Insurance Intermediaries Qualifying Examination

General Insurance Examination

Study Notes

2022 Edition

Corrigendum

This Corrigendum is to supplement the Study Notes for the General Insurance Examination (2022 Edition) **with effect from 13 November 2023**.

The following paragraph of **2.2.5(a)**:

"Funding for payments made by the MIB comes from a premium levy, imposed by insurers on all motor policies they issue. Set at a rate of 1% of motor premiums, the levy does not belong to the insurers, and must be passed to the MIB."

is repealed and replaced with

"Funding for payments made by the MIB comes from a premium levy, imposed by insurers on all motor policies they issue. Set at a rate of 3% of motor premiums, the levy does not belong to the insurers, and must be passed to the MIB.".

PREFACE

These Study Notes have been prepared to correspond with the various Chapters in the Syllabus for the General Insurance Examination. The Examination will be based upon these Notes. A few representative examination questions are included at the end of each Chapter to provide you with further guidance.

Immediately following the descriptions of some aspects of the practice of general insurance, you will find actual cases of general insurance claims, which are there mainly to facilitate your understanding of the subject and to make your learning more interesting. The decisions you will find in those cases were based on their particular facts, including the actual wording used in the insurance policies in question. Some of these cases are decided cases of the then Insurance Claims Complaints Bureau (ICCB) which is now The Insurance Complaints Bureau ("ICB"), and the rest concern claims disputes that were ultimately settled between the claimants and the insurers concerned without being referred to the then ICCB for adjudication. It is worth noting that the Insurance Claims Complaints Panel (Complaints Panel) of the ICB is empowered by its Articles of Association to look beyond the strict interpretation of policy terms in making a ruling.

Please also note that these Study Notes will not make you a fully qualified practitioners or insurance specialist. It is intended to give a preliminary introduction to the subject of General Insurance, as a ***Quality Assurance*** *exercise for Insurance Intermediaries.*

We hope that the Study Notes can serve as reliable reference materials for candidates preparing for the Examination. While every care has been taken in the preparation of the Study Notes, errors or omissions may still be inevitable. You may therefore wish to make reference to the relevant legislation or seek professional advice if necessary. As further editions will be published from time to time to update and improve the contents of these Study Notes, we would appreciate your feedback, which will be taken into consideration when we prepare the next edition of the Study Notes.

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NOTE

If you are taking this Subject in the Insurance Intermediaries Qualifying Examination, you may also be required to take the Subject ***"Principles and Practice of Insurance"****. Whilst the examination regulations do not require you to take that Subject first, it obviously makes sense to do so. That Subject lays a foundation for further studies and many of the terms and concepts found in that Subject will be assumed knowledge with this Subject.*

For your study purposes, it is important to be aware of the relative "weights" of the various Chapters in relation to the Examination. All Chapters should be studied carefully, but the following table indicates areas of particular importance:

Chapter	Relative Weight
1	46%
2	34%
3	10%
4	10%
Total	**100%**

1 INSURANCE PRODUCTS

In this Chapter, we shall look at the major classes of business in General Insurance. Whilst it will not be necessary for you to have a very detailed understanding of each and every class of business in a wide range of subjects, it is good for the professional insurance intermediary to have a working knowledge of the various products.

It must be noted that insurers generally differ from each other in various degrees in the policy wording and terms adopted for the same type of insurance. From a practical point of view, we shall present in these notes what may be considered a representative summary of the particular types of business. Insurance intermediaries should check specifically with the insurers regarding exact policy wording and cover.

Important as the above point is from a professional viewpoint, it may be appropriate to mention again that the Insurance Intermediaries Qualifying Examination will be conducted on the basis that the Study Notes will contain everything sufficient for a successful examination result.

Before we look at individual classes, from the Core Subject of the said Examination, "**Principles and Practice of Insurance**", we have the following three reminders, which concern topics that will be referred to later in these Study Notes:

(a) **Classification of Insurance**

One method of classifying insurance, sometimes called the *functional method*, is to look at insurances according to their subject matter. There are four categories under this classification and General Insurance is so wide in scope that it can provide cover of all four types. The categories are:

(i) *Insurance of the Person*: Here, the term "person" means the body of a human being, not "an individual as opposed to an organisation". So an "insurance of the person" is one whose subject matter is a human being's life, limbs or health, or medical expenses. In General Insurance, this category includes **Personal Accident** insurance.

(ii) *Insurance of Property*: where the subject matter of insurance consists of physical things, such as **buildings**, **ships**, **motor vehicles,** etc.

(iii) *Insurance of Pecuniary Interests*: it covers financial interests in connection with potential loss of wealth or future income, including such classes as **Fidelity Guarantee** and **Business Interruption** (or "**Consequential Loss**"**)**.

(iv) *Insurance of Liability*: it covers liability at law for the death, bodily injury or disease of **third parties,** or for loss of or damage to their property.

(b) **Types of Cover with Property Insurances**

Many types of General Insurance cover loss of or damage to property belonging to or in the custody of the insured. Such **property insurances** cover either:

(i) *Specified Perils* (or *"Named Perils"*): meaning that to be recoverable a loss or damage must have been proximately caused by a peril (i.e. cause of loss) specifically mentioned (specified) in the policy, e.g. lightning under a fire policy. It will be for the claimant to prove that a loss has been caused by a specified peril.

Or

(ii) *"All Risks"*: this form of cover means that loss or damage arising from any conceivable risk is covered by the policy **unless** an **exclusion** applies. The **claimant** merely has to show that an accidental loss has occurred, without the need to pinpoint its exact cause – e.g. where a consignee insured under a cargo "all risks" policy has suffered short delivery of the insured cargo, it will be sufficient for him to submit to the insurer a document issued by the carrier or another third party which certifies the loss without suggesting its cause. It will then be for the **insurer** to prove that the loss is **not** covered if policy liability is to be denied.

Note: Technically the description of "all risks" is not totally correct, since there must be some **excluded** risks (that is why this term is sometimes expressed in inverted commas).

(c) **Fundamental Risks**

Put simply, a fundamental risk is basically one whose causes are outside the control of any one individual or even a group of individuals, and whose outcome affects large numbers of people, so that they frequently form standard policy exclusions. Below are examples in general insurance:

(i) *war and associated risks* (but waterborne war risks in marine insurance and airborne war risks in aviation insurance are insurable);

(ii) *nuclear risks*; and

(iii) *terrorism*.

It is important to understand and remember points (a) - (c) above. The substance of them is very likely to arise repeatedly, without further explanation, in the Notes ahead.

1.1 MOTOR INSURANCE

The significance of motor insurance (or "car insurance") is chiefly attributed to the fact that in Hong Kong use of motor vehicles on roads is subject to a statutory requirement for motor liability insurance. There are some exceptions to this compulsory (or "mandatory") motor insurance requirement, for example, when a Government-owned car is being used by an authorised person, or when a car owned by a person who has made a deposit with the Director of Accounting Services to the value of HK$2,000,000 is being driven by the owner or an employee of the owner.

We shall be looking at the three major classes of motor insurance: *Private Vehicle (Private Car)*; *Motor Cycle* and *Commercial Vehicle*. First of all, let us consider some of their common features below:

(a) **Basic intentions and scope of cover**

All three major types of motor insurance cover **Third Party** liability (including such liability as is statutorily required to be covered), and all of them include liability to pay third party claimants' costs and expenses, and costs and expenses incurred with the insurer's written consent. In addition to the third party cover, **property** insurance on the insured's vehicle is also available under the same policy. The three most well known types of motor cover are:

(i) *Third Party Only cover*: this covers any insured driver (or any passenger) for his **liability at law** to **third parties** for their death, injury or property damage that arises out of an accident caused by or in connection with the insured car including the loading or unloading of "goods" (which term may include domestic articles being removed to a new home) onto or from the vehicle.

It is sometimes asked, 'Who is a third party?' Although the term 'third party' is often used in a liability policy, it is often left undefined in the policy, in which case it is likely to be construed to mean any person other than the insurer and the person who is seeking indemnity under the policy. For illustration purposes, imagine a case in which the policyholder is injured in an accident which occurs whilst he is a passenger in the insured car and it is his wife who is driving the car. What follows could be a successful lawsuit filed by the policyholder against his wife for damages for his injuries. If the wife is an insured driver under the policy, she will be entitled to seek indemnity in her name from the insurer, notwithstanding her husband's status as the policyholder.

(ii) *Third Party, Fire & Theft cover*: this comprises the cover described in (i) above, and **property** insurance of the insured vehicle covering its loss or damage resulting from the risk of **Fire** or **Theft**.

Note: Among themselves, insurance practitioners often use the term "own damage" to refer to loss of or damage to the insured's property, particularly in connection with a policy that covers both property damage and third party liability.

(iii) *Comprehensive cover*: being the widest form of motor cover available, this includes all that (i) and (ii) above cover, with "**all risks**" insurance on the insured vehicle. Obviously, the premium for comprehensive cover is the highest.

(b) **"Act" insurance**

There is another possible form of cover, known as **Act** (or "**Act Only**") cover. The name derives from the original U.K. *Road Traffic Act 1930*, which laid down the requirements for compulsory motor insurance at that time. These requirements are closely followed in Hong Kong's *Motor Vehicles Insurance (Third Party Risks) Ordinance* (Cap. 272).

According to the said Ordinance, liability in respect of the *death of or bodily injury* to any person caused by or arising out of the use of a motor vehicle on a road (inclusive of private roads, other than private roads in areas wholly or mainly used for the carrying on of construction work or industry) must be insured against, except for employers' liability and contractual liability (see **1.1**(d)(iii)(4)). Such liability is referred to as "Act Liability" and policies which only cover Act Liability are known as "Act Policies" – not "Ordinance Liability" and "Ordinance Policies".

Three important things should be noted with "**Act**" insurance (referred to as "Third Party" insurance in the Ordinance):

(i) The **minimum** amount of cover required in respect of Third Party **Death and Injury** liability is **HK$100 million** any one event (in practice, this is the **normal** limit of indemnity (or "limit of liability") offered by motor policies in Hong Kong). Liability for **Property Damage** to third parties is **not** required by law.

(ii) The term "Third Party" has a double meaning. The Ordinance, when referring to "Third Party" risks, means potential liability for **death or injury** only. On the other hand, a motor insurance policy described as "Third Party", covers liability for **Property Damage** to third parties, in addition to liability for death or injury.

(iii) The Act Only cover is now rarely found in the market.

(c) **No Claim Discount**

A significant and almost unique feature of motor insurance is the practice of granting a progressive discount, called the "No Claim Discount" (NCD) or "Claim Free Discount", on the renewal annual premium if the preceding policy year has been claim-free. Its purpose is to encourage safe driving. Different insurers may adopt different scales of NCD. A typical scale of NCD for private cars is such that one claim-free year earns a 20% NCD, the second year 30% and so on, rising to a maximum of 60% after five consecutive claim-free years. With other classes of vehicles, the scale of discount is very likely to start from 10%, rising to a maximum of 30% after three consecutive claim-free years. Some features to note about the no claim discount system are:

(i) Originally, the system was known as a No Claim Bonus (NCB). Technically, this is an incorrect title, since a bonus implies the receipt of extra money. "No claim discount", implying a reduction in next year's premium, is more accurate.

(ii) With private cars, the NCD system operates on what is called a "*step-back system*". This means that a single claim will not necessarily destroy an entitlement to next year's discount. For instance, with a four years' entitlement (i.e. 50% NCD) for a policy year, a single claim during the year will reduce the discount on renewal to 20%. Such an (50%) entitlement coupled with two or more claims in the current year, or a lesser entitlement (i.e. 20%, 30% or 40%) coupled with a single claim in the year, will mean that there will not be a discount at renewal, so that one will have to be built up again from the ground as if the insured was a first time purchaser.

(iii) With other types of vehicles, a single claim will mean that there will not be any NCD in the forthcoming year and a fresh claim-free year will be needed to earn the minimum discount again.

(iv) As the NCD is not a "no-blame" discount, the step-back system will apply as usual where a claim has happened not because of the fault of the insured.

(v) It is a universal practice for motor insurers to accept a transfer of NCD from another insurer, which means that when a policyholder arranges to switch to another insurer for the coming year's insurance, that other insurer will recognise the NCD earned under the policyholder's previous policies.

(d) **Common exclusions/exceptions**

Some important limitations on the cover, common with the policies for all classes of vehicles, are such that cover of whatever description will not be available in any of the following circumstances:

(i) Accidents occurring outside the specified *Geographical Area* of cover (normally "the territories of Hong Kong").

(ii) Insured vehicle being used otherwise than in accordance with the specified *Limitations As To The Use Of The Vehicle*. The purpose of use is such an important feature in determining the premium that if a policy restricts the use of the insured car to use for social, domestic and pleasure purposes, but it is being used as a taxi when an accident occurs, that accident will not be covered.

(iii) Certain *fundamental or high risks* (except insofar as is necessary to meet the compulsory insurance requirements):

(1) *War* and the like.

(2) *Act of terrorism*.

(3) *Nuclear weapon materials* and *radioactive risks*.

(4) *Contractual liability*: a term commonly used in liability insurance to refer to such liability of the person claiming to be indemnified under the policy which he has assumed under an agreement, and which would not otherwise have arisen. (Illustration: suppose a person in persuading his girlfriend to take a ride on his new sports car offers to indemnify her for any personal injury she may sustain during the ride *irrespective of legal liability*. Further suppose that an accident does occur during the ride, injuring the girl, wholly as a result of the fault of a third party. In such circumstances, the boyfriend would only be able to escape liability to the girlfriend for the injury had he not made the said indemnity agreement. Such liability is an example of "contractual liability". On the other hand, if the boyfriend's negligence has contributed to the injury, his share of liability to the girlfriend so arising – independently of the indemnity agreement - does not constitute "contractual liability".)

Note: When a tropical cyclone warning signal no. 8 or above is in force, we might hear remarks that any car that is still running on the road will have its motor insurance cover automatically suspended. In fact, it is not a universal practice in motor insurance to expressly prohibit the use of cars in times of typhoon. But we cannot rule out the possibility of a particular insurer arguing that the circumstances in which an insured car has been involved in an accident are suggesting that the insured was in breach of that common policy condition which requires the taking of reasonable steps to safeguard the car from loss or damage. By law, to be able to rely on such a policy condition, the insurer is most likely to be under the onus to prove that the alleged breach constituted recklessness. This is based on the judicial presumption that no insurance is intended to exclude a claim whose cause has been contributed to by the insured's careless or negligent conduct. Having said that, it should be noted that some policies on commercial vehicles do expressly prohibit the use of

the insured cars whilst a tropical cyclone warning signal no. 8 or above is in force.

(iv) Driving by any person other than an "Insured Driver", which is usually defined as:

(1) The *insured*, anyone who is driving on the insured's order or with the insured's permission, or anyone named in the policy schedule as an "Insured Driver",

(2) who holds a licence to drive the car or has held and is not disqualified from holding or obtaining such a licence. (The latter phrase, "or has held...", means that a person can still be an insured driver even if his licence is merely out of date, but not taken away by the authority.)

Note: An Insured Driver is either a Named Driver or Unnamed Driver.

(v) Driving by any insured driver:

(1) in violation of the statutory prohibition against drink-driving;

(2) with the proportion of alcohol in his breath, blood or urine exceeding the statutory limit; or

(3) in violation of the statutory requirement to provide a specimen of breath, oral fluid, blood or urine for testing or analysis, or to perform any other relevant test.

(e) **Common rating features**

Individual features may affect the premium for particular risks, but as a general rule motor insurance premiums in Hong Kong are very likely to be based upon the following factors:

(i) *Type of cover* and any *extra benefits*.

(ii) *Engine power/carrying capacity*: The cubic capacity of the engine (or *carrying capacity* with commercial vehicles) directly affects the risk and therefore the premium.

(iii) *Car value* (if own damage cover is to be included).

(iv) *Use of the vehicle*: Clearly, a private car put to extensive business use, for example, represents a higher risk than one used only for social, domestic and pleasure purposes.

(v) *Physical features of the car*: its age, whether it is a high performance vehicle, etc.

(vi) *Details of the regular drivers*, those who will regularly drive the insured vehicle (age, driving and accident experience, etc.).

(f) **Policy excesses**

An **excess** (or "**deductible**") means that up to the stated amount of each loss is not insured. Usually applicable to property cover (i.e. insurance of the insured's own vehicle), an excess of HK$2,000, for example, means that with damage of HK$12,000 the insured can only recover HK$10,000 under the policy. Sometimes, an excess is stated as a proportion of each loss, subject to a minimum amount.

An excess may either be a *voluntary* excess (i.e. one requested by the insured, in return for a premium discount) or a *compulsory excess*. And a compulsory excess may either be an *underwriting* excess (i.e. one imposed by the underwriter with no accompanying premium reduction to meet an undesirable underwriting feature with the risk concerned) or a *standard* policy excess (i.e. one applicable to **all policies** within the class). Features of standard excesses are:

(i) Where a voluntary excess and/or underwriting excess as well as a standard excess apply to a particular claim item, they will produce cumulative effects.

(ii) They do not qualify for any discount on the premium.

(iii) They may be applicable by reference to some particular features (age of driver, whilst vehicle parked, etc.), or applicable to eliminate small claims or to involve the insured in the cost of his own accident experience.

(g) **"Avoidance of Certain Terms and Right of Recovery" Clause**

According to the Motor Vehicles Insurance (Third Party Risks) Ordinance (Cap. 272), any condition in a policy issued for the purposes of the Ordinance, providing that no liability shall arise under the policy, or that any liability so arising shall cease, in the event of some specified thing being done or omitted to be done after the happening of the event giving rise to a claim under the policy, shall be of no effect in connection with any claims to which the compulsory insurance requirements apply. Most commonly this will arise where the insured fails to report an accident to the insurer, or admits liability to a third party in whatever manner without obtaining the insurer's prior written consent.

The Ordinance also provides that, where a certificate of insurance has been issued under its section 6(3), so much of the policy as purports to restrict the insurance by reference to any of the matters which the Ordinance specifies – i.e. the age or physical or mental condition of the drivers; the condition of the car; the horsepower or value of the car; the times at which or the areas within which the car is used; etc. – will be of no effect as far as compulsorily insurable liability is concerned.

As a relief, the Ordinance allows an insurer who has paid any sum which he would not have been liable to pay but for the taking effect of any of the above statutory provisions to recover it from the person who has been held liable to the third parties. To preserve or stress such and similar rights of recovery, insurers universally include in their motor policies a provision called "Avoidance of Certain Terms and Right of Recovery" Clause. This Clause will also apply to circumstances in which the insurer is obliged to pay third parties by virtue of any agreement between the insurer and the Motor Insurers' Bureau of Hong Kong (see **2.2.5**(a)).

(h) **Importance of Certificate of Insurance**

The certificate of insurance is uniquely significant in motor insurance. Before a policy becomes effective *for the purposes of the Ordinance*, the insurer must have issued a certificate of insurance in the prescribed form. As an illustration, suppose on 2 April 2017 an annual policy was issued together with a certificate of insurance, for commencement on 1 April 2017. Although the insurer's intention to provide cover with effect from 1 April was crystal clear, any use of the insured car on a road on that date would, from the legal point of view, be a contravention of the Ordinance with criminal consequences. Nevertheless, further suppose that the insured was convicted under the Ordinance for such use, through which third party liability was incurred. This would not allow the insurer to break his contractual promise to the insured. Disregarding the above hypothetical situations at the moment, we should take note that backdating a certificate of motor insurance may constitute the offence of forgery of certificates under the Ordinance.

In another respect, the certificate of motor insurance is so significant that once a policy has been cancelled or avoided, the insurer will endeavour to recover any certificate of insurance issued under the policy, in order to avoid incurring liability under the Ordinance to pay a sum in respect of the insured's liability to a road accident victim incurred after the insurance cover has ceased. On the other hand, the insured is obliged under the Ordinance to, within 7 days from the effective date of cancellation, surrender the certificate to the insurer or, if it has been lost or destroyed, make a statutory declaration to that effect.

1.1.1 Private Vehicle

Also known as **Private Car** insurance, this form of cover has the following features:

(a) **Basic intentions and scope of cover**

In the context of motor insurance, a car is classified as "private car" on the basis of the use to which it is put, instead of its construction. The Limitations As To The Use Of The Vehicle typically prescribed in a private car policy are that the car must only be used for social, domestic and pleasure purposes or for the Insured's business or profession, but not for hire or reward, racing…or any purpose in connection with the motor

trade. It is interesting to note that in a real case where the owner of a car drove a few neighbours to work every day in return for their sharing part of the fuel cost, it was held that he was using the car "for reward" for the purposes of his motor insurance.

The scope of the **comprehensive private car** policy is basically:

(i) *Loss of or damage to the insured vehicle (own damage):* This is property insurance on an "**all risks**" basis, covering the insured's car, and its accessories and spare parts whilst thereon, with indemnity limited to the reasonable market value of the car at the time of loss or damage. In addition, where the car is disabled by reason of any insured damage, the typical policy will pay the reasonable costs of protecting the car and removing it to the nearest repairer, and of delivering it to the insured's address after repairs, subject to a limit equal to, say, 20% of the agreed cost of repairs. The policy is most likely to allow the insured to authorise repairs as well, subject to a specified "authorised repair limit" (e.g. HK$1,000) and a couple of other provisos.

With the ready availability of vehicular anti-theft alarm systems, the own damage section is typically subject to a condition precedent to liability that the car is fitted with an approved anti-theft alarm system, that the system is maintained in good order, etc.

This section of the policy has some specific exclusions, such as:

(1) Consequential loss (e.g. the cost of hiring another vehicle whilst the insured vehicle is undergoing repairs after an accident).

(2) Depreciation, wear and tear, and electrical or mechanical breakdown. (NB Depending on the wording used, it is normally loss or damage itself which is excluded, rather than loss or damage caused by "depreciation …". Therefore, where the insured vehicle is destroyed as a result of a collision consequent upon wear and tear of its brakes, only the destruction of the brakes will be excluded.)

Case 1 Insured's responsibility for betterment contribution to cost of reinstatement

The insured vehicle was damaged in an accident. The repair cost was agreed at HK$73,000, of which the insurer requested the insured to bear HK$10,000 for an excess and HK$13,000 for depreciation. The insured agreed to bear the excess, but not the depreciation cost.

It was stated in the exclusions of the subject motor policy that the insurer would not be liable for depreciation. As the insured vehicle was already eight years old at the time of the accident, the insurer requested the insured to bear a betterment contribution of 35% towards the value of the new parts. The insurer indicated that its use of a 35% depreciation rate was very favourable in view of the normal 50% depreciation rate for an eight-year-old vehicle.

The Complaints Panel noted that the subject motor policy was an indemnity policy whose compensation shall mean an exact financial compensation sufficient to place the insured in the same financial position after a loss as he enjoyed immediately before the accident occurred. As the life span and condition of the new parts were obviously better than the original parts that had been used for a long time, depreciation or betterment allowance should be applied to reflect the post-repairs better-off position. Furthermore, having considered the year of manufacture and the mileage of the insured vehicle, the Complaints Panel considered that the 35% depreciation rate the insurer used was reasonable.

As the subject policy specifically excluded depreciation, the Complaints Panel ruled that the insurer's claim decision was appropriate and the insured should be responsible for a 35% betterment contribution.

Remarks*: the issue of depreciation rate is rather problematic partly because there is not a universally accepted method of calculation.*

(3) Damage to its tyres unless damage to another part of the car is caused at the same time.

(4) Cumulative excesses. In addition to a general excess, there are standard excesses relating to a number of situations (other than loss or damage independently caused by fire, self-ignition, lightning or explosion), i.e.:

(A) **Unnamed Driver Excess**: Driving by a person who is not a **Named Driver** (driver named in the schedule) (NB It must be an insured driver who is driving; otherwise cover will not be available at all (see **1.1**(d)(iv));

(B) **Young Driver Excess**: Driving by a **Young Driver** (usually defined as one below age 25);

(C) **Inexperienced Driver Excess**: Driving by an **Inexperienced Driver** (usually defined as one who has not held a valid driving licence (other than a provisional driving licence) for 2 years);

(D) **Parking Excess** (or **Parking Damage Excess**): Loss or damage whilst the car is parked;

(E) **Theft Excess** (or **Theft Loss Excess**): Loss or damage arising from theft.

(5) Unlike the third party liability section, the "own damage" section is subject to the policy condition of pro rata contribution, instead of non-contribution.

(ii) *Legal liability* (Third Party liability): This includes **compulsory insurance** cover (usually for the minimum **HK$100 million** any one event required by law) and cover for **property damage liability** towards third parties (the customary private car policy gives cover of **HK$2 million** any one event). The third party liability cover applies to:

(1) The insured and any other **insured drivers**; and

(2) Any passenger (who may cause an accident by negligently opening a door, for example);

The specific **exclusions** applicable to this section include:

(1) No cover if the person claiming (e.g. one of the Insured Drivers) is covered by another policy. (This person does not mean a third party claimant.)

(2) Claims within the scope of Employees' Compensation insurance. This exclusion may operate, for instance, when a domestic servant of the insured was injured in a car accident caused by the insured's negligence. It operates even where no employees' compensation policy was in force.

(3) Property belonging to or held in trust by the insured or his household member(s) – this risk is supposed to be dealt with under property insurance instead of liability insurance.

(4) Any applicable policy excess (normally inclusive of an unnamed driver excess, a young driver excess and an inexperienced driver excess - all applicable to third party property, on top of a third party property excess).

(iii) *Medical expenses*: This is an insurance of the person on an *indemnity* basis (not liability insurance), that covers medical expenses reasonably incurred in connection with any bodily injury sustained through violent accidental external and visible means by the policyholder, any insured driver or any occupant of the car as the direct result of an accident to the car. The cover is likely to be subject to a limit any one event of a few thousand dollars.

(iv) *Personal accident benefits*: The amount payable will be that specified for that type of bodily injury which is sustained through violent accidental external and visible means by any named driver who is within a specified age range (say, 18 – 70) and who is driving the insured car at the time of accident.

(v) *NCD protection*: If the total claim amount for a period of insurance is below a prescribed level, the claims concerned will be disregarded for the purposes of determining the NCD for the year that follows. But the protected NCD may not be transferred to another insurer.

(vi) *New for old replacement*: If the car becomes an insured total loss within the first 12 months of its first registration and the insured wants a replacement car, then the insurer will provide a replacement car of the same make and model without deducting any depreciation, subject to the availability of such a new vehicle and some other provisos.

(vii) *Nil depreciation on repairs*: If replacement of spare parts is necessitated by the happening of an accident that occurs within the first 12 months of the first registration of the insured car, no deduction for depreciation will be made from the insured replacement costs, subject to a couple of other provisos.

(viii) *Windscreen replacement*: If any glass in the windscreen or windows of the insured car is accidentally broken without any other damage to the car, the policy will pay the necessary repair or replacement cost subject to a specified limit any one period (say, HK$5,000), without affecting the NCD entitlement. This cover is in fact an option the policyholder may go for, instead of making a claim under the terms of the "own damage" section (e.g. various excess provisions).

(ix) *Towing services*: If the insured car is immobilised or made unfit or unsafe to be driven by an accident to it or by its mechanical breakdown, and is left in a condition beyond repair at the roadside, the insurer will at his own expense arrange for it to be towed to any car repairer or any other place in Hong Kong to be designated by the insured, subject to a limit any one period of, say, HK$2,000.

(x) *Rental car*: If the insured car is immobilised by an accident necessitating repairs at a garage/workshop or is stolen, so that the insured or a named driver is deprived of the use of the car for, say, more than 48 hours, the policy will pay the costs reasonably incurred for renting a temporary substitute car of the same make and model, subject to an excess, a limit per accident and per period, and some other conditions.

(xi) *Claims recovery service*: The insurer will, on behalf of the insured, pursue recovery of any uninsured losses – perhaps due to the operation of an excess provision - from a negligent third party, if any.

Note: 1 Policies which only provide **Third Party** cover will only consist of (ii) above. **Third Party, Fire and Theft** cover, of course, is merely a combination of fire and theft own damage cover and the third party cover.

2 The HK$2 million third party **property** damage liability limit may be **increased** for an extra premium.

(b) **Other Features**

(i) **Extra benefits**: A number of extensions of cover may be possible on payment of an extra premium. These include:

(1) Deletion of a policy exclusion, such as riots.

(2) Adding benefits, such as extended personal accident cover, waiver of excess for third party property damage (only available to named drivers), "own damage" and medical expenses cover when the insured car is being used in Guangdong Province, etc. Specific details vary with insurers.

(ii) **Discounts**: Apart from **NCD** and discounts for **voluntary excesses** (see above), discounts may be available for insuring more than one car under the same policy (in which case the limits of indemnity applicable to the third party liability section will stay the same as if only one car was insured), or whilst the insured car is "laid-up" (i.e. temporarily out of use) for a minimum period.

1.1.2 Motor Cycle

Like Private Car insurance, Motor Cycle insurance is primarily intended for use of privately owned vehicles for social, domestic and pleasure purposes. However, the market for commercial motor cycles and scooters (e.g. pizza delivery scooters) has shown a strong growth in recent years because of the popularity of food delivery. Motor cycle cover is similar to that applicable to private cars, except for:

(a) **Own Damage/Accidental Damage** (OD/AD), i.e. loss of or damage to the insured vehicle. Two things should be noted:

(i) **Theft** claims are only admissible if the whole machine is stolen. Loss of accessories alone is therefore not covered.

(ii) There is usually a **standard excess** in respect of any loss of or damage to the insured machine (other than that arising from **fire** or **theft**).

(b) **Third Party** cover: It is not usual to grant cover for the liability **of** passengers. Of course, cover for liability **to** passengers in respect of death or injury is statutorily required.

Available in the market are the minimum **HK$100** million limit of liability any one event required by law for third party **death/injury** liability, and **HK$1 million** any one event (increasable for an extra premium) for third party **property damage**.

(c) **Medical Expenses and Personal Accident Benefits**: There is neither a standard policy section for medical expenses nor an extended personal accident cover.

1.1.3 Commercial Vehicle

(a) **Basic intentions and scope of cover**

A moment's thought will bring to mind that there are immense varieties of vehicles which fall under this category, ranging from taxis and light vans to huge container lorries. In addition, there are numerous examples of specially constructed or adapted vehicles, intended for specialized use. The scope of commercial vehicle policies may be summarized as follows:

(i) **OD/AD cover** (for loss of or damage to the insured vehicle): This is very likely to be on an "**all risks**" basis, with an additional exclusion of damage caused by **overloading** or **strain** – not found with cover for private cars or motor cycles.

(ii) **Third Party cover**: it is subject to certain exclusions which are not applicable to private car third party cover:

(1) Use of the vehicle as a **tool of trade** (e.g. a mechanical digger whilst being used as such), except as required by the statutory provisions regarding compulsory insurance. (This exclusion is known as the "tool of trade clause".)

(2) Food poisoning and related claims (in case the vehicle is used as a mobile food-vending outlet).

(3) Damage to stock-in-trade and specified categories of equipment on the vehicle.

(4) Damage caused by vibration or the weight of the vehicle to any road, weighbridge, etc. or anything beneath.

(iii) **Medical expenses**: These are not insured under the basic policy, although cover may be available as an extra benefit, for an extra premium.

(b) **Features**

The range of vehicles under this heading is so wide that it is not possible in this abbreviated study to cover all aspects of commercial vehicle insurance. It will be readily understood that there are very considerable differences in the underwriting of taxis, buses, privately owned small and heavy goods vehicles and a host of other specialized vehicles. Some considerations may be mentioned, however, by way of example:

(i) **Liability limits**: Readily available in the market are **HK$100 million** any one event in respect of third party **death/injury** (which is the minimum required by law) and **HK$1 million** any one event for third party **property damage**. These figures are for standard policy cover, and the latter may be increased for an extra premium.

(ii) **Specialized vehicles**: Vehicles with unusual risk exposures, such as ambulances and vehicles used by undertakers, warrant special terms.

(iii) **Fleet rating**: A "fleet" of vehicles mean a number of vehicles under the same ownership or management (perhaps a minimum of five vehicles). Included in this classification could be taxis and vehicles belonging to large companies. Such risks usually have rating related to the loss experience of the particular fleet, rather than the average industry experience.

(iv) **Motor Trade risks**: Those whose businesses largely concern motor vehicles, such as the selling, buying, repairing, moving, cleaning and recovering of vehicles, have special insurance needs. Policies for such risks, or motor trade policies, may relate to the road use of vehicles or premises risks, with various combinations of cover available.

1.2 HEALTH INSURANCE

Health insurance (also known as "accident and health insurance") is a type of "insurance of the person", in the sense that the subject matter of the insurance is the life, limbs or health of a human being. Some insurers now offer this kind of cover through their life insurance departments, but originally it was general insurance business, and still is for the purposes of this study.

1.2.1 Personal Accident and Sickness Insurance

(a) **Basic intentions and scope of cover**

Personal accident (PA) insurance was the first major class of accident insurance, originally developed to deal with a demand arising from the many accidents involving the early railways. Its basic intentions have remained constant, although the scope of cover has widened over the years. The PA policy in the early days only covered the event of bodily injury resulting in death or disablement, while the Personal Accident and Sickness Policy which emerged later added in the insured event of disablement caused by sickness – see more details of PA and Sickness insurance in **1.2.1**(e)(ii).

PA cover may be described under three main headings, with the insured person sustaining a prescribed bodily injury (see **1.2.1**(b)(i)) as a common criterion for policy liability:

(i) *Lump sum benefits*: As the name suggests, these are single amounts payable in the event of death or other specified injury arising from an accident.

(ii) *Weekly benefits*: These are periodic payments related to temporary total (i.e. 100%) disablement or temporary partial (i.e. less than 100%) disablement. The benefit is calculated on a weekly basis, but payments are usually made monthly during disablement, subject to a maximum period (say, 104 weeks) of payment.

(iii) *Medical expenses*: To be reimbursable, the medical expenses incurred must arise from "bodily injury" (see (b)(i) below) rather than sickness and are subject to a limit any one event.

To expand slightly on (i) and (ii) above:

(1) Compensation under (i) above is usually expressed as a percentage of a sum specified in the policy (often called the *Principal Sum Insured* or *Capital Sum*). Death merits a 100% benefit, so does any one of such specified *major* injuries as *Loss of Two Limbs and Total Loss of Sight*. Total (and) permanent disablement (which may be defined as a state of being totally and permanently unable to engage

in ANY occupation for which the insured person is reasonably qualified by education, training or experience) that does not constitute any of the specified major injuries also merits a 100% benefit. Lesser permanent injuries have lower percentages, ranging from, for example, 50% for the loss of sight in one eye, to as low as 5%, for example, for the loss of one finger joint. The table of benefits included in the policy may be quite detailed.

(2) Different amounts of weekly benefits apply to *Temporary Total Disablement* and *Temporary Partial Disablement*, with "disablement" being qualified as disablement from the insured's *usual occupation* - although alternative policy wording may be used such as "*any occupation*".

Case 2 Different benefit amounts for Temporary Total Disablement and Temporary Partial Disablement

The insured was a businessman who frequently travelled between Hong Kong and the Mainland of China. He sustained a back injury due to a fall at work in October 1998. A scan of lumbar spine confirmed a disc herniation. In January 1999, he received laminectomy in a hospital in Shanghai. Medical reports respectively dated April and June 1999 from the insured's attending doctors confirmed that he still had right thigh and left toe pain/numbness and could not walk for a long distance. Medical certificates also stated that he was unable to perform any work until 15 July 1999.

The insurer had already paid the insured 159 days' Temporary Total Disability benefits. However, having learned from the medical examiner that the insured's range of trunk movement had reached three quarters of his normal range since 15 May 1999, the insurer then decided that the insured was only entitled to Temporary Partial Disability benefits. This was because his present condition would not prevent him from performing his duties.

Facing conflicting medical opinions from the insured's attending doctors and the insurer's in-house medical consultant, as to whether the injury had prevented the insured from performing any of his duties or not, the Complaints Panel was inclined to believe that the insured's attending doctors were in a better position to comment on the health condition of the insured, and thus put more weight on their views. As such, the Complaints Panel ruled that the insured should continue to receive Temporary Total Disability benefits from 15 May to 15 July 1999.

***Remarks**: as a personal accident policy normally provides different benefit amounts for temporary total disablement and temporary partial disablement, it is important to determine which of these the insured person has sustained.*

Case 3 Different benefit amounts for Temporary Total Disablement and Temporary Partial Disablement

The insured was involved in a motorcycle traffic accident and suffered multiple fractures of upper limbs and skin abrasions. He was given a total of 122 days of sick leave by his doctor.

The insurer granted him 100 days' Temporary Total Disability benefit and 22 days' Temporary Partial Disability benefit. However, the insured was not satisfied with the settlement and considered that the insurer should settle his entire claim as 122 days' Temporary Total Disability benefit. The difference in the claim amount was nearly HK$6,400.

The Complaints Panel noted from the physiotherapy report that the insured's condition was much improved after attending 10 physiotherapy treatment sessions during his first 100 days of sick leave but he defaulted on further treatment. In view of his improved condition, the Complaints Panel agreed that the insured should be able to perform certain parts of his duties as an air-conditioning repairer during his last 22 days of sick leave. It thus concluded that the insurer's decision to pay Temporary Partial Disability benefit for the last 22 days was fair and reasonable.

***Remarks**: as a personal accident policy normally provides different benefit amounts for temporary total disablement and temporary partial disablement, it is important to determine which of these the insured person has sustained.*

Case 4 Different benefit amounts for Temporary Total Disablement and Temporary Partial Disablement

The insured slipped and hit herself on a washing basin at home and sustained contusion over her sacrum area. She was granted a total of 13 days of sick leave. The insurer paid her eight days' temporary total disability benefit and five days' temporary partial disability benefit. However, the insured was not satisfied with the settlement and considered that the insurer should settle her entire claim as 13 days' temporary total disability benefit.

The Complaints Panel noted that the insured had no fracture or nerve injury and there was also no healing complication. As the insured was a self-employed director and her job mainly involved office duties, the Complaints Panel, in the light of the nature of the injury and the degree of severity and complication, was of the view that she should be able to perform some of her duties eight days after the injury.

As the insured's condition during her last five days of sick leave only fulfilled the definition of Temporary Partial Disability but not Temporary Total Disability in the policy, the Complaints Panel concluded that the insurer's claim offer was appropriate.

Remarks*: as a personal accident policy normally provides different benefit amounts for temporary total disablement and temporary partial disablement, it is important to determine which of these the insured person has sustained.*

(b) **Limitations and exclusions**

(i) *Accidental bodily injury*: the "bodily injury" covered may be required to be one "solely and directly arising from or caused by accidental, external, violent and visible means". A less restrictive wording may get rid of "external, violent and visible" and expressly cover food poisoning and gas poisoning solely caused by an accident in addition to accidental bodily injury.

Case 5 Personal accident policy requires "accidental" bodily injury

After an operation to remove a craniopharyngioma, the woman became blind in the right eye. She considered her blindness an unfortunate accident and submitted a claim under her personal accident policy, which the insurer rejected.
A key issue in the claims dispute was whether the injury of blindness had resulted from an "accident" or not, which was defined in the policy as 'an unforeseen and involuntary event which causes a bodily injury'. The woman was referred to have the operation because the craniopharyngioma had caused deterioration and visual field defect to both eyes. The insurer believed that the woman should have been informed of the possible risks, including blindness, for undergoing such a complicated operation. In other words, the woman's blindness should have been a risk known to her, rather than an injury caused by an 'unforeseen and involuntary event'.

Having considered all available facts, the Complaints Panel agreed that the woman's blindness was not caused by an accident, but was one of the foreseeable consequences of the surgery. Thus, the insurer's decision to reject the claim was upheld.

***Remarks**: it is normal for each personal accident policy to specifically define "accident" for the purpose of qualifying the insured bodily injury.*

Case 6 Personal accident insurance claimant is required to produce evidence of "accidental bodily injury"

The insured, who works as a store assistant in a fruit juice store, sprained his lumbar region while carrying a heavy load of sugar cane shoots. He was granted 14 days' sick leave due to the sprain back injury.

The insurer rejected the insured's claim for accident benefit on the grounds that no visible contusion or wound was noted on his body. Moreover, the x-ray taken showed no abnormal finding.

The Complaints Panel learnt from the attending physician's report that there was redness, stiffness and swelling noted on the insured's para lumbar region and the injury would have prevented him from working as the pain had limited his lumbar movement. The Complaints Panel believed that such physical signs and findings could reasonably be interpreted as a visible sign of an injury. Having further taken into consideration relevant circumstances, the nature and the extent of the injury, the Complaints Panel was convinced that a genuine accident had taken place resulting in the insured's back injury. It therefore ruled in favour of the insured and awarded him 14 days' temporary disability benefit.

Remarks: the Complaints Panel was apparently of the view that what the policy in question required as evidence of an "accidental bodily injury" was a "visible sign of the injury", which was not necessarily an open wound.

(ii) *Injury/disablement definitions*: These will vary between insurers, but typically the following will apply:

(1) **Permanent** means lasting for at least 12 months, at which time there is no reasonable hope of improvement.

(2) **Loss of limb** means physical separation at or above the wrist or ankle, or permanent loss of use of such a limb.

(3) **Loss of sight** means total and irrecoverable loss of all sight in the eye(s) concerned.

(iii) *Time limits*: Insured death or disablement must take place within 12 months (or another specified period) of the injury concerned. Of course, special circumstances (e.g. a long-lasting coma and then death) would merit sympathetic consideration.

(iv) *Benefit limitations*:

(1) A PA policy will typically provide for the reduction of the sum insured (meaning maximum policy liability), in response to a paid claim, for the period between the date of the accident to which the claim relates and the policy expiry date by the amount paid, with termination of the policy without premium refund when the sum insured is exhausted. The policy may go on to stipulate that in calculating individual benefits (e.g. with loss of one hand: 50% of the sum insured), the original sum insured will still be used.

(2) Where more than one insured event results from the same accident, payment will only be made for that event which carries the greatest amount of benefit payable, except for circumstances in which payments of weekly benefits are followed by the death of the insured person.

(v) *Exclusions*: They may be considered under various headings:

(1) **Fundamental risks**, such as war, rebellion and nuclear risks.

(2) **Hazardous activities**, such as riding or driving in motor racing, engaging in a sport in a professional capacity, and aviation other than as a fare-paying passenger.

Case 7 "Winter-sports" are generally excluded from personal accident insurance

The insured sustained an accident while engaging in ice-skating with his son in a shopping complex in Hong Kong. He was granted a total of 67 days' sick leave due to fracture of the left tibia and fibula.

As the insured's injury was caused by participating in ice-skating, the insurer declined his claims for hospital income and disability benefits on the grounds that the policies explicitly excluded any loss caused by or related to participating in or training for winter-sports.

Although the policies failed to provide any definition for "winter-sports", the Complaints Panel believed that "winter-sports" generally refer to sports that take place on snow or ice. As such, ice-skating (whether outdoor or indoor) should be a kind of winter-sports.

As the policies specifically excluded loss resulting from participating in winter-sports, the Complaints Panel endorsed the insurer's decision to reject the insured's claims.

***Remarks**: for the purposes of the winter-sports exclusion, winter-sports are not restricted to sports actually played in winter time, or sports played outdoors.*

Case 8 Exclusion of motorcycling (whether direct or indirect) from personal accident cover

The deceased was killed in a traffic accident, when he was a passenger on a motorcycle.

It is stipulated in the policy exclusions that "no benefit will be payable for any accidental death directly or indirectly caused by or resulting from engaging in hazardous activities including but not limited to...motorcycling...". Considering that the circumstance leading to the deceased's death was outside the scope of the policy cover, the insurer refused to pay accidental death benefit.

The deceased's mother presented a traffic accident report in order to substantiate that her son's death was caused by the negligence of the driver of a public light bus, who talked on a mobile phone while driving. She emphasized that her son was merely a passenger at the time of the accident and was not being engaged in hazardous activities.

Although the deceased was merely a motorcycle passenger at the time of the fatal accident, the Complaints Panel, having thoroughly studied the subject exclusion clause, was of the view that a motorcycle passenger should be treated as indirectly engaging in motorcycling. In the circumstances, the Complaints Panel resolved to uphold the insurer's decision to decline the claim for accidental death benefit.

***Remarks**: the scope of certain excluded causes of loss is sometimes broadened by using the term "directly or indirectly".*

(3) **Anti-social activities**, such as suicide, deliberately self-inflicted injury, abuse of alcohol or drugs (other than taking of drugs prescribed by a qualified medical practitioner).

Case 9 Injury must have been caused by an accident for purposes of personal accident claims

The insured submitted an accident claim for multiple chop wounds sustained during an attack by a gang. According to the insured's statement made to the police, he went to the scene of a fight with the intention of rescuing his friends from a mob's assaults. In his rescue mission, the insured was seriously wounded by the assailants who were armed with weapons.

Although the insurer rejected the claim on the grounds that the circumstances of the incident which led to the injury of the insured had violated the law, the Complaints Panel was in no doubt that the insured had deliberately joined the fray himself. The Complaints Panel was of the view that it was an easy matter to foresee that pushing some of the mobsters at the scene of the fight would result in the insured being attacked. As that was what actually happened, the Complaints Panel reached the finding that the insured's injury was not accidental but was a natural consequence of his own actions. It therefore ruled in favour of the insurer.

Remarks*: the insured person's foreseeability of being attacked as a result of his own deliberate action has taken his injury out of the scope of injury caused by an "accident".*

Case 10 Exclusion of "violation of the law" from personal accident cover

The insured, a truck driver, died in a traffic accident in the Mainland of China as a result of his truck colliding with another vehicle, whose driver fled the scene after that. According to the police, the deceased had failed to observe traffic conditions and keep a safe distance from the car in front, which did not have appropriate lighting. The police report concluded that the deceased should be responsible for 70% of the economic loss while the vanished driver the remaining 30%.

The insurer refused to pay the accidental death benefit by exercising an exclusion clause in the policy, which specifically excluded any loss directly or indirectly, wholly or partly caused by violation or attempted violation of the law.

The Complaints Panel noted that the reports were made by the officers who arrived at the scene after the accident. It transpired that the allegations made against the deceased were not supported by eyewitnesses or circumstantial evidence. In addition, there was no clue as to how the official findings were arrived at. In this regard, the Complaints Panel found the contents of the police reports dubious and was not fully satisfied that they were safe and could be relied upon.

Furthermore, in the law related to insurance contracts, the following fundamental principles are relevant in the present case:

1. The fact that the document records a contract means that the parties' intention is paramount.

2. Where two constructions are possible, the one which tends to defeat the intention or to make the contract practically illusory shall be rejected. Similarly, where a literal construction manifests absurdity, it shall be rejected in favour of a construction which is broad, liberal and reasonable, where both constructions are possible.

3. An exclusion clause shall be construed in such a way as to be consistent with the purpose or objects intended to be effected by the contract.

The policy in question was a personal accident policy containing the term "...sustain injury effected directly and independently of all other causes through external, violent and accidental means...". The Complaints Panel was of the view that the intention of both parties must have been to cover claims arising from accidents, i.e. events that are unforeseen and unintentional. Taking a purposive approach, the Complaints Panel interpreted "violation of law" as criminal acts of an intentional nature instead of mere infringements of traffic regulations.

Based on the above facts and reasoning, the Complaints Panel decided to rule in favour of the claimant and award her the death benefit.

***Remarks**: on the facts of the case, the Complaints Panel adopted a purposive approach to the interpretation of the exclusion, rather than the more widely known 'literal approach' to contract construction. At common law, courts consider themselves empowered to adopt this approach whenever they see it fit to do so.*

(4) **Other exclusions**, for example, childbirth, pregnancy, miscarriage, injury which is a consequence of a disease, disablement arising from or aggravated or accelerated by a pre-existing condition, whilst on duty with the fire or armed services, and whilst engaging in a duty in an occupation falling within a higher risk class than the occupation class to which the insured person has been assigned for underwriting and rating purposes.

(c) **Premium basis**

Quite a number of individual features (e.g. age) may have underwriting consequences, but the standard premium calculation is based upon the insured's occupation. All occupations will be classified according to their potential accident risk into several classes – typically four. The typical change of occupation provision stipulates that when there is a change of occupation during the currency of the policy, the insured should immediately notify the insurer of the change in writing, who is entitled to adjust the premium or benefit levels or revise other policy terms accordingly. Other things being equal, premium rates will be the same for male and female risks.

(d) **Sum Insured**

Cover may be purchased on the basis of one or more units (i.e. defined levels of cover), each having a table of benefits. Alternatively, individual sums insured may be selected for different kinds of benefits. From a legal point of view, there is no limit to the sums to be insured, since every individual has an unlimited insurable interest in himself. In practice, however, insurers would be reluctant to issue cover for amounts well in excess of normal requirements, e.g. where weekly benefits represent far more than the insured is very likely to be earning.

(e) **Other features**

(i) **Group policies**: PA cover may be provided as a "fringe benefit" by employers. Cover under such policies may be restricted to **working-hours** only, but is more likely to be on a **24 hours** basis.

(ii) **Sickness cover**: The above comments refer almost exclusively to **Accidents Only** cover. Sickness benefits are provided by the PA and Sickness policy, but these will only be benefits for *Temporary Total Disablement* and *Temporary Partial Disablement* from the insured person's usual occupation by sickness, payable during the period of disablement for a maximum number of weeks (say, 104 weeks). Death from sickness is not covered under the PA and Sickness policy, it being deemed a life insurance risk. Because of a higher morbidity (sickness) rate, sickness insurance premiums for female risks are normally higher than for male risks.

Note: Sickness cover, whilst traditionally linked with PA insurance, is now unlikely to be included with PA policies written in Hong Kong, which may therefore be said to be **Accidents Only** policies.

(iii) **Other policies**: Frequently, PA cover is given under a combined policy or package policy (see **1.3**), together with other types of cover. Life insurance policies are often issued with accident riders. In general insurance, PA benefits are frequently covered under policies of travel insurance, money insurance, household insurance, motor insurance, etc.

(iv) **Cancellable**: PA policies normally last for one year, renewal being a matter of mutual agreement. A cancellation clause is usually included to allow unilateral cancellation of the policy mid-term with premium refund, subject to prescribed notification to the other party.

(v) **Age limits**: Although premiums are not based on the age of the insured person, policies usually specify an insurable band of ages (e.g. 18 to 70 years for adult cover).

1.2.2 Medical Insurance

(a) **Basic intentions and scope of cover**

Whereas PA insurance is primarily intended to provide a benefit to the insured in the event of death or injury from accident, medical insurance is intended to cover *medical expenses* arising from accident or sickness.

Medical policies are usually annual policies, which may be renewed with the benefit of days of grace (see Glossary) for payments of renewal premiums. Some insurance plans are renewable at the option of the insured so that the insurer is bound to meet a renewal request.

Practice varies as to cancellation entitlements. Most policies allow cancellation by the insured, but not all grant the same rights to the insurer.

(b) **Limitations and exclusions**

(i) *PA exclusions*: As the cover includes circumstances covered by PA policies (e.g. an injury sustained while participating in mountaineering may result in both medical expenses and disablement), nearly all the usual PA exclusions apply (see above).

(ii) *Special exclusions*, including:

(1) Congenital conditions;

(2) Pre-existing (i.e. prior to insurance) conditions and disabilities;

Case 11 Pre-existing conditions are excluded from medical insurance

The insured was admitted to hospital for abdominal pain and blood in stool 10 days after she has effected a hospitalization policy. Histopathology report confirmed a colon tumour measuring about 5 cm.

The insurer revealed that the insured had consulted for rectal bleeding with hard stool 15 months prior to her application for insurance. Furthermore, based on the size of the tumour, the insurer was of the view that the tumour could not have developed within 10 days. As such, the insurer rejected her hospitalization claim on the basis of pre-existing condition.

The insured alleged that her consultation for rectal bleeding some 15 months ago was only due to haemorrhoid and she had fully recovered. She believed that the insurer was unreasonable to decline her hospitalization claim as the diagnosis of carcinoma of colon was made 10 days after the policy inception date.

Although the available information failed to indicate the exact onset date of the insured's colon cancer, the Complaints Panel, having taken into account the size of the colon tumour, was of the view that the tumour might take some time to grow until it was revealed by colonoscopy.

Given the diagnosis of carcinoma of colon was made only 10 days after the policy was effected, the Complaints Panel was of the view that tumour of that size could not have developed within less than 10 days after the commencement date of the policy. As the policy excludes any illness or injury that commenced or presented signs and symptoms prior to the policy commencement date, the Complaints Panel endorsed the insurer's decision to reject the hospitalization claim.

***Remarks**: a problem often met in applying the "pre-existing condition" exclusion is that it could be difficult to ascertain the exact onset date of a condition.*

(3) Birth control/infertility treatment;

(4) Cosmetic surgery;

(5) Routine medical examinations and check-ups;

(6) Dental treatment (unless arising from an accident during policy period).

(c) **Premium basis**

Resembling PA insurance, the insured person's occupation is an important rating factor in medical insurance. Equally important, if not more, are the age and health of the insured person, as in the case of sickness cover under the PA and Sickness policy. Other considerations include sex, levels of cover and geographical limits.

(d) **Other features**

(i) **Group policies**: These policies are often on a group or family basis.

(ii) **Variations**: Some insurers offer cover for maternity and dental related expenses, as standard or extra benefits.

(iii) **Hospitalization cover**: A medical insurance policy may provide a stated benefit per day spent in hospital as an inpatient. Alternatively, an indemnity cover may be given.

1.2.3 Voluntary Health Insurance Scheme ("VHIS")

(a) **Background**

The Voluntary Health Insurance Scheme ("VHIS") was fully launched to consumers on 1 April 2019. The VHIS is a policy initiative implemented by the Food and Health Bureau ("FHB") of the Government to regulate individual indemnity hospital insurance products, with voluntary participation by insurance companies and consumers. Under the VHIS, the participating insurance companies can offer **indemnity hospital insurance plans** ("IHIP") that have been certified by the FHB ("Certified Plans") for individual consumers to purchase voluntarily.

The VHIS is designed to bring certain benefits to consumers. By enhancing the accessibility, quality and transparency of individual hospital insurance, the VHIS provides an additional option for consumers who are willing and can afford to pay more to use private healthcare services.

(b) **Tax Deduction under the VHIS**

With the passage of the Inland Revenue (Amendment) (No. 4) Bill 2018 on 31 October 2018, taxpayers are now entitled to tax deductions under salaries tax and personal assessment for qualifying premiums they pay on or after 1 April 2019 for Certified Plans for themselves or any of their "specified relatives" – defined to cover the taxpayer's spouse and children and the taxpayer's or his/her spouse's grandparents, parents and siblings. The deduction ceiling is HK$8,000 per insured person per year, irrespective of the number of policies that cover the insured person. However, there is no cap on the number of specified relatives who are eligible for tax deductions. For instance, if the taxpayer purchases a total of four policies for four insured persons (e.g. the taxpayer himself and three "specified relatives") and the taxpayer is the policyholder of these policies, then the annual deduction ceiling would be HK$32,000 (i.e. HK$8,000 x 4) for the qualifying premiums paid.

(c) **Administration of the VHIS**

The VHIS is administered by the Voluntary Health Insurance Scheme Office ("VHIS Office") of the FHB. Insurance companies seeking to offer VHIS-compliant products must first register as VHIS Providers and, before their **Standard Plans** and **Flexi Plans** (if offered) are marketed, each plan must have been successfully certified as a **Certified Plan** (see (c)(iii) below for these three terms) by the FHB. The FHB has set out the scheme rules in a set of scheme documents for compliance by VHIS Providers:

(i) **Registration Rules for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** ("Registration Rules"): Insurance companies must be successfully registered with the FHB as VHIS Providers according to the Registration Rules before they are allowed to sell Certified Plans.

(ii) **Voluntary Health Insurance Scheme Certified Plan Policy Template** ("Policy Template"): The Policy Template illustrates the minimum requirements on the policy structure, terms and benefits of Certified Plans, including **Standard Plans** and **Flexi Plans**. Where a Certified Plan provides terms and benefits that exceed the minimum requirements, the insurance policy concerned may require additional, amended or supplementary terms that the Policy Template does not stipulate. Where an insurance policy covers not only a Certified Plan but also another insurance plan (e.g. where a Certified Plan forms a rider to a life insurance policy), the policy will contain terms and benefits that the Policy Template does not stipulate, and these terms and benefits will not be subject to the requirements of the VHIS.

(iii) **Product Compliance Rules under the Ambit of the Voluntary Health Insurance Scheme** ("Product Compliance Rules"): The Product Compliance Rules sets out the minimum product design requirements for an insurance plan to be certified as VHIS-compliant and the relevant product certification procedure. The basic principles are set out below:

(1) An individual IHIP must be certified by the FHB before it can be marketed as a Certified Plan.

(2) All **Certified Plans** must be individual IHIP. The following are some examples that are not deemed to be individual IHIP: group insurance plans with master policy for employees; outpatient insurance plans; non-indemnity insurance plans including hospital cash plans and critical illness cash plans; and indemnity insurance plans that cover specific illnesses (e.g. cancer) only.

(3) An individual IHIP can qualify as either type of Certified Plans, namely a **Standard Plan** or a **Flexi Plan**, subject to product compliance and prior certification by the FHB.

(4) The product design of a **Standard Plan** is basically fixed, save for minor allowable variations. It must offer terms and benefits equivalent to the minimum requirements of Certified Plans under the VHIS, namely **Basic Benefits**, as prescribed in the Policy Template (see (c)(ii) above).

(5) A **Flexi Plan** must provide **Enhanced Benefits** in addition to the **Basic Benefits**. The design of **Flexi Plans** must adhere to the "better-off principle" entailing terms and benefits which will bring more protection to customers when compared with a **Standard Plan** while policyholders' entitlement to the **Basic Benefits** would not be adversely affected, save for specified exceptions.

(6) Both **Standard Plan** and **Flexi Plan** may encompass a minor element of benefits other than **Basic Benefits** and **Enhanced Benefits**, namely **Other Benefits**. **Other Benefits** are allowed to form part of a Certified Plan to cater for the licensing requirement for long-term insurers to provide long-term insurance benefits (e.g. life insurance) in the individual IHIP they offer.

(7) The table below illustrates the principles in defining **Standard Plan** and **Flexi Plans**:

	Standard Plan	**Flexi Plan**
Basic Benefits	Must include	Must include
Enhanced Benefits	Must not include	Must include
Other Benefits	Optional	Optional

(8) An insurance policy issued under a Certified Plan may attach or be attached to other insurance plans (e.g. a Certified Plan serves as a rider attached to a life insurance policy). However, such other insurance plan(s) will not be considered as part of the Certified Plan, and the policy terms and conditions must not contradict with the objectives of the VHIS and must not reduce the protection of the Certified Plan to the policyholders under the same policy.

(iv) **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** ("Code of Practice"): The Code of Practice sets out the required conduct and practices covering product offering, migration arrangement, sales and marketing, handling of application, cooling-off period, after-sales services, etc. for VHIS Providers to comply with so as to

supplement the Policy Template. It is particularly important for insurance intermediaries to get familiar with the requirements of the Code of Practice on "**sales and marketing**", which are summarised below:

(1) In conducting sales and marketing activities, VHIS Providers should provide clear, accurate, non-misleading and easily accessible **information of the VHIS and Certified Plans** to consumers for them to make informed choices.

(2) VHIS Providers should ensure that all **sales and marketing materials** are accurate and in a non-misleading manner, in Chinese and English (except for social media and advertisements), in plain language and complete.

(3) VHIS Providers should ensure consumers, policyholders and insured persons can easily **distinguish terms and benefits** under Certified Plans from non-VHIS products across all sales and marketing materials.

(4) In the course of marketing Certified Plans, VHIS Providers and their sales representatives should disclose and exercise due diligence in explaining the **key product and premium information** of Certified Plans to consumers.

(5) VHIS Providers should provide an **easy access to essential information** (such as company website, communications with sales/service representatives, enquiry hotline, etc.) so that consumers can easily enquire about the information on the VHIS and the Certified Plans, e.g. their registration status as a VHIS Provider; product and premium information of the Certified Plans on offer; underwriting factors, material facts and information of consumers for underwriting purposes; eligibility for tax deduction; complaint handling procedures.

(6) VHIS Providers should inform applicants of their obligations to disclose **personal information and material facts** for underwriting, and the possible consequences of material non-disclosure, misrepresentation and fraud.

(7) Where VHIS Providers stipulate in the VHIS Certified Plan Policy Template that they may withhold part of premium refund for **reasonable administration charges**, they should explain the relevant practices and calculation to the applicants upfront.

(8) VHIS Providers should explain to applicants for Certified Plans the **cooling-off right** (see (d)(vii)(4) below) that policyholders will have during the cooling-off periods prescribed in the policies.

(9) In the case of a **Standard Plan**, VHIS Providers should explain to consumers during the selling process and upon enquiry that all benefits described in the **Standard Plan** are applicable **worldwide** except for psychiatric treatments. With **Flexi Plans** subject to restrictions in territorial scope of cover, they should instead explain the definition of regions with restrictions and the benefit adjustment rules, and that the reduction is inapplicable to the **Basic Benefits** of the **Flexi Plans**, i.e. the coverage equivalent to the **Standard Plan**.

(10) In the case of a **Standard Plan**, VHIS Providers should explain to consumers during the selling process and upon enquiry that all benefits described in the **Standard Plan** are not subject to any restriction in the **choice of healthcare services providers**. With **Flexi Plans** subject to restrictions in the choice of healthcare services providers, they should instead explain the list of selected healthcare services providers, and that the restrictions are inapplicable to the **Basic Benefits** of the **Flexi Plans**, i.e. the coverage equivalent to the **Standard Plan**.

(11) In the case of a **Standard Plan**, VHIS Providers should explain to consumers during the selling process and upon enquiry that all benefits described in the **Standard Plan** are not subject to any restriction in the **choice of ward class**. With **Flexi Plans** subject to restrictions in the choice of ward class, they should instead explain the targeted ward class and the details of benefit adjustment upon voluntary choice of higher ward classes, and that the insurance company will guarantee that such benefit adjustment will not apply in the event of involuntary ward upgrade, or to the **Basic Benefits** of the **Flexi Plans** (i.e. the coverage equivalent to the **Standard Plan**) in the event of voluntary ward upgrade.

(12) VHIS Providers should explain to consumers during the selling process and upon enquiry the **coinsurance** arrangement of prescribed diagnostic imaging tests under the **Standard Plan**, and the coinsurance and deductible arrangements approved by the FHB for eligible **Flexi Plans**, if any.

(13) Subject to the rules on tax deductions promulgated by the Government, VHIS Providers should, in the selling process and upon enquiry, inform consumers of the eligibility of Certified Plans for claiming **tax deductions**.

It is worth noting that the IA has issued a **guideline on medical insurance business (GL31) (see 1.2.4 for more details of this guideline)** to be applicable to all medical insurance business, including the VHIS. The guideline will provide guidance on the expected standard and practices to ensure fair treatment of customers.

(d) **Fundamental Features of the VHIS**

The VHIS is equipped with the following features in order for it to function effectively:

(i) Insured Persons under the VHIS must be **Hong Kong residents** (including holders of Hong Kong Identity Card) aged between 15 days and 80 years.

(ii) There are **two types of Certified Plans**: **Standard Plan** and **Flexi Plan**. The **Standard Plan** provides standardised basic coverage according to the minimum requirements of the VHIS, whereas the **Flexi Plan** provides enhanced coverage while generally preserving all the coverage provided by the **Standard Plan**. Examples of **Flexi Plan** enhanced coverage include higher benefit amounts and a choice of products that suit different consumers' needs.

(iii) **Setting of premiums** is virtually unconstrained. In line with the free market principle, VHIS Providers are free to set their own premium levels. By common market practice, Certified Plans may charge **standard premiums** that differ by age and gender, and adjust the overall premium level annually according to factors like medical inflation and revisions of benefit amounts. In order to enhance market transparency and promote price competition, it is a requirement that VHIS Providers publish age-banded premium schedules for their Certified Plans.

(iv) It is **not mandatory** for VHIS Providers to accept any applications. They may underwrite the insured persons to assess their risks, and decide whether to accept the applications unconditionally, accept the applications with premium loading and/or **case-based exclusions**, or reject the applications. They are required to explain their underwriting decisions and application results to the applicants concerned and, upon the applicants' request, provide written notice for such explanations.

(v) Certified Plans' coverage is not restricted to charges of private hospitals. Insured Persons may claim reimbursement of healthcare expenses incurred in **healthcare institutions, whether public or private**. Besides, purchases of Certified Plans will not affect Insured Persons' entitlement to use public healthcare services.

(vi) Upon successful registration as VHIS Providers, insurance companies must provide their existing policyholders of individual hospital insurance with an opportunity to switch (or "**migrate**") to Certified Plans.

(vii) Compared with many existing indemnity hospital insurance products, Certified Plans are more attractive in a number of ways, as reflected by the following **product features** of both the **Standard Plan** and the basic coverage of the **Flexi Plan**:

(1) The policy terms and conditions, benefit coverage and benefit amounts are standardized.

(2) Premium transparency is enhanced by easy access to the standard premium schedule by age, gender and other factors of each Certified Plan on the VHIS website and the websites of VHIS providers. Upon policy renewal, a VHIS Provider may adjust the standard premium for a VHIS policy according to the prevailing standard premium schedule adopted by it on an overall portfolio basis. During each policy year and upon renewal, no additional rate or amount of premium loading or **case-based exclusion(s)** on the insured person may be imposed by reason of any change in the insured person's health condition.

(3) The insured is guaranteed a right of renewal up to the age of 100. Moreover, there is no "**lifetime benefit limit**" - the maximum amount of benefits that a medical insurance policy says it will pay cumulatively during the lifetime of the insured person.

(4) The policyholder has the right ("**cooling-off right**") to cancel a newly effected policy during the 21-day period (or a longer period offered by the VHIS providers) after the delivery of the policy to the policyholder or to the policyholder's representative or the issuance of notice of policy availability to the policyholder or to the policyholder's representative, whichever is the earlier, with full refund of the premiums paid provided no benefit payment has been made or is to be made or impending.

(5) Coverage is extended to include:

- **Unknown pre-existing conditions** - Pre-existing conditions not known at the time of joining are partially covered during a waiting period of 3 years upon policy inception (i.e. no coverage in the 1st policy year, 25% reimbursement in the 2nd policy year and 50% in the 3rd policy year) and fully covered from the 4th policy year onwards.

- **Treatment of congenital conditions** – Investigation and treatment of congenital conditions which have manifested or been diagnosed after the age of 8 is covered, subject to the same reimbursement arrangement that applies to unknown pre-existing conditions.

- **Day case procedures** – Surgical procedures (including endoscopy) not conducted in hospital are covered, subject to such provisos as "medical necessity".

- **Prescribed advanced diagnostic imaging tests** – Computed Tomography ("CT scan"), Magnetic Resonance Imaging ("MRI scan") and Positron Emission Tomography ("PET scan") not conducted in hospital are covered, subject to 30% coinsurance.

- **Prescribed non-surgical cancer treatments** – Chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatments are covered.

- **Psychiatric treatments** – Psychiatric treatments during confinement in Hong Kong as recommended by a specialist are covered.

1.2.4 Guideline on Medical Insurance Business (GL31)

In order to make sure that fair treatment is applied to customers when selling the medical insurance products, IA has prepared GL 31 which is regarded as minimum standards for authorized insurers, licenced insurance intermediaries, and licensed insurance brokers. In fact, IA has considered the feedback from various stakeholders, insurance industry as well as the Insurance Core Principles, Standards, Guidance and Assessment Methodology ("ICP"). Generally speaking, ICP were circulated by the International Association of Insurance Supervisors on relevant aspects and practical application of supervisory concepts.

(a) **Purpose, Application and Status**

(i) Fair treatment of customers is a crucial principle which reinforces public trust and confidence in the insurance sector. In accordance with Insurance Core Principles (ICP) 19, fair treatment of customers includes achieving outcomes such as:

(1) developing, marketing and selling products in a way that concerns for the interests and needs of customers;

(2) providing customers with information before, during and after the point of sale that is accurate, clear, and not misleading;

(3) minimising the risks of sales which are not appropriate to customers' interests and needs;

(4) ensuring that any advice given is of a professional standard;

(5) dealing with customer claims, complaints and disagreements in a fair and timely manner; and

(6) protecting the privacy of information obtained from customers.

ICP 19 also shows that fair treatment of customers involves concepts such as ethical behaviour, acting in good faith and the prohibition of abusive practices.

(ii) GL31 applies to all authorized insurers underwriting medical insurance business, and all licensed insurance intermediaries carrying on regulated activities in respect of medical insurance business. GL31 applies in respect of all medical insurance business, including individual and group business, Certified Plans under the VHIS and any other types of medical insurance business. Besides, GL31 provides guidance on the standards and practices which are expected to be met in order to ensure fair treatment of customers across all aspects of medical insurance business.

(iii) GL31 does not have the force of law because it is not subsidiary legislation. Thus, it should not be interpreted in a way that would override the provision of any law. A non-compliance with the provisions in GL31 would not by itself make an authorized insurer or a licensed insurance intermediary liable to judicial or other proceedings. A non-compliance may, however, for example reflect on the IA's view of the continued fitness and properness of (1) the directors, controllers or key persons in relevant control

functions of the insurers to which GL31 applies and (2) the licensed insurance intermediaries to which GL31 applies and (in the case of licensed insurance agencies and licensed insurance broker companies) their directors, controllers or responsible officers. The IA may also take guidance from GL31 in considering whether there has been an act or omission likely to be prejudicial to the interests of policy holders or potential policy holders. In addition, the IA will always take account of the full context, facts and impact of any matter before it in this respect.

(b) **Product Design**

Authorized insurers should take into account the interests and needs of different types of customers when developing medical insurance products. Before launching a medical insurance product to the market, insurers should carry out a careful review of the product by making reference to their business models; the applicable law, regulations and rules (including but not limited to the Product Compliance Rules under the Ambit of the VHIS published by the FHB); and their risk management approach. In particular, insurers should put in place appropriate policies, procedures and controls to enable them to:

(i) design a medical insurance product that seeks to meet the identified needs and the expectation of the target customer base;

(ii) price a medical insurance product reasonably taking into account the sustainability of the product; and

(iii) adopt channels of distribution which are aimed at targeting the identified target customers.

(c) **Sales Process**

After launching any medical insurance product, an authorized insurer, licensed insurance agencies and licensed insurance broker companies should monitor the processes by which the product is distributed against the requirements set out in the section 6 (Sales Process) of GL31, with a view to ensuring customers are treated fairly during the selling process. If the insurer, licensed insurance agency or licensed insurance broker company identifies any shortfall from the requirements, they should take appropriate remedial action(s).

1.3 COMBINED POLICY AND PACKAGE POLICY

Either the combined policy or the package policy is a single policy document that provides more than one type of insurance, e.g. fire insurance, business interruption insurance, theft insurance, employees' compensation insurance and public liability insurance. This is increasingly the trend, as large organisations particularly become more sophisticated in their risk management and insurance appreciation. The form of such policies may be relatively simple, involving little more than a series of policy sections for the respective cover traditionally provided by separate policies. Alternatively, the policies may be very progressive in design, quite unlike traditional forms of cover.

The major difference between the combined policy and the package policy is that whereas each section or class of insurance of the combined policy is underwritten and rated separately, the package policy has pre-determined restrictions in cover and sums insured (and limits of liability) and has a radically different rating structure.

1.3.1 Household Insurance

Household insurance (or "home insurance") represents a major element in *private insurances* (sometimes called **personal** or **private lines**) which most insurers underwrite through their Fire Departments or Property Departments. This class of business also represents one of the oldest forms of a "package" policy, including not only **property insurance** (mainly on an "all risks" basis), but also some **liability insurance** and even some **insurance of the person** and **pecuniary insurance** (details later).

(a) **Basic intentions and scope of cover**

The main element of cover for household insurance is **property insurance** of the buildings and/or contents belonging to the insured. Cover may be purchased to insure the respective interests of landlords and occupiers:

(i) *Buildings only cover*

(ii) *Contents only cover*

(iii) *Buildings and contents cover*

Cover may either be on a **specified perils** basis or **"all risks"** basis. Buildings cover tends to be on a specified perils basis whereas contents cover on an "all risks" basis. The wording used to describe cover is detailed and complex and varies from one insurer to another, requiring careful study, but an outline of the cover provided includes:

(1) *Buildings* belonging to the insured or for which he is responsible. The **specified perils** cover starts with **Fire** and goes on to include most if not all of the **Extra Perils**

available with fire insurance. (The list of Extra Perils is long and includes **Storm/Cyclone, Earthquake, Explosion, Animal/Vehicle Impact,** etc.) In addition, loss or damage from **Theft** is included.

(2) *Contents* belonging to the insured or members of his family permanently residing with him. If not otherwise insured, property of resident household servants is also covered. Some insurers give new for old cover for household contents other than items like clothes and footwear. On a **specified perils** basis, Contents cover shares similar insured perils with Buildings cover.

Note: If the cover for (1) or (2) above is on an **"all risks"** basis, all loss of or damage to the insured property is covered, unless the cause or form of loss is specifically **excluded**.

(3) Contents temporarily removed but contained in premises within the specified geographical area.

(4) *Contents in transit* to a new home.

(5) *Other "property" cover* including such miscellaneous items as replacing locks if keys are lost or stolen, and replacing frozen food which spoils owing to breakdown of refrigerators.

(6) *Architects' and Surveyors' Fees* in respect of reinstatement of damaged buildings.

(7) *Accommodation/Rent*: if the insured premises are made uninhabitable by an insured peril, the policy will reimburse the insured occupier for any costs of alternative accommodation or the insured landlord for any loss of rent. (These are actually **pecuniary** insurance.)

(8) *Liability* of the insured, his family members residing with him and his domestic helpers (while performing their duties) towards third parties incurred as an owner, occupier or tenant of the insured premises, or as a private individual anywhere in Hong Kong. The policy may also expressly cover the insured's liability incurred as a part owner of the common parts of the building (e.g. external walls and walls enclosing corridors), with a provision dealing with the possible situation where the insured is also insured against such liability under a "building owners' corporation third party liability policy" (see **1.6.5**(e)) and/or any other third party liability policies effected by or on behalf of the owners of the building.

(9) *Personal accident*: a lump sum PA benefit is payable if the insured or any of his family members should die in a fire or at the hands of thieves.

(10) *Free services of referral to:* locksmiths, plumbers, electricians, air-conditioning technicians and the like.

(b) **Limitations and exclusions**

(i) *War, riots* and similar risks;

(ii) *Nuclear* risks;

(iii) *Consequential loss* (other than (a) (7) above);

(iv) *Unoccupancy*: Policies usually suspend cover for theft and escape of water from a washing machine and the like when the premises have been unoccupied for more than, say, **30 consecutive days**. In fact, household policies usually require the insured to notify the insurer in writing of any anticipated period of unoccupancy exceeding, say, 30 days;

(v) *Policy excesses*: Some perils (e.g. windstorm, etc.) are very likely to be subject to excesses, partly to eliminate trivial losses and partly to involve the insured in his own loss experience. On the other hand, "all risks" property cover is universally subject to excesses. Discounts are available for voluntary excesses;

(vi) *Pro rata average condition*: Where the premium is based on a sum insured selected by the insured, the policy terms will include a pro rata average condition, so that if under-insurance exists at the time of loss, the insured will not be covered for the full amount of loss. For example, if at the time of loss the sum insured represented only 80% of the value at risk, the claim payment would be limited to 80% of the loss, in no case exceeding the sum insured. On the other hand, where the household policy provides for limits of liability instead of a sum insured and the premium is based on the gross floor area of the insured premises, no pro rata average condition will be included so that losses are payable up to the applicable limit of liability without the exemplified proportional reduction.

(c) **Premium basis**

Although a number of different types of risk are covered, the premium is traditionally based upon a rate per cent (per $100) or per mille (per $1,000) applied to the value of the buildings (exclusive of foundation and land value) and/or contents, with a higher contents rate than the building rate. Most insurers now offer household contents cover with

standard limits of liability and with premiums based on the gross floor area of the insured flat, and are ready to increase the limits for specified items in return for additional premiums. This is a contrast to the traditional rating method, by which a premium rate is applied to the sum insured granted.

1.3.2 Domestic Helper Insurance

(a) **Scope of cover**

Offered as a standalone policy or as an optional cover under a household policy, domestic helper insurance is basically a package of cover for *employers' liability* to domestic helpers and *employees' benefits* to them such as:

(i) *medical expenses*;

(ii) *repatriation expenses*: i.e. the costs of returning the domestic helper or his or her remains to his or her home country in the event of his or her physical incapability to continue to be employed or death (as the case may be);

(iii) *personal accident benefits;* and

(iv) *public liability*: i.e. the domestic helper's legal liability incurred in Hong Kong towards third parties.

The following may also be covered: *temporary domestic helper allowance*, a daily cash subsidy, to the insured householder in the event of the domestic helper's hospitalisation for, say, over 3 days, the *cost of replacing the domestic helper* in the event of his or her leaving the insured without notice, disability or death, and financial loss to the insured due to the domestic helper's *infidelity*.

(b) **Limitations and exclusions**

These will be in line with the various types of insurance offered. For example, personal accident cover will be subject to the customary PA exclusions (specified sports, suicide, childbirth, pregnancy, etc.), and medical expenses cover will exclude pre-existing condition, cosmetic surgery, routine medical examinations, etc.

(c) **Premium**: a flat premium per domestic helper is charged.

1.3.3 Travel Insurance

With increased prosperity and higher standards of living, international travel is now commonplace for many Hong Kong residents. This has given rise to great demand for travel insurance, another type of "package" policy of many years' standing.

(a) **Basic intentions and scope of cover**

The intentions are virtually self-explanatory, to meet unforeseen financial and other problems encountered whilst on holiday outside Hong Kong. Specifically, the cover provided is very diverse and is very likely to include:

(i) *Medical expenses and hospital benefit*: Private medical treatment in some countries, notably the United States and Canada, is very expensive. High limits of cover for necessary medical treatment incurred as a result of an illness or accidental bodily injury are therefore given, sometimes amounting to several millions of dollars. The policy may also offer a daily hospital cash allowance in the event of the insured person's hospital confinement necessitated by an illness or accidental bodily injury.

(ii) *PA benefits*: On a similar basis to PA cover already discussed.

Case 12 Definition of "loss of one limb" for the purposes of personal accident insurance cover

The insured had a fall and fractured his right elbow bone during a trip to the USA. He submitted claims for medical expenses incurred and partial disablement of his right hand under his travel insurance.

The insurer paid the medical expenses incurred but rejected his claim for partial disablement of right hand since the insured's physical condition did not fulfil the definition of "Loss of one Limb" or any other insured injuries under the personal accident section of the travel policy. In the policy, "Loss of one Limb" is defined as "loss by physical severance of a hand at or above the wrist or of a foot at or above the ankle, or loss of use of such a hand or foot" and "Loss of Use" is defined as "total functional disablement".

Although the insured was confirmed by an occupational therapist that some of the functional abilities of his right hand were permanently affected and the injury had caused a lot of inconvenience to his daily life, there was no physical severance of a hand at or above the wrist or total functional disablement. As such, the Complaints Panel did not agree that his physical

condition fulfilled the basic claim requirement for the benefit of "Loss of one Limb".

More importantly, the policy does not specify any proportional compensation for partial permanent disability or partial functional loss. The Complaints Panel concluded that the insured's physical condition did not qualify for the "Loss of one Limb" benefit. It therefore supported the insurer's decision to reject the claim.

***Remarks**: the specific policy definition for "loss of one limb" was well respected by the Complaints Panel.*

(iii) *Luggage and personal effects loss/damage*: The cover is on an "**all risks**" basis.

(iv) *Loss of deposits or cancellation of trip*: Where the insured trip has been cancelled because of the happening of any of the specified perils and some or all of the payments, if any, that have been made in advance or have become due for a tour, a flight or other travel arrangements are irrecoverable or unavoidable, such a loss is recoverable under the policy. In response to the introduction of an Outbound Travel Alert (OTA) System by the Security Bureau, travel policies issued in Hong Kong include as an insured peril the issuance within, say, 7 days before the scheduled departure date of a black or red OTA by the Security Bureau for the planned destination.

(v) *Curtailment of trip:* Where the insured trip has commenced outside the place of origin but, because of the happening of any of the specified perils, has to be curtailed unavoidably, the policy will pay for any loss of pre-paid travel fare or accommodation expenses, and any additional costs of returning to the place of origin. Included in the specified perils is the issuance of a black or red Outbound Travel Alert by the Security Bureau for the planned destination.

(vi) *Loss of personal money*: Loss of personal money (as defined in the policy) caused by theft, robbery or burglary (their definitions in the Theft Ordinance (Cap 210) may be used as a reference) is covered.

(vii) *Travel delays and baggage delays*: A specified sum is payable in the event of inordinate delays of aircraft for time in excess of, say, 6 hours. Where the insured person has been temporarily deprived of his baggage for a period exceeding, say, 6 hours after arriving at the destination because of delay or misdirection in delivery, the policy will reimburse him for any cost of recovering the baggage or purchasing essential items of toiletries or clothing.

(viii) *Emergency services*: Such as emergency evacuation, repatriation for medical care, repatriation of remains or ashes, burial and funeral expenses, and deposit guarantee for hospital admission.

(ix) *Personal liability*: This covers the liability of the insured person towards third parties in respect of death, injury or property damage, and the relevant costs and expenses.

(x) *Loss of travel documents:* This is cover for the costs of replacing passports, travel tickets or other travel documents lost as a result of theft, robbery or burglary (or any other insured peril), and the costs of travel or accommodation incurred in arranging such replacement documents.

(xi) *Miscellaneous cover*: A wide variety of cover and services may be found in this competitive class of business, including a benefit for hijack, and consultation and advice on an international "helpline".

(b) **Limitations and exclusions**

(i) *Generally*: These will be in line with the various types of insurance offered. For example, PA cover will be subject to the customary PA exclusions, and liability cover may exclude liability arising from the use of motor vehicles, etc.

(ii) *Excesses*: Most sections of the policy are very likely to be subject to an excess, mainly to eliminate trivial claims.

(c) **Premium basis**

Policy cover is usually offered as a "package" deal, with optional plans distinguishable mainly by sums insured, limits of liability and amounts of benefits. The important elements in deciding the premium are:

(i) *Geographical area*: Many insurers offer either World-Wide cover, or two bands of cover: (a) about a dozen of named Asian or East Asian countries, and (b) World-Wide, obviously with increasing premium rates.

(ii) *Duration*: Premiums are usually quoted according to the number of days involved with the trip.

(iii) *Number of persons covered*: Travel insurance is obviously related to family holidays. The insured's spouse, family members or friends travelling with him may be offered advantageous overall rates.

(iv) *Annual policies*: For frequent travellers (business and/or holiday) an annual contract may be arranged at an attractive single premium.

(d) **Other features**

(i) *Underwriting*: A feature of this type of business is that everything is made as simple as possible, because cover is usually obtained at the last minute and a product which is not "user friendly" with this mass market is not likely to succeed. As a consequence, there is little individual underwriting of risks.

(ii) *"Master policies"*: It is quite common for "master policies" to be issued to travel agents, who arrange many "package" holidays. Individual customers merely receive an insurance certificate outlining the major insurance provisions.

1.3.4 Commercial Combined Policies

The nature of such policies is that they are often individually designed by a particular insurer and/or for a particular client. As such, detailed descriptions are not really feasible in these Study Notes. However, the existence of such cover and certain features may usefully be mentioned.

(a) *Combined Property and Pecuniary Policy*

This tends to offer cover on an "**all risks**" basis, covering both material damage and business interruption under the same policy.

(b) *Combined Liability Policy*

Typically, such a policy includes within a single document cover for **Public Liability**, **Products Liability** and **Employees' Compensation Liability**. Individual clients may also require **Directors' and Officers' Liability** cover and/or **Professional Liability** cover.

(c) *Combined "Umbrella" type cover*

These could include any types of cover, including **property**, **pecuniary** and **liability** risks. They are very likely to be individually designed to meet the requirements of specific insured. It is not feasible in these Notes to identify specific limitations or other features with such cover, as they are so individual. One common intention, however, is that the insured would look not only to the convenience of single-document cover, but would also expect overall savings in premiums.

CAUTION: The insured, or his agent, should take great care to ensure that each of the policy sections or types of insurance is the subject of a separate contract as reflected by completely clear policy wording, despite a possible argument that that is implicitly intended. Otherwise, the breach of a contract term which at first glance is solely applicable to a particular section or type of insurance may, when a claim arises, possibly be found to be construed as affecting all other sections or insurances as

well on the basis that the policy represents a single contract, rather than concurrent, separate contracts. In this regard, particular attention should be paid to the use of warranties, the nature of which is such that their operation does not turn on materiality or causation (see **2.3.4**(a) below).

1.4 PROPERTY INSURANCE AND PECUNIARY INSURANCE

To remind you, **property insurance** means that the subject matter of insurance is physical objects (e.g. buildings and ships) and **pecuniary insurance** covers a non-tangible financial interest that may be threatened by an insured event (loss of future rent, incurring of extra expenses, etc.).

1.4.1 Fire and Extra Perils Insurance

While a preponderance of property insurance policies on commercial property are now effected on an "all risks" basis, the traditional fire policy (perhaps with extra perils extension) is largely purchased by home owners for the benefit of the mortgagees as well as themselves.

(a) **Basic intentions and scope of cover**

This is virtually self-explanatory for this class of business, but specifically the policies cover the following perils:

(i) *Fire*: This may seem totally obvious, but some features need to be noted:

(1) "Fire", as a peril, means actual ignition of something (whether or not it be an insured property) that *should not be on fire*, not deliberately caused or arranged by the insured (i.e. not fraudulent). [Illustration: fire in a fireplace is intended, and is therefore not covered by the fire policy. However, if sparks from the fire ignites pieces of wood lying somewhere close to the fireplace, such wood is said to be damaged or destroyed by "fire" within the meaning of the fire policy.]

(2) "Fire" damage will include damage caused by smoke, heating and extinguishing water, if the proximate cause is fire as understood above. Damage reasonably caused by the fire brigade or others in the course of fighting a fire is also covered.

(3) The fire does not have to burn on the insured premises. Thus, a fire as defined above burning in a neighbouring property could create a valid fire claim from heat, smoke or water damage, etc. to the insured property.

(ii) *Lightning*: whether followed by fire or not.

(iii) *Explosion*: although there is an excluded peril of explosion under the standard fire policy, the relevant exclusion clause explicitly does not apply to damage arising from the insured peril of explosion of gas (or boiler) used for **domestic** purposes.

(iv) *Extra perils*: also known as **special perils**, **allied perils**, or **extended perils**. These perils can hardly be said to be similar to the basic perils of fire, lightning and "limited" explosion, but are traditionally available with fire insurance for an extra premium. The extra perils insured by a particular fire policy are specified in the policy schedule, and may include riots & strikes, subsidence & landslide, storm & typhoon, impact by vehicle and damage by aircraft.

(b) **Limitations and exclusions**

(i) *Pro rata average condition* (or "*average condition*"): The customary property insurance requirement for full insurance, with a penalty for under-insurance in the event of a claim, applies.

(ii) *Excesses*: It is not usual to have an excess in respect of the basic cover (i.e. fire, lightning, and "limited" explosion), but a standard one will apply with certain of the **extra perils**.

(iii) *Policy exceptions*: The "standard" exclusions relating to war, nuclear incidents and terrorism appear, with a number of others, some of which may be added as extra perils. It is not necessary for us to make a complete list of the policy limitations, but it should be noted that **Theft** during or after the occurrence of a fire is specifically excluded.

(c) **Premium basis**

As with most property insurances, the premium will be based on a rate (per cent or per mille) applied to the sum insured. Properties are classified according to relative risk for rating purposes, with loading or discounting of premium as appropriate according to individual features such as the height of the insured buildings, their remoteness or otherwise, and their fire fighting facilities.

(d) **Other features**

(i) The proposer's selection of appropriate **extra perils** is important.

(ii) The need for an adequate **sum insured** is also important, because of the **average condition**.

(iii) With complex fire risks or considerable values at risk, it is prudent to have a **risk survey** of the premises to be insured carried out by or on behalf of the insurer, mainly to reveal the hazards involved.

(iv) It is common for separate sums insured to be shown on a fire policy for different types of insured property, such as:

(1) buildings;

(2) stock in trade;

(3) machinery;

(4) other contents.

1.4.1a Fire Business Interruption Insurance

This is a pecuniary insurance, separate from but very closely connected with fire insurance. Whereas fire insurance (or fire material damage insurance, to be more specific) indemnifies the insured for loss of or damage to physical property, fire business interruption insurance compensates him for other types of after-effects of a fire, etc. (in the form of loss of profit, extra expenses, etc.). Of course, a business interruption (BI) policy may be effected in association with other types of material damage cover, e.g. commercial property "all risks" cover and marine cover.

(a) **Scope of cover**

(i) Loss of **Gross Profit** (as defined in the policy) caused by an insured peril.

(ii) **Additional expenses** necessarily and reasonably incurred as a result of an insured peril (e.g. hiring alternative premises).

(iii) **Wages** (sometimes included with (i) above instead) paid during an interruption period.

(b) **Limitations and exclusions**

The policy wording is similar to the fire policy wording, covering almost the same set of perils (fire, lightning, etc.), but two important features of the Fire BI policy should be noted:

(i) **Material damage proviso (MD proviso)**: The typical MD proviso provides that no loss will be recoverable under the BI policy, if there is not a material damage (another term for physical damage) insurance in place in respect of the same policyholder's interests or if the fire material damage insurer neither admits liability nor pays for the material damage from which business interruption results. What is the purpose of the MD proviso? With an uninsured property loss, the policyholder might be short of funds for the necessary repairs or reinstatement, so that the resulting interruption period would be extended, very likely

increasing the liability of the BI policy if not for its MD proviso.

Technically the fire material damage policy does not need to be with the fire BI insurer, but no Hong Kong insurer is very likely to give BI cover without also covering the material damage risk.

(ii) **Policy specification** (or "**Specification**"): A very important part of the BI policy is the definitions of **gross profit** (which has a different definition from that normally used by accountants) and other terms applicable to the cover.

(c) **Premium basis**

The premium calculation is complex, but it begins by using the rate charged for insuring the **contents** of the building for **fire** insurance. This is then loaded according to the **time factor** involved with the cover (see below).

(d) **Other features**

These notes give a much abbreviated summary of a fairly complicated class of business, but the following should be noted:

(i) *Alternative names*: "Business Interruption Insurance" is the most modern term for this class of business, but it may also be called "**Consequential Loss Insurance**" or "**Loss of Profits Insurance**".

(ii) *Time element*: With material damage, the most important time is the date of the accident (e.g. fire), since the amount of claim will be related to that. With BI insurance, the loss is spread over a period after an insured accident. Clearly there must be a limit to this interruption period (the **"Indemnity Period**") for the purpose of defining policy liability. Known as the **"Maximum Indemnity Period**", this limit may be as short as three months or much longer (say, 18 months) from the date of an insured accident. The features of individual risks and their ability to return to normal business levels (e.g. the likely length of time taken to repurchase pieces of specialized equipment) are vital in this area.

(iii) *Loss calculation*: This is a very complex matter, usually requiring the help of professional accountants. In essence, however, an attempt is made to measure the loss sustained during the indemnity period by comparing income, etc. during that period with the comparable period last year

(when business was not interrupted), making any necessary **"trend adjustments**" for such factors as increased market competition and the outbreak of an epidemic during the indemnity period which in no way are imputed to the insured accident.

1.4.2 Property "All Risks" Insurance

When this class of business was first introduced, it was thought this was too daring. For the first time, accidental loss or damage, sometimes even without knowing the real cause, was covered. To remind you, "**all risks**" insurance means that all loss or damage is covered unless specifically **excluded**. Once the insured has proved accidental loss of or damage to the insured property, the onus is on the **insurer** to prove that an exclusion applies if policy liability is to be denied.

(a) **Basic intentions and scope of cover**

The nature of the cover is described above. It will immediately be seen that the scope of cover is very wide. Originally, "all risks" cover was offered only in respect of individually specified articles of significant value, such as jewellery, furs, etc. (in the early days, also limited to well-known and trusted clients). Competition and market development led to the cover being provided much more freely on a vast range of tangible property.

(b) **Limitations and exclusions**

The name "all risks" is usually expressed in inverted commas, to signify that strictly speaking not **all** conceivable risks are insured. There are exclusions, which are very likely to include:

(i) *Inevitable loss*: wear and tear, depreciation, etc. will certainly happen and are therefore uninsurable.

(ii) *Lack of routine care*: Losses from the effects of light, vermin and atmospheric conditions are foreseeable and are either inevitable or should be prevented by reasonable precautions.

(iii) *"Standard" exclusions*: War, nuclear risks and terrorism.

(iv) *Unreasonable causes*: It is not considered proper to insure losses deliberately caused by the insured or suffered while participating in illegal activities (including confiscation by customs or other authorities).

If the insurance includes **unspecified** items, the cover is very likely to be subject to **average**. Average does not always apply where each item has its own sum insured.

(c) **Premium basis**

The premium will invariably be based upon a rate applicable to the sum insured, with different rates for different geographical areas of cover (world-wide cover naturally being the most expensive).

(d) **Other features**

(i) *Application*: "All risks" cover applies in many types of insurance. As a separate class of business, it is mainly concerned with **personal** property owned by individuals. However, "all risks" cover on commercial property has become very common, particularly for large clients.

(ii) *Agreed values*: The original intention for "all risks" cover to insure valuable items is still important. With high-value items insured on this basis, **agreed value** cover is common, so that the sum insured is payable for a total loss, without regard to the actual value. The sum insured or agreed value is likely to be the result of an independent professional valuation.

1.4.3 Theft Insurance

(a) **Basic intentions and scope of cover**

The intentions are virtually self-explanatory: to cover loss of or damage to the insured property caused by theft or attempted theft. For domestic and personal risks, such cover is very likely to be provided by a household, "all risks" or travel policy. A standalone **theft** policy is largely confined to **commercial** risks.

One important feature about the scope of the cover is that policies normally include **damage** caused by thieves to the insured premises in making **forcible and violent entry to or exit from** the insured premises (see (b)(i) below), without a separate sum insured for such damage. Separate sums insured are normally specified for **stock** and other **contents** such as office equipment.

(b) **Limitations and exclusions**

(i) *"Theft"*: There must be some breaking down of the security defences of the insured premises before any claim is payable. A customary limitation is that theft is only covered if accompanied by "**forcible and violent** entry to or exit from" the insured premises. Such an entry can be made by, say, damaging the lock on a door or smashing a window. Sometimes, a thief may enter, say, a department store as a customer, hide somewhere until it is close for business, and escape with stolen goods by force and violence to the doors or windows of the premises. (**Note**: insurers

do not construe the phrase to include force and violence to people.)

(ii) *Theft by staff*: Theft by staff is a **fidelity guarantee** risk (see **1.4.6** below) and is excluded from the theft policy. Theft with the **collusion** of staff members is also not covered.

(iii) *Fire damage*: It is not unknown for thieves to start a fire to destroy evidence of their theft. But damage by fire is excluded under the theft policy.

(iv) *Average condition and first loss insurance*: Full value insurance - insurance effected on a full value basis - is normally expected, so pro rata average will apply in any under-insurance situation. However, where a risk situation is such that a total loss or very large loss is assessed to be rare, a theft policy may be issued on a "first loss basis", that means a sum insured lower than the value declared to the insurer is allowed so as to achieve savings in premiums. The first loss policy, though not subject to the normal average condition, will still penalise the insured in a somewhat similar manner for any undervaluation situation where at the time of loss the declared value is found to be below the actual value at risk.

(v) *Floating policy*: Where stocks are kept at different locations and at any point of time the insured will have difficulty giving separate, precise values in those locations, a floating policy may be issued with a single sum insured for all those locations combined.

(vi) *Warranties*: It is quite common for theft policies on valuable property to be subject to warranties. Examples include requirements for specific security devices (types of lock, iron bars, etc.) and/or security measures (systems regarding use and custody of keys, stock left in public view overnight, etc.). (To remind you, a breach of warranty will automatically discharge policy liability as from the date of the breach.)

(c) **Premium basis**

The premium will usually be calculated by applying a rate to the sum insured, which varies with the attractiveness of the property to thieves.

(d) **Other features**

(i) *Extensions of cover*: Various extensions are available, e.g. **hold-up** cover, which insures against theft accompanied by actual violence or a threat of violence against the insured or his employees, but not by violation of the security defences of the insured premises. Also, PA cover for staff may be included.

(ii) *Risk surveys*: Frequently necessary because of premises-specific hazards, substantial values or attractive stock at risk, or proposal from a new client.

(iii) *"Target risks"*: Some goods are particularly attractive to thieves owing to such features as value, weight, size and ease of disposal. They include gold, jewellery and furs. Target risks are very likely to face more severe policy terms and premiums.

(iv) *Alternative title*: Originally, this class of business was known as **Burglary** insurance. Some insurers in Hong Kong may still be using this title.

1.4.4 Glass Insurance

(a) **Basic intentions and scope of cover**

It is immediately obvious in Hong Kong how glass has become a very fashionable building material. Such structures, particularly with very large areas and/or tinted glass involved, are very expensive. The need for separate insurance is therefore apparent.

The insurance is on an "**all risks**" basis, covering not only actual breakage of the fixed glass insured but any cost in the necessary temporary boarding-up of the premises concerned.

(b) **Limitations and exclusions**

(i) *Fire risks*: Risks insurable under a fire policy, such as fire, storm and earthquake, are excluded.

(ii) *Wear and tear, etc.*: As is customary with "all risks" cover, losses attributable to the effect of time (in this case dilapidation of frames or framework) are excluded, as is scratching without actual breakage of the glass.

(iii) *Standard property insurance exclusions*: War, nuclear risks, terrorism, etc.

(iv) *Consequential loss*: Loss of business and extra expenses (other than boarding-up expenses) resulting from breakage of the insured glass are excluded.

(c) **Premium basis**

Clearly, the quality of the glass concerned has an influence on the premium, which is generally based on the area of the glass to be insured.

(d) **Other features**

(i) *Decoration, etc.*: Commercial glass is frequently decorated with words or pictures. If such decoration is to be covered, it need be specified in the policy, which otherwise will only replace the broken glass.

(ii) *Social disorder*: Glass in public places is particularly vulnerable in the event of any strikes, riots, etc. Such perils are **excluded** by the glass policy, so enquiries should be made whether the glass or fire policy can be extended to cover such risks.

(iii) *Alternative title*: Originally, this class of business was known as **Plate Glass** insurance (since it only covers fixed glass installations). Some insurers in Hong Kong may still be using this title.

1.4.5 Money Insurance

Thought to be too hazardous to contemplate in earlier days, money insurance is now commonly provided for a wide range of commercial organizations.

(a) **Basic intentions and scope of cover**

Originating from a class of business called **Cash in Transit Insurance**, the modern money policy covers various forms of money in various locations. Features to note are:

(i) *Cover* is on an "**all risks**" basis. In addition to loss of money, damage to safes and strong-rooms, etc. caused by thieves is usually covered.

(ii) *"Money"* means much more than legal tender, extending to include cheques, bank drafts and other forms of financial documents.

(iii) *Location*: While **cash in transit** remains a major element of cover, cover at other locations (including the homes of specified staff and the insured's business premises) is also very likely.

Case 13 Loss of cash outside business hours

On the way back home after her shop had closed, a shop owner discovered that her wallet together with some cash was missing from her bag. She immediately reported the loss to the nearest police station.

Declaring that the lost cash was business income, with which goods were to be purchased, the insured shop owner submitted an insurance claim for the loss under a money policy. The policy covers "loss of money and securities caused by robbery, burglary or theft only up to a specified limit outside the Insured Premises while being conveyed by messenger during normal business hours and within the territory of Hong Kong."
Since the loss had occurred outside business hours, the claim was rejected.

***Remarks**: intending to insure only business money (rather than personal money), the money policy normally restricts insured losses to losses occurring during normal business hours.*

(b) **Limitations and exclusions**

(i) *Separate sums insured* may apply to different locations.

(ii) *Security*: It may be required that money be kept in a safe or a similar secure place, except for limited amounts and limited times. Money is required to be deposited with a bank as soon as possible.

(iii) *In transit*: Still on the question of security, the policy may require that money be transported only by male escorts (at least two with sums exceeding a specified amount) and the manner or route of transit may have to be agreed.

(iv) *Theft committed by staff* or with the collusion of staff is insurable by fidelity guarantee insurance and is therefore excluded.

(c) **Premium basis**

The premium is calculated by applying a rate to the estimated annual carryings of money to and from the bank. As such, a **provisional** premium is payable, subject to an **annual adjustment** when the final figures are known.

(d) **Other features**

(i) *Proof of loss*: Adequate records must be kept to establish loss figures and to enable premium adjustment.

(ii) *Extensions*: It is quite common to provide a PA extension to money policies, covering injuries caused to staff by thieves.

1.4.6 Fidelity Guarantee Insurance

(a) **Basic intentions and scope of cover**

Perhaps the earliest form of **accident** insurance, fidelity guarantee insurance is a **pecuniary** insurance which insures an employer against loss of money or property as a result of any act of fraud, theft or dishonesty by any person in the course of employment by him. Features to note with the general scope of this class of insurance are:

(i) *Causes of loss*: The policy covers **dishonest** acts by staff. It will therefore not apply to general errors and omissions.

(ii) *Staff covered (or guaranteed)*: Various forms of policy cover are available, the commonest being:

(1) **Individual cover**: the guaranteed staff are individually named and subject to a specified limit.

(2) **Combined cover**: where a schedule of names (or positions) is given, either with separate sums insured, or with a floating sum insured (i.e. a sum insured not divided among the insured individuals or positions), or a combination of the two.

(3) **Blanket cover**: where the policy covers all the insured's staff, usually with separate categories (inside/outside, handling/not handling cash, etc.) and separate sums insured.

(b) **Limitations and exclusions**

(i) *System of check and supervision* is a very important underwriting consideration. The approved system must not be varied without the written consent of the insurer.

(ii) *Second chance*: Employers may sometimes be very forgiving and allow persons who have defrauded them to continue in their employ. In this regard, the policy provides that any knowledge of or reasonable suspicion about an employee's dishonesty must be reported in writing to the insurer within say 7 days after discovery of such circumstances, who will suspend cover in respect of that employee until he is satisfied otherwise. The policy may also make provision for immediate, automatic cessation of guarantee in respect of that employee after such discovery.

(c) **Premium basis**

A rate is applied to the amount guaranteed, influenced considerably by the nature of the employment and some other factors.

(d) **Other features**

(i) *A "guarantee"*: As far as the **employee** is concerned, it is a **guarantee**. But to the **employer**, it is insurance. The main difference is that the dishonest employee is liable in law to reimburse the **guarantor** (in this case the insurer) for payments the latter makes to his employer on account of his default. In practice, this may not be worth much.

(ii) *Default items*: Originally, these policies only covered defaults relating to **money**. It is now quite normal for the policy to cover defaults concerning **stock** as well.

1.4.7 Surety Bonds

Most insurance contracts are **simple contracts** and thus do not have to be evidenced in writing (although they almost invariably are). **Surety bonds**, on the other hand, are very formal types of contract.

(a) **Basic intentions and scope of cover**

A surety bond is an agreement in writing involving three parties, namely the principal, the obligee and the surety (or "guarantor"), under which the surety, in consideration of a fee paid by the principal, provides a financial guarantee to the obligee that the principal will fulfil his obligations – statutory obligations, contractual obligations, etc.

Issued by insurers, sometimes by banks, surety bonds are different from insurance. Unlike insurance, which protects the party obtaining the insurance, a surety bond protects the party requiring the bond rather than the party paying for the bond. If the principal, for whatever reason, fails to meet his obligations to the obligee, the obligee may seek compensation from the surety up to the bond amount. Under the terms of the bond, the surety will then have the right to be repaid by the principal.

There are a few types of surety bonds, perhaps with the performance bond being the mostly known type. What is a performance bond? A contractor, upon winning a bid, may be obliged to submit a performance bond to the principal of the contract, which bond will guarantee that the contractor will complete the job according to the terms of the contract.

(b) **Limitations and exclusions**

With bond claims, almost none of the usual exclusions and limitations surrounding insurance contracts will apply. The surety may, of course, decide to pay or deny a claim. Apart from these, the surety is likely to have options to remedy a performance default, e.g. advancing funds to finance completion of the job by the principal, or assuming the responsibility for completing the remaining work with the help of appointed construction professionals (i.e. the takeover option).

(c) **"Premium" basis**

The payment to the surety is not a premium, and is more properly called a "fee" or a "charge". It is usually a single payment.

(d) **Other features**

(i) *No renewals*: Normally, a surety bond is not subject to a renewal, although an extension of the designated time for the bonded contract may arise. Technically, a renewal is not necessary because a surety bond normally has no expiry date.

(ii) *Counter guarantees*: The surety usually requires **personal counter guarantees** in its favour from the directors of the principal or of the principal's parent company, or others acceptable to the surety, to safeguard recovery prospects in the event of a bond claim.

(iii) *"Signed, sealed and delivered"*: A surety bond must be evidenced in writing and must be issued **under seal**, otherwise the obligee, who has provided no consideration to the surety, will not acquire the right to make a claim under the bond. The classic phrase used with such contracts is that they must be "signed, sealed and delivered" and these words usually appear in the bond document. Surety bonds are usually issued from the **Fidelity** or **Accident** department of the insurer concerned.

1.5 ENGINEERING INSURANCE

Most of the insurances under this heading are technically complex and both underwriting and claims work associated with them is very likely to need the technical help of suitably qualified experts. These Notes, therefore, will be briefer than for classes of business previously discussed. Only outline knowledge of this insurance is needed.

1.5.1 Boiler Explosion Insurance

(a) **Cover**

Boiler Explosion Insurance (or "Boiler and Pressure Vessel Insurance") insures against the results of an **explosion** (which is physical in nature as opposed to chemical) or **collapse** of a boiler or pressure vessel "*whilst in the course of ordinary working*". It can be in the form of a separate policy or an extension to a machinery breakdown policy or fire policy. The cover usually consists of the following:

(i) Damage to the boilers or pressure vessels of the insured.

(ii) Damage to other property of the insured.

(iii) Liability for damage to third party property or the death of or bodily injury to third parties, plus costs and expenses.

(b) **Exclusions/limitations**

(i) *Risks normally insurable by other policies*, such as fire and extra perils.

(ii) *"Standard" exclusions*, such as war, nuclear risks and terrorism.

(iii) *Inappropriate cover*, such as wilful act and wilful neglect of the insured, and wear and tear.

(iv) Extraneous cause: own damage resulting from any extraneous cause.

(c) **Some other terms**

(i) The policy usually specifies a sum insured for each boiler or pressure vessel and a limit of indemnity for damage to other property of the insured and third party liability.

(ii) Each item of boiler or pressure vessel insured is separately subject to the typical average condition.

1.5.2 Machinery Breakdown Insurance

(a) **Cover**

"Breakdown" is a situation in which a machine stops working. While a typical commercial property policy does not cover loss or damage caused by electrical arcing, mechanical breakdown and the like, Machinery Breakdown (MB) Insurance gives "all risks" cover for "*unforeseen and sudden*" physical loss of or damage to the insured plant, machinery, equipment, computer, etc. which have been erected and are operational or at rest. Some MB policies combine inspection service by qualified people with cover for material damage (or material damage plus business interruption).

(b) **Exclusions/limitations**

(i) *Policy deductible*, which may be of a fairly significant amount.

(ii) Perils insurable by a standard fire and extra perils policy – MB insurance is meant to supplement such a policy.

(iii) *"Standard exclusions"*, such as war, nuclear risks, terrorism, etc.

(iv) Deterioration of machines resulting from normal use.

(v) Pre-existing defects.

(vi) Overload experiments and abnormal operating conditions.

1.5.3 Contractors' "All Risks" Insurance

With enormous amounts of construction work of all kinds constantly going on in Hong Kong, this is a very important class of business, involving a huge premium volume. All parties involved in any way in a construction project may be insured, namely, the owner, the contractors, etc. In order to avoid gaps in insurance cover and to achieve overall savings in premiums, it is advisable to put in place a single policy for the whole project, with all the project participants as the insured parties – named or unnamed.

(a) **Cover**

The usual form of policy is in two Sections:

(i) Section I provides property insurance on an "all risks" basis in respect of specified property, which is very likely to include the contract work, and any materials supplied by the Principal, with add-on cover for construction plant and equipment and construction machinery (as an alternative to a separate plant and machinery policy). Clearing of debris costs may also be included.

(ii) Section II provides liability insurance for third party injury or property damage arising out of the construction work.

(b) Exclusions/limitations

(i) Section I has the usual exclusions applicable to "all risks" cover. Other specific exclusions include faulty design, defective material, bad workmanship, and losses only discovered on taking an inventory.

(ii) Section II excludes liability in respect of loss of or damage to property belonging to the insured (e.g. work covered under Section I of the policy) and various perils, including weakening or removal of support (which can be covered under an endorsement to the policy for an extra premium).

(iii) Deductibles are normal with Section I, varying in amount according to the peril and property concerned. It is also the custom to have a deductible under Section II for third party property damage.

1.5.4 Erection "All Risks" Insurance

This form of policy very closely follows the format and wording of the Contractors' All Risks policy (see above). With the latter, the insured work involves the actual construction of buildings, etc. With erection all risks insurance, it is "all" loss of or damage to the insured machinery, plant or steel structures resulting during the course of erection, installation, storage, testing or commissioning that is covered. Add-on cover for third party liability is available.

1.6 LIABILITY INSURANCE

Several of the products we have already considered contain policy divisions giving third party liability cover. Those in this section, however, are exclusively third party cover. The liability for respective cover may arise from Statute (i.e. law made by the legislature) and/or in the Common Law (usually negligence). Liability at law can also arise under Contract, but it is usual to exclude from liability cover contractual liability, i.e. liability assumed under an agreement (see **1.1**(d)(iii)(4) for an illustration). Such an exclusion is necessary because the nature and scope of potential contractual liability vary a lot from one insured to another, and an extension to cover contractual liability will be inappropriate without a meticulous risk assessment.

It is important to understand that liability insurance is an agreement intended to protect the insured instead of third parties, and to cover "liability for third party injury or property damage" instead of "third party injury or property damage". That means a third party generally has not the right to claim against the insurer that has insured the person alleged to have caused the third party injury or damage. And the liability insurer is not obliged to pay under the policy unless and until the third party has succeeded in establishing liability on the part of the insured in addition to proof of injury or damage.

Before going to the specific types of liability insurance, we should look at two of the common features of liability insurance as follows:

(a) *"Long-tail" business*: All liability insurances are long-tail in nature, i.e. claims may arise and develop over a long period of time (possibly years after policy expiry), so it is necessary to keep the relevant files and claims reserves open for much longer than with "short-tail" business, such as property insurance generally. Underwriters should, of course, handle long-tail risks with more caution than short-tail risks.

(b) *"Claims-made"* and *"Claims-occurring"* (or "Occurrence") bases: A policy issued on a "claims-made" basis (i.e. a "claims-made" policy) is one which stipulates that any third party claim in respect of injury or property damage must be made when the policy is in force or within any extended reporting period, a limited period that immediately follows non-renewal or cancellation, regardless of when the injury or damage occurs. To further limit the range of claims covered, a claims-made policy may include a Retroactive Date (or "Retro Date"), the date before which the injury or damage must not occur. A claims-made policy is likely to take to be the Retroactive Date the date from which the insured has had non-interrupted claims-made cover, or the inception date of the first policy issued by the insurer to the insured. Another usual limitation of a claims-made policy, known as the "Known Circumstances Exclusion" or "Known Prior Acts Exclusion", excludes any incidents of which the insured has knowledge when the policy commences.

Restricting claims to the policy period or shortly thereafter will "shorten the tail" considerably and is therefore attractive to the insurer from the risk management perspective. Whether the insured will be happy with

the possibility of being uninsured for third party claims made after policy expiry is another matter.

Some policies, called "occurrence policies", are written on a "claims-occurring" (or "losses-occurring") basis, meaning that they will only respond to a third party claim in respect of injury or property damage that occurs during the period of insurance, regardless of when the claim is made.

Warning: As different liability insurers may provide cover on different bases or adopt different wording, clients (and the insurance intermediaries) should be beware of potential gaps in scope of cover should they change from one insurer to another.

1.6.1 Employers' Liability Insurance

Though not a title used with Hong Kong policies, it accurately describes the nature of the cover provided by the **Employees' Compensation** (EC) policy. As with **motor** insurance, EC insurance represents a major branch of compulsory insurance. Cover for employers' liability towards domestic helpers is normally given under domestic helper package policies (see **1.3.2**).

(a) **Basic intentions and scope of cover**

EC policies cover the insured employer's liability at law towards his employees. The liability covered is very often classified into the following two types, both being subject to the compulsory requirements for insurance:

(i) *Liability under the Employees' Compensation Ordinance* (EC Ordinance): This is the **statutory** liability which is placed upon an employer to pay **compensation** in stipulated amounts (which may possibly fall short of the actual losses in individual cases) to his employees or their dependants in respect of injury or death caused by an accident arising *out of and in the course of* their employment. Such liability is "strict" (as opposed to "fault-based") in the sense that it is not dependable on fault on the part of the employer.

Case 14 Accident happening outside working hours

A worker was injured in a traffic accident when she was on her way home by taxi after having a meeting with a client at night time. This gave rise to the question of whether the injury was covered by the employer's EC policy or not, which required that the injury must have been caused by accident arising out of and in the course of the injured employee's employment.

Considering that this criterion had not been satisfied, the insurer rejected the employer's claim under the EC Policy.

***Remarks**: since the EC policy only intends to cover the insured's liability incurred in the capacity of an employer, injuries not caused by an accident that has "arisen out of and in the course of employment" will not be covered.*

(ii) *Liability independent of the EC Ordinance* (much more often referred to as *"common law liability"*, which is a misnomer): This is employers' liability that arises otherwise than under the EC Ordinance, and relates to liability in tort (mainly negligence) in respect of the death of or injury to employees, again arising out of and in the course of their employment. Included under this heading are employers' liability incurred in the common law and that which arises from a breach of certain statutory provisions concerning industrial safety. Injured or deceased employees or their dependants are entitled to full compensation, but the liability of the employer must be established and it is contestable by the employer or his insurer. "Liability independent of the EC Ordinance" comprises fault-based liability and strict liability. Court awards for this kind of liability will be net of any compensation paid or payable under the Ordinance.

(b) **Limitations and exclusions**

As EC insurance is compulsory by statute, exclusions are limited and may be overruled by statutory provisions (see below). Typically, however, the policy will exclude:

(i) contractual liability (see **1.1**(d)(iii)(4) above);

(ii) liability to the employees of the insured's **contractors**;

(iii) injured or deceased persons who are not **employees** within the meaning of the EC Ordinance;

(iv) "**standard**" exclusions, such as war, nuclear risks and terrorism.

(c) **Premium basis**

EC premium is usually calculated by applying a rate per cent or per mille (mainly according to the type of business carried on by the employer) to the **payroll** of the employer for the period of insurance. As such, the initial premium must be **provisional**, subject to **adjustment** when the final figures are known.

(d) **Other features**

(i) *"Avoidance of certain terms and right of recovery" clause*: This clause is identical in intent to that in motor policies. It gives the

insurer a right of recovery from the insured if the compulsory insurance legislation compels the insurer to pay a claim when a breach of contract terms would otherwise allow the insurer to avoid liability.

(ii) *Premium adjustments*: It is widely said that many employers understate their payroll when the provisional premium is being calculated. So following up premium adjustments is quite important to maintaining an equitable premium system.

(iii) EC policies are written on a "**claims-occurring**" basis.

(e) **Employees' Compensation Insurance Residual Scheme (ECIRS)**

There have been cases in which employers appeared to have difficulty obtaining EC insurance in respect of employees engaged in certain high-risk occupations. A scheme named the **"Employees' Compensation Insurance Residual Scheme"** has been launched to resolve this issue by providing the insurance cover needed. The ECIRS is run by the Employees' Compensation Insurance Residual Scheme Bureau Limited ("the Bureau"), with the Hong Kong Federation of Insurers acting as the Administrator of the Scheme. By a market agreement, all insurers writing EC insurance business in Hong Kong must become members of the Bureau, taking on risks on a collective basis (in other words, under a co-insurance arrangement so that they will only incur liability severally, as opposed to jointly).

Certain criteria must be met in applying for insurance under the Scheme. An applicant employer must either have been declined EC insurance cover by at least three insurers (provided that the non-availability of insurance is not by reason of the employer failing to pay premiums due or meet statutory requirements on occupational health and safety imposed as a condition of the grant of insurance), or quoted EC premium rates that are 30% over the corresponding benchmark premium rates for the relevant High Risk Groups specified by the Scheme (blasting, diving, excavation, etc.). If necessary, the benchmark premium rates may be loaded or discounted to arrive at actual premium rates for particular risks, in order to discourage insured employers from safety malpractices or encourage them to adopt good safety practices.

1.6.2 Products Liability Insurance

Manufacturers and sellers each owes a duty of care to his consumers not to cause them injury or damage by making or selling to them "defective products". A products liability policy covers liability in respect of injury or damage caused by goods sold, supplied or repaired, services rendered, etc. and happening elsewhere than on premises owned or occupied by the insured. Such liability as happens on the insured's premises should be insured against under a public liability policy.

In terms of basic cover and wording, the Products Liability policy resembles the Public Liability policy (see **1.6.5** below) very closely. Here are the special features that should be noted:

(a) *Defendants*: Those who may incur product liability include manufacturers, assemblers, repairers, and suppliers.

(b) *Claimants*: The range of claimants has been extended from consumers with or without contractual relationships with the defendants to those who are not strictly "consumers" (e.g. bystanders of a motor repairing process who are injured by flying fragments).

(c) *Exclusions*:

(i) Common liability exclusions: employers' liability, property in the insured's custody, contractual liability (see **1.1**(d)(iii)(4) above), etc.

(ii) Liability arising from the design, plan, formula or specification of the goods. (Suppose a TV cabinet which was designed to carry an *unusually light* maximum weight of 50 kg cannot bear the weight of a 55 kg TV and collapses. Liability so arising, if any, is not normally insurable by a products liability policy.)

(iii) Liability arising from instruction, advice or information given on the characteristics, use, storage or application of the goods.

(iv) Liability in respect of the repair, alteration or replacement of any goods. (Suppose an insured is a supplier of CD players, and a consumer has had one of these properly installed in his car. Owing to some manufacturing defect in this CD player, it catches fire when being in use, destroying itself and the whole car. In such circumstances, only the liability in respect of the destruction of the car will be covered, but not the responsibility for replacing the CD player.)

(d) *Policy limit*: The limit of indemnity may be an aggregate limit (or "limit per period"), so that early claims reduce the amount of cover available for the rest of the policy period accordingly unless the cover is reinstated in time.

(e) *"Dangerous" markets*: Some parts of the world are notoriously claims-conscious, especially the U.S. and North America generally. Supplying products to these markets is fraught with risk and cover may be expensive or difficult to obtain.

(f) *"Claims-made" policies*: These are described above and are slightly more likely with products liability insurance.

1.6.3 Professional Indemnity (PI) Insurance

PI policies are intended for "**professional**" people, such as lawyers, doctors (**Medical Malpractice** insurance or medical indemnity insurance), accountants, architects, fund managers, trustees and the like. The cover is therefore intended to protect against mistakes in professional acts and omissions, including the giving of incompetent advice.

This is a specialized class of business, requiring high expertise to run successfully. International exposures, if any, may again raise the issue of claims-conscious cultures.

(a) **Basic intentions and scope of cover**

Numerous policy forms are available in the professional indemnity insurance market, which will vary depending on the activities or professions involved, and from one insurer to another. Typically the professional indemnity insurance policy covers the insured's **legal liability** in respect of *third party claims first made* against the insured **during** the policy period for third party injury, third party death, third party property loss or damage, or third party financial loss (depending on the activities or professions being covered), caused by a "wrongful" act or omission on the part of the insured.

In addition to liability in respect of injury, property loss or damage, or financial loss (as the case may be), the policy also covers **legal expenses**, of both the insured in defending or resisting third party claims and the successful third party. The policy is usually subject to an aggregate limit of liability (or "limit any one period"), which limit may or may not be applicable to the insured costs and expenses.

(b) **Limitations and exclusions**

(i) *Pollution and contamination* are excluded.

(ii) *Dishonesty:* Liability arising from or contributed to by any dishonesty, fraudulent, criminal or malicious act or omission of the person claiming indemnity under the policy is excluded.

(iii) *Fines, penalties, punitive damages, exemplary damages and non-compensatory damages* are irrecoverable.

(iv) *Geographical Area*: Activities performed outside the specified *geographical area* are not covered. Also, by virtue of a *jurisdiction clause*, third party claims are restricted to those subject to the prescribed legal jurisdictions.

(v) *Contractual liability* is excluded (see **1.1**(d)(iii)(4) above).

(vi) *"Standard" exclusions* of war, nuclear risks, etc.

(vii) *Deductible*: A deductible could be included which applies to each third party claim.

(c) **Premium basis**

The premium is very likely to be **adjustable**, i.e. based upon a variable factor, such as **annual revenue** in the case of cover for accountants or **aggregate fund size** in the case of cover for fund managers. Thus, a provisional premium is paid initially, adjusted to the correct amount when final figures are available. Obviously, the rate charged will reflect the potential risk, according to the profession of the insured.

(d) **Basis of cover**

PI insurance is most likely to be written on a **claims-made** basis.

Note: It will be remembered that **insurance brokers** in Hong Kong are required to carry PI cover, for enhanced security to their clients, before they can be authorized to do business here.

1.6.4 Directors' and Officers' Liability Insurance

The Directors' and Officers' liability insurance policy (or "D&O policy") insures the insured company, and its directors and officers. The company's shareholders, employees, customers and creditors are among the possible third party claimants. A company as well as its directors and officers may be brought to a civil or criminal court for alleged wrongful acts done by any of the directors and officers in their capacity as such. Regardless of whether or not the directors and officers are given the benefit of such an indemnification provision under the company's articles of association that will hold them harmless for losses incurred in their official roles in the company, it is sensible to extend the company's D&O policy to cover their respective interests. Although there is no standard D&O policy form, each D&O policy will follow the same basic principles.

(a) **Basic intentions and scope of cover**

D&O insurance covers the liability of a company's directors and officers and, normally, that of the company as well, to pay damages in respect of "wrongful acts", which may be defined in the policy to include omission, breach of duty, breach of trust (in the capacity of a trustee), breach of warranty of authority (creating a false impression of agency), misstatement and misleading statement. It is not unknown for a D&O policy to define the term "insured" to include all employees of the company for the purposes of, say, claims relating to harassment, discrimination or wrongful termination of employment.

The policy may also cover **legal expenses**, of both the insured in defending or resisting third party claims and the successful third party. The policy is usually subject to an aggregate limit of liability, which may or may not be applicable to the insured costs and expenses.

(b) **Limitations and exclusions**

(i) *Pollution and contamination* are excluded.

(ii) *Personal profit:* The policy excludes claims based upon or attributable to a director or officer gaining personal profit or advantage to which he was not entitled.

(iii) *Dishonesty or fraud:* The policy excludes claims brought about by or contributed to by the dishonesty or fraud of the individual director or officer who is claiming indemnity under it. However, costs incurred in *successfully* defending an allegation of dishonesty or fraud will usually be covered.

(iv) *Breach of professional duty:* Claims for alleged breach of professional duty are excluded – they are properly covered under a professional indemnity policy.

(v) *Guarantee or warranty:* Liability arising under guarantee or warranty (other than warranty of authority) is excluded.

(vi) *Known circumstances:* Any circumstance known or which ought reasonably to have been known about at policy inception is excluded.

(vii) *Fines, penalties, punitive damages, exemplary damages and non-compensatory damages* are irrecoverable under the policy, except for punitive or exemplary damages in respect of libel or slander.

(viii) *Geographical Area*: Activities performed outside the specified *geographical area* are not covered. Also, by virtue of a *jurisdiction clause*, third party claims are restricted to those subject to the prescribed legal jurisdictions.

(ix) *Public liability risks:* Third party bodily injury, and loss of or damage to third party material property are excluded.

(x) *Contractual liability* (see **1.1**(d)(iii)(4) above) is excluded.

(xi) *"Standard" exclusions* of war, nuclear risks, etc.

(xii) *Deductible*: Deductibles, if any, will very likely apply to each director or officer insured, with an aggregate deductible for all claims made against any of the insured during the insurance period.

(c) **Premium basis**

A flat premium is normally charged.

(d) **Basis of cover**

D&O insurance is written on a **claims-made** basis. Therefore individual directors will need to consider how cover can be maintained after they leave the company for possible personal liability arising from prior wrongful acts. Besides, consideration will have to be given to the extent to which cover should be maintained if a company ceases trading or is dissolved or taken over.

1.6.5 Public Liability (PL) Insurance

The PL policy covers liability in respect of death, injury or property damage that is not insurable by specialized liability insurances such as motor insurance, EC insurance, products liability insurance and professional indemnity insurance.

(a) **Basic intentions and scope of cover**

This is to cover the insured's **legal liability** (sometimes expressed as "liability at law") to third parties in respect of *accidents occurring* **during** the policy year. *Claims arising* from such accidents may do so late (sometimes years later), but they are still covered, provided the insured satisfies the notification requirement specified in the policy.

Normally the policy will cover third party bodily injury, death and property damage liability. It also covers **legal expenses**, of both the insured in defending or resisting such claims and the successful third party. The policy is usually subject to a limit of liability any one occurrence, with or without a limit any one period. The insured costs and expenses are usually payable *in addition* to the limit of liability.

(b) **Limitations and exclusions**

(i) *Geographical Area*: Accidents occurring outside the specified *geographical area* are not covered. Also, by virtue of the typical *jurisdiction clause*, third party claims are restricted to those subject to the legal jurisdiction of Hong Kong.

(ii) *Other policies*: Other types of policies may cover liability risks. To avoid overlap and confusion, such risks (e.g. motor and EC) are excluded.

(iii) *Contractual liability* (see **1.1**(d)(iii)(4) above).

(iv) *"Standard" exclusions* of war, nuclear risks, etc.

(c) **Premium basis**

The premium may be **adjustable** where it is based upon a variable factor, such as **wages** or **turnover** (but see **Note** below). Thus, a provisional premium is paid initially, adjusted to the correct amount when final figures are available. Obviously, the rate charged will reflect the potential risk, according to the occupation or business of the insured.

Note: Although the traditional premium basis for these policies was adjustable, to reflect the actual volume of business activity during the policy year, it is now quite common to find non-adjustable premiums being charged in Hong Kong. With these, the insurer accepts the projected wageroll/turnover as the final figure, so that no additional or refund premium has to be considered.

(d) **Basis of cover**

Whilst not unknown, "claims-made" basis is not common with public liability insurance, which is usually on a "**claims-occurring**" basis.

(e) **Building owners' corporation third party liability policy**

Under the Building Management Ordinance (Cap. 344), the owners of any one building are required to get registered by the Land Registrar so as to become a corporation commonly referred to as the "Incorporated Owners" of the building concerned. And each corporation is required to procure and keep in force in relation to the common parts of the building (such as external walls and walls enclosing corridors) and the property of the corporation, a policy which covers its liability for the death of, or the bodily injury to, any person, except for certain types of liability such as compulsorily insurable motor liability, employers' liability and contractual liability. The limit of indemnity of such a policy should not be less than $10 million any one event. Any non-compliance with these statutory requirements may render every member of the management committee guilty of an offence.

(f) **Hotel or guesthouse operator's public liability policy**

Anyone applying for a licence to operate, keep, manage, or otherwise has control of a hotel or guesthouse under the Hotel and Guesthouse Accommodation Ordinance (Cap. 349) is required by the Home Affairs Department to take out a public liability policy in respect of the use of the licensed premises by any person with a limit of indemnity per event of not less than $10 million but not a limit per period of insurance.

1.7 MARINE INSURANCE

Perhaps the most ancient class of business, marine insurance is really a profession in its own right, with terminology at times quite different from all other types of insurance. Without trying to give a comprehensive summary, we should mention a few points about marine insurance before we look at some different forms of cover.

(a) **Average**: When we were referring to a property insurance contract being "subject to average", in earlier notes, this means that full insurance is expected and that there will be a claims penalty according to the degree of any under-insurance at the time of loss. In marine insurance, "average" means **partial** (i.e. non-total) **loss**. There are two kinds of average in marine insurance:

(i) *Particular Average (PA)*: Put simply, this is "*Average*" (i.e. partial loss) affecting the subject matter insured, other than a *General Average Loss* (see (ii) below).

(ii) *General Average (GA)*: A General Average Loss is a loss caused by a General Average Act (the word "average" here means that the loss is a partial loss of a whole marine adventure (i.e. the combined interests represented with a ship's voyage, especially including the vessel itself and any cargo being carried on the vessel)). There is a General Average Act where any extraordinary sacrifice or expenditure is voluntarily and reasonably made or incurred in time of peril for the purpose of preserving the property imperilled in the common adventure. GA Sacrifice, as opposed to GA Expenditure, is physical loss or damage. For example, throwing heavy cargo overboard in the event of stranding and the like is a GA Act leading to a GA Loss known as GA Sacrifice. GA Expenditure may be incurred, say, in circumstances where a disabled ship and its cargo have to be towed to a port of distress.

Where there is a *General Average Loss*, the party on whom it falls (e.g. the owner of a cargo which the master has thrown overboard as a *GA Act*) is entitled, subject to the conditions imposed by maritime law, to a rateable contribution (called "*General Average Contribution"*) to his loss from each of the parties interested (the shipowner, the cargo owners, etc.) who have been saved by the GA Act, **including himself**. One of those conditions is that the *GA Act* must have achieved its purpose, i.e. the adventure must, as a result of the act, be free from a total loss. Such a condition will be satisfied if, for instance, the total loss of a cargo has saved the ship and all other cargoes from a total loss.

Note: Whilst participants in a marine adventure are potentially liable for *GA Contributions*, it is customary to insure against such liability under marine insurance policies.

(b) **Salvage**: With non-marine insurance, the word "**salvage**" refers to any residual value in what is left of the subject matter of insurance (e.g. the scrap value of a destroyed vehicle). On the other hand, the term "salvage" has a very different meaning in maritime law - it usually refers to saving a vessel or other maritime property from perils of the seas, pirates or enemies, on a "no cure - no pay"

basis, for which a sum of money called "salvage award" or "salvage" (or "salvage charges" in marine insurance clauses) is payable by the property owners to the salvor provided that the operation has been successful. The term is sometimes also used to describe property which has been salved.

(c) **Sue and Labour Charges**: This curious expression refers to expenses reasonably incurred by the assured in preserving the insured property from an insured loss or in minimizing an insured loss. Such expenses are covered *in addition* to the sum insured, so that twice the sum insured may ultimately be payable for own damage. (NB: although such charges are invariably insured by marine cargo policies, the term "sue and labour charges" is not used in their wording.)

(d) **Actual Total Loss (ATL)**: Total loss (TL), in marine insurance, may either be an "actual total loss" (ATL) or a "constructive total loss" (CTL). There is an ATL:

(i) where the subject matter insured is destroyed,

(ii) where it is so damaged as to cease to be a thing of the kind insured (e.g. where a cargo of cement has irreversibly turned into solid masses due to raining), or

(iii) where the assured is irretrievably deprived of the subject matter insured (e.g. where a cargo of gold bullion has sunk into the deep sea).

Note: In marine cargo insurance, there is total loss of an apportionable part, such as each craft load of goods.

(e) **Constructive Total Loss (CTL)**: Short of an **actual total loss**, a property loss may in certain circumstances (e.g. where the damage, although technically repairable, is by the relevant legal or policy standard uneconomical to make good) constitute a **constructive total loss**, in which case the insured can treat it as if it was an actual total loss. With either an ATC or CTL, the unfortunate property owner will find himself in pretty much the same financial distress.

(f) **Valued Policies**: For the sake of commercial convenience, insurance on ships or cargo is normally made on an agreed value basis by specifying an agreed value, as well as an amount insured, in the policy. For the purposes of both total and partial losses, the agreed value (instead of the actual value of the property insured) is taken as the property value that prevails at the time of loss.

(g) **Liability Insurance**: In addition to the collision liability cover which we shall mention in **1.7.2**(a)(iv) below, another major type of liability cover called "P&I" liability cover is available. P&I cover is traditionally provided by **Protection and Indemnity Associations** (or **"P&I Clubs"**), which are corporations established to provide their member shipowners with certain insurances not readily made available by commercial insurers (or profit-making insurers). Please see **1.7.4** below for the statutory requirements for compulsory launch and vessel liability insurance.

(h) **Institute Clauses**: Commercial marine insurances in Hong Kong mostly use these Clauses with their policy wording. **Institute** (the Institute of London Underwriters, or **ILU**) **Clauses** are renowned throughout the international marine insurance world and form a recognized policy wording. These forms of cover are accepted almost universally by insurers, banks and interested organizations.

(i) **Marine Risks and War Risks**: Of the various classes of property insurance, marine and aviation insurances are the only ones that cover war risk. In marine insurance markets, specialised Institute Clauses are often used to cover the perils of war and strikes, and those that exclude these perils are said to cover marine risk. Yet the war cover given is subject to a "waterborne" limitation, so that cover will not be available when the insured property is out of the water.

1.7.1 Marine Cargo Insurance

(a) **Basic intentions and scope of cover**

Apart from cover for GA Contributions and Salvage Charges, which are in the nature of legal liability, insurance on marine cargo is substantially property insurance, usually in the form of a set of Institute Cargo Clauses (**ICC**). The three most well-known sets of ICC are:

(i) *ICC (A)*: The own damage cover is on an "**All Risks**" basis and is in most cases the only cover acceptable to banks who are advancing money or giving guarantees in respect of cargo shipments;

(ii) *ICC (B)*: The own damage cover is on a **specified risks** basis (see (d) below); and

(iii) *ICC (C)*: Own damage is covered for even fewer **specified risks** (see (d) below).

Marine cargo cover is mostly on a so-called "**Warehouse to Warehouse**" basis, meaning that the cargo is covered from the time it leaves the sender's premises until it reaches the final storage destination. This almost always will involve both **land and sea** transits.

(b) **Exclusions**

The ICC (A), (B) and (C) each contains a number of exclusions, including:

(i) loss due to *wilful misconduct* of the assured.

(ii) *inevitable losses*, such as wear and tear, ordinary loss in weight (say, of liquid cargoes), etc.

(iii) loss due to *inadequate packing*, bearing in mind the journey and nature of the cargo.

(iv) loss due to *inherent vice*, that is, damage arising from the quality in the insured cargo itself (e.g. meat or fish going bad, and wine turning sour).

(v) loss due to *unseaworthiness* (meaning not being reasonably fit in all respects to encounter the ordinary perils of the seas of the insured adventure) of the carrying vessel, of which the assured is aware at the time of loading.

(vi) loss due to *war, strikes, etc.*, which are, nevertheless, insurable under Institute War and Strikes Clauses for an extra premium.

(c) **Premium basis**

In the case of large turnover, the identity and loss record of the assured will have an important bearing upon the premium charged, which is normally as a rate per cent on the amount insured.

(d) **ICC (B) and (C)**

In addition to total loss of any package, etc. whilst loading or unloading and General Average sacrifice, the **ICC (B)** covers other own damage due to any of the following perils:

(i) specified major casualties (fire, stranding, sinking, collision, etc.);

(ii) earthquake, volcanic eruption and lightning;

(iii) discharge of cargo at a port of distress;

(iv) jettison and washing overboard;

(v) entry of sea, lake or river water.

The **ICC (C)** is more limited, covering GA sacrifice, jettison, and (i) and (iii) above.

The exclusions with both sets of clauses are the same, being very similar to those in the ICC (A), except that whereas the ICC (B) and (C) expressly exclude the deliberate or wrongful act of any person, the ICC (A) impliedly does not cover such an act on the part of the insured or the claimant. Thus fire damage deliberately caused by anyone other than the insured and the claimant is recoverable under the ICC (A) but not under the ICC (B) and (C).

1.7.2 Marine Hull Insurance

(a) **Basic intentions and scope of cover**

(i) **Property Damage**: The **hull** of a vessel is its main body. Marine Hull Insurance (sometimes called "Hull and Machinery Insurance") covers, in addition to the hull of the insured vessel, its equipment, stores, fuel for propelling the vessel, safety boats, etc. Institute Hull Clauses normally provide property cover on a specified perils basis (perils of the seas, fire, explosion, etc.). Claims are payable on a new for old basis, i.e. without deduction for wear and tear, and depreciation.

(ii) **General Average and Salvage Charges** (see **1.7** (a) and (b) above) are covered.

(iii) **Sue and Labour Charges** (see **1.7** (c) above) are covered.

(iv) **Collision Liability**: Here the cover only applies to liability arising from the insured vessel's **collision** with another vessel and only **75%** (always expressed as **3/4ths**) of such liability is covered. The other **25%** of such liability, together with certain other types of "shipowner's liability", is insured with a **P&I Club**. It is important to note that such collision liability cover, whether provided by a commercial insurer or by a P&I Club, excludes loss of life, personal injury and illness. Please see **1.7.4** below for the statutory requirements for compulsory launch and vessel liability insurance.

(b) **Limitations and exclusions**

(i) *"Standard" exclusions* of war, nuclear and similar risks apply but the perils of war and strikes are insurable under Institute War and Strikes Clauses.

(ii) *Deductible*: A deductible is applicable to **partial loss** claims, but not a total loss claim. This is quite different from the practice with other classes of insurance.

(c) **Premium basis**

The premium is a matter which heavily depends upon the claims experience of the individual assured. Very different premiums could be payable in respect of the same vessel, under different ownership or management.

1.7.3 Pleasure Craft Insurance

Many such craft are insured under a policy against both **property** and **liability** risks. The commonly used **Institute Yacht Clauses** include the following features:

(a) *Specified perils cover*: The perils specified include **perils of the seas,** fire, lightning, explosion and earthquake.

(b) *Exclusions* include:

(i) **Outboard motors** dropping off or falling overboard.

(ii) **Personal effects**.

(iii) **Consumable stores**, fishing gear and moorings.

(iv) **Ship's boat** not permanently marked with the parent vessel's name.

(c) *Warranties*: There is a warranty that the maximum designed speed of the vessel does not exceed 17 knots (note: craft capable of greater speeds than that are speedboats, requiring quite different contract terms), and that it is used solely for private pleasure purposes and not for hire charter or reward.

(d) *Deductible*: The provisions are similar to those with commercial vessels, the deductible not applying to a **total loss** claim.

(e) *New for old*: Own damage claim settlements are made on a new for old basis, except that deduction up to one third may be made for depreciation, etc. on specified items (e.g. sails and outboard motors).

(f) *Liability* co*ver*: Unlike commercial hull policies, the pleasure craft policy provides full (i.e. 100% rather than 75%) third party insurance, covering liability for **personal injury** or **property damage** and **legal costs**. Please see **1.7.4** below for the statutory requirements for compulsory launch and vessel liability insurance.

1.7.4 Statutory Requirements for Third Party Risks Insurance

It is a statutory requirement under the Merchant Shipping (Local Vessels) Ordinance (Cap. 548) that no owner, charterer or coxswains of a local vessel (see Glossary), with a couple of exceptions, may use, or cause or permit any other person to use, the vessel in the waters of Hong Kong unless there is in force a liability insurance policy in respect of the death of or bodily injury to any person caused by or arising out of such use by such owner, charterer or coxswain or by that other person, as the case may be. The minimum cover (or limit of indemnity) that the law requires varies primarily according to the

number of passengers permitted to be carried by the vessel under the conditions of its operating licence. With effect from 1 September 2016, the figures are: $10 million any one occurrence in the case of a vessel of more than 12 permitted passengers (except where it falls within one of two prescribed categories of vessel), or $5 million any one occurrence in any other cases. In practice, such a policy, like a motor liability policy, will always contain an "Avoidance of Certain Terms and Right of Recovery" Clause for a similar reason.

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Representative Examination Questions

Type "A" Questions

1 The widest form of motor insurance cover is:

(a) "Act" only; .....
(b) Third Party only; .....
(c) Comprehensive; .....
(d) Third Party, Fire and Theft. .....

[Answer may be found in **1.1**(a)]

2 A "standard" policy excess is one that:

(a) applies to all policies of a particular class; .....
(b) does not apply if the risk has any abnormal features; .....
(c) is chosen by the insured to obtain a premium discount; .....
(d) is imposed by the underwriter to counteract an adverse feature. .....

[Answer may be found in **1.1**(f)]

3 With a commercial vehicle which is also used in construction work, for example to dig holes, the commercial motor policy may exclude cover during such operations. This exclusion is known as the:

(a) business use clause; .....
(b) tool of trade clause; .....
(c) working operations clause; .....
(d) professional liability clause. .....

[Answer may be found in **1.1.3**(a)]

4 Which of the following is/are very likely to be found in a conventional personal accident insurance policy?

(a) lump sum benefits; .....
(b) medical expenses cover; .....
(c) weekly benefits for temporary disability; .....
(d) all of the above. .....

[Answer may be found in **1.2.1**(a)]

5 The primary consideration in calculating the premium for any personal accident insurance is the proposer's:

(a) age; .....
(b) sum insured; .....
(c) insurable interest; .....
(d) profession or occupation. .....

[Answer may be found in **1.2.1**(c)]

6 The premium calculation most commonly used in Hong Kong for household contents insurance is very likely to be based upon:

(a) the age of the proposer; .....
(b) the square feet area of the insured flat; .....
(c) the sum insured selected by the proposer; .....
(d) the amount of mortgage loan advanced by a bank. .....

[Answer may be found in **1.3.1**(c)]

7 Which of the following is **not** very likely to be within the **standard** cover of a commercial fire insurance policy?

(a) fire; .....
(b) lightning; .....
(c) earthquake; .....
(d) explosion of gas used for domestic purposes. .....

[Answer may be found in **1.4.1**(a)]

8 A fire business interruption insurance policy is primarily intended to cover losses:

(a) of buildings destroyed by a fire; .....
(b) of the contents of building destroyed by a fire; .....
(c) to the insured in respect of legal liability to third parties; .....
(d) arising after an fire or other insured event, which are not material, such as loss of profit. .....

[Answer may be found in **1.4.1a**]

9 Which of the following are very likely to be excluded from property "all risks" insurance policies?

(a) wear and tear; .....
(b) war and similar risks; .....
(c) confiscation of property by customs authorities; .....
(d) all of the above. .....

[Answer may be found in **1.4.2**(b)]

10 Which of the following is **not** within the usual basic cover of a boiler explosion insurance?

(a) damage to the insured boiler; .....
(b) liability for third party injuries; .....
(c) liability for damage to third party property; .....
(d) personal accident benefits for the insured and his employees. .....

[Answer may be found in **1.5.1**]

11 "Common law" cover is normally given under Employees' Compensation (EC) policies. This means that cover is applicable:

(a) in respect of benefits under the EC legislation only; .....
(b) only when liability has been incurred in a common law jurisdiction; .....
(c) only in respect of liability applicable under Hong Kong law; .....
(d) when the insured has incurred employers' liability otherwise than under the EC Ordinance. .....

[Answer may be found in **1.6.1**]

12 A "claims-made" cover in liability insurance means that claims are only admissible if they:

(a) occurred during the policy year; .....
(b) were made before the policy began; .....
(c) are actually paid during the policy period; .....
(d) are made during the period of insurance or a specified period thereafter. .....

[Answer may be found in **1.6**]

Type "B" Questions

13 Which **three** of the following are always included within the comprehensive private car cover?

(i) Fire damage to the insured car.
(ii) Impact damage to the insured car.
(iii) Hiring an alternative parking space.
(iv) Theft or attempted theft of the insured car.

(a) (i), (ii) and (iii); .....
(b) (i), (ii) and (iv); .....
(c) (i), (iii) and (iv); .....
(d) (ii), (iii) and (iv). .....

[Answer may be found in **1.1.1**]

14 Which of the following are very likely to be included in travel policies issued in Hong Kong?

(i) Personal liability cover.
(ii) Medical expenses cover.
(iii) Personal accident benefits.
(iv) Loss of or damage to luggage.

(a) (i) and (ii) only; .....
(b) (ii) and (iii) only; .....
(c) (i), (ii) and (iii) only; .....
(d) (i), (ii), (iii) and (iv). .....

[Answer may be found in **1.3.3**(a)]

15 Which **two** of the following circumstances are covered by the usual form of commercial theft insurance policies in Hong Kong?

(i) Theft after entry is gained by smashing a window.
(ii) Theft of stock by members of the insured's own staff.
(iii) Theft after thieves crash a vehicle into the insured shop.
(iv) Damage caused by thieves setting fire to the insured premises.

(a) (i) and (ii); .....
(b) (i) and (iii); .....
(c) (ii) and (iii); .....
(d) (iii) and (iv). .....

[Answer may be found in **1.4.3**]

16 Which of the following comments regarding **general average** (GA) contributions are true?

(i) The GA act must have been deliberately done.
(ii) The sacrifice must have achieved its desired objective.
(iii) The loss is to be shared by all interests in the marine adventure.
(iv) The loss is to be shared by all except the owners of the goods sacrificed.

(a) (i) and (ii) only; .....
(b) (ii) and (iii) only; .....
(c) (i), (ii) and (iii) only; .....
(d) (i), (ii), (iii) and (iv). .....

[Answer may be found in **1.7**]

Note: *The answers to the above questions are for you to discover. This should be easy, from a quick reference to the relative part of the Notes. If still required, however, you can find the answers at the end of the Study Notes.*

2 UNDERWRITING AND POLICY WORDING

In this and later Chapters we look at the practical applications of the principles and terminology introduced in the Core Subject "**Principles and Practice of Insurance**". From the Notes for that Subject, you will recall that **underwriting** concerns two very important processes:

(a) the *selection of risks* (i.e. determining their insurability); and

(b) deciding the *terms of the contract*.

Bearing this simple summary in mind will help considerably with the Notes below.

2.1 PROPOSAL AND MATERIAL FACTS

Again to assist with understanding the applications we shall meet, it is good to remember the following basic definitions:

(a) **Proposal Forms** may also be called **Applications**, a term more commonly used in life insurance. These are documents in the form of a **questionnaire** that the proposer completes when making an application for insurance cover. They will be considered in more detail in **2.1.3** below.

(b) A **Material Fact** is legally defined as "every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will accept the risk". In practice, underwriters are generally interested in any fact that makes a difference with the **insurability** of or **terms** to be applied to a proposed risk.

It will be remembered that at law, a proposer is under a duty of **Utmost Good Faith**, a duty to reveal all material facts, *whether the insurer asks specific questions or not*.

2.1.1 Material Facts and Risk Assessment

(a) **Material Facts**

We looked at a definition of these above. An alternative description for the term could be "*facts which must be disclosed*" (by law, and in order to enable the underwriter to make a professional assessment of the proposed risk). These include circumstances which:

(i) render a **risk** greater than would otherwise be supposed, e.g. highly flammable materials stored on the insured premises (in the case of fire insurance), when the insured's business would not lead a prudent underwriter to assume this;

(ii) render a potential **loss** greater than would otherwise be supposed, e.g. stock items of gold and other precious materials in a general store where a prudent underwriter would not expect such things (in the case of theft insurance);

(iii) relate to **previous losses** or claims' experience;

(iv) relate to **previous adverse insurance** experience, e.g. being refused cover or having abnormally restrictive terms applied by another insurer;

(v) relate to the nature of the **subject matter** of the proposed insurance;

(vi) may affect the legal rights of the insurer, e.g. special terms of trade which may prejudice any future **subrogation** rights;

(vii) the insurer requests but which the proposer is not under a duty to disclose in the absence of such enquiry.

(b) **"Non-material" Facts**

Obviously, any facts that do not constitute material facts need not be revealed (e.g. one's exact age when seeking fire insurance). There are certain facts, however, which might fall under the definition given in **2.1** but which do not have to be revealed, simply because that is what the law provides for. These include circumstances which:

(i) improve or **decrease** the risk, e.g. the installation of an **automatic sprinkler system** (in the case of fire insurance);

(ii) are matters of **common knowledge**, e.g. Hong Kong is subject to the risk of typhoons (in the case of "all risks" insurance);

(iii) an insurer may be **deemed to know**, e.g. the normal processes and dangers involved with various occupations (in the case of EC insurance);

(iv) the proposer cannot **reasonably** be expected to know, e.g. he is suffering from an undiscovered brain tumour (in the case of medical insurance);

(v) were open to discovery but were **not** discovered in a **risk survey** carried out by or on behalf of the insurer, e.g. with public liability insurance;

(vi) should have been the subject of **further enquiry** by the insurer, e.g. some questions on a proposal form have been left blank or answered in uncertain terms.

Note: 1 It is the proposer's legal responsibility to reveal material facts, but the courts are very reluctant to allow this to be too strong a weapon for insurers. Judges will want strong evidence that a piece of undisclosed information is indeed **material**, if there is no specific question from the insurer concerning it. Also, they will expect the most scrupulous care to be given to any information supplied, so that any argument that the insurer should have been **put on enquiry** or should reasonably have been aware of materiality might very much count against the insurer in any formal dispute.

2 The normal situation is that with any uncertainties it will be the responsibility of the **insurer** to prove that the fact concerned was indeed **material** and that information supplied was **inadequate**. This is not an easy responsibility to discharge.

(c) **Risk Assessment**

In a broad sense, **Risk Assessment** is the process of underwriting a proposed risk with a view to determining the **insurability** of the risk and, if it is insurable, the **contract terms** to be offered. These considerations will be examined in more detail in the Notes below. However, with general insurance (unlike **life insurance**), risk assessment is an **on-going**, or at least a **repeatable** process. It arises:

(i) at the **proposal** stage.

(ii) at policy **renewal**. General insurance contracts are normally valid for **one-year**, with no binding obligations on either party to continue for a further period. Of course, insurers normally like to **retain** business, but renewal gives them an opportunity to review both insurability and contract terms again. While the insured need not disclose any material facts arising or coming to his attention during the currency of the contract (unless disclosure is required by an express contract term), he must disclose them on renewal because each renewal will constitute the creation of a new contract.

(iii) with **claims**. Facts may emerge in a claim situation (concerning the **risk** or the **insured**) which may give rise to second thoughts. Many general insurance policies have a **cancellation clause,** allowing the insurer to cancel the policy by giving, say, seven days' notice. This is not often used, but the opportunity is there if circumstances warrant it.

(iv) with proposed **material changes to the present terms** (e.g. naming an inexperienced driver in an existing policy). The above remark about cancellation applies.

(v) where there is a **change in risk** that was not within the contemplation of the parties at the time the insurance was taken out. Again, the above remark about cancellation applies.

(d) **Risk Assessment Factors**

Whilst later Notes will concentrate on some specific areas of attention in underwriting, it may be helpful to mention at this stage a few things that risk assessment is very likely to embrace:

(i) *acceptance* (under **any** terms): it is always easy to say "no", but if we always say "no", we will soon be out of a job, or of business;

(ii) *standard premium?*: if the risk is insurable, do we need more than or less than the normal premium for various reasons?

(iii) *standard wording?*: can we issue the normal policy form, or are amendments (or even a specially drafted wording) needed?

(iv) *warranties*: do we need to insist that the insured does something, or refrains from doing something, to make the risk insurable? See **2.3.4** below;

(v) *excess/deductible*: do we wish to eliminate small claims and/or wish the insured to bear part of his loss? See **2.3.3** below;

(vi) *expert help*: do we need further information on technical matters, so that a risk surveyor or another professional (medical, engineering, etc.) needs to be engaged before we can quote final terms?

We shall meet most of these considerations again, but it should be remembered that the assessment of risk, carried out conscientiously and at the right time, is the foundation of success in the insurance business. Failure to conduct this process, or to do it properly, means we are leaving too much to chance. That is not insurance. It is **gambling!**

2.1.2 Physical Hazards and Moral Hazards

In assessing a particular proposal, an underwriter needs to gain a complete picture of the risk presented. Apart from the hazards involved, he will also have to take into account such factors as the state of the market (e.g. the intensity of market competition), his company's marketing and business philosophy, the company's premium targets, etc. Underwriters classify hazards into the following two types:

(a) **Physical Hazards**

They are the objective, material features of a risk, i.e. the factors which are self-evident or easily ascertained, which bear upon the likelihood or possible severity of losses.

The word "*hazard*" normally suggests "danger" or some such adverse meaning. In the context of insurance, the term "hazard", when used without semantic qualification, is neutral. It is therefore perfectly correct to talk of "good" or "excellent" physical hazard, where the nature of the subject matter of insurance or other related factors suggest less likely or less serious claims, a state-of-the-art fire protection system being an example of good hazard.

Mostly, physical hazards concern matters of common sense. Examples of physical hazards will easily come to mind with different classes of business, including the following:

(i) *Construction materials* have an obvious significance with fire insurance. Buildings of wood are naturally likely to warrant higher premiums than comparable buildings of concrete construction.

(ii) *Attractiveness to thieves* will be an important underwriting feature with theft insurance. High value/low bulk items, like gold, cigarettes, certain Chinese medicines, and drugs will clearly represent adverse physical hazards.

(iii) *Physical and health condition* can be important with PA and/or sickness cover.

(iv) *Dangerous occupations*: PA cover for construction or demolition workers will clearly warrant different terms from clerks.

(v) *Engine power* will be an important consideration with motor and pleasure craft insurances.

The list could be endless, but perhaps sufficient has been said to appreciate the significance of this (perhaps primary) factor in underwriting.

(b) **Moral Hazards**

In many ways, this is an unfortunate expression, because it tends to focus upon the moral behaviour and ethics of the insured. Whilst these are important, and certainly part of the **moral hazard** picture, the term embraces wider issues, inclusive of such things as **attitudes, life styles** and **carelessness**. A person (e.g. a particular actor) may be an excellent person, as far as the normal understanding of morality is concerned, but still represent **poor moral hazard** (perhaps because of the typical life style of an actor).

Perhaps a better understanding will arise if we think of moral hazard as the "**human element**", i.e. those features and characteristics surrounding **attitudes**, **behaviour** and **conduct** of the insured and others who may be associated with the risk (e.g. the insured's family members and employees).

This aspect is more difficult and **subjective** than physical hazards. Also, the true nature of the insured may not be apparent until a claim arises. Despite these, we may briefly say that moral hazard, in its **adverse** form, could show itself in:

(i) *Dishonesty*: in extreme or serious forms, this means **fraud**;

(ii) *Carelessness and recklessness*: which can easily produce losses or accidents;

(iii) *Unreasonableness*: a person may be totally honest in the accepted sense of the word, but they may create big problems by opinionated views and inflexibility;

(iv) *Anti-social behaviour*: by which is meant behaviour that is disruptive to others in society, such as vandalism and social disturbances.

As with many things in life, a total appreciation must take into account not only the **physical** factors, but also the **human element**, which is sometimes equally or even more important.

2.1.3 Proposal Forms

These are insurance companies' printed documents on which prospective insured are required to submit details of the risks to be insured. The questions on a proposal form are meticulously designed by the **insurer**, and presented in such a way as to be as "**user-friendly**" as possible, whilst at the same time covering all important areas in which the underwriter needs information. Although the proposer is under an active duty of disclosure, where the facts of a court case are such that not all material facts are covered by the questions set out in the proposal form, the court might infer that the insurer has restricted his right to receive material facts to those covered by those questions.

There will be many different questions arising with specific classes of business, but some common features in virtually all proposal forms include:

(a) *Proposer's details*: such as **name**, **address** and **occupation**. These may have a bearing on the physical hazards, and are in any event needed for identification and communication purposes.

(b) *Insurance history*: the underwriter will need to know whether there are other existing insurances, and whether there have been refusals to insure or applications of abnormally restrictive terms (such as removal of theft cover from a household policy) by other insurers.

(c) *Losses/claims history*: previous losses, whether insured or uninsured, could have an obvious importance with the present application.

(d) *Insured's valuations*: with many classes of business, these include the sum insured, which represents the insurer's **maximum** liability under the policy and is in many cases also the basis of premium calculation.

There are other features, of which we shall look at some examples in **2.2.2** below, but the above are typical areas from which **material facts** may be supplied.

2.1.4 Methods of Obtaining Material Facts

There are a number of ways in which and sources from which the underwriter can obtain the details of the **material facts** of a proposed risk. These include:

(a) *Proposal form*: as considered above. In some classes of business (mostly **personal lines**, e.g. private car), the proposal form is virtually the only source of underwriting information. On the other hand, it is not unknown for insurers to dispense with the use of proposal forms in certain classes of insurance business.

(b) *Professional help*: where a proposed risk involves highly technical matters, the assistance of qualified professionals may be needed. These range from **medical** matters to **risk surveys** and **reports** from various technical experts.

(c) *Risk surveys*: a physical site inspection is often advisable in the case of large or complicated fire, theft and liability risks. This may be carried out by independent surveyors or the insurer's own staff.

(d) *Insurance intermediaries*: especially **insurance brokers**. As agent of the **proposer**, an insurance broker is identified with the **proposer** and bound in law to disclose **material** information he has concerning the client and the proposed risk. If an insurance broker fails to do so, this will constitute a breach of **utmost good faith** imputed to the proposer.

(e) *Recording*: material facts may be given in the form of **answers** on a proposal form, or other documents (e.g. a feasibility report for an engineering project). They may also be **verbally** disclosed, in response to direct questions on a risk survey or during pre-contract discussions. It is sometimes advisable to have written confirmation of verbal representations, in correspondence or otherwise, to avoid possible misunderstandings later.

(f) *Miscellaneous*: several other possible sources exist for obtaining material information. These include:

(i) enquiries with **previous insurers** (e.g. about past claims);

(ii) enquiries with professional **enquiry agents** (or "**private investigators**") (e.g. with fidelity guarantee proposals);

(iii) enquiries regarding possible **hire-purchase** commitments (e.g. with motor vehicles);

(iv) confidential **market information** exchanges among insurers (should there be suspicions of earlier **frauds,** etc.).

Note: As with other Notes, the above give a representative selection only.

2.2 UNDERWRITING PROCEDURES

2.2.1 Quotations

It is very common, in several classes of general insurance, for a prospective insured or his representative (usually an **insurance broker**) to seek information about the terms the insurer might be prepared to offer, without any commitment on the part of the prospective insured. Such information is given in the form of a **quotation**, which will consist of one or more of the following features:

(a) it may be **in writing** or **verbal**;

(b) it may concern the envisaged **premium** only, or refer to other **contract terms** as well;

(c) as a **quotation** may possibly be taken as an offer capable of being accepted, much care should be exercised in using the terms "quotation" and "quote", and in writing the text of the quotation. The court, when called upon to determine whether a particular "quotation" constitutes an offer or a mere invitation to treat, will take into account all the relevant facts, including the circumstances of negotiations between the parties coupled with their intentions.

2.2.2 Proposal Forms

These we have already considered from various perspectives. As part of the underwriting process, we may note or note again:

(a) *only source of underwriting information*: with relatively minor risks, the proposal form is likely to be the only practical tool of enquiry, and risks may be accepted or otherwise solely on its answers;

(b) *"trigger" for other enquiries*: answers given on proposal forms or deductions from such answers may indicate that further enquiries need to be made, in the form of additional questions to the proposer, more formal enquiries through **surveyors** or other professionals, etc.;

(c) *basis of the contract*: information supplied on a proposal form is the main (and sometimes the only) information available for the making of underwriting decisions. Almost all general insurance proposal forms contain a **declaration** that the information supplied will form the basis of the contract to be made. Referred to as a "basis of contract clause" or "basis clause", such a declaration will usually be incorporated into the contract in the form of an **insurance warranty** regarding the truth of the information, so that any inaccuracy of the information, regardless of materiality, is expected to render the contract void as from inception. This is quite a contrast to the principle of utmost good faith, which only requires representations of material facts to be substantially correct;

(d) *"permanent" document*: because the completed proposal has a fundamental role with the contract, it should not be regarded as a temporary document. Because of its importance, some insurers include a photocopy of the completed proposal when sending out the policy document. This will serve as a reminder to the insured of the information he supplied, which is the basis of the insurer's undertakings;

(e) *supplementary information*: any experts' reports or other documentation, perhaps arising with (b) above, must be considered part of the proposal, and this fact should be brought to the proposer's attention.

2.2.3 Issue of Cover Notes, Policies and Certificates of Insurance

These documents all fulfil roles in the underwriting process. A brief reminder of their respective functions will be sufficient to identify the roles concerned:

(a) **Cover Notes**

A cover note is a **temporary** document, effectively constituting a temporary policy. However, as its name suggests, it does provide **cover**, i.e. it is **not conditional** upon a satisfactory proposal form, to be submitted later. In other words, a cover note **binds** the insurer. The following features may be noted:

(i) Its *primary purpose* is to give **documentary evidence** to the insured that insurance exists as described. Commonly, cover notes are issued with **motor** insurance, incorporating a **temporary certificate** of insurance (see (c) below), which confirms that the insurance required by law exists. As with a certificate of insurance, a properly prepared motor cover note may be used to assist with **vehicle registration,** etc.;

(ii) *other functions*: motor is not the only class of business where cover notes are used. A bank, for example, may require evidence in the form of a cover note or policy that **fire** insurance exists, before it advances an agreed **mortgage loan**;

(iii) *not "conditional"*: to repeat what was said above, the document does provide **unconditional cover**. However, cover notes frequently have **cancellation** provisions, so that the insurer may come off cover, by giving notice in a prescribed manner;

(iv) *"temporary"*: again to reinforce a previous comment, a cover note is a convenient way of confirming the insurance requested, but the cover given is temporary - effective for say 30 days or another short period, during which a **policy** is to be issued to replace the cover note.

(b) **Policies**

A **policy** (or "**insurance policy**") is visible evidence of an **invisible contract** of insurance, which is most formal and most commonly used. As previously mentioned, most general insurance contracts are **simple contracts**, which do not have to be in writing in order to be effective. In practice, a policy is almost invariably issued. However, issuing the policy is usually the **last** stage in the underwriting process, representing as it does the final result of all enquiries, deliberations and decisions of the underwriter. We shall look in more detail at policy structures in **2.3**, but in the **underwriting** context we may note the following:

(i) *evidence of the contract*: legally, the correctness of the policy may be challenged, but the law will assume that its contents represent the **intentions** of the parties, unless compelling evidence is produced to prove otherwise;

(ii) *incorporates other material*: the policy will specifically incorporate the completed **proposal form** and perhaps other supplementary documentation, etc. as being part of the contract;

(iii) *replaces any cover notes*: as noted above, **cover notes** may be considered as temporary policies, to be replaced by the final policy document.

(c) **Certificates of Insurance**

Insurance certificates may have differing roles. When issued as a summary of the cover provided under a **master policy**, as is sometimes the case with **travel** and **marine cargo** insurances, certificates have more or less the same function as **cover notes** (see (a) above). Unlike the case with cover notes, a separate policy is not subsequently issued except in the case of motor insurance.

The usual understanding of the **insurance certificate** embraces the following features:

(i) *proof of compulsory insurance*: with either **motor** or **pleasure vessel** insurance, a certificate of insurance serves as the only legally recognised **proof** to people (e.g. police officers) who need to know that the insurance required by statute does exist;

(ii) *independent of the policy*: a certificate is a totally **separate** and **permanent** document (unlike a cover note). However, a **temporary** motor insurance certificate is usually incorporated into a motor cover note, as noted above;

(iii) *contents and format*: a cover note will have an abbreviated summary of cover, but a certificate may or may not. For example, you cannot tell from a certificate of motor insurance whether the cover is **Comprehensive** or **Act Only**; it merely confirms the existence of **compulsory** motor insurance in a form prescribed in the relevant Ordinance;

(iv) *why issued*: certificates of compulsory insurance are issued solely because **statute** requires them. If one is not issued by an insurer, this constitutes a **criminal offence**, for which both the **insured** and the **insurer** may be prosecuted. In **motor** insurance, the certificate has such a legal importance that it is essential for the insurer to recover the document once the policy is **cancelled**.

2.2.4 Premium

(a) Methods of Calculation

As to the method of premium calculation, in the context of underwriting procedures, individual comments were made in respect of different classes of business in Chapter **1** of these Notes, but we may also note the following:

(i) *Risk classification*: With many types of insurance, the risk is assigned to a particular category, to which pre-determined average premium rates will apply. For example, in personal accident insurance, risks are classified into four or more classes by reference to the insured person's occupations.

(ii) *Risk discrimination*: Any idea of "discrimination" is not politically correct these days, but the term is of very long standing with insurance underwriting where it has no wicked implication. It refers merely to distinguishing the features (good or bad) of individual risks falling within the same risk category, so that adjustment up or down to the broad classification premium can be

made. Suppose a fire underwriter is underwriting two private warehouse risks located in the same building, the first one being in the basement and the other on the second floor. Although they belong to the same risk category, "private warehouse", the underwriter may impose a premium loading for the first risk because it is considered to be an above average risk, while charging the average or normal premium for "private warehouse" for the second risk.

(iii) *Different bases*: general insurance has a very wide range of different products, so it is only to be expected that the premium base will differ between various classes. Frequently, a designated rate (usually per cent or per mille) is applied to a factor such as:

(1) the **sum insured**;

(2) the **annual turnover**;

(3) the **annual wageroll**;

but different classes of insurance may have different criteria, as previously noted.

(b) **Relevance of Premium Payment to Valid Cover**

With **life** insurance, it is almost the invariable practice that cover does not commence until after the first premium has been received. This is not necessarily the case with general insurance. This is an important issue, so the following comments should be noted carefully:

(i) *Common Law position*: unless the **contract terms** specify to the contrary, payment of the premium is **not** a **condition precedent**, so that the contract may exist, even though the premium has not yet been paid. When a valid claim arises, it will have to be paid, with the insurer having a separate right to the premium due.

(ii) *Policy provisions*: practice varies with policy wording. Some policies strictly provide that cover is **conditional** upon the premium having been received. Other policies may require that the insured "has paid **or agreed to pay**" the premium. An insured's conduct of paying premiums in past years may possibly constitute a current **promise** to pay premiums.

(iii) *Other considerations*:

(1) Payment to **insurance intermediaries**: A question arises as to whether a premium payment made to an insurance intermediary constitutes payment to the insurer. It hinges

upon on whose authority the payment has been received or paid. Was it the insurer who has given authority to the insurance intermediary to receive the payment? Did the insured authorize the insurance intermediary to make payment to the insurer? Of course, that provision of the Insurance Ordinance which makes an insurer vicariously liable for the conduct of its appointed insurance agent in *prescribed circumstances* is relevant to these issues. Also note that another provision of the Ordinance prohibits an insurer from excluding or limiting such liability.

(2) **Waiver** and **estoppel**: In the context of punctuality of premium payment, waiver is a clear representation or conduct on the part of the insurer that it will not insist on an express contractual requirement of premium payment before commencement of cover. Thus, if an insurer has in the past accepted late payments of premiums without hesitation, he may possibly be regarded as having waived punctuality of payments in the future. For the doctrine of estoppel to apply alternatively, the insured must show that he has reasonably relied on the said representation or conduct of the insurer.

Note: These are complex areas, in which important legal issues may arise. Appropriate legal advice should therefore be obtained with specific cases.

2.2.5 Levies on Premiums

(a) Motor Insurers' Bureau of Hong Kong

Despite the third party insurance requirements of the Motor Vehicles Insurance (Third Party Risks) Ordinance (Cap. 272), there have been instances of victims of traffic accidents being unable to recover the damages awarded to them against the wrongdoers, owing to the lack of valid third party insurance or to breaches of third party policy terms by virtue of which the insurers concerned were allowed to repudiate policy liability. Other instances have also happened where insolvent insurers failed to satisfy liabilities under third party motor policies. Set up against this background is the Motor Insurers' Bureau of Hong Kong (MIB), whose principal objective is to secure the satisfaction of claims made by the injured or his/her dependents in respect of liability for death or bodily injury which arises from the use of motor vehicles on the road, when the use of the vehicle is required to be covered by the Ordinance. All insurers who are authorised under the Insurance Ordinance to write third party motor insurance in Hong Kong are required to be members of the MIB.

The MIB will step in to compensate a traffic accident victim in any of the following circumstances: (a) a judgment debt in respect of uninsured "Act" liability (see **1.1**(b)) has not been paid whether in whole or in part within 28 days; (b) a judgment award in respect of "Act" liability arising out of a terrorist act has been made; and (c) a final claim has not been paid in full by the insurer concerned by reason of its insolvency. Compensation in cases (a) and (b) is paid under a scheme called the First Fund Scheme, and those in (c) under the Insolvency Fund Scheme. In addition to these promises, the MIB pledges to safeguard the interests of "hit and run" victims, in which suing an unidentified driver is impossible, by financially assisting them on an ex-gratia basis under the First Fund Scheme, provided that in its view there is reasonable certainty that the injury or death was caused by negligent driving.

Funding for payments made by the MIB comes from a premium levy, imposed by insurers on all motor policies they issue. Set at a rate of 1% of motor premiums, the levy does not belong to the insurers, and must be passed to the MIB.

(b) **Employees Compensation Assistance Scheme**

Set up under the Employees Compensation Assistance Ordinance (Cap. 365), this Scheme provides payment to injured employees or family members of deceased employees who are unable to receive their entitlements to compensation and damages for work-related injuries or fatalities from their employers or the EC insurers concerned. However, cases of EC insurers' insolvency are now the exclusive responsibility of the ECIIB referred to in (c) below. The Employees Compensation Assistance Fund is financed by a levy on EC premiums at a current rate of **5.8%**.

(c) **Employees Compensation Insurer Insolvency Bureau**

The Employees Compensation Insurer Insolvency Bureau (ECIIB) is an organization of all EC insurers in Hong Kong, which has been set up by the insurance industry for operating the Employees Compensation Insurer Insolvency Scheme. The objective of the Scheme is to indemnify EC policyholders against their insurers' failure to pay EC insurance claims because of their insolvency. It is funded by way of contributions made by EC insurers calculated by a rate of **2%** of gross EC premium income.

(d) **Government Facility for Terrorism Risks**

At the beginning of this century, EC insurers in Hong Kong encountered immense difficulty in seeking reinsurance cover for terrorism risks. To help resolve this issue, the Government set up a $10 billion facility to cater for terrorism risks in respect of EC insurance, thereby ensuring that

protection is rendered to employees, that employers continue to enjoy insurance cover, and that insurers could underwrite the risk of work-related death or injury caused by terrorist activities. While participation in the facility is voluntary, non-participating insurers who wish to underwrite EC insurance should demonstrate to the Insurance Authority that they are able to secure alternative cover. Participating insurers are required to pay to the Government a monthly charge calculated at a rate of 3% of the gross premiums of the EC policies they underwrite in Hong Kong for the month.

(e) **Premium Levy Collected by the Insurance Authority**

The Insurance Authority (IA) is a regulatory body which is not only operationally but also financially independent of both the Government and the insurance industry. It is empowered under the Insurance Ordinance (Cap. 41) to recover its operating costs by collecting fees from insurance companies and users for specific services, as well as a premium levy from policyholders. Starting from 1 January 2018, the IA collects a levy on insurance premiums from policyholders through insurance companies. Except for certain policies which are exempt from the levy by law, policyholders of all new or in-force life insurance policies and general insurance policies (such as travel, motor, property and household policies) must pay the levy along with their premium payments. The levy rate is 0.04% of the insurance premium in the first phase of introduction, increasing gradually to 0.1% in April 2021 for the fourth and final phase, and subject to various caps.

2.3 POLICY WORDING, TERMS AND CONDITIONS

To remind you, a policy is the **written evidence** of an **insurance contract**. It is therefore of great importance to understand the usual form that insurance policies take in Hong Kong. Before we do so, however, two points should be noted:

(a) Policy wording in Hong Kong is **not regulated**. Insurers are therefore free to construct and market their own individual products.

(b) Most insurers in fact tend to provide wording which is very similar to what is found in the market. We shall thus use **representative** examples, which will broadly suffice to explain the general practice.

2.3.1 Policy Forms and Policy Schedules

General insurance policy forms in Hong Kong are predominantly scheduled forms, and are increasingly written in plain English.

(a) *"Plain English" policy forms*: They are a result of a modern attempt to avoid the formal traditional language of a legal document. In an effort to make the document more "**user-friendly**", the text is expressed in the

first and second person, rather than the impersonal third person, so that it talks of "**we**" and "**you**", rather than "**the company**" and "**the insured**". The policy is also very likely to be in a smaller **booklet** form, perhaps with diagrams and cartoon drawings. This style of policy presentation is used with **personal lines** insurance, rather than with **commercial** risks.

(b) *Scheduled policy forms*: The "**Schedule**" (or "**Policy Schedule**") is that part of the policy which contains all information relating solely to the risk concerned. The rest of the policy is standard wording, for all policies in that class of business, presented in separately designated sections, having different functions.

The scheduled policy form is of long-standing tradition, and will be the basis for comment and study in the Notes that follow.

The **scheduled** policy form consists of the following sections:

(i) *The Schedule*: as mentioned, this contains all information which applies exclusively to the specific contract concerned. It is to this section that attention must be given, for example, to ascertain:

(a) policy **number**;

(b) details of the **insured** (name, address, occupation, age, etc.);

(c) policy **limits** (sums insured, limits of liability, etc.);

(d) effective **dates** (commencement date, renewal/expiry date, etc.);

(e) description of the **subject matter of insurance**;

(f) **premium**;

(g) identity of the **insurance intermediary** (where shown in the policy);

(h) any **special terms** applicable (e.g. warranties requiring specific risk improvement measures);

(i) any **extra benefits** applicable to this contract (extra perils, etc.);

(j) any **endorsements** (i.e. modifications and amendments of any kind).

(ii) *The Recital Clause* (or "*Preamble*"): whilst this name, as such, does not appear in the policy document, the recital clause is effectively an **introduction** to the contract. It will make reference to the **contracting parties** (not by name, which is shown in the Schedule). It will also refer to the **proposal form** and **declaration**, recognizing them as being incorporated into and forming the **basis** of the contract (see **2.2.2**(c)). **Premium payment** (not by amount) may also be mentioned.

(iii) *The Operative Clause*: this indicates the circumstances under which **cover** is **operative** (hence, it is sometimes called the **Insuring Clause**). Again, this title does not appear in the document. The Operative Clause usually follows the **Recital Clause**, with the following features:

(a) it may be quite **short** (e.g. with glass insurance) **or quite long** (e.g. with **motor** insurance);

(b) it specifies the **perils** covered or mentions that cover is on an "**all risks**" basis (with **property** insurance);

(c) it may comprise one or more **sections** (e.g. **motor** insurance);

(d) these sections may have their own **exceptions**, limiting the cover given under **that section** only (see (iv) below);

(e) any **excess/deductible** for the section concerned may be shown here or in the Schedule.

(iv) *General Exceptions*: the word "**General**" in this context means that the exceptions apply to the **whole** contract (i.e. **every** section of the policy). As noted above, individual sections in the Operative Clause may have their own exceptions (e.g. cover against damage to the insured vehicle, with a **motor** policy, typically excludes damage to tyres unless another part of the vehicle is also damaged). **General** exceptions apply with every type of claim (e.g. in motor insurance, a non-permitted use of the vehicle).

The title "**General Exceptions**" is clearly indicated in the policy document, although the term "**Exclusions**" or less often "**Provisos**" might be used instead.

(v) *Policy Conditions*: Put simply, these are various standard, written provisions **regulating** the insurance contract. We shall discuss them in more detail in **2.3.2** below.

(vi) *Signature Clause* (or "*Attestation Clause*"): Not given this title in the policy, this section is very short (often appearing in the **Schedule**), providing for the signature(s) on behalf of the insurer, to confirm the terms of his undertakings as expressed in the policy document. (The policy document is **not** signed by the insured.)

2.3.2 Common Policy Exceptions and Conditions

Individual risks may have specific provisions and/or limitations imposed by the underwriter, but we shall consider this topic in general terms, as follows:

(a) **Policy Exceptions**

These we examine specifically under the heading of "**Exclusions**" in **2.3.5** below, but just a reminder that **exceptions** may apply to the **whole** of the contract ("**General Exceptions**") or merely exclude part of the cover from individual policy sections ("**Sectional Exceptions**"). All insurance contracts will have some exceptions. As a commercial undertaking, it is not possible to provide cover with no limitations. Even if no exceptions as such appear in the policy document, there will always be provisos which the law **implies** (i.e. shall be **read into** any insurance contract), e.g. the exclusion of **fraud**.

(b) **Policy Conditions** (or "**Conditions**")

Non-marine policies usually contain a group of terms labelled as "policy conditions" or "conditions", which lay down the important relationships, rights and duties of the insurer and the insured. Some commonly met policy conditions are:

(i) *Claims*: relating to procedures and rights and obligations associated with making a claim under the policy (see **3.1.3,** etc. below);

(ii) *Arbitration*: outlining the procedure for settling claim disputes between the insured and the insurer by involving arbitrators as their "private judges" (see **3.2.1** below);

(iii) *Cancellation*: in general insurance, the **insurer** is usually given the right to cancel. Most if not all policies also give the insured the right to cancel. (See **2.4.2** (a) and (b) below for more details);

(iv) *Average*: the provision for a penalty for **under-insurance** existing at the time of loss;

(v) *Policy modifying legal positions*: in **indemnity** policies, the attendant principles of **subrogation** and **contribution** are very likely to be mentioned, possibly with contractual modifications to their applications (studied in "**Principles and Practice of Insurance**");

(vi) *Adjustable premiums*: where premiums have to be on a provisional basis because they are based upon variable factors (e.g. payroll, turnover, etc.), there will be a policy condition requiring the insured to keep adequate records, so that actual premiums may be calculated for the purpose of premium adjustment upon the expiry of the policy.

2.3.3 Use of Excesses, Deductibles and Franchises

A reminder of the meaning of each of these terms will serve as a useful basis for considering its application, as follows:

(a) **Excess**

This is a policy provision whereby up to the first stated amount, or a stated proportion (subject to a minimum amount), of the amount of a loss, is **not** recoverable. Time excesses are sometimes met. Policy excesses may be:

(i) *standard*: applicable to all policies in that class (e.g. "**Young Driver Excess**" in a motor policy);

(ii) *imposed*: applied **additionally** by the underwriter (with **no** premium reduction) to counteract a proposed risk's adverse features (e.g. following a number of small claims under an "**all risks**" policy);

(iii) *voluntary*: chosen by the **insured** in order to obtain a premium **reduction** (e.g. where the insured company has a self-insurance fund for absorbing small or moderate losses).

The primary intention of an excess is to **eliminate** small claims, which the insurer regards as uneconomical to handle. It may also be intended to make the insured **participate** in his own **loss experience.**

(b) **Deductible**

The terms "deductible" and "excess" are interchangeable.

(c) **Franchise**

It is no longer common to find a monetary (or dollar) **franchise** with policies in Hong Kong. The function of the franchise is to **eliminate** small claims, whilst paying **in full** any one loss reaching or exceeding the franchise, depending on the wording used. Such a provision used to be found in some property insurances, but an **excess/deductible** is now preferred. A **time franchise** may still be found, however, with:

(i) some general insurances: which provide compensation or a benefit related to **disability** or **incapacity**, but the benefit is only payable after the person concerned has been so

disabled/incapacitated for a minimum period, with entitlement for the **full** incapacity period. For example, in **PA** insurance weekly benefits will not be payable unless disablement lasts for at least, say, **2 weeks**, such a minimum period being known as the waiting period.

(ii) business interruption insurance: BI policies sometimes specify that any loss occurring during the indemnity period is not payable unless it is for at least, say, 48 hours.

Note: With neither of the above examples does the usual policy actually uses the word "**franchise**", which term is incomprehensible to the majority of the insuring public.

2.3.4 Warranties, Conditions and Representations

Again, a reminder of the meanings of the respective terms will help in their understanding:

(a) **Warranties**

A warranty in insurance (not in the law of contract) may be thought of as an undertaking to the insurer on the part of the insured which must be exactly complied with. That undertaking may be to:

(i) *do something*: e.g. to have a burglar alarm fitted to the insured premises, to keep it in working order, and to switch it on after working hours (in the case of theft insurance);

(ii) *refrain from doing something*: e.g. not to store flammable liquids on the insured premises (in the case of fire insurance);

(iii) *affirm the existence of certain facts*: e.g. the warranty in the declaration on a typical general insurance proposal form warrants that answers given on the form are complete and true; or

(iv) *negative the existence of certain facts*: e.g. a warranty of no smoking habit.

A **breach** of warranty will automatically discharge policy liability as from the date of breach. It is a strict legal rule, in that the breach does **not** have to have a **causal relationship** to a claim situation (i.e. the breach need not have caused or in any way been relevant to a loss situation). In order to relieve the harshness of insurance warranties, the Hong Kong Federation of Insurers has issued the **Code of Conduct for Insurers** for compliance by its members, which provides that only where a **causal connection** between a breach of warranty and a loss exists, or where the breach is fraudulent, will the breach be used to refuse a claim.

Note: 1 Warranties are normally **express warranties**. They may be **standard** (i.e. applicable to all policies in that class) or specially **imposed** by the underwriter for a particular risk.

2 Technically, **implied** (automatic, unwritten) warranties may exist (e.g. the warranty of seaworthiness of ship implied by the Marine Insurance Ordinance).

3 As the effect of a breach of warranty is automatic, no election by the insurer to rescind the contract is required. Besides, its operation will give rise to no right to a premium refund, whether total or partial, except for a full refund in the event of a breach of warranty prior to attachment of risk.

(b) **Conditions**

The use of the term "conditions" in insurance is rather problematic and confusing. Whenever this term is come across, one may have to figure out from the context - not without difficulty - whether it is a "policy condition" (an insurance term) or a "contract condition" (a legal term) that is being referred to. The terms "policy condition" and "contract condition" are not synonyms and should be dealt with carefully in order to avoid confusion.

In the *law of contract*, a **condition** of a contract is such a fundamental term of the contract that a breach of it will entitle the aggrieved party to treat the contract as repudiated and to seek some other remedies as well. For example, a reasonable standard of food hygiene is an implied contract condition to be complied with by a food supplier.

On the other hand, in *insurance terminology*, "conditions" (or "policy conditions") are a collection of standard, written policy provisions which specify the important relationships, rights and duties of the insurer and the insured, and whose nature is so varied that some of them are fundamental and some are not. At this stage, it might be too complicated for you to learn how to tell contract terms which are fundamental from those which fall into either one of the other two categories of contract terms.

That said, it is beneficial for you to learn that the terms (whether express or implied) of an insurance contract can be classified into the following three types by the criterion of time of operation:

(i) *Condition precedent to the contract*: a term which must be complied with in order for the contract to **commence**, e.g. misrepresentation condition.

(ii) *Condition subsequent to the contract*: For example, in PA insurance, where the premium largely depends upon the insured's profession, a change of profession *during the policy term* is expressly required to be notified and agreed.

(iii) *Condition precedent to liability*: such a term, if breached, does **not** destroy the contract as a whole, but will invalidate a particular **claim**. A notification condition which *expressly and clearly* states that the insured will forfeit his rights in the event of its breach is unquestionably an example.

Note: The nature of a contract term depends on the intention of the contracting parties. The label given by the parties to a contract term is merely an indication of their intention, but is not conclusive.

(c) **Representations**

In insurance context, a representation is a representation as to a matter of fact or of belief (e.g. "the total value of the household contents to be insured is $1m - $1.5m"), made by one party to another, and bearing upon a risk proposed for insurance; it may be **verbal** or in **writing**. An untrue representation is called a "**misrepresentation**". Disregarding any overriding effects of warranties and some other policy terms, the following legal rules apply to representations:

(i) representations **only** need to be **true** if they are **material** to the risk (if they are not material, e.g. an incorrect age of a fire insurance proposer, they are effectively irrelevant to the contract and the error has no legal consequence);

(ii) a representation as to a matter of fact is true, if it is substantially correct (that is to say, if the difference between what is represented and what is actually correct would not be considered material by a prudent insurer), whereas a representation as to a matter of belief is true if it is made in good faith;

(iii) representations **need not** appear in the policy or become contract terms in order to apply the law of representation; but they do of course have a bearing on the contract, subject to the above.

2.3.5 General, Specific and Market Exclusions

An **exclusion** is a policy provision which means that cover does **not** apply in the circumstances described. The various types of exclusion are:

(a) **General Exclusions**

These may be defined as exclusions which are applicable to **all** policies within the particular class. Some examples are:

(i) *"All Risks" insurance*: the cover is intended to relate to loss or damage which may or may not happen, not those which must happen. Thus, **wear and tear**, **depreciation** and **gradually operating** causes (atmospheric conditions, etc.) are standard exclusions for any type of "all risks" insurance.

(ii) *Private car insurance*: cover is intended for normal usage on business or pleasure, so **racing, speed-testing** and **motor trade** uses are standard exclusions.

(iii) *Liability insurance*: because of its uncertain scope, contractual liability (see **1.1**(d)(iii)(4) above) is made a standard exclusion.

(iv) *Personal accident insurance*: cover is intended to apply in respect of **accidents** whilst the insured is following a normal non-hazardous lifestyle. Thus, **suicide** and **extra-hazardous** activities such as driving or riding in **motor racing** are standard exclusions.

(b) **Specific Exclusions**

These are exclusions which the underwriter decides should be applied to the policies for particular risks, because of the extra hazards these risks present. Individual circumstances vary enormously, but a few examples may serve as illustrations:

(i) *Personal accident insurance*: suppose an insured person has a particular problem to his back (e.g. "slipped disc"). Apart from that problem, he represents a standard risk, so the underwriter may in accepting the proposal delete cover for the back problem by a specially worded exclusion.

(ii) *Private car insurance*: for instance, if a particular member of the insured's family has a bad record of driving accidents, the policy is likely to prohibit him from driving the car.

(iii) *"All risks" insurance*: insuring an item of jewelry which is perhaps worth millions of dollars presents certain problems. The underwriter may decide to exclude cover for this item unless it is kept in a particularly secure place, or the insurer's consent is given for its use elsewhere.

(iv) *Household insurance*: suppose, for example, that the premises are situated at a dangerous corner and the surrounding wall of the property has been knocked down quite a few times by a vehicle. The insurer may decide to exclude the peril of impact by vehicles from the policy.

(c) **Market Exclusions**

These are really another form of **General Exclusion**, but they are common to policies issued by virtually **all** insurers operating in the market. Often, they concern **fundamental risks**, and in some territories the exclusions concerned are results of discussions and agreement with the **government** concerned. Examples include:

(i) *nuclear and radioactive risks*;

(ii) *terrorism*;

(iii) *sonic boom damage;*

(iv) *war risks* (in the case of non-marine insurance).

(d) **Other Exclusions**

For completeness, we should mention the following:

(i) **Fraud**: the law in Hong Kong will never support **fraud**. Even if there is no specific reference to it in policy wording, it always constitutes legal grounds for denying policy liability.

(ii) **Public policy**: sometimes, the courts would not allow something to be done, because that is contrary to public policy. As far as insurance is concerned, it means that there may be occasions where society (through the decisions of judges) in effect says that a particular insurance contract or some of its provisions should not be enforceable, leaving aside any mutual intention of the contracting parties.

An example may illustrate the point. A **public liability** (PL) insurance claim was invalidated when the insured shot his wife's lover, even though the gun allegedly went off by accident during a struggle between the two men. The judge said that the husband's behaviour in even holding a loaded weapon was improper. The husband was liable, but his PL insurer was not liable to him. Making a liability insurer pay in such circumstances will be against public policy. This concept may also be exemplified by an insurance for the benefit of an enemy alien in time of war, which may be held to be void as being contrary to public policy.

(iii) **Special situations**: sometimes local conditions are in turmoil because of social unrest, the outbreak of an epidemic, etc. In those circumstances, insurers may agree on a temporary or permanent **market exclusion**.

2.4 RENEWALS AND CANCELLATIONS

2.4.1 Renewals

The following features should be noted:

(a) *A new contract*: general insurance contracts are normally for **one year** only. A renewal therefore constitutes a **new** contract, even though the same policy is used. This gives an opportunity for an **underwriting review** of insurability and terms (which must of course be agreed by the **insured**, if the insurance is to continue).

(b) *Utmost good faith revives*: any **material** information that has arisen since the contract was concluded (or last renewed) must be disclosed to the insurer.

(c) *Freely negotiable*: normally, neither the insurer nor the insured is bound to renew or to accept particular terms. The precise terms of renewal are open for discussion and negotiation, and considerations of offer and acceptance apply.

(d) *Legal obligations*: in law, the insurer does not have to remind the insured that the renewal date is approaching. Obviously, it is normally in the insurer's interest to do so, but if he does not and the insured takes no action the policy merely **lapses** at the end of the period of cover.

Note: We should not say that the policy is **cancelled** if it is not renewed. **Cancellation** is always a premature termination of cover.

2.4.2 Operation of Cancellation Clauses

It is important to note that there is no automatic right to cancel any contract (and this includes insurance contracts). Apart from situations where the law allows or requires the contract to end, cancellation can only happen by mutual consent unless contract terms specifically allow unilateral cancellation.

In practice, most general insurance policies do have a **cancellation clause** (or "**cancellation condition**"). Features to be noted with such a clause are:

(a) *The insurer may cancel*: cancellation clauses, if any, **always** allow the **insurer** to cancel. Notice must be given to the **insured** in a prescribed manner (e.g. 7 days in advance, by registered mail, to the insured's last known address) and a **pro rata** refund of premium is payable. Suppose an annual policy is cancelled by the insurer with effect from the 66^{th} day of cover. The refundable premium will be: annual premium x 300/365.

(b) *The insured may cancel*: whilst not universal, cancellation clauses usually also allow the **insured** to cancel by giving an immediate notice or a, say, 7 days' notice, with an entitlement to a **short-period or pro rata** refund of premium, depending on policy wording. However, some policies allow the insured to cancel only where a claim has not arisen in the current period of insurance. To understand how a short-period refund of premium operates, one must first of all understand the short-period rating table or scale. In general insurance, if cover for a term of less than a year is purchased, instead of charging a pro rata premium, the insurer will impose a "short-period premium", which is more than the pro rata premium, by reference to a short-period rating table. According to such a table, where the proposed term is, say, one month, the premium will be, say, 20% of the annual premium; 30% for a two-month term; 100% for 9 months and so on. Each insurer may possibly have their own short-period rating tables printed on their policies. Coming back to the short-period refund of premium and by way of example, if an insured wishes to cancel an annual policy after it has been in force for, say, 35 days - deemed to be two months for the purposes of the table - the refundable premium will be (assuming the above hypothetical scale) a sum equal to: annual premium x 70%.

(c) *Practical applications*: it is rare for an **insurer** to invoke the cancellation clause. The traditional view of many insurers was that having underwritten the risk, they would "grin and bear it" with disappointing results until renewal. Of course, there are circumstances where the traditional view is modified. These will include:

(i) **suspected fraud**: if the insurer *feels* sure that the insured is guilty of fraud, he may wish to terminate association with him immediately (of course, if fraud can be **proved**, the insurer is entitled to terminate policy with immediate effect without relying on the cancellation clause);

(ii) **disastrous experience**: there is a limit to the extent that an insurer can be expected to "grin and bear it". Sometimes circumstances change so rapidly that continuation of cover (perhaps for the whole **class** of business) becomes near "suicidal" (e.g. a spate of terrorists' attacks in recent years). The cancellation clause is useful in such extreme cases.

(d) *Miscellaneous considerations*: generally, neither party is obliged to say **why** they wish to invoke the cancellation clause. It is a **right**, not a conditional privilege.

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Representative Examination Questions

Type "A" Questions

1 Another name for "proposal form" in the Hong Kong insurance market is:

(a) application; .....
(b) insurance request note; .....
(c) insurance proposition form; .....
(d) insurance procurement form. .....

[Answer may be found in **2.1**]

2 When considering "moral hazards" and "physical hazards":

(a) there is no difference between the two terms; .....
(b) physical hazards relate to the human factors concerned; .....
(c) physical hazards are less subjective, relating to objective facts; .....
(d) moral hazards are easier to determine, as they relate to objective facts.....

[Answer may be found in **2.1.2**]

3 An insurance cover note:

(a) usually has a cancellation provision; .....
(b) is a temporary document, normally replaced by a policy; .....
(c) is not conditional; it binds the insurer to provide cover; .....
(d) conforms to all of the above statements. .....

[Answer may be found in **2.2.3**(a)]

4 The so-called "plain-English" policy wording, used in an attempt to make policy wording easier to understand, is very likely to be found with:

(a) personal lines of insurance; .....
(b) commercial lines of insurance; .....
(c) marine insurance policy wording; .....
(d) compulsory classes of insurance only. .....

[Answer may be found in **2.3.1**]

5 Implied warranties:

(a) do not appear in the policy wording; .....
(b) do not actually have the full force of law; .....
(c) must be written or printed in the policy; .....
(d) are exactly the same as express warranties. .....

[Answer may be found in **2.3.4** (a)]

6 Representations regarding material facts, made by the proposer in connection with an intended insurance, in the absence of specific contract provisions:

(a) must be substantially correct; .....
(b) must always be expressed in writing; .....
(c) must be absolutely true and accurate; .....
(d) can be true or untrue without affecting the contract. .....

[Answer may be found in **2.3.4**(c)]

Type "B" Questions

7 Which **two** of the following statements regarding certificates of insurance are true?

(i) Certificates in due time are replaced by the policy.
(ii) Certificates are quite separate documents from the policy.
(iii) Certificates of insurance will give full details of policy cover.
(iv) Certificates are often used to provide formal proof of compulsory insurance.

(a) (i) and (ii); .....
(b) (ii) and (iii); .....
(c) (ii) and (iv); .....
(d) (iii) and (iv). .....

[Answer may be found in **2.2.3**(c)]

8 Which **three** of the following statements regarding general insurance policy renewals are **true** in Hong Kong?

(i) At renewal, the duty of utmost good faith revives.
(ii) The renewal technically constitutes the making of a new contract.
(iii) Terms of the renewal are freely negotiable between the parties.
(iv) If the insurer does not intend to renew, he must inform the insured.

(a) (i), (ii) and (iii); .....
(b) (i), (ii) and (iv); .....
(c) (i), (iii) and (iv); .....
(d) (ii), (iii) and (iv). .....

[Answer may be found in **2.4.1**]

[If still required, the answers may be found at the end of the Study Notes.]

3 CLAIMS

3.1 VALID CLAIMS

For a claim to be valid, it must satisfy a number of requirements (see **3.1.1** below). The great majority of insurance claims, however, are quite valid. Indeed, public acceptance and the overall effectiveness of general insurance require this to be so. A major purpose of insurance is to provide **help** in various kinds of trouble. That purpose is frustrated if a disproportionate number of claims are **invalid**.

Given this premise, we should note the following:

(a) *Claims are the insurer's "shop window"*: the public opinion of an insurer may easily be ruined if its claims handling is perceived to be **unjust, unfair**, **unreasonable** or **unduly slow**. Within reason, the payment of claims is the insurer's best form of advertising.

(b) *Claims should not be refused lightly*: refusing a claim is a serious matter. Good insurance practice often means that a claim is never rejected, except with the confirmation of a **senior** member of the insurer's staff. Under the **Code of Conduct for Insurers** issued by the Hong Kong Federation of Insurers, the member insurers undertake to give a full explanation to the claimant if a claim has to be refused.

(c) *Confidence of the customers*: an insured should never be embarrassed or afraid to make a claim. The possibility of a claim is why he paid his premium. Of course he must act **honestly** and **reasonably.** The insurer and **insurance intermediary** should therefore always be helpful and sympathetic if a claim situation arises.

3.1.1 Legal Requirements for Valid Claims

A valid claim is one which meets all **contractual** and **other** legal requirements. In practice, from the insured's perspective, what seems to happen in the great majority of cases is that a loss arises, he tells the insurer and with very few formalities he receives a claim payment. Sometimes, of course it is more complex, but in fact in **every** case a considerable number of **criteria** must be satisfied. We may consider these under no less than eleven different headings:

(a) *Fraud by or on behalf of the insured*: whether the policy has any reference to this or not, **fraud** (in any form) can defeat an insurance claim, and indeed is a ground for repudiating the contract.

(b) *Policy must be in force*: the usual requirement is that the event giving rise to the insured loss must **occur** between the policy commencement and termination dates.

(c) *Premium considerations*: if payment of the premium before policy commencement or during **days of grace** is a pre-requisite of cover, this must be complied with.

(d) *Peril considerations*: is the **cause** of the loss covered by the policy? It is for the **insured** to prove that a loss falls within the **Operative Clause**. This is not difficult with "**all risks**" insurance, which requires the proof of the happening of a "risk", whether it is a fire, theft or whatever not being crucial. With "**specified perils**" cover, the insured is required to prove that a loss has happened and that it was caused by an "insured peril".

(e) *Policy exclusions*: the **Operative Clause** or basic cover under the policy is generally **limited** by **exclusions**. It is the **insurer's** responsibility to prove that an exclusion applies if it wants to deny a claim by relying on this, except where a reverse onus provision applies.

(f) *Implied and express contract terms*: is the insured in breach of an **implied** *contract term*, the most important of which being the existence of an **insurable interest**? Regarding **express terms**, some of them apply to claims' procedures. These we look at in **3.1.3** below, but all must be complied with.

(g) *Duty of utmost good faith*: claims handlers should compare information given during the claim enquiries with that supplied at the proposal stage. Sometimes there are surprising inconsistencies.

(h) *Warranties*: if the policy is subject to an **insurance warranty**, has this been **breached**? In good insurance practice, the question really should be "was any breach of warranty **causative** or otherwise significant with the claim?"

(i) *Quantum* (amount of the claim): it is the **insured's** legal responsibility to prove the **amount** of the loss (see **3.1.5**).

(j) *Excess or franchise*: if the policy is subject to either of these, is the **amount** of the loss sufficient to involve the insurer's liability?

(k) *Public policy*: in addition to all the above **contractual** or other legal considerations, **public policy** could conceivably be relevant, a contravention of which may invalidate a claim (see **2.3.5**(d)).

(l) *Change in risk*: where the circumstances of a case are indicating that the risk as existed at the time of loss is different from the risk as existed at policy inception, the claims handler should try to find out whether the risk has changed in such a way that the cover has automatically ceased on the date of change. In this regard, a distinction must be made between changed circumstances which may make a loss more likely to

occur and those which make the risk entirely different from that originally accepted. Based on the relevant common law principle – express contract provisions aside - neither the validity of the contract nor of the claim will be affected in the former case, whereas the cover will have ceased in the latter case.

3.1.2 Invalid Claims

An invalid claim is one that does not satisfy all the criteria in **3.1.1** above. Those criteria represent **contractual** or **legal** provisions. Some further comments, however, are appropriate under this heading:

(a) *Reasonable flexibility*: it must not be assumed that insurers are constantly looking for ways to "**escape**" from claims. The above points are all legally sound and the professional insurance claims person will be aware of them, but the overriding consideration will be to have a **satisfied** claimant (**especially** our own policyholder) where reasonably possible.

(b) *Generous interpretation*: an old claims' maxim with reputable insurers is "pay the **good** ones immediately, be as generous as possible with the **doubtful** ones, and **resist** the **bad** ones firmly". These are good guidelines when thinking about invalid claims.

(c) *Ex gratia considerations*: an **ex gratia** payment (one without **legal** obligation) is always an option, in doubtful cases or where real hardship may otherwise be caused. But whether the prior consent of the reinsurers, if any, is required is always a related issue.

(d) *Firmness with fairness*: notwithstanding the above, if a claim is definitely **not** covered, in normal circumstances it should be **politely** but **firmly** declined. Good practice should mean that a reasonable **explanation** be offered. This is not only basic **courtesy**; it may also avoid unnecessary and expensive future **legal action**.

3.1.3 Operation of Policy Provisions Affecting Claims

Different classes of General Insurance may well have somewhat different claims requirements, but in broad terms the following are very likely to be among the policy conditions concerned:

(a) *Notification to the insurer*: instructions are always given as to the **manner** (in writing, to the Head or Branch Office, etc.) in which notification of a **possible** claim should be given.

Case 15 Notification of claim is required to be made as soon as possible

The insured dropped a luxury watch on the floor accidentally at home. He immediately brought the damaged watch to the designated service centre for repair. He collected the repaired watch two weeks later and lodged a claim to the insurer for the repair cost of the watch under his household insurance policy.

The insurer appointed a loss adjuster to carry out the investigation. As the watch had already been repaired when the claim was filed, the loss adjuster was unable to investigate the cause of the incident and the extent of the damage. The insurer, having no chance to evaluate or assess the reasonableness or genuineness of the claim, declined the insured's claim on the grounds that he had breached the policy condition which requires the insured to advise the insurer in writing as soon as reasonably possible in any event of any happening which may give rise to a claim.

The insured contended that the insurer's allegation of late notification of claim was not appropriate as the claim was lodged within 20 days after the watch was damaged. Moreover, the debris of the hands and dial of the damaged watch were shown to the loss adjuster during their visit.

Whilst the Complaints Panel agreed that the insured's reporting of the claim after the watch was repaired had prejudiced the insurer from investigating the claim, the Complaints Panel was convinced that this was a genuine case as the circumstances leading to the damage were simple and consistent with the statement given by the insured. Moreover, the insurer was able to verify the extent of damage from the repair slip issued by the service centre stating that the dial, hands, glass, case, bezel and band of the watch had been scratched, cracked and dented, and from an inspection of the damaged parts of the watch.

While the Complaints Panel noted that reporting a loss after repair was not desirable, it believed that a layman, in this particular instance, would expect a claim which was lodged within 20 days after a loss to be considered as "as soon as reasonably possible". In the absence of any proof that the insured had a poor claims record, the Complaints Panel resolved to give him the benefit of doubt and award him the repair cost of the watch.

Remarks*: the Complaints Panel was apparently of the view that there was not a condition precedent to liability requiring the insured to report the happening of an accident to the insurer prior to sending a damaged article for repairs.*

Case 16 Failure to report an accident within the prescribed time limit

The insured slipped and was injured in early January 2001. Her sick leave ended in early April 2001. In late April 2001, she submitted a claim, which was rejected by the insurer on grounds of a breach of the policy condition that required the insured to report an accident within 30 days after its happening.

The insured claimed that it was her belief that the 30-day time limit would begin to run upon her recovery from the injury. In support of her claim, she also cited that the same insurer had settled an earlier claim from her despite the fact that her reporting was done a few days after the time limit had expired.

The Complaints Panel agreed that the insured had clearly breached the policy condition by failing to report the accident to the insurer within 30 days after its happening. Moreover, it was unreasonable to argue that the settlement of the prior claim should be made a precedent for any subsequent claim. The Complaints Panel was further of the view that the delay in reporting had prejudiced the insurer's position in investigating the claim. It, therefore, endorsed the insurer's rejection of the claim on the basis that the insured was in breach of the policy condition.

Remarks*: as a matter of fact, the insured had failed to report the accident within the time limit as required by the policy. In addition, the Complaints Panel was satisfied that the omission had prejudiced the insurer's position in investigating the claim. Both of these formed the basis of the Complaints Panel's ruling.*

(b) *Notification of "possible" claim*: it is worth stressing that a **possible** claim incident should be reported. With **property** insurance, this is seldom a problem. But with **liability** insurance, the insured sometimes waits for a third party to make a definite claim before telling his insurer; this appears to be a breach of the notification condition.

(c) *Time for claims notification*: policies usually require notice to be given **immediately**, or as soon as **practicable** (in some cases a specific **time limit** may be mentioned). Delay in investigating losses or in appointing professionals such as solicitors (especially with **liability** claims) may be very detrimental to the insurer's interests.

A vital issue that will come up when such a notice is given late is whether such a "breach" will have the effect of nullifying the insured's right to claim for the loss altogether regardless of whether or not that has caused prejudice or is expected to cause prejudice to the insurer, and of the extent of the prejudice, if any. Legally, what matters is the contractual intention of the parties in inserting this provision as to the effect of its breach.

Note: With **compulsory** classes of business, delay in reporting accidents may not enable the insurer to refuse to satisfy valid third party claims. It could, however, give rise to the possible application of the **Avoidance of Certain Terms and Right of Recovery Clause** (see **1.1**(g)).

(d) *Duties upon the Insured*: see **3.1.4** below.

(e) *Resolution of disputes*: see **3.2.1** below.

(f) *Policy modifications of legal positions*: these may affect a number of issues, e.g.:

(i) **Average**: unless otherwise agreed, an insurance policy must pay a valid claim **in full**, subject to the sum insured or limit of indemnity (a term customarily used in liability insurance). The **pro rata** condition of average in most **property** insurances reduces the amount payable in proportion to the degree of **under-insurance** present at the time of loss.

(ii) **Contribution**: in the absence of contractual restrictions, an insured may claim the **whole** insured loss from any one insurer who covers it. However, under the typical **contribution condition** (or "**rateable proportion clause**"), the insurer restricts his liability to a **rateable share**.

(iii) **Subrogation**: under this doctrine of equity, **subrogation** rights are only acquired **after** an indemnity has been provided. However, under the typical subrogation condition, the insured should, at the request of the insurer, permit the insurer to exercise subrogation rights upon the happening of an event which may give rise to a claim under the policy.

3.1.4 Duties of Insured after a Loss

These may be considered under the **common law**, or in accordance with **contractual** (policy) provisions. Those which are imposed by common law are implied terms, e.g. the insured's duty to act as if uninsured. Sometimes, insurers insert provisions into policies to govern those duties which are apparently implied terms. They do so for reasons. Perhaps these terms are so important that it is advisable to provide the insured with written versions. Secondly the insurers might intend to modify the legal position in favour of either themselves or the insured. Thirdly, it may be beneficial to both parties to make explicit provision for something the relevant law on which is too uncertain.

In the **common law,** the insured's duties will include:

(a) reasonable **cooperation** with the insurer;

(b) a duty to **minimize loss** as far as is reasonably possible;

(c) not to jeopardize the **insurer's rights** (e.g. **right of subrogation**);

(d) absence of **fraud** (in any form).

Policy requirements relating to the duties of an insured after a loss will include:

(a) *Reasonable proof of a valid claim*: this heading will embrace:

(i) **liability** of the insurer, i.e. proof that the loss falls within the cover outlined in the **Operative Clause**.

(ii) **quantum** (i.e. the **amount** of the claim).

(b) *Preservation of damaged property*: specifically, the insured must **not** dispose of damaged property without the insurer's permission. He must also take **reasonable** care of damaged property to avoid further loss or exacerbation (protection against **theft**, cleaning and lubricating wet machinery after a fire, etc.).

(c) *Cooperation with the insurer*: this includes the basic **response** to reasonable requests for information, allowing **access** to staff and insured premises for enquiries to be made, and actively assisting with **subrogation** efforts, as necessary.

(d) *Not to compromise the insurer*: by admitting **liability** to third parties, or by prejudicing **subrogation** rights in any way.

(e) *Disclosure of any other insurances*: to assist with **contribution** or other interests of the insurer. Explanations for "double-insurance" situations may be required.

(f) *Absence of fraud* (again).

3.1.5 Documentary Evidence

This may take various forms, and could be the responsibility (with the **cost**) of either the **insured** or **insurer**. Specifically, the following should be noted:

(a) *Receipts and other proof of quantum*: these will invariably be the responsibility of the **insured** and at his expense. Theoretically, receipts will always be required, but insurers should adopt a **realistic** and **reasonable** approach. Receipts may reasonably be expected to substantiate a **commercial** loss, but may well be the exception for relatively minor **personal** insurance claims.

(b) *Contractually required documents*: commercial insurances (e.g. **fire**, **theft** and **consequential loss**) will invariably require adequate records to be maintained, so that a loss may be verified. Insurers are very likely to **insist** upon these.

(c) *Marine insurance claims*: documentation with such claims is very important. It will include such items as a **survey report**, the **original policy**, the **bill of lading** and perhaps other documents of title.

(d) *Medical evidence*: to support claims for **incapacity (PA),** medical reports will be needed. These will be at the **insured's** expense. Expenses of medical examination of injured employees instigated by the employer are payable by the employer under the EC Ordinance, and in turn by the insurer.

(e) *Witness and police reports, etc.*: normally the **insurer** attends to these.

3.1.6 Functions of Various Related Professionals

During the course of claims enquiries, technical issues may arise where **special expertise** may be required. Additionally, insurers sometimes do not have sufficient staff available to investigate all claims. In these cases, the services of one or more of the following professionals may be engaged:

(a) **Surveyors**

Surveys are an important part of **underwriting**, of course. In the context of claims, **surveyors** will mostly be concerned with marine losses. Nearly all marine claims will require a surveyor's independent investigation into the cause and extent of a reported loss, and a **survey report** containing the relevant findings. **Surveyor** includes **Cargo Surveyor** and **Marine Surveyor** (or **Hull and Machinery Surveyor**).

Marine cargo policies normally indicate that a survey report will be needed. The surveyor, naturally, charges a fee, for which the claimant will be reimbursed by the insurer with valid claims.

(b) **Loss Adjusters**

These are specialists in insurance claims investigations and negotiations. Points to note with loss adjusters include:

(i) *commonest engagement*: they may be engaged in virtually any kind of claim, but they are especially employed with **property** and **liability** claims. Their expertise is particularly valued with **large** or **complex** claims, although some insurers may "outsource" nearly all of their claims to loss adjusters;

(ii) *independent experts*: although normally engaged and paid by the **insurer**, loss adjusters profess to be **independent** experts, offering **impartial** advice and services;

(iii) *fees and remuneration*: these may be based on a **scale** according to the amount of the claim **settlement** agreed, or separately negotiated;

(iv) *settlement recommendations*: their reports will include comments on the circumstances of the loss, the liability or otherwise of the insurer, and eventually upon the negotiated settlement. However, the settlement is subject to the **insurer's** agreement.

One main difference between the appointment of **marine surveyors** and the appointment of **non-marine loss adjusters** is that the **insurer** normally appoints the latter, but marine surveyors are appointed and at least initially paid for by the **insured** (more often referred to as "**assured"** in marine insurance).

(c) **Engineers**

Sometimes highly technical issues are involved, with **Engineering**, **Contractors' "All Risks"** or indeed **Liability** insurances, where the expertise of qualified engineers is essential. The advice they give may be related to **causes** of losses, or other issues requiring their specialist knowledge.

They are invariably engaged on a **consultancy** basis, paid by the **insurer** at an agreed fee or rate.

(d) **Settling Agents**

These are firms named on **marine cargo** policies or certificates of insurance, which have the insurer's authority to settle claims on the insurer's behalf in areas where the insurer does not have an office of its own. They can be Lloyd's Agents, firms appointed by Lloyd's of London and found in the major ports and areas of the world, including Hong Kong.

(e) **Survey Agents**

It is common for marine cargo insurers to specify in their policies or certificates of insurance the name and address of their survey agent appointed in respect of the destination concerned, to whom the consignees are required to apply for marine damage survey. Where a particular survey agent does not employ surveyors, it will have to arrange for them when required. Lloyd's Agents often act as survey agents for marine insurers and an insurer often appoints the same firm as both its survey and settling agents.

Surveys with marine claims are very important. Except for very minor claims, it is almost certain that marine claims will not be completed without an independent survey. This is a particular feature which is not found to anything like the same extent with other classes of General Insurance. With other classes, the insurer's own staff frequently deal with claims direct, but where outside help is needed **Loss Adjusters** are more commonly used (see (b) above).

(f) **Average Adjusters**

These experts are found with **Marine** insurance claims. More specifically, they specialize in **General Average** (GA) claims (see **1.7**(a)). This is an extremely complex area of claims' work, requiring considerable experience and expertise. Bearing in mind the usual circumstances under which GA claims may arise, adjusting them must take into account a number of important factors, including:

(i) *Detailed legal knowledge*: the international law of the sea and the law of various individual countries may be critical.

(ii) *Large number of interested parties*: sometimes the number of GA collections necessary will run into many **hundreds** (imagine the vast number of cargo owners who may be called upon for GA contributions if a large container ship incurs GA sacrifice or expenditure).

(iii) *Long term investigations*: the completion of GA claims collections and apportionments usually take **years**, rather than weeks or months, to settle. This requires patient and methodical work, where experience is essential.

Because of their special expertise, **average adjusters** may also be used with **hull** & machinery and with especially complicated **cargo** losses.

3.2 CLAIMS HANDLING

3.2.1 Methods of Settlement

A valid claim may be settled in a number of ways, by mutual agreement or in accordance with policy provisions. The actual method used may well depend on whether an **indemnity** or a **policy benefit** is being provided. The different methods and comments thereon are as follows:

(a) **Payment of Money**

Payment with cash (invariably by cheque or transfer to a bank account) is by far the commonest method of claims settlement. Indeed, in some cases it is the **only** way (e.g. **PA** benefits to the insured). In many ways, it is the most satisfactory from everybody's point of view, forming a neat and final conclusion to the claim process, leaving the payee with the choice of how to use the money.

In the absence of specific policy terms, there would have to be **mutual** consent for a settlement based on anything but money. Policy wording with **property** insurance (invariably **indemnity insurance**), however, does allow alternatives to cash settlement, at the **insurer's** option. These we consider in (b) - (d) below.

(b) **Paying for Repairs Direct**

With non-total loss claims in some classes of business (especially **motor**), the customary way of providing an indemnity is for the insurer to pay the **repairer**. Care has to be taken that the repairer is reputable, or suggested by the insured/third party personally, so that embarrassment over the quality of the repairs is avoided as far as possible.

An additional factor with **motor** claims involving damage to the insured vehicle is that paying a reputable garage for repairs will avoid two potential problems: (1) cash is paid against an "inflated" repair estimate, and (2) cash is paid to the insured, who does not have the vehicle repaired (perhaps leaving it in a dangerous condition) or he has it done badly by a much cheaper and less reputable repairer, pocketing the difference.

(c) **Replacement**

This is another option allowed by most **property** insurance policies. It is not always appropriate to consider replacement, as the accumulated **depreciation** of the property lost or damaged, and thus the **betterment contribution** due from the claimant, are not easy to agree on. However, there are instances where this method is suitable, including:

(i) *items not subject to depreciation*: the value of some items does not go down, at least not rapidly, and these may well be replaced to the satisfaction of both parties, e.g. jewelry, precious watches, etc.;

(ii) *new or virtually new items*: theoretically the value of most items depreciates as soon as they are purchased, but it is difficult to persuade an insured on this point at the time of loss or destruction. It will be less of a problem if replacement takes place within a short period after purchase.

(d) **Reinstatement**

This is a word that has a number of meanings in insurance. In the context of claims settlement methods, it means the restoration of the insured property to the condition in which it was immediately before its destruction or damage. In the case of a destroyed building, reinstatement will involve demolition cost apart from rebuilding cost. As with replacement and repair, reinstatement is not without potential problems - complaints may arise as to the quality of the replacement or work done, etc. However, this form of settlement is quite common with **damaged buildings**.

It may also be appropriate where the insured has a totally unrealistic opinion of the value of his building and the insurer is quite positive that reinstatement will be much cheaper.

Note: 1 The term "reinstatement" overlaps in meaning with "repair" and with "replacement".

2 The **option** as to the method of providing an indemnity to the insured is with the **insurer**. But, remembering the desire to have a **satisfied** customer, it will be rare to force a method of settlement upon the insured which he does not prefer.

3.2.2 Claims Dispute

3.2.2a Arbitration Condition

Sometimes a claim proves difficult to handle and a dispute arises between the **insured** and the **insurer**. Of course, disputes may also arise between the insurer and **third party** claimants, but the latter are not parties to the insurance contract and cannot be bound by **arbitration conditions**.

Arbitration conditions provide an alternative to **litigation** (formal court action) in resolving disputes. The following features of **arbitration** and its relevant policy condition should be noted:

(a) *Less formal than litigation:* whilst arbitration is conducted in a formal manner, cases are not heard in court and it is not even essential that legally qualified persons represent the parties or decide the issues.

(b) *Not binding upon third parties:* as stated above, third parties cannot be bound by insurance contract terms.

(c) *Customary basic procedure:* the typical arbitration condition provides that all differences and disputes arising out of the policy should be determined by arbitration in accordance with the prevailing Arbitration Ordinance (Cap. 609), and that if the parties fail to agree upon the choice of arbitrators or umpires, then the choice should be referred to the Chairman for the time being of the Hong Kong International Arbitration Centre. Where the insurer disclaims liability to the insured, the insured will have 12 calendar months from the date of the disclaimer within which to commence arbitration, failing which the claim will be deemed to have been abandoned.

(d) *Litigation may still be possible:* the arbitration condition also stipulates that the obtaining of an arbitration award is a condition precedent to any right of action arising out of the policy. However, and this is very important, courts are unlikely to overrule a properly conducted arbitration, unless there was a clear mistake in law or there is proof of bias against the claimant.

3.2.2b Alternative Dispute Resolution Condition

A general insurance policy may, in place of an "Arbitration Condition", contain a similar condition named "Alternative Dispute Resolution Condition" ("ADR Condition" in short). The typical ADR Condition stipulates that the parties may settle a dispute through mediation in accordance with the relevant Practice Direction on civil mediation issued by the judiciary of Hong Kong and applicable at the time of dispute, and that all unresolved disputes should be determined by arbitration in accordance with the Arbitration Ordinance (Cap. 609).

But what is mediation? Like arbitration, mediation is a common form of ADR. While arbitration is a legal process which will result in the arbitrator(s) issuing an award that is final and binding on the parties involved, mediation is a flexible process in which a mediator helps the disputing parties reach a mutually accepted settlement, rather than impose a settlement.

3.2.3 Insurance Complaints Bureau

The structure and functions of the Insurance Complaints Bureau (ICB) (formerly known as the Insurance Claims Complaints Bureau (ICCB)) were discussed in detail in "**Principles and Practice of Insurance**" (Chapter **6.1.3**), but by way of summary, several important features of its disputes resolution services are repeated below:

3.2.3a Claims Adjudication Service

Below are the terms of reference for the ICB's claims adjudication service:

(a) the complaint is of a monetary nature;

(b) the claim amount/monetary value of the complaint does not exceed HK$1,000,000;

(c) the insurer concerned is an ICB member;

(d) the policy concerned is a personal insurance policy;

(e) the complaint is filed by a policyholder/policy beneficiary/ insured person/rightful claimant (e.g. an assignee);

(f) the insurer concerned has made its final decision on the claim/dispute;

(g) the complaint is filed with the ICB within 6 months from the day of notification by the insurer of its final decision;

(h) the complaint does not arise from commercial, industrial or third party insurance; and

(i) the complaint is not subject to legal proceedings or arbitration.

3.2.3b Non-claim Related Mediation Service

On 16 July 2018, the ICB launched a new mediation service to handle non-claim related insurance disputes of a monetary nature. Where the parties concerned in dispute have failed to reach an amicable resolution despite the ICB's encouragement to do so, they may select a mediator from a list of qualified mediators with relevant experience and qualification that the ICB maintains for mediation service. With a jurisdiction limit of **HK$1,000,000**, the mediation service is free to complainants.

The terms of reference for the ICB's mediation service are as follows:

(a) – (i) same as (a) – (i) under **3.2.3a**;

(j) the complaint is not about quality of service or an underwriting decision of an insurer; and

(k) the complaint is not related to investment performance, level of a fee, premium, charge or interest rate unless the dispute concerns an alleged non-disclosure, misrepresentation, incorrect application, negligence, breach of any legal obligation or duty or maladministration on the part of an insurer.

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Representative Examination Questions

Type "A" Questions

1 Which of the following is/are legal requirement(s) to be satisfied before a valid claim arises under a general insurance policy?

(a) the absence of fraud; .....
(b) the cause of the loss must be covered; .....
(c) the loss occurrence must normally arise within the policy dates; .....
(d) all of the above. .....

[Answer may be found in **3.1.1**]

2 An "ex gratia" claim payment is one which:

(a) is not legally required; .....
(b) is legally required under the policy; .....
(c) relates to a benefit rather than an indemnity; .....
(d) concerns liability under compulsory insurance requirements. .....

[Answer may be found in **3.1.2**(c)]

3 Producing a receipt for property lost or destroyed is:

(a) never insisted upon by insurers; .....
(b) always insisted upon with every type of claim; .....
(c) a legal requirement that the insurer has no right to waive; .....
(d) a requirement sometimes waived with minor personal insurance claims. .....

[Answer may be found in **3.1.5**(a)]

Type "B" Questions

4 Which of the following statements regarding the claims adjudication service of the Insurance Complaints Bureau (ICB) are true?

(i) The service only applies to personal insurance claims.
(ii) The complainant is never charged a fee for this service.
(iii) Either the insured or the insurer may appeal against an award.
(iv) The maximum amount of a claim under dispute is limited to HK$1,000,000.

(a) (i) and (ii) only. .....
(b) (i), (ii) and (iv) only; .....
(c) (ii), (iii) and (iv) only; .....
(d) (i), (ii), (iii) and (iv). .....

[Answer may be found in **3.2.3**]

[If still required, the answers may be found at the end of the Study Notes.]

4 CUSTOMER SERVICE

Insurance is part of **financial services**. With increased competitiveness and growing **consumer awareness**, the concept of "**service**" is gaining an ever-increasing significance. The realization that service is not only related to good business practice, but is also the legitimate expectation of customers, may be seen from three perspectives:

(a) *In-house (individual companies)*: more and more companies are producing guidelines and policy statements on this important issue, for the instruction of their **staff** and information of their **customers**.

(b) *The insurance industry*: central associations of insurers and/or insurance intermediaries have appreciated the importance of public declarations and codes of practice in this area, to raise public confidence in the industry.

(c) *Regulator*: the insurance regulator is under a duty to protect policyholders and potential policyholders. Seeing that they get fairly treated in such an important matter as insurance is an issue of high profile. Cooperation with, and as necessary the regulation of, the insurance industry in various aspects of customer service, is important.

Specific considerations for this very high-profile subject were studied in detail in "**Principles and Practice of Insurance**". The following Notes are therefore by way of revision and reminder.

4.1 CUSTOMER SERVICE AND ITS IMPORTANCE

The bad insurer and staff may adopt a "take it or leave it" approach to customers. This short-sighted approach will create a bad image for the industry as a whole. Customer service is no longer an **option** (i.e. only a matter of opinion and personal preference). If the insurer does not address this issue and ever seek to improve the service provided, the results will almost certainly include:

(a) *Loss of business*: the public are increasingly aware of their perceived rights. These include courteous and efficient service.

(b) *Loss of insurance intermediaries' support*: insurance agents must have confidence in their principals and insurance brokers in the insurers recommended. It is not reasonable to expect the insurance intermediaries to be able to produce the business if their efforts are not backed up by quality service. Those insurers who are seen to be providing quality service will be in a better position than others to attract and retain insurance intermediaries.

(c) *Loss of market prestige*: confidence in the integrity and efficiency of an insurance company is extremely important. This goes far beyond any question of not "losing face", important as this is in our culture. Bad service is one of the qualities that peer group associations and market colleagues will be very concerned about.

(d) *Regulator's involvement*: insurers are authorized to do business in Hong Kong not only to make insurance products available, but to enhance the standing and reputation of the territory. The last thing Hong Kong wants, as an important financial services centre, is for that service to be indifferent or suspect. Bad service will sooner or later, quite rightly, be the subject of the insurance regulator's concern and, if necessary, action.

4.1.1 The Importance of Customer Service

Much of this will be evident from the above comments. However, the importance of this issue must not only be seen in the need to avoid **negative** results. There are extremely important **positive** issues to be recognized as well. These include:

(a) *Customer loyalty*: general insurance business usually involves policy renewals. People do not stay with companies who do not treat them well. It is true that intensive marketing may produce short-term increases of business, but **continuity** (or the **retention** of business) is extremely important. Renewals are much less labour-intensive (costly) than underwriting new risks, and keeping good customers makes obvious sense.

(b) *Customer "productivity"*: customers who are happy and comfortable with their insurers not only remain loyal with their own business, but also are a most productive source of extra business, by recommendations and word of mouth advertising to family and friends.

(c) *Increased profitability*: good service means few complaints. Complaints are "bad news" in every respect. Not only are they bad publicity, they are often very time-consuming and expensive to handle. Avoiding complaints by an efficient and fair treatment of customers leaves more time for productive work and therefore must impact upon profitability.

Customer service relates to **efficiency**, **courtesy** and, in considerable measure, **business ethics**. The following Notes touch upon each of these aspects.

4.2 POLICIES AND CODES OF CONDUCT OF ORGANIZATIONS

By "policies", of course, the heading refers to openly declared principles, not contract documents given to the insured. Increasingly, individual companies are realizing the practical importance of stating their corporate principles and business practice in writing. Whilst such documents are **not** legal, in the sense of contractual obligations, they have an extremely important **persuasive** influence on the company, both as a **standard** of declared intentions and as a **measure** of performance.

Many companies in Hong Kong have already produced such published declarations. It is almost certain that this practice will grow. Each company will of course have its own style of presentation and content with such documents, but typically the documents will be produced for **insurance intermediaries** and **policyholders** and are very likely to include:

(a) a commitment to *quality and service*;

(b) a dedication to high *professional standards*;

(c) a promise of *efficiency* and high *business ethics*;

(d) an undertaking to deal with claims *fairly* and *promptly*;

(e) specific information on *business conduct* and certain *practices*.

Some examples of (e) will be considered in **4.3** below. Those and subsequent Notes will outline the fact that declared criteria and business intentions are not only self-imposed commitments, but will at times be required by central associations or even by statute.

4.3 CUSTOMER SERVICE STANDARD AND ITS IMPLEMENTATION

Specific details of the declared standards for customer service will vary with different insurers, but a representative set of openly declared standards is very likely to include the following:

(a) *identification of customer needs*: instead of promoting insurance products for the benefit of the insurer only;

(b) *confidentiality and compliance*: with regards to information supplied and strict compliance with the customer's wishes;

(c) *provision of desired cover*: any inability to meet the customer's requirements will be honestly brought to the customer's attention;

(d) *insurance documentation*: all documents (**cover note**, **insurance certificate**, **policy**, **endorsement,** etc.) will be supplied promptly and as required by the customer;

(e) *claims commitments*: claims will be handled promptly and fairly, with a promise to keep the insured informed, as appropriate.

The above, in one form or another, represent **promises** on behalf of the insurer. Additionally, open declarations of policies are very likely to remind the **insured** and **insurance intermediaries** of certain obligations that are required of them, including:

(f) *disclosure requirements*: the duty of **utmost good faith**;

(g) *premium payments*: the obligation to pay premiums when due, and (for **insurance intermediaries**) any **credit** facilities allowed;

(h) *Code of Practice*: insurance agents will be bound by a Code of Practice (see **4.4**(e) below). A reminder of this is usually given.

4.3.1 Implementation of Customer Service Standard

The commitments expressed in an individual company's policy statement will be **monitored** by **internal audit personnel**. Companies will take this responsibility very seriously, because any lapse of declared standards is important. Also, discovery and correction "in-house" is always preferable to the embarrassment and other consequences of public examination.

This is not to say that the company has total control over such matters. That would be too subjective and open to criticism. The fulfilment of company promises, or any obligations imposed by industry associations or the insurance regulator, is under actual or potential monitoring by:

(a) *policyholders and the general public*;

(b) *industry associations*; and

(c) *the insurance regulator*.

It must not be assumed from this that insurers are in a constant state of fear from oppressive scrutiny. That is going too far. But an important word in our society today is "**transparency**", by which is meant an openness to conduct and practice, which must at all times be legally and ethically justifiable.

4.4 LEGAL AND REGULATORY OBLIGATIONS OF ORGANIZATIONS

This area was dealt with in some depth in "**Principles and Practice of Insurance**", so we will not repeat the details here. However, by way of reminder, the following important aspects of customer service obligations in connection with General Insurance should be noted:

(a) **Contract and Common Law**

All relevant aspects of the **contract law** apply to the obligations of insurers towards the insured (their contract partners and **customers**). As far as the **common law** is concerned, it should be remembered that the duty of **utmost good faith**, which is applicable to insurance contracts, applies to the **insurer** as well as the **insured**.

(b) **Insurance Ordinance (IO)**

The details we need not repeat here, but it will be recalled that the Insurance Ordinance (Cap. 41) has certain strict requirements regarding insurance companies, which include reference to:

(i) *authorization of insurers*;

(ii) *capital requirements*;

(iii) *solvency margin requirements*;

(iv) *"fit and proper" requirement for controllers, directors, key persons in control functions and appointed actuaries*;

(v) *"adequate" reinsurance*.

These are all requirements to try to ensure the economic and social viability of insurers, which in the broader sense must be related to customer service. Some other important aspects of the IO will be considered in the Notes below.

(c) **The Code of Conduct for Insurers**

This Code was introduced by The Hong Kong Federation of Insurers (HKFI) and applies to insurances effected in Hong Kong and in private capacity by individual policyholders resident in Hong Kong, to promote good insurance practice among insurance companies to strengthen consumers' awareness of the expected practice of insurance service.

The Code sets standards for insurers in a number of areas, including:

- Advising and selling practices
- Handling of claims
- Management of insurance agents
- Management of staffs
- Misconduct by insurers
- Handling of inquiries, complaints and disputes

Again this area has been dealt with in some depth in "**Principles and Practice of Insurance**".

(d) **The Insurance Ordinance and Insurance Intermediaries**

The Insurance Ordinance (IO) (in Part X) gives statutory weight to the requirements on licensed insurance intermediaries, with specific reference to such matters as:

(i) roles and responsibilities of licensed insurance agents and licensed insurance brokers;

(ii) *definitions* of licensed insurance agents and licensed insurance brokers, with prescribed penalties for anyone illegally claiming to be one or the other.

As mentioned in the Study Notes for "**Principles and Practice of Insurance**" Examination, the Insurance Authority (IA) took over the functions of the former Office of the Commissioner of Insurance (OCI) on 26 June 2017 to regulate insurers. On 23 September 2019, the IA took over the regulation of insurance intermediaries from the three Self-Regulatory Organisations

("SROs"). The three SROs are the Insurance Agents Registration Board (IARB), the Hong Kong Confederation of Insurance Brokers (CIB) and the Professional Insurance Brokers Association (PIBA).

(e) **Codes and Guidelines**

Section 133 of the IO empowers the IA to publish non-statutory codes and guidelines for matters in relation to any of the functions of the IA or the operation of a provision under the IO. The purpose of codes and guidelines is to provide the industry with practical guidance to facilitate compliance with the regulatory requirements.

While the codes and guidelines are not statutory requirements and failure to comply with them does not by itself render a person liable to any judicial or other proceedings, the codes or guidelines are admissible in evidence in any proceedings under the IO before a court. The IA will also have regard to the codes and guidelines when excising its powers, including taking disciplinary actions where applicable.

(f) **The Code of Conduct for Licensed Insurance Agents**

The Code of Conduct for Licensed Insurance Agents (the Agents' Code) is issued and published by the IA pursuant to section 95 of the IO. Once more not giving full details, we may note that this Code consists of three Parts with the below contexts:

(i) *introduction to this Code;*

(ii) *interpretation*; and

(iii) *general principles with the following 9 sections*;

(1) general principle 1 – honesty and integrity;

(2) general principle 2 – acting fairly and in the client's best interests;

(3) general principle 3 – exercising care, skill and diligence;

(4) general principle 4 – competence to advise;

(5) general principle 5 – disclosure of information;

(6) general principle 6 – suitability of advice;

(7) general principle 7 – conflicts of interest;

(8) general principle 8 – client assets; and

(9) Corporate governance and controls and procedures;

(g) **Insurance (Financial and Other Requirements for Licensed Insurance Broker Companies) Rules**

A licensed insurance broker company is required to comply with the Insurance (Financial and Other Requirements for Licensed Insurance Broker Companies) Rules, which set out, inter alia, the requirements in relation to:

(i) *share capital and net assets*;

(ii) *professional indemnity insurance*;

(iii) *client accounts*;

(iv) *proper books and accounts*; and

(v) *accounting disclosure*.

(h) **Code of Conduct for Licensed Insurance Brokers**

As regards the conduct requirements in relation to insurance brokerage business, the IA issued the Code of Conduct for Licensed Insurance Brokers (the Brokers' Code) to set out the general principles, together with the standards and practices relating to each general principle, serving as the minimum standards of professionalism to be met by licensed insurance brokers when carrying on regulated activities.

(i) **Other Legislation and Related Ethical Issues**

Reference can be made to the Study Notes for the Core Subject "Principles and Practice of Insurance" for specific details, but for completeness in this review we may mention:

(i) Personal Data (Privacy) Ordinance (Cap. 486);

(ii) Sex Discrimination Ordinance (Cap. 480);

(iii) Disability Discrimination Ordinance (Cap. 487);

(iv) Family Status Discrimination Ordinance (Cap. 527);

(v) Race Discrimination Ordinance (Cap. 602);

(vi) Two Ordinances connected with money laundering: Drug Trafficking (Recovery of Proceeds) Ordinance (Cap. 405) and Organized and Serious Crimes Ordinance (Cap. 455);

(vii) United Nations (Anti-Terrorism Measures) Ordinance (Cap. 575);

(viii) Prevention of Bribery Ordinance (Cap. 201);

(ix) Prevention of insurance fraud.

Each of the above could have a direct or indirect application to the broad meaning of customer service.

4.5 LEGAL IMPLICATIONS OF REBATING OF COMMISSION

Rebating of commission means that the insurance intermediary gives part of his commission to his client, thus producing a "cheaper" premium for the latter. In most cases, this is a harmless and understandable gesture. However, if the practice occurs as an improper inducement for securing business, it is a grave matter.

Rebating may in certain circumstances constitute bribery and corruption. Certainly, it undermines the basis of rating and honest establishment of due reward (commissions) for insurance intermediaries. Authorized insurers should not offer rebates of premiums or commissions to customers in marketing and distribution of insurance products. However, this does not apply to any rebates which are recorded in the insurance contract such as the insurance policy, the policy schedule, the quotation or offer letter, or any promotional material. Authorized insurers, licensed insurance agencies and licensed insurance broker companies should maintain robust internal procedures and controls to observe this principle. In this way, customers will not be distracted when they are making informed decisions on insurance products and the suitability of such products to meet their insurance needs.

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Representative Examination Questions

Type "A" Questions

1 Customer service is an issue which is the concern of:

(a) individual companies; .....
(b) central insurance associations; .....
(c) the Hong Kong insurance regulator; .....
(d) all of the above. .....

[Answer may be found in **4**]

2 Customer service relates to:

(a) courtesy; .....
(b) business ethics; .....
(c) efficiency of business operations; .....
(d) all of the above. .....

[Answer may be found in **4.1.1**]

3 Which of the following is **not** one of the areas with specific requirements for insurance companies in Hong Kong, under the Insurance Ordinance?

(a) authorization; .....
(b) capital requirements; .....
(c) existing reinsurance arrangements; .....
(d) profitability each year of operation. .....

[Answer may be found in **4.4**(b)]

Type "B" Questions

4 The Code of Conduct for Licensed Insurance Agents which was published by IA outlines the expected standards of good insurance practice in certain areas. Which of the following areas are covered by the Code?

(i) Disclosure of information.
(ii) Honesty and integrity.
(iii) Conflict of interest.
(iv) Exercising care, skill and diligence.

(a) (i) and (ii) only; .....
(b) (ii) and (iii) only; .....
(c) (ii), (iii) and (iv) only; .....
(d) (i), (ii), (iii) and (iv). .....

[Answer may be found in **4.4**(c)]

[If still required, the answers may be found at the end of the Study Notes.]

GLOSSARY

Accidental Bodily Injury（意外身體受傷） A requirement for personal accident claims, and subject to a precise definition (usually requiring external, visible and violent means). **1.2.1**(b)(i)

Accidental Loss or Damage（意外損失或損害） A material loss or damage caused by an undersigned, sudden and unexpected event, usually of an afflictive or unfortunate character, and often accompanied by a manifestation of force. **1.4.2**

Accidents Only Cover（純意外保險保障）Personal accident cover which does not include benefits for sickness incapacity. **1.2.1**(e)(ii)

"Act" Insurance（「法令」保險）Deriving its name from the UK Road Traffic Act 1930, this relates to compulsory third party insurance for use of motor vehicles on a road. The extent of such cover is limited, consisting only of liability in respect of the death of or injury to third parties. **1.1**(b)

Actual Total Loss (ATL)（實際全損）There is an ATL in marine insurance where the subject matter insured is destroyed, where it is so damaged as to cease to be a thing of the kind insured, or where the assured is irretrievably deprived of the subject matter insured. **1.7**(d)

Additional Expenses（附加費用）As an item normally covered under a business interruption policy, they are expenses necessarily and reasonably incurred so as to reduce the extent of an insured loss. **1.4.1a**(a)(ii)

Adjustment (of Premiums)（調整（保費））Where the premium is based upon a factor that is very likely to vary during the policy year, a provisional premium may be paid at policy inception/renewal, and then adjusted with additional/return premium when full information is to hand. Found, for example, with liability insurance (where the premium may be based upon annual wages or turnover.) **1.6.1**(c)

Agreed Values（約定價值） "All risks" cover on valuable items such as jewelry and antiques is sometimes effected on an agreed value basis so that the sum insured (or the agreed value) is payable for a total loss regardless of the actual value of the subject matter of insurance at the time of loss (but with strict indemnity for partial losses). **1.4.2**(d)(ii)

"All Risks"（「全險」）Property insurance cover where every accidental cause of loss or damage is covered, unless excluded by the policy. **1**(b)(ii), **1.4.2**

Arbitration（仲裁）A legal process (short of litigation) which will result in the arbitrator(s) issuing an award that is final and binding on the disputing parties. **3.2.2**

Attestation Clause（簽證條款）See **Signature Clause**（簽署條款）. **2.3.1**(b)(vi)

Average (Marine)（部分損失（水險））Non-total (i.e. partial) loss. It may either be **Particular Average**（單獨海損）affecting particular interests (cargo interest, ship interest, etc.), or **General Average**（共同海損）, being a loss voluntarily sustained to prevent a total loss of a common marine adventure and shared by all interests represented in the adventure. **1.7**(a)

Average (Non-marine)（比例分攤（非水險））A claim-related penalty for under-insurance, in the form of a standard provision in most property policies in Hong Kong. **2.3.2**(b)(iv)

Average Adjusters（海損理算師或海損理算人）Experts in adjustment of losses in marine insurance, notably general average claims. **3.1.6**(f)

"Avoidance of Certain Terms and Right of Recovery" Clause（「使若干條款無效及有權追回款項」條款）The insurer must meet compulsory insurance claims even where there has been a breach of a contract term that would otherwise allow such claims to be refused. In such circumstances, the Clause will give the insurer a right of recovery from the insured for direct payments of such claims to the third parties. **1.1**(g)

Betterment Contribution（改善分擔）Where an improvement in property insured results from its repair, replacement or reinstatement necessitated by a loss of or damage to it, the insurer may ask the insured to contribute accordingly to the cost of repair, etc. on the grounds that such an improvement is outside the scope of the insurance. The payment made by the insured in such circumstances is termed "betterment contribution". **3.2.1**(c)

Blanket Cover（不記名／總括保險保障）Fidelity guarantee insurance covering the whole of the insured's staff, sub-divided into various categories. **1.4.6**(a)(ii)(3)

Boiler Explosion Insurance（鍋爐爆炸保險）An engineering insurance against damage to the insured boilers and/or liability for third party property loss or damage or third party death or injury. **1.5.1**

Buildings and Contents Cover（建築物及家居物件保險保障）Household insurance designed for owner-occupiers, covering buildings, contents, and all sorts of subject matter. **1.3.1**(a)(iii)

Buildings Only Cover（純建築物保險保障） Household insurance not covering the contents, very likely to be effected by a non-resident landlord. **1.3.1**(a)(i)

Burglary Insurance（入屋盜竊保險）See **Theft Insurance**（盜竊保險）**1.4.3**(d)(iv)

Business Interruption Insurance（營業中斷保險）See **Consequential Loss**（後果損失）. **1.4.1a**

Case-based Exclusion(s)（個別不保項目） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "The exclusion of a particular sickness or disease from the coverage of Certified Plan that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person." **1.2.3**(d)(iv)

Cash in Transit Insurance（現金運送保險） An early name for **Money Insurance**（金錢保險）. **1.4.5**(a)

Certificate of Insurance（保險憑證（或保險證書）） 1 A permanent document separate from the policy, giving formal confirmation of the existence of the prescribed compulsory insurance. **1.1**(h), **2.2.3**(c)(i)

2 A document confirming the cover granted under a master policy (e.g. in travel insurance). **2.2.3**(c)

Certified Plans（認可產品） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "Individual IHIP [indemnity hospital insurance plans] certified by FHB [the Food and Health Bureau] as VHIS [Voluntary Health Insurance Scheme]-compliant, including the **Standard Plan** and **Flexi Plans**." **1.2.3**(a)

"Claims-Made" Basis（「索償申報」方式） A liability insurance policy written on a "claims-made" basis is one which will only respond to third party claims *made* during the currency of the policy. **1.6**(b)

"Claims-Occurring" Basis（「索償發生」方式） A liability insurance policy written on a "claims-occurring" basis is one which will only respond to third party claims arising from incidents that *occur* during the currency of the policy, regardless of when the claims are made. **1.6**(b)

Classification of Insurance（保險分類） Grouping insurance business under a series of categories for identification and perhaps statistical purposes. There are a number of ways in which classification may occur, e.g. under the Insurance Ordinance (by statute), by the traditional departmental method, etc. **1**(a)

Code of Conduct for Insurers（承保商專業守則） Issued by The Hong Kong Federation of Insurers, this applies to insurances arranged in Hong Kong and in private capacity by individual policyholders resident in Hong Kong. It concerns a range of matters, including good insurance practice and advising and selling practices, etc. **4.4**(c)

Code of Conduct for Licensed Insurance Agents（持牌保險代理人操守守則） Issued in accordance with the relevant provisions of the Insurance Ordinance by the Insurance Authority covering the principles of professional conduct for insurance agents. **4.4**(f)

Coinsurance (Medical Insurance Policy)（共同保險（醫療保險單）） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "A percentage of eligible expenses the Policy Holder must contribute after paying the Deductible (if any) in a Policy Year. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policyholder is required to pay if the actual expenses exceed the benefit limits of the Certified Plan." **1.2.3**(c)(iv)(12)

Collision Liability（碰撞責任） In marine insurance, liability incurred as a result of the insured vessel's collision with another vessel is traditionally insured three fourths by the marine hull policy and the remaining fourth by a Protection and Indemnity Association. **1.7.2**(a)(iv)

Combined Liability Policy（責任保險組合保單） A combined policy covering a few types of liability, such as public liability and employees' compensation. **1.3.4**(b)

Combined Policy（組合保單）

1 A single policy document representing more than one type of insurance, each section or type of insurance being underwritten and rated separately. **1.3**

2 Fidelity guarantee policy covering a number of employees named or specified on a schedule with individual sums insured and/or a floating sum insured. **1.4.6**(a)(ii)(2)

Combined Property and Pecuniary Policy（財產及經濟權益保險組合保單） A combined policy offering a mix of property insurance and pecuniary insurance (e.g. business interruption insurance). **1.3.4**(a)

Combined "Umbrella" Type Cover（「傘括」類型組合保險保障） Individually tailored cover for very large risks, comprising a wide range of insurance. **1.3.4**(c)

Common Law（普通法） Put simply, the Common Law is some sort of unwritten (non-statute) law, developed over centuries and consisting of prolific judicial decisions. This term is often used in a sense distinct from Equity, which is law made by judges to supplement the rules and procedures of the Common Law for enhanced fairness. **1.6**

"Common Law" Liability（「普通法」責任） In the context of EC insurance, the meaning of this term goes beyond "liability incurred in the common law". It is used to represent the liability of an employer towards his employees which arises otherwise than under the Employees' Compensation Ordinance. **1.6.1**(a)(ii)

Comprehensive Cover（綜合保險保障） The widest form of motor insurance, including third party liability cover and "all risks" "own damage" cover. The comprehensive private car policy also gives other benefits, such as personal accident and medical expenses insurances. **1.1**(a)(iii)

Condition Precedent to Liability（責任出現前的先決條件） In insurance, this is a contract term a breach of which will invalidate a particular claim. **2.3.4**(b)(iii)

Condition Precedent to the Contract（合約生效前的先決條件） In insurance, this is a contract term which must be complied with in order for the contract to commence. **2.3.4**(b)(i)

Condition Subsequent to the Contract（合約生效後的條件） In insurance, this is a contract term which is to be complied with during the currency of the insurance contract (e.g. notifying a change of occupation under a personal accident policy) other than a condition precedent to liability. **2.3.4**(b)(ii)

Consequential Loss（後果損失或災後損失） 1 Exclusion: as property insurance is chiefly meant for material damage, any consequent expense (e.g. renting an alternative vehicle) is excluded specifically. **1.1.1**(a)(i)(1)

2 Cover: a pecuniary insurance, also known as **Loss of Profits Insurance**（利潤損失保險）or **Business Interruption Insurance**（營業中斷保險）, covering loss of income, additional expenses, etc. consequent upon a fire or any other insured peril. **1.4.1a**(d)(i)

Constructive Total Loss (CTL)（推定全損） Put simply, this is a term mostly used in marine insurance to describe such a situation of the subject matter of insurance that is not much different from an **Actual Total Loss**, when it is beyond economic repair or restoration and the like. **1.7**(e)

Contents Only Cover（純家居物件保險保障） Household insurance not covering the buildings, very likely to be effected by a tenant. **1.3.1**(a)(ii)

Contractors' "All Risks" Insurance（建築工程「全險」保險） An important class of business in Hong Kong, covering construction risks usually under two sections. Section I provides "all risks" cover on prescribed property. Section II provides liability insurance for third party injury and property damage arising out of the construction work. **1.5.3**

Contractual Liability（合約附加的責任） In insurance, this means legal liability assumed by an insured under an agreement, which would not attach to him but for this agreement. As its nature and scope vary a lot, it is invariably excluded by standard liability policies. **1.1**(d)(iii)(4)

Contribution（分擔） This is a claims-related doctrine of equity which applies as between insurers in the event of double insurance. Apart from any policy provisions, any one of the insurers involved is liable to pay to the insured the full amount for which he would be liable had other policies not existed. After an insurer has made an indemnity in this manner, he is entitled to call upon other insurers liable to the same insured to contribute to the cost of the payment. **3.1.3**(f)(ii)

Cooling-off Period（冷靜期） Among the standardised provisions of Certified Plans under the Voluntary Health Insurance Scheme ("VHIS") is one that grants policyholders the right to cancel their newly effected policies within the relevant cooling-off periods with full refund of the premiums paid provided no benefit payment has been made or is to be made or impending. The cooling-off period lasts for 21 days (or a longer period offered by the VHIS providers) after the delivery of policy or the issuance of notice to the policyholder or the policyholder's representative stating that the policy is available and when the cooling-off period would expire, whichever is the earlier. **1.2.3**(d)(vii)(4)

Counter Guarantee（反擔保） A performance bond or a similar surety bond is issued invariably on the condition that a counter guarantee is given to the surety to enable the surety to seek indemnity from the guarantor for any payment made under the bond. **1.4.7**(d)(ii)

Cover Note（暫保單） Written confirmation of (perhaps temporary) cover. It may be regarded as a temporary policy, although it has only a summary of contract terms. In Hong Kong, a motor insurance cover note invariably incorporates a temporary certificate of insurance. **2.2.3**(a)

Days of Grace（寬限期） A prescribed period after policy expiry within which the renewal premium may be paid to keep the cover continuous. **1.2.2**(a)

Deductible（免賠額）
1 Has the same meaning as the excess, but the term is more often used by U.S. insurers, and is used in connection with certain classes of business. **1.1**(f), **2.3.3**(b)
2 Every marine hull policy is subject to a deductible, which is not applicable with total loss claims. **1.7.2**(b)(ii)

Directors' and Officers' Liability Insurance （董事及高級管理人員責任保險）
A liability insurance intended to cover senior company personnel and officers who might be sued personally in respect of the company business. It is usual to insure the company as well under the same policy. **1.6.4**

Employees Compensation Assistance Fund（僱員補償援助基金） A statutorily established fund, financed by a levy on EC premiums, that pays compensation to injured employees or family members of deceased employees where compulsory employees' compensation insurance does not exist or is ineffective. **2.2.5**(b)

Employees' Compensation (Insurance)（僱員補償（保險）） Compulsory insurance for employers potentially liable for the death, injury or disease to their employees arising out of and in the course of their employment. **1.6.1**

Employers' Liability（僱主責任） The liability at law of an employer in respect of the death, injury or disease of his employees. This may arise under the Employees' Compensation Ordinance or otherwise. **1.6.1**

Engineering Insurance（工程保險） This term is used to refer to any of the following: contractors' all risks insurance, erection all risks insurance, machinery breakdown insurance, boilers explosion insurance, etc. **1.5**

Erection "All Risks" Insurance（安裝工程「全險」保險） Rather similar to contractors' "all risks" insurance in many aspects, it covers the processes of erection, installation, testing, etc. of machinery, plant and steel structures, rather than construction. **1.5.4**

Estoppel（不容反悔） Under this doctrine, denying or asserting a fact in legal proceedings will be disallowed in certain circumstances. **2.2.4**(b)(iii)(2)

Ex Gratia Payment（通融賠付） A payment (usually with a claim) made on the understanding that there is no legal liability to make it. **3.1.2**(c)

Excess (or **Policy Excess)** （自負額或免賠額（或保單自負額、保單免賠額））
A contractual provision that requires the insured to be responsible for the first stated figure or for a stated proportion in respect of each and every claim. **1.1**(f), **2.3.3**(a)

Express (Warranty)（明示（保證）） An insurance warranty that appears in a policy (unlike an implied warranty). **2.3.4**(a) **Note** 1

Extra Benefits（額外利益） An extended cover of a particular policy, normally at the request of the insured and for an additional premium. **1.1.1**(b)(i)

Extra Perils（附加危險） Perils which traditionally are able to be added to a fire policy for an extra premium. Also known as **Special Perils**（特殊危險）, **Allied Perils**（類似危險）, or **Extended Perils**（擴展危險）, they include a wide range of risks, including explosion, typhoon, malicious damage, vehicle impact, etc. **1.4.1**(a)(iv)

Fidelity Guarantee Insurance（忠實保證保險） It insures an employer against loss of money or property as a result of any act of fraud, theft or dishonesty by an employee in the course of employment. **1.4.6**

"Fire"（「火災」） Fire, within the meaning of a fire policy, is a fire meeting the three criteria of actual ignition, something on fire which should not be on fire, and fire which is not deliberately caused or arranged by the insured. **1.4.1**(a)(i)

Fire and Extra Perils (Policy)（火災及附加危險（保單）） A fire insurance policy which, apart from the perils of fire, lighting and explosion of gas or boiler used for domestic purposes, also gives extended cover for "extra perils" such as typhoon, explosion and impact by vehicles. **1.4.1**

Fleet Rating（車隊保險定價） Special rating in motor insurance for a "fleet" (a number of vehicles of various types under a common ownership or management) to be covered under a single policy, being influenced by the loss experience of the fleet itself in direct proportion to the fleet size. **1.1.3**(b)(iii)

Flexi Plan（靈活計劃） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "Any individual IHIP [indemnity hospital insurance plans] under the VHIS [Voluntary Health Insurance Scheme] framework with enhancement(s) to any or all of the protections or terms and benefits that the **Standard Plan** provides to the Policy Holder and the Insured Person, subject to the certification by FHB [the Food and Health Bureau]. Such plan shall not contain terms and benefits which are less favourable than those in the **Standard Plan**, save for the exception as may be approved by FHB from time to time." **1.2.3**(c)(iii)(5)

Forcible and Violent Entry or Exit（以強行及暴力方式進入或離開）A standard requirement for valid claims under a theft insurance (and sometimes the theft cover given by a household policy as well). **1.4.3**(b)(i)

Franchise（起賠額） A policy provision which eliminates small claims (amounts within the franchise) but pays larger claims (attaining or higher than the franchise figure, depending on wording) in full. **2.3.3**(c)

Fundamental Risks（基本風險） They are risks whose causes are outside the control of any one individual or even a group of individuals, and whose outcome affects large numbers of people, so that they frequently form standard policy exclusions. **1**(c)

General Average（共同海損） Put simply, this is a loss which is voluntarily incurred to save an endangered marine adventure from a total loss. If that is successful, all interests represented in the adventure must contribute towards the loss. **1.7**(a)(ii)

General Exceptions (or **General Exclusions)**（通用除外責任） These are exceptions which apply to every part of the policy, with "exceptions" meaning those provisions which describe the causes or types of losses for which or the circumstances in which the policy liability will be eliminated or reduced. **2.3.1**(b)(iv)

Geographical Area（地理區域） Losses occurring otherwise than within this area as defined in the policy are outside the scope of the cover. Applicable to a number of classes, e.g. motor and travel insurances. **1.1**(d)(i)

Glass Insurance（玻璃保險）Also known as **Plate Glass Insurance**（平板玻璃保險）, this is an "all risks" type cover on fixed glass. **1.4.4**

Gross Profit（毛利潤） A primary item of subject matter insured by a business interruption policy. It is specifically defined in the policy, not identical with an accountant's definition. **1.4.1a**(a)(i)

Health Insurance（健康保險） It covers accidental injury, sickness or disability of the insured person. **1.2**

Hold-Up Cover（搶劫保險保障） An extension to a theft policy, providing cover for theft accompanied by violence or threat of violence. **1.4.3**(d)(i)

Household Insurance (or **Home Insurance**)（家居保險） A package of personal insurances on domestic property (covering buildings only, contents only, or combined buildings and contents), liability and all other types of subject matter of insurance. **1.3.1**

Implied (Warranty)（隱含（保證）） An insurance warranty that is applicable, but does not appear in the policy, e.g. "fitness to carry" warranty in marine cargo insurance. **2.3.4**(a)**Note** 2

Indemnity Period（彌償期間） In business interruption insurance, it is a period, starting from the date of an insured occurrence (e.g. a fire) and ending when the results of the business insured cease to be affected but not exceeding the **Maximum Indemnity Period**（最長彌償期間）. The date of the insured occurrence must be within the (annual) period of insurance; otherwise no losses will be recoverable. **1.4.1a**(d)(ii)

Inevitable Loss（不可避免的損失） A standard exclusion under "all risks" insurance, since such losses, being losses which must happen, should not be made the subject of any insurance. **1.4.2**(b)(i)

Inexperienced Driver（缺乏經驗司機（或新牌司機）） One who has not held a full driving licence longer than the specified minimum period (often 2 years) and therefore subject to a specific excess. **1.1.1**(a)(i)(4)(C)

Inherent Vice（固有缺點） Being a standard exclusion in marine cargo insurance, it means a peril which occurs owing to an action set up in the property itself without the assistance of an outside agency (e.g. meat or fish going bad, and wine turning sour). **1.7.1**(b)(iv)

Institute Cargo Clauses (A), (B) and (C)（協會貨物條款**A, B**和**C**） The three most well-known and most commonly used sets of Institute Clauses designed for marine cargo insurance cover. Arranged in a descending scope of cover, Institute Cargo Clauses (A) is on an "all risks" basis, and (B) and (C) on a specified risks basis. **1.7.1**(a)

Institute Clauses（協會條款） Institute of London Underwriters (ILU) policy wording used with marine insurance. **1.7**(h)

Insurance Authority（保險業監管局） The independent insurance regulator established under the Insurance Ordinance (Cap. 41) to regulate the carrying on of insurance business and to regulate the insurance industry in Hong Kong for protecting policyholders and potential policyholders and for promoting the stable development of the insurance industry. **4.4**(d)

Insurance Complaints Bureau (ICB)（保險投訴局） Formerly known as the Insurance Claims Complaints Bureau (ICCB), the ICB provides an adjudication facility for dealing with personal insurance policyholders' complaints about claim-related matters. The facility is free to complainants and the insurers concerned are bound by the decisions of the Insurance Claims Complaints Panel under the ICB. Besides, the ICB has launched a new mediation service in 2018 to handle non-claim related insurance disputes of a monetary nature, which is also free to complainants. **3.2.3**

Insurance (Financial and Other Requirements for Licensed Insurance Broker Companies) Rules（保險業(持牌保險經紀公司的財務及其他要求)規則） The rules set out the requirements applicable to licensed insurance broker companies for minimum share capital, net assets, professional indemnity insurance, the keeping of proper books and records, and contents for audited financial statements and auditor's report. **4.4**(g)

Insurance Ordinance（《保險業條例》） Formerly known as the Insurance Companies Ordinance (Cap. 41), it is the legislation for regulating the Hong Kong insurance industry. With the relevant provisions of the Insurance Companies (Amendment) Ordinance 2015 coming into operation on 26 June 2017, the Insurance Companies Ordinance (Cap. 41) was renamed the Insurance Ordinance (Cap. 41). **4.4**(b)

Insurance of Liability（責任保險） Insurance whose subject matter consists of the insured's liability at law towards third parties. **1**(a)(iv)

Insurance of Pecuniary Interests（經濟權益保險） Insurance whose subject matter is some legal right or financial interest (e.g. fidelity guarantee and business interruption insurances). **1**(a)(iii)

Insurance of Property（財產保險） Insurance whose subject matter consists of physical things (e.g. fire insurance). **1**(a)(ii)

Insurance of the Person（人身保險） Insurance whose subject matter is a human being's life, limb, health, or medical expenses (e.g. personal accident insurance). **1**(a)(i)

Jurisdiction Clause（司法管轄條款） Where contained in a liability policy, this clause excludes liability of the insured established by judgements made by courts outside of the territory specified. **1.6.3**(b)(iv)

Levies（徵款） Calculated as specified percentages of insurance premiums, they are collected primarily to enhance the protection afforded by particular compulsory insurance systems. **2.2.5**

Liability Insurance（責任保險）Same as **Insurance of Liability**（責任保險）. **1.6**

Limitations As To The Use Of The Vehicle（受保汽車使用限制） The use of a motor vehicle is so important a rating factor that, the policy and certificate of insurance always make reference to this provision whereby cover does not apply if the vehicle is used for purposes other than the permitted ones. **1.1**(d)(ii)

Litigation（訴訟） The formal process of having a dispute resolved through the courts. **3.2.2**

Local Vessel（本地船隻）

(a) any vessel used solely within the waters of Hong Kong, whether registered under the Merchant Shipping (Registration) Ordinance (Cap 415) or in a place outside Hong Kong;
(b) any vessel regularly employed in trading to or from Hong Kong unless registered in a place outside Hong Kong;
(c) any vessel possessed or used for pleasure purposes in the waters of Hong Kong;
(d) any vessel employed in sea fishing plying regularly in the waters of Hong Kong, or using the waters of Hong Kong as a base; or
(e) any vessel –
    (i) registered in the Mainland of China or Macau;
    (ii) employed in trading to or from Hong Kong; and
    (iii) issued with any certificate by a government authority of the Mainland of China or Macau permitting its trading to Hong Kong other than any accepted convention certificate. **1.7.4**

"Long-Tail" Business（「責任長期待決」業務） Insurance business where claims are expected to develop slowly over a number of years and take a long time to settle (especially liability classes). **1.6**(a)

Loss Adjusters（理賠師） Professing to be an independent claims professional, the loss adjuster is appointed to verify whether certain loss or damage is covered by a particular policy and the amount that policy should pay out. Loss adjusters are typically appointed by insurers but can also be appointed by policyholders. They are sometimes given authority to settle claims on insurers' behalf. **3.1.6**(b)

Loss of Profits Insurance（利潤損失保險）See **Consequential Loss**（後果損失或災後損失）. **1.4.1a**(d)(i)

Machinery Breakdown Insurance（機器損壞保險） It is an "all risks" cover against loss of or damage to plant, machinery and equipment, other than those insurable under a standard fire and extra perils insurance policy. **1.5.2**

Marine Cargo Insurance（海上貨物保險）Basically property insurance on goods being transported by sea. **1.7.1**

Marine Hull Insurance（船舶保險） Marine insurance on a waterborne craft, and its equipment, stores, etc., with own damage and collision liability being the major cover. **1.7.2**

Market Exclusions（業界除外責任） Recognised by the majority of, if not all, insurers to be necessary policy limitations, and forming standard policy exclusions, e.g. nuclear, radioactive, terrorism and war risks. **2.3.5**(c)

Master Policy（總保險單） A policy found with travel insurance, marine cargo insurance, etc. whereby numerous persons or voyages are covered by the issue of certificates of insurance, cover notes or even separate policies. **1.3.3**(d)(ii)

Material Damage Proviso（實物損害附帶條件） A condition precedent to liability under a business interruption policy, stipulating that the property damage from which business interruption flows must have given rise to a valid claim under a property insurance policy, with both policies covering the same affected insured. **1.4.1a**(b)(i)

Material Fact（重要事實） Legally defined to mean every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will accept the risk. **2.1**(b)

Maximum Indemnity Period（最長彌償期間） In business interruption insurance, where the period of interruption following an insured occurrence (e.g. a fire) is longer than the Maximum Indemnity Period (specified in the policy in terms of months), those losses which occur subsequent to the expiry of the Maximum Indemnity Period will not be recoverable. **1.4.1a**(d)(ii)

Mediation（調解） A flexible process in which a mediator helps the disputing parties reach a mutually accepted settlement, rather than impose a settlement. **3.2.2b**

Medical Insurance（醫療保險） Insurance related to the cost of medical expenses and medical treatment arising from accident or sickness. **1.2.2**

Medical Malpractice Insurance（醫療事故責任保險） A form of professional indemnity insurance that covers medical practitioners' liability for breach of professional duty. **1.6.3**

Money Insurance（金錢保險） Originally known as **Cash in Transit Insurance**（現金運送保險）, this cover is on an "all risks" basis covering various types of "money" in various situations/locations. **1.4.5**

Moral Hazard（道德危險） The human factor associated with a risk, bearing upon the likelihood and extent of claims. **2.1.2**(b)

Motor Cycle Insurance（電單車保險） A division of motor insurance, to insure motorised two-wheeled (sometimes three-wheeled) vehicles. **1.1.2**

Motor Insurance（汽車保險） The insurance of motor vehicles and third party or other associated risks. **1.1**

Motor Insurers' Bureau of Hong Kong (MIB)（香港汽車保險局） A central body, funded by a levy on motor insurance premiums, whose function is to fulfil the intentions of compulsory motor insurance, where such insurance is unavailable or ineffective, the insurer concerned is insolvent, etc. All authorized motor insurers in Hong Kong must be a member of the MIB. **2.2.5**(a)

Motor Vehicles Insurance (Third Party Risks) Ordinance（《汽車保險（第三者風險）條例》） The statute embodying the requirement for compulsory motor insurance in Hong Kong. **1.1**(b)

"New for Old" Cover（「以新代舊」（或以新換舊）保險保障） A term used in marine hull insurance, household contents insurance, etc. to signify that the basis of claim settlement for own damage will disregard wear and tear, depreciation, etc., which are normally uninsurable. **1.7.2**(a)(i)

No Claim Bonus（無索償獎金） An inaccurate historic term for a no claim discount, in motor insurance. **1.1**(c)(i)

No Claim Discount（無索償折扣） A system of rewarding the insured for one or more claim-free years in motor insurance (possibly occurring with other classes), by allowing a discount on the renewal premium for the coming year. **1.1**(c)

Non-Material Facts（非重要事實） Circumstances which, although possibly falling within the definition of "material fact", are not required to be disclosed under the principle of utmost good faith. These include circumstances which improve the risk and those which the insurer may be deemed to know. **2.1.1**(b)

"One Third" (Deductions)（「三分之一」（扣減）） A provision of Institute Clauses for pleasure craft insurance that allows up to one third of the cost of repair or replacement to be deducted from the settlement of claims for certain items (e.g. sails and outboard motors), cover otherwise being on a "new for old" basis. **1.7.3**(e)

Operative Clause（履行條款） That section of a scheduled policy form which outlines the circumstances in which cover operates. Also known as the **Insuring Clause**（承保條款）. **2.3.1**(b)(iii)

Package Policy（一籃子保單） Put simply, it is a single policy giving different types of cover (e.g. different kinds of liability insurance), with pre-determined restrictions in cover and sums insured (and limits of liability). **1.3**

Particular Average（單獨海損） Put simply, this is "**Average**"（部分損失）(i.e. partial loss) affecting the subject matter insured, other than a **General Average Loss**（共同海損損失）. **1.7**(a)(i)

Performance Bond（履約保證書） A contractor, upon winning a bid, may be obliged to submit a **Performance Bond** to the principal of the contract, which bond will guarantee that the contractor will complete the job according to the terms of the contract. **1.4.7**(a)

Permanent Disablement（永久殘疾） A heading under which lump sum personal accident insurance benefits may be paid. May be total permanent disablement (e.g. two or more limbs lost) or partial permanent disablement (e.g. one limb lost). **1.2.1**(a)(1)

Personal Accident and Sickness Insurance（人身意外及疾病保險） A traditional form of cover, providing stated benefits for accidental death and various specified injuries, with weekly benefits for temporary disability. Only weekly benefits are included in the sickness cover. **1.2.1**

Personal Lines Insurance（個人險種） Non-commercial insurance designed to satisfy the private needs of individuals, including private motor insurance, household insurance, etc. **2.3.1**(a)

Physical Hazards（實質危險） The objective, physical features of a proposed risk, bearing upon the likelihood or extent of claims. **2.1.2**(a)

"Plain English" Policy（「淺白英語」保單） A policy whose wording is more "user friendly" and comprehensible to the general public than traditional wording. Mostly used with personal lines insurance (e.g. household insurance). **2.3.1**(a)

Pleasure Craft Insurance（遊艇保險） Insurance of pleasure craft, covering property and liability risks. **1.7.3**

Policy（保險單（或保單）） The most formal and most commonly used documentary evidence of the existence and terms of a particular insurance contract. **2.2.3**(b)

Policy Conditions（保單條件） Put simply, these are various standard, written provisions regulating the insurance contract. **2.3.1**(b)(v), **2.3.2**(b)

Policy Specification（保單說明書）Same as **Specification**（說明書）. **1.4.1a**(b)(ii)

Pro Rata Average (Non-Marine)（比例分攤（非水險）） A contractual penalty for under-insurance, whereby the amount of loss payable by the insurer is reduced in proportion to the degree of under-insurance. **1.3.1**(b)(vi)

Products Liability Insurance（產品責任保險） It covers liability in respect of injury or damage caused by goods sold, supplied or repaired, services rendered, etc. and happening elsewhere than on premises owned or occupied by the insured. **1.6.2**

Professional Indemnity Insurance（專業彌償保險） A liability insurance covering professional people (doctors, lawyers, insurance brokers, etc.) for legal liability in respect of injury, death, loss or damage caused through their mistakes in professional acts or omissions. **1.6.3**

Proposal Form（投保書（或投保單）） A questionnaire, often constituting the basis of the proposed contract, designed to obtain information from a prospective insured on the risk he wishes to insure. Also known as an **Application**（申請表）. **2.1**(a)

Protection and Indemnity Associations (P&I Clubs)（船東保賠組織） Insurance organizations formed by shipowners mainly to cover the members against those marine liability risks which profit-making insurers traditionally would not cover. **1.7**(g)

Provisional (Premium)（臨時（保費）） An initial premium with an insurance where the final premium can only be calculated when information is available later (e.g. size of payroll or turnover). An adjustment with an extra or refund premium is to be made at the end of the policy year. **1.6.1**(c)

Public Liability Insurance（公眾責任保險） It covers liability in respect of death, injury or property damage that is not insurable by specialized liability insurances such as motor insurance, EC insurance, products liability insurance and professional indemnity insurance. **1.6.5**

Public Policy（公共政策） At least to the layman, this legal term is rather flabby and amorphous. Sometimes, the courts would not allow something to be done, because that is contrary to public policy. For example, agreements which will have the effect of restricting an individual's freedom of marriage and contract terms which purport to oust the jurisdiction of the courts are both void. Further, a person who falls from scaffolding when trying to break into a flat is unlikely to have a valid tortious claim for the resultant injury against the building owners because his claim would have to be based on his illegal conduct. **2.3.5**(d)(ii)

Quantum（金額） The amount of a loss (rather than the question of the insurer's liability). **3.1.1**(i)

Rating Features（釐定保費的因素） They are factors to be considered when setting premium rates or premium amounts. **1.1**(e)

Recital Clause or Preamble（敘文條款或（前言）） The introductory paragraph in a scheduled policy form, which introduces the parties (not by name) and usually makes reference to the premium (not by amount), and to the proposal form and declaration as the basis of the contract. **2.3.1**(b)(ii)

Reinstatement（恢復原狀） As a method of providing an indemnity, it means the restoration of the insured property to the condition in which it was immediately before its destruction or damage. **3.2.1**(d)

Renewals（續保） The continuation of an existing policy for a further period. In general insurance, these are not automatic and they provide an opportunity to either party for reconsidering the terms of the contract. **2.4.1**

Repatriation（運返） The cost of returning the insured person or a domestic helper or his or her remains to his or her place of residence is covered under the travel insurance policy or domestic helper insurance policy. **1.3.2**(a)(ii)

Replacement（更換） Less common than cash payment, it is a method of providing an indemnity by giving the insured a replacement item. **3.2.1**(c)

Representation（陳述） In insurance context, a representation is one as to a matter of fact or of belief, made by one party to another, and bearing upon a risk proposed for insurance; it may be verbal or in writing. **2.3.4**(c)

Risk Assessment Factors（風險評估因素） Those elements associated with a risk which help to determine its insurability and the terms under which it may be insured. **2.1.1**(d)

Risk Classification（風險分類） The practice of placing risks within various groups of homogenous or similar risks for rating purposes. **2.2.4**(a)(i)

Risk Discrimination（風險差別對待） Distinguishing individual risks within a risk category, for the purpose of considering the application of improved or stricter terms according to those features of the individual risks which are not possessed by the average risks belonging to the same category. **2.2.4**(a)(ii)

Road Traffic Act 1930（**1930**年的《道路交通法令》） The original piece of UK legislation introducing compulsory motor insurance, and giving its name to "Act" insurance. **1.1**(b)

Salvage (Marine)（救助（水險）） The term "salvage" in maritime law usually refers to saving a vessel or other maritime property from perils of the seas, pirates or enemies, on a "no cure - no pay" basis, for which a sum of money called "salvage award" (or just "salvage") is payable by the property owners to the salvor provided that the operation has been successful. It is sometimes also used to describe property which has been salved. **1.7**(b)

Salvage (Non-Marine)（損餘（非水險）） It refers to any residual value in what is left of the subject matter of insurance (e.g. scrap value of a destroyed vehicle). **1.7**(b)

Schedule（承保表（或明細表））That section of a policy form which contains all the information exclusive to that particular policy, e.g. the insured's name, subject matter of insurance, premium, policy dates, etc. **2.3.1**(b)

Scheduled Policy Form（承保表式保單）A common type of policy structure which contains a (policy) schedule. **2.3.1**(b)

Second Chance（改過機會） In fidelity guarantee insurance, it relates to the employer who, upon discovery of dishonesty on the part of an employee, allows him to continue in his duties and employment. This will constitute grounds for refusal of a claim in respect of a subsequent default, unless the insurer has been informed and signified acceptance. **1.4.6**(b)(ii)

Settling Agents（理賠代理人） Agents named on marine cargo policies, to be contacted in the event of a claim, having authority to investigate and in some cases settle claims on behalf of the insurer. **3.1.6**(d)

Short-Period Premium（短期保費） A higher than pro rata premium for an insurance period shorter than one year, with policies which are normally on an annual basis. **2.4.2**(b)

Short-Period Refund of Premium（短期保費退款） A return of premium for an annual policy terminated mid-term by the insured. Such a return premium will be less than the pro rata amount. **2.4.2**(b)

Signature Clause（簽署條款） That part of a scheduled policy form where the insurer signs to confirm his undertakings under the contract. Also known as the **Attestation Clause**（簽證條款）. **2.3.1**(b)(vi)

Simple Contract（簡單合約） It is a valid contract made verbally, in writing or by conduct, but not under seal. **1.4.7**

Specific Exclusions（特定除外責任） These are exclusions which the underwriter decides should be applied to a particular policy, because of the extra hazards the particular risk presents. **2.3.5**(b)

Specification（說明書） An important part of the typical business interruption policy, containing definitions of various terms used, e.g. Gross Profit, Indemnity Period, etc. **1.4.1a**(b)(ii)

Specified Perils（指明危險） Causes of loss which are specifically mentioned as being covered by the policy (unlike “all risks” type cover). **1**(b)(i)

Standard (Policy Excess)（標準（保單自負額）） An excess imposed by the insurer, without premium reduction, to a class of policy rather than for individual risks, and applicable to all claims or in certain specified circumstances, e.g. inexperienced driver excess. **2.3.3**(a)(i)

Standard Plan（標準計劃） Defined in the **Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme** as "The insurance plan with terms and benefits equivalent to the minimum compliant product requirements of the VHIS [Voluntary Health Insurance Scheme], which are from time to time published and subject to regular review by the Government." **1.2.3**(c)(iii)(4)

Step-Back System（折扣回減機制） A feature of modern no claim discount (NCD) schemes, whereby a single claim does not wipe out an NCD for the ensuing year, where a high entitlement is being enjoyed. Put simply, for every claim in a year, the NCD for the ensuing year will be dragged backwards along the NCD scale for three steps or years. **1.1**(c)(ii)

Subrogation（代位） Under this doctrine of equity, an indemnifying insurer is entitled to exercise subrogation right, the right to take over and benefit from recovery rights possessed by the insured against third parties. **3.1.3**(f)(iii)

Sue and Labour Charges（損害防止費用） They are expenses reasonably incurred by the assured under a marine policy in preserving the insured property from an insured loss or in minimizing an insured loss. Such expenses are covered in addition to the sum insured. **1.7**(c)

Surety (or **Guarantor**)（擔保人） That party to a surety bond who provides a financial guarantee to the obligee that the principal will fulfil his obligations. **1.4.7**

Surety Bond（保證書） An agreement in writing involving three parties, i.e. the principal（被保證人), the obligee （權利人）and the surety（擔保人）, under which the surety, in consideration of a fee paid by the principal, provides a financial guarantee to the obligee that the principal will fulfil his obligations. **1.4.7**

Survey Agents（檢驗代理人） Marine claims investigators, especially concerned with marine cargo claims. **3.1.6**(e)

Survey Report（檢驗報告（書）） The document prepared by an appointed surveyor to report on the findings of a survey he has performed. **3.1.5**(c)

Surveyors（檢驗人、查勘人、勘探人） Specialised staff, or independent experts, engaged by an insurer to carry out an inspection of a proposed risk and report on its insurability or otherwise. Surveyors may also be employed to carry out inspection in connection with marine insurance claims or maritime claims. **3.1.6**(a)

Surveys（檢驗、查勘、勘探） The main work carried out by surveyors. In marine insurance, a survey may be connected with a proposed risk or a claim. **2.1.4**(c), **3.1.6**(a)

System of Check（核查制度） An important element in the underwriting of fidelity guarantee insurance, relating to the internal discipline and control the employer exercises over the guaranteed staff. **1.4.6**(b)(i)

"Target Risks"（「目標風險」） In general insurance, this term may be used to refer to large, hazardous risks. **1.4.3**(d)(iii)

Temporary Disablement (Benefits)（暫時殘疾（利益）） A heading of benefits under personal accident insurance. May be temporary total disablement or temporary partial disablement, for different weekly benefits and with payments limited to a maximum number of weeks. **1.2.1**(a)(2)

Theft Insurance（盜竊保險） Also known as **Burglary Insurance**（入屋盜竊保險）, this insures loss/damage caused by actual or attempted theft. As a condition for theft claims, however, commercial policies (and sometimes household policies as well) require evidence of forcible and violent entry to or exit from the insured premises. (This limitation can sometimes be removed by the payment of an extra premium.) **1.4.3**

Third Party, Fire and Theft（第三者責任、火災及盜竊） A form of motor insurance cover, covering third party liability, and loss of and damage to the insured's vehicle caused by fire or theft. **1.1**(a)(ii)

Third Party (Insurance)（第三者（保險）） 1 Insurance to indemnify the insured and other specified persons against their legal liability towards third parties for death, injury or property damage. **1.1**(a)

2 (Motor Insurance) It has a wider scope of cover than the "Act" cover, and includes liability to third parties for property damage. **1.1**(b)

Travel Insurance（旅遊保險） A package insurance, offering a wide range of cover, including personal accident, loss of or damage to luggage and a range of miscellaneous headings such as loss of deposits, loss of money, medical expenses, etc. **1.3.3**

Trend Adjustment（趨勢調整） In adjusting business interruption claims, an attempt is made to measure the loss sustained during the indemnity period by comparing income, etc. during that period with the comparable period last year (when business was not interrupted), making any necessary **"trend adjustments**" for such factors as increased market competition and the outbreak of an epidemic happening during the indemnity period which in no way are imputed to the accident that has occurred. **1.4.1a**(d)(iii)

Underwriting（核保） The process of determining the insurability and terms of a proposed insurance. **2**

Underwriting Excess（承保自負額） A policy excess imposed by the insurer on an individual policy, without premium reduction and additional to any other excess, to deal with an adverse feature of the proposed risk. **1.1**(f)

Unnamed Driver Excess（不指名司機自負額） An excess that will apply to claims happening while a person other than a named driver is driving the insured car. **1.1.1**(a)(i)(4)(A)

Unoccupancy（處所空置） A policy provision in household insurance whereby cover will be automatically suspended once the property has been left unoccupied for longer than a specified period (e.g. 30 consecutive days). **1.3.1**(b)(iv)

Unseaworthiness（不適航） A ship's state of not being reasonably fit, in all respects, to encounter the ordinary perils of the seas of the insured adventure. **1.7.1**(b)(v)

Unspecified Items（不指明的物件） Items insured but not individually specified in a property insurance policy. **1.4.2**(b)

Utmost Good Faith（最高誠信） The common law duty upon the proposer and the insurer to reveal all material information to each other before contract conclusion, even without a specific enquiry. **2.1**(b)

Valued Policies（定值保單） Insurance policies on ships or cargo are normally valued policies. For the purposes of total or partial loss claims, the agreed value (instead of the actual value of the property insured) is taken as the value that prevails at the time of loss. **1.7**(f)

Voluntary (Excess)（自願性（自負額）） An excess requested by the insured in order to obtain a premium discount. **2.3.3**(a)(iii)

Wages（工資） A subject matter of business interruption insurance (if not included within the Gross Profit item). **1.4.1a**(a)(iii)

Warehouse to Warehouse（倉至倉） A description of the transit insured under a marine cargo policy, meaning that the cargo is covered from the time it leaves the sender's premises until it reaches the final storage place. **1.7.1**(a)

Warranty（保證） It is one by which the insured undertakes to do, or refrain from doing, a specified thing, or affirms or negatives the existence of a particular state of facts. Breach of a warranty will automatically relieve the insurer from liability under the policy as from the date of breach. **2.3.4**(a)

Weakening of Support（減弱支撐） A standard exclusion in the liability section of a contractors' all risks policy, but which may be insurable as an extra benefit. It relates to the undermining or weakening of the support to third party property. **1.5.3**(b)(ii)

Weekly Benefits（按周計算的利益） Payments for temporary incapacity under personal accident insurance. **1.2.1**(a)(ii)

Young Driver Excess（年輕司機自負額） An excess in motor insurance that applies where claims occur while an insured driver below the stated age (often 25 years) is driving the insured car. **1.1.1**(a)(i)(4)(B)

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