surplus; Quota share; and four main types of non-proportional reinsurance: Facultative excess of loss; Risk excess of loss; Catastrophe excess of loss; Stop loss or aggregate excess of loss.

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1.2.1. Treaty

The treaty is an arrangement in writing between the direct insurer and the reinsurer or a number of reinsurers, whereby the reinsurer will accept automatically without further negotiation any cessions falling within the terms of the agreement. Treaty reinsurers are provided with bordereaux consisting of lists containing details of all business placed on the treaty (premiums, return premiums, cancellations and claims). The advantage of treaty is that the insurers can give the insured immediate direct cover and they will have reinsurance cover for the amount of retention.

1.2.2. Facultative

Facultative means optional, the power to act according to a free choice. If an insurer wishes to insure an individual risk with a sum insured greater than its selected gross retention, then it might offer the balance to another reinsurer as a facultative placement. The reinsurer has the liberty to choose how much of the risk to reinsure and what premium to charge. The insurer must make full disclosure of the material facts.

1.3. Proportional Reinsurance

1.3.1. Facultative Proportional

Facultative proportional reinsurance could be used: where the insurer requires capacity beyond its treaty; to reinsure risks where no treaty protection is available; to reinsure risks which the company does not wish to cede to its treaties; to reinsure hazardous or complicated risks, including 'target' risks; for unique commercial, financial or strategic reasons.

Advantages of facultative reinsurance are: risks are considered individually; it increases the insurer's competitive edge within its chosen market; there is freedom to offer any risk which may be accepted or decline; a general account might be protected by use of facultative reinsurance; the insurer might benefit from specific knowledge on the part of facultative reinsurer; there is opportunity for both parties to develop a successful and professional relationship.

Disadvantages are: the insurer cannot rely on successful placement of risk; the administration involved is labor intensive and expensive; full risk details and loss information have to be disclosed; 'error factor' exists in hasty facultative placements; there is low commission reimbursement to the insurer – if the insurer arranges surveys,

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reinsurers might be obtaining business at improved terms; cover cannot be confirmed until reinsurance placement is effected or completed.

1.3.2. Proportional Reinsurance Treaties

There are three types of proportional treaties: surplus, quota share and facultative obligatory.

A. Surplus Treaties

The capacity of a surplus treaty is divided into the cedant's retention and the lines ceded to reinsurers. Furthermore, multiples of lines can be added beyond the first surplus treaty, becoming the second surplus treaty. For example, a four-line surplus treaty (with the retention of $1 million) gives the insurer an automatic underwriting capacity of $5 million ($1 million own gross retention plus $4 million comprising of 4 lines of $1 million each).

The main use of surplus treaties is to attain automatic underwriting capacity to enable the insurer to transact business in its chosen market and compete with its peer companies.

The **advantages:** allow the insurer to vary its retention upon a particular risk or line of business; there is automatic capacity available upon a particular class and size of risk; the insurer is allowed to retain a greater proportion of income.

Disadvantages: The insurer stands or falls by its chosen retention – fundamental calculation for the insurer; Comparison of results between the insurer's net results and those of its surplus reinsurers might be different.

The problems of a second surplus treaty

The second surplus treaty will only be accepting the larger, target risks. Therefore, fewer cessions will be made to it. This means that there will be fewer premiums available to build a common pool to pay claims. Consequently such treaties may be vulnerable to considerable fluctuation to results. Thus, we should take more care as we should balance between the available premium income and the assumed liabilities.

B. Quota Share Treaties

A quota share treaty protects the insurer's gross retention. The mechanics of a QS are

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the purest form of proportional reinsurance. The insurer agrees to cede a stated percentage amount of all business within its gross retained account, irrespective of the class of risk and individual retention chosen.

If an insurer decided upon a 20% QS, then it would cede 20% of all business within its retention pattern and reinsurers would receive 20% of all premiums on such business, but pay 20% of all commission and claims arising on such business. If the gross retention is $1 million, a 20% QS cession ($200,000) would reduce the retention to $800,000.

QS would be used for new insurers, or developing a new line or class of business, or for experimental or special classes. It is used to reduce net retained income in order to improve or protect solvency requirements; and to balance a surplus treaty which has poor results.

Advantages: Reinsurer follows the fortune of the insurer almost identically; The account and reporting of business is simple; Flexibility exists in increasing or decreasing the amount of QS ceded; Unlimited cover is provided for aggregation of risk losses in a single loss event.

Disadvantages: Under the quota share treaty the insurer agrees to cede a stated percentage amount of all business within his gross retained account, irrespective of the class of risk and individual retention chosen. Therefore, the disadvantages of the quota share treaty are as follows: The insurer agrees to cede a stated percentage amount of all business within his gross retained account, irrespective of the class of risk and individual retention chosen; Since a stated percentage of the retention is ceded away, there is no choice of selecting the risks. Insurer has to cede both good and bad risks to reinsurer; The quota share treaty is inflexible: no choice of selecting a retention exists; Large amounts of premium income are ceded away and this might be to the detriment of the insurer.

C. Facultative Obligatory

Facultative obligatory is used for a book or substantial number of individual facultative cessions. The details of the treaty are concluded in advance and the insurer has the option to cede risks to the treaty. The obligatory element rests with the reinsurer, who must accept such cessions once they have been made to the facility. A facultative obligatory treaty offers an insurer flexibility and complements its existing automatic treaty facilities, and such facilities follow the insurer's gross retention pattern.

The insurer benefits from the knowledge that should it be offered large target risks from within the market, then a facultative obligatory treaty would offer sufficient automatic underwriting capacity. The insurer would not have to resort to the extensive administration required in making an individual facultative placement.

For reinsurer, facultative obligatory could give a reasonable indication of original terms, premium rates and conditions. Reinsurer is totally reliant on the good faith of the insurer to operate the treaty in the manner expected.

C. "Loss Participation" in a Proportional Reinsurance Treaty

The sliding scale commission is usually to reward the cedeant for good results and protect the reinsurers against a worse than expected performance. However, it does little in the event of the results of a treaty being exceptionally poor. A flat-rate profit commission is also being purely used as an extra reward for good performance.

However, proportional reinsurance has its foundations in "Sharing" arrangements-the cedant and the reinsurer sharing in the fortunes of the original business. Therefore, a proportional reinsurance treaty stipulates that if there are expected heavy losses, then some form of loss participation clause may be adopted to ensure a more equitable distribution of the net loss between the cedant and its reinsurers.

This is a reverse profit commission situation where by the loss above an agreed loss ratio would be redistributed so that the cedant bears some portion of an inordinately heavy loss rather than the reinsurers bearing the whole burden alone. In the event that the loss ratio for the treaty exceeds 100% then reinsured shall bear 25% of all losses in excess of this figure.

In order to operate equitably between the cedant and the reinsurer any such clause should take into account a number of issues and seek to establish the obligations of both parties to the contract as unambiguously as possible.

The key points to be included in any wording are: definition of the extent of the reinsured's liability, e.g. "If the loss ratio" of any treaty year exceeds X% the reinsured shall bear Y% of the amount by which the loss ratio exceeds X%; provision for how the loss ratio shall be calculated; definition of incurred losses and earned premiums; the limit of the percentage borne by the reinsured of earned premiums for each treaty year; when any such calculation shall be made.

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1.4. Non-Proportional Reinsurance

Advantages: Administrative costs reduced because: No submission of bordereau; No quarterly account; Retained higher gross original premium (GOP); Provide absolute limit to retained cost of claim.

Disadvantages: Protect only large claims; Negative cash flow.

Special features: The 3 most important words in a non-proportional contract: **Ultimate Net Loss**:

Loss: A loss has occurred

Net: Deduct all recoveries

Ultimate: Final net loss

1.4.1. Facultative Excess of Loss

In a non-proportional, or excess of loss, reinsurance the reinsured selects a fixed monetary amount to retain on a particular account and arranges excess of loss protection with reinsurers for any claim amounts which might exceed the fixed monetary amount. For example the reinsured has chosen $500,000 as its retention. It arranges excess of loss protection for $1,000,000 above its retention. This means $1,000,000 in excess of $500,000.

The growth of captive insurance market has influenced the increasing use of facultative reinsurance. Maintaining an acceptable level of exposure is best achieved through the use of excess of loss reinsurance.

Excess of loss reinsurance program consists of retention or deductible – fixed monetary amount retained by the reinsured; and a few layers of limits – liability of excess of loss reinsurers. For, example:

1st layer $4,500,000 excess of $500,000

2nd layer $ 5,000,000 excess of $5,000,000

3rd layer $10,000,000 excess of $10,000,000

The underwriting of excess of loss is based on maximum probable loss (MPL). The first

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layer will provide protection for losses occurring within the estimated MPL – assessed at 25%,i.e. $5 million in respect of normal loss – in excess of the desired retention of $500,000. The second layer will provide protection in respect of higher exposure; while the top layer will provide protection in the event of total loss.

Facultative excess of loss reinsurance can be used in conjunction with proportional treaties to protect reinsured retention. Research has shown that the claims experience on any one risk decreases significantly as the amount retained by the reinsured (the deductible) increases. Consequently the amount of the original premium to be paid to facultative excess of loss reinsurers should also reduce as the deductible increase. Reinsurers will be less exposed to a loss and therefore should expect to receive reduced premium.

1.4.2. Treaty Excess of Loss

Treaty excess of loss is available in a variety of forms: Risk excess of loss, catastrophe excess of loss and stop loss.

A. Risk Excess of Loss

Annual Aggregate and/or Event Limits

Risk Excess of Loss is also known as Working Excess of Loss. It is a cover that protects within a reinsured's retention. The underlying retention is so pitched that a number of ordinary sum of losses may be expected to affect reinsurers. This type of cover can even replace normal proportional reinsurance, but for reason of cost, it cannot match the capacity.

The purpose is to limit the reinsured's liability in respect of individual risks or accidents or events. Such classes are motor vehicle third party liability, employer's liability and general third party liability. In each case, the 'profile' of the reinsured's original portfolio in graphical presentation is either rectangular or alternatively, a profile curve that demonstrates a high proportion of the individual risks which exceed the desired retention of the reinsured.

It is essential for both the reinsured and reinsurers to be in agreement as to what constitutes "one risk", " one accident" or "one event". The proper application of the underlying retention and the amount of reinsurance cover available, are dependent on a clear understanding on this very vital point. It is quite possible for one occurrence to involve several individual risks, and whether the deductible is applied once or several

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times depends entirely upon the retention of the contracting parties.

The common use of this cover for property class is to increase the original net retention. It enhances the capacity under the proportional program. Such increased amount is known as "gross net retention". It reduces the number of cession and retain large volume of the premium for its own account. In a gross net position, it is advisable to inform the proportional reinsurers of the per risk, net, protection.

	Net Net Retention	**Gross Net Retention**
Retention	100,000	300,000
Per risk protection	Nil	200,000 xs 100,000
Surplus treaty	20L 2,000,000	20L 6,000,000

B. Catastrophe Reinsurance

In reinsurance terms, the definition of a catastrophic loss event is that it should be caused by a specific, sudden, unexpected, shocking and external happening that can be located in time and place. Any such event must be the proximate cause of each and every loss to the original insureds that the insurer is accumulating to calculate its catastrophe claim and will be a peril covered by the catastrophe treaty.

Catastrophic event would result in a number of original policy holders making claims against the insurer at the same time. Usually it involves huge losses arising from a single event, such as flood that damages the property of the policyholders. For example, the recent Katrina hurricane in the US has brought about huge damages to insured property in the US.

The catastrophe excess of loss reinsurance contract is designed to limit in monetary terms the financial consequences to a reinsured of an unusual increase in the normal loss frequency (i.e. the number of claims) of a portfolio. It follows that catastrophe cover is only needed if the possibility of such an unusual increase exits. It does not always do so. But it does if the perils covered in the original portfolio include damage by natural elements; such as windstorm, flood and earthquake.

Most catastrophe Excess of loss [Cat XOL] covers apply to property portfolios: fire and special or extended perils, including consequential loss, marine and even aviation hull. The Catastrophe Excess of loss (Cat XOL) commonly carries a deductible which is a

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multiple of the maximum retention, as in the event of a catastrophe, the reinsured can call upon some of its reserves to meet the obligation. Although the two risks warranty is applied for Cat XOL, it is a redundant since the priority is never pitched below one risk retention. Indeed, a minimum of two risks is normally required in order to calculate a viable cost for the reinsured. The cover is structured as a function of the catastrophe accumulation in the country's most exposed zone.

Pitching the priority and limit	
Maximum Retention (Per Risk)	100,000
Reinsured EQ Accumulation in a Major Zone (Sum insured basis)	100,000,000
Reinsured's Priority	300,000
Limit	20,000,000

Priority—The priority is normally pitched at a minimum of two times of the maximum retention. In this instance, it is pegged at three times.

Limit—Reinsurers use an EML of between 20 percent and 35 percent of the top accumulation per zone to set their limits. It is advisable to use EML factor to 100 percent for countries where social unrest exist in recent times. In this example, 20 percent is used to set the limit.

Layering—The same question also exists as to how many layerings are practical. The most common number is three for a Cat XOL and where the exposure is too high, it may be increased to five. There are, however, some basic rules.

On 1st Layer, the limit should be pegged as low as possible as the high cost is revolving in this area.

On the 2nd Layer, the limit is medium in size and it is used to round of any odd figures.

On the 3rd Layer, the limit must be pegged as high as possible as it carries a low costing factor.

On $20,000,000 EML exposure with a priority of $300,000, the layers follow manners basing on the above rules.

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First Layer	700,000 xs 300,000
Second Layer	4,000,000 xs 1,000,000
Third Layer	15,000,000 xs 5,000,000

In some countries like Thailand, Malaysia and Singapore where windstorm and earthquake elements are not pronounce, there are other considerations to buy a Cat XOL and these are:

Strike, Riots and Civil Commotion (SRCC) - Cat XOL cannot always be equated with earthquake alone. There are other elements that needed protection and SRCC is just one of them. Economic growth will inevitably bring with it a different set of problems: society high expectation that leads to social unrest once the halcyon of good days is over.

Flood—The intensive project development, both in the public and private sectors makes flood exposure high when drainage system is neglected. The accumulation effect is equally dangerous to a portfolio where flood cover is extended freely.

Major Conflagration—Human error in accumulation control; for example, individual shop units under one building. it will give rise to a large number of individual retentions in an event loss.

C. Stop Loss Reinsurance

The prudent company must consider the effect of an unforeseen increase in the frequency of claims that may result in an overall underwriting loss for any particular year. It is not just the size and severity of losses that can affect the stability of a company. If there is a significant increasing trend in general small losses on an account, the company may find itself having to meet all the liability whilst being unable to recover anything from its excess of loss reinsurers as the losses involved do not exceed the reinsurance deductibles.

An insurer can provide for this contingency by looking to purchase an alternative form of non-proportional protection known as stop loss excess of loss ratio reinsurance. Stop loss treaty reinsures aggregate losses arising in respect of a specific class or classes of business. Stop loss reinsurance limits are expressed in percentage amounts of the reinsured's gross net retained premium income (e.g. 50% GNRPI xs 105% GNRPI).

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Stop loss reinsurance is used to protect the reinsured's net absolute retained account against those attritional losses that are relatively small in size, but have a potentially substantial impact on overall loss ratios. Stop loss reinsurance guarantees to meet retained losses which exceed a pre-agreed percentage or amount of the reinsured's net retained income up to a further pre-determined percentage or amount. The reinsured's net retained income is that income remaining after the deduction of all prior reinsurance costs.

Stop loss can be used in all classes of reinsurance as a means of limiting aggregate losses on an account during any one underwriting year though it is not widely used for non-marine accident, marine, aviation and life insurance accounts. For some classes of business where the individual loss events are hard to determine and/or there may be a high incidence of losses over a short period of time, such as hailstorm protection, stop loss has bee used as the only form of reinsurance.

In such instances it is simpler for the reassured and reinsurers to consider the total claims in a given period rather than trying to define individual locations or events. In other instances it may be considered as an additional weapon in the reinsurance armoury to assist the reassured to expand its account and to spread its risk.

It should always be remembered though, that the purpose of stop loss reinsurance is to relieve an insurer from having too great a loss. It was never intended and should not be considered to guarantee a profit to the company. Consequently great care must be taken in the setting of the deductibles and limits and it would be normal to obtain statistical data over as long a period as possible.

No matter what the class of business concerned or the size of deductibles and limits, the reinsured should not be able to bring a claim to its stop loss reinsurers unless and until it has already made a loss on the account or business concerned. Stop loss is particularly suitable for those classes which are subject to volatile loss ratio, for example the insurance of crops against hailstorms; one storm could destroy a whole year's crop and result in a disastrous underwriting result. The cedant therefore needs some form of protection which will enable it to maintain an acceptable loss ratio, if the results for a particular year are adverse. A stop loss (or excess of loss ratio) treaty can be arranged to meet this eventuality. The purpose of the cover is to restrict the annual aggregate losses to a predetermined percentage of the annual premium. The cover operates after all other reinsurance recoveries have been made and the reinsured usually has to be in a loss position.

To ensure that the reinsured maintains prudent underwriting standards it will be

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expected to participate in any loss to the cover, to the extent say, of 10%, so that the reinsurer's liability does not fluctuate widely with variations in the cedant's premium income.

1.5. The Common Types of Rating

1.5.1. Burning Cost System

Burning cost system usually applies to Working Excess of Loss (WXL). Working layers of risk excess reinsurance produce a loss experience (losses in relation to the premium income of the original portfolio) regularly each year. When the aggregate losses exceed the underlying retention are expressed as a percentage of the premium income of the original portfolio protected by the cover, the Burning Cost (B/C) is obtained.

The working layers are rated by applying, upon expiry, an agreed loading to the burning cost rate. It may sometimes subject to a minimum rate to safeguard the reinsurer and a maximum rate to safeguard the reinsured.

1.5.2. Loading Factor

Example of a Portfolio and its Underwriting Result			
Year	**OGP**	**Incurred Loss**	**B/C**
1990	1,000,000	20,000	2.00%
1991	1,200,000	18,000	1.50%
1992	1,500,000	12,000	0.80%
1993	1,800,000	0	0
1994	2,000,000	0	0
	7,500,000	50,000	0.86%
EPI for 1995	2,200,000		

A loading is levied for B/C rating in a variable premium system. Generally a loading does not: Drop below 100/80 for property class; Drop below 100/75 if brokerage is 10%; Exceed 100/70 or it losses to a flat rate system. Loading factor should be between 20% and 60% of the pure cost or risk premium. The factor used is not scientifically

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created and is therefore never justified. It deemed as a straightforward but an imperfect factor.

1.5.3. Key Factors in the Rating Process

The rating process depends on the following key factors: Original underwriting limits of the reinsured; The basis of these limits: sum insured or EML; Claim experiences are required to set the rate; Nature of account: the reinsurer will expect that during the period of reinsurance, the reinsured's underwriting policy will not materially alter; The effect of inflation; Currency fluctuations; Risk profiles: An analysis of the risks within a portfolio of business should be made available which will group the policies, aggregate sums insured and applicable premiums into specified bands; Catastrophic perils: the extent to which a portfolio of business is exposed to natural catastrophic perils; Underlying protections: the existence and extent of any underlying proportional or risk excess of loss should be considered as any such covers will reduce the reinsured's net retained losses arising out of any one event and consequently reduce catastrophe reinsurers' potential exposure to loss; The amount of cover being requested will have an effect on the final rate to be quoted. The total amount of cover required is being layered, then the extent to which a reinsurer is willing to be involved will be taken into account; Relationship with the reinsured: long-term relationship will affect the rating; Quality of the business.

1.6. The Alternative Risk Transfer

Alternative risk transfer (ART) is a way of meeting or passing on part of all of losses or smoothing results either by not using conventional treaty and facultative reinsurance methods at all or by using them with other methods of a character. ART provides the possibility of a choice that is tailored to the need of the insurance company. ART reflects convergence of the insurance, banking and capital markets. The examples of ART are as follows:

Captives: A captive is an insurance company owned by its parent company (generally not an insurance or reinsurance company) established and managed in an offshore financial center (tax-free or low-tax; less regulation), such as Bermuda. A captive insurance company insures the risks of its parent company. A captive also buy reinsurance protection and some also write other reinsurance business in addition to their parent's business.

Finite Risk Contracts: Finite risks are multi-year programmes generally involving payment of a regular fixed premium. They combine both risk transfer and risk

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financing. The risk transfer is limited (finite) to an aggregate or overall limit of liability, often defined by utilizing conventional excess of loss methodology. The risk financing recognizes the time value of money, so that in part the insured is funding its own loss experience, but investment income from the premiums is brought into calculation. The insured has its programme tailed to its own experience. To ensure that the premiums are regarded as business expense and subject to tax deduction, some jurisdictions require that there be genuine risk transfer, not just spreading of losses over a period of years.

Insurance-linked securities: It is linked to the development of capital market. For example, the issuance of insurance catastrophe bonds. The bonds are issued to investors and securitized by the stream of future insurance premium payment. Because they are related to catastrophe perils, the operation of catastrophe peril may put either or both the principal and interest on the bond at risk. These bonds have been bought by banks, insurance or reinsurance companies and other financial institutions as a way of taking extra risk for extra reward.

Securitisation is the means by which providers of finance fund a specific set of assets rather than the general business of a company. The word asset-backed securities mean a financial instrument is guaranteed by a type of asset. For example, the homeowner's mortgage is guaranteed by the home. Asset-backed bonds mean using an asset, such as a building to guarantee the payment of interest and redeem a bond. This process gives the bond higher market value.

Reinsurance securitization is the means in which reinsurance risk is taken from a cedant and packaged in a way that allows it to be taken by an investor outside the traditional market for acceptance of such risks. Investors can invest in insurance risk without being themselves a reinsurance company. As mentioned earlier, an investor is looking for forms of diversifying investments and prepared to take a risk by buying catastrophe bonds with a ten-year maturity for a higher return.

2. Operation of Reinsurance

2.1. Reinsurance Premium

Annual premium income: The annual premium income is the amount of premium generated by a particular class or account of business or a combination of accounts or classes within a defined twelve-month period.

Written premium income: The premium entered in the records of an insurer for all

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risks written or renewed during a specified period of time.

Earned premium income: The premium entered in the records of an insurer as written premium income plus any premium reserves being released from the previous underwriting year to the current year, minus any new or revised premium reserves established in the current year in respect of liability carrying forward to the subsequent underwriting year.

Accounted for premium income: The premium entered into the accounting records of the insurer having actually received or paid during the underwriting year in question.

Gross premium income: The premium entered in the records of the insurer and from which no deductions of whatsoever nature have been made, e.g. no commissions, agents' fees, brokerage, taxes, administration or other acquisition cost to be taken into account.

Gross net premium income: The gross premium income as defined above less only returns and cancellations, premium paid for any reinsurances.

Net premium income: The premium entered in the records of the insurer but from which deductions in respect of all other acquisition costs of the reinsured have been made, e.g. commissions, agents' fees, brokerage, taxes etc. allowed by the reinsured on its original premium.

***Deposit premium*—**Under the non-proportional treaty premium income to be used will be the actual income generated during the period of cover. Thus, actual premium for the reinsurance cannot be calculated until the reinsurance period has expired. To overcome this, a provisional or deposit premium is applied. The deposit premium is an agreed amount of money to be paid by the reinsured and which will be subject to adjustment at the end of the contract. If the final adjusted premium is less than the deposit premium paid then reinsurers will be obliged to return to the reinsured the difference between the actual premium and the deposit premium paid. Any amount that is greater than the deposit will be payable to reinsurers as an additional premium.

2.2. Commissions

With proportional reinsurances where the reinsurer is participating in and sharing the fortunes of the reinsured, the reinsurer potentially benefits by being offered directly a share in original risks that they would not otherwise have been able to get without some considerable extra expense on their part and without any contribution to the costs of running the account.

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Therefore, the reinsured have sought to recover some of the administration and acquisition costs incurred in obtaining the original portfolio of business. This recovery is achieved by the application of ceding commissions to the reinsurance premium, thereby reducing the 'cost' of the reinsurance to the reinsured.

Under proportional reinsurance treaties a cedant might receive two types of commissions: (i) ceding commission; and (ii) profit-sharing commission.

A ceding commission is an amount that the reinsurer pays to the reinsured to reimburse him for part of all of its policy acquisition costs and general overhead, thereby reducing the cost of the reinsurance to the reinsured.

A flat rate ceding commission is a fixed percentage of the reinsurance premium, with no adjustment for the reinsured's loss experience. A flat rate commission is usually applied when the reinsured is newly formed or is entering new line of business with which it is unfamiliar. Under this circumstances, the reinsurer would not want to pay the reinsured a share of its profit; the reinsurer can use the profit to balance possible future unfavorable loss experience.

The size of the ceding commission will depend on the type of reinsurance arrangement concerned, the class of business, previous results, geographical scope, market conditions etc., but it should be sufficient to cover the ceding company's own acquisition costs and make a contribution to its administrative expenses.

In general, flat-rate commissions will be lower for facultative business than treaties, and surplus treaty commissions will be lower than for quota share arrangements, mainly because of the additional administration involved in the reinsurer's offices and the greater scope for increased variability of results in surplus treaty.

Another factor influencing the size of the flat-rate commission will be whether the premiums are ceded to the reinsurers on an original gross basis or are subject to deduction. If the reinsurance is ceded net of any original commissions, the reinsurance commission will be reduced accordingly.

Profit commission is used to provide incentive to the reinsured to underwrite a sound, profitable account, as the better the business the more of its gross premium income will be retained.

A profit commission is based on the excess profit generated by the treaty after the reinsurer has deducted the desired minimum profit level. Excess profit is the amount of profit that the reinsurer is willing to share with the reinsured.

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There are no hard rules in determining the percentage of profit commission. Influencing factors include: commissions prevailed in the market; whether the treaty is part of reciprocal exchange or a new treaty; reinsurer's expenses; effect of any deficits in previous accounts; whether the profit is averaged over a number of years.

2.3. Retrocessions

A retrocession is a reinsurance of a reinsurance. Reinsurers, like insurers, need to consider the risks that they are assuming and the amount of those risks that that they are able or wish to retain.

3. Law Related to Reinsurance

A contract of reinsurance should conform with the formal requirements necessary for a normal contract: an offer; an acceptance; consideration; certainty; an intention to create legal relations; lack of illegality.

Consideration: both parties must promise to do something. The insured will promise to pay a premium and the reinsurer will promise to provide an indemnity.

Lack of Illegality: contracts to do things that are illegal are unenforceable.

Doctrine of privity: only the parties to a contract can have any rights under that contract.

Cover note: The cover note is not a contractual document between the reinsured and reinsurer. It is a document between the broker and the broker's client, the reinsured. The reinsurer will not see the cover note. It is good practice for the cover note to follow the terms of the slip.

Incorporation of terms – 'As Original': Sometimes the parties to reinsurance contract will only sign the slip and will not intend to enter into a wording. This happens in facultative reinsurance when the parties agree that the reinsurance will be back-to-back with the underlying insurance and will express this in terms such as 'as original' on the slip.

The basic rules: In English law, the basic rule for the interpretation of contracts (*Golden Rule*), is that words will be interpreted according to their natural and ordinary meanings in the context in which they are used.

Construing ambiguity: If there is ambiguity in words used in a contract, there are a number of ways in which those ambiguities may be used.

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The doctrine of "Contra Proferentum" means that the contract will be construed, i.e. interpreted, against the interests of the person who drafted it. In a reinsurance context, the draftsman is quite often the broker who acts on behalf of the reinsured. Where there is no broker involved, the reinsured will draft the wording although the wording can also be drafted by the reinsurer. When the contract or the amendment contains ambiguity, they will be construed against the person who drafted them.

2.3. Terms conditions and warranties

A warranty is a contractual promise made by a reinsured either as to an existing state of affairs or as the things that the reinsured will do in the future. If there is a breach of a warranty, the breach will discharge the contract from that time. A failure to meet a warranty to pay premiums within 90 days will terminate the contract after those 90 days.

A condition is a promise by which the reinsurer agrees to perform some act but does not make its right to recover dependent upon performance of the act. A promise to notify claims as soon as possible. The breach of a condition entitles the reinsurer to claim damages for any harm caused by non-compliance.

Innominate terms such as inspection clause. The consequences of a breach of an innominate term cannot be laid down in advance, but must depend upon the nature and gravity of the relevant breach.

Follow the settlements: All settlements by the reinsured shall be binding upon reinsurers provided that such settlements are within the terms and conditions of the original policy and within the terms and conditions of this policy.

The following three principal tests are applied by the use of a 'follow the settlements' clauses: The claim fell within the terms and conditions of contracts; The claim was adjusted in a proper and businesslike manner; and There was an absence of a fraud.

Aggregation cases: With respect to the aggregation of claims arising out of large liability losses or related losses such as asbestos-related claims, claims made by Names against Lloyd's members' agents and professional indemnity claims, the court held that an 'event' in an excess of loss wording required three elements: there must be a common factor which can properly be described as an 'event'; a test of a causation must be satisfied; and the event must not be too remote for the purposes of the clause in the contract defining each and every loss.

Alternative dispute resolution (ADR): fall between simple negotiation between the parties and resolution through litigation and arbitration. The most common are mediation and

early neutral evaluation.

Mediation involves a mediator seeking to find a resolution of the dispute by talking to the parties and having the parties talk to each other. Mediation may result in compromise between the parties.

Early neutral evaluation occurs when the parties submit their cases to a neutral party, quite frequently a retired judge or senior lawyer, who reviews the issues and renders a determination. It will allow a win or lose result.

Limitation and time: Under the Limitation Act (1980), how long does an insurer have to commence an action before the reinsurer can argue that the 'cause of action' is time barred?

Under English law, one must either issue a writ or, if an arbitration clause appears in the contract, commence arbitration proceedings within six years from the date that the 'cause of action' accrues. The date upon which a cause of action accrues is the date upon which the creditor is able to commence action or arbitration to recover the debt. If no action is commenced within six years, the debtor will be able to deny liability for the debt on the basis that it is 'time-barred'. However, in reinsurance contract, certain claims may be time-barred where others are not. It is clear, however, that a reinsured cannot extend the limitation period by failing to submit accounts to reinsurers. Partial payment of a debt will extend the limitation period until six years after that partial payment. Furthermore, limitation period can be extended by a written acknowledgement of debt or by agreement.

4. Wordings

4.1. Terms and Conditions

Express terms are used to extend or limit the scope of the implied conditions or warranties, or to exclude any term that is not clearly expressed. Express terms are used for the following matters: misrepresentation, mis-description, or non-disclosure in any material particular; increase of risk; alienation of interest; payment of premium; notice and details and proof of claims; fraudulent claims; rights of the insurers upon loss; the existence of other insurances; arbitration or jurisdiction.

Implied Terms: A term will be implied if it is shown that it: (i) is necessary to give efficacy to the contract; (ii) is consistent with the express terms of the contracts; (iii) would have been agreed to by both parties.

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The Marine Insurance Act (1906) warrants that a ship under a voyage policy is deemed to be seaworthy and the voyage is a lawful one.

The implied terms of the treaty would mean that the reinsured should: keep full and proper records and accounts of all risks accepted or premiums received and receivable and all claims made; investigate all claims and confirm that they fell within the terms of the contract and were properly payable before accepting them; properly investigate risks offered to them before accepting; keep full and proper accounts.

Original terms, conditions and rates: cessions to the treaty are subject to identical terms and conditions to those of the original business and that premium is to be paid to the reinsurer at the same rates as received by the reinsured.

Period: specifies the basis upon which the agreement has been concluded, e.g. 'losses occurring' or 'risk attaching'.

Risk attaching basis is alternatively called the policies issued basis and excess of loss reinsurers will assume liability for any losses that affect original policies issued or renewed by the reinsured during the period of reinsurance. Provided that the inception dates of the underlying policies fall within the period of the reinsurance contract in question, then the reinsurers on that contract will be liable for all claims arising from those policies (even if the actual date of loss is after the period of reinsurance).

Loss occurring basis: insurers assume liability for all claims that have loss dates within the period of the reinsurance, irrespective of the inception date of the underlying policies giving rise to a claim.

Loss discovered/ claims made basis: Reinsurance protections placed on this basis will have their exposure to loss determined not be the inception date of the original policy nor by the date that the loss 'occurred' but by the date when a claim is made by the original insured. In the case of long-tail liability reinsurances, a major problem can be the determining of the precise date or time when an original loss actually occurred. This may be particularly difficult if the claim is as result of exposure to some detrimental environmental conditions over a long period of time.

Ultimate net loss clause: shall mean the sum actually paid by the reinsured in respect of any loss occurrence including the expenses of litigation, and all other loss expenses of the reinsured (excluding office expenses and salaries of the officials of the reinsured) but salvage and recoveries, including recoveries from all other reinsurances, shall be first deducted from such loss to arrive at the amount of liability.

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Salvage clause: All salvages, recoveries or payment recovered or received subsequent to any loss settlement shall be applied as if recovered or received prior to the aforesaid settlement, and all necessary adjustments shall be made by the parties hereto. This clause should be read in conjunction with the Ultimate net loss clause for covers involving legal liabilities and also marine risks where cross-liabilities frequently arise between cargo and hull, with long drawn-out recovery procedures. For bodily injury classes, salvage should be deleted.

Net retained lines: is to stress that the reinsurance applies only to that proportion of any insurance which the reinsured retains net for its own account. This clause emphasizes that the excess of loss reinsurance is not to be treated as a protection for the reinsured against one of its proportional or other excess of loss reinsurers being unable or unwilling to pay their share of a claim. That is if a proportional reinsured does not pay its share of the claim, the reinsured cannot increase its ultimate net loss by the amount not collected and recover from the excess of loss reinsurer.

Definition of loss occurrence: Loss occurrence shall mean any one accident, disaster, casualty or happening, or series of accidents, disasters, casualties or happenings arising out of or caused by one event, regardless of the number of interests insured or the number of contracts involved or the number or kinds of perils involved.

An event limit will prevent the reinsurer having to pay more than one specified number of losses or monetary amount due to a number of individual risks being involved in losses caused by one event.

Claim cooperation clause: defines the reinsured's obligations to liaise with the reinsurer over the conduct of claims. The reinsured shall keep the reinsurer informed of all developments likely to affect the cost of any claim or claims and undertakes to cooperate with the reinsurer or its representative in the conduct and settlement of such claim or claims and in the estimating of claims reserves.

Loss reporting and settlement: Reinsurers require prompt advice of a loss that could give rise to a claim under a cover.

Loss reporting: The reinsured shall give immediate notice in writing to the reinsurers of any accident or claim;

Loss settlements: All loss settlements made by the reinsured, providing same are within the terms of the original insurances and within the terms of the agreement, shall be unconditionally binding upon the reinsurers and amounts falling to the share of the reinsurers shall be payable by them upon reasonable evidence of the amount paid being

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given by the reinsured.

Extended expiration: if a loss event occurs, then it must be claimed against the period in which the loss event commenced, not any renewal or replacement of the agreement.

Extra-contractual obligation: is to limit reinsurance cover to that provided under original policies only and to exclude punitive damages, unless they are connected with claims payments in certain circumstances.

A 'claims related extra-contractual obligation' shall be defined as the amount awarded against an insurer or reinsurer found liable by a court of competent jurisdiction to pay damages to an insured or reinsured in respect of the conduct of a claim made under an insurance and/or reinsurance policy and/or contract.

Interlocking clause: in the event of the reinsured being involved in a loss from more than one policy and such policies attaching to different 12 month periods, the amount of the excess to be retained by the reinsured under this agreement shall be reduced to that percentage of the retention which the reinsured's settled losses on the original policies incepting during the 12 month period of this agreement bears to the total of the reinsured's settled losses arising out of all the policies contributing to the loss.

Index (stability) clause: apportions the effect of inflation between limit and deductible, and is normally geared to wages.

Aggregate deductible: comes into being after losses have breached their own deductible to actually reach the contract layer. The reinsurer is protected from an immediate impact on the reinsurance treaty and hence able to obtain slightly further benefit of the investment income of the premium.

Aggregate extension clause: is to allow the individual claims to be aggregated together to be presented as one loss to reinsurance.

Claims series clause: A claims series event (i) is attributable to one specific common cause; (ii) arising from ingredients and/or components and/or products which are of intended identical design; specifications or formulae; and (iii) incurred under one or more policies issued to one original insured.

Acts in force clause: allows the reinsurer to adjust the terms of the reinsurance in the light of changes in the law after the date of inception.

Law & Jurisdiction (Applicable Law) This provision identifies the law (s) to which

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the reinsurance agreement should apply. Usually the agreement sets the law which is applied to it or in default of express choice, the proper law of the agreement shall be the law of the country with which it is most closely connected.

The express intention has to be 'bona fide and legal'. (**BONA FIDE – Lat. In good faith; without fraud or deceit. The law requires all persons in their transactions to act with good faith and a contract where the parties have not acted bonafide is void at the pleasure of the innocent party.)**; Where the choice of law is meaningless or incapable of application, it will not be implied; It is possible that a contract, while governed as a whole by a chosen law, is divisible, and that parts of it may be governed by another more appropriate law.

Underwriting policy: the agreement has been concluded on the basis of the reinsured's know management and underwriting policies. Any change in such policies must be advised to reinsurers.

Errors and omissions: This stipulates that these should be rectified immediately upon discoveries. The reinsurer would follow the ceding company's fortunes even when the ceding company had made some error or omission in supplying the reinsurer with information concerning a risk ceded to the treaty.

Alterations: agrees the method by which alterations can be made to the agreement.

Special cancellation 'Sudden Death' - The Special cancellation 'Sudden Death' provision will allow reinsurance agreement to be immediately terminated by either party because of a major alteration to the character of either party and hence to reinsurance agreement or to the commercial or political background against which the reinsurance agreement was concluded.

The clause says: "Either party shall have the right to terminate this agreement immediately by telex or telegram addressed to the other party in any of the following circumstances: if the other party fails to carry out fully its obligations as set forth in this agreement; if the other party becomes bankrupt or insolvent or enters into liquidation whether voluntarily or otherwise; if the other party loses more than 30% of its paid up capital; if the business of the other party be acquired controlled or administered by any other company or authority; if the country in which the other party resides or is incorporated be in a state of war; if the other party has its license or authority to operate withdrawn or suspended. In this case the premium due to reinsurers shall be calculated up to the date of termination.

Special conditions, warranties, special acceptances: This clause would highlight

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any deviations from the norm and identify such deviations in the relevant Item in the Schedule.

Schedule: This identifies the terms concluded for the period and contract in question and is issued to ensure accuracy.

4.2. Application of Reinsurance

To protect your motor account, you have the following excess of loss treaty arranged on a year of account basis:

1994: $175,000 in excess of $75,000 (1st year)

1995: $200,000 in excess of $100,000 (1st year)

The motor account has incurred the following losses as a result of the windstorms:

Year of Account	**Incurred Loss**
$400,000	
$100,000	

The treaty has an interlocking clause. How much can you claim from the reinsurer each year account:

In the 1994 year of account:

Retention = $\$75,000 \times \frac{400,000}{500,000} = \$60,000$

Limit = $\$175,000 \times \frac{400,000}{500,000} = \$140,000$

Loss $400,000

Retention $60,000

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Reinsurer share $140,000 (maximum loss under interlocking conditions)

Retention = $\$100,000 \times \frac{100,000}{500,000} = \$20,000$

Limit = $\$200,000 \times \frac{100,000}{500,000} = \$40,000$

Loss $100,000

Retention $20,000

Reinsurer share $40,000

5. Pricing of Reinsurance

5.1. Broker Slip & Its Use

Successful completion of any reinsurance negotiation is dependent on the exchange of information between the reinsured and its potential reinsurers. The more data is available and the more professional the manner in which it is presented, the better the chances will be of obtaining cover and at satisfactory terms and condition to all the parties involved.

Utmost good faith is of paramount importance in negotiation and contract implementation. It is important that information is set out clearly so that it can be easily assessed by potential reinsurer. The details of a reinsurance risk, its terms and conditions, are summarized in a slip. Full details of the cover provided, its limitations, exclusions, scope of cover etc. will be set out it the policy/ wording document that will be prepared after the coverage required has been confirmed.

The slip had its origin in the operation of the Lloyd's insurance market: the details of the risk to be offered to the Lloyd's market were traditionally written on to a slip of paper which was then taken and shown to underwriters who might be interested in writing the risk concerned. The underwriters would then indicate their willingness to participate in the risk that they were prepared to accept, as well as quoting the price at which they were prepared to participate.

A reinsurer's liability will only attach to a reinsurance risk from the time that it enters on

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the slip the amount or percentage of the risk that it is prepared to accept.

'Writing a line' is used to indicate that the underwriter has committed itself to participate in a reinsurance arrangement, i.e. the underwriter 'write on the line' on a slip. The underwriter also enters on the slip the percentage of the risk that it is prepared to accept. However, the parties will have to agree to the full terms and conditions to be set out in a reinsurance contract wording.

5.2. 'Writing a Line'

The slip summarizes the details of a proposed reinsurance arrangement that the reinsured offer to the reinsurer. The reinsurer should confirm the amount of the risk that it is prepared to underwrite. 'Writing a line' is used to indicate that the underwriter has committed itself to participate in a reinsurance arrangement, i.e. the underwriter 'write on the line' on a slip. The underwriter also enters on the slip the percentage of the risk that it is prepared to accept. However, the parties will have to agree to the full terms and conditions to be set out in a reinsurance contract wording.

5.3. Material Information When Negotiating a Reinsurance Contract

Successful negotiation of a reinsurance contract depends on the quality and quantity of the information being made available to potential reinsurers. Reinsurance underwriter will have a limited amount of time available to review information. The principle of utmost good faith is adhered to by the reinsured. Without having detailed and accurate information the reinsurer cannot make a proper assessment of the risk and may be put in a prejudiced position by quoting terms based on inadequate and wrong data.

Key data should include general information about the reinsured, its overall portfolio of business, the way the company is managed, as well as specific data about the risk or particular account to be protected:

Details of cedant : The date of the company was established; Capital structure and ownership; Trading results – balance sheets; Knowledge and experience of the individual underwriters; Ability and competence of management,

The company's business: Class of business to be covered; Original sum insured; Risk profile; General experience; Claim experience; Exclusions;

Reinsurance preference: it will have major influence on the price of its reinsurance and its availability;

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5.4. Reinsurance Practice

Reciprocity—reciprocity is the exchange of comparable business on a proportional basis by one company with another. This is designed to spread the risk for the insurer and reduce any future adverse financial outcome. Exchanging its business with business of a comparable or better quality the insurer would be able to retain its gross profit instead of giving business to reinsurers. However, this practice may lead to accumulation of losses, if a major loss occur.

A good spread of business can also be achieved by reciprocally exchanging their business with companies overseas. International companies can provide a wide geographical spread on their own reinsurance treaties. The aim of this exercise is to achieve a good mix of different risks to avoid accumulation. However, there is a risk of an insurance company exchanging profitable business for poor quality inwards reinsurance.

A wide geographical spread would help to ensure stable profit, as the losses in one country can be offset by the profits from another. But care must be taken to select good business and good company. The business to be exchanged should produce stable results as quota share and first surplus treaties with a high ration of premium income to PML.

Cover note—A cover note is issued to provide confirmation of a cover, as it is not always possible to issue an actual policy as soon as the terms of the contract have been agreed. It is a summary of terms and conditions of the reinsurance that has been placed, as well as details that the reinsurers have accepted. Cover notes are issued to the reinsured as soon as possible after the risk has been placed and should be signed by a director or senior executive of the company that has arranged the reinsurance. The cover note is temporary and will be superceded once the policy is issued. It could take the form of a letter from the reinsurer to the reinsured.

Cash loss clauses—A cash loss clause is a 'special payment' when the reinsured are being involved in a significantly large individual loss. The treaty provides for the cash loss clause, which allows the reinsured to recover cash from the reinsurer in order to improve its own cash flow. However, the payment of a cash loss is not automatic. It depends on the agreement of reinsurers.

Class of business to be covered: the precise risks to be protected and the nature and extent of original coverage's should be outlined;

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Original sum insured: the details of the sums insured or the limits of liability being issued by the cedant would be made available;

Risk profile: whether the account consists of similar risks or is a varied book of business (simple, commercial or industrial risks); direct insurance or inward reinsurance business; hazardous and non-hazardous; special perils;

General experience: positive information confirming the overall experience of the company to manage its accounts and its claims as well as experience and competence of the actual underwriters can be beneficial in negotiating reinsurance;

Claim experience: it will form the basis of the negotiations on the price of the reinsurance and allow the reinsurer to assess what its future liability may be;

Exclusions: in addition to any standard exclusions, such as nuclear risks and war risks, the cedant should provide details of the business or perils that it does not underwrite or for which it does not require reinsurance;

Reinsurance preference: it will have major influence on the price of its reinsurance and its availability;

'Closing' a proportional treaty business—Once the original business has been ceded, the technical accounting or closing process for quota share and surplus treaties are the same.

Premium and claims—The normal settlement pattern would be on a balanced account basis. The premium accounted for during a specific period would be calculated as would be the claims for the same business for the same period. The claims would be deducted from the premium and the debtor party would pay, i.e. if premiums exceed claims then the reinsured will pay the balance, if claims exceed premiums then reinsurer will pay the balance.

Profit commissions—Regardless of whether the profit commissions are part of an overall settlement or not, full details of the profit commission calculated must be provided for each reinsurer. The method of calculation normally combine the results of a number of underwriting years so that the true profit position on one particular account is not distorted by an unusually profitable or unprofitable individual year.

Settlement periods—Settlements will take place at agreed periodic intervals. Quarterly accounts are the most common but half-yearly or annual settlements can be agreed between reinsured and reinsurers.

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***Currency*—**Technical accounts, which are presented in different currencies, should be converted to a common currency for actual settlement purposes.

***Reserves*—**The majority of treaties will be subject to the establishment and accounting of reserves. These transactions will involve: bringing premiums and/ or claims forward from the previous accounting period; releasing reserves previously held by the reinsured; carrying premium and/ or claims forward to the subsequent accounting period; and payment of interest on any reserves being release.

***Overriding commissions and brokerage*—**While overriding commissions will be shown, brokerage would not normally appear in the ceding company's quarterly account although they would both be included in the treaty statements forwarded to reinsurers for settlement as brokerage is paid by the reinsurers and not by the reinsured.

6. Reinsurance Markets

6.1. Issues and Motivation in Purchasing Reinsurance

6.1.1. Business Reasons

- Portfolio management is important; certain classes of business such as liability are better suited to excess of loss protection;

- Excess of loss protections become more relevant as they reduce the outgoing premium;

- If stock market is strong and more investment income could be derived from premium then insurers will wish to retain premium, thus more interested in proportional reinsurance which will be paid out during the year than non-proportional which would require minimum and deposit premium paid up-front;

- To protect shareholder profit and Chairman's bonus, insurers will purchase excess of loss protection more often than proportional reinsurances as this will maintain sufficient premium income for investment purposes but still protect against cat losses;

- Growth is a motivation for the purchase of reinsurance, the tendency with the development of new lines of insurance is to use non-proportional reinsurance at the outset to reduce premium outlay;

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- Reciprocity is an important factor for large insurance companies with an international portfolio in order to gain geographical spread;
- Concentration on security has been greater, especially in long-tail business, due to the failure of reinsurers;
- Purchase may be made in a bouquet, i.e. asking reinsurers to take bad business in with the good;

6.1.2. The Regulatory/Solvency/Licensing of Insurers

When marketing a reinsurance contract, the following factors regarding the regulatory, solvency and licensing of insurers should be considered: Is the insurer licensed to do the insurance business? Are there strict requirements regarding licensing of insurers? Less regulatory requirements could mean less guarantee of solvency of the insurer; Are there any obligations as to where an insurance company has to provide compulsory cessions, for example certain percentage to government-owned reinsurers? Solvency requirements – whether the insurance company requirements in the country allow the use of reinsurance as part of the solvency margins. If so this will encourage the purchase of reinsurance.

6.1.3. Difference between Lloyd's and Insurance and Reinsurance Companies

The fundamental difference between Lloyd's and other insurance and reinsurance companies are the following:

Firstly, the nature of the account that tends to be written by a Lloyd's syndicate can be more complex and varied than may be the case of a general company insurer. This demands a sophisticated approach to buying reinsurance. For example, the account may include direct and facultative reinsurance acceptance, as well as low- and high-level risk and catastrophe excess of loss treaties from all over the world. For that reason, Lloyd's tend to put emphasis on excess of loss protection when purchasing cover, as its accounts have the risk of accumulation. Risk excess of loss treaties gives Lloyd's syndicates adequate underwriting capacity to compete in the markets. Over and above this, catastrophe cover is purchased to provide protection against accumulations of losses arising out of one event.

Secondly, all dealings of the Lloyd's syndicates are handled through the intermediary of Lloyd's brokers and much of the reinsurance purchased by Lloyd's syndicates will be placed outside the Lloyd's market with companies in London and the international

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reinsurance markets.

6.1.4. The Disadvantages of Captives

Changing risk management practices have resulted in more risks being retained by organizations rather than passed on to insurers. A captive insurer is a risk-bearing entity controlled or owned by an organization whose primary business is not that of insurance. However, the disadvantages of captives are the following: Capital requirements: investment funds tied up in captives; Captive management costs; Traditional covers are often competitive in prices; Tying up senior management time.

6.2. The Development of the Bermudan Reinsurance and Property/ Catastrophe Markets

Bermuda is an island situated close to the Eastern seaboard of the US, with good access to the US, Europe and East Asia. The Bermudan insurance market has evolved from captives in the late 1940s into a global insurance and reinsurance market. Moreover, Bermuda has a reputation for innovation in meeting the demands of a changing market.

In the early 1990s, the global property/ catastrophe market had gone through unseen five-year losses, caused by both natural perils, such as tornadoes, hurricanes, earthquakes and hailstorms, and man-made perils, such as petroleum accident. Many insurers and reinsurers had become bankrupt. This phenomenon, followed by the reduction in underwriting capacity of the remaining companies allowed for the development of the property/ catastrophe market in Bermuda.

The process commenced with the creation in 1992 of Mid Ocean Re and in 1993 seven more companies were established with a total capital of US$5.5 billion financed from the US capital markets. Now the Bermudan market accounts for some 25% of the world catastrophe premiums, compared to a share of less than 2% in 1993.

The Bermudan market has been able to attract high caliber senior personnel and highly experienced management coming from established market world wide. The managers are multi-disciplined, with skills in underwriting, capital management and advanced natural perils and financial modeling. Particular features are capital efficiency, with small staff numbers. Many functions are outsourced to specialist providers.

Bermuda has from time to time overhauled its legal and regulatory framework to meet market demand. For example, Bermuda Insurance Act 1978 was replaced by the Insurance Amendment Act (IAA) 1995 to tighten up reporting and solvency

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requirements and to increase protection of policyholders. It also gives more power to the finance minister to intervene when needed.

The factors contributing to the successful development of the Bermudan market are as follows: its offshore low tax regime; low-entry barriers for insurance companies; government supervision and regulation is ensured by a self-policing Insurance Advisory Committee (IAC) made up of industry members. This environment encourages investment. However, as the recent case involving AIG has shown, the Bermudan market is less effective in protecting policy holders and less rigorous in terms of supervision and regulation, compared to other markets. The recent AIG saga has shown that much more remained to be done to protect policyholders and shareholders of the insurance companies.

6.3. The International Underwriting Association of London

The International Underwriting Association of London (IUA) was formed on 31 December 1998, through the merger of the London International Insurance and Reinsurance Market Association (LIRMA) and the Institute of London Underwriters (ILU). It is the world's largest representative organisation for international and wholesale insurance and reinsurance companies. This union brought together the representative bodies for the marine and non-marine sectors of the London company insurance market. It exists to protect and strengthen the business environment for its member companies operating in or through London.

All IUA activity is based on a business plan which focuses on the following key priorities: Making the market more efficient; Helping insurance and reinsurance companies to comply; Supporting underwriting and claim practitioners; Talking to brokers; Represent members' interests to governments and regulators worldwide.

6.3.1. Making the Market More Efficient

In 1999 the IUA and Lloyd's joined forces to propose reform of traditional London Market business processes. This initiative then received the support of the broker market and developed into the London Market Principles (LMP) programme. The reforms aim to improve the market's placing, claims, wording and settlement processes.

A standardised LMP placement slip with accurate information enables all contracting parties to be informed and a wording to be constructed. At the same time the repository will receive new broker accounting messages, including signed lines, from which premiums and claims are processed and send new messages to carriers. Should a

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claim arise, an electronic advice and settlement system will link into the repository along with other expert reports and a copy of the slip and wording. In the longer term the LMP slip may be submitted to underwriters electronically and provide the catalyst for the subsequent processes. Moreover, streamlining business processes will make the market more efficient and allow substantial cost savings to be achieved.

6.3.2. Helping Companies to Comply

Regulatory compliance is now a key concern for IUA members. The IUA has a very close relationship with the Financial Services Authority (FSA), which has a high regard for IUA as a representative voice for the marketplace and uses it as one of few pre-consultation bodies when drafting new proposals. Given the international nature of London's company market business the IUA also provides compliance information from many overseas jurisdictions.

6.3.3. Supporting Underwriting and Claims Practitioners

The provision of a market forum for the discussion of technical underwriting issues between members occupies much of the IUA's time and is a core part of its service to companies. In this area the association liaises closely with the Lloyd's Market Association (LMA) through the operation of a number of cross-market class of business committees.

IUA groups work on clauses, wordings and the analysis of technical model regulations which are important in the underwriting business. Another key work is the provision of market statistics that can be used by companies to benchmark their own individual performances. IUA also organizes seminars, conferences and monthly forum meetings.

6.3.4. Talking to Brokers

London is a broker market and the IUA aims to help build relationships between brokers and underwriters in the company market. There are many areas where these two sectors can work together, either directly or through the London Market Insurance Brokers' Committee (LMBC). For example, the establishment of model terms of business agreements, commission disclosure and general compliance matters.

6.3.5. Represent members' interests to governments and regulators worldwide

Many European, US and other regulators around the world look to the IUA to provide

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a voice for the London company market. The association is keen to ensure that legislation impacting its members is appropriate and based on a well-informed understanding of the insurance and reinsurance market.

7. Specific Issues: Property

7.1. Estimated Maximum Loss

The concept of Estimated Maximum Loss (EML) is used for the calculation of retentions based on the sums insured. EML is a probability estimate of the monetary loss which could be sustained on a single risk as a result of a single fire or explosion.

The insurer considers the possibility of the maximum loss being less than the sum insured. A fire policy with a building sum insured of $1,000,000. The underwriter ascertains that the building is divided into two separate units with values of $600,000 and $400,000. Thus, if the unit with the higher value (the target risk) is totally destroyed, the underwriter's liability, it's EML, is unlikely to exceed $600,000. The concept of EML allows the insurer to consider its expected exposure in relation to its theoretical one and adjust its retention.

The calculation of EML is based on the definition of a "single risk". A building standing on its own in isolation is a single risk. However, separate buildings of normal construction not separated from each other may be considered as a single risk. Several building on a site may constitute a single risk. The difficulty arises when the EML has been miscalculated, know as EML error factor', resulting in a higher cost than was anticipated.

For this reason, the reinsurer must establish that it is confident in the method that the cedant is using to calculate its estimated maximum loss figures. Any error in these amounts will leave the reinsurer exposed for far greater amounts of liability than will be expressed as the EML limit. The difficulty arises when the EML has been miscalculated, know as EML error factor', resulting in a higher cost than was anticipated.

The error is the difference between the estimated value and the worst possible loss, where the EML for an individual risk has been underestimated. Therefore, to provide an extra safeguard, the reinsured has resorted to a facultative excess of loss arrangement.

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7.2. Maximum Probable Loss

Maximum Probable Loss (MPL) is used to consider aggregation of retentions arising out of losses to a variety of insured properties, houses, farms, offices, manufacturing plants, petrol stations in a wide geographic area, caused as a result of natural perils, such as flood, earthquake or hurricane. MPL is used to calculate how much the insurer suffers in the event of a catastrophe, and how much of this it could 'retain' for its own account. It is use to estimate the accumulation.

The concept of retention is extremely important in the consideration of the extent and type of reinsurance cover an insurer needs. Apart from the values, hazards, physical circumstances or geography associated with property risks, there will be others which will also have a bearing: strength of the company measured by the amount of capital invested, how realizable is the capital, the strength of the solvency margin, nature of market, its growth potential, the loss pattern and the size of risks.

7.2.1. Event Limit

An event is the incident giving rise to a claim under the treaty on account of a single occurrence.

Several individual risks may be affected at the same time by the same event such as in the case of several buildings damaged by flood. An event limit is used to limit the liability of the reinsurer to the limit.

7.2.2. Hour Clause

Catastrophe treaties are intended to protect the reinsured against the risk of an accumulation of claims arising out of an event. To avoid dispute reinsurers have introduced the Hour Clause, which serves to enable the treaty to cover all damage arising out of the same insured event within a specified number of hours, even although in reality there may be interludes when there is no 'activity'.

The term 'Loss Occurrence' shall mean all individual losses arising out of and directly occasioned by one catastrophe.

The imposition of the Hour Clause will limit the reinsurer's liability for the event. 72 hours is appropriate for earthquake and weather perils. It represents the period during which the reinsured have suffered the highest level of losses.

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7.3. Rating Excess of Loss Treaty

Excess of loss is the standard form of reinsurance bought to protect casualty account. This can be done for each casualty class separately or for all classes as a whole for smaller-sized accounts. Deductibles vary, and limits can extend to unlimited layers for countries where insurers give unlimited motor insurance cover.

Rates are expressed in terms of percentage of base premium and are calculated for lower layers by reference to historical burning cost (claim over premiums income) with a margin built in for brokerage (commonly 10%) and reinsurers' expense and profit. Upper layers, where no experience exists, are rated on an exposure basis or by extrapolating the burning cost price calculated for lower layers.

7.3.1. Exposure Method

The exposure method of rating for the excess of loss treaty is based on the principle that as the deductible declines in relation to the average value of the band, the reinsure premium should rise.

Property risks are sorted into bands, an average value calculated and the deductible expressed as a ratio of the average value for each band.

7.3.2. Burning Cost Method

The majority of excess of loss casualties treaties use the burning cost method, whereby the reinsurance premium can be adjusted regularly, and gradually to changes in the reinsurer's loss expectancy as revealed by the ceding company's loss experience. The method is suitable only for working excess of loss treaties that produce a regular flow of reinsured losses each year.

The reinsurer must allow its own acquisition and administrative costs and provide contribution to the contingency reserve to cover claims fluctuations in its portfolio. Therefore, burning costs (or pure burning costs) are loaded by some percentage to produce a loaded burning cost, which gives the rate to be applied to the cedant's premium income to calculate the reinsurance premium.

Example: if it was agreed to base the reinsurance premium on the claims result for the year of account only, the pure burning cost for Year 5 as calculated at the end of that year would be 3.895%. Given the loading factor of say 100/70, the loaded burning cost for Year 5 would be 5.563%. Based on a figure of $1,900,000, the reinsurance premium

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would be $105,697.

When the method is used correctly variable premium rates offer advantages for both parties. The cedant knows it will benefit by way of lower premium if it is successful in improving its loss experience, but at the same time it will still be able to budget within limits each year for the cost of its reinsurance protection because of the premium adjustment limits. Conversely the reinsurer can be sure that if the reinsured's loss experience does deteriorate, the premium rate will increase automatically.

7.3.3. Rating a Non-Proportional Reinsurance Contract.

Rates of a non-proportional reinsurance contract are expressed in terms of percentage of base premium and are calculated for lower layers by reference to historical burning cost (claim over premiums income) with a margin built in for brokerage (commonly 10%) and reinsurers' expense and profit. Upper layers, where no experience exists, are rated on an exposure basis or by extrapolating the burning cost price calculated for lower layers.

A. Exposure Method

The exposure method of rating for the excess of loss treaty is based on the principle that as the deductible declines in relation to the average value of the band, the reinsure premium should rise.

Property risks are sorted into bands, an average value calculated and the deductible expressed as a ratio of the average value for each band.

B. Burning Cost Method

The majority of excess of loss casualties treaties use the burning cost method, whereby the reinsurance premium can be adjusted regularly, and gradually to changes in the reinsurer's loss expectancy as revealed by the ceding company's loss experience. The method is suitable only for working excess of loss treaties that produce a regular flow of reinsured losses each year.

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7.4. Underwriting of Non-Proportional Reinsurance

Non-proportional reinsurance gives the reinsured considerable flexibility in arranging a balanced reinsurance programme. It provides cover for losses to large risks and the catastrophe.

7.4.1. For the Reinsured

The reinsured must be careful in deciding this type of cover, where the working excess of loss treaty is being considered as a replacement for the proportional treaty; the reinsured has to consider on the one hand, whether it would be better (i) to bear the deductible for all losses, and (ii) to pay a large premium from the outset, but (iii) save on admin expenses; or on the other to cede premiums under the proportional treaty;

The reinsured must consider the level of the deductible for excess of loss: (i) if the reinsured pitches the deductible at too high a level, it may have to fund more losses than it anticipated if the loss experience deteriorates; (ii) if the reinsured chooses a deductible which is too low, thereby causing more claims to be made to the non-proportional contract than were intended, the number of reinstatements available may be used up;

The reinsured must take care when considering cat cover to record its commitments which could aggregate for the purposes of earthquake, flood, hurricane or environmental perils; failure to do so could result in the MPL and the deductible underestimated; The reinsured must ensure that there are no gaps between different layers.

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7.4.2. For the Reinsurer:

The reinsurers must consider the followings: The reinsurance portfolio is difficult to balance, as it consists of many contracts, from many reinsureds, each addressing their own markets and types of risks; There are large differences in the exposures as shares and limits vary; Many treaties can be hit by the same catastrophe; The premiums charged are small in relation to the potential liabilities; The reinsurance underwriter is distant from the cedant's original rating structure.

Questionnaire: (i) size, nature, sums insured and complexity of portfolio; (ii) risk profile: commercial, industrial or residential and their values; (iii) geographical distribution of risks; (iv) possible risk accumulation; (v) susceptibility to 'cat perils' such as hurricane;

The reinsurer will consider its own exposure; the problem of aggregation of risks from a number of cedants; thus ensure that it does not exceed a prudent exposure in terms of 'catastrophe' cover.

7.4.3. Specific Issue to Underwriting a Non Proportional (Excess of Loss) Treaty

The Non Proportional (Excess of Loss) Treaty allows the cedant to bear all the losses in their entirety up to a deductible or retention and to recover any amounts above this sum up to the reinsurer's limit.

From the reinsurer's point of view, the reinsurance portfolio is difficult to balance, as it consists of many contracts, from many reinsured, each addressing their own markets and types of risks; there are large differences in the exposure as shares and limits vary.

Many treaties can be hit by the same catastrophe. Thus, the Excess of Loss Treaty may make him greatly exposed to possible major loss. Therefore, having historical loss detail is important to predict future losses and consequently provide adequate rating for the reinsurance is important.

For the reinsurer, the premium charged are small vis-à-vis the potential liabilities and the underwriter is distant from the cedant's original rating structure.

Furthermore, the nature of reinsured's business must be clearly established. In particular, the reinsurer should ascertain whether the reinsured is specialized in one specific class of business or underwrite a general book of insurance. For this reason, reinsurers ask for the completion by the reinsured of questionnaire to know the size, sums insured and complexity of the portfolio.

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Under the Excess of Loss Treaty the reinsurer is exposed to catastrophic losses, such as flood, earthquake or windstorm. Thus, the reinsurer should obtain the information regarding geographic locations of the reinsured's operations to avoid accumulation. The reinsurer should consider its own exposure by not exceeding a prudent exposure in terms of 'catastrophe' cover.

The reinsurer may not wish to participate in all layers of the program by limiting its involvement to certain, non-consecutive layers. In an event/ catastrophe treaty, the reinsurer should use Hours Clause, the extent of co-reinsurance and the terms of reinstatement. In per risk treaties, the number of 'free' reinstatements and the size of the event limit in relation to individual risk deductibles will be important. It is good to know how the reinsurance is exposed to the different categories of risks, especially those of poorer classes; if the deductible is low, the treaty will be used frequently.

Finally, there must be high level of trust between the reinsurer and the reinsured.

For the reinsured, the non-proportional treaty gives him considerable flexibility in arranging a balanced reinsurance program. It provides covers for losses to large risks and the 'catastrophe'. However, the reinsured must consider the level of the deductible for all losses, and pay a large premium at the outset, but save on administrative expenses. If the reinsured chooses the deductible too high, it may have to fund more losses than anticipated if the loss experience deteriorates. If the deductible is too low, more claims to be made to the non-proportional contract than were intended, and the number of reinstatements available may be used up, and the reinsurance cover exhausted before the end of the reinsurance period.

8. Specific Issues: Casualty

8.1. Underwriting Consideration

The factors and general information that would be material to the negotiation of property risks apply equally to liability risk.

8.1.1. Proportional Reinsurance

A. Motor

- Limits being written by the reinsured for bodily injury and property damage; overseas exposure; exposure to natural perils; attitude and philosophy to high-risk vehicles such as sports cars and specialized vehicles;

- Attitude to high-risk drivers such as young or inexperienced drivers;
- Reinsured's exclusion list (buses, coaches and petrol tankers);
- Balance between TP and comprehensive liability policies.

B. Public Liability

- Nature of classes of business: commercial or industrial, large or small operations;
- Past loss history and allowance for IBNR losses;
- Basis of losses: claim made or risk attaching basis;
- Original policies allow for legal costs;
- Pollution coverage provided?
- Coverage for product liability?
- Details of exclusion.

C. Product Liability

- Additional information on coverage for exports to North America;
- Maximum and average limit of any acceptance;
- Defective design coverage is granted by cedant?
- Exclusion of products guarantee and products recall;

8.1.2. Non-Proportional Treaty

A. Motor

- To have reliable view of how reinsured's account has been developing it would be necessary to provide a breakdown of the premium income for five years: split between private (fewer claims) and commercial vehicles;
- Separate PI for TP and comprehensive policies;

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- Excess of loss treaties are mainly affected by larger TP claims (portfolio with higher TP business will have higher claims);
- Location of risks and territorial scope is important;
- Provision of motor insurance may be a legal requirement;
- Does the reinsured accept high value vehicles and are there any known accumulations of risk at any one location?

B. Public Liability

- Many of the requirements that apply to a motor liability account will also apply to a public liability account;
- A detailed description of the reinsured's portfolio of risks (simple risks, commercial and heavy industrial risks);
- Details of the policy limits and a profile of the limits and premiums.

8.1.3. Common Public Liability Exclusions under Treaty Reinsurance

- Aircraft;
- Vessels;
- Motor vehicles;
- Contractors engaged in building, wrecking, demolition;
- Dam and subaqueous work;
- Mining, quarrying and excavating;
- Erection and work on towers;'
- Gases and explosives;
- Oil companies;
- Tobacco;

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- Asbestos;
- Pollution;

8.1.4. Common Employers' Liability Exclusions under Treaty Reinsurance

- Aircraft crews;
- Ships' crews;
- Offshore;
- Underground and underwater mines;
- Dams;
- Shipbuilding, ship repairing, stevedoring;
- Subaqueous work;
- Explosives, inflammable gases;
- Asbestos;
- Tunnels, towers, steeples, bridges;
- Oil and gas.

8.1.5. Common Motor Exclusions under Treaty Reinsurance

- Racing, rallies;
- Motor coaches, omnibuses, tramways and vehicles on rails;
- Loss, damage or liability for goods conveyed in connection with any trade;
- Ownership, operation or use of vehicle the principal use of which is:
- Transport of high explosives;
- Transport of any inflammable liquid;

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- Carrying of passengers for hire and reward;
- Contractor's plant and equipment not on a public highway;

8.1.6. Advantages and Disadvantages of Combining Several Classes of Casualty Business in One Treaty

Insurance classes are often combined for reinsurance purposes, especially for small insurance companies as liability accounts are not large enough to buy separate excess of loss treaties.

The advantages of combining different classes of casualties business in one treaty are as follows: Analysis of reinsurance requirements by classes indicates that these casualty classes are similar, thus one treaty for all classes is sensible; Ease of administration – calculation and payment of installments, adjustments etc. Allows small insurance companies to include classes too small to have separate reinsurance treaties; Can ensure flexibility by purchasing different limits under excess of loss treaties for different classes;

Classes are often combined for reinsurance purposes, especially for smaller companies.

Advantages: Reinsurance requirements are similar across the classes, one treaty is sensible; Ease of administration; Allow small companies to include classes too small to have separate reinsurance treaties; Can maintain flexibility by purchasing different limits under excess of loss treaties for different classes.

Disadvantages: Cedant is unable to split reinsurance costs; Common retention level across all classes for excess of loss cover. Can be less appealing for a cedant if their combined account is dominated by motor business (Motor can have high reinsurance retention); More difficult for reinsurer to exercise underwriting judgment; Different classes of business may end up subsidizing one another.

8.2. Definition of Loss Event

Under excess of loss it is not the intention that the reinsurers should respond to claims in the same way as the reinsured. Excess of loss reinsurance for casualty classes is written on an ***any one loss or event basis***. Professional indemnity losses are prone to complications in event definition.

Motor:

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Ultimate net loss each and every loss or series of losses arising out of one event.

In motor liability, event is an accident involving however many vehicles. For motor own damage, natural catastrophe losses an event is defined by using the Hours Clause in the same way that it would apply to property reinsurance.

Liability classes:

Ultimate net loss each and every loss, each risk;

Ultimate net loss each and every assured;

Each and every loss occurrence.

In this instance event definition is more complicated, when a series of claims arises out of a **'common cause'** but to many different insureds, especially for professional indemnity. Reinsurers try to limit the number of claims from different assureds that can be brought together under the same event arising out of the same cause.

8.3. Long Tail

Casualty classes are long tail in that some time can elapse between when a claim occurs when it is notified to insurers and when it is settled. Notification of claims to insurers and reinsurers can be lengthy especially in relation to latent exposures. For example an employee could have been exposed to asbestos dust during the 1950s but not developed health problems until the 1980s. The loss occurs during the exposure period but insurers are not informed until the illness sets in and a doctor gives an appropriate diagnosis in the 1980s. Settlement of claims can take a few years as a third party's medical condition should be given time to stabilize before a proper assessments on liability can sometimes take time to resolve, especially when litigation is involved.

8.4. Material information for Contractors All Risk, Erection All Risk, All Risks and Engineering Treaty

The Contractors All Risk, Erection All Risks and Engineering classes cover many kinds of risks, including hazardous risks. Therefore, in addition to premium income and loss experience, the following material information is required: Details of the type of risk that makes up the cedant's portfolio, such as building risks, civil works, annually renewable covers or major projects; Types of engineering risks written by the cedant and the proportion of the overall account, such as boiler, machinery breakdown, cranes, loss of profits, increased cost of working, computer all risks; Maximum policy or

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contract period that the cedant write; Details of the cedant's table of limits; Policy limits issued on an EML basis and criteria used for the assessment of its EML predictions; Extent of the portfolio of original risks exposed to natural perils and territorial concentrations of risk; Inspection and survey facilities used by the cedants; Full details of any risk written by the reinsured that fall within their own standard exclusions.

8.5. Inflation and Insurance

Inflation can either be vertical (individual claims increase in value over time) or horizontal (more claims occur or are made over time). Casualty insurance is long tail. It can elapse between when the claim occurs, when the insured informed it to an insurer and when it is settled. The loss occurs during the exposure period, but insurers are informed only when the illness sets in.

Settlement of claims can take a few years since it takes time to make a proper assessment regarding the extent of care required. Moreover, arguments on liability also take time to resolve, when there is a lawsuit.

Levels of compensatory awards for bodily injury, physical damage and financial loss increase every year due to monetary inflation. Inflation affects the levels of award. Moreover, the limits and deductibles on excess of loss contracts are also devalued in real terms. Therefore, an Index Clause or a Severe Inflation Cause is applied. These move the limit and deductible of reinsurance contracts in line with inflation. A Severe Inflation Clause will be applied when inflation has exceeded a certain percentage.

Super-imposed inflation applies to third party bodily injury claims which take a few years to settle. Super-imposed inflation is additional inflation over and above monetary inflation and is caused by the following factors: the increasing cost of medical care, increasing labor cost of medical professionals and prolonged care provided to accident victims; public awareness prompts people to sue for higher amount of claims.

To address this problem, provisions should be made by insurers for inflation when setting the rates.

9. Marine and Aviation Reinsurance

9.1. Hull Underwriter

As the values of fleets all over the world have become increasingly higher and higher, the hull underwriter is required to take reinsurance in order to expand capacity and

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ensure prudent retention. This situation brings about a problem for the original underwriters who wish to maintain their percentage involvement in the fleet but at the same time find themselves with considerably more of the peak values than they think prudent.

It is this imbalance that necessitates some form of reinsurance to ensure that the hull underwriter is left with an involvement which represents an acceptable percentage of their premium income and which would not ruin their hull account or threaten their solvency. The underwriter may reinsure a particular class or type of vessel or classify their reinsurance needs by way of a flag (country of registration) to improve the quality of their retained hull account.

As vessels can accumulate in the same risk area, it can result in an accumulation of values well in excess of a single hull value. Therefore the hull underwriter is required to assess carefully the need for any form of reinsurance.

Even when considering large ocean-going hulls, hull underwriter must bear in mind the fact that several such vessels could be in the same area at the same time of a major disaster such as fire or windstorm, or even a warlike act. Therefore, there is not only a need for hull reinsurance of a specific nature to reduce an individual involvement to an acceptable level, but also a need to guard against the catastrophe risk of several vessels being involved in the same event. The above consideration applies to tankers which constituted a single and very highly valued risk.

The prudent hull underwriter will need to assess all the above considerations and arrange their reinsurance so as to ensure that both their individual vessel retention and their catastrophe risk potential do not represent more than a small percentage of the premium they earn in that class of business.

9.2. Tonnage Policy

Tonnage policies were often effected on behalf of companies and Lloyd's underwriters in order to diminish losses in the event of total losses occurring within a twelve moths period. In one sense, tonnage policies are a form of aggregate excess of loss reinsurance. They covered not only the reinsurance to the hulls but also passenger deaths.

The insured receives a pre-arranged sum each and every time a total loss occurs, even though they may have no direct involvement in the original hull policy covering the aircraft which is the subject matter of the claim.

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The sum insured for such policies was often quite small and it could be restricted to an aggregate number of losses during the twelve-month period. Sometimes these policies would only pay after a certain number of losses had occurred and the only up to a maximum number of losses occurring during a policy period. The premium charged was usually a flat premium for the period in question. Alternatively, it may have been a rate percentage on the sum insured agreed at inception covering one loss, and the made subject to pro-data additional premium for reinstatements after each and every loss.

Tonnage policies were usually effected on behalf of companies or syndicates having a large portfolio of aviation, hull and liability business. As such, these had an 'indirect' insurable interest in the aircraft which was the subject of the claim. It is the 'indirect' nature of the insurable interest that led to the outlawing of this type of policy at Lloyd's.

The types of aircraft covered by these policies would have varied considerably, according to the reinsured's requirements, but they were usually limited to a specific type of aircraft and only applied in the event of the total loss of such an aircraft.

9.3. Factors to be Considered in Marine Business

All the factors and general information that would be material to negotiation of property and liability risks, such as details of the ceding company, the portfolio to be reinsured, claims experience, original policy sums insured or limits of liability, exclusions, etc. – will apply equally to marine risks.

Because of the diverse nature of marine risks, reinsurers have usually paid particular attention to the nature of the portfolio and the risks and/or liabilities. For this reason, reinsurers have resorted to use more of facultative reinsurance. It allows reinsurers to carefully assess the quality of the risk itself and pay less attention to long-term relationship between the reinsured. Therefore, treaty reinsurance reflects the terms and conditions available predominantly determined by the reputation and performance of the cedant.

9.3.1. Cargo

- Writing a balanced book of business and a resort to reinsurance is the only way to reduce peak line commitment to an acceptable level;
- Cargo is more likely to accumulate without the knowledge of the underwriter;
- Many cargo policies cover the goods from the initial warehouse to the final

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destination; a large part of the risk is unidentified and the risk of accumulation is unknown to the underwriter;

- Most cargo reinsurance contracts have the aggregate voyage extension clause (AVEC) which allows separate losses occurring during a single voyage to be aggregated and defined as any one loss;
- Consideration should be given to the construction of cargo surplus treaties, which may have a schedule of retentions, and limits categorized by a type of vessel or tonnage;

9.3.2. Containerization

- Aggregation of high limits on one container ship or in one container terminal because of the near impossibility of establishing when any damage occurred to the contents;
- Containerisation has eliminated or reduced the incidence of theft and pilferage claims, but the whole containers were stolen;
- Aggregation of values – hull and cargo – has escalated beyond predictions.

9.4. Aviation Account

- Underwriting aviation reinsurance requires considerable detailed information;
- Reinsured may abuse the facility by ceding poor quality business; very often underwriter will commence business with a company on a purely facultative basis, in order to establish liaison and have the opportunity of examining each piece of business in detail.
- The underwriter often imposes the aviation reinsurance underwriting and claims control clause, AVN41. Under its term, they are able to control claims negotiation and settlements, determine details of policy wording and find out policy premium;
- Maintaining detailed records so that adequate excess of loss or suitable protection may help avert accumulation of risks.

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10. Information Technology in Reinsurance

10.1. Structure of a Typical IT Division

The structure of a typical IT division would include the following functions:

A development department, which is responsible for the design, creation and support of systems to meet business requirements.

A data center, responsible for the operation of the computer hardware, which may include telecommunications equipment. In some organizations this activity is outsourced to a third party.

A technical support department, responsible for the computer operating systems and other bought-in software. This department often acts as the technical 'nerve center' for the IT division and may be responsible for communications, including voice and computer networks. **The database** administrator function normally resides in this department.

A service desk, whose purpose is to act as a help desk by answering queries about using the IT system. This group responds to systems problems and ensures that users are aware of any operational issues that might affect the business activity.

The quality assurance team carries out a function for IT that is similar to that of internal audit in business and financial processes.

A business systems group able to work with the business departments to assist in investigating business processes.

10.2. Systems of Security in an IT System

The following systems of security will be needed to be incorporated into an IT system: system controls; back-up; virus protection; access security; firewalls; public key infrastructure and disaster recovery.

System controls—Business controls and audit trails need to be incorporated into the design, as they provide the right level of information for use by the auditors, both internal and external. There is a clear advantage to be gained from including the auditors with the users in the team reviewing the system definition and data structure.

Back-up—Comprehensive back-up procedures is necessary to go back to a known and

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secure starting point and begin again, in case of loss of power, equipment failure or data corruption that may cause a system to malfunction. The back-up copies should be held off-site in order to protect against damage to the operational site. For critical databases, systems are written so that copies of data records showing before and after images are stored on a journal file which is itself copied in real time off-site.

Viruses—It is very important to have virus protection software running on all processors in order to protect the computer against viruses, which can cause problems by corrupting data or deleting important information. Viruses are often transmitted through a network, by floppy disk or through the Internet. Therefore, strict procedures should be put in place to prevent virus transmission into the computer system.

Access security—The security administrator is responsible for setting up the access tables which determine who can access which system and who has authority to change the data content. Access to systems is controlled by a system of identification and passwords.

Firewalls—Firewalls, either hardware or software, are used to protect computer environment from interference from an external source by virtue of the installation being connected to a network. Access to the Internet will normally be achieved through a firewall. Any connection to a public network should be so protected.

Public Key Infrastructure (PKI) - The security via a network is crucial for electronic transactions. Security of the link should be maintained at all time so that each sender and receiver of messages can be assured that the messages are being sent by the sender and data are as sent. A public key and private key infrastructure would enable that only intended recipient of a message will be able to know its contents.

Disaster Recovery—There are two levels of back-up available in the case of a disaster:

- A hot restart facility which provides almost immediate access to a computer facility to run the critical systems; and

- A cold restart facility which would provide a similar alternative computer facility within a week of the disaster.

10.3. Proposal for an IT System

The development and the implementation of the IT system will consist of the following phases:

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1. Defining User Requirements

Before developing an IT system, it is necessary to establish business requirements for an IT system at Cambodia Re. This user requirement can be prepared through a process of consultation with all Cambodia Re staff members, taking into account the specific needs of the company. At this stage, attention should be given to the format of borderaux that Cambodia Re will require from cedants, borderaux that Cambodia Re will send to reinsurers, the format of consolidated financial statements, Profit and Loss Statement and Cash Flow Statement. The time frame for preparing user requirements will be one month.

2. IT Solution

The proposed IT system can be developed by using a software package, based on an Oracle software, that was developed to meet the needs of reinsurance companies. However, this system should be compatible with the existing systems being used by ceding insurance companies so that there is no need to key in data again into the new system. Cedants will be required to submit diskette-formed report that will be inserted into the proposed IT system.

3. Creating a System

A team of 6 persons will be needed to creating a new IT system, which consists of the following phases: (i) system design; (ii) technical design; (iii) programming; (iv) testing; (v) and implementation.

At the design stage, the project team will work closely with the users to maximize the benefits. Two staff members, one from the Account Department and the other from the Underwriting Department, will be seconded with the project team. Moreover, the IT project team will be partly located in the Underwriting Department to allow for interactions between the project team and the users.

4. Technical Design

Data submitted by the cedants will be processed by using online processing. Transactions will be entered and processed immediately and then will be made available to all users. This online system will enable periodic extraction of analysis, summaries and reports.

Users may make enquiries to the database by entering key information and requesting a screen display of data with matching key information. When considering renewal, it is

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necessary to request an up-to-date position of the treaty. The user may make on-line enquiries to produce summarized information from the database.

To ensure efficient management of the database, the software should allow the users to extract only appropriate information. The system organizes the data, alerting the user that the information is available.

5. Hardware component

The hardware component consists of a network of personal computers and a server, which is a more powerful processor. The server is the mainframe computer, which can handle large volumes of data and business processes with high-volume transaction flows.

6. System security

The security of the IT system allows the system administrator to ensure business controls and audit trails of the operations. Comprehensive back-up procedures will be carried out by taking back-up copies of data, which will be held off-site in order to protect against damage to the operational site.

Access to the system will be controlled by a system of identification and passwords. A security administrator will be nominated to set up the access tables, which determine who can access which system and who has authority to change the data content.

7. Benefits of the IT system

IT is an integral part of the reinsurance business, which relies upon effective use of information. Thus, competitive advantage can be gained through effective data management.

The use of the IT system will enable Cambodia Re to improve operational performance by handling large amounts of data accurately, quickly, securely and cost-effectively. The system will enable Cambodia Re to reduce the transaction costs, improve the levels of customer's service and ensure closer interactions with both cedants and reinsurers.

8. Costs of the project

The project is expected to cost $500,000, with the following breakdowns: the hardware component is estimated at $100,000; software development is estimated to cost around $200,000; with the remaining $200,000 will be used to miscellaneous expenses.

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Part VII

Claims Management

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Part VII

Claims Management

1. Overview of Claims Terminology, Process and Concepts

1.1. Distinction Between a Claim and a Loss

1.1.1. What is a Claim?

A claim can be made without an 'insured loss event' happening. In such a case, the claim would be invalid. Similarly an insured loss event can occur without a claim being made.

1.1.2. What is a Loss?

A loss is the occurrence of an insured event, such as fire, which results in financial disadvantage for the insured.

1.2. Claims Process

The actual procedure for handling claims varies according to the class of business, the type of cover, the amount of claim, and whether it is a personal or commercial risk insured.

A. Claim Notification

This is the reporting (in the prescribed format, e.g. by filling in the claim form of the claim by the insured to the insured. All appropriated documentation, such as receipts, will be enclosed.

The purpose of claim notification is to enable the insurer to take steps to investigate claims, enable loss adjusters and lawyers to be appointed so that evidence is not lost. It gives insurer opportunity of investigating possible recoveries from third parties and avoid the insurer missing the tight deadlines involved in the new code of conduct of civil litigation.

The new Rules:

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- to encourage a pre-action contact between the two parties to a dispute (before court proceedings);
- to require the early exchange of information between the two parties in an attempt to reach a negotiated claim settlement.

A completed claims form may be sent to the insured for confirmation and signature. A record of the telephone conversation is kept as substantiation of the information provided.

B. Claim Review

This involves the analysis of the claim by the insurer in the light of: The appropriateness of the amounts claimed; The proposal form, e.g. whether the claim contradicts earlier statements; The exact term of the policy; Legal requirements; Economic considerations, such as the internal cost of pursuing extra documentation; Market practice; Corporate claim philosophy.

C. Response to Claimant

The initial response from insurer to insured is acknowledgement or a request for further information. Then the insurer must convey his claim decision: Payment; Negotiation, e.g. the offer of a lower amount; Rejection, e.g. liability is not accepted by the insurer.

New rules: standard procedures set out in documents known as pre-action protocols (only two). A pre-action practice direction provides that for cases not covered by the current protocols, the court will expect the parties to all disputes to 'act reasonably in exchanging information and documents' and in trying to avoid court proceedings.

The insurer must either: follow the exact procedures laid down in the relevant pre-action protocol for the particular type of claim; or 'act reasonably' in respect of all other types of claim.

Ex. for the personal injury pre-action protocol, the insurer is required to covey the claim decision within 3 months of the date of the defendant's acknowledgement of a letter of claim from the claimant; admit liability; or reject liability, giving reasons.

The insurer must provide standard disclosure of relevant documents which substantiate their reasons for denying the claim.

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D. Claim investigation

In order to establish such facts it may be necessary to instruct an internal claims inspector to undertake further investigations or they may appoint loss adjusters who undertake an independent investigation.

Under the new Civil Procedure Rules, claim investigation must be both thorough and immediate:

- Swift, yet efficient – investigate loss incidents within the necessary timeframe;
- In-depth – distinguish claims worth settling at an early stage and those which they wish to fight;
- Pro-active – the insurer is properly responding to and investigating the claim;
- Productive – to say defendant is not liable and substantiate with evidence;
- Organized – internal accident investigation procedures in place, including a nominated person to take statements; identify witnesses; and take photographs in order to establish the facts surrounding the loss.

D. Claim Negotiation

Armed with the full facts of the case the insurer may decide that a lesser amount should be offered.

The new Civil Procedure Rules allow both claimant and the insurer to make an offer of settlement at any time and through the increase in pre-action contact between the parties, better exchange of information, and better pre-action investigation, the claim negotiation process should be improved.

F. Claim Settlement

This stage (the financial settlement of the claim by the insurer) may quickly follow the response to the insured in the case of simple claims.

The new Civil Procedure Rules speeds up the claims settlement process due to: pre-action protocols which: encourage the settlement of claims; have tight deadlines for action; and are supported by sanctions for non-compliance, such as imposition of costs by the court; case management by judges.

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The increased speed of settlement has implications:

- Claims process. Working practices of claims department will change;
- More senior staff will be needed at an early point in the life of a claim;
- Transaction costs reduced;
- Incurred but not reported (IBNR);
- Higher per insurance claim nuisance value (it makes sense to pay than to deny liability), i.e. to pay claims rather than investigate; leading to: increasing customer satisfaction; increasing the certainty of the amount of settlement; and reducing administration cost.
- Further claims;
- Cash flow of an insurer;
- Investment policies as more liquid assets are needed.

G. Claim recoveries

The insurer will be able to recover part of the outlay from other sources. Subrogation rights may exist, one or more reinsurance protections.

H. Review of performance

Is to ensure that standards of service are being maintained; that internal decisions were correctly.

1.3. The Difference Between Claims Management and Claims Handling

Claims management encompasses:

1. The carrying out of the entire claims process from notification to review of performance.
2. The monitoring of claims expenses, legal costs, and claim settlements;

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3. For self-insurers, the review of performance would include attempting to minimize future losses in order to reduce claims costs.

Claim management can be defined as: "The carrying out of the entire claims process with a particular emphasis upon the monitoring and lowering of claims costs."

'Claim handling' – handling the various stages of the claim process. It encompasses none of the risk management issues and instead emphasizes the functions of claim review; claim investigation; and claim negotiation, the most problematical elements of claims work.

Claim handling can be defined as: "The original term for handling the claims process with emphasis upon claim review, investigation and negotiation, but excluding risk management issues."

1.4. Role of the Claims Department

The claims department is one of the key departments, has many role:

Strategic-role : to provide, a high quality of service so that it can differentiate itself from its competitors

Cost-monitoring role: to ensure that the amount paid on any claim is contained

Service: to meet or exceed customer's expectation regarding the quality of service.

Management: to meet or exceed the standards of service set and to operate within budget.

1.5. Importance of Claims Costs

The importance of the cost of claims in the insurance industry cannot be underestimated. If the cost of claims at any point in time (including the estimated future cost) exceeds the available resources to pay such liabilities, then the insurance/ reinsurance company is technically insolvent and must legally enter into one of the forms of insolvency. It cannot continue to write new business. From this we can see that the estimation of future liabilities (see chapter 7) is just as important as the control of current claim payments.

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1.6. Reinsurance and Claims Handling

The essential difference is that reinsurance claims handling involves negotiation between two insurance specialists in a business environment where a continuing business relationship may exist.

Insurance claims handling in comparison, often involves an insurance specialist negotiating with a member of the public where a continued relationship is unlikely if the claim settlement fails to meet the insured's expectations.

1.6.1. Notification Conditions

The reinsured is bound to notify the reinsurer of claims and or accidents in certain circumstances.

1.6.2. Claim Cooperation Clause

The reinsurer must be promptly notified of losses which may involve the reinsurer. The reinsured must cooperate with the reinsurer in handling the claim.

1.6.3. Claims Control Clause

The reinsured must notify the reinsurer promptly of losses that may involve them and allow the reinsurer to control the claim. If a reinsured fails to notify the reinsurer at the appropriate time, they may be in breach of this clause.

1.6.4. Accumulations

Accumulations – pooling together of losses for collection under a reinsurance policy. The insurer will seek to protect itself against the possibility of a single event resulting in claims being made under different policies underwritten by the insurer. This type of reinsurance is known as accumulation or aggregate protection.

2. Corporate Claims Philosophy

2.1. General Concept

A claims philosophy can be defined as: 'a specified approach to key claim issues'. A written claims philosophy will normally consist of three sections.

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Firstly, the general section:

- The quality of service aimed for;
- How valid claims should be handled.

The example: "We aim to provide a high quality service. All claims falling within the policy terms will be paid fairly and promptly".

The second section:

- The nature of the claims service at each stage of the claims process;
- The speed of the claims service;
- The economic efficiency of the claims service.

Examples:

- Provide a prompt and courteous response
- Enquire into the claim quickly and expertly
- Assess the claim and make a clear decision taking into account the policyholder's rights, legal requirements, and economic considerations.
- Handle claimants sympathetically and sensitively
- Be polite but firm
- Be aware of the total costs associated with the handling of a claim

The third section sets out the benefits of the claims philosophy. The benefits can be divided between external benefits, i.e. benefits to external customers; and internal benefits, i.e. benefits accruing within the organization.

2.2. FSA Handbook: Insurance: Conduct of Business Sourcebook (ICOB):

Section 7.1

Claims must be handled fairly and promptly; customers given information on the claims

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handling process and explanation.

Section 7.3

Insurers must have systems in place to take account of reasonably foreseeable peaks in demand. Insurers must not unreasonably reject claims on grounds of:

- non-disclosure of material fact;
- misrepresentation of a fact material to the risk;
- breach of warranty or condition;

Section 7.4

Insurance intermediaries must act with due care, skill and diligence when dealing with a claim.

Section 7.5

Performance standards to be provided to customers when claims are being handled.

Section 7.7

Claims records should be kept for a minimum of three years.

2.4. Benefits of a Corporate Claims Philosophy

The benefits can be divided between:

- External benefits, i.e. benefits to external customers;
- Internal benefits, i.e. benefits accruing within the organization.

2.4.1. External Benefits

A. Strategic

Organization is able to position itself among the best in its field as regards its claims processing efficiency, friendliness and professionalism. Part of the marketing strategy,

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B. Cost

Claimant is more likely to produce documentary evidence of any valid claim and less likely to make speculative claims. In such circumstances, the claims process should be shorter and disputes which are costly for both parties should be less common.

Some reinsurers have established teams to unlock historical reinsurance debts held up by technical queries to prevent queries arising relative to new claims. Such departments liaise with the inwards claims department and create a claim information pack which explains the basis of outwards claims recovery.

C. Service

Customers can refer to the claims philosophy to compare it with the actual service delivered. If one of the key promises is not fulfilled, they may have a legitimate complaint.

D. Personnel

By use of a written claims philosophy, the organization is able to offer a consistent claims stance since the general approach is written, understood and applied by each member of the claims team.

2.4.2. Internal Benefits

A. Strategic

The process of producing a corporate claims philosophy involves analyzing each stage of the claims process within the organization and making an assessment of the nature, speed, and efficiency of each element. A claims philosophy is aim and thus implicitly sets management goals and objectives.

The prestige of a management model where the claims department has internal customers such as the underwriting department, the establishment of high-quality service ideals will serve to define the focus of its work and the level of commitment of its members.

B. Cost

The clear statement of the characteristics of claims which will be promptly paid is intended as a side-effect to discourage speculative claims which are wholly without

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substantiation. The claims process should be quicker and contain fewer disputes if such claims can be avoided. This saves claims costs, administration costs, and litigation costs.

In reinsurance, it makes sense to set out clearly the required level of claims detail, since there is often a wide spectrum of market practice regarding certain claims issues (such as aggregation) which arises from the use of non-standard contract wordings, geographical locations.

C. Service

With the publication of a claims philosophy, an organization is likely to set specific internal goals and objectives. Claims philosophy will provide a focus for the claim department's work and set broad standards internally.

D. Personnel

The claims personnel will be aware of what is expected of them and will work towards achieving the targets set.

The staff will be able to take pride in the provision of an efficient service.

2.5. An Insurance Claims Philosophy

The users of an insurance company claims philosophy

- External-customers, members of the public, reinsurers.
- Internal-claims department; management; and marketing department.

2.5.1. Analysis of Claims Process

A claim philosophy must define minimum and maximum future targets for the quality of claims service. The new Civil Procedure Rules: deadlines; conduct of the parties; and information to be exchanged between the parties.

The assessment of the claim stage of 'claim review': the current service offered (claims take on average 15 days to review); minimum services (claims must be reviewed within 18 days in order to reply to letter of claim within 21 days); and maximum services (claims could realistically be reviewed in 10 days);

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This requires an assessment of: Current service offered and Ideal service.

External customer's view of the quality of the service by a market research company on:

- Current weaknesses;
- Current strengths;
- Possible improvements.

The maximum service could, for example, read:

Claim review

Nature - pro-active;

- professional;

- consider 'strict' policy term;

- consider legal obligations;

Speed - 10 days;

- consider Civil Procedure Rules deadlines;

Efficiency - ensure full reasons provided by claimant;

- consider the information requirements of the Civil Procedure Rules (information, statements and records);

- Pay valid claims immediately.

2.5.2. Future Standard of Service

The insurance/reinsurance company would now be in a position to decide upon the future standard of service is a part of the strategic business objectives and the overall marketing strategy.

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2.6. Reinsurance Aspects

Reinsurance claims departments do not deal with the public but with other reinsurance specialists. Very few reinsurance companies have a written claims philosophy for the following reasons:

- Reinsurance companies were not chosen on the quality of their claims service as such but rather on their financial strength and specialization.
- The external benefits were not recognized because there was traditionally less focus upon the need to be considered among the best as a development of the total marketing concept.
- The internal benefits were equally not seen before it was recognized that the claims department has internal customers.

2.7. Introduction of Written Claim Philosophies

Changes in claims philosophies:

- The larger reinsurance companies are now marketing themselves as global asset managers. As such, they are using modern management techniques to define their key objectives over the next five to ten years.
- Many reinsurance companies forced into run-off by the aforementioned competitive pressures have developed internal claims philosophies, with the assistance of reinsurance consultants to control their inward claims.

2.8. Interrelationship with Overall Business Objectives

The decision to develop and implement a corporate claims philosophy will have an effect on several business areas within a company.

The introduction of a corporate claims philosophy can affect:

- Average claims costs, excluding expenses;
- Average claims expenses, such as legal expenses;
- Number of customers, both new and retained;

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- Company image;
- Cash management.

2.8.1. Claim Costs and Expenses

Experience shows that claims are more expensive where they are not settled expediently:

- Aggrieved parties become less inclined to accept moderate settlements,
- Inflation increases the amounts at stake;
- Court cases tend to go against insurers where delay exists.

2.8.2. Number of Customers

Higher standard of claims service, likely that the number of customers, both new and retained, will increase.

2.8.3. Company Image

A. Cash Management

The event of a claims philosophy being introduced which tends to tighten claims controls it is possible that the short-tern effect will be to reduce the average claims cost and the speed of settlement. However, the longer-term effect may be an increase in costly claims disputes. In this scenario, cash flow will be reduced in the short term but will ultimately increase.

Increased speed of the payment of valid claims will tend to increase cash flow in the short term, but may reduce it in the longer term. However, the actual effect of a claims philosophy will depend upon the actual philosophy; the class of business; and the historical claims philosophy employed.

Slow-paying or non-paying reinsurers can financially cripple an insurance company in certain circumstances. Badly performing reinsurers may cause solvency and credit-rating problems.

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B. Business Objectives

These objectives will vary depending upon the prevailing

Examples of objectives could be:

- 10% premium growth per year;
- 5% increase in market share per year;
- 10% increase in after-tax profit per year;
- To leave the insurance/reinsurance industry;
- To hold market share in a soft market;
- To be considered the 'best' in the market.

C. Reconciling Philosophy and Objectives

An appropriate claims philosophy must be chosen in order to achieve the specific objective, for example:

Philosophy	**Objective**
Increase the number of customers	premium growth and market share increase
Reduce claim costs	increase after-tax profit and leave the industry
Enhance company image	hold market share in a tough market and be considered the 'best'

E. Significance of the claims settlement profile to marketing strategy

D. Customers Key Needs

Marketing concerns ensuring that the organization meets and continues to meet its defined customers. Companies are selecting their chosen market and targeting customers who will provide profitable growth. This will be successful when strategy is

combined with brand image. Customers will choose a supplier based on their perception of who provides the greatest value at reasonable cost.

Most major insurers/reinsurers develop an annual marketing plan, designed to reinforce the company's essential advantages and promote its differences versus the competitors.

Various forms of marketing: the use of Internet sites; providing speakers, exhibition stands, and sponsorship at insurance conference; publishing newsletters; links with respected global publications; business briefing; and research.

2.9. Establishing Business Objectives

In development a marketing strategy, objectives (such as an increase in market share) must first be established. The target market and associated needs should then be identified. The next step is to position the organization within the market with differentiation based upon:

- Product (in our case the insurance/reinsurance terms);
- Service offered with the product (including the claims service);
- Promotion (such as adverts in the insurance press);
- Distribution (i.e. the geographical location of branches);
- People (those who have contact with the customer including the claims personnel).

2.10. Complementary Claims Philosophy

A successful claims philosophy will have an effect.

2.10.1. Service

The organization is able to differentiate itself from its competitors.

2.10.2. Promotion

Attempts to build their brand names and establish their corporate identities, insurance companies have been placing their claims function in the forefront of their promotion activities.

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2.10.3. Price

A company is consistently able to keep its claims costs below those of the competition, it will be in a position, to charge a lower premium.

2.10.4. People

The insurance and reinsurance world is said to be a people business. The person representing the insurance company becomes the face of the company to the company to the claimant. A clear claims philosophy can define the company's expectations of how staff should behave while still being firm but fair.

3. Claims Procedures, Management of the Claims Operation

3.1. General Features of Insurance Claims Procedures

3.1.1. Claims Notification

Claims notification serves several purposes:

- it enables the insurer to take steps to investigate claims;
- it enables loss adjusters and lawyers to be appointed;
- it allows the circumstances to be investigated so that detailed evidence is not lost;
- it gives insurers the opportunity of investigating possible recoveries from third parties.

The first party is the person/ company insured by the insurer. The second party is the insurer. The third party is anyone else involved in the lost event. In motor insurance, a third party may be another vehicle owner, property owner or persons such as passengers or pedestrians. Third party claimants are the person/ company who have sustained personal injuries or property damage who may claim against the insured for the insured's liability arising from the loss event.

The policyholder should notify claims quickly to avoid the insurer missing the tight deadlines involved in the new Civil Procedure Rules. The insurer must be able to substantiate their response to proceedings with evidence.

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Notification of a claim is the responsibility of the insured. The insurance policy, which will require prompt notification within specified time limits. Initial notification may be by telephone or in writing.

The insurer requires the insured to complete a questionnaire which seeks details of the insured, the incident giving rise to the claim and the claim itself (e.g. time, place, nature of loss and financial value).

3.1.2. Claims Processing

Most claims will be dealt with by the insurer's claims department. The insured is responsible for proving:

- That he or she has suffered a loss by a peril which is insured by the policy
- The value of the amount of the loss. The extent and nature of that proof

The insurer is responsible for checking that:

- Cover was in force at the time of the loss;
- The insured is the correct insured;
- The peril is covered by the policy;
- The insured has complied with the policy conditions;
- No exclusions apply.

3.1.3. The Use of Loss Adjusters and Other Professionals

Loss adjusters are expert in the processing of claims from the early stages to settlement. The services which they offer include:

- Ensuring that all the interests of the insured are preserved;
- Checking that the cover was in force and was adequate;
- Acting to minimize the extent of the loss;
- Attempting to bring about a swift settlement.

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A loss adjuster will supply:

- A preliminary report on the claim, perhaps including photographs;
- A final report detailing the amount of the actual loss.

3.1.4. Claims Settlement

Claim settlement is the financial payment of money to the insured. It represents the final stage in the claims procedure.

Once an insurer is convinced that a claims is valid (i.e. falling within the scope of the contract) the size of the payment must next be assessed. The type and amount of the settlement depends:

- the nature of the cover – the contract can be: (i) on an indemnity basis; (ii) on a reinstatement basis; (iii) a valued policy; (iv) an agreement to pay a specified sum;
- the adequacy of the cover;
- the application of any conditions which limit the amount payable.

3.1.5. Adequacy of Cover

In property policies, under-insurance may trigger the application of average which will affect the size of the claim payment. In liability policies, the award of damages may exceed the limit of indemnity or the cover may prove inadequate due to the application of the annual aggregate limit.

3.2. General Features of Reinsurance Claims Procedures

Reinsurance claims must be handled efficiently and adequately in order to:

- restrict claim payments to those which are properly due;
- confine claim payments to those which are correctly presented;
- maintain accurate and representative statistical records of losses advised;
- ensure that all possible recoveries are made.

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A reinsurance company's claims experience is likely to vary significantly from that of a direct company. There are two methods of reinsurance: proportional and non-proportional.

3.2.1. Claim Notification and Conditions

The claims department receives its daily claim advices from either a broker or the cedant. A broker may advise reinsurers of a claim by post, in person, or electronically.

Losses arising from a proportional treaty are generally advised through the medium of a quarterly account. Certain larger losses, which exceed contractually stipulated amounts, and which reinsurers are generally requested to settle immediately, are notified to reinsurers as cash losses, outside of normal quarterly reporting procedures.

Non-proportional or excess of loss treaties generally provide for all losses to be payable by the reinsurers upon receipt of a statement of the settlement of the original loss or within a specified period of time thereafter.

The primary responsibility for the handling of losses rests with the ceding company. Reinsurers need prompt advice of losses which may involve them in a significant liability. Proportional treaties, they require sufficient information to enable them to understand the nature of the loss and form a view of liability, to assess the probable cost and to keep their own retrocessionaires informed about large losses.

Following the recent changes to the Civil Procedure Rules, reinsurers may wish to investigate the claims processes employed by cedants. The reinsurance claim presentations may include costs awarded against the cedants resulting from the insurer's non-compliance with the pre-action protocols.

The treatment of expenses incurred by the ceding company in commencing or defending any legal proceedings in connection with any claim:

- Under proportional treaties, the ceding company and the reinsurer share proportionately the costs and benefits of litigation.

- Under non-proportional treaties, such costs, plus the costs of a successful claimant, are included in the calculation of ultimate net loss. The benefit of a successful defense will accrue solely to the ceding company if the amount of the disputed claim is within the treaty retention. If the case is lost, the reinsurer may become liable for some of the extra costs incurred.

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Reinsurers writing business on an excess of loss basis may have to wait several years before large claims, which are subject to litigation.

Notification conditions are written into reinsurance contracts. Two most common clauses are: claims control clause and claims cooperation clause.

3.2.2. Checking Procedures

Once a quarterly account or cash loss in respect of a proportional treaty, or loss advice in respect of a non-proportional treaty is received, certain steps are take by the reinsurer:

- Checking the reinsurer's proportion of the loss and intermediaries order
- Ensuring that the underlying layer, has been exhausted;
- Seeking evidence that the cedant has settled the loss;
- Checking the validity of the loss;
- Reviewing the size of the loss in relation to the treaty limits;
- Establishing the cause of the loss;
- Comparing the promptness of the loss notification;
- Ensuring that outstanding loss information is provided;
- Checking whether any reinstatement premiums are due;
- Collating information on major market losses;

3.2.3. Claims Processing

Upon receiving each new claims advice the claims examiner allocates a unique claim number, and his or her reference.

All major market losses should be specially coded so that a computer listing of such losses can be produced and to facilitate recovery from retrocessionaires.

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If a reinsurer is not satisfied with the level of information provided in, it may be able to withhold payment

3.3. The Role of the Claims Manager

The managers of insurers and reinsurers are the stewards of two sets of funds:

- The funds provided by the shareholders;
- The funds created by the premiums paid by policyholders.

The functions of the claims department are the following:

- To deal quickly and fairly with all claims submitted;
- To be able to distinguish between valid and invalid claims;
- To operate at minimum expense.

This requires:

- Competent and well-trained staff;
- Efficient administrative support;
- Efficient claims procedures;
- Efficient record-keeping;
- Clear corporate claims philosophy.

The claims department is normally headed by a claims manager who is supported by a number of claims examiners or handlers. The claims manager will usually report to the Chief Executive.

The role of the claims manager can be analysed under the following headings: Strategy;

Cost; Service; Personnel.

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3.3.1. Strategy

Insurers and reinsurers alike require a coherent approach to all aspects of claim management. This will encompass:

- A corporate claims philosophy ;
- Clear claims procedures;
- Use of a quality management system;
- An efficient use of information technology;
- Use of outsourcing where appropriate.

The claims manager must ensure that they:

- Have sufficient financial resources
- Use an effective departmental structure;
- Have a logical and smooth work-flow;
- Have suitable computer systems, which allow the claims department to properly and accurately record each claim;
- Can apply the corporate claims philosophy effectively;
- Set procedures for initiating claim reviews;
- Have proper systems and procedures in place to identify any potential recoveries;
- Maintain a close relationship with the principal reinsurers/ retrocessionaires;
- Maintain senior status within the company
- Are involved in the cash management strategy. If large claims are being paid in full and promptly, but recoveries from reinsurers/retrocessionaires are subject to bad debt or late payments this could have a significant effect;
- Set internal guidelines to aid claims processing;

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- Are aware of current underwriting practice and reserving methodology.

3.3.2. Cost

- The internal cost of running the claims department must be monitored and controlled. To outsourcing certain functions, the information technology systems and staff salaries.
- The cost of the claims. The average speed of payment and of recovery from reinsurers/retrocessionaires is also important.

3.3.3. Services

- The identification of valid/invalid claims by careful analysis of the terms and conditions of the policy together with the claim information;
- The payment of valid claims in a timely manner;
- Making all possible recoveries promptly;
- he provision of advice to internal customers.

3.3.4. Personnel

- Recruit, train, and retain intelligent and competent staff;
- Effectively delegate responsibilities within the department handling and settling authorization;
- Effectively manage and motivate the claims staff.

3.3.5. Catastrophe management

An occurrence which claims more than 20 lives, badly injures more than 50 people, makes more than 2000 people homeless or causes insured damage of over $29m or a total loss of over $457m.

3.4. Analyzing the Catastrophe Risk

A distinction should be drawn between natural and man-made catastrophes. Natural

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catastrophes: Floods; Storms; Earthquakes; Droughts; Bush fires; Cold weather. Such events lead to huge numbers of claims.

3.4.1. Predicting Catastrophe

Since 1990 there have been on average over 100 catastrophe events per year. The annual cost has been increased from $5 billion a year (1970-1988) to $14 billion.

3.4.2. The Effect of Global Warming

"The increased intensity of all connective processes in the atmosphere will force up frequency and severity of tropical cyclones, tornadoes, hailstorms, floods and storm surges in many parts of the world with serious consequences for all types of property insurance."

3.4.3. Per and Post Loss Control

Once risks have been identified and analysed consider how they can be controlled.

- Protect people and/or property from loss;
- Detect and limit the extent of any loss that may occur;
- Maximize the recovery from any loss that has occurred.

A catastrophe falls the category of high severity and low frequency.

3.5. Catastrophe Risk Financing

Risk financing methods fall into two classes:

- Risk retention;
- Risk transfer.

Risk retention is an arrangement whereby the insurer bear the whole of the loss. Risk transfer is an arrangement whereby some other entity bears part or all of the direct financial consequences.

- Reinsurance;

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- Use of financial products supplied by capital markets.

On the assumption that catastrophes can be adequately predicted in terms of frequency and severity, an adequate level of reinsurance protection can be put in place to meet the financial consequences.

Due to high amount, the capital markets have played an increasing role in protecting against catastrophes. In capital market solutions, there is no requirement for insurable interest and the cover provided does not necessarily provide indemnity against loss. One such product is the **Catastrophe Bond**. Such a bond covers the occurrence of a defined catastrophe occurring within a 12-month period. Such as bond may be related to the simple fact of the earthquake occurring irrespective of whether the earthquake causes losses to the insurance company:

- the bonds are issued in the capital markets by the (re)insurer;
- they are bought and sold by insurers, reinsurers (and other financial institutions);
- the bonds pay a certain rate of interests (a yield) which is set at a level to reflect the risk;
- the price of the bond can increase or decrease;
- upon the happening of the catastrophe, both the amount originally invested (the principal) and the interest (coupon) may be at risk.

3.6. Effects on the Claims Department

		Frequency	
		High	**Low**
Severity	**High**	Avoidance	Loss reduction Risk transfer
	Low	Loss prevention Risk retention	Risk retention

In the event of a major catastrophe such as a hurricane affecting a densely populated, wealthy and highly insured area, the effect upon the claims department of an insurance company is as follows:

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- a sudden and unprecedented increase in the number of claims being made;

- a sudden increase in the number of inquiries being made by brokers, loss adjusters, the press en the media.

The increase in both short- and long-term workload will inevitably mean that the claims department's normal systems and methods of operating will be inadequate. Therefore a contingency plan should set out predetermined response:

- pre-assigned duties and claims team;

- claims personnel from other areas to be called in;

- work on a rotating basis; and

- independent adjusters to be called in.

3.7. Response of the Claims Department

A Claims Department must make special efforts to respond to a catastrophe. An active, aggressive approach is required, including:

- be active in claims handing and not delegate unless it is unavoidable;

- ensure good communication between all parties involved in the claims process;

- investigate immediately after the occurrence of a disaster. This helps understanding of the scope of the problem and enables an early and appropriate response;

- concentrate on settling as many claims as possible, as quickly as possible – losses become more expensive the longer negotiations continue; and

- prepare for the worst: catastrophe plans are necessary before it occurs. In the state of shock and disorganization which follows any disaster, these problems can seem insurmountable: with a plan, they can all be overcome.

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3.8. Catastrophe Modeling

The Need for Catastrophe Modeling Using Computer Techniques

Catastrophe modeling is a management tool that has been developed to enable companies to monitor their exposure to catastrophes efficiently and effectively. The computer-aided catastrophe models incorporate the frequency of catastrophe loss scenarios (such as European windstorms, US hurricanes and Californian earthquakes) and the severity of the catastrophe losses that may occur in any one year.

- The models are developed from research into catastrophes that have occurred in history:
- information about the earth's atmosphere, the frequency of catastrophe and seismologists' analysis of fault lines;
- the conditions, such as construction of buildings, population density; and urban growth and economic conditions;
- other factors such as losses similar to those that have occurred in history, variations on those losses and new losses;
- geographical location and weighted according to probability of occurrence in any one year.

Catastrophe modeling can be used by an insurer to determine the annual probability of exceeding a range of loss levels, so that they can take the following action:

- The level of catastrophe they should prudently underwrite, based on their capital base;
- The level of reinsurance required to protect companies from excessive catastrophe exposures;
- Reducing its territorial exposure to certain classes of business in the following year.

3.9. Potential Overpayment of Claims

There are a number of stages in the claims process where the claims handler has to make decision: the validity of the claim; the size of the claim payment;

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This potential overpayment is referred to in insurance circles as 'leakage' and can be defined as: 'avoidable overspend in settlement'.

In reality, it is the amount by which the actual settlement exceeds the amount which would have been required to make an acceptable settlement under the policy.

Ex gratia payments are made:

- Where the exclusion is a borderline one;
- Where there is a genuine oversight by the insurer;
- Where hardship would be created;
- To avoid contesting liability in the courts;
- To preserve good business relationships.

Avoiding ex gratia payments would lead to increased claim payments in the future (in the form of legal expenses for contested claims) and bad publicity.

Ex gratia payment is more problematic for reinsurers, since the effect of overpayments may fall largely on the reinsurer.

3.9.1. Identification and quantification of overpayment

This requires a detailed review of the handling of a claim through its various stages. The review may consider whether:

- The cause of loss falls within the exclusions;
- The date of loss falls within the policy effective dates;
- The proximate cause falls within the scope of the policy;
- The claim was notified within the time limit;
- There is sufficient proof of the extent of the loss;
- The policy excess has been properly applied;
- The effect of under-insurance has been properly calculated;

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- All recoveries have been made;
- All subrogation has taken place;
- All contribution has been taken into account;
- Depreciation has been taken into account;
- It is a repeat claim;
- The insured damage or damage site has been re-inspected;
- The settlement was appropriate.

Quantifying overpayment is not an exact science due to the subjective nature of the subject. Overpayment can be categorized as either:

- **Soft leakage**: leakage which is relatively difficult to identify- for example failure to negotiate an adjustment for wear and tear; or
- **Hard leakage**: leakage which is relatively easy to identify- for example, failure to apply a deductible.

To quantify overpayment, the reviewer has to judge what should have been paid according to the strict policy terms and compare that with what was actually paid.

Following the introduction of the new Rules, leakage may tend to increase due to:

- new deadlines which may lead to the proper examination of complex claim issues being overlooked;
- pre-action protocols which encourage settlement of claims as the main priority; and
- structured procedures which reduce the possibility of correction of errors/ oversights before final settlement. It will not be possible to depart from best practices without severe penalty being imposed by the courts.

3.9.2. Reducing Overpayment

Steps should be taken to reduce its, following steps can reduce it:

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Senior management focus—Emphasis must be put on reducing claim payments in particular, management control should encompass all claims rather than just large claims.

Employee skills—Research has identified a lack of technical knowledge on the part of claim handlers. To rectify this situation, employees must be trained to the appropriate level and be encouraged to take professional qualifications. Legal training; Awareness of market practice; Knowledge of best practice.

Supervision of staff—As part of the claims review procedure, the claims handler's work is often reviewed by more senior staff.

3.9.3. Reinsurance

In reinsurance circles, such overpayment may be referred to as 'passive claims handling'.

A. Increase Scrutiny on Overpayment

Emergence of latent claims increased reinsurers's focus on it. Latent claims is a 'specific type of long-tail liability where there is a time lag between the occurrence and manifestation of injury and/ or damage".

Reinsurance dispute have increased due to:

- The move away from proportional reinsurance to non-proportional (reinsurer does not share the fortunes of the insurer and act less as a business partner);
- The expansion of the concept of product liability in the USA since the 1970s. The risks of danger inherent in a design outweigh the benefits of a design. (Insurers are more likely to face claims, but reinsurers are more likely to resort to courts);
- The critical recognition by the courts that reinsurers 'obligation differ from insurers' obligations (the exact boundary of the obligations can be argued);
- The replacement of long-term relationships between insurer and reinsurer with shorter, profit-orientated relationships.

Some of the inherent characteristics of the reinsurance industry may make it prone to overpayment of claims:

- Use of non-standard contract wordings.

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- In many cases there is little loss information provided;
- In certain cases, the reinsured will retain very little of the original risk and in turn will have very little incentive to restrict the size of the insurance claim.
- Evaluation of a reinsurance claim requires access to the facts of the original insurance claim;

B. Identification and Quantification of Overpayment

Identification requires a detailed review, which may encompass the following areas:

Policy file review—Class of business; Period; Expenses; Reviews specific to asbestos-related claims and pollution claims.

Claim file review—Review of each file to establish the claim number, name of insurance/reinsured: Date of loss; Claims handling; Paid indemnity and expenses; Reserved indemnity and expenses; Reviews specific to asbestos-related claims concerning the basis of claim settlements and whether the reinsured was ceding the losses on an aggregate basis.

C. Reducing Overpayment

Overpayment can be reduced by addressing:

Senior management focus—The ultimate responsibility for initiating and developing a strategy to deal with passive claims handling rests with the senior management.

Employment of appropriate claim-handling methods Establish the representations made by the reinsured in the placement of the contract; Establish the contractual parameters: slip, wording, endorsements; Review the claim in detail: Check arithmetic; Consider case law; Consider market practice; Consider corporate claims philosophy; Consider consistency of claims presentation; List of available defences and queries; Consider the response to the cedant: Differentiate between strong/weak defences to the claim; Consider negotiation strategy and likely response to the rejection of the claim; Consider legal position of response/non-response; Consider party with whom we are negotiating; Following full evaluation, respond to cedant; Bywords to be adopted throughout the evaluation: Attitude (remain skeptical at all times); Alert (be alert to all issues); Ambiguities (question and clarity all ambiguities).

Employee skills—Knowledge of the main types of reinsurance claim arising; Legal

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knowledge: the implications of representations, and the duties of parties etc.; Awareness of case law in the USA/UK etc.; Awareness of market practice in USA/UK/Europe; High technical reinsurance ability; Knowledge of best practice.

Quality management—Computerized processing systems which identify oversights such as the application of deductibles and retrocession recoveries; The use of claim guidelines as an aid to the adjustment of claims.

D. Considerations Relevant to the Civil Procedures Rules

Reinsurance claims handlers should consider whether reinsurance claim is higher due to: the cedant's 'non-compliance' with the Rules (i.e. deadlines; information exchange requirements; and the court's expected spirit of cooperation between the parties); the cedant's compliance with the rules.

The use of pre-action protocols may encourage the settlement of claims at the insurance level.

The court's expected spirit of cooperation between the parties may manifest in the willingness to negotiate. Insurers may be more willing to settle claims than to fight in the court;

The font-loading of costs at the insurance level arising from the need to investigate the claims thoroughly and within strict deadlines may lead to a higher insurance per claim nuisance value (the cost of settling a claim on an ex gratia basis as compared to the economic value of investigating, legally defending and forced to pay claims in the future).

2.10. Management the Cost of the Claims Operation

2.10.1. Operating Cost

The operating costs can be analyzed as:

- Claims department costs, i.e. claim staff salaries;
- Allocated company costs, i.e. costs which are incurred as part of running the insurance company as a whole such as IT, lighting, office space, accounting staff etc..
- External costs, i.e. the charges of service suppliers such as any outsourced functions, use of loss adjuster etc.

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Some traditional measures are the: Unit case costs, i.e. the average operational cost of handling a claim; Average time spent on one claim; Claims expenses ratio, i.e. the ratio of internal costs (as above) to premiums.

Such figures will then often be compared to those of competitors writing the same or similar classes of business. This process is know as competitive benchmarking.

- Competent and well-trained staff;
- Efficient administrative support;
- Efficient claims procedures;
- Efficient record-keeping;
- Clear corporate claims philosophy;
- Use of a quality management programme;
- Effective management of the claims department;
- Effective use of IT;
- Use of outsourcing, where appropriate.

More radical solutions may be sought to attack operational costs:

- Restructuring;
- Merging;
- New management;
- New IT systems; or Total outsourcing of the claims function.
- The levels of overpayment of inwards claims
- The level of customer dissatisfaction as reflected in : The reduction of customer retention; The reduction in customer referrals; Insurance ombudsman Bureau referral charges; and Possible punitive awards.

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2.10.2. Claims Function Within the Organization Structure

Structure is based on size and the number of activities, including: underwriting, claim investigation and payment; marketing and investment.

The structure should define such things as: the division of work; the chain of command and communication; the type of tasks performed; the internal groupings which undertake similar work; and the management hierarchy.

There are two main ways to structure a company's departments: by functions (claims, underwriting, marketing); and by division (e.g. product, geographical area, type of customers).

The advantages of the above system: Employees can specialize in the type of work they carry out; A larger unit may be more cost effective due to the standardization of the procedures used.

The disadvantages are as follows: The inflexibility of the structure : the claims personnel tend to see their role as purely claims handling; The difficulty in coordinating the different functions

Most large multi-product companies are organized by division, with each division being partially autonomous to the extent of designing, producing and marketing its own products. The choice of a system will depend upon: The size of the company; The type of business being writing.

The advantages of a centralized claims settlement method include: Ensuring that the required level of expertise, is applied; Ensuring that access to paper records and the underwriting staff is easy.

The disadvantage may be that there is a lack of contact between policyholders and local staff.

2.11. Woolf Reforms

The Woolf reforms (the Civil Procedure Rules) came into effect on 26 April 1999. This has the impact on the processing and handling of claims.

2.11.1. Key Procedural Changes

Case management by judges – judges will become pro-active and manage the case in

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accordance with the Civil Procedure Rules. A court is allowed to decide in which order the issues will be tried. It encourages early settlement.

The case will be allocated by the court to three case management tracks: The Small Claims Track – claims under £5,000; The Fast Claims Track – between £5,000 and £15,000; The Multi-Track more than £15,000.

The Personal Injury Pre-Action Protocol includes the following: Immediately the claimant has sufficient information, they send two letters of claims to the potential defendant; The defendant must acknowledge this within 21 days of posting; Three months from the date of acknowledgement, the defendant or insurers must either: admit liability; or deny liability, giving reasons; and give standard disclosure of relevant documents to substantiate;

The impact of the changes

Claims may be resolved more quickly. The insurer is under pressure to make decision on the claim, given the earlier disclosure of the main facts and the tight timetables;

- Font-loading of legal and investigation costs;
- Early settlement may have the advantage of restricting costs, but open invitation to other claims;
- The drive for speed may undermine the proper examination;
- Less litigation is likely to take place;
- As far as practical claims handling is concerned: speed is of the essence; additional time and resources are required; earlier decision will be required in respect of the coverage of the claim.
- Reserving. Claims reserves are likely to be raised earlier.

4. Claims Arising under Specific Types of Policies

4.1. Claims Under Personal and Commercial Insurances

The most common examples of personal lines are as follows: Private motor; Household (contents, buildings, and all risks); Travel and accident.

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The major commercial markets : Fire (property); Employers' liability; Professional indemnity; Motor (usually involving vehicle fleets); aviation; and marine.

4.2. Claims Under Personal Insurances

4.2.1. Private Motor Claims

The claims process is as follows:

- The insured is bound by the claims notification condition to report all accidents;
- As notification, the insured must complete an accident report form.
- Upon receipt of the necessary information, the insurer will set up the appropriate records.
- If a claim is to be made, the insurer will establish whether there is a policy in force and whether the insured is entitled to indemnity.
- If there are claims under other sections of the policy.
- A third party may claim for damage to their vehicle, or there may be damage to other property such as a boundary, fence or hedge.
- Where there is third party injury involved, claims are complex and costly to settle.

Personal injury claims are covered under the Personal Injury Pre-Action Protocol, which includes the following:

- deadlines for notification of the claim to the potential defendant;
- deadlines for the defendant's acknowledgement of the claim notification; and
- deadlines for the defendant or insurers to either admit liability or deny liability, giving reasons.

4.2.2. Household Claims

Household contents are divided into:

- Durable goods – such as household furniture, e.g. refrigerators and freezers;

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- Consumer goods – such as less durable items, e.g. curtains, towels and clothing, all of which are likely to wear out more quickly.
- Claims for durable goods are settled on the 'new for old' basis where the damaged goods are replaced by new items.
- Claims for consumer goods are settled on the basis of the cost of replacement, less wear and tear according to their age.

4.2.3. Buildings

The normal basis of settlement for buildings claims is to repair them. In practical terms the indemnity sum for loss or damage to buildings has been calculated as cost of repair or reinstatement at the time of loss less an allowance for betterment.

4.3. Claims Under Commercial Insurances

4.3.1. Fire Claims

The insured has the following duties in the event of loss or damage:

- Notify the insurer immediately;
- Carry out or permit to be taken any action which may be reasonable practicable to prevent further damage;
- Deliver to the insurer full information in writing about the property lost, destroyed or damaged and the amount of damage;
- Within 30 days provide proofs of loss (e.g. builder's estimate for repair) and, if required, complete a statutory declaration of the truth of the claim.

The insurer would then establish whether the claim was valid and ascertain whether the policy was in force and whether it covered the loss.

A monetary payment is sometimes made. Otherwise, the insurer decide to exercise its option to reinstate by either rebuilding, replacing, repairing or restoring the property, as appropriate.

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4.3.2. Liability Claims

Liability losses are losses arising out of legal liability for incidents involving injury to third parties or damage to property.

Upon being notified of a liability claim within the timeframe, an insurer checks that policy is in force at the time of the loss. For large claims, a full investigation will be carried out:

- what work was being undertaken and whether it was included within the business description;
- interviewing witnesses;

In respect of third party property damage, insurers will carry out investigation:

- a request for a written report of the negligence against the insured;
- evidence to support the amount of the claim; and
- an inspection of the damaged property.

Claims involving personal injury comes via the third party's solicitors. The insurer will obtain a medical report:

- special damages;
- general damages, i.e. compensation for future losses.

Matter may go to court; the judge may:

- make a decision which allows for reassessment;
- allow a structured settlement (provides an income to the claimant over a period of time rather than payment of a single lump sum).

A. Employers' Liability

Employers' Liability Act 1969 of insurance offers protection against bodily injury or disease sustained by the employers' employees arising out of and in the course of their

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employment. It is common for combined employers liability and public liability policies to be issued.

B. Public Liability

Public liability insurance offers protection to the insured against legal liability in respect of third party property damage or bodily injury.

C. Professional Indemnity

The purpose of the professional indemnity policy is to protect a professional against legal liability towards third parties for injury, loss or damage arising from their own professional negligence or that of their employees. Liability to third parties may also arise under the Hedley Byrne principle (i.e. liability for negligent misstatements) or from a breach of a (common law) duty of care.

Professional indemnity business is written on a claims-made basis. Claims should be made during the period of insurance, regardless of when the event took place.

Upon being notified of a liability claim within the prescribed time frame, an insurer checks that the policy was in force at the time of the incident. For all large claims a full investigation will then be carried out, including:

- What work was being undertaking and whether it was included within the business description on the policy schedule;
- Interviewing witnesses, if applicable.

In respect of third party property damage, insurers will carry out an investigation and will need to establish the facts of the case so that a decision can be made on liability. This investigation will include:

- A request for a written report of the negligence alleged against their insured;
- Evidence to support the amount of the claim;
- An inspection of the damaged property.

Claims involving personal injury are likely to come via the third party's solicitors. The insurers will obtain a medical report on the injury and damages will be paid to the claimant under two headings:

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- Special damages, i.e. all items which can be quantified and are in the past;
- General damages, i.e. compensation for future losses.

4.3.3. Aviation Claims

The standard policy normally covers:

- Loss or damage to aircraft (hull);
- Legal liability to third parties other than passengers (liability);
- Legal liability to passengers (liability).

A. Notification

The aircraft accident must be reported to the authorities of the countries in which it occurred. Most policies require immediate notice of a loss. Some policies require a proof of loss.

The insured has the following duties after notification:

- They must use due diligence to avoid or reduce a loss;
- There must be no dismantling or repairs except in the interest of safety;
- Repairs and transport should be by the most economical method;
- The insured must not admit liability or offer any payments.

B. Use of Aviation Loss Specialists

Once a claim has been notified of loss adjusters will be appointed. In the case of aircraft hull losses a surveyor is sent to investigate the claim and to try to discover the circumstances which have given rise to the accident.

Liability claims are less straightforward than hull losses. It depends on the type of loss and the underwriter as to whether a loss adjuster or a lawyer is appointed.

The loss surveyor will advise on the most efficient method of repair and in the case of total loss will advise where a replacement aircraft can be obtained. Where serious

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liability to passengers or members of the public has been incurred, the insurers adjusters will be armed with immediate authority to arrange repatriation of bodies, or the transport of relatives to the scene.

4.3.4. Marine Claims

Marine insurance relates to three areas of risk:

- Hull;
- Cargo;
- Freight.

The risks against which insurance is provided are collectively termed 'perils of the sea' (marine perils) and include fire, theft, collision and a wide range of other perils arising from vessels used on the sea or inland waterways.

All claims are notified immediately to insurer in order to allow them to instruct surveyors, lawyers or other representatives appropriate to the loss. The Tender Clause of the new Institute Time Clauses states that:

- Failure to notify insurers promptly of a casualty may result in the claim being disallowed;
- Underwriters have the right to decide where a vessel may be repaired.

A. Hull Claims

The most common types of claim are the following:

- Machinery damage to the vessel;
- Contact with piers, docks or other fixed or floating objects;
- Heavy-weather damage;
- Contact with ground or submerged objects.

A surveyor will prepare a report regarding:

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- The cause of the damage;
- The extent of the damage;
- Recommendations for repairing the damage.

The surveyor will review the various accounts. A professional average adjuster will be appointed by the owner to assess the amount recoverable from the insurer.

A solicitor is often appointed in the case of a liability claim (e.g. collision or crew injury). The claims themselves are complex and the international nature of shipping

B. Cargo Claims

In the event of loss or damage to cargo, the loss must be notified to the insurer's agent at the ship's destination. A surveyor is appointed to survey the damage. Report is sent to the insurer together with the bill of lading and the policy form.

C. Freight Claims

The amount to be paid in the event of loss of freight is the gross freight lost less any charges that have been avoided because of the loss.

4.3.4. Requirements of personal and commercial policyholders

The broker should outline their complaints procedure; if the complaint is not handled properly the matter can be referred to the Financial Ombudsman Service.

4.3.5. Differences in Nature of Risk and Motivation for Purchasing Insurance

Personal lines insurance is to protect against the unexpected losses of a private person, whereas commercial lines insurance – to protect companies. Personal policyholder wishes to protect their personal property. A commercial enterprise desires to protect its assets and its profit-making ability.

4.3.5. Effect on Claims Presentation

The result of these two factors are differences arising in the:

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- Preparedness of policyholders in the event of a loss event. A commercial organization has systems, procedures and people to respond, while a private citizen is taken by surprise;

- Level of insurance expertise – commercial policyholders are more familiar with the claim process. They might have a risk manager;

- Type of claim arising – the length of time taken to settle the claims. Most personal line claims can be processed and settled quickly, commercial claims tend to be more complicated and take longer to investigate and settle;

- Size and frequency of claims – commercial policyholders will make a greater number of claims; its claim size is larger than personal claims;

- Level of excess point – personal policyholder may have an excess much lower than commercial. The commercial policyholder may have self-insurance or a captive;

- Use of litigation – in the event of a disputed loss, personal policyholders my be less willing to resort to the court;

- Use of brokers - most commercial business is placed via brokers.

4.4. Requirements of Own Clients and Third Party Claimants

4.4.1. Definition

Own client are people/ companies insured by the insurance companies. They are 'first party' claimants. The first two parties are: the insured; and the insurer.

The third party is anyone else who is involved in a loss event. In motor insurance a third party may be another vehicle owner, property owner or persons (such as passengers or pedestrians) who have sustained personal injuries and/or property damage.

4.4.2. Liability of the Insurer to Meet Third Party Claims

Unless the person responsible for the accident has a policy of insurance covering liability for the type of loss event involved (Road Traffic Act), insurers will not be involved in the claim.

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4.4.3. Third Party Claim Procedures

Insurers insert conditions on policies in respect of claims against the insured arising from a loss or injury to a third party, that:

- require prompt notification of any accident or incident;
- require any communication relating to the loss event from the third party or their agent. The insured may lack the expertise to deal with correspondence without prejudicing their position;
- give them full powers to control all proceedings.

In case of accident in which a third party is involved, motor policy insurers require the insured not to accept blame. To do so may well invalidate a claim. The claim should be reported to insurers within a time limit to enable the insurer to take steps to investigate claims in order to minimise exposure.

4.4.4. Rights of the Third Party

The third party has no rights under the liability insurance policy itself, since this is a contract between the insured and insurer. Privity of contract – a person could only enforce a contract if that person was a party to it.

4.4.5. Potential Problems

Third party claims can be the cause of a disagreement between an insurer and their insured. The insurer may decide to settle a third party claim, affecting the no claim discount available to the insured. The insurer should make sure that policyholders wants them to settle a third party claim.

4.4.6. Variations in the Requirements of Own Clients and Third Party Claimants

Distinction between requirements of own clients and third party claimants has the following consequences:

- The insured has a contractual relationship with the insurer, a third party does not:

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- ⇒ The third party must pursue claim against the insured rather than the insurer;
- ⇒ The third party is at 'arms length' to the insurance company;
- ⇒ A third party claimant is often the victim of the insured's negligence;
- ⇒ The third party claimant does not identify with the insurer;
- ⇒ The third party will not make claim via broker;
- ⇒ The third party will not expect to be fully compensated in the event of a negligence;
- ⇒ The third party will not recover the payment of deductible;
- ⇒ The recovery of legal costs is more prevalent with third party;

- The use of litigation – a solicitor is likely to be utilized to present third party claims (personal injury) to the insured;
- The propensity of the claimant to make a claim;
- The types of claim arising – third party claims are necessarily liability claims and therefore complex.

5. The Use of IT in Claims Handling

5.1. Design a Claims Management System

The design of a claims management system must permit the recording of information relevant to the claims management strategy, which has been developed in accordance with the insurer's overall business objectives. Both effective control and effective planning are dependent upon information. Managers use information to make informed decisions.

The most important aspect of designing a claims management system is a prior analysis of the insurer's business to identify its particular needs. The IT system is one element of a much bigger network that encompasses the whole of the claim management process, including: corporate claims philosophy; management of the claims operation; quality management..

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5.2. Role of IT in Claims Handling

5.2.1. Some Characteristics of Insurance Claims

- ***Volume*** – the number of insurance claims must be phenomenal. The large number of claim transactions to be processed include: claim payments and outward reinsurance recoveries;

- ***Complexity*** – due to the following factors:

  ⇒ the bigger the risks, the greater the number of insurers, the greater the complexity;

  ⇒ a large number of UK commercial insurance is handled by brokers;

  ⇒ insurance companies need reinsurance;

  ⇒ The claim process (notification, agreement and settlement) requires interchange between the insured, the broker and insurer;

  ⇒ It is possible that a certain number of claims will be fraudulent;

An information system is required to be capable of (the role of IT in claims handling):

- processing large amounts of data;
- processing quickly;
- processing accurately; and
- delivering information in a meaningful manner.

5.2.2. Key Issues

- The application of IT must be accompanied by a review of claims procedures and practices;

- A powerful, flexible and adaptable computer system is a very valuable tool in the hands of experienced user.

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5.2.3. Major Components of a General Insurance Claims System

The claims management systems may vary depending on their structure, the type of business written, and also management decisions about computer systems.

The basic elements recorded on all claims include:

- contract and claim reference;
- claim event details and dates;
- claim estimates;
- claim payments; and
- outstanding loss reserves.

Details recorded at the underwriting stage will be used:

- description of risk, including specification;
- description of cover;
- supporting risk information; and
- insurer details – name, share of risk and own reference.

5.2.4. Benefits and Difficulties in Using IT in Claims Handling

The main aims of the use of IT in claims handling are: to reduce the cost of claims administration; and to improve the service provided to the insured.

A. Benefits

- ***Single data entry*** – this eliminates duplication of effort and data, as it involves fewer people in the data entry process and should lead to fewer errors;
- ***Reduced use of paper-based claim files***. The claim file will be created electronically, images of damage and reports from loss adjusters can be added. It allows speedier distribution of claim details to insurers on one risk;

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- ***Electronic***, it allows faster circulation of proof of loss to insurers, leading to speedier claims settlement;

- ***Electronic authorization of claim payment***, which will automatically trigger cash movements;

- ***Use of originally claim details*** in the outwards reinsurance recovery process and settlement;

- ***Electronic issuing of collection notes*** in the outwards reinsurance recovery process;

- ***Use of electronic funds transfer***.

There are also associated benefits:

- Information regarding the insured can be used for marketing purposes;
- Increased customer retention from improved service;
- Technical assistance to claims handler via the computer;
- Streamlining of administration;
- An automated check against fraudulent claims;
- Automated payment of fees for loss adjusters.

B. Difficulties

- an adverse effect upon cash flow as inwards claims payments are speeded up;
- Increase in claims costs – if the IT system is used as an alternative to investigative technical claims;
- IT systems are not suited to the bigger, more complex liability claims which are non -standard;
- The system may be more difficult to operate;
- The use of electronic communication coupled with a centralized claims function may result in a dogmatic approach to the delivery of services to customers;

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- Individual systems may produce productivity gains, but huge investments may just contain costs.

5.2.5. Influence of Customer's Expectations on the Design of a Claims Management System

A. Insurance Company as Customer

The insurance company may expect the following from a claims management system:

- the ability to process large amounts of data;
- the ability to process data quickly and accurately;
- delivery of information in a meaningful manner.

The system must be flexible to deal with matters as:

- notification of claims;
- the involvement or non-involvement of loss adjusters;
- the correct amount of claim detail for the class of business written;
- the authority levels afforded to different grades of staff.

B. Ultimate Customer – the Insured

Customers' expectations influence the process of designing a claims management system as follows:

- Customers' expectations are canvassed before the design process begins. This will establish the level of claims service quality;
- Both personal and commercial customers have more knowledge of what they want. Customers want innovative, reliable and cost-effective solutions;
- Innovative ideas in the claims management, such as claims notification via the Internet are difficult to evaluation;

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- General expectations of a good claims service (quick response, quick agreement, and quick payment of valid claims) can be assumed to exist when designing a claims management system;

- Insurance industry has overlooked the expectations of its customers and tended to deploy modern technology to streamline operations and to generate economies of scale.

5.3. Use of Management Information Generated by IT

A management information system is the means by which data is captured, processed, accessed, and distributed to inform and facilitate management decision-making. A management needs to know:

- what resources are available (staff, budget);

- the rate at which resources are being consumed and the level of productivity;

- how well resources are being used; the objectives of departments and business are met.

The information allows the manager to decide what should be done and he needs feedback to assess how well it is being done.

5.3.1. Uses of Claims Management Information

Due to the volume and complexity of insurance claims the insurance industry depends on IT. Management information system consolidated data into meaningful reports. By using the data generated by the claims management IT system, the management of an insurance industry can:

- use it for regulatory requirements, such as FSA return;

- monitor the claims handling process by:

  ⇒ calculating the average claim size;

  ⇒ calculating the unit case costs;

  ⇒ identifying and quantifying processing backlogs;

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  - ⇒ highlighting large movements in claim reserves;
  - ⇒ comparing incurred losses with the eventual cost of settling the claims;
- ⇒ reviewing inactive claims on a regular basis;
- ⇒ identifying large claims.

- analyze the frequency and cost of the use of experts (loss adjusters, lawyers and accountants);
- model loss reserving;
- monitor the overall level of settled and outstanding claims; the speed of claim settlement;
- monitor the claims statistics by companies or territory;
- produce specific reports on profitability and ledger account balances specific to reinsurance recoveries.

The use of IT in claims handling has increased following the introduction of the new Civil Procedure Rules:

- Front-loading / pro-active – movement of the claims process towards front-loading, such as early investigation, early claim decision-making and early settlement. The new procedure requires that claims are investigated as soon as it is notified. The use of IT allows insurer to monitor:
  - ⇒ the average length of time required to investigate claim;
  - ⇒ the speed of the solicitor's response;
  - ⇒ compliance with the deadline (warning flags);
  - ⇒ acceptance by the claimant of offers of settlement and reasons for rejection;
  - ⇒ acceptance by the insurer of offers of settlement.

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- Use of structured procedures via the use of pre-action protocols; insurers would benefit from the system to:
  - ⇒ respond to the issuing of proceedings by providing evidence; and IT system provides rapid access to information, documents and image;
  - ⇒ provide IT system-generated standard letters prepared and reviewed by the counsel to comply with the information exchange requirements;
  - ⇒ provide an on-line list of acceptable and non acceptable expert witnesses.
- The courts' expected spirit of cooperation between the parties; the insurers are able to supply information and efficient working practices.

5.3.2. Role and Benefit of Helplines

A. Development of Helplines

A helpline can be defined as: "the provision of an advisory and/or assistance service via the telephone".

Helplines can be seen as a product of the IT revolution, stemming from:

- Modern telecommunications;
- Immediate access to a wealth of information;
- Affordable computer processing power;
- Enhanced computer processing speeds
- The willingness of insurers to develop innovative products and service;
- And critically the expansion of customer expectations

The reasons for the helplines are:

- An attempt to increase customer retention;

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- An attempt to copy the success of the direct insurers who transformed the motor insurance industry;
- A response to customer expectation;
- The need for insurers to control claim costs.

There are three main services:

- Advice and assistance in the notification, processing and settlement of a claim;
- Advice and assistance in respect of potential claim;
- Advice only. Such schemes offer no element of insurance but simply provide 24 -hour advice.

B. Operation of Helplines

The provision of helplines service is outsourced to specialist providers, due to the experience, economies of scale and IT specialization offered by the helpline and claims management companies.

The use of helplines and assistance firms is largely confined to personal lines insurance, as brokers can accept direct contact between the insurer and insured in personal lines claims. However, in commercial lines, the broker prefers to advise the insured on claims process.

C. Household Policy Helpline

Traditional claim process was as follows:

- Sending a claim form to the insured;
- Asking the insured to obtain two or three estimates for the cost of repairs and/ or replacements;
- Reviewing the damage on-site;
- Sending the cheque for the completed repairs to the insured.

In many companies this has been replaced by:

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- Customers can free phone a helpline 24 hours;
- Insurance staff take details of the claim, advise on coverage and issue a part-completed claim form;
- Insurance staff organize a recommended plumber;
- Insurers settle the bill direct with supplier;
- Insurance staff call back to ensure that the customer is satisfied.

D. Motor Policy Helpline

- The insured can ring a 24-hour freephone helpline;
- Insurance staff take down all the claim details;
- Insurance staff organizes a garage to contact the insured within two hours to arrange to pick up the damaged car and drop off a courtesy car;
- Details are input directly onto computer;
- The bill is settled direct with the recommended garage;
- Any excess is paid to the garage by the policyholder.

E. Legal Advice Helpline

- Whether the insured has the basis of a claim in law;
- What legal rights are involved;
- The best way to enforce such legal rights.

F. Cost of Helpline

- The expensive technology involved,
    - ⇒ On-line verification of claimant and policy;
    - ⇒ On-line checks for authenticity of the claim;

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⇒ Routing of calls to third parties;

⇒ Computerized access to over 8,000 tradespeople throughout the UK, in some cases;

- The need to run a 24-hour operation;
    - The need to employ a reasonable number of operators
    - The ability to deal with a large number of calls

G. Benefits

Benefits for the Insured—Every policyholder has immediate access to the service at whatever time of day; The inconvenience is taken out of the process, making it as simple as possible; The quality of repair and replacement work is, of a much higher standard; Claims are generally settled much more quickly.

Benefits for the Insurer—Customer loyalty increases; There are marketing advantages; Increased control over the cost of claims, allowing the insurer to dictate: Who should do the repair work; How much the repairs will cost; Whether the goods should be replaced by the insurer's replacement goods supplier; Whether the insured property damaged needs replacement; Fewer exaggerated claims.

Use of the Internet—The growing use of Internet is due to:

- insurers looking to expand their distribution channels, with the Internet growing alongside the use of call centres, and to attract a wider customer base through a new medium for marketing activities;
- customers demanding access via the Internet.

The possible effects upon claims handling—At present, the Internet is used in a limited way to sell certain classes of insurance. In the future claims will also be transacted via the Internet, with the following impacts:

- notified – claims will be notified via the Internet with instant photographic evidence of damage; interactive communications helps customers provide missing information;

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- reviewed – claims analysis may be possible electronically; information can be cross-referenced to the electronic proposal form (policy conditions; past claim history);
- respond to by the insurer – insurer can respond quicker by reducing administrative delays due to postal system. An integrated system would harness interchanges between the insurer, brokers, agents, call centers, the customer, experts and doctors;
- investigated – on-site investigation will be reduced, as the system provides clear proof of damage;
- negotiated – offers may be sent out via the Internet with documentary evidence;
- settled – payment by electronic funds transfer;
- recovered from other sources.

H. Advantages and Disadvantages

Advantages:

- reduction of administrative costs;
- improvement of the service provided to the insured (improvement of data accuracy);
- reduction in paper files;
- quicker settlement of claims;
- access to a vast warehouse of knowledge;
- access to information: weather reports, catastrophe information, law reports; external benchmarking, surveys on customer expectations; quality management.

Disadvantages:

- cash flow;
- its no-suitability to complex claims;

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- a reduction in personal service;
- confidentiality of data sent and received;
- computer viruses imported via the Internet.

6. Quality Management

6.1. Definition of Quality and Quality Management

The concept of quality management is: "**conforming exactly to the agreed documented specification".**

Quality management can be defined as: "**The introduction and use of a set of documented and defined service standards and procedures which have been systematically and independently assessed and audited by experienced and qualified assessors."**

Quality management can therefore be seen to be a mechanism by which insurance and reinsurance companies endeavour to make their work efficient and there outputs effective. Part of its purpose is to meet customer expectations.

Quality management has implications on claims management operation:

- Development of a corporate claims philosophy;
- Use of information technology;
- Use of outsourcing;'
- Use of intermediaries;
- Marketing;
- Customer retention.

6.2. ISO 9000 Certification – An Explanation

The ISO 9000 series is a quality assurance standard. The ISO 9000 family of standards arose following the successful application of quality assurance standards throughout the British Ministry of Defence and its large procurement agencies during the 1970s. In

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order to ensure the quality of products supplied, the MoD employed 16,500 inspectors who visited the suppliers at source to inspect raw materials, castings, forgings etc. When adopted by the International Organization for Standardization (ISO) as the ISO 9000 series.

There are two quality assurance standards which may apply to claims management:

IS0 9001: 1994 Quality systems;

IS0 9002: 1994 Quality systems.

That IS0 9001 has an additional section on design control.

6.2.1. Procedure for Becoming Certified

- The company purchases a copy of the relevant quality assurance standard which sets out the formal requirements of the standard.
- The quality assurance standard must then be interpreted to apply to the insurance industry (including claims management operations).
- The company must then clearly set out in simple language its own internal quality specification (designed to meet the expectations of its customers).
- The company must introduce documented management systems and procedures, with in-built controls to monitor performance.
- The company is assessed by a Registered Lead Assessor working for an accredited certification body.
- Following the initial assessment, continuing surveillance is carried out on a regular basis.

6.2.2. Some Advantages and Disadvantages to Certification

Introducing such a system:

- Creates documentary evidence of the procedures which should be followed;
- Lays down standards to be achieved;

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- Provides guidelines on monitoring and measuring outcomes;
- provides guideline for the training of staff;
- promotes greater consistency in the level of service provided by different staff members and by staff at different company locations;

can lead to indirect cost savings in the form of customer retention.

On the other hand, there may be associated disadvantages:

- the introduction of an over-documented system may actually slow the response to customers
- the running costs of an over-documented system can be very high;
- the initial cost of introducing the system may be high.

6.2.3. The Application of ISO 9001 to Claims Management

The broker would produce a procedures manual which would define the required quality approach in all key procedures. By defining the management organization responsible for quality, describing the system structure, and cross-referring to individual operational procedures that affect quality, the manual would set out the broker's quality system. The manual would also refer:

- levels of authority and authorization guide;
- service quality policy statement;
- data protection Act 1984;
- employee handbook.

The procedures manual will set out the: objectives; correct procedure.

Objective – to acquire sufficient accurate loss information from insureds and/or reinsureds.

Logging of claim advices—Upon receipt, claim advices are date-stamped and logged in the computer system. This begins the monitoring process.

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Establish a claim file—The relevant slip/policy/certificate is obtained for insertion in the claims file; The validity of the loss is checked as per departmental procedures; Claims queries are referred to the appropriate manager; Claims details are entered onto the computer system including claim estimates; The claim advice from the insured/ reinsured is placed in the claim file; The computer system file copies are placed in the claim file.

Claims processing—The computer system produces claim advice documentation which is sent to the underwriters by post or electronically.

Response to insured/reinsured—Prompt acknowledgement of the claims advice

Claims notification on excess layers—The possibility that the claim may, affect excess layers should be highlighted, and the appropriate claim notification carried out. The exact wording of the policy condition should be noted and adhered to:

Subsequent advices—Subsequent advices are to be recorded as per the above procedures; The computer system must be updated to reflect the current estimate/ payment and status of claim; Underwriters must be kept advised of all material developments; Any queries regarding procedures should be referred to the claims manager.

6.3. Quality Management Issues and Their Impact on Corporate Claims Philosophy and Other Areas

6.3.1. Relationship Between Quality Standards and Corporate Claims Philosophy

Adoption of a quality assurance standard such as the ISO 9000 series is, *inter alia,* aimed at defining procedures and precise standards of performance, the corporate claims philosophy (which sets down the company's requirement on key claim issues, usually in a written format) attempts to define the overall approach to claims in less specific terms. The concept and use of a corporate claims philosophy is discussed in detail in corporate claims philosophy. Clearly, both the company's quality policy and its corporate claims philosophy must work in tandem, with the corporate claim philosophy reflecting the stated quality policy.

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6.3.2. Other Quality Management Issues

A. Use of Information Technology

Information technology is an essential part of the logging and monitoring system of any efficient management or quality control system.

B. Use of Outsourcing

It may decide that the outsourcing of part or all or the claims service is the most efficient way to meet the quality assurance standard.

The experience of the service provider, the cost of the service, and the flexibility of the service offered may also be important.

C. Use of Intermediaries

Once a company is ISO 9000 registered, it may decide to use only intermediaries with a similar registration. This may apply to both insurance and reinsurance brokers. By insisting that its partners themselves conform to ISO 9000, it can cut out less scrupulous companies.

D. Marketing

There is considerable status and marketing advantage to be had if a company has independent quality assurance approval to ISO 9000.

E. Customer Retention

This means keeping existing customers. Another way to express this is 'to avoid losing customers'.

6.3.3. Quality Must Reflect Customers Expectations

A quality service should provide at least the quality that the customer expects (An insurance company may aim to respond to a claims advice within a specified time frame in line with a survey of customer expectations.). This is known as "threshold quality".

There are four levels meeting expectations:

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- Below threshold quality: fails to meet the expectations;
- Basic threshold quality: meets the expectations, but does neither more nor less;
- Enhanced threshold quality: identifies that the customer would see an element of quality which they may not spontaneously expect, they will wee as no more than a reasonable meeting
- Incremental quality: identifies that there are elements of quality which can be delivered, at a reasonable cost compared to revenue, and which the customer would see as exceeding expectations.

6.3.4. Meeting Customer Expectations and Retaining Customers

A. Establishing Customer Expectations

Customers are more demanding today than they ever have been in the past. They have higher expectations of products and customer service. Commercial organizations, too, are more sophisticated in how they buy insurance

Insurance buyers have a clear idea of what makes a good insurance company. They seek:

- Clear communication;
- The ability to make coverage changes easily;
- A simplified insurance purchasing process;
- Clear policy wordings;
- An elimination of errors.

B. Customer Satisfaction

The 1992 survey: The participants identified 18 factors which affected their overall satisfaction with their insurers:

- Obtaining clear explanations of the required action in the event of a claim;
- Being sure that a fair settlement will occur in the event of a claim;

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- Knowing that a fast claims service exists;
- Trusting the insurance representative;
- The insurance representative's ability to return phone calls within one or two days;
- The insurance representative's ability to convey what options are available.

6.3.5. Effect of the New Civil Procedure Rules

The introduction of the rules requires that the defined service standards and claims procedures be reviewed in the following areas:

- **Pro-active management of claims** – move toward front-loading: early investigation and early claim decision making and early settlement;
- **Deadlines** – shortened deadline for responding to the claimant; need to set deadlines on:
    - ⇒ the average length of time for investigation;
    - ⇒ speed of solicitor's response;
    - ⇒ acceptance by the claimant of offers of settlement;
    - ⇒ acceptance by the insurer of offers of settlement by claimant.
- **Monitoring** – changes introduced by pre-action protocols to be monitored;
- **Offers to settle** – to be shown through the claims procedures adopted;
- **Structured procedures** – the use of structured procedures via the use of pre-action protocols;
- **Cooperation** – the court's expected spirit of cooperation between the parties will involve the insurer supplying the information and efficient working practices to improve claims service;
- **Monitoring – incurred but not reported (IBNR)** – procedures to estimate the impact of change on paid and incurred;

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6.4. Retaining Customers

Policyholders stay with their companies because:

They receive the service they expect;

It is too much of a hassle to leave.

6.4.1. Managing Customer Expectations

A. Customer Expectations of a Good-Quality Claims Service

Possible expectations:

- Speed of response – both on initial acknowledgement and on subsequent enquiries;
- Well-trained staff who are responsive to customer needs;
- Prompt authorization of repair for property and motor losses;
- Fair settlement;
- Prompt issue of cheques in settlement of claims.

Claims provide companies with the opportunity to deliver real value to their customers.

B. Alignment with the Service on Offer

Customer expectations can never be completely managed.

- Their awareness of what is available in the insurance marketplace (due to advertising or recommendation);
- What levels of service are available to them generally for all products and services; and
- What they instinctively feel is acceptable

However, insurers should intervene where possible to try to bring customer expectations of the service on offer in line with that actually available.

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- Advertising of the claim service;
- Presentation of the policy documentation;
- Provision of guidance by the insurer to the insured at the time of claim notification;
- Manner of claim negotiation and settlement.

If the level of service provided matches (or exceeds) expectations, this will lead to customer satisfaction.

6.4.2. Other Aspects of Quality Management

A. Establishment of Protocols

In order to ensure that the required levels of quality are established, to establish protocols:

- Service delivery standards
- Claims estimating;
- Internal benchmarking.

Service delivery standards—In the event that the claims function has been outsourced, a third party administrator will often supply so-called service protocols, which set the standards by which the provider will be judged.

Claims estimating—If it is not certified, it may wish to introduce such standards in this important area as a prelude.

Internal Benchmarking—Benchmarking can be defined as: "**The process of continually researching for new ideas and methods, practices and processes, and either adopting the practices or adapting the good features and implementing them to obtain the best of the best."** It involves comparing your practices to others. There are two main types of benchmarking:

- Competitive, which involves comparing your practices against direct competitors;

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- Internal, which involves comparing practices with other functions within one's organization.

Would compare the claim department with the underwriting department.

B. Value of Audits

In order to ensure that the required levels of quality are being maintained, it may make sense to carry out audits

- Own staff;
- Suppliers of services.

C. Own Staff

Audits of staff can reveal:

- The level of service offered in practice as compared to that offered in theory;
- Any shortcomings in claims procedures or management systems;
- Staff reaction to current working practices;
- The level of knowledge generally available;
- The effectiveness of the claims manager.

D. Suppliers of Services

- The level of service offered in practice if this could not be ascertained from the management reports supplied;
- Any shortcomings in claims procedures;
- The level of knowledge generally available.

E. Monitoring and Updating of Agreements with Suppliers

ISO 9000 includes the following monitoring procedure:

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- Identify quality;
- Monitor quality;
- Analyze quality;
- Take corrective action.

7. Claims Estimating and Reserving

7.1. The Need for Claims Reserving

The collapse of the UK companies in the 1960s and 1970s alerted the Department of Trade and Industry (DTI) to the need for adequate claims reserving.

Over time, companies have begun to adopt more statistical approaches to claims reserving to cater for high volumes of data and to assess the reserves needed to cover the cost of future claims, as well as known claims.

Claims reserving is required for FSA reporting, internal and external reporting purposes and for monitoring financial performance. The estimate techniques may result in a range of reserves, from worse-case reserves (using pessimistic assumptions) to best-case reserves (using optimistic assumptions). The insurance companies should consider the implications of the claims reserving method adopted in light of internal and external reporting requirements.

7.1.1. HM Treasury (HMT) Requirements

HMT requires insurance companies to submit detailed annual returns, in a specified format, to enable it to assess the continued solvency of those companies subject to its regulations. These returns require a breakdown of the claims reserve by class of business and year of origin.

7.1.2. Annual Report and Accounts Requirements

All insurance companies are required to prepare an annual report and accounts and the external auditors are required to consider and report no the adequacy of the claims reserves. The claims reserve is disclosed in the report and accounts and is often the largest component of a company's balance sheet.

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The annual report and accounts will provide information to many other users, amongst whom are:

- Competitors
- Insurance and reinsurance brokers
- Companies looking to grow by merger or acquisition

7.1.3. Inland Revenue Requirements

The Inland Revenue will determine for each insurance company, the level of tax exemption for the reserves stated in the annual report and accounts and may disallow.

7.1.4. Management Information Requirements

Management, including underwriter, will require claims reserve information for the following reasons:

- To assess the overall financial performance of the company,
- To assess the relative profitability of the various classes of business;
- To assess the adequacy of premium rates,
- To assess a commutation price – this is an agreement between a reinsured and reinsurer whereby the reinsurer agrees to pay the reinsured a sum of money to bring the reinsurance contract to an end;
- To estimate a portfolio transfer value
- In respect of a Lloyd's syndicate only, to assess a reinsurance to close (RITC).

7.2. Components of Claims Reserves

The insurance market and the processing mechanisms that operate within it involve various delays:

- Incident and notification of a claim to the insurer;
- Notification and settlement of that claim by the insurer.

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Because of these delays, an insurance company will need to set up reserves in respect of these unsettled or unnotified liabilities:

7.2.1. Outstanding Claims Reserve

This reserve covers claims that have been incurred and reported to the insurer. This figure may be as per the broker's or reinsured's advice or it may be a figure determined by the claims adjuster.

7.2.2. Incurred But Not Reported Reserve (IBNR Reserve)

This reserve covers claims that have been incurred but not yet reported to the company. This reserve is calculated by using statistical techniques based upon the insurer's past experience of claims.

7.2.3. Incurred But Not Enough Reported Reserve (IBNER Reserve)

This reserve covers deficiencies in the system of claims reporting. It covers shortfalls in provisions for outstanding claims reserves. These would occur where the company suffers late notification of reserves, where amounts reported are understated or where the insured has insufficient information on which to assess adequate reserves.

A. Equalization Reserves

The Insurance Companies (Reserves Regulations) 1996 require the establishment of equalization reserves. These are provisions designed to smooth fluctuations is loss ratios for certain classes of business. The insurer is required to make an annual transfer to the equalization provision of a specified percentage on net written premium for certain business classes.

B. Catastrophe Reserves

These are additional reserves that are set up to cover large numbers of related individual losses arising from one event. Catastrophes usually arise from natural causes, such as hurricanes and earthquakes. There are also man-made catastrophes, such as hurricanes and air crashes. Catastrophe reserves, they would form part of outstanding, IBNR, or IBNER Reserves.

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C. Unearned Premium Reserve and Unexpired Risk Reserve

The unearned premium reserve is the element of premium for which insurance coverage has not yet been provide. HMT requires the unearned premium reserve to be calculated in case of policy cancellations or liquidations. An unexpired risk reserve is only needed where a loss is foreseen in relation to the unearned premium reserve. The unexpired risk reserve should cover any such losses.

D. Provision for Claims Handling Expenses

This provision is required to cover the anticipated future costs of settling claims incurred up to the balance sheet date and includes both direct costs (such as loss adjusters fees) and indirect costs (such as office expenses).

E. Reopened Claim Reserves

This provision covers claims which are closed but subsequently re-opened due to a deterioration in the underlying circumstances of the claimant (often in personal injury claims).

7.2.4. Estimating and Reserving Methods

A. Case-by-Case Estimates

This type of estimating involves making allowances for all the know facts about the claim (or classifying the claims into homogeneous groups and ascribing a value to the claim on the basis of past experience with claims in each group). However, for larger claims (especially liability) the claim factors cannot be quantified explicitly, and the process is allowance for direct claims expenses (such as loss adjuster's fees) is then added, and the result is adjusted to take into account the estimated date of payment and likely changes in the intervening period such as inflation, social change and legislative change.

Many companies use case estimates as the basis for their claim negotiations but utilize statistical methods for other purposes, such as their published and management accounts.

One approach to producing global claims reserves is simply to aggregate the case-by-case estimates, and to add an allowance for indirect claims expenses and IBNR.

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B. Statistical Reserving Methods

The actual method used will depend upon:

- The purpose for which it is required;
- The volume of data;
- The class of business;
- The types of claim;
- The company carrying out the projection.

C. The Loss Development Factor Method (LDP Method)

The LDF method assumes that future claims costs can be estimated by extrapolating historical claims information. It is suited to more mature classes of business which have a relatively stable development pattern.

D. The Loss Ratio Method

This method relies on the use of estimated ultimate losses – i.e. the estimated aggregate amount for which claims will finally settle, including claim expenses. Under this method an estimated ultimate loss ratio (the estimate of ultimate uncured losses to earned or written premium) is applied to the total premium for a class of business to calculate claims reserves. This method may be used for new lines of business or classes of business with little development.

E. The Bornhuetter - Ferguson Technique (B-F Method)

A combination of the LDF and the loss ratio method. Under this method, the reserves are initially calculated using the loss ratio method. The company's actual claims experience is used to determine the proportion of total reserves that have not yet been paid or incurred ('Proportion'). This is calculated using the LDP method.

The projected ultimate claims figure results from adding the current value of claims to the undeveloped proportion of the claims liability. The reserves are calculated by deducting the paid claims to date from the estimated ultimate claims.

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This method is suited to classes of business where the reporting of incurred losses is more volatile. Such circumstances would include:

- Liability and other long tail classes of business;
- Recently occurring accident years;
- Change in types of business written;
- New classes of business.

F. Exposure Based Calculations

This method is used for long tail liability, such as asbestos, pollution and health hazard claims (APH claims) and LMX claims. LMX claims are claims arising from the London Market Excess of Loss spiral business. These types of other. The LMX spiral has created considerable delays in the reporting of losses. For LMX business, the reserving specialist (usually an actuary) can assess the maximum exposure by taking into account limited of liability and the number of reinstatements.

***Average cost per claim*—**This is similar to the LDF method. By analyzing the claims history (in terms of claim numbers), the insurer can estimate the number of claims and settlement pattern which will arise in future years. By applying the average cost of claims to the number of claims it anticipates in future, the insurer can calculate the cost of future claims. This method is suitable for liability claims for personal injury.

***Industry Information – Benchmarking*—**The company may use industry statistics as benchmark comparisons if there is no historical data with which to estimate future claims.

G. A combination of methods

The company may well use more than one method in an attempt to produce what it considers to be the most reliable claims reserve. For motor book of business, it is possible that the following methods will all be used:

- The loss development factor method (LDF method);
- The loss ratio method;
- The Bornhuetter-Ferguson technique (B-F method).

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7.3. The Claims Reserving Process

The statistical claims reserving process will normally be carried out by in-house or external actuaries.

The claims reserving process can be split into various stages.

7.3.1. Checking Data Integrity

A company must ensure that the outstanding claims reserves (case estimates) set by the claims adjusters no processing backlogs. The data should also be correctly coded to show type of business, class or sub-class of business, type of loss, catastrophe event code.

7.3.2. Collating Historical Data

The data should be collated into homogeneous groups. The reserving specialist has to take care in determining the category of data to be used. The data groupings could be further separated by:

- Short tail and long tail business;
- Gross and net of reinsurance;
- Personal and commercial lines;
- Direct and reinsurance business;
- Geographical area;
- Catastrophes;
- Proportional and non-proportional treaty business and facultative business.

The class split may be based on those required under HMT returns:

- Accident and health;
- Motor vehicle damage and liability;
- Aircraft damage and liability;

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- Ships damage and liability;
- Goods in transit;
- Property damage;
- General liability;
- Pecuniary loss;
- Non-proportional treaty reinsurance;
- Proportional treaty reinsurance.

7.3.3. Projection of Claims – Loss Development Factor Method

This method can be broken down into the following steps:

- Setting out the data in the form of a triangulation
- Analyzing the trend;
- Calculating the claims reserve.

A. Triangulating Data

The collaged data should be set out in the form of a triangulation.

- Accident year/year of loss: this is the calendar year in which the occurrence resulting in a claim took place.
- Underwriting year: this is the year in which the policy was written. This type of analysis is suitable to Lloyd's syndicates and reinsurance business.

Development factors (also know as development ratios) are calculated from one development period to the next. The table above shows that development factors for later years are less than those for earlier development years.

Various averaging techniques are used to determine average development factors for all underwriting years combined.

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B. Analyzing the Trend

- arithmetic average;
- curtailed average;
- exceptional average;
- weighted average.

C. calculating the Claims Reserves

The claims reserves for each accident year is calculated by multiplying the cumulative claims to date for that year by the development factors for the number of years which remain undeveloped.

5,699 x1.020 = 5,813

For the 1997 accident year, the calculation is as follows:

5,789 x 1.36 x 1.045 x 1.025 x 1.022 x 1.020 = 8,791

Accident year	Projected ultimate IBNR	cumulative	claims
	Claim	to date	
1993	**5813**	**5699**	**114**
1997	**8791**	**5789**	**3002**

D. Conclusion

The LDF method can be used on both paid and incurred development data. As a rule of thumb, both the paid and incurred development data should be used for medium to long tail business.

Projection is affected by changes in:

- the method of assessing outstanding reserves;

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- settlement practices, staff and claims procedures;
- mix of business written, policy conditions or change in risk profile.

7.3.4.. Factors Affecting Reserving

Inflation—The reserves set will have to take into account whether the claims are subject to indexation clauses.

Exchange Rates—This will avoid distortions caused by currency fluctuations year on year.

Legislation—New legislation or changes in legislation may have an impact on the frequency and level of claims and the timing of the claims development. This is particularity true for product-related claims such as asbestos, pollution and health hazard claims.

Litigation—The insurance environment today is rather litigious. The change in social attitude to litigation has led to increased awards for damages and liability claim have been affected by the rate of increase in court awards.

Long Tail considerations—When assessing claims reserves for long tail liability business, the reserving specialist (normally a qualified actuary) must select an appropriate reserving technique.

- The bornhuetter-Ferguson technique;
- Exposure based method;
- Average cost per claim method .

For long tail lines of business, greater reliance will be placed upon incurred claims data than on paid claims data.

Long tail liability claims are subject to external factors such as inflation in respect of personal injury claims and changes in legislation, in particular in relation to APH claims.

Latent Claims—Latent claims can be defined as: a specific type of long tail liability where there is a time lag between occurrence and manifestation of injury and/or damage.

The main types of latent claims relate to:

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- Asbestos products leading to asbestos-related diseases. Claims are categorized as either bodily injury or property damage;
- Environmental pollution;
- Pharmaceutical drugs,
- Chemical products , e.g. Agent Orange;
- Lead products resulting in lead poisoning;
- Tobacco products which result in tobacco-related illnesses;
- Electromagnetic fields (EMF).

Such losses are also referred to as APH (i.e. asbestos, pollution and health hazard) claims.

7.4. Actuarial Reviews for Monitoring Financial Performance

The main reasons for monitoring

- FSA regulation;
- Annual report and accounts;
- Management control – especially budgetary control.

7.4.1. FSA Regulation

Authorization: authorizing new insurance companies to underwrite insurance and reinsurance business or authorizing existing companies to extend their business activities to other class.

Monitoring: FSA is responsible for monitoring the continued solvency of companies and their compliance with FSA rules and regulations.

Control: FSA has certain powers of intervention and can withdraw an authorization to carry out insurance business.

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Insolvency: FSA may petition for the winding up of a company on certain grounds, which include the company's inability to pay its debts and its failure to keep proper accounting records.

7.4.2. Annual Report and Accounts

The Companies Act 1985 requires every company to prepare an annual report and accounts

A. Profit and Loss Account

B. Balance Sheet

The claim reserve is usually one of the largest components of a balance sheet for an insurance or reinsurance company.

The 1993 Insurance Accounting Regulations allow for explicit discounting or claims reserves under certain circumstances. This is calculated by estimating the future payment pattern of claims and discounting this for the time value of money at a prudent discount rate.

7.4.3. Impact of Claims on Underwriting and Pricing

An underwriter has the responsibility for deciding:

- Whether or not to accept a proposal of insurance;
- What terms and conditions to set;
- The proportion of risk to underwrite;
- The price at which to sell the insurance (known as rating).

A. Impact of Claims on Pricing

When rating the risk the underwriter will need to take into account the following factors:

Break-even: the price must be set at a level to cover the costs of future claims , administrative expenses and commission.

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Profitability: the price set should achieve the insurance company's profitability goal.

Market conditions: these also affect rating. In a hard market, where there is less competition, insurers may be able to charge higher rates.

The premium charged can be broken down into various components:

Risk premium. This is the level of premium that the underwriter must charge to cover the present value of the cost of future claims. Claims, especially long tail claims, occur after that period, possibly many years after.

Expense loading. This is the amount that is charged to cover the insurer's administrative expenses, such as broker's commission, claims handling cost and office expenses.

Profit loading. This is the amount that is charged in order to achieve a profit.

Contingency loading. This element of the price covers unexpected claims. This loading provides a buffer for the insurance company to ensure it remains solvent.

B. Impact of Claims on Underwriting

In order to be in a position to analyse the impact of claims on underwriting the underwriter requires:

- Good line of communication between the claims department and the underwriting department.
- A suitable computer system which allow the claims department to property and accurately record each claim notified.
- Policies to carry a claims notification clause giving sufficient notice.
- A set of procedures for highlighting popential claim problems before the next renewal.
- A set of internal review procedures so that likely claims can be anticipated before any policies are issued following an amendment of company standard underwriting terms and conditions.

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The underwriter has a number of possible responses to an increase in the frequency or severity of claims. These include:

- Change the class of business. If a certain class of business proves to be unprofitable owing to exceptional losses or high risk, the underwriter should determine whether to include such business in the underwriting plan.

- Change particular terms and conditions, including:

  ⇒ The scope of the territory;

  ⇒ The number and/or the wording of the exclusions – it may be that a subtle change in one of the exclusions will have a dramatic impact upon the profitability of the account;

  ⇒ Increasing the excess point;

  ⇒ Introduction of an inner aggregate deductible, if appropriate;

  ⇒ The type of policyholder protected;

  ⇒ The type of cover offered e.g. from a losses-occurring to a claims made basis;

  ⇒ The period of cover e.g. from 36 months to 12 months.

8. Outsourcing the Claims Functions

Outsourcing is using a skilled resource outside the company to handle work traditionally performed by in-house staff. Such outsourcing is normally for a renewable fixed term of 5 years, but it can be on a short-term or temporary basis.

Two reasons for outsourcing:

- perceived cost benefits; and

- access to a wider skills base.

8.1. How Much of the Claims Function to Outsource

The stages of the claims process:

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- Claim notification;
- Claim review;
- Response to insured;
- Claim investigation;
- Claim negotiation;
- Claim settlement;
- Claim recoveries;
- Review of performance.

Each of these separate sub-functions can be outsourced. Alternatively, the whole process can be outsourced, together with the financial reporting and management of the operation so that no internal claims department is required at all.

8.1.1. Claims Notifications

It is possible to instruct a third party to process claims notifications only.

8.1.2. Claims Review and Respond to Claimant

Responding to claimant is governed by the Civil Procedure Rules. The outsource provider must:

- follow the exact procedures in the pre-action protocol;
- 'act reasonably in respect of all other types of claims. This requires the outsource provider to convey their claim decision within three months of the date of the defendant's acknowledgement of a letter of claim.

This response can be either:

- admit liability;
- deny liability, giving reasons;

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The outsource provider must provide standard disclosure of relevant documents which substantiate their reasons for denying claim.

Early claim decisions are required in respect of the coverage of the claim.

In the area of reinsurance in particular, where outsourcing of the whole claims process is seldom the case, external claim reviewers offer to analyze each claim in the light of:

- Representations made;
- Contractual parameters;
- Market practice;
- The legal background;
- Corporate claims philosophy;
- The continuing business relationship with the reinsured;
- Arithmetical correctness.

8.1.3. Claims Settlement

Claims settlement has been enhanced by outsourcing:

- Claims settlement via provision of replacement goods rather than money is one example of this. Outside companies offer the service of supplying and delivering such goods to the insured. In many cases this is combined with claim negotiation.
- In the area of motor claims, the use of externally managed approved repairer networks has given insurer access to a high-quality and speedy repair service.

In general, the extent to which the claims function is outsourced will depend upon the classes of business written and therefore the nature of expected claims. Claim can usually be categorized as either bulk (high frequency ,low severity) or complex (low frequency, high severity).

A. Bulk Claims

Straightforward but labor-intensive claims which do not require a site visit, such as:

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- Personal injury;
- Medical expenses;
- Transit;
- Baggage and travel;
- Some motor;
- Employer's liability; and
- Minor public liability claims;

Lend themselves to outsourcing.

B. Complex Claims

These lie at the other end of the spectrum, claims from the following classes of business were described as problematic by the participants (in descending order of importance):

- Pollution;
- General US liability;
- London market excess of loss spiral;
- Professional indemnity/errors and omissions;
- Maritime liability;
- Non-US liability;
- Savings and loans;
- Workers compensation (employers liability;
- Warranty insurances;
- Personal accident reinsurance.

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8.2. Users and Providers of Claims Outsourcing Services

8.2.1. Outsourcing Service Users

There are basically three groups of users of claims outsourcing services:

- Self-insurances such as local authorities, utility companies, and large corporations;
- Insurance companies;
- Reinsurance companies.

A. Rationale for Outsourcing

Self-insurers, often do not process the necessary staff resources and technical skills, or are unwilling to develop and maintain expensive IT systems. Self- insurers are aware of:

The likely frequency and severity of many of the self-insured risks;

The fact that the claims function is not a core activity of the organization;

The possibility of being pressurized into paying claims which are not valid;

For insurance companies, the main reason to consider outsourcing is the containment of expenses. For reinsurers, it is the availability of high technical skills which plays a major role in the decision to outsource.

8.2.2. Outsourcing Service Providers

The providers of outsourcing services can be divided into two groups:

- Internal (i.e. a subsidiary company, or a joint venture);
- External. In the vast majority of cases, the service provider will be external. External providers are:

  ⇒ Third party administrators;

  ⇒ Insurance company claim departments

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⇒ Brokers;

⇒ Solicitors;

⇒ Loss adjusters;

⇒ Reinsurance.

A. Third Party Administrators (TPAs)

These are independent companies which specialize in claims administration. Their sole area of expertise, and hence their sole source of income, is the administration of claims. Earn fees which are usually based either on a fixed cost per year plus some allowance for variation, or on a claim quantum and time-expended basis.

The services which they offer include:

- Claims handling;
- On-site claims investigation;
- Claims payment;
- IT systems;
- Telephone helplines;
- Technical training.

B. Insurance Company Claim Departments

They offer their services to non-insured who are usually the self-insurers referred to above.

C. Brokers

Brokers have traditionally provided large corporations with insurance arrangement and placement services. However, many organizations have employed in-house risk managers to carry out this function.

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D. Solicitors

Solicitors offer bulk claims administration services and specialized services such as the processing of problematical motor claims.

E. Loss Adjusters

The very use of loss adjusters represents an outsourcing of the claims investigation process. In addition to this service, loss adjusters are also offering bulk claims administration services.

F. Reinsurance Consultants

Service to:

- Inspection of records;
- Portfolio analysis;
- Claims reviews;
- Reinsurance run-off;
- Reinsurance claim collections; and
- Commutations.

As opposed to TPAs, reinsurance consultants tend to ve relatively small companies. their major asset is the skill of their workforce .

8.3. Deciding Whether to Outsource the Claims Function

Assess the potential requirement;

Choose a provider;

Prepare the outsourcing contract;

Begin operations.

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8.3.1. Assess the Potential Requirement

The potential gains and pitfalls of the following factors should be analysed:

- Strategy ;
- Costs
- Services
- Personnel.

8.3.2. Choose a Provider

- Experience;
- Cost;
- Flexibility.

A. Experience

- References from current and former users,
- Clearly defined service levels. A TPA, for example, will often supply so-called service protocols
    - ⇒ Turnaround times for advice on liability and investigation
    - ⇒ Regular provision of management information;
    - ⇒ Attendance at meetings;
    - ⇒ Advice and payment arrangements;
    - ⇒ The quality of the processes used,

B. Cost

Although cost reduction is one of the main reasons for considering outsourcing in the first place , the cost of the service is, not the most important factor when considering

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which provider to choose. The biggest potential problem in outsourcing that of choosing an incompetent service provider is considered more vital.

Fixed fees per claim may be offered on bulk but not on complex claims, as such long-tail exposures (e.g. liability business) require a more structured approach to remuneration to be negotiated, to include some allowance for the length of time spent on the claims.

C. Flexibility

Flexibility can be demonstrated by:

- The inclusion in the contract of service of certain additional services, such as monthly status reports on large claims, as standard with no extra charge;
- Willingness to amend the format of management reports to fit the organization's standards;
- With regard to reinsurance, the adaptability of the consultant to meet the needs of the claims department,

8.4. Advantage of Outsourcing the Claims Function

- Strategy;
- Cost;
- Service;
- Personnel;

8.4.1. Strategy

Here the advantages of outsourcing are:

- Concentration upon the core activities of the insurance/reinsurance company.
- Possibility of radical change in the structure of the company, especially in the IT area. Lean and efficient business processes may need to be implemented and unnecessary hierarchical structures swept aside.

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- Transfer of economic and technological risks to the outsourcer.

8.4.2. Cost

Outsourcing often, but not always, results in a saving of 10% or 20% over the cost of carrying out the function in house. This may be explained by:

- The provider's specialization in the area (leading to higher efficiency);
- Economies of scale;
- Office locations in a lower rent environment; and
- The provider's pro-active approach to claims handling (resulting in lower claim costs).

8.4.3. Service

Higher standards of service may be achieved through the improved performance of the computer system as a result of access to new technology; and through access to a wider skill base

8.4.4. Personnel

The advantages of outsourcing are:

- Releasing the management from routine work;
- Reducing the personnel requirement
- Avoiding peaks and troughs in workload and personnel requirements.

8.4.5. Most Significant Advantages

The most important are held to be:

- Concentration on the core activities;
- Cost reduction;

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- Increased flexibility.

8.5. Disadvantages of Outsourcing the Claims Function

These can similarly be categorized under the headings:

- Strategy;
- Costs;
- Service;
- Personnel.

8.5.1. Strategy

The strategic disadvantages of outsourcing lie in three main area: loss of control over the outsourced function; reduction of in-house expertise; and dependence on the service provider.

A. Loss of Control

The claim manager in particular, can control each stage of the claims process when it is handled internally, this control will be lost , or serverely reduced, by the use of outsourcing.

B. Lack of Expertise

Outsourcing can result in the opportunity to develop in-house expertise being lost.

C. Dependency

A company can become highly dependent on its outsourcing service provider.

- After handling the claimsfor a few years, the providers is likely to be the only party fully conversant with the technical and IT requirements;
- There can be a "snowball effect" with future outsourced functions or subfunctions being likely to go to the same providers since a working relationship will have been developed and the IT sources will be known.

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8.5.2 Costs

Savings from outsourcing are wildly overstated. Particular problems with costs are:

- The occurrence of unforeseen problems:
    - ⇒ IT incompatibilities or difficulties;
    - ⇒ Legal headaches; and
    - ⇒ Deadlines not being met.
- Extra co-ordination costs;
    - The provision of extra services. The service provider is itself profit-making and will tend to maximize any opportunities to provide extra services.

8.5.3 Service

The user may experience problems with the quality of the outsource service provided to customers. The outsource provider may also fail to take into account the importance of retaining business from major insured customers when handling claims.

8.5.4 Personnel

The disadvantages of outsourcing from a personnel perspective are:

- If one function is outsourced, employees carrying out other functions may feel uneasy about their own future prospects;
- In the event that internal staff are employed by the outsource provider, there may be legal and contractual problems.

8.5.5. Most Significant Disadvantages

The greatest disadvantages are:

- relinquishing exclusive control to the service providers;
- high dependency on the service and the provider;

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- loss of opportunity to retain and develop expertise in-house.

8.6. Reinsurance Industry Aspects

8.6.1 Market Changes Favoring Outsourcing

The cumulative effect of these changes is:

- a drive to reduce costs, including claims costs;
- an increased claim workload, especially with respect to latent claims, e.g. those related to asbestos, which require high reinsurance technical skills;
- skills shortages in reinsurance companies;
- a more litigious environment where legal arguments, for example that claims are lime barred, have been used as technical barriers to barriers to paying claims.

8.6.2 Market Changes Precluding Outsourcing

Certain factors tend to make outsourcing less in demand:

- The reinsurance mergers and acquisitions have increased the size and expertise of in-house claims resources;
- Reinsurances are becoming more global which makes outsourcing to external companies concentrating their efforts in one geographic area less attractive;
- Reinsurers are generally reluctant to hire permanent external assistance in the claims area due to the perceived loss of control and possible increased costs.

8.6.3. Future Trends

It is likely that the increasing of outsourcing will continue apace. The dominant reason will remain the drive towards focusing strategic attention upon the core activities of the insurance or reinsurance operation.

Especially in the insurance sector, the claims functions is likely to be increasingly separated from risk transfer. The service providers can bring greater specialisation, with their innovative use of new technology, outsourcing will benefit all parties.

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8.6.4. Civil Procedure Rules

- **Reasons for decreased use –** the financial effect of an incorrect claims notification by the outsourcer could be very large if there are costs sanctions imposed by the courts. If insurers miss the new deadlines they may suffer in reputation and financially;

- **Reasons for increased use –** outsource provider's ability to provide the spare capacity to meet the peaks and troughs of claims advice and the latest IT to meet the Civil Procedure Rules deadlines.

9. Insurance Intermediaries and Claims

9.1. Intermediaries

9.1.1. Definition of Intermediary

An insurance intermediary is: 'Someone who brings together the buyer (insured) and seller (insurer) for the purpose of comleting a contract of insurance'.

9.1.2. Intermediaries and the Claim Process

A. Brokers

The broker sold the insurance policy to the insured. The policyholder will contact their broker giving them brief details of the claim. It is the duty of the broker to supply this information to the insurance company.

Insurance brokers:

- at all times conduct their business with utmost good faith and integrity;

- shall do everything possible to satisfy the insurance requirements of their clients and shall place the interests of those clients before all other considerations;

- Statements made by or on behalf of insurance brokers when advertising shall not be misleading or extravagant.

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B. The insurance Company

The insurance company receives details of a claim from the broker or from policyholder directly. If the insurance company has delegated part of its claim management function, an outsource provider may be involved. The majority of claims will require investigation by in-house claims specialists or loss adjusters appointed by insurance company.

C. Outsource Providers

If delegated, the outsource provider may be involved in all or part of the claims process. This depends on the extent of duties delegated to the outsource provider.

D. Loss Adjusters

If the in-house claims specialists are not used, the insurance company may employ a loss adjuster, who will investigate claim in accordance with the instruction given by the insurance company.

9.1.3. The Various Types of Intermediary

Independent intermediaries—Independent intermediaries act on behalf of their clients not the insurer when placing business and demonstrate their expertise by recommending to their clients the most appropriate insurer for their need.

As well as placing the risk, the independent intermediaries offer:

- risk management;
- claim notification;
- recovery of uninsured losses following a claim incident;
- mid-term changes;
- reviewing client needs; and
- negotiating renewal.

Lloyd's brokers—Lloyd's broker should be registered with the Council of Lloyd's; they must satisfy the Council as to their expertise, integrity and financial standing. They must

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also satisfy the requirements of the FSA's rules for independent intermediaries. Only Lloyd's brokers are permitted to place insurance with Lloyd's underwriters in the Room at Lloyd's of London.

Multi-tied agents—A multi-tied agent offers or sells the general insurance products of only one insurer. They may offer the products of many insurers but for each product type they may offer the product of one insurer.

***Single-tied agent*—**A single-tied agent only offers the general insurance products of one insurer.

9.2. The Law of Agency

An agent is a person who is employed to do something in the place of another (the principal). Insurance intermediaries usually act as an agent of the insured. However, in certain circumstances they may act instead as an agent of the insurer. It is even possible for the intermediary to act for the insured and the insurer in the course of one transaction.

In the context of claims, the intermediary will normally be acting for the insured. The act of advising the insured on the presentation of a claim will be deemed to be an agent for the insured. Where there is a conflict of interest, the law requires the agent to gain the permission of all parties.

If the agent acts outside the scope of their authority, their principal may:

- adopt and ratify the agent's action;
- not ratify the action, and allow the agent to be sued by any third party with whom the agent has contracted;
- recover compensation from the agent.

The principal is liable for any:

- fraud;
- concealment or misrepresentation;
- non-disclosure; or

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- breach of warranty;

9.2.1. The Role of the Intermediary in the Claims Handling Process

When the insured wishes to make a claim, the intermediary is often involved by advising the insurers involved and by collecting the claim monies. The intermediary's presence eases the flow of information to the insurer.

A. Indirect Roles

Such role includes – helping the insured to choose the right policy and to disclose all material information.

Selecting an appropriate insurance policy

The ability of the intermediary to:

- recommend the appropriate type and level of insurance cover;
- recognize subtle differences in cover between the various policies on offer;
- select an insurer which provides an efficient claim service.

Disclosure of material information

The intermediary can be acting as agent for both the insurer and the insured. It is essential to ensure that all information material to the risk is disclosed to the insurer.

B. Direct Roles

Specific roles include providing assistance in various aspects of the claim process.

Claims notification

Where an intermediary is involved in the purchase of an insurance contract, notification of any claims arising therefrom normally takes place via the intermediary. The key issue with regard to the notification condition are:

- Those circumstances that must be notified to the insurer: "circumstances which might give rise to a claim".

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- The time frame specified in the contract;
- The consequences of the insured failing to notify in a timely fashion.

The intermediary should draw the insured's attention to the need to:

- notify claims promptly; and
- disclose all material facts in relation to the claim;

Legally the insured's notification of loss to the intermediary is not deemed to be notification to the insurer. Therefore, the intermediary must ensure that the insurer is informed of the claim in a timely fashion.

Help with claim documents

Intermediaries often complete, or assist the insured in the completion of the claim form to be presented to the insurer.

Claim review

The intermediary wants to review the claim for two main reasons:

- to identify any area that may otherwise delay the claims agreement and settlement process. Required information has been provided with the claim presentation and that no obvious mistakes have been made by the insured;
- to ensure that they fully understand the circumstances of the claim to enable the claim to be broken to the insurer.

Some of the questions considered by the intermediary include:

- Is the claim covered by the policy?
- Do any policy exclusions apply in the circumstances of the loss?
- Has the insured complied with relevant policy conditions including payment of the premium?
- Has the insured complied with any warranties imposed by the insurers?
- Has the insured applied any applicable deductible?

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- Is the insured submitting sufficient proof of loss?
- In the event of a third party claim, are sufficient details of the third party and the third party's cause of action provided?

Under the Civil Procedure Rules, immediately the claimant has sufficient information available to sustain a realistic claim, they should send two letters of claim to the potential defendant. The claimant is encouraged to supply more detailed information about the claim such as a full summary of the factual background at the early stage (the 'card on the table approach').

The insurer is required to convey their claim decision within three months of the defendant's acknowledgement of a letter of claim from the claimant. This response can be either:

- admit liability; or
- deny liability, giving reasons.

The insurer must provide standards disclosure of relevant documents which substantiate their reasons for denying the claim. The intermediary must ensure that they play their role in helping the parties meet the tight deadlines involved by providing swift and effective communication channel between the insured and the insurer.

Recording and monitoring of the claim

An intermediary, upon receipt of a claims advice, will establish a claim file with all the relevant information including all coverage documentation. The claim will be logged on the computer system. Thereafter the progress of the claim will be monitored through to claim settlement.

Claims negotiation/ broking

If the claim is of a type that requires the intermediary to meet with the insurer's claim handler, the intermediary is undertaking a claims broking role. While this function is rare in relation to personal insurances, broking a claim involves:

- making arrangements to present the claim to the insurer;

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- discussing the claim with the insurer;
- answering any technical questions regarding the claim presentation;
- noting any queries which have been raised by the insurer.

The intermediary uses the following knowledge and skills in the claim broking process:

- familiarity with the insurer's policy wording;
- understanding of technical insurance issues;
- negotiation skills, including the ability to present facts in the best light;
- awareness of arguments that have been successfully utilized against insurers in the past.

Communication of insurer's and insured's position

By assisting both sides to communicate only with each other, intermediaries undertake a valuable role in ensuring the efficient and proper handling of the claim.

If the insurer is not satisfied with the claim presented, it may raise questions or deny liability. The intermediary must convey them to the insured.

Claim settlement

The insurer may agree to settle the claim on an '*ex gratia*' basis. Such payments are made where:

- the application of the exclusion was unclear;
- there was genuine oversight by the insured, such as an administrative error;
- hardship may be created for the insured or a third party claimant;
- the insurer wishes to avoid a court battle;
- the insurer wishes to avoid the possibility of souring good business relationships;

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- the insurer wants to avoid possible adverse publicity.

Recommendations to insured in event of a claim dispute

Disputes tend to concern:

- the liability of an insurer to pay a claim;
- the amount which should be paid.

In either of the above, the intermediary's role to:

- inform the insured and seek instructions;
- advise the insured on an appropriate response or course of action.

Such advise may include:

- drafting a suitable response to the insurer explaining the insured's position;
- meeting with the claims handlers or senior personnel of the insurer;
- recommendation of an expert witness to form part of the insured's short-list of candidates;
- negotiation of a compromise (ex gratia) payment;
- helping the insured to follow the insurer's grievance procedure;
- helping the insured submit a claim to the Financial Ombudsman Service;
- recommending that the insured take legal action against the insurer and suggesting a qualified solicitor.

Funding of the claim

In the event of:

- a claim being presented by a major client of the intermediary; or
- delay in settlement of the claim by the insurer; or

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- the intermediary believing that settlement of the claim will take place from its own funds, prior to having received settlement from the insurer. This practice is known as funding.

9.2.2. Remuneration of Intermediary for Roles Performed in the Claims Process

The intermediaries are paid commission by the insurer, between 5-25% of the premium. There is no separate payment for the claims process. Assistance in the claims process is the service provided by the intermediary. Unsatisfied customers will take their business elsewhere or insure direct.

9.2.3. Reinsurance Aspects

Reinsurance brokers perform similar claims roles to those undertaken by the insurance intermediary including:

Indirect roles

- Identification of suitable (financially secure) reinsurers and advice on the appropriate type and level of reinsurance cover;

Direct roles

- Performance of many accounting functions;
- Forwarding collection notes or bordereaux to reinsurers;
- Developing and maintaining good business relationships with the various reinsurers;
- Pursuing reinsurers for overdue payments;
- Ensuring reinsurer's queries are being answered on a timely basis;
- Monitoring reinsurer security in order to advise reinsureds on the avoidance of bad debts;
- Advising the reinsured on the insolvent reinsurer issues.

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9.2.3. Different Emphasis

While the reinsurance claims services are similar to those performed by insurance intermediaries there are differences in emphasis.

- simultaneous collection of a number of claims;
- international claims;
- complex claims arising from the USA, including long-tail liabilities such as asbestos, pollution, and health hazard;
- higher use of electronic claims advice in the reinsurance industry;
- greater utilization of claims bureaux in the reinsurance industry;
- dealings are with other insurance professionals rather than members of the public or corporate clients;
- multiple reinsurers on one risk, including overseas reinsurers;
- complex and non-standard reinsurance contracts;
- higher degrees of broker funding in the reinsurance industry.

9.3. Use of Delegated Claims Settlement Authority

Delegated claims settlement authority can be defined as: "The transfer of the decision making process of a self-insurer; insurer; or reinsurer (the "delegator") to accept or reject a claim, to another party (the "delegatee").

The delegation is made by:

- a self-insurer (such as local authorities, utility companies, and large corporation);
- an insurer;
- a reinsurer;
- an insurer's agent who himself has authority to delegate this function.

Delegation is made to:

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- Another underwriter;
- agents of the insurers (or reinsurers) which include:
    - ⇒ Loss adjusters;
    - ⇒ other agents;
    - ⇒ Underwriting agents;
    - ⇒ Lloyd's agents
- Providers of professional outsourcing services such as third party administrators, brokers, solicitors, loss adjusters, or reinsurance consultants.

Reasons to delegate

- Business efficiency;
- Lack of expertise in the particular class of business;
- Lack of resources;
- The containment of expenses;
- Claim settlement authority is granted as part of the delegation of underwriting authority.

Key considerations

There are three key matters to be considered when delegating claims settlement authority:

- ***Scope of authority*** – the scope of authority may be limited by such thing as:
    - ⇒ the value of the claim;
    - ⇒ classes of business;
    - ⇒ types of claim;
    - ⇒ restrictions on the actual individuals performing the function.

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- Position in event of breach of authority – Clients should not allow themselves to be placed in a position where they settle claims agreed by the delegatee which they themselves may have rejected. Penalties for breach of authority may be provided for in the delegation agreement;

- Conflict of interest – a conflict of interest may arise where an intermediary is acting on behalf of an insured, but also the insurer's authority to settle.

10. Handling Fraudulent Claims and Codes of Practice

10.1. Insurance Fraud

Insurance fraud can take a variety of forms, such as:

- the inflation of a genuine claim, e.g. in the case of burglary including items that were not in fact stolen;

- creating an entirely fictitious event, e.g. a theft that never took place; and

- causing deliberate, as opposed to accidental, damage to insured property, i.e. pouring water into video recorder.

The following examples illustrate what insurance fraud is:

- inventing loss event which in reality never took place, e.g. a robbery;

- exaggerating the number of items stolen during an otherwise honestly reported break-in;

- deliberately creating an insured event, e.g. throwing paint over an insured carpet at home;

- exaggerating the effects of an insured event, e.g. pretending that a personal injury is more serious than it really is in order to receive higher compensation;

Fraud varies from the simple inflation of genuine claims to the creation of an entirely false claim. An additional common and potentially costly type of fraud involves multiple insurance with a view to staging a loss and recovering many times over.

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10.1.1. Classification of fraud

A degree of exaggeration designed to improve an insured's bargaining power is permissible but submitting claims for amounts known to be incorrect and substantially in excess of the correct figure constitutes fraud.

10.1.2. Insurer's attitude to fraud

Insurers are showing a more hard-nosed approach to fraud adn will not hesitate to take legal action in appropriate cases.

- **Hard fraud** – is generally a deliberate attempt to invent an accident, injury, theft or some other type of insured loss event. Hard fraud is also committed by executives and employees within the insurance industry. Fraud also includes the actions of insurance agents who fail to pass on premiums to the insurance company. In this case there is no valid contract of insurance and the remedy would lie against the insurance agent.

- **Soft fraud** – is sometimes called opportunity fraud, and it occurs where a policyholder or claimant exaggerates an otherwise legitimate claim. Soft fraud also occurs during the underwriting process when people apply for new or renewal coverage. Some people provide false information to reduce insurance premiums or else to increase the likelihood of proposal beeing accepted.

10.1.2. Quantifying the Fraud Problem

Collecting data on the types and amounts of fraud is becoming important; many believe that quantifying the problem of fraud is the first step towards eliminating it.

A. Change of Approach

Three elements lie at the center of this change:

- Enhanced understanding of fraud motivators;

- Cooperation between the insurance companies to re-educate the public;

- Advances in technology.

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B. Enhanced Understanding of Fraud Motivators

The research has identified a number of questions which individuals ask themselves before embarking upon a fraudulent act.

- What is in for me?
- What is the chance that the fraud will be discovered?
- What is my punishment likely to be in the event of my being found out?

C. Cooperation Between the Insurance Companies to Re-educate the Public

There is increasing focus on the education of the public. Apart from moral arguments, the payment of fraudulent claims entails the increase of premiums for the insurance industry. Though the costs of defense is high, there is a tendency to challenge and question fraudulent claims.

D. Advances in Technology

Fighting against fraud includes the use of pooled claims database where insurers can share information from a variety of different insurers and try to trap those repeated claimants.

Relational databases can be used to link apparently unrelated policies and policyholders and which are specifically designed to filter out fraudsters before they are even able to arrange cover. While implemented on the grounds of enhancing customer service and cutting costs, have also directly impacted upon fraud.

10.1.3. Detection of Insurance Fraud

Pre-fraud indicators:

- Frequent change of insurer;
- Uncharacteristic increase in the level of cover – a request to add accidental cover mid-term;
- Unclear ownership of goods, particularly of motor vehicles;

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- Financial difficulties.

In addition, presence of the following will cause suspicion:

- prevarication by the insured;
- excessive pressure to settle;
- an inconsistent story which may suggest that the insured is fabricating facts;
- lack of cooperation;
- poor documentation;
- perfect documentation.

10.1.4. Insurer's Responses to Fraud

Insurers are raising the general awareness of fraud within the insurance industry and are adopting a healthy level of professional scepticism towards claims; use of confidential telephone lines to facilitate anonymous tip-offs; establishing anti-fraud units; claims believed to be fraudulent should be subject to rigorous challenge.

A. Fraud Clauses

Many insurance policies contain an express clause stating that all benefits, otherwise due under a claim will be forfeited where fraud is proven:

"If a claim had been in any respect fraudulent or if any fraudulent means or devices be used by the insured or anyone acting on his behalf to obtain any benefit under this policy or inf any destruction or damages be occasioned by the willful act or with the connivance of the insured all benefits under this policy shall be forfeited."

B. Centralized Databases

These databases include the following:

- The Motor Insurance Anti Fraud and Theft Register;

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- Common Loss Underwriting Exchange – this is essentially a series of registers participating insurers to check information on a proposal form with that held on the register, with the aim of eliminating multiple claims on parallel policies held by a single assured;

- The Art Loss Register – this is designed to track claims made in respect of valuable items of fine art and antiques;

- The Equipment Register – this tracks losses in respectof industrial machinery.

10.1.5. Legal Remedies for Fraud

A. Onus of Proof

It has been very difficult to prove fraud in civil litigation. This is particularly so with insurance cases. Suspicion of fraud will not be sufficient and there must be enough evidence of a kind which is admissible to the court in order for ***the onus of proof*** to be discharged.

One very good illustration of this is found in the case of exaggerated claims. Mere exaggeration is not enough to amount to fraud; it is possible that the insured may honestly over-estimated a loss. In addition, cases of over-valuation may be instances of non-disclosure or misrepresentation and will not necessarily be fraudulent.

B. Moral Hazard

Another area of concern when considering remedies for fraud is that of moral hazard. An example may be where the insurer wishes to be told if the insured has a criminal record:

Can the insurer prove the existence of the criminal record?

Can they show satisfactorily that the criminal record was a fact which the insured was obliged to disclose at the time of completing the insurance proposal?

10.1.6. Remedies Available

- Cancellation of the policy;

- Avoidance of the policy ab initio (i.e. from the very beginning of the contract);

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- In certain circumstances, the insurer has the right to retain any premiums paid on policies where fraud is subsequently discovered;

- Damages may also be available to an insurer who suffers loss directly attributable to fraud by the insured;

- Various criminal remedies, for example confiscation of property or term of imprisonment.

A. Avoidance of the Policy ab initio

Generally speaking, a contract is rendered voidable at the option of the injured party wherever fraud is present. The effect of this is that the contract is rescinded adn the insured party can recover their outlay, which will be the claims payment. The policy is then considered void *ab initio*, which means that the policy is treated as if it never existed and the parties are each put back in the position they would have been in but for the contract.

It is important to note that completely innocent non-disclosure or misrepresentation will not give rise to any remedy.

B. Avoidance and Declinature

We must be careful to distinguish between the avoidance and declinature of claims. Where an allegation of fraud is raised, the insurer is entitled to avoid the whole policy as above and the consequences go beyond the mere loss of the claim moneys.

C. Express Warranties

Warranties are often contained in insurance contracts. Warranties must be strictly complied with. Frequently warranties are incorporated into the contract by a statement in the policy that the proposal is the basis of the conctract adn on the proposal form there is a declaration by the insured as to the truth of the answers given.

D. Cancellation of the Policy

This is weaker remedy than avoidance from inception. Although a particular claim may be avoided, there may be a policy liability.

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E. Retention of Premiums

There is frequently dispute between insurer and insured as to the ownership of premiums in cases of fraud.

Where the policy is void or is avoidable by the insurer as from the commencement of the risk, the premium is returnable, provided there has been no fraud or illegality on the part of the assured.

F. Damages

Damages are not a suitable remedy where fraud is present. In that case, it was said that the only remedy properly available in such circumstances was rescission of the policy and the recovery of any premiums paid.

10.2. Fraud Against Reinsurers

The remedies are available to a reinsurer in cases of fraudulent pre-contractual negotiations are the same as those available to an insurer where the insured has been fraudulent towards them.

10.2.1. Affirming the Contract

An insurer may have reasons for choosing not to avoid or terminate a policy even where the law will clearly permit them to do so, and they may be content simply to avoid the fraudulent claim while the policy continues. The insurer will be prohibited from avoiding the policy once they have affirmed the contract.

10.2.2. Fraud by a Broker or Agent

- The agent fraudulently claims biding authority which does not exist, i.e. where they have been advised by the insurer that certain risks must be specifically referred to head office before cover can be offered yet deliberately lead the insured to believe that they possess the authority to issue such cover without referral;

- Fraudulent issue of policies or certificates – this may occur where cover is purportedly to be sold on authority of a given insurer but where in fact the broker is simply retaining the premium and failing to pass details to the insurer;

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- Failure to issue a cover-note at the commencement of a risk and the subsequent 'back-dating' of cover.

10.2.3. Suspected Fraud by the Insured

If insurance brokers have reason to believe that the disclosure of material facts by the client or the notification of the facts of a claim by a client is not true, fair and complete, they should request the client to make the necessary true, fair and complete disclosure. In the absence of such disclosure, insurance brokers should consider whether they should decline to continue acting for the client.

10.3. Role of the Insurance Ombudsman Bureau in Fraud Cases

Many cases referred to the Financial Ombudsman Service (FOS) involved disputed claims and a small number will involve fraud. Those were fraud is suspected clearly need careful investigation and experienced legal advisers are employed to repudiate the claim, avoid the policy and defend any ensuing litigation as far as the insurer is concerned.

Where there is substantial ***non disclosure at the proposal stage*** the FOS may not uphold complaints against insurers.

10.3.1. Code of Practice

In support of the concern that policyholders might not be sufficiently protected from unfair treatment arising from the terms of insurance contracts, the insurance industry has agreed two codes of practice. These did not have the force of law, but the majority of insurers abide by them and have altered their proposal forms and declaration accordingly.

10.3.2. Insurance: Conduct of Business – Claims Handling

A. Non-Disclosure of a Material Fact

According to the doctrine of *uberrima fides* an insured person must disclose all material facts: ***which would influence the judgment of a prudent underwriter in fixing the premium or determining whether or not he will accept the risk offered to him.***

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An insurer will not unreasonably reject a claim or refuse to meet a claim made by a retail customer on the ground of:

- non-disclosure of a fact material to the risk that the retail customer could not reasonably be expected to have disclosed;
- misrepresentation of a fact to the risk, unless the misrepresentation is negligent;
- in the case of a general insurance contract, on the breach of a warranty or condition.

11. Approaches to Complaint Handling and Dispute Resolution

Sometimes it is not possible to settle a claim amicably. There are three basic dispute solutions:

- Discussion between the parties alone;
- Alternative Dispute Resolution (ADR);
- Litigation.

11.1. Overview of the Forms of ADR

- Mediation;
- Mediation-arbitration;
- Mini-trial or structured settlement procedure;
- Expert appraisal;
- Judicial appraisal;
- Expert determination.

11.1.1. How ADR Differs From Other Forms of Dispute Resolution

Litigation is not voluntary and, once a case started, neither party can withdraw without the consent of the other. If the parties are unable to negotiate settlement the court will

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impose a solution. By contrast, arbitration is voluntary, in the sense that the parties enter into the arbitration agreement of their own free will. However, when a dispute arises, one party can then forde the other to arbitrate against their will and the arbitrator can impose a solution which ultimately the winning party is free to enforce against the losing party.

11.1.2. Independent Third Parties

It is an essential feature of ADR that the third party is entirely independent. It is also important that they are not able to impose any solution upon the parties. This independence frequently leads to a greater degree of trust and openness being shown by the parties in dispute. The third party is not regarded as an obstacle to settlement, but rather as a figure to accommodate it.

11.2. Types of ADR

There are a number of different forms of ADR available:

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Table. 11.1. Comparison of litigation, arbitration and other forms of ADR

Characteristic	Litigation	Arbitration	Mediation
Procedure	The adjudication is based upon a reasoned decision itself based upon fact and law	Similar to litigation but the formal requirements of law needed not be followed	Seeks to facilitate a mutually acceptable commercial agreement – informal and without obvious structure
Degree of formality	Highly structured and formal forum with predefined rules and regula-	Less formal than litigation. Certain rules can be waived by agree-	Informal and without obvious structure
Voluntary/ involuntary	Involuntary	Voluntary at the point of entering the contract	Voluntary
Binding/ non-binding	Binding and subject to the appeal process	Binding but with limited grounds for review	Enforceable as a contract on agreement between the parties
Third party involvement	A judge is selected without intervention of the parties and rarely has expertise for the given are of the dispute	Arbitrators are chosen by the parties and often possess relevant specialised knowledge	Mediators are chosen by the parties and often possess relevant specialised knowledge
Private/public	Public	Private	Private
Cost	High	Moderate	Low
Delays	High	Moderate	Low
The party's involvement	Low	Low	High

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11.2.1. Mediation and Conciliation

The only real difference between the two is that the conciliator in a conciliation will be more pro-active than the mediator in a mediation. Rather than letting the parties find their own way to the settlement, the conciliator will suggest areas the parties should consider and even the terms they feel should be agreed.

In a mediation procedure there is provision that a third party selects a mediator who is provided with the written statements of both parties. They discuss the case in detail with each of the parties and tell them what their opinion is on a strictly without-prejudice basis. It is the intention that the discussion between the parties will identify the real issues of disagreement and, therefore narrow the dispute. The mediator will suggest constructive solutions.

11.2.2. Mediation-Arbitration

This form of ADR allows the parties to agree to submit their dispute to mediation and, in the event of not reaching an agreement, to refer the matter to arbitration. The person who acts as a mediator may, therefore, go on to become the arbitrator if the matter is not settled and costs are saved where the inevitable duplication is avoided.

11.2.3. Mini-Trial or Structured Settlement Procedure

Here the parties appoint a neutral person to sit as a chairman of a tribunal coposed of the chairman and a senior representative of each of the parties. It is important that the representatives are not people immediately connected with the dispute but that they also have authority to reach a compromise as and when they see fit.

11.2.4. Expert Appraisal

Parties can refer their dispute to an expert in that particular field for them to give an opinion. While this opinion will not subsequently be binding upon the parties, the expert can none the less influence their approach to subsequent negotiations.

11.2.5. Judicial Appraisal

The Center for Dispute Resolution has a scheme whereby judges and senior counsel are available to give a preliminary and speedy view on the legal position as between the

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parties. The parties can then subsequently decide whether or not the opinion will be binding.

11.2.6. Expert Determination

This is considered by many to be something of a halfway house between arbitration and ADR because, as in arbitration, the parties select experts to decide the case for them. They agree to accept the decision which is made with the ultimate saction of breach of contract.

11.2.7. Advantages of ADR

- It saves litigants the ever-mounting cost of bringing their actions to trial;
- It saves them from the delay of litigation in reaching finality in their dispute;
- It enables them to achieve settlement of their disputes while preserving their existing commercial relationships;
- It provides them with a wider range of settlement solutions;
- It makes a substantial contribution to the more efficient use of judicial resources.

A. Speed and Cost Effectiveness

ADR is significantly cheaper than both arbitration and litigation, because of its enhanced speed. The parties do have to pay for their third party's services but this will normally be significantly less than the cost for the time that the individual's lawyers would spend in preparing and presenting a case (less document preparation).

B. Flexibility

The parties can choose one of several forms of ADR available to them and they do not have to comply with any statutes or rules of court.

C. Preserving Business Relationships

ADR, like arbitration, has the benefit of being heard in private. It is therefore, particularly useful, where the parties wish to continue with their business relationship after the dispute has been resolved.

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D. Commercial Reality

The mediator, who is wholly unconnected with the dispute, is able to support settlement terms which the parties would perhaps be too subjective to envisage for themselves.

In sum, the advantages of ADR over litigation:

- greater flexibility;
- cost savings;
- great confidentiality;
- more control retained by the parties;
- stronger commercial focus to negotiation;
- enhanced independence of the mediator;
- greater speed of resolution.

11.2.8. Disadvantages of ADR

A. Non-Binding Nature

The parties are not bound by the procedures. It is a general principle of ADR that no one can be forced to resolve a dispute by any form of ADR which is against their wishes, and most ADR agreements allow either party to withdraw at any stage in the procedings.

B. Non-Enforceability

Awards are not enforceable. ADR procedures do not provide an equivalent to the Arbitration Act 1996 and therefore ADR awards cannot be enforced by the court. However, if the parties do agree to terms suggested as a result of ADR and have entered into a contract on this bgasis, there is always the possible option of suing for breach of contract.

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C. Incomplete Disclosure

Facts may not be fully disclosed. There is no equivalent procedure to that of discovery in ADR and it is therefore pissble that a dispute will be resolved without all of the facts ever becoming known. The obvious conclusion is that the wrong decision may be made.

D. Non-Universal Application

ADR is not always appropriate; it requires that both parties are willin to resolve the problem. ADR is not appropriate where the client needs an injunction to protect their interests or where there is no real dispute.

E. Choosing ADR

Not all disputes are appropriate for ADR. Legal precedents are required in some cases to clarify certain ambiguities and court is the only forum which can properly achieve this aim, since decisions made in ADR are binding only on the parties in dispute.

11.3. Arbitration

The object of arbitration is obtain the fair resolution of disputes by an impartial tribunal without necessary delay or expense.

and

The parties should be free to agree how their disputes are resolved, subject only to such safeguards that are necessary in the public interest

and

The court should not intervene except as provided by the Act.

11.3.1. Arbitration as an Alternative to litigation

Insurers frequently choose to refer their disputes to arbitration rather than to litigate as this enables them to have their disputes resolved in private by a person or group of people who have been chosen for their experience in that particular class of business. Arbitration avoids a public hearing in an open court by a judge who may have no particular expertise about the insurance/ reinsurance matter in dispute. Arbitration also

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enables the parties to decide the procedure the arbitrator will be following adn what their powers will be.

An arbitrator has similar powers to a court of law, except that arbitrators do not have the power to make orders such as injunctions ro to carry out sanctions such as imprisonment.

11.3.2. The Arbitration Agreement

Many modern insurance contracts contain a clause in the policy requiring subsequent disputes between the parties to be referred to arbitration in preference to issuing of litigation proceedings.

11.3.3. Incorporating the Arbitration Act 1996

This Act only applies to arbitration agreements which are made in writing. Wherever there is an arbitration agreement, certain provisions of the Act are compulsory and will therefore apply irrespective of any attempt by the parties to exclude them.

11.3.4. Commencement of Arbitration

It is common for the claimant to send a written request to arbitrate to the respondent setting out the following points:

- The name and addresses of the parties;
- A brief statement of the nature of the circumstances of the dispute and the relief that is being sought;
- Who the claimant thinks the arbitrator should be and/or how they should be appointed.

A. Appointing an Arbitrator

It is more usual for the agreement to state the way in which an arbitrator may be appointed at a future date, "the parties are free to agree on the number of arbitrators to form the tribunal".

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B. Sole Arbitrators

"If there is no agreement as to the number of arbitrators the tribunal shall consist of a sole arbitrator".

C. Three Arbitrators

Alternatively, an arbitrator agreement may specify three arbitrators where the parties are free to agree on the procedures again for appointing them.

D. Two Arbitrators

It is also possible for a tribunal to consist of just two arbitrators, although this creates the obvious risk that they will not be able to agree.

11.3.5. The Arbitrators' Duties on Being Appointed

The arbitrator is appointed and the claimant sends them a copy of the arbitrator agreement so that they can decide whether the agreement gives them power to act and that they have been validly appointed.

The Chartered Institute of Arbitrators has drawn up guidelines for good practice to this effect, requiring the following to be revealed:

- Past or present relationships with either of the parties or any important witness;
- Substantial social relationships with any of these people;
- Any poor knowledge of this dispute;
- Commitments which may affect the arbitrator's availability to arbitrate.

11.3.6. The Arbitration Process

A. The arbitrator's Duties

The tribunal shall:

- act fairly and impartially as between the parties, giving each party a reasonable opportunity of putting his case and dealing with that of his opponent; and

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- adapt procedures suitable to the circumstances of the particular case, avoiding unnecessary delay or expense, so as to provide a fair means for the resolution of the matters.

B. The Parties' Duties

The parties must comply with certain criteria "The parties shall do all things necessary for the proper and expeditious conduct of the arbitrational proceedings". This includes:

- complying without delay with any determination of the Tribunal as to procedural or evidential matters, or with any order or directions of the Tribunal and

- taking without delay any necessary steps to obtain a decision of the court on the preliminary question of jurisdictional law.

C. Sealed Offers

On certain occasions during the arbitration process, the respondent will want to settle and may wish to put pressure on the claimant to do so. They may also send a sealed letter to the arbitrator which contains details of the offer they are putting forward. A calderbank letter is an alternative means of pressing a plaintiff to settle a claim. It requires the defendant to make a written offer to the plaintiff which is expressed to be "without prejudice save to costs".

D. Hearing

It is open to the parties to agree what powers the arbitrator is to have but in the absence of any agreement to the contrary, an arbitrator can make a declaration, order payments of money, and have the same powers as the court to order the parties to do something or to stop doing something, to order specific performance of a contract.

E. The Arbitration Award

The parties are free to agree on the form and content any arbitration award should take but in the absence of such agreement the award should be in written form and signed by the arbitrator who must give reasons for their decision.

Costs—The arbitrator can order on party to pay the costs of the arbitration unless agreed to the contrary.

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Challenging the award—The following means of remedy are available, albeit the parties must first have exhausted their remedies in the arbitration agreement itself:

- A challenge may be made under the Act where a decision is challenged on the basis that there is a lack of jurisdiction;
- Where the challenge is to an issue of facts, there is no right of appeal to the courts. This means that the arbitrator's decision is final on all questions of fact but is is possible to challenge the award on the basis of serious irregularity:
    - ⇒ failure to comply with the general duties imposed upon the Arbitrator;
    - ⇒ exceeding the arbitrator's power;
    - ⇒ failure to deal with all the relevant issues;
    - ⇒ uncertainty or ambiguity as to the effect of the award;
    - ⇒ obtaining an award by fraud;
    - ⇒ the award obtained is contrary to public policy;
    - ⇒ the award fails to comply with formalities required by the Act;
    - ⇒ an admitted irregularity has occurred in the conduct of the proceedings.

Issues of law—Any party may also appeal to the court on a question of law arising out of the award unless agreed otherwise. Appeal can only be made if the court grants leave and this will only be done if a decision will substantially affect the rights of one or more of the parties. An appeal from a decision of the Court of Appeal is also possible.

11.3.7. Enforcing the Award

Arbitration is the only alternative to litigation that produces a result which can be enforced without commencing litigation proceedings. This enables the winning party to apply to the High Court for leave to enforce an award as if it were a court judgment.

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A. Time Limits

The Limitation Acts will apply to arbitration in the same way as they do to other disputes.

B. Trends in Awards

The tendency of arbitration panels to make compromise awards which do not stand up to legal scrutiny.

C. Financial Ombudsman Service (FOS)

The FOS will only become involved once all normal negotiations have been exhausted. The FOS provides a free, independent service, which is flexible and informal. It is impartial and decides on each complaint on its own merits.

11.4. Procedure for Referring a Dispute

If policyholders wish to refer a dispute to the Ombudsman, they must first confirm that all normal negotiations have been exhausted. This means that the claimant must have referred their complaint to the very highest levels of management and still be dissatisfied with the response. Also any legal proceedings must have been withdrawn, as the FOS will not become embroiled in legal proceedings.

Limitation: the matter must be referred to the Ombudsman within the earliest of:

- 6 months of the date on the firm's letter advising the claimant of its final decision;
- 6 years after the event complained about; or
- 3 years after the complainant knew, or should have known that they had cause for complaint.

11.4.1. Procedures at Lloyd's

The complaints department of Lloyd's Market Supervision deals with the resolution of complaints against or concerning Lloyd's underwriting agents and Lloyd's brokers. Specific areas of the department's responsibility include the resolution of complaints from policyholders or others action on their behalf from around the world.

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11.4.2. Obligations on Insurers

There are certain obligations on those insurers who are participants in the scheme. These are as follows:

- In the event of a dispute they must advise the insured of the FOS service;
- Insurers must abide by the Ombudsman's decision up to an award of £100,000;
- They must provide the Ombudsman with full particulars of the policy. FOS must be in possession of the full fact.

11.4.3. Options and Obligations of the Ombudsman

The Ombudsman:

- may seek professional assistance and advice;
- must make decisions based on what is fair and reasonable, taking into account the law, the FSA rules and good insurance practices;
- may reject any complaint;
- must publish an annual report.

11.4.4. Terms of Reference

- the complaint must first have been considered by the senior management of the member insurer;
- the complainant must not have instituted proceedings in any court of law;
- the complaint must not have been considered previously;
- the Ombudsman must have received the complaint within six months of the member company making its decision known to the complainant.

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12. Role of Litigation in the Claims Process

12.1. Why litigate?

Litigation is the word used to describe the use of Civil Justice system (i.e. the courts) by parties to a dispute to hear, and adjudicate upon their difference of opinion.

12.1.1. The Advantages and Disadvantages of Litigation

The advantages of litigation include:

- it gives the parties access to the knowledge and experience of the judiciary;
- The court's judgment is enforceable against the losing party;
- Costs follow the event. The winning party will be awarded their legal costs;
- Litigation is an involuntary process. It can be used to force a party to a dispute to deal with a claim, which can be ignored;
- The rules of court provide a mechanism for curtailing disputes in respect of which there is no reasonable defence;
- The courts have the power to award interest on damages.

The disadvantages to litigation:

- the procedural requirements and the work required to interview witness;
- litigation tends to be very slow;
- litigation is a public forum (it may cause some embarrassment);
- the court can only resolve disputes by reference to the laws (statutes and precedents);
- the remedies which the courts can order tend to be limited to damages and/or commercial declarations (no commercial compromises);

12.1.2. Why Instruct a Lawyer?

The areas of expertise a lawyer can bring to the process include:

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- an objective assessment of the merits of the claim or defence and an assessment of what evidence needs to be collated;

- an objective assessment of the amount in dispute and what damage;

- the collation, management and preservation of documentation and other evidence;

- the instruction of appropriate experts in order to provide advice on technical aspects to the claim or defence;

- the development of a claim strategy and tactics for the future conduct of the claim;

- advice on which is the most appropriate dispute resolution process for the particular claim;

- ensuring witnesses attend to give oral evidence;

- advice on policy issues such as notification, material non-disclosure and aggregation;

- advice on specific defences such as limitation; and

- providing guidance on practice, procedure and the presentation of the claim or the defence.

12.1.3. Litigation Team

The litigation team comprises of the claims manager, a firm of solicitors, a barrister and one or more expert.

It is the responsibility of the claims handlers to manage the litigation process. The relationship between the solicitor and the claims handler will be regulated by an agreed service protocol:

- a clear description of the solicitor's role;

- the establishment of effective lines of communication between the claims handler and the solicitor;

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- the creation of a regular reporting format to include advice on the factual background, liability, quantum, the liability of the insurer, the insured, tactics and recommendations;

- a agreed philosophy for determining a reserve of costs and claim payment;

Barristers are the advocates in the team. They are responsible for the presentation of the claim in the court-room.

In the most complex cases Leading Counsel may be instructed. These are the elite of the barristers' profession who have extensive legal experience. They are known as Queen's Counsel (QCs).

12.2. Woolf Reforms

The Civil Justice system in England and Wales has been subject to a major overhaul which came into effect on 26 April 1999.

12.2.1. Why Change the Old System?

- Litigation should be avoided wherever possible; if necessary it should be less adversarial and increased cooperation;

- Litigation should be simpler, faster and more certain;

- Litigation should be more affordable;

- The courts and the entire legal process should be more user friendly.

12.2.2. Key Features of the Regime

- the parties are on equal footing;

- expense is saved;

- the case is dealt with in a way which is 'proportionate':

- the claim is dealt with expeditiously and fairly;

- the claim receives its fair share of the court's resource.

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The court is given wide ranging power of active case management:

- encouraging cooperation between the parties;
- identifying the issues at an early stage and deciding which need full investigation and which can be disposed of quickly;
- encouraging the use of ADR;
- fixing timetables and controlling the progress of the case to ensure claims proceeds quickly.

12.3. Civil Practice Procedure

12.3.1. Pre-Action

For personal injury and clinical negligence cases, there is a formal pre-action protocol which sets out the way in which the parties must behave and information exchange before the formal proceedings are commenced to avoid the necessity for the start of the proceedings.

A letter of claim issued by the claimant's solicitors initiate the process. The protocols set out a strict timetable for investigation and disclosure of information. Failure to comply with a pre-action protocol may be penalised heavily.

Full investigation must be carried out prior to the issue of proceedings. Witnesses must be identified and the content of their evidence established.

12.3.2. Commencing Proceeding

Parties to the dispute must summarize the nature of their claim or defense in the "Statement of Case" (Pleadings). Proceedings are commenced by issuing a claim form, which include a concise statement of the nature of claim and remedy sought. The Particulars of claim include:

- Where the claim is based on breach of contract, the precise terms of that contract. Where – negligence, the relationship which gave rise to the duty of care;
- A clear and chronological factual summary;

- Details of the alleged wrongdoing;
- The consequences of that wrongdoing and the amount of loss;
- All of the facts and matters upon which the claimant relies;
- A Statement of Truth (an honest belief that the facts set out in the document are true.

Upon receipt of the claim form the defendant has 14 days in which to file an acknowledgement of service confirming that they have received the paperwork and that they intend to defend all or part of the action. The defendant must serve their defence within 28 days of service of the claim form.

12.3.3. Allocation

After the claimant and the defendant have filed their Statement of Case the court will ask the parties to the dispute to fill an ***allocation questionnaire***. The purpose is to decide which 'track' the claim should be handled under.

- **Small claims track** – for claims of not more than £5,000 or £1,000 for personal injury:
    - ⇒ no oral or written expert evidence without permission of the court;
    - ⇒ an informal hearing;
    - ⇒ only fixed costs will be allowed;
    - ⇒ fixed amounts are payable for witness expenses and expert's fees;
    - ⇒ there is a limited right of appeal.
- **Fast track** – for claims of not more than £15,000:
    - ⇒ a trial date to be fixed for a date not more than 30 weeks ahead;
    - ⇒ the exchange of documentary evidence may be limited;
    - ⇒ a single expert will be appointed if needed.

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- **Multi track** – for claims of more than £15,000

12.3.4. Disclosure

This is the process of revealing documents to the other side. A party must disclose documents which could adversely affect their own case or support another party's case and document to rely.

12.3.5. Expert Evidence

No party may call an expert or use an expert's report without the court's permission. Meetings between experts to narrow the issues in dispute are encouraged.

12.3.6. Third Party Proceedings

If a defendant believes that another party is responsible for the claimant's loss, they may issue third party proceedings against that party in order to ensure that, in the event that they are found liable to the claimant, they can ask the court to order that the third party ought to bear all or at least some of the loss.

12.4. Key Themes of the Civil Procedure Rules

12.4.1. Cooperation

The regime discourages a belligerent approach to dispute resolution. The courts expect parties to co-operate.

12.4.2. Alternative Dispute Resolution and Settlement

As part of cooperation, the court expects parties to use Alternative Dispute Resolution (ADR) to try to resolve their disputes. Although ADR is not compulsory, the judge responsible for making decisions may decide that it should not be permitted to go any further.

ADR is a means of resolving disputes by using an independent third party as a mediator. They may suggest a solution but cannot impose a solution. ADR is voluntary; the parties choose the process and either of them can withdraw at any time. There are various types of ADR such as mediation, expert appraisal or expert determination.

The advantages of an ADR are that it can be quicker and cheaper than litigation; it is very flexible; and it is less destructive that court proceedings on the relationship between parties.

The disadvantages: either party may withdraw at any stage; the awards are not enforceable in the same way as a court judgment; there is a risk that the parties may resolve the dispute without showing all facts; it is not appropriate in certain cases, when the client needs a ruling.

12.4.3. Front loading

Much of the work need to be done before proceedings are commenced to adhere to the strict timetable. Defendant should identify problems which may lead to court proceedings.

A. Judge in charge

The Rules transfer considerable power from the parties to the judge in deciding how a case should be handled: what evidence should be given; how long the trial will last.

B. Strict timetables

As soon as court proceedings are commenced the case become subject to a court imposed timetable which requires procedural steps to be completed within strict time period.

C. Costs

At the heart of the Woolf Reforms is a desire to make litigation cheaper. Costs are also used to control litigants. A part who fails to co-operate, or meet a court deadline may be required to pay a costs penalty.

D. Interpretation

The Woolf reforms are a flexible tool and it remains to be seen precisely how the court will interpret and apply the CPR.

12.4.4. Structured Settlements

A structured settlement is a different way of paying damages, i.e. damages awarded in a court case. Instead of making a lump sum payment to the claimant, the defendant invests a sum of money which is designed to make a series of payments to the claimant over a period of time.

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Structured settlement tends to be used in serious personal injury or death claims. The traditional lump sum is replaced with payment of an annuity so that a settlement involving two distinct elements emerges, namely a capital portion and a stream of future payments.

The key elements are:

- claimant receives a reduced lump sum payment;
- in addition the claimant receives sums of money payable by regular instalments; and
- the instalments are guaranteed for life.

A. Advantages of Structured Settlements

- **Tax benefits –** tax can be avoided in the case of structured settlements. The result is that insurers are able to buy annuities for less than they would otherwise have to pay the plaintiff;
- **Security against market fluctuations –** structured settlements neutralise the vagaries of a fluctuating economy. Annuity payments can be inflation proofed;
- **Security against life expectancy risks –** Annuity payments last for the whole of the plaintiff's lifetime.
- **Security against dissipation –** under structured settlement the capital element is 'locked away' and the fund, therefore, cannot be squandered.
- **Increase benefits where life is impaired –** where the plaintiff's life expectancy has been impaired, a higher level of income can be secured from an annuity.
- **Removing the burden of administration**

B. Disadvantages of Structured Settlements

- **Requirements to prepare a complex advance budget for life** – experts and advisers to prepare a complex advance budget for life;
- **Inflexibility** – once determined, structured settlements cannot be changed;

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- **Risk dissipation does not disappear** – structured settlements do not completely remove the risk that the moneys will be not adequate to meet the claimant's need;

- **The cost of care may move ahead of RPI** – it cannot guarantee that costs of future care will always be met;

- **A structure settlement may not be desired by the claimant** – a severely injured claimant may wish to take a large lump sum in order to move to another country.

12.4.5. Negotiation of Third Party Claims

Third party claims are very important part of the work of a claims department. Cover under a motor policy will include personal injury to third parties arising out of the use of a motor vehicle and third party property damage claims.

The following are points which need to be considered when dealing with claims advanced directly by third parties.

- **Policy** – The third party will be bound by the terms of the original policy wording and limits, such as a deductible or excess. Insurer might deny liability to the insured in compliance with provisions, such as condition precedent to liability;

- **Position of the insured** – the insured should be fully advised of the claim being advanced by the third party, so that they can be involved as much as possible in defending the claim. The insured should cooperate and provide witness statement evidence;

- **Decision to pay** – When an insurer decides to pay a claim advanced by an insurer, the insurer may be influenced by the need to maintain a good relationship with the insured. The insurer may look more closely at the claim being advanced. The claim is more likely to be presented by the third party's lawyers. In this case, the insurer will seek to instruct legal expert assistance.

13. International Aspects of Claims Handling

13.1. Insurance Contract and International Interpretation

The insurance contract dictates the rights of the parties to the contract and their respective obligations. The terms and conditions of the contract describe the subject

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matter that is insured, the limits of cover, the premium payable, the claims procedure, the date of termination of contract as well as the law under which policies are to be interpreted and dispute resolutions to be arbitrated.

Crucial differences in interpretation and different national laws may impact heavily upon the expectation which a policyholder may reasonably have towards the sum they will recover in the event of claim. Another example is found where national rules determine which courts have jurisdiction in the event of a dispute.

13.1.1. Implied Terms

Contracts do not necessarily set out all the rights and duties of the parties since further ones may be implied as a matter of general laws. In English law an insurance contract is subject to the doctrine of *uberrima fides* or 'utmost good faith'. This doctrine obliges the policyholder to disclose to the insurer all material facts relevant to the assessment of a risk anD failure to disclose these facts may entitle the insurer to avoid a policy so that the policyholder's claim will not be paid. In other legal systems this right of avoidance does not exist.

13.1.2. Difficulties of Litigating Foreign Claims

There will be cases where it is not possible to avoid litigation in a foreign country. The following are the most obvious ones:

- **Limitation period** – foreign limitation periods may be much shorter than the English equivalents;
- **Causes of action** – some countries may not recognise a cause of action which is part of English law;
- **Remedies** – remedies may differ. Some countries exercise much tighter control over the defendant's property pending trial than we do and give creditors greater rights to an early judgment;
- **Time** – the time it takes for an action to come to trial can vary widely from state to state;
- **Costs** – in most countries, costs follow the event but this is not always the case;

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- **Judicial expertise** – in some countries the judges will have considerable commercial expertise, being local businessmen themselves.

13.1.3. Insurance Contract Law and Relevant European directives

In 1979the Eupopean Commission attempted to introduce the Directive on Insurance Contract Law with a view to co-ordinating the laws, regulations and administrative provisions relating to insurance contracts throughout Europe. Members States were too entrenched in their own views and were reluctant to alter their long standing national laws. Unable to introduce the proposal in its original form, the Commision adopted a more piecemeal approach by introducing rules relatin to contracts in later insurance directives.

A. Insurance Contract Law

Rules on the law applicable to contracts of insurance were introduced by the Second Life and Second Non-Life Directives.

These rules entitle member states to subject insurance contracts to the law of their state. Policyholders, as a result, contract under their own legal system even when the insurer is located in another EU members state.

B. Jurisdiction and the Enforcement of Judgments

Insurance transactions typically involve parties from more than one country, a policyholder in Madrid may hold the insurance contract with an insurer in Scotland for a risk which is situated in Rome where the policy cover provides for the dispute to be brought before the English Courts. In the event of a dispute, and before litigation proceedins can begin in relation to such an international transaction, it is first necessary to consider the principles of international law.

It is possible for an English court to decide cases concerning contracts governed by French law. In such circumstances, a judge in England would listen to French lawyers giving evidence as experts as to the meaning and interpretation of French law.

plies some form of uncertainty about an outcome, which is not favorable; risk implies both doubt about the future and the outcome leaves us in a worse position. Chance also implies some doubt about the outcome, which is favorable: chance of passing an examination.

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