

Insurance Intermediaries Quality Assurance Scheme

Travel Insurance Agents Examination

Study Notes

2017 Edition

PREFACE

Divided into Part I – Principles and Practice of Insurance, and Part II – Travel Insurance, these Study Notes have been prepared to correspond with the various Chapters in the Syllabus for the Travel Insurance Agents 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.

*It should be noted, however, that these Study Notes will not make you a fully qualified underwriter or other insurance specialist. It is intended to give a preliminary introduction to the subject of Principles and Practice of 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 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

For your study purposes, it is important to be aware of the relative ‘weight’ of Parts I and II in relation to the Examination. Both Parts should be studied carefully, but the following table indicates areas of particular importance:

Part	Relative Weight
I	35%
II	65%
Total	100%

Part I

Principles and Practice of Insurance

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1 RISK AND INSURANCE

1.1 CONCEPT OF RISK

1.1.1 Meaning of Risk

There have been many attempts to define 'risk'. Probably, to most of us, 'risk' contains a suggestion of *loss* or *danger*. We may therefore define it as '**uncertainty concerning a potential loss**', a situation in which we are not sure whether there will be loss of a certain kind, or how much will be lost. It is this uncertainty and the *undesirable* element found with risk that underlie the wish and need for insurance.

The potential loss that risk presents may be:

- (a) *financial*: i.e. measurable in monetary terms (e.g. loss of a camera by theft);
- (b) *physical*: death or personal injury (often having financial consequences for the individual or his family); or
- (c) *emotional*: feelings of grief and sorrow.

Only the first two types of risks are likely to be (commercially) **insurable risks**. Also, from a wider perspective, not every risk will be seen in the **negative** form we have just outlined (see **1.1.2a** below).

Note: Without trying to complicate matters, we should also be aware that insurance practitioners may use the word 'risk' with other meanings, including:

- 1 the property or person at risk that they are insuring or considering insuring; and
- 2 the *peril* (i.e. cause of loss) insured (so, some policies may insure on an '**all risks**' basis, meaning that any loss due to any cause is covered, except where the cause is excluded from cover).

1.1.2 Classification of Risk

To simplify a complex subject, we may classify risk under two broad headings (each having two categories) according to:

- (a) its potential *financial results*; and
- (b) its *cause and effect*.

1.1.2a Financial Results

Risks may be considered as being either *Pure* or *Speculative*:

- (i) *Pure Risks* offer the potential of **loss** only (no gain), or, at best, no change. Such risks include fire, accident and other undesirable happenings.
- (ii) *Speculative Risks* offer the potential of **gain or loss**. Such risks include gambling, business ventures and entrepreneurial activities.

The majority of the risks which are insured by commercial insurers are pure risks, and speculative risks are not normally insurable. The reason for this is that speculative risks are engaged in voluntarily for gain, and, if they were insured, the insured would have little incentive to strive to achieve that gain.

1.1.2b Cause and Effect

Risks may also be considered as being either *Particular* or *Fundamental*:

- (i) *Particular Risks*: They have relatively limited consequences, and affect an individual or a fairly small number of people. The consequences may be serious, even fatal, for those involved, but are comparatively localised. Such risks include motor accidents, personal injuries and the like.
- (ii) *Fundamental Risks*: Their causes are outside the control of any one individual or even a group of individual, and their outcome affects large numbers of people. Such risks include famine, war, terrorist attack, widespread flood and other disasters which are problems for society or mankind rather than just the 'particular' individuals involved.

The majority of the risks which are insured by commercial insurers are particular risks. Fundamental risks are not normally insurable because it is considered financially infeasible for insurers to handle them commercially.

1.1.3 Risk Management

'Risk management' is a term which is used with different meanings:

- (a) in the world of banking and other financial services outside insurance, it is probably used with reference to investment and other *speculative* risks (see **1.1.2a** above);

- (b) insurance companies will probably use the term only in relation to *pure* risks, but they may well restrict it even further to *insured* risks only. Thus, when insurers talk about '**risk management**', they could well be referring to ways and means of reducing or improving the *insured loss potential* of the 'risks' they are insuring, or being invited to insure;
- (c) as a separate field of knowledge and research, risk management may be said to be that branch of management which seeks to:
- (i) *identify*;
 - (ii) *quantify*; and
 - (iii) *deal with* risks (whether **pure** or **speculative**) that threaten an organisation. Tools or measures of risk handling include:
 - *risk avoidance*: elimination of the chance of loss of a certain kind by not exposing oneself to the peril (e.g. abandoning a nuclear power project so as to eliminate the risk of nuclear accidents);
 - *loss prevention*: the lowering of the frequency of identified possible losses (e.g. activities promoting industrial safety);
 - *loss reduction*: the lowering of the severity of identified possible losses (e.g. automatic sprinkler system);
 - *risk transfer*: making another party bear the consequences of one's exposure to loss (e.g. purchase of insurance and contractual terms shifting responsibility for possible losses);
 - *risk financing*: no matter how effective the loss control measures an organisation takes, there will remain some risk of the organisation being adversely affected by future loss occurrences. A risk financing programme is to minimise the impact of such losses on the organisation. It uses tools like: insurance, risk transfer other than insurance, self-insurance, etc. (Whilst insurance is closely connected with risk management, it is only one of the tools of risk management.)

To illustrate (i) - (iii) above, suppose a supermarket finds that it is losing goods from its shelves. It *identifies* its possible causes by observation, which could be theft by customers, theft by staff, etc. It *quantifies* the loss from frequent stocktaking compared with cash receipts (making allowance for staff errors). It may *deal with* the risk, for example, by installing closed circuit TV, or (if market conditions allow) by raising prices generally to offset such losses, or by setting up a self-insurance fund for them.

1.2 FUNCTIONS AND BENEFITS OF INSURANCE

Insurance has many functions and benefits, some of which we may describe as **primary** and others as **ancillary** or secondary, as follows:

- (a) **Primary functions/benefits:** Insurance is essentially a *risk transfer mechanism*, removing, for a **premium**, the potential financial loss from the individual and placing it upon the insurer.

The primary benefit is seen in the *financial compensation* made available to insured victims of the various insured events. On the commercial side, this enables businesses to survive major fires, liabilities, etc. From a personal point of view, the money is of great help in times of tragedy (life insurance) or other times of need.

- (b) **Ancillary functions/benefits:** Insurance contributes to society directly or indirectly in many different ways. These will include:
- (i) *employment*: the insurance industry is a significant factor in the local workforce;
 - (ii) *financial services*: since the relative decline in manufacturing in Hong Kong, financial services have assumed a much greater role in the local economy, insurance being a major element in the financial services sector;
 - (iii) *loss prevention and loss reduction* (collectively referred to as ‘*loss control*’): the practice of insurance includes various surveys and inspections related to **risk management** (see 1.1.3(b) above). These are followed by requirements (conditions for acceptance of risk) and/or recommendations to improve the ‘risk’. As a consequence, we may say that there are fewer fires, accidents and other unwanted happenings;
 - (iv) *savings/investments*: life insurance, particularly, offers a convenient and effective way of providing for the future. With the introduction of the Mandatory Provident Fund Schemes in 2000, the value of insurance products in providing for the welfare of people in old age or family tragedy is very evident;
 - (v) *economic growth/development*: it will be obvious that few people would venture their capital on costly projects without the protection of insurance (in most cases, bank financing will just not be available without insurance cover). Thus, developments of every kind, from erection of bridges to building construction and a host of other projects, are encouraged and made possible partly because insurance is available.

Representative Examination Questions

*The examination will consist of 80 multiple-choice questions. The majority of the questions will be very straightforward, involving a simple choice from four alternatives. These we may call **Type 'A' Questions**. A selection of the questions (probably between 10% and 15%) will be slightly more complex, but again involving a choice between four alternatives. These we may call **Type 'B' Questions**. Examples of each are shown below.*

Type 'A' Questions

- 1 Risk may be described as the uncertainty concerning a potential loss. That potential loss may be:
- (a) physical;
 - (b) financial;
 - (c) emotional;
 - (d) all of the above.

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

- 2 A risk which offers the prospect of loss only, with no chance of gain, may be described as a:
- (a) pure risk;
 - (b) particular risk;
 - (c) speculative risk;
 - (d) fundamental risk.

[Answer may be found in **1.1.2a**]

Type 'B' Questions

- 3 Which of the following statements concerning risk are **true**?
- (i) All risks are commercially insurable.
 - (ii) Not all risks are commercially insurable.
 - (iii) The only remedy for any kind of risk is insurance.
 - (iv) Insurers may mean a number of things when talking about 'risk'.
- (a) (i) and (iii) only;
 - (b) (ii) and (iv) only;
 - (c) (i) and (iv) only;
 - (d) (i), (iii) and (iv) only.

[Answer may be found in **1.1-1.1.1**]

4 Which of the following may be considered as being among the secondary or subsidiary benefits of insurance to Hong Kong?

- (i) means of savings
- (ii) source of employment
- (iii) encouragement of economic development
- (iv) reduction in number of accidents/losses

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

[Answer may be found in **1.2(b)**]

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

2 LEGAL PRINCIPLES

This and the next Chapter will concern principles of law, but the Notes will not provide a comprehensive survey of some very complex issues. The purpose of the Notes, as with the overall study, is to give an insight into the important aspects of an insurance intermediary's professional activities.

2.1 THE LAW OF CONTRACT

This is an area of law which affects every one of us, whether in our personal or business lives. As we shall see, contract is an essential element in civilised societies, therefore it is important to have some appreciation of this important subject.

2.1.1 Definition

The simplest definition for 'contract' is probably: a *legally enforceable agreement*. There are a large variety of agreements, but not all are intended to have legal consequences. A *social arrangement* between two persons, such as a lunch appointment for example, is an agreement, but where either of them unilaterally cancels the appointment, there is no suggestion that the disappointed party should be able to take legal action against the other party, because the agreement is not legally recognised as valid.

Contracts comprise promises or undertakings, usually given in exchange for a promise or undertaking from the other side. In legal terminology, contracts are something intangible. Therefore, an insurance policy in itself is not a contract; instead it is the most commonly used evidence of an insurance contract. An insured who has been affected by a fire will not expect the insurer to deny his insurance claim on the grounds that the insurance contract no longer exists after the insurance policy has been destroyed in the fire.

Contracts may concern relatively *trivial* (such as buying a newspaper or taking a tram ride) or very *important* matters (such as a major building project or employment). In any event, the contracting parties expect promises to be honoured, and can demand compensation or enforced performance if they are not honoured.

2.2 THE LAW OF AGENCY

Before we commence this section, it is very important to realise that the law of agency is much wider than its application to *insurance agents* (important as that is). Therefore, in the following paragraphs, do not think only of **insurance** agents. The comments apply to every kind of **agent** (a shipping agent, an estate agent, etc.), an explanation of which immediately follows.

- (a) An *agent* in this context is a person who represents a *principal*. In insurance, the position is made a little complex because insurance intermediaries may be described as **Insurance Agents** (usually representing the insurer) or as **Insurance Brokers** (usually representing the insured/proposer), as the case may be. Within the law of agency, they are both **agents**.
- (b) The law of agency is deceptively simple in theory, but sometimes quite complex in practice. Essentially, this whole area of law is governed by the legal principle that '*he who acts through another is himself performing the act*'. In other words, the principal is bound (for good or ill) by the authorised actions, and sometimes even the unauthorised actions (see **2.2.2** and **2.2.3** below), of his agent. Thus, when a child (agent) buys something on credit from a grocery store at his mother's (principal) bidding, a contract of sale is created between the store and the mother so that she becomes liable to pay the price.
- (c) The principal who becomes bound by the acts of his agent is exposed to *vicarious liability*, liability incurred as a result of an act or omission of another.

2.2.1 Definition

Agency is the *relationship* which exists between a *Principal* and his *Agent*. Because it is a relationship, it may arise as a matter of fact rather than as a precise agency appointment. In legal terms, an agency relationship may be *deemed* to arise in certain given circumstances.

The *law of agency* are those rules of law which govern an agency relationship. The law of contract also has to be considered as the agent often arranges an agreement with the *third party*, or performs it, on behalf of his principal. There are two contracts to consider:

- (a) one between the **agent** and the **principal**; and
- (b) another quite different one between the **principal** and the **third party**.

Note: an agency can exist without an agency contract. For example: a child (gratuitous agent) goes to buy a pack of sugar on behalf of his mother (principal), with authority to bind the mother in so doing, which is not granted under a contract of agency between them (remember that a domestic arrangement generally does not constitute a contract).

2.2.2 How Agency Arises

When we say that an agency relationship exists between two parties, we are, in essence, saying that the agent owes certain duties to the principal and vice versa, and that the agent has some sort of authority to bind the principal in respect of some contract or transaction to be made on the principal's behalf with another person (third party).

There are a number of ways in which an agency relationship may arise. These we consider below:

- (a) *By agreement*: whether contractual or not; express, or implied from the conduct or situation of the parties.
- (b) *By ratification*: Ratification is the giving of *retrospective authority* for a given act. That is to say, authority was not possessed at the time of the act, but the principal subsequently confirms the act, effectively **backdating** approval. It can be done in writing, verbally, or by conduct.

For example, an insurance agent who is only authorised to canvass household insurance business for an insurer has an opportunity to secure an attractive fire insurance risk and purports to grant the required fire insurance cover to the client. The proposed insurance contract is technically void for it has been made without authority from the insurer. However, the insurer may subsequently accept the insurance and confirm cover so that the contract becomes valid retrospectively.

2.2.3 Authority of Agents

The issue of authority is related to, but distinct from, the issue of agency relationship. Where a certain act done by A purportedly on behalf of B will be binding on B, A is said to have B's authority to do it; but that does not necessarily mean that there is an agency relationship, or a full agency relationship, between them, which will, for instance, entitle A to reimbursement by B of expenses incurred on behalf of B. The various types of authority that an agent may have are considered below:

- (a) *Actual authority*: The authority of an agent may be actual where it results from a manifestation of consent that he should represent or act for the principal, expressly or impliedly *made to the agent himself* by the principal. An actual authority can be an express actual authority or an implied actual authority. An *express actual authority* is an actual authority that is deliberately given, verbally or in writing. By contrast, an *implied actual authority* arises in a larger variety of circumstances; put simply, it may arise out of the conduct of the principal, from the course of dealing between the principal and the agent, or the like.

- (b) *Apparent authority*: The authority of an agent may be apparent instead of actual, where it results from a manifestation of consent, *made to third parties* by the principal. The notion of apparent authority is essentially confined to the relationship between the principal and a third party, under which the principal may be bound by an unauthorised act of the agent of creating a contract or entering into a transaction on behalf of the principal.

Suppose an underwriting agent has been expressly forbidden by his principal from accepting cargo risks destined for West Africa. In contravention of this prohibition, the agent has on several occasions verbally granted temporary cover to a client for such risks purportedly on behalf of the principal, each time followed by issuance of policies for them by the principal to the client. Because of such past dealings, future similar acceptance by the agent may be binding on the insurer on the basis of apparent authority to the agent.

- (c) *Authority of necessity*: In urgent circumstances where the property or interests of one person (who may possibly be an existing principal) are in imminent jeopardy and where no opportunity of communicating with that person exists, so that it becomes necessary for another person (who may possibly be an existing agent) to act on behalf of the former, the latter is said to have an authority of necessity so to act and becomes an agent of necessity by so acting even though he has not acquired an express authority to do that. The implications are that: by exercising such an authority, the agent creates contracts binding and conferring rights on the principal, and becomes entitled to reimbursement and indemnity against his principal in respect of his acts. Besides, he will have a defence to any action brought against him by the principal in respect of the allegedly unauthorised acts.

For example, when a person is very ill in hospital, a neighbour and friend volunteers and gives help, by assisting with domestic arrangements at his home. This includes payment of the renewal premium for his household insurance. As a result, he will probably be unable to refuse repaying the neighbour for the premium, as the neighbour will almost certainly be considered an *agent of necessity*. Secondly, he will probably be unable to declare the insurance void and demand a return of premium from the insurer. Thirdly, it is unlikely that the insurer will be able to deny claims under the policy on the grounds that the policy was renewed without his authority.

- (d) *Agency by estoppel*: Where a person, by words or conduct, represents or allows it to be represented that another person is his agent, he will not be permitted to deny the authority of the agent with respect to anyone (third party) dealing with the agent on the faith of such representation. Despite the binding effect of the acts of the agent done in such circumstances, this doctrine, *agency by estoppel*, does not generally create an agency relationship unless, say for example, the unauthorised act of the agent is

subsequently ratified. In other words, the operation of this doctrine only concerns the relationship between principal and third party.

Note The doctrine of apparent authority is distinct from the doctrine of estoppel. The first doctrine applies where an agent is allowed to appear to have a greater authority than that actually conferred on him, and the second doctrine applies where the supposed agent is not authorised at all but is allowed to appear as if he was.

2.2.4 Duties Owed by Agent to Principal

These may be summarised as follows:

- (a) *Obedience*: The agent has to follow all lawful instructions of his principal, strictly or as best as is reasonably possible.
- (b) *Personal performance*: The agent is not allowed to *delegate* his authority and responsibilities to others (subagents) unless he has authority to do so.
- (c) *Due care and skill*: The law does not demand perfection, and an agent is normally only required to display all reasonably expected skills and diligence in performing his duties. Whilst his principal may be bound by his lack of care, the principal may in turn reclaim from the agent in respect of a loss caused by the lack of care.
- (d) *Loyalty and good faith*: The agent's obligations of loyalty and good faith are governed by several strict rules of law, the no conflict rule being one of them.
- (e) *Accountability*: The agent has to account for all moneys or other things he receives on behalf of his principal. He also has to keep adequate records relating to the agency activities.

2.2.5 Duties Owed by Principal to Agent

These may be summarised as follows:

- (a) *Remuneration*: The agent is entitled to receive commission or other remuneration (such as bonus) as agreed. This the principal has to pay within a reasonable time or any specified time limit, as the case may be.
- (b) *Expenses, etc.*: The principal, subject to any express terms in the agency agreement, has to reimburse the agent for costs and expenses properly and reasonably incurred by the agent on behalf of the principal; e.g. legal defence expenses paid by a claims settling agent.
- (c) *Breach of duty*: The agent may take action against the principal for the latter's breach of obligations to him.

2.2.6 Termination of Agency

There are a number of ways in which an agency agreement can be brought to an end. These include:

- (a) *Mutual Agreement*: Generally speaking, all agreements may be terminated by mutual agreement, on terms agreed between the parties.
- (b) *Revocation*: Subject to any contract terms as to notice and/or compensation, either the principal or the agent may **revoke** (i.e. cancel) the agreement during its currency.
- (c) *Breach*: If either the principal or the agent commits a fundamental breach of contract, the other party may treat the contract as ended (with a possible right of compensation). For example, an exclusive agent, upon discovering that the principal, in breach of a contract condition, has appointed a second agent before the expiry of the agency agreement, may terminate performance immediately and sue the principal for any loss of the profit expected from performing the agreement during the remainder period.
- (d) *Death*: Because an agency relationship is a personal one, the death of either the principal or the agent will end the agreement. Should either party be a corporate body (company), its liquidation will have the same effect.
- (e) *Insanity*: If either the principal or the agent becomes insane so that he no longer can perform the agreement, the agreement will automatically come to an end.
- (f) *Illegality*: If it happens that the agency relationship or the performance of the agreement is no longer permitted by law, this will automatically end the agreement. Suppose a British company (buying agent) has a contract with a company (principal) incorporated and domiciled in another country whereby the buying agent will purchase in the United Kingdom stuffs like wheat, steel, sulphur and other chemicals on behalf of the principal. On the outbreak of a war between the two countries, this agreement will, in the English law, automatically end for illegality.
- (g) *Time*: If the agreement is for a determined period, it will terminate at the end of such period.

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Representative Examination Questions

Type 'A' Questions

- 1 A contract may be defined as:
- (a) a legally enforceable agreement;
 - (b) a promise between two or more people;
 - (c) an agreement that is expressed in writing;
 - (d) any agreement between two or more parties.

[Answer may be found in **2.1.1**]

- 2 Ratification by a principal of the actions of his agent effectively means that:
- (a) the agency agreement is terminated;
 - (b) the agent will not be entitled to any commission;
 - (c) the principal 'back-dates' approval of the actions;
 - (d) the principal refuses to accept responsibility for those actions.

[Answer may be found in **2.2.2(b)**]

Type 'B' Questions

- 3 Which of the following are ways in which an agency relationship may arise?
- (i) By order of the Chief Executive;
 - (ii) By agreement;
 - (iii) By court order;
 - (iv) By ratification.
-
- (a) (i) and (ii) only;
 - (b) (i), (ii) and (iii) only;
 - (c) (iii) and (iv) only;
 - (d) (ii) and (iv) only.

[Answer may be found in **2.2.2**]

[If still required, the answers may be found at the end of this Part of the Study Notes.]

3 PRINCIPLES OF INSURANCE

3.1 INSURABLE INTEREST

The word 'interest' can have a number of meanings. In the present context, it means a *financial relationship* to something or someone. There are a number of features to be considered with 'insurable interest', as below.

3.1.1 Definition

Insurable interest is a person's *legally recognised relationship* to the subject matter of insurance that gives them the right to effect insurance on it. Since the relationship must be a **legal** one, a thief in possession of stolen goods does not have the right to insure them.

3.1.2 Importance of Insurable Interest

An insurance agreement is void without insurable interest. The rules relating to return of premiums under such an agreement vary as between the different classes of insurance. These rules are the general rules on illegality of contract and the relevant provisions of the Insurance Ordinance and of the Marine Insurance Ordinance.

3.1.3 Its Essential Criteria

For insurable interest to exist, the following criteria must be satisfied:

- (a) there must be some *person (i.e. life, limbs, etc.), property, liability or legal right* (e.g. the right to repayment by a debtor) capable of being insured;
- (b) that person, etc. must be the *subject matter* of the insurance (that is to say, claim payment is made contingent on a mishap to such person, etc.);
- (c) the proposer must have the *legally recognised relationship* to the subject matter of insurance, mentioned in **3.1.1** above, so that financial loss may result to him if the insured event happens. (However, insurable interest is sometimes legally presumed without the need to show financial relationship. For example, any person is regarded as having an insurable interest in the life of their spouse.)

Note: A financial relationship alone is not sufficient to give rise to insurable interest. For instance, a creditor is legally recognised to have insurable interest in the life of his debtor, but is not allowed to insure the debtor's property despite his financial relationship to it, unless the property has been mortgaged to him.

3.1.4 How It Arises

Insurable interest arises in a variety of circumstances, which may be considered under the following headings:

- (a) Insurance of the **Person**: everyone has an insurable interest in his own life, limbs, etc. One also has an insurable interest in the life of one's *spouse*. Further, one may insure the life of one's *child* or *ward* (in guardianship) who is under 18 years of age, and a policy so effected will not become invalid upon the life insured turning 18.
- (b) Insurance of **Property** (physical things): the most obvious example arises in *absolute ownership*. Executors, administrators, trustees and mortgagees, who have less than absolute ownership, may respectively insure the estate, the trust property and the mortgaged property. Bailees (i.e. persons taking possession of goods with the consent of the owners or their agents, but without their intention to transfer ownership) may insure the goods bailed.
- (c) Insurance of **Liability**: everyone facing potential legal liability for their own acts or omissions may effect insurance to cover this risk (sometimes insurance is *compulsory*), such liability being termed '*direct liability*' or '*primary liability*'. Insurance against *vicarious liability* (see 2.2(c) above) is also possible, where, for example, employers insure against their liability to members of the public arising from negligence, etc. of their employees.
- (d) Insurance of Legal **Rights**: anyone legally in a position of potential loss due to infringement of rights or loss of future income has the right to insure against such a risk. Examples include landlords insuring against *loss of rent* following a fire.

Note: Anyone (agent) who has authority from another (principal) to effect insurance on the principal's behalf will have the same insurable interest to the same extent as the principal. For instance, a property management company may have obtained authority from the individual owners of a building under its management to purchase fire insurance on the building. There is no question of a fire insurance effected under such authority being void for lack of insurable interest, even if it is the property management company (rather than the property owners) which is designated in the policy as the insured.

3.1.5 When Is It Needed?

- (a) With life insurance, insurable interest is **only** needed at **policy inception**. Suppose a woman had effected a whole life policy on the life of her husband, who died some years later. When the woman presented a claim to the insurer, the latter discovered that at the time of the man's death, they were no longer in the relationship of husband and wife. That means the woman had no insurable interest in the life of the deceased at the time

of the death. Nevertheless, this lack of insurable interest will not disqualify her for the death benefit.

- (b) However, with marine insurance, insurable interest is **only** needed **at the time of loss**.
- (c) The above marine insurance rule is *probably* applicable to other types of indemnity contracts as well.

3.1.6 Assignment

‘Assignment’ is a legal term that generally means a *transfer of property*.

In insurance, there are broadly **two types of assignment**: *assignment of the insurance contract* (or *insurance policy*) and *assignment of the right to insurance money* (or *insurance proceeds*). They are different from each other in the following manner:

- (a) **Effect of an assignment of the insurance contract:** With an effective assignment of a policy (or contract) from the assignor (original policyholder) to the assignee (new policyholder), the interest of the assignor in the contract passes wholly to the assignee to the effect that when an insured event occurs afterwards, the insurer is obliged to pay the assignee for *his* loss, not that suffered by the assignor, if any. In the case of life insurance, assignment will never substitute a new life insured.
- (b) **Effect of an assignment of the right to insurance money** (sometimes simply referred to as an assignment of policy proceeds): Assignment of policy proceeds will have an effect on both losses that have arisen and those that may arise. An assigned policy remains to cover losses suffered by the assignor, not those by the assignee, although it is now the assignee (instead of the assignor) who has the right to sue the insurer to recover under the policy.
- (c) **Necessity for insurable interest:** With assignment of the insurance contract, both the assignor and the assignee need to have insurable interest in the subject matter of insurance at the time of assignment; otherwise the purported assignment will not be valid. (Taking assignment of motor policy as an illustration, the requirement of insurable interest will be satisfied by having the motor policy assigned to the purchaser contemporaneously with the transfer of property in the insured car.) However, with assignment of the right to insurance money, no insurable interest is needed on the part of the assignee, so that it may actually take effect as a gift to the assignee.
- (d) **Necessity for insurer’s consent:** An assignment of the right to insurance money requires no consent from the insurer, irrespective of the nature of the insurance contract concerned. But the position is not that simple with assignment of the insurance contract. Different types of insurance are subject to different legal rules as to whether a purported assignment of

the insurance contract will have to be agreed to, by the insurer. The matter is further complicated by the fact that very often non-marine policies include provisions that override these legal rules. Fortunately, it is sufficient for you simply to know that, in practice, unlike all other types of policies, life policies and marine cargo policies are assignable without the insurers' consent.

- (e) **Assignment of benefits as opposed to obligations:** Assignment does not have the effect of transferring the assignor's obligations under the insurance contract to the assignee. Such a transfer requires the insurer's consent.

Note: 1 It is sometimes misunderstood that any policy provision that claim payments have to be made to a designated person other than the insured is an assignment of the right to insurance money. In fact, the courts may construe such a provision as a mere instruction to pay, which will at most give the designated payee an expectation to be paid, rather than the right to sue the insurer, which right remains in the hands of the insured.

2 Statutory assignment, the best known form of assignment, is subject to the requirements of Section 9 of the Law Amendment and Reform (Consolidation) Ordinance.

3.2 UTMOST GOOD FAITH

3.2.1 Ordinary Good Faith

At common law, most types of contracts are subject to the principle of good faith, meaning that the parties have to behave with honesty and such information as they supply must be substantially true. However, it is not their responsibility to ensure that the other party obtains all vital information which may affect his decision to enter into the contract, or may affect the terms on which he would enter into the contract. For example, if only after you have boarded a double-decker and paid the fare do you find that no seats on it are vacant, you will have no grounds for complaint. In technical terms, you are not entitled, in such circumstances, to avoid your contract with the bus company for its failure to voluntarily disclose to you the fact that all the seats have been taken on the bus.

3.2.2 Utmost Good Faith

Insurance is subject to a more stringent common law principle of good faith, often called the principle of utmost good faith. It means that each party is under a duty to reveal all vital information (called **material facts**) to the other party, *whether or not* that other party asks for it. For example, a proposer of fire insurance is obliged to reveal the relevant loss record to the insurer, even where there is not a question on this on the application form.

Note: 1 Insurers sometimes *extend* the common law duty of utmost good faith by requiring the proposer to declare (or *warrant*) that all information supplied, whether relating to ‘material’ matters or not, is totally (not simply substantially) true. For example, where a proposer for medical insurance enters ‘30’ as his current age on the proposal form when he is aged 31, this is a technical breach of the above kind of warranty, if any, although this inaccuracy is unlikely to be material in the eyes of the common law principle of utmost good faith as applied to medical insurance.

2 On the other hand, a policy provision may state that an innocent or negligent (as opposed to ‘fraudulent’) breach of the duty will be waived (excused).

3.2.3 Material Fact

(a) **Statutory Definition:** ‘Every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will accept the risk’.

From this definition, it can be seen that there are three categories of material facts, by reference to the kinds of decisions likely to be affected by their disclosure. The first one only concerns the decision to accept or to reject a proposed risk (e.g. the fact that a proposed life insured has an inoperable malignant brain tumour.) The second only concerns the setting of premium (e.g. the fact that the insured person of a proposed personal accident insurance is a salesperson). And the third concerns both (e.g. where a proposed life insured is a diabetic).

You should also note that the law looks at an alleged ‘material fact’ in the eyes of a prudent insurer - not a particular insurer, a particular insured or a reasonable insured.

(b) **Facts that need not be disclosed:** In the absence of enquiry, certain facts need not be disclosed; they include:

(i) matters of common knowledge (e.g. the explosive character of hydrogen);

(ii) facts already *known*, or deemed to be known, to the insurer (e.g. the problem of piracy in Somalia);

(iii) facts which diminish the risk.

[Example: A proposer for commercial fire insurance did not mention the fact that his premises were protected by an automatic sprinkler system, which fact, if disclosed, would have influenced

the determination of the premium. This omission does not breach utmost good faith, as the fact (although very relevant) actually indicates a lower risk.]

3.2.4 When to Disclose Material Facts

It may be said that utmost good faith involves a duty of disclosure by the proposer/insured. Technically, the insurer is under the same duty, but here we will concentrate on the proposer's duty. This duty has some features that we should note:

- (a) *Duration* (at common law): Those material facts which do not come to the proposer's (or his agent's) knowledge until the insurance contract has been concluded do not have to be disclosed. Suppose a proposal for a one-year medical insurance commencing on 15 January 2011 was accepted on 2 January, and the insured had a routine medical examination on 10 January, which revealed to him on 16 January the contraction of malaria. An important question to ask is: 'Is the insured legally obliged to disclose such finding to his insurer?' Applying the legal rule just said, the insured is not obliged to do so, assuming that the terms of insurance are silent on this point. Of course, the policy will normally contain an exclusion for pre-existing diseases, in which case the insurer may rely on this exclusion rather than a breach of utmost good faith in trying to deny a claim in respect of malaria.
- (b) *Duration* (under policy terms): Some non-life policies require the disclosure of material changes in risk happening during the currency of the contract, such as a change in occupation in the case of a personal accident insurance. At common law, such a change, which could at most represent an increase in risk, need not be notified until renewal.
- (c) *Renewal*: when the policy is being renewed, the duty of utmost good faith revives. (Note: the duty of utmost good faith does not revive when a life policy is approaching its anniversary date.)
- (d) *Contract alterations*: If these are requested during the currency of the policy, the duty of utmost good faith applies in respect of these changes. Where, for example, the insured of a fire policy is requesting an extension to cover theft, he is immediately obliged to disclose all material facts relating to the theft risk, e.g. the physical protections of the insured premises and his record of theft losses, if any.

3.2.5 Types of Breach of Utmost Good Faith

A breach of utmost good faith can be in the form of either a **misrepresentation** (i.e. the giving of false information) or a **non-disclosure** (i.e. failure to give material information). Alternatively, it can be classified into a **fraudulent** breach and a **non-fraudulent** breach (i.e. a breach committed

either innocently or negligently, rather than fraudulently). Both classifications combined produce a four-fold categorisation as follows:

- (a) *Fraudulent Misrepresentation*: an act of fraudulently giving false material facts to the other party;
- (b) *Non-fraudulent Misrepresentation*: an act of giving false material facts to the other party done either innocently or negligently;
- (c) *Fraudulent Non-disclosure*: a fraudulent omission to give material facts to the other party; or
- (d) *Non-fraudulent Non-disclosure*: an omission to give material facts to the other party done either innocently or negligently.

3.2.6 Remedies for Breach of Utmost Good Faith

If the duty of utmost good faith is breached (any one of the four types mentioned above), the aggrieved party (normally the insurer) may have available certain remedies against the guilty party:

- (a) To *avoid* within a reasonable time the whole contract as from policy inception, with the effect that premiums (and claims) previously paid without knowledge of the breach are generally returnable, unless it was a fraudulent breach on the part of the insured or his agent;
- (b) In addition to (a) above, it is in principle possible to *sue in tort* (*see Glossary*) *for damages* in the case of fraudulent or negligent misrepresentation;
- (c) To *waive* the breach, alternatively, in which case the contract becomes valid retrospectively.

Note: An insurer aggrieved by a breach of utmost good faith has not the option to refuse payment of a particular claim, to treat the policy as valid for the remainder of the insurance period, and to retain part of or the whole of the premium paid. This is because rescinding only part of a contract is not an available remedy.

3.3 PROXIMATE CAUSE

3.3.1 Meaning and Importance of the Principle

The proximate cause of a loss is its effective or dominant cause.

Why is it important to find out which of the causes involved in an accident is the proximate cause? A loss might be the combined effect of a number of causes. For the purposes of insurance claim, one dominant cause must be singled out in each case, because not every cause of loss will be covered.

3.3.2 Types of Peril

In search of the proximate cause of a loss, we often have to analyse how the causes involved have interacted with one another throughout the whole process leading to the loss. The conclusion of such an analysis depends very much on the identification of the perils (i.e. the causes of the loss) and of their nature. All perils are classified into the following **three** kinds for the purposes of such an analysis:

- (a) *Insured peril*: It is not common that a policy will cover all possible perils. Those which are covered are known as the 'insured perils' of that policy, e.g. 'fire' under a fire policy, and 'stranding' under a marine policy.
- (b) *Excepted (or excluded) peril*: This is a peril that would be covered but for its removal from cover by an exclusion, e.g. fire damage caused by war is irrecoverable under a fire policy because war is an excepted peril of the policy.
- (c) *Uninsured peril*: This is a peril that is neither insured nor excluded. A loss caused by an uninsured peril is irrecoverable unless it is an insured peril that has led to the happening of the uninsured peril. For example, raining and theft are among the uninsured perils of the standard fire policy.

3.3.3 Application of the Principle

The principle of proximate cause applies to all classes of insurance. Its practical applications may be very complex and sometimes controversial. For our purposes, we should note the following somewhat simplified rules:

- (a) There must always be an *insured peril* involved; otherwise the loss is definitely irrecoverable.
- (b) If a *single cause* is present, the rules are straightforward: if the cause is an **insured peril**, the loss is covered; if it is an **uninsured** or **excepted peril**, it is not.
- (c) With more than one peril involved, the position is complex, and different rules of proximate cause are applicable, depending on whether the perils have happened as a chain of events or concurrently, and on some other considerations. Specific cases should perhaps be a matter of consultation with the insurer and/or lawyers, but the general rules are:
 - (i) **uninsured perils** arising directly from **insured perils**: the loss is covered, e.g. water damage (uninsured peril) proximately caused by an accidental fire (insured peril) in the case of a fire policy;

- (ii) **insured perils** arising directly from **uninsured perils**: the loss from the insured peril is covered, e.g. fire (insured peril) damage proximately caused by a careless act of the insured himself or of a third party (uninsured peril) in the case of a fire policy.
 - (iii) the occurrence of an **excluded peril** is generally fatal to an insurance claim, subject to complicated exceptions.
- (d) Other Features of the Principle
- (i) Neither the first nor the last cause necessarily constitutes the proximate cause.
 - (ii) More than one proximate cause may exist. For example, the dishonesty of an employee and the neglect on the part of his supervisor of a key to a company safe may both constitute proximate causes of a theft loss from the safe.
 - (iii) The proximate cause need not happen on the insured premises. Suppose a flat insured under a household policy is damaged by water as a result of a fire happening upstairs. The damage is recoverable under the policy, although the insured flat has never been on fire.
 - (iv) Where the proximate cause of a loss is found not to be an insured peril, it does not necessarily mean that the loss is irrecoverable under the policy.

[Illustration: There are four containers of cargo being carried on board a vessel and insured respectively under four marine cargo policies. The first policy solely covers the peril of collision, the second fire only, the third explosion only, and the fourth entry of water only. During the insured voyage, because of the master's negligence, this vessel collides with another. The collision causes a fire, which then triggers an explosion. As a result, the vessel springs several leaks and all the cargo is damaged by seawater entering through the leaks. These facts show that the cargo damage was proximately caused by negligence. Bearing in mind that negligence is merely an uninsured rather than insured peril of each of the four cargo policies, an immediate, important question that has to be grappled with is: 'Is the cargo damage irrecoverable under those policies?' In search of an answer to this question, we must look at the links between the individual events of the incident. Negligence, the identified proximate cause, naturally causes a collision, which then naturally causes a fire. The fire naturally leads to an explosion, which then naturally causes an entry of water. At last, the water damages the cargo. Before us is a

chain of events, happening one after another without being interrupted by other events. With respect to each policy, the water damage is regarded as a result of its sole insured peril, notwithstanding that this peril can be traced backward to an uninsured peril. Therefore, the only conclusion that we can reach is that each of the policies is liable for the water damage to the cargo it has insured. (Of course, if the proximate cause is found to be an excepted peril, the opposite conclusion will have to be made.)]

3.3.4 Policy Modification of the Principle

It is very common for insurers to adopt policy wording that has the effect of modifying the application of proximate cause rules. Two examples of such practice are given below:

- (a) ***‘Directly or indirectly’***: There are a whole number of ways that an insurer can frame his policy wording for the purposes of specifying what he wants to cover or not to cover. For instance, it may use such wording as ‘loss caused by ...’, ‘loss directly caused by ...’ and ‘loss proximately caused by ...’. Well do they mean different things to you? Will any of them have the effect of modifying the rules of proximate cause? The answer is that they have been held to mean the same thing. That is to say, whether the term ‘directly’ or ‘proximately’ is adopted or left out, the legal rules to be applied are exactly the same and the same scope of cover is given or excluded, as the case may be. But what if the term ‘indirectly’ is used? A policy exclusion that says that loss *‘directly or indirectly’* arising from a particular peril (excepted peril) is excluded has been construed by the courts to mean that a loss will not be recoverable even where the operation of that excepted peril has only been a *remotely* (as opposed to ‘proximately’) contributory factor. Read the following decided court case for illustrations:

An army officer was insured under a personal accident policy, which excluded claims ‘directly or indirectly caused by war’. During wartime, the insured was on duty supervising the guarding of a railway station. Walking along the track in the darkness, he was struck by a train and killed. It was held that although the war was merely an ‘indirect’ cause of the death, the policy wording meant that the insurer was not liable.

- (b) ***‘Loss proximately caused by delay, even though the delay be caused by a risk insured against’*** (an exclusion wording quoted from a marine cargo insurance clause most commonly used): Suppose an insured shipment of calendar for the year 2011, expected to arrive on 1 December 2010, does not arrive until 15 February 2011 because of a collision (insured peril) involving the carrying vessel during the insured voyage. By relying on the exclusion, the insurer can deny a ‘loss of

market' claim from the insured even though the loss is due to an insured peril.

Note: Remember that the principle of proximate cause is sometimes very complicated. There have been many interesting, sometimes surprising court cases which have decided its application. In particular, not too rarely are inconsistent or opposing judicial decisions seen in factually similar cases which are made on the basis of the same rule(s) of proximate cause, perhaps because the judgments of the judges vary from one case to another on how the facts of a case relate to one another. Therefore, please do not assume that knowledge of the above brief notes will make you an expert in this area.

3.4 INDEMNITY

3.4.1 Definition

Indemnity means *an exact financial compensation* for an insured loss, no more no less.

3.4.2 Implications

Indemnity cannot apply to all types of insurance. Some types of insurance deal with 'losses' that cannot be measured precisely in *financial* terms. Specifically, we refer to **Life Insurance** and **Personal Accident Insurance**. Both are dealing with death of or injury to human beings, and there is no way that the loss of a finger, say for instance, can be measured precisely in money terms. Thus, *indemnity* cannot normally apply to these classes of business. (Note: medical expenses insurance, which is often included in personal accident and travel insurance policies, is indemnity insurance unless otherwise specified in the policies.)

Other insurances are subject to the principle of indemnity.

Note: It is sometimes said that life and personal accident insurances involve *benefit policies* rather than policies of *indemnity*. Since indemnity cannot normally apply, the policy can only provide a **benefit** in the amount specified in the policy for death or for the type of injury concerned.

3.4.3 Link with Insurable Interest

We studied insurable interest in **3.1**. That represents the financial 'interest' in the subject matter, which is exactly what should be payable in a total loss situation, if the policyholder is to be completely compensated. However, life and personal accident insurances may generally be regarded as involving an *unlimited insurable interest*, and therefore indemnity cannot apply to them.

3.4.4 How Indemnity is Provided

It is common for property insurance policies to specify that the insurer may settle a loss by any one of four methods named and described below. However, both marine and non-property policies are silent on this issue so that the insurer is obliged to settle a valid claim by payment of cash.

- (a) *Cash payment* (to the insured): This is the most convenient method, at least to the insurer.
- (b) *Repair*: Payment to a repairer is the norm, for example, with motor partial loss claims.
- (c) *Replacement*: With new items, or articles that suffer little or no depreciation, giving the insured a replacement item may be a very suitable method, especially if the insurer can obtain a discount from a supplier.
- (d) *Reinstatement*: This is a word that has a number of meanings in insurance. As a method of providing an indemnity, it means the restoration of the insured property to the condition it was in immediately before its destruction or damage.

Note: You are absolutely correct if you understand that the term ‘reinstatement’ overlaps in meaning with ‘repair’ and with ‘replacement’.

3.4.5 Salvage

When measuring the exact amount of loss (which indemnity is), it has to be borne in mind with certain property damage that there will sometimes be something left of the damaged *subject matter of insurance* (fire-damaged stock, the wreck of a vehicle, etc.). These remains are termed ‘**salvage**’. If the remains have any financial value, this value has to be taken into account when providing an indemnity. For example:

- (a) The value of the salvage is *deducted* from the amount otherwise payable to the insured (who then keeps the salvage); or
- (b) The insurer pays in full and *disposes* of the salvage for its own account.

Note: The term ‘salvage’ in maritime law has a very different meaning, where it usually refers to acts or activities undertaken to save a vessel or other maritime property from perils of the sea, pirates or enemies, 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. The term is sometimes also used to describe property which has been salvaged.

3.4.6 Abandonment

This is a term mostly found in marine insurance, where it refers to the act of *surrendering* the subject matter insured to the insurers in return for a total loss payment in certain circumstances. This is quite standard in marine practice, but in other classes of property insurance, policies usually specifically exclude abandonment.

The important thing to be remembered with abandonment is that the subject matter insured (or what is left of it) is *completely* handed over to the insurer, who may therefore benefit from its residual value. (This will be important with **Subrogation**; see 3.6 below).

3.4.7 Policy Provisions Preventing Indemnity

While policies in some classes of business promise to *indemnify* the insured, this has to be done subject to the express terms of the policy, if any. Some of these terms mean that something less than indemnity is payable. For example:

- (a) *Average*: Most non-marine property insurances are expressly *subject to average*. This means that the insurer expects the insured property to be insured for its full value. If it is not, in the event of a loss the amount payable will be reduced in proportion to the *under-insurance*. For example, if the actual value of the affected property at the time of a loss was \$4 million and it was only insured for \$1 million, we may say that the property was at the time of the loss only *25% insured*. Therefore, by the application of **average**, only 25% of the loss is payable.

In view of this penalty for under-insurance, it is very important for insurance intermediaries to do their best to ensure that their clients will arrange full value insurance.

Note: In marine insurance, ‘**average**’ has a totally different meaning. Here it means *partial loss*, a loss other than total loss. Average in marine insurance is complex and beyond the needs of this present study.

- (b) *Policy excess/deductible*: An excess or deductible is a policy provision whereby the insured is not covered for losses up to the specified amount, which is always deducted from each claim.

Suppose a motor policy is comprehensive, with a \$4,000 excess for damage to the insured vehicle. If an accident occurs and the repair bill for the car amounts to \$14,000, the insurer is only liable for \$10,000. On the other hand, with a minor accident and repairs costing \$3,000, the insurer would have no liability at all.

- (c) *Policy franchise*: Seldom seen today (except for time franchise – see example below), it is similar to an excess in that it eliminates small claims. On the other hand, it is different from an excess in that if the loss exceeds or reaches the franchise – depending on the wording used - the loss is payable *in full*. Like an excess, a franchise can be expressed as a percentage, an amount of loss, or a time period.

Suppose a ship which is insured for \$5,000,000 subject to a 5% franchise sustains insured damage. If repairs cost only \$100,000 (2%), nothing is payable by the insurer. But if repairs cost \$1,000,000 (20%), the loss is payable in full.

Example of time franchise: A particular hospitalisation policy contains a 2-day franchise provision; in other words, there is a waiting period of two days. If the insured person stays in hospital for one day, no expenses are reimbursable. But if he has to stay for 5 days, the policy pays the medical expenses incurred during the whole of that 5-day period.

- (d) *Policy limits*: As the *sum insured* is the insurer's maximum liability, any loss exceeding that limit will not be fully indemnified. Other types of limits may also exist within the policy terms; examples include:

(i) *Single Article Limit*: It is a limit commonly found in a household contents policy. Where such a policy covers property described in broad terms like 'contents' for a stated amount, there is no way the insurer can tell whether the insured contents will not, at the time of loss, be found to include an article which is so valuable that its value already accounts for, say, 90% of the sum insured for the whole of the contents. This is a situation the insurer will not want to see, partly because of the theft risk it represents. In fact, the insured could have declared the value of this item of contents to the insurer, requiring that it be separately subject to a sum insured representing its value. The benefit of this approach is that the insurer will be liable for an insured loss of this item of property up to its own sum insured. On the other hand, in the event that an insured has not made such an article the subject of a separate sum insured, the insurer will have to restrict the amount payable for a loss of this item to a limit specified in the policy, called the 'single article limit'.

(ii) *Section Limit*: A policy may contain two or more sections, which take effect in relation to different subject matter of insurance (as in the case of a travel insurance policy, which normally covers property damage, legal liability and others), different insured perils, etc. Each of these sections is usually made subject to its own limit of liability, which operates similarly to a sum insured.

3.4.8 Policy Provisions Providing More Than Indemnity

Indemnity is very logical and technically easy to defend. However, in practice, most policyholders are ignorant of this and are confused and offended when insurers 'reduce' their claims, by deducting depreciation, wear and tear, etc. As a marketing or public relations exercise, insurers sometimes offer or agree to grant property insurances which may be said to give a *commercial* rather than a *strict* indemnity. Some examples are as follows:

- (a) *Reinstatement insurances* (or insurances on a reinstatement basis): This is one of the several uses of the term 'reinstatement' (see 3.4.4(d) above) and is often found with fire and commercial 'all risks' insurances. The meaning is that where reinstatement takes place after a loss, no deductions are made from claim payments in respect of wear and tear, depreciation, etc.
- (b) *'New for Old' cover*: Again, this means that no deductions are made in respect of wear and tear, depreciation, etc. This term is more generally used with household and marine hull policies.
- (c) *Agreed value policies* (or valued policies): Such policies may be used for articles of high value, where depreciation is unlikely to be a factor (e.g. works of art, jewellery, etc.) or where property valuation contains a rather subjective element. The sum insured is fixed on the basis of an expert's valuation, and agreed between the insured and the insurer as representing the value at risk of the property *throughout* the currency of the policy. In non-marine insurance, a valued policy undertakes to pay this sum in the event of a total loss, without regard to the actual value at the time of loss, whereas in the event of a partial loss, the actual amount of loss would instead be payable without regard to the agreed value.
- (d) *Marine policies*: Almost without exception, marine hull and marine cargo policies are written on a valued basis, and the agreed value will be taken as the actual value at the time of loss for the purposes of both partial and total loss claims.

3.4.9 The Practical Problems with Indemnity

Indemnity, as mentioned above, is extremely logical. What makes more sense than to say that a person should only recover what he has lost? He should not *profit* from a loss! However, most people feel that they should receive the amount they have insured for, with a total loss. Moreover, the fact or amount of *depreciation* is an area where you, or the claims handler, may definitely expect problems with the claimant. When claims are being made, a lot of claimants will say that their property has not depreciated at all, or only marginally!

3.5 CONTRIBUTION

3.5.1 Equitable Doctrine of Contribution

This is a claims-related doctrine of equity which applies as between insurers in the event of a double insurance, a situation where two or more policies have been effected by or on behalf of the insured on the same interest or any part thereof, and the aggregate of the sums insured exceeds the indemnity legally allowed.

[Example: Suppose a husband and wife each insure their home and contents, each thinking that the other will forget to do it. If a fire occurs and \$200,000 damage is sustained, they will not receive \$400,000 compensation. The respective insurers will share the \$200,000 loss.]

Apart from any policy provisions, any one insurer is bound to pay to the insured the full amount for which he would be liable had other policies not existed. After making an indemnity in this manner, the insurer is entitled to call upon other insurers similarly (but not necessarily equally) liable to the same insured to share (or to contribute to) the cost of the payment.

3.5.2 How Applicable

Contribution will only apply if **indemnity** applies. Thus, if a person dies whilst insured by two or more separate *life insurance* policies, each has to pay in full, because the insurances are not subject to indemnity.

3.6 SUBROGATION

3.6.1 Definition

Subrogation is the exercise, for one's own benefit, of rights or remedies possessed by another against third parties. As a corollary (i.e. a natural consequence of an established principle) of indemnity, subrogation allows proceeds of claim against third party be passed to insurers, to the extent of their insurance payments. At common law, an insurer's subrogation action must be conducted in the name of the insured.

Suppose, for example, that a car, covered by a comprehensive motor policy, is damaged by the negligence of a building contractor. The motor insurer has to pay for the insured damage to the car. *As against the negligent contractor*, the insured's right of recovery will not be affected by the insurance claim payment. However, the motor insurer may, after indemnifying the insured, take over such right from the insured and sue the contractor for the damage in the name of the insured.

From this, it will easily be seen how subrogation seeks to protect the parent principle of **indemnity**, by ensuring that the insured does not get paid twice for the same loss.

3.6.2 How Applicable

As with contribution, **subrogation** can only apply if **indemnity** applies. Thus, if the life insured of a life policy is killed by the negligence of a motorist, the paying life insurer will not acquire subrogation rights, as this payment is not an indemnity.

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Representative Examination Questions

Type 'A' Questions

- 1 Insurable interest may be described as:
- (a) possession of certain goods;
 - (b) the amount always payable for insurance claims;
 - (c) a legally recognised relationship to the subject matter;
 - (d) the interest payments due if the insurance premium is paid late.

[Answer may be found in **3.1.1**]

- 2 For marine insurance, insurable interest is required:
- (a) certainly at the time of loss;
 - (b) only when the policy is first arranged;
 - (c) only at the time the first premium is paid;
 - (d) only if this is specifically mentioned in the policy.

[Answer may be found in **3.1.5**]

Type 'B' Questions

- 3 Which of the following are the types of breach of utmost good faith?
- (i) Fraudulent non-disclosure
 - (ii) Non-fraudulent non-disclosure
 - (iii) Non-fraudulent misrepresentation
 - (iv) Fraudulent misrepresentation
- (a) (i) and (ii) only;
 - (b) (i) and (iii) only;
 - (c) (ii), (iii) and (iv) only;
 - (d) (i), (ii), (iii) and (iv).

[Answer may be found in **3.2.5**]

4 Which **three** of the following insurance policy provisions could mean that something **more** than indemnity is payable with claims?

- (i) 'New for Old' cover
- (ii) Agreed value policies
- (iii) Reinstatement insurances
- (iv) The condition of average

- (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 **3.4.8**]

[If still required, the answers may be found at the end of this Part of the Study Notes.]

4 STRUCTURE OF HONG KONG INSURANCE INDUSTRY

4.1 TYPES OF INSURANCE BUSINESS

Insurance is classified in different cross-cutting ways for different purposes. Without trying to give an exhaustive review, we may consider the topic under three headings:

- (a) *Statutory*: for the purposes of the insurance regulator's authorisation and supervision.
- (b) *Practical*: for the purposes of internal company organisation.
- (c) *Academic*: for the purposes of professional study and training.

4.1.1 Statutory Classification of Insurance

This is found in Schedule 1 of the Insurance Ordinance, which specifies the various classes of business, using essentially the format used in the U.K. and the European Community. The Ordinance divides insurance into *Long Term Business* and *General Business*, with a number of sub-divisions, as follows:

- (a) **Long Term Business** (predominantly Life Insurance): this is divided into nine categories, with a designated letter per class, i.e.

A	<i>Life and annuity</i>	-	life insurance and annuity (see Glossary), excluding class C below
B	<i>Marriage and birth</i>	-	insurance contracts providing benefits payable on marriage or on the birth of a child
C	<i>Linked long term</i>	-	unit-linked life insurance and unit-linked annuity (see Glossary for 'Unit-linked Business')
D	<i>Permanent health</i>	-	essentially long term policies providing benefits for incapacity from accident or for ill-health (the policy is not normally cancellable by the insurer)
E	<i>Tontines</i>	-	A tontine is an unusual contract on a group of persons, the accumulated contributions payable to the last survivor(s) at the end of a defined period.

F	<i>Capital redemption</i>	-	a contract to provide a capital sum at the end of a term in order to replace one's capital because, e.g. debentures will become repayable; not related to human life
G	<i>Retirement scheme management category I</i>	-	group retirement scheme contracts providing for a guaranteed capital or return
H	<i>Retirement scheme management category II</i>	-	group retirement scheme contracts not providing for a guaranteed capital or return
I	<i>Retirement scheme management category III</i>	-	group contracts providing insurance benefits under retirement schemes, but excluding classes G and H above

Note: It will be appreciated that not all the above will have equal significance in the day to day business of the Hong Kong insurance market. For instance, only a handful of companies are currently authorised to write class B, E or F business.

(b) **General Business:** this is divided into 17 categories, with a designated number per class, i.e.

1	<i>Accident</i>	-	this is more usually referred to by insurance practitioners as Personal Accident (and Sickness) , providing benefits or indemnity in the event of accident or sickness
2	<i>Sickness</i>	-	policies providing benefits or indemnity for loss due to sickness or infirmity, but excluding class D above
3	<i>Land vehicles</i>	-	property insurance on vehicles used on land, including motor vehicles but excluding railway vehicles)
4	<i>Railway rolling stock</i>	-	property insurance on such vehicles
5	<i>Aircraft</i>	-	property insurance on aircraft
6	<i>Ships</i>	-	property insurance on ships
7	<i>Goods in transit</i>	-	property insurance on goods in transit, including marine cargo

8	<i>Fire and natural forces</i>	-	property insurance covering fire and some other perils (e.g. storm and explosion)
9	<i>Damage to property</i>	-	property insurance exclusive of classes 3-8 above
10	<i>Motor vehicle liability</i>	-	third party Motor insurance (including compulsory motor insurance)
11	<i>Aircraft liability</i>	-	covering liabilities for property damage or personal injury/death arising out of the use of aircraft
12	<i>Liability for ships</i>	-	covering marine liabilities for property damage or personal injury/death
13	<i>General liability</i>	-	liability insurance exclusive of classes 10-12 above; employees' compensation insurance is included here
14	<i>Credit</i>	-	covering loss to creditors from debtors' failure to pay debts
15	<i>Suretyship</i>	-	contracts of guarantee, including fidelity guarantee, performance bonds (see Glossary for the meanings of these two terms)
16	<i>Miscellaneous financial loss</i>	-	any other classes of business (business interruption, loss of use, etc.)
17	<i>Legal expenses</i>	-	insurance to pay legal costs, with the insured as defendant or as claimant)

Note: 1 Few, if any, local insurers are likely to use the above classification in their internal organisation, but authorisation to transact business will be granted in respect of the classes indicated.

2 While travel insurance is indeed a combination of several of the above categories of insurance, it may be considered to be predominantly 'category 1 Accident insurance'.

4.2 SIZE OF INDUSTRY

As insurance is a dynamic element in the financial services industry of Hong Kong, statistics are always likely to be somewhat out of date. Nevertheless, we may usefully consider this topic under four headings (source of figures: the Insurance Authority, unless otherwise stated):

- (a) number of authorised *insurers* (including those which are professional reinsurers);
- (b) number of registered or authorised *insurance intermediaries*;
- (c) number of persons *employed* in the industry;
- (d) premium volume.

4.2.1 Authorised Insurers

As at 31 December 2013, there were totals as follows:

- (a) **‘Pure’ Long Term Business** (see 4.1.1 (a) above): ‘pure’ in this context means ‘only’ or ‘exclusively’ (specialising) in this class. A total of 44 pure long term insurers were authorised, comprising 16 Hong Kong incorporated companies and 28 others (including 1 from the Mainland of China).
- (b) **‘Pure’ General Business** (see 4.1.1 (b) above): 92 pure general insurers were authorised, comprising 59 Hong Kong incorporated companies and 33 others (including 1 from the Mainland of China).
- (c) **‘Composite’**: the term implies carrying on both Long Term and General Business. 19 insurers were so authorised, comprising 10 Hong Kong incorporated companies and 9 others (none from the Mainland of China).

4.2.2 Registered or Authorised Insurance Intermediaries

As at 31 December 2013, adding the total number of appointed insurance agents and their Responsible Officers and Technical Representatives in Hong Kong to that of authorised insurance brokers and their Chief Executives and Technical Representatives gave a grand total of 81,042.

Note: An ‘*insurance intermediary*’ is defined in the Insurance Ordinance as either an ‘*insurance agent*’ or an ‘*insurance broker*’ (see 5.2 below). Whether the intermediary being referred to is a firm or an individual, the same set of terms are used.

4.2.3 Persons Employed

The biennial Manpower Survey Report on the Insurance Industry in Hong Kong (commissioned by the Vocational Training Council) was most recently conducted in 2013. This survey concluded that the industry on 2 January 2013 had a workforce of 58,900 people. 68% of this workforce were mainly connected with Life Insurance (79% of these being insurance agents or technical representatives of insurance agents) and 32% mainly with General Insurance.

4.2.4 Premium Volume

When discussing premiums, many technical considerations arise which are beyond the scope of the present study. We shall therefore confine ourselves to the broad picture. In 2012 (source of data: the Insurance Authority):

- (a) the gross premiums for *General Insurance Business* (comprising Direct Business and Reinsurance Inward Business) amounted to a total of HK\$39,204.8 million, representing 1.92% of Hong Kong's Gross Domestic Product;
- (b) the premiums for Long Term Business were as follows: HK\$209,041.1 million of Individual Life In-Force Business office premium, HK\$1,978.4 million of Group Life In-Force Business office premium, HK\$9,330.3 million of contributions for Retirement Scheme In-Force Business transacted by insurers, HK\$3,774.4 million of Annuity and Other In-Force Business office premium. The total premium (HK\$224,124.2 million) represents 10.98% of Hong Kong's Gross Domestic Product.

4.3 INSURANCE INTERMEDIARIES

As noted above (4.2.2), insurance intermediaries comprise *insurance agents* and *insurance brokers*. More detailed comments on their respective roles and legal requirements appear elsewhere in these Notes (see especially 5.2 below), but considering them under the topic of the structure of the Hong Kong Insurance Industry, we should note the following:

- (a) **Registration/Authorisation:** Insurance intermediaries in Hong Kong are required by the Insurance Ordinance to be formally registered or authorised, as the case may be (see 5.2.1 below).
- (b) **Qualifications:** Before a person can be registered or authorised to act as an insurance intermediary, he must satisfy certain criteria. These are considered in detail later (see Chapter 5).

- (c) **Role:** It is true that insurance may be arranged *direct* with the insurer, i.e. without using an insurance intermediary, but this is not the norm, especially in Long Term Business. It would be relatively rare, for instance, to find life insurances being arranged in Hong Kong without an insurance intermediary being involved. Also, with complex commercial risks, it is quite normal for an insurance broker to be engaged, in view of the wide experience and independent expertise which they are generally seen to possess. It is therefore quite clear that insurance intermediaries have, and are very likely to continue to have, an important role in the structure of the Hong Kong insurance industry.
- (d) **Market Co-operation:** It would probably be fair to say that the roles of *insurance agents* and *insurance brokers* are quite distinct. All, however, through their market representations and individually, have a common interest in quality service and the integrity of the market.

4.4 THE HONG KONG FEDERATION OF INSURERS ('HKFI')

There is a major insurance trade organisation in the Hong Kong insurance market which you must at least be aware of. This is The Hong Kong Federation of Insurers (HKFI).

- (a) The importance of the HKFI on the local insurance scene cannot be overstated. An important objective of the HKFI is to promote and advance the common interests of **insurers** and **reinsurers** transacting business in Hong Kong. As a major influence in the **self-regulatory** process, the HKFI has numerous areas of activity.
- (b) According to its Mission Statement, the HKFI exists to promote insurance to the people of Hong Kong and build **consumer confidence** in the industry by encouraging the highest standards of **ethics** and **professionalism** amongst its members.
- (c) The HKFI established the *Insurance Agents Registration Board* ('IARB') in January 1993 to perform the dual role of **registering** insurance agents and their Responsible Officers and Technical Representatives, and of **handling complaints** against insurance agents or their Responsible Officers or Technical Representatives, pursuant to the Code of Practice for the Administration of Insurance Agents (see **5.2.2** below).

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Representative Examination Questions

Type 'A' Questions

- 1 The Insurance Ordinance in Hong Kong divides insurance business into two broad categories. One is General Business and the other is:
- (a) Specific Business;
 - (b) Accident Insurance;
 - (c) Long Tail Business;
 - (d) Long Term Business.

[Answer may be found in **4.1.1**]

Type 'B' Questions

- 2 Which **two** of the following are classes of Long Term Business?
- (i) Aircraft liability
 - (ii) Life and Annuity
 - (iii) Permanent Health
 - (iv) Damage to property
- (a) (i) and (ii);
 - (b) (ii) and (iii);
 - (c) (ii) and (iv);
 - (d) (iii) and (iv).

[Answer may be found in **4.1.1(a)**]

[If still required, the answers may be found at the end of this Part of the Study Notes.]

5 REGULATORY FRAMEWORK OF INSURANCE INDUSTRY

All civilised societies recognise that a financial service as important as insurance must be subjected to some form of supervision or control. This is a sensitive area, since on the one hand it is not good for society to ‘strangle’ any kind of worthwhile business activity with excessive controls. On the other hand, left totally unsupervised, the huge amounts of money involved with insurance have over the centuries proved irresistible to fraudsters and irresponsible people, to the great harm and detriment of the societies affected.

A measure of balance is therefore to be sought. That balance, to some extent, is achieved by a judicious mixture of *statutory regulation* and *self-regulation*, where representatives of the industry itself exercise discipline and oversight. Below, we shall examine both these aspects of the Hong Kong insurance industry regulatory framework.

5.1 REGULATION OF INSURANCE COMPANIES IN HONG KONG

The Insurance Companies (Amendment) Ordinance 2015 (‘the Amendment Ordinance 2015’) enacted by the Legislative Council of Hong Kong on 10 July 2015 provides for, among other things, the establishment of a new and independent statutory body officially known as the “Insurance Authority” (‘IA’), as the new insurance regulator independent of the Government, to take over the statutory functions of the Office of the Commissioner of Insurance (‘OCI’) in regulating the insurance industry in Hong Kong.

The policy objectives of setting up the IA are to modernise the insurance industry regulatory infrastructure to facilitate the stable development of the industry, provide better protection for policy holders and potential policy holders, align Hong Kong with the international practice that insurance regulators should be financially and operationally independent of the government and industry, and set up a direct regulatory regime for insurance intermediaries to replace the existing self-regulatory system administered by three self-regulatory organisations (‘SROs’).

5.1.1 Insurance Ordinance

This very important piece of legislation provides the framework for the prudential supervision of the insurance industry of Hong Kong. In fact, it covers not only the supervision and regulation of insurers, but also that of insurance intermediaries. The Insurance Ordinance (Cap. 41), formerly entitled the Insurance Companies Ordinance (‘ICO’), came into effect in June 1983. The principal functions of the then Insurance Authority under the ICO were to ensure that the interests of policy holders and potential policy holders are protected, and to promote the general stability of the insurance industry.

With the relevant provisions of the Amendment Ordinance 2015 coming into operation on 26 June 2017, the ICO was renamed the Insurance Ordinance (Cap. 41). The IA took over the statutory functions of the OCI to regulate the

insurance industry in Hong Kong and the OCI was disbanded on the same day. The principal functions of the new regulator remain unchanged but it is also tasked to (i) regulate the conduct of insurance intermediaries through a licensing regime; (ii) promote the understanding by policy holders and potential policy holders of insurance products and the insurance industry; (iii) formulate effective regulatory strategies and facilitate the sustainable market development of the insurance industry, and promote the competitiveness of the insurance industry in the global insurance market; (iv) conduct studies into matters affecting the insurance industry; and (v) assist the Financial Secretary of the Government in maintaining the financial stability of Hong Kong by taking appropriate measures in relation to the insurance industry.

The IA took over the statutory functions of the OCI on 26 June 2017 to regulate insurance companies; it will eventually take over the regulation of insurance intermediaries from the three SROs through a statutory licensing regime in the next stage (see section 6.2 for the regulation of insurance intermediaries in Hong Kong). Some of the major provisions of the Insurance Ordinance concerning the regulation of insurance companies are outlined below.

5.1.1a Authorisation of Insurers

Any ‘person’ (which may, as a legal term, mean a corporation), before they carry on insurance business in or from Hong Kong, must first of all obtain authorisation to do so from the IA. The Insurance Ordinance prescribes certain minimum requirements for authorisation, relating to such matters as:

- (a) *paid-up capital*;
- (b) *solvency margin*;
- (c) *directors and controllers*;
- (d) *adequate reinsurance arrangement*.

In addition, the IA has issued *Guidelines* which seek to ensure that the applicant insurer is financially sound and otherwise suitable, not only at the time of authorisation but continuing to be so in the future.

5.1.1b Capital Requirement

Minimum paid-up capital required:

- (a) **HK\$10 million:** if carrying on only General or only Long Term business, but not any statutory (or compulsory) insurance business;
- (b) **HK\$20 million:** if carrying on any *statutory* (or compulsory) insurance business, either alone or together with any other insurance business;

- (c) **HK\$20 million:** if carrying on *both* General *and* Long Term business;
- (d) **HK\$2 million** (instead of the above figures): if the insurer is a *Captive Insurer* (see Glossary).

Note: The above figures are merely **minimum** requirements. Insurers in Hong Kong almost invariably have paid-up capital well in excess of these requirements.

5.1.1c Solvency Margin Requirement

‘Solvency’ may be thought of as the point at which *assets* are just sufficient to meet *liabilities*. A *margin of solvency* is therefore the degree or amount by which assets *exceed* liabilities. Insurance companies must have a **solvency margin** of not less than the ‘**relevant amount**’ – the minimum amount of solvency margin required of a particular insurer - as a safeguard against the risk that the insurer may not be able to meet its liabilities. The **relevant amount** is prescribed as follows:

- (a) **General Business:** calculated on two different bases,
 - (i) ‘*Premium Income*’ (the higher the volume of premium income, the larger the relevant amount) and
 - (ii) ‘*Claims Outstanding*’ (the higher the amount of claims outstanding (see Glossary), the larger the relevant amount),

whichever produces the higher figure; and subject to a Minimum Amount of HK\$10 million (or HK\$20 million if carrying on statutory insurance business).

- (b) **Long Term Business:**

Calculated in accordance with the detailed requirements of the Insurance Companies (Margin of Solvency) Regulation, subject to a total of not less than **HK\$2 million**.

- (c) **Composite Business:**

In respect of the Long Term Business, the calculation of the relevant amount follows (b) above. In respect of the General Business, it will be calculated in the usual manner for General Business (see (a) above).

(d) **Captive Insurer:**

Either the ‘premium income’ basis or the ‘claims outstanding’ basis, whichever produces the higher figure; subject to a **minimum of HK\$2 million.**

5.1.1d Fit and Proper Requirement for Controllers, Directors, Key Persons in Control Functions and Appointed Actuaries

Controllers, directors and key persons in control functions of an authorised insurer must be **fit and proper** to assume such a position. In addition, prior approval of the IA is required for an authorised insurer’s appointment of such persons. The appointment of an appointed actuary by a long term insurer is also subject to prior approval of the IA as well as the fit and proper criteria.

In determining whether a person is a fit and proper person for this purpose, the IA will give due regard to the following matters in addition to any other matter that the IA considers relevant:

- (a) education, qualification or experience of the person;
- (b) the person’s ability to act competently, honestly and fairly;
- (c) reputation, character, reliability and integrity of the person;
- (d) the person’s financial status or solvency;
- (e) disciplinary action taken by any other authority or regulatory organisation against the person;
- (f) if the person is a company in a group of companies, any information in the possession of the IA relating to any other company in the group of companies, or to any substantial shareholder or officer of the person or of any other company in the group of companies; and
- (g) the state of affairs of any other business which the person carries on or proposes to carry on.

Related but distinct from the concept of ‘fitness and properness’ is that of corporate governance, which term refers to the rules and practices put in place within a corporation for the management and control of its business and affairs. The IA has issued the **Guideline on the Corporate Governance of Authorised Insurers** (the ‘Guideline on Corporate Governance’), which sets out the minimum standard of corporate governance that is expected of authorised insurers. A high standard of corporate governance established by authorised insurers is

considered to be an essential step in instilling the confidence of the insuring public and encouraging more stable and long term development of the insurance market. The Guideline on Corporate Governance covers all levels of management, and all functions (risk management, underwriting, claims, client servicing, audit, etc.), of an authorised insurer.

5.1.1e Adequate Reinsurance

Reinsurance is an extremely important, in many cases **crucial**, element in the financial security of an insurer. Its importance is much influenced by various factors, including the financial strength of the insurer, and the type and volume of business. The Insurance Ordinance requires authorised insurers to have adequate reinsurance arrangements in force. It is a vital consideration in the overall financial supervision of an insurer, both with regard to the *quantity* and the *quality* (probable ‘**collectability**’) of the reinsurance effected.

The IA has issued and implemented a guideline on the subject, the ‘**Guideline on Reinsurance with Related Companies**’. This Guideline applies only where an authorised insurer reinsures with a ‘related reinsurer’ (meaning one within the same grouping of companies, as defined in Section 2(7)(b) and (c) of the Insurance Ordinance). The reason why this Guideline is important is that the prudent control that any one insurer should exercise on its reinsurance arrangements may possibly be compromised when the reinsurer is related to it. This situation, if allowed to be loosely supervised, will put the interests of the insuring public at risk.

The Guideline aims to promulgate how reinsurance arrangements with related companies will be considered adequate by the IA in terms of financial security, and how the IA intends to address the supervisory concern if such reinsurance arrangements are not considered adequate.

5.1.1f Powers of Intervention

It is often said that for effective supervision, insurance regulators must not only have ‘eyes’, but must also have ‘teeth’. The statutory provisions therefore outline various actions the regulators may take for protecting the interests of policyholders and potential policyholders. These actions include:

- (a) **Limitation of premium income:** if, for example, it is deemed that an insurer is growing too fast or may otherwise be facing potential difficulties with the inevitable liabilities that new business might produce.

- (b) **Restrictions on investments:** on the type and/or location of investments.
- (c) **Restrictions on new business:** on the capacity to effect or vary any contracts of insurance or contracts of insurance of a specified description.
- (d) **Custody of assets by an approved Trustee:** for additional security.
- (e) **Special actuarial investigation:** probably when there is cause for concern on a particular insurer's ability to meet liabilities.
- (f) **Assumption of control by a Manager appointed by the IA:** in serious cases.
- (g) **Winding up (liquidating) the insurer:** in extreme cases; by presenting a petition to the courts.

5.1.2 Code of Conduct for Insurers

This Code was implemented by the Hong Kong Federation of Insurers ('HKFI') in May 1999. It applies to insurance effected in Hong Kong by **individual** (not company) policyholders resident in Hong Kong, insured in their *private capacity* only.

5.1.2a Objectives

These set out the expected standards of **good insurance practice** relating to such matters as

- (a) underwriting and claims;
- (b) product understanding;
- (c) customers' rights and obligations under insurance contracts;
- (d) customers' rights and interests generally;
- (e) the industry's public image as a good corporate citizen.

Sections of the Code relevant to the activities of insurance agents are covered below.

5.1.2b Advising and Selling Practices

This Part of the Code makes specific comment on:

- (a) **Sales Materials:** these should be up to date, accurate, in understandable language and not misleading to the public.

- (b) **Proposal/Application Forms:** these are documents of prime importance to the formation of the contract, being the vehicle through which the intending insured supplies information to the insurer. As such, the forms should:
 - (i) be in understandable language, with clear guidance as necessary;
 - (ii) carefully explain the significance of *utmost good faith* requirements;
 - (iii) make matters of *material significance* the subject of clear questions;
 - (iv) explain carefully the importance of any associated questionnaires.
- (c) **Policies:** these provide visible evidence of the insurance contract terms. As such, they should be clear and as understandable as possible to the consumer. Also, any utmost good faith implications regarding material facts to be disclosed at *renewal* should be carefully explained.
- (d) **Administration:** this covers such matters as *confidentiality*, *service standards*, *customer enquiries* and the fact that customers should not be the loser from *inaccuracy* on the part of the insurer's employees.
- (e) **Medical Evidence:** confirmation that the *Personal Data (Privacy) Ordinance* requirements will be observed in this sensitive area.

5.1.2c Claims

Since claims, or their possibility, are at the heart of insurance, clear statements are necessary to establish good practice in this area. These include:

- (a) **General Handling:** should be fair, efficient and speedily.
- (b) **Denial of Claims:** This should **not** happen
 - (i) unreasonably, especially with *non-disclosure* of material facts and particularly where no proposal form was obtained;
 - (ii) with *innocent misrepresentation* of material facts (other than with **marine** or **aviation** insurance);

- (iii) with a *breach of warranty* committed **without fraud**, where it has **not caused the loss**.
- (c) **Claim Forms:** to be issued promptly without charge, and in understandable language.
- (d) **Other Issues:** specific mention is made of other matters such as:
 - (i) claimants to be kept *reasonably informed* of claim progress;
 - (ii) *reasonable explanation* to be given, if a claim cannot be admitted;
 - (iii) payment made **promptly** with *valid claims*;
 - (iv) third parties acting for the insurer (*adjusters* etc.) should always act reasonably and should be professionally qualified.

5.1.2d Management of Insurance Agents

Generally, insurers are to ensure that insurance agents comply with the law and all relevant HKFI Codes. Specifically, insurers should give attention to the following:

- (a) **Registration:** all insurance agents must be registered under the provisions of the Insurance Ordinance and governed by the *Code of Practice for the Administration of Insurance Agents* (see **5.2.2** below).
- (b) **Complaints:** proper procedures should be in place to deal with complaints against insurance agents.
- (c) **Adequate Support:** insurers should ensure that insurance agents have adequate support to perform their duties efficiently.
- (d) **Miscellaneous:** insurers must not seek to limit their liability for the actions of their insurance agents and should ensure as far as possible that the insurance agents act fairly and honestly.

5.1.2e Inquiries, Complaints and Disputes

Insurers should handle inquiries in a fair and timely manner, have in place documented internal complaint-handling procedures for resolving complaints by policyholders, and:

- (a) comply with the *Code of Practice for the Administration of Insurance Agents* (see **5.2.2** below), which provides an external

mechanism for dealing with complaints against insurance agents;
and

- (b) participate in the *Insurance Claims Complaints Bureau* ('ICCB') (see **5.1.4** below), which adjudicates insurance claims disputes between insurers and individual policyholders.

5.1.3 Guidelines on Complaint Handling

The HKFI has issued the 'Guidelines on Complaint Handling' to supplement the requirements stipulated in the Code of Conduct for Insurers on the handling of inquiries, complaints and disputes. The Guidelines apply to complaints about an insurer's provision of, or failure to provide, a service or product. They are summarised as follows:

5.1.3a Recommended Internal Complaint Handling Procedures

- (a) **General Principles:** The Guidelines lay down general principles for complaint handling procedures as: comprehensive cover, transparency and accessibility to customers, ease of use, fairness, impartiality, consistent approach to provision of redress, flexibility, simplicity, promptness, efficiency, measurability of performance standards, and provision of feedback to all the relevant regulatory or public bodies.
- (b) **Policies and Procedures:** Insurers should have in place appropriate and effective internal procedures for handling customer complaints, subjected to management controls. The procedures should be in writing, and should at least cover:
 - receipt of complaints;
 - response to complaints;
 - investigation of complaints; and
 - provision of redress.
- (c) **Accessibility:** Insurers should ensure that customers know where and how to complain, and that complaints are courteously received. They should:
 - publish their internal complaint handling procedures;
 - provide access to them in each of their offices;
 - supply them freely to customers upon request;
 - supply them freely and automatically to complainants;
 - inform new customers of the availability of the procedures.

- (d) **Communications:** Complainants should be allowed to complain by any reasonable means, including verbal means. Communications with complainants should be made in clear and plain language, and in a language that the complainants desire or use.
- (e) **Confidentiality:** Information relating to complaints including the complainants' identity should be treated as confidential, and access to it restricted.
- (f) **Independence and Authority in Handling Complaints**
- Complaints should not be investigated by an employee who was directly involved in the matter complained about;
 - Those responsible for responding to complaints must have the authority to settle them or have ready access to those who have it;
 - Serious matters should be brought to the attention of senior management.
- (g) **Redress:** Where a complaint is upheld, appropriate redress (e.g. apology, fair compensation, including compensation for loss of interest) should be offered.
- (h) **Resources and Staff Training**
- Adequate resources should be provided to ensure the efficiency and effectiveness of the complaint management system;
 - Insurers should ensure that all relevant employees and registered persons are aware of the procedures and comply with them. Staff having contact with customers should be trained in complaints handling.
- (i) **Monitoring and Audit**
- Effective procedures should be set up to monitor complaints and to make regular reports for senior management's review.
 - To measure the attainment of the procedures, regular audits should be conducted by competent and independent staff. Based on the results of the audits, improvements to the procedures, where necessary, should be made by competent staff.

- (j) **Management Review:** Insurers should carry out periodic reviews of the ability of their complaint management systems to meet customers' expectations.
- (k) **Time Limit for Dealing with Complaints:** Upon receipt of a complaint, the insurer should send a written acknowledgement advising the complainants of:
 - the name or job title and contact details of the complaint handler;
 - expected date of final response to the complaint; and
 - the internal complaint handling procedures.
- (l) **Final Response**
 - Insurers are encouraged to give the complainant, no later than 30 days after receiving the complaint,
 - (a) a final response, or
 - (b) the reasons for not being able to make the final response yet together with the expected date of a final response.
 - Insurers should consider including in the final response:
 - (a) the outcome of the investigation,
 - (b) whether there has been fault on the part of the insurer,
 - (c) what redress, if any, will be made, and
 - (d) when the redress will be made.

5.1.3b External Dispute Resolution

Insurers should inform the complainants of the existence of the following bodies/regulator to which the complaints could be referred if they are not satisfied with the insurers' response:

- Insurance Agents Registration Board;
- The Insurance Claims Complaints Bureau; and
- Insurance Authority.

5.1.3c Record Keeping

Insurers should record details of complaints properly, and provide them to the relevant self-regulatory bodies/regulator upon request.

5.1.4 Insurance Claims Complaints Bureau ('ICCB')

The ICCB has a membership of all authorised insurers underwriting personal insurance in Hong Kong. Its primary objective is to handle insurance claims complaints from individual policyholders, arising out of personal contracts with its members.

5.1.4a Composition and Powers

- (a) The *Insurance Claims Complaints Panel* (the 'Panel') is appointed by the ICCB to handle complaints. It consists of a Chairman and four members and is **independent** in the sense that the incumbent Chairman is independent of the industry and is appointed with the prior consent of the Secretary for Financial Services and the Treasury.
- (b) Of the four members on the Panel, two are nominated by the HKFI, and two from outside the insurance industry (one representing the legal/accounting profession and the other representing consumer interests).
- (c) No fee is charged to the complainant, whether he wins his case or not.
- (d) The Panel can make an award against an insurer up to **HK\$800,000**, who has no right of appeal against an award. If the complainant is unsatisfied with an award, he may, however, seek legal redress.
- (e) Further points on the powers of the Panel: The Articles of Association of the ICCB stipulates that the Panel, in making its ruling, '*shall have regard to and act in conformity with the terms of the relevant policy, general principles of good insurance practice, any applicable rule of law or judicial authority; and any codes and guidelines issued from time to time by the Hong Kong Federation of Insurers (HKFI) or the Bureau. In respect of the terms of the policy contract, these shall prevail unless they would, in the view of the Complaints Panel, produce a result that is unfair and unreasonable to the complainant*'. The gist of these provisions is that, the Panel, in making a ruling, is given the power by the ICCB Members to look beyond the strict interpretation of policy terms.

As far as good insurance practice is concerned, the Panel relies heavily on the expected standards set out in *The Code of Conduct for Insurers*, with particular reference to 'Part III: Claims'. The first requirement of the section states, '*Insurers should seek to handle all claims efficiently, speedily and fairly*'. As such, as to

whether an insurer has acted fairly in the settlement of claims or not is subjected to the scrutiny of the Panel.

5.1.4b Terms of Reference

To summarise, the ICCB can only deal with a particular case if:

- (a) the complaint is **claim-related**;
- (b) the claim amount does not exceed **HK\$800,000**;
- (c) the insurer concerned is an **ICCB member**;
- (d) the policy concerned is a personal insurance policy;
- (e) the complaint is filed by a policyholder/beneficiary/rightful claimant (e.g. an assignee);
- (f) the insurer concerned has made its final decision on the claim;
- (g) the complaint is filed within 6 months from the date of notification of the insurer's final decision on the claim;
- (h) the dispute in question does not arise from **commercial, industrial or third party** insurance; and
- (i) the claim is not subject to **legal proceedings or arbitration**.

5.2 REGULATION OF INSURANCE INTERMEDIARIES IN HONG KONG

The self-regulatory system for insurance intermediaries, i.e. insurance agents and brokers, has been in operation since 30 June 1995. It is supported by legislation which is contained in Part X of the Insurance Ordinance (Cap. 41) (formerly known as the Insurance Companies Ordinance). Under the current self-regulatory regime, insurance intermediaries are required to be registered with and be regulated by one of the three self-regulatory organisations ('SROs'), namely the Insurance Agents Registration Board (IARB), the Hong Kong Confederation of Insurance Brokers (CIB) and the Professional Insurance Brokers Association (PIBA).

As mentioned in section **5.1.1**, the Insurance Authority took over the functions of the OCI on 26 June 2017 to regulate insurance companies; it will eventually take over the regulation of insurance intermediaries from the three SROs through a statutory licensing regime in the next stage. In the meantime, the existing self-regulatory system for insurance intermediaries will continue.

Some details of the requirements of the current regulatory system are set out below.

5.2.1 Roles and Responsibilities of Insurance Agents and Brokers

- (a) **‘Insurance agent’:** The Insurance Ordinance prohibits any person from acting as an **‘insurance agent’** unless he has become an **‘appointed insurance agent’** in accordance with the relevant provisions of the Insurance Ordinance. (Remember that in law a corporation is a ‘person’.)

But what is an ‘insurance agent’? In the Insurance Ordinance, *‘a person who holds himself out to advise on or arrange contracts of insurance in or from Hong Kong as an agent or subagent [i.e. an agent of an agent] of one or more insurers’* is termed an ‘insurance agent’.

How to become an ‘appointed insurance agent’? To become an ‘appointed insurance agent’, one must get registered with and appointed by an insurer.

- (b) **‘Insurance broker’:** The Insurance Ordinance prohibits any person from acting as an ‘insurance broker’ unless he has become an ‘authorised insurance broker’ in accordance with the relevant provisions of the Insurance Ordinance.

But what is an ‘insurance broker’ within the meaning of the Insurance Ordinance? *‘A person who carries on the business of negotiating or arranging contracts of insurance in or from Hong Kong as the agent of the policyholder or potential policyholder or advising on matters related to insurance’* is termed an ‘insurance broker’ in the Insurance Ordinance.

How to become an ‘authorised insurance broker’? To become an ‘authorised insurance broker’, one either has to obtain authorisation from the Insurance Authority or to become a member of a body of insurance brokers that has been approved by the Insurance Authority for such purpose.

- (c) **No wearing of two hats:** The Insurance Ordinance prohibits any person from being *an appointed insurance agent and an authorised insurance broker at the same time*, whether in relation to the same or different clients.
- (d) **Further Insurance Ordinance prohibitions:**
- (i) A proprietor of, or partner in, an insurance agent shall not be a proprietor or employee of, or partner in, another insurance agent or an insurance broker.
 - (ii) An employee of an insurance agent who provides insurance advice to a policy holder or potential policy holder shall not be a proprietor or employee of, or partner in, another insurance agent or an insurance broker.

- (iii) A proprietor or employee of, or partner in, an insurance agent may be a director of another insurance agent or of an insurance broker only if he does not provide insurance advice to a policy holder or potential policy holder for the company.
- (iv) Where a director of an insurance agent does provide insurance advice to a policy holder or potential policy holder, he may be a director of another insurance agent or of an insurance broker only if he does not provide insurance advice to a policy holder or potential policy holder for the other company.
- (v) A proprietor of, or partner in, an insurance broker shall not be a proprietor or employee of, or partner in, an insurance agent.
- (vi) An employee of an insurance broker who provides insurance advice to a policy holder or potential policy holder shall not be a proprietor or employee of, or partner in, an insurance agent.
- (vii) A proprietor or employee of, or partner in, an insurance broker may be a director of an insurance agent only if he does not provide insurance advice to a policy holder or potential policy holder for the insurance agent.
- (viii) Where a director of an insurance broker does provide insurance advice to a policy holder or potential policy holder, he may be a director of an insurance agent only if he does not provide insurance advice to a policy holder or potential policy holder for the insurance agent.

Note: Breach of the relevant provisions of the Insurance Ordinance is a serious **criminal offence**. For example, claiming to be an insurance broker without having obtained an authorisation, could result in a fine as much as **HK\$1 million** and **2 years'** imprisonment on conviction upon indictment (or up to **HK\$100,000** and **6 months'** imprisonment on summary conviction).

5.2.1a Appointed Insurance Agent's Relationship with Insurer

The Insurance Ordinance says that an 'appointed insurance agent' (note: it does not say 'insurance agent') is the agent of the insurer when dealing with a third party for (1) the issue of a contract of insurance and (2) insurance business relating to the contract. What this provision is largely saying is that whenever someone who is an appointed insurance agent of an insurer is dealing with a client in respect of (1) or (2) above, he is treated as having authority to bind the insurer; in other words, the insurer will be vicariously liable to the client for the agent's acts or omissions in the course of such dealings.

You will recall the common law rule you have learnt in Chapter 2 that the principal is vicariously liable for the agent's conduct. But if you think that the said Insurance Ordinance provision is just repeating this common law rule, you are missing the essence of the Insurance Ordinance with respect to regulation of insurance agents.

Before the said provision was enacted, a dispute between an insured and an insurer as to for whom an insurance intermediary has acted would have to be adjudicated on the basis of the relevant common law rules. In the common law, the nub of this issue is best represented by this question: 'For whom at the material time was the insurance intermediary acting in respect of the act which is alleged to have given rise to a contract or transaction between the insured and the insurer?' The courts would resolve this question on the particular facts of the case and might possibly hold that the insurance intermediary was an agent of the insured for the act in question, even if he was at and about the material time in the business of insurance agency rather than insurance broking. In other words, this is a question of *fact*, rather than a question of law.

Now that the said provision has come into effect, when a similar dispute arises, the insurer will be held vicariously liable for the acts of the insurance intermediary provided that he was at the material time its 'appointed insurance agent' and that the acts in question fall within the scope of (1) or (2) (see the first paragraph of **5.2.1a**).

5.2.2 The Code of Practice for the Administration of Insurance Agents (the Code)

The Code is in seven Parts (A - G) and was issued by the HKFI with the approval of the Insurance Authority ('IA') in accordance with the provisions of the Insurance Ordinance. It is therefore of considerable legal and professional importance. The following summary of the Code should be noted carefully.

5.2.2a PART A: Interpretation

Two matters to note are:

- (a) Various definitions for the purposes of the Code, and these Notes, i.e.

<i>"HKFI"</i>	= The Hong Kong Federation of Insurers
<i>"IARB"</i>	= the Insurance Agents Registration Board established by the HKFI to administer the Code pursuant to Article 48 of its Amended Articles of Association
<i>"Individual Agent"</i>	= an Insurance Agent who is an individual, natural person and who is not registered as an Insurance Agency

"Insurance Agency" = an Insurance Agent operating as an insurance agency business in the form of a sole proprietor, a partnership or a corporation

"Insurance Agent" = a person who holds himself out to advise on or arrange contracts of insurance in or from Hong Kong as an agent or subagent of one or more insurers and for the purposes of the Code includes:

(i) an Individual Agent; and

(ii) an Insurance Agency; but does not include a Responsible Officer or a Technical Representative of an insurance agent

"Line of Insurance Business" = (a) General Business (as defined in the *Insurance Ordinance*);

(b) Long Term (excluding Linked Long Term) Business (as defined in the *Insurance Ordinance*);

(c) Long Term (including Linked Long Term) Business (as defined in the *Insurance Ordinance*); and/or

(d) Restricted Scope Travel Business

"Principal" = an insurer to whom Part X of the Insurance Ordinance applies. However, unless otherwise stated, persons collectively represented as a syndicate of Lloyd's should be treated as one Principal for the purposes of any insurance business relating to the syndicate

"Registered Person" = a person who has been registered under clause **15** or **30** of the *Code* as either:

(a) an Individual Agent;

(b) an Insurance Agency;

(c) a Responsible Officer of an Insurance Agency; or

(d) a Technical Representative of an Individual Agent or Insurance Agency

"Responsible Officer" in relation to an Insurance Agent which is an Insurance Agency = a person who, alone or jointly with others, is responsible for the conduct of the insurance agency business of such Insurance Agent, not being a person who:

- (i) is also responsible for the conduct of other business; and
- (ii) has a subordinate responsible for the whole of the insurance agency business

"Responsible Officer" in relation to an Insurance Agent which is an Insurance Agency formed outside Hong Kong = a person who, alone or jointly with others, is responsible for the conduct of the whole of the insurance agency business of such Insurance Agent carried on within Hong Kong, not being a person who:-

- (i) is also responsible for the conduct of the insurance agency business carried on by the Insurance Agent elsewhere; and
- (ii) has a subordinate responsible for the whole of the insurance agency business carried on by the Insurance Agent within Hong Kong

"Restricted Scope Travel Business " = effecting and carrying out contracts of travel insurance tied to a tour, travel package, trip or other travel services which the same travel agent arranges for his clients, excluding any annual travel insurance policies or any travel insurance policies for tours, travel packages, trips or other travel services which the travel agent does not arrange for his clients

"Technical Representative" in relation to an Insurance Agent = a person (not being an insurance subagent, who is classified as an Insurance Agent for the purposes of the *Code*) who provides advice to a policy holder or potential policy holder on insurance matters for such Insurance Agent, or arranges contracts of insurance in or from Hong Kong on behalf of that Insurance Agent

- (b) All words and expressions not defined in the *Code* carry the meanings ascribed to them by the *Insurance Ordinance*. In the event of a conflict between the *Code* and the *Insurance Ordinance*, the *Insurance Ordinance* will prevail and the *Code* will be invalid to the extent of any such inconsistency.

5.2.2b PART B: General Principles

- (a) **Functions of the IARB:** subject to any general or specific directions given to it by the HKFI as to the execution of its functions under the *Code*, the IARB may do anything it considers necessary or desirable for the purposes of implementing and administering the provisions of the *Code*. Specifically, the IARB may:
- (i) investigate any matters in respect of any application for registration or renewal of registration of a proposed Registered Person or Registered Person, or any complaints against any Registered Person;
 - (ii) refer any matters or complaints received by it to any Principal or Registered Person as appropriate for investigation;
 - (iii) receive investigation reports from any Principal or Registered Person relating to any matters or complaints;
 - (iv) require any Principal or Registered Person to take disciplinary or other action in respect of a Registered Person;
 - (v) register Insurance Agents, Responsible Officers and Technical Representatives as Registered Persons or revoke such registration; and
 - (vi) report to the IA where it appears to the IARB that any Registered Person, Principal or insurer has breached Part X of the *Insurance Ordinance* or the *Code*, or that any Registered Person is not or has ceased to be a fit and proper person to be registered as such.
- (b) **Guidance Notes:** the HKFI/IARB may issue Guidance Notes from time to time as to how it intends to exercise its powers and fulfil its responsibilities under the *Code*.
- (c) **Interpretation of the Code:** the *Interpretation and General Clauses Ordinance* shall apply to the construction and interpretation of the English language text and Chinese language text of the *Code*, and the HKFI has the power to determine the meaning of both versions and to resolve inconsistencies, if any, between them. Its determination will be conclusive and binding.

5.2.2c PART C: Rules

- (a) **Confirmation of Appointment** of an Insurance Agent by his Principal or of a Responsible Officer or Technical Representative by his appointing Insurance Agent must not take place until the IARB's confirmation is obtained.
- (b) **Registration of Insurance Agents, Responsible Officers and Technical Representatives**
- (i) The IARB, on behalf of the relevant Principal, may, upon application in the prescribed manner and payment of the prescribed fee, register an insurance agent as the insurance agent of that Principal. It may, upon application in the prescribed manner by an insurance agent and payment of the prescribed fee, also register a person as a Responsible Officer or Technical Representative of an insurance agent.
- (ii) Each registration will be for a specified period, **not exceeding three years**. A Principal may apply for re-registration of an Insurance Agent, and an Insurance Agent may apply for re-registration of his Responsible Officer/Technical Representative, not earlier than **3 months** before the current registration expires. (**Note:** the appointees are required to fulfil the 'fit and proper' criteria (see **5.2.2e** below), including the requirement of the Continuing Professional Development Programme.)
- (iii) The Registered Person has to disclose the registration number that the IARB assigned to him if so requested, and identify the number on his business cards, if distributed. He also has to display his name and registration number on the name plate put in front of the service desk or counter if he is registered as engaging in the Restricted Scope Travel Business and provides face-to-face insurance service at service desk or counter.
- (c) **Cancellation of Registration:** the appointing Principal or appointing Insurance Agent, as the case may be, has to notify the IARB within **7 days** of an appointee ceasing to be an appointed Insurance Agent of the Principal, or a Responsible Officer or Technical Representative of the Insurance Agent and provide such details as the IARB may require. When such notification is received, the relevant registration of the appointee is deemed cancelled and the IARB has to remove the Insurance Agent from the relevant part of the register of Insurance Agents or remove the Responsible Officer or Technical Representative from the relevant part of the sub-register of Responsible Officers and Technical Representatives, as the case may be.

- (d) **Representation of Principals by Insurance Agents** is subject to the following:
- (i) A person must not act as or be registered as an Insurance Agent for more than four Principals of whom no more than two may be insurers who conduct Long Term Business;
 - (ii) for the purposes of (i) above, a **composite** insurer constitutes **two** Principals, one general and one long term, unless the Insurance Agent's activities are restricted to either (i) General Business or Restricted Scope Travel Business or (ii) Long Term Business;
 - (iii) for the purposes of (i) above, a **group** of companies (see Glossary) constitutes one Principal if their activities are limited to either (i) General Business or Restricted Scope Travel Business or (ii) Long Term Business; or two Principals if their activities include both (i) General Business or Restricted Scope Travel Business and (ii) Long Term Business unless the Insurance Agent's activities are restricted to either (i) General Business or Restricted Scope Travel Business or (ii) Long Term Business;
 - (iv) for the purposes of (i) above, a group of Lloyd's syndicates constitutes:
 - (1) one Principal if the activities of the syndicates are limited to either (i) General or Restricted Scope Travel Business or (ii) Long Term Business;
 - (2) one Principal if the activities of the syndicates include both (i) General or Restricted Scope Travel Business and (ii) Long Term Business, but the insurance agent's activities are restricted to just one of those activities;
 - (3) two Principals if the activities of the syndicates include both (i) General or Restricted Scope Travel Business and (ii) Long Term Business, and the insurance agent's activities are not restricted to either (i) General or Restricted Scope Travel Business or (ii) Long Term Business.
 - (v) the Insurance Agent has to obtain the consent of his Principal(s) **prior** to accepting an appointment to act as an Insurance Agent for another Principal.

- (vi) Subject to (i)-(iii) above, if a person is registered as an agent of another Insurance Agent, he is deemed to act for and has to register to represent all the Principal(s) of the appointing Insurance Agent. In addition, he is deemed to engage in and has to register for all appointed Line(s) of Insurance Business of the appointing Insurance Agent.
- (e) **Representation of Insurance Agents by Responsible Officers and Technical Representatives:** A person must not act as a Responsible Officer or Technical Representative for more than one Insurance Agent.
- (f) **Obligations of Principals** in respect of Insurance Agents: The Principal has to ensure that the Insurance Agent:
 - (i) does not, at any one time, act for more than the maximum number of Principals allowed;
 - (ii) is eligible to engage in a Line of Insurance Business in respect of which the Principal is authorised to conduct and in which he has appointed the Insurance Agent to engage;
 - (iii) meets the ‘fit and proper’ criteria set out in the Code;
 - (iv) has his appointment confirmed by and is registered with the IARB;
 - (v) is appointed as an Insurance Agent of the Principal **in writing** by an **agency agreement** that requires the Insurance Agent to comply with Part F (Minimum Requirements of Model Agency Agreement) of the Code (see **5.2.2f** below);
 - (vi) discloses his registration number upon request, and identifies the number on his business cards, if distributed;
 - (vii) displays his name and registration number on the name plate put in front of the service desk or counter if he is registered as engaging in Restricted Scope Travel Business and provides face-to-face insurance service at the service desk or counter;
 - (viii) complies with the Code; and
 - (ix) has been licensed as a travel agent under the *Travel Agents Ordinance* where the Insurance Agent is registered to engage in Restricted Scope Travel Business.
- (g) **Obligations of Insurance Agents** in respect of their Responsible Officers and Technical Representatives: An Insurance Agent has to ensure that any person acting as its Responsible Officer or Technical Representative:

- (i) does not, at any one time, act for more than one Insurance Agent;
 - (ii) meets the ‘fit and proper’ criteria for Registered Persons set out in the Code;
 - (iii) is eligible to engage in a Line of Insurance Business in which the Insurance Agent is eligible to engage;
 - (iv) has his appointment confirmed by and is registered with the IARB;
 - (v) discloses his registration number upon request, and identifies the number on his business cards, if distributed;
 - (vi) displays his name and registration number on the name plate put in front of the service desk or counter if he is registered as engaging in Restricted Scope Travel Business and provides face-to-face insurance service at the service desk or counter; and
 - (vii) complies with the Code.
- (h) **Obligations of Responsible Officers:** a Responsible Officer of an Insurance Agent has to ensure that all Technical Representatives of that Insurance Agent comply with the Code.
- (i) **Training of insurance agents** has to be sufficiently provided by the Principal so that a **reasonable person** receiving such training would:
- (i) be familiar with the requirements of the Insurance Ordinance and the Code; and
 - (ii) be able to competently undertake the duties of an Insurance Agent in accordance with the requirements of the Insurance Ordinance and the Code.
- (j) **Training of Responsible Officers and Technical Representatives** has to be sufficiently provided by the Insurance Agent so that a **reasonable person** receiving such training would:
- (i) be familiar with the requirements of the Insurance Ordinance and the Code; and
 - (ii) be able to competently undertake the duties of a Responsible Officer or Technical Representative, in accordance with the requirements of the Code.

5.2.2d PART D: Procedures

- (a) The **IARB** has to maintain a register of Insurance Agents, and a sub-register of Insurance Agents' Responsible Officers and Technical Representatives, whose appointments it has confirmed. The register and sub-register have to be kept in a manner and form determined by the IA and be available for public inspection at any time at the website of the HKFI or during normal working hours at the HKFI's registered office.
- (b) **Applications** for confirmation of appointment and registration of Registered Persons are in substance subject to the following:
 - (i) an application for registration as an Insurance Agent has to be submitted by the relevant Principal, and an application for registration as a Responsible Officer or Technical Representative has to be submitted by the appointing Insurance Agent;
 - (ii) they have to be in a manner and form prescribed by the IARB;
 - (iii) the appointing Principal or the appointing Insurance Agent, and the applicant, have to provide to the IARB such additional, relevant information as the IARB may require;
 - (iv) the IARB is not required to consider an application unless it is made in the prescribed manner and form, it is complete and the information requested has been provided in full;
 - (v) if the appointing Principal or the appointing insurance agent becomes aware of any changes in the circumstances of an applicant who is the subject of a pending application which may potentially affect the IARB's consideration of the application, they have to notify the IARB forthwith of such changes;
 - (vi) the applicant has to satisfy the IARB that he is **fit and proper** to be or continue to be registered as a Registered Person and, unless the IARB is so satisfied, it must not confirm the appointment of the applicant as a Registered Person.

(c) **Procedures for Determining Fitness and Propriety of Registered Persons and Complaints against Registered Persons.**

If the IARB becomes aware of any matter or complaint which may involve a breach of the Code or render a Registered Person not fit and proper to remain appointed and registered as a Registered Person:

- (i) the IARB may investigate the matter or complaint or refer it to any Principal or Registered Person for investigation;
- (ii) if the matter or complaint is referred to a Principal or Registered Person for investigation, the Principal or the Registered Person has to diligently and expeditiously investigate the matter or the circumstances of the complaint, and, if so requested by the IARB, report the progress and findings of the investigation within 14 days of the date of referral or such further period as may be specified by the IARB. The IARB may request the Principal and/or the Registered Person to conduct further inquiries;
- (iii) if the IARB considers that it will likely take disciplinary or other action if the matter or complaint is proven, it has to provide (i) the respondent to whom the matter or complaint relates and (ii) any Principal or appointing Insurance Agent who will likely be adversely affected by such action, with an opportunity to make representations in such a manner and form as it considers appropriate and within 14 days or such further period as it may specify, and the IARB has to consider such representations;
- (iv) when all representations concerning the matter or complaint have been considered by the IARB and it is of the view that either there has been a breach of the Code or the matter at issue renders the respondent not fit and proper to be or continue to be registered as a Registered Person, it may take disciplinary or other action in the manner set out in (v) below and/or require the Principal or any Registered Person (including the respondent's appointing Insurance Agent) to take disciplinary or other action in the manner set out in (v) below;
- (v) disciplinary or other action may include:
 - (1) issuing a **reprimand** to the relevant respondent ;

- (2) **suspending or terminating** the appointment of the relevant respondent;
- (3) taking or refraining from taking such **other action** (including refunding premiums paid by persons affected by the conduct of the relevant respondent) as the IARB thinks fit;

Any respondent whose appointment has been terminated in these circumstances will have their registration cancelled and will be barred from appointment and registration as an Insurance Agent, a Responsible Officer or Technical Representative for a period specified by the IARB;

- (vi) when taking disciplinary or other action and/or when requiring any Principal or Registered Person (including the respondent's appointing Insurance Agent) to take disciplinary or other action, the IARB has to serve upon:

- (1) any party who is the subject of disciplinary or other action; and
- (2) any Principal or Registered Person (including the respondent's appointing Insurance Agent) required to take or otherwise likely to be adversely affected by disciplinary or other action;

a notification of the disciplinary or other action and a statement of the grounds thereof;

- (vii) if a relevant Principal and/or Registered Person (including the respondent's appointing Insurance Agent) fails to comply with a requirement to take disciplinary or other action, the IARB may report such failure to the IA and impose a further requirement by way of disciplinary or other action on the Principal or Registered Person (including the respondent's appointing Insurance Agent) who has failed to comply; and
- (viii) Registered Persons and Principals have to comply with any directions issued by the IARB in connection with the conduct of investigations or proceedings carried out in accordance with the abovementioned procedures. The IARB may, in its discretion, vary the procedures in any particular case where it considers it appropriate to do so.

- (d) The *Code* provides for an **Appeals Tribunal**, which is to determine appeals against the IARB's decisions, in respect of which the following apply:
- (i) its decisions shall be **final**;
 - (ii) its members shall be persons (not being members of the IARB) **nominated** by the HKFI and **confirmed** by the IA;
 - (iii) an appeal lies in the following circumstances;
 - (1) Where the IARB refuses to confirm an application for registration under the *Code*, the applicant will be entitled to appeal to the Appeals Tribunal; and
 - (2) Where the IARB determines to impose disciplinary or other action under the *Code*, the party who is the subject of the disciplinary or other action will be entitled to appeal to the Appeals Tribunal;
 - (iv) any decision of the IARB which is subject to a right of appeal will take effect 14 days after the party with a right of appeal has been notified of the decision;
 - (v) any party with a right of appeal in respect of a decision of the IARB may apply to it for a stay of the decision pending the outcome of their appeal, which application may be granted at its discretion. If an application for a stay is made prior to the decision taking effect, the decision will not take effect until it has determined the stay application. If an application for a stay is made after the decision has taken effect, the decision will continue in effect pending determination of the application and the IARB, in deciding whether to grant a stay, will consider whether a stay is reasonable and practicable in the circumstances;
 - (vi) the Appeals Tribunal may determine its own procedures, but otherwise an appeal has to be conducted and determined in accordance with the Appeals Tribunal Proceedings Rules;
 - (vii) the Appeals Tribunal may confirm, vary or reverse the IARB's decision being appealed or substitute such other decision, consistent with the powers of the IARB, as it thinks fit.
- (e) **Reports to the IA** may be made by the IARB on any matters concerning a complaint or an investigation under the *Code*, and such disclosures if made in good faith will not incur any liability for the IARB or its members towards any person concerned.

5.2.2e PART E: 'Fit and Proper' Criteria for Registered Persons

- (a) In considering whether a person is fit and proper to be or continue to be registered as a Registered Person, the IARB may take into account:
- (i) whether that person has ever been declared bankrupt;
 - (ii) whether that person has ever been a controller, a director, a company secretary or a senior manager of a corporation that has become insolvent in Hong Kong or elsewhere;
 - (iii) whether the person has acquired educational or other qualifications commensurate with his proposed responsibilities or responsibilities as a Registered Person;
 - (iv) whether the person has ever been convicted of any criminal offence in Hong Kong or elsewhere which may affect his fitness, suitability or properness to be registered as a Registered Person;
 - (v) whether the person has ever been found guilty of misconduct in a profession, trade or industry to which he belongs or has belonged;
 - (vi) whether the person has ever been subject to any order of the court or other competent authority in Hong Kong or elsewhere for fraud, dishonesty or misfeasance
 - (vii) whether the person has failed to conduct insurance agency business in a manner complying with Part F: Minimum Requirements of Model Agency Agreement, and Part G: Conduct of Registered Persons (see **5.2.2f** and **5.2.2g** below), of the Code, and/or the rules of the HKFI;
 - (viii) whether the person is or has ever been found not to have complied with or to be in breach of this Code and/or the rules of the HKFI;
 - (ix) whether the person possesses the qualifications specified in clauses 61 to 70 (Minimum Qualifications for Persons to be registered as Registered Persons) of the Code (see (d) below); and
 - (x) such other matters as the IARB considers relevant in the circumstances.
- (b) The IARB may consider a person not fit and proper to be or continue to be registered as a Registered Person if:

- (i) his appointment as a Registered Person was terminated by a Principal or appointing insurance agent pursuant to a requirement imposed by the IARB or the IA; or
 - (ii) in the opinion of the IARB, by his words or actions, he has manifested a material lack of understanding of the duties and ethical responsibilities of a Registered Person.
- (c) The IARB may consider a person not fit and proper to be or continue to be registered as an insurance agent if:
- (i) its appointed Responsible Officers or any of its Technical Representatives would not be considered fit and proper to act as an insurance agent if he applied as an individual; or
 - (ii) any of its controllers or directors would not be considered fit and proper to act as an insurance agent if he applied as an individual. For the purposes of this sub-clause, the requirements specified in clauses 61(b) to (d) (see (d)(i)(2)-(4) below) and 70 (see (d)(iii) below) of the Code are not applicable to any controller or director not being an insurance agent, a Responsible Officer or Technical Representative.
- (d) **Minimum Qualifications**
- (i) Minimum qualifications for a fit and proper Registered Person are that:
 - (1) he has attained the age of **18**;
 - (2) he is a Hong Kong Permanent Resident or Hong Kong Resident whose employment visa conditions, if any, do not restrict him from acting as an Insurance Agent, a Responsible Officer or a Technical Representative;
 - (3) he has completed education to a level of Form 5 or equivalent unless he has been exempted under the criteria specified in the Code;
 - (4) he has successfully passed the relevant papers of the Insurance Intermediaries Qualifying Examination ('IIQE') recognised by the IA, unless he has been exempted under the criteria specified in the Code;
(Note: an Insurance Agency is only eligible to engage in the Line(s) of Insurance Business in which its Responsible Officer is eligible to engage.)
and

- (5) he complies with such rules and policies as may be prescribed by the IA or the HKFI as applicable to him from time to time.
- (ii) A person's non-engagement in insurance-related work in the insurance industry in Hong Kong for two consecutive years after passing any of the papers will nullify the recognition of his qualification in respect of such paper(s).
- (iii) All Registered Persons have to comply with the requirements of the Continuing Professional Development Programme in such manner and form as specified by the IA.

5.2.2f PART F: Minimum Requirements of Model Agency Agreement

To appoint an Insurance Agent, a Principal has to do so under a **written agency agreement** that meets the minimum requirements of a *model agency agreement* adopted by the HKFI. The model agency agreements, for selling long-term insurance and general insurance respectively, are published on the HKFI's website. The minimum requirements of these model agency agreements will be inclusion of the Conduct of Registered Persons.

5.2.2g PART G: Conduct of Registered Persons

- (a) **Conduct of Registered Persons for General Insurance Business and Restricted Scope Travel Business**
 - (i) Business is to be conducted at all times in **good faith** and with **integrity**.
 - (ii) The Registered Person has to co-operate with the IARB and the Principal or Insurance Agent concerned to establish the facts if there is a complaint concerning his conduct. The complainant has to be informed that he should in the first instance refer the complaint to the relevant Principal or Insurance Agent. If the complainant is still dissatisfied, he may refer the matter to the IARB.
 - (iii) The Registered Person should:
 - (1) ensure that he is registered with the IARB in respect of the Line of Insurance Business to be engaged in prior to conducting such business;
 - (2) before discussing insurance policies with any person, identify himself as a Registered Person acting on behalf of the Principal(s) or Insurance Agent he represents;

- (3) disclose his registration number upon request, and identify the number on his business cards, if distributed;
- (4) display his name and registration number on the name plate put in front of the service desk or counter if he is registered as engaging in Restricted Scope Travel Business and provides face-to-face insurance service at the service desk or counter;
- (5) give advice **only** where he is **competent** to do so or seek advice from his Principal(s) or appointing Insurance Agent when necessary;
- (6) explain the **policy cover** recommended to ensure that the potential policy holder understands what he is buying;
- (7) explain the specific **differences** to which he is referring when making comparisons with other types of policies;
- (8) treat all information supplied by a potential policy holder as **confidential** and disclose it **only** to the Principal(s) or appointing Insurance Agent concerned, and otherwise comply at all times with the Personal Data (Privacy) Ordinance when dealing with personal data provided by a potential or current policy holder;
- (9) **not** make **inaccurate** or **misleading** statements about any Principals or appointing Insurance Agent, or their policies, or any other intermediaries;
- (10) **not** make any charge additional to the premium without disclosing to the policy holder, before the policy becomes binding, the amount and purpose of such charge; and
- (11) **not** pay any part of any commission or discount allowed to him to any partner, director or employee of any insured as an inducement to place the business with the Principal or appointing insurance agent, or assist any other Registered Person to make such a payment, unless prior **written agreement** and approval of the payment by the insured is received.

- (iv) When assisting with the completion of a **proposal** or **application**, the Registered Person has to:
 - (1) **refrain from** influencing the potential policy holder, and make it clear that the answers or statements given are the latter's own responsibility; and
 - (2) **explain** to the potential policy holder the consequences of fraud, non-disclosure and inaccuracies, drawing his attention to the relevant statements on the form.

(b) **Conduct of Registered Persons for Long Term Business**

Many of the requirements for Registered Persons of Long Term Business are identical with those indicated above.

Part G of the Code also prohibits the Registered Person from acting as an authorised insurance broker or as the Chief Executive or Technical Representative of an authorised insurance broker.

5.2.2h Guidance Notes

As said, the HKFI/IARB may issue Guidance Notes from time to time as to how it intends to exercise its powers and fulfil its responsibilities under the Code of Practice for the Administration of Insurance Agents. Below are summaries of some of the prevailing Guidance Notes that have been issued under the Code. The full text of the Guidance Notes can be found on the website of the HKFI.

(a) **Guidelines on Misconduct ('IARB – GN4')**

(i) **Background**

This *Guidance Note* is intended to help both insurers and insurance agents comply with the Code and in particular Part F of the *Code*. The phrase 'in good faith and with integrity' used in this Part cannot have a fully defined meaning; however, it is clear that it is in the best interests of customers, insurance agents and Principals to set out, from time to time, certain guidelines which if followed, will provide comfort to all concerned that all possible steps are being taken to conduct business in good faith and with integrity. Failure to comply may constitute a breach of the *Code* by either a Principal/an insurance agent under Part C or an insurance agent under Part F.

- (ii) **On no account will insurance agents ask customers to sign blank or incomplete forms and any alterations to forms must be initialled by the customers**

In order to protect the insuring public against potential losses arising from misrepresentation or forgery, insurance agents should not request their prospective customers and/or clients to sign blank forms or sign any documents relating to the policy before they have been duly completed and any alteration should be initialled by the customer.

- (iii) **An insurance agent selling a life assurance policy shall ensure that the prescribed *Customer Protection Declaration ('CPD')* form is completed**

It is an insurance agent's duty to present each policy with complete honesty and objectivity. In the case where the client is already a policyholder, this means that full and fair disclosure of all facts regarding both the new cover and the existing insurance is necessary. Policyholders should be made fully aware of the estimated cost of replacing an existing policy. In selling a life insurance policy, insurance agents have to duly complete the Customer Protection Declaration ('CPD') form as prescribed by the HKFI from time to time and bring its contents to the attention of the customer.

- (iv) **Principals must establish control procedures to monitor insurance agents' compliance with the *Code***

Principals will take all necessary steps to satisfy themselves that insurance agents are complying with the *Code* and with any Guidance Notes issued (as required by Part C).

- (b) **Guidelines on Handling of Premiums ('IARB – GN5')**

- (i) **Background**

This *Guidance Note* is intended to help both insurers and insurance agents comply with the *Code* and in particular Part F of the *Code* which stipulates that an insurance agent shall at all times conduct business in good faith and with integrity. Failure to comply may constitute a breach of the *Code* by either a Principal/an insurance agent under Part C or an insurance agent under Part F.

(ii) **Handling of Premiums**

Customers will want to pay their premiums in a variety of ways, including cash, credit card, cheque and bank transfer. It is up to the Principal to decide which methods are acceptable, but the following methods are recommended:

Cheque in favour of the Principal; or

Credit card/direct deposit/bank transfer from the customer's account to the Principal.

Any other method of payment or credit facilities extended to an insurance agent should be subject to clear rules set out by the Principal designed to avoid the mixing of customers' money with insurance agents' personal funds.

(c) **Guidelines on the Effective Date of Registration of Insurance Agents, Responsible Officers and Technical Representatives ('IARB – GN6')**

(i) **Background**

This *Guidance Note* is intended to help both insurers and insurance agents comply with the *Code* and in particular Part C of the *Code*, which stipulates that the appointment of insurance agents, Responsible Officers and Technical Representatives shall be confirmed in accordance with the *Code*.

(ii) **Provisions of the Guidance Note**

No prospective or current insurance agents, their Responsible Officers or Technical Representatives shall hold themselves out as engaging in the insurance agency business relating to a Principal before the IARB confirms their relevant registrations in writing by way of a Notice of Confirmation of Registration.

A prospective or current **insurance agent** must take note that it may be an offence under Section 77 of the Insurance Ordinance to hold himself out as an insurance agent of a Principal before he is registered by the IARB. Therefore, no person shall act or hold himself out as an insurance agent for and on behalf of any prospective appointing Principal before the date specified by the IARB in the Notice of Confirmation of Registration. Any breach may render that person liable to criminal prosecution for an offence under Section 77 of the Insurance Ordinance.

A prospective or current **Responsible Officer or Technical Representative** of an insurance agent should also take note that it may be a breach of the Code for him to hold himself out as the Responsible Officer or Technical Representative of such insurance agent before he is registered by the IARB.

Therefore, no person shall be a Responsible Officer or Technical Representative of any prospective appointing insurance agent before the date specified by the IARB in the Notice of Confirmation of Registration. Any breach may affect the fitness and properness of the Responsible Officer, Technical Representative or insurance agent concerned.

(d) **Guidance Note on Restricted Scope Travel Business ('IARB – GN9')**

(i) **Background**

This *Guidance Note* aims to:

- (1) provide waiver for a person who has not completed education to a level of Form 5 or equivalent but wishes to be registered with the IARB in order to be engaged in Restricted Scope Travel Business only (the 'Applicant'); and
- (2) facilitate the identification of the registration status of insurance agents, Responsible Officers and Technical Representatives engaging in Restricted Scope Travel Business.

(ii) **Waiver of Requirement for Form 5 or Equivalent Education**

This *Guidance Note* waives the requirement for Form 5 or equivalent education as stipulated under clause 61(c) of the *Code* in favour of an Applicant who complies with prescribed criteria under the *Guidance Note*. Nevertheless, such a waiver is no longer available to new applicants as the time limits imposed by the *Guidance Note* have expired. Apart from the requirements specified in Clause 61(c), the Applicant should meet the Minimum Qualifications for Persons Acting as Insurance Agents specified in the Code.

Unless and until the Applicant has been successfully registered with the IARB, he should not be engaged in Restricted Scope Travel Business.

Should the Applicant wish to be engaged in any other lines of business other than Restricted Scope Travel Business, he should fulfil all the requirements specified in the *Code*, including Clause 61(c).

(iii) **Identification of the Registration Status of Insurance Agents, Responsible Officers and Technical Representatives Engaging in Restricted Scope Travel Business**

The IARB may consider a person not fit and proper to act or continue acting as an insurance agent, a Responsible Officer or a Technical Representative engaging in Restricted Scope Travel Business, who provides face-to-face insurance service at service desks or counters, if he does not show his name and registration number, whether printed or in handwriting, on receipts for premium on travel insurance directly arranged by him for his clients.

(e) **Guidance Note on Compliance with the Requirements of the Continuing Professional Development (CPD) Programme for Registered Persons Who are Registered as Engaging in Restricted Scope Travel Business (RSTB) Only ('IARB – GN10')**

(i) **Background**

Part E of the Code stipulates that a Registered Person ('RP') should comply with the CPD requirements in such manner and form as specified by the IA. This *Guidance Note* aims to assist RPs who are registered as engaging in RSTB only to comply with the annual CPD requirements. Those RPs who engage in other line(s) of business should refer to the **Guidance Note on Compliance with the Requirements of the Continuing Professional Development (CPD) Programme**.

For the purposes of this *Guidance Note*, any reference to 'RP(s)' should include insurance agent(s), responsible officer(s) and technical representative(s).

(ii) **CPD Requirements**

The IA has specified that: *'From 1 August 2008 onwards, travel insurance agents, their responsible officers and technical representatives are required to earn 3 CPD hours every year.'*

Subject to compliance with other fitness and properness criteria, the IARB should deem an RP who is registered as engaging in RSTB only having complied with the CPD requirements under Part E of the Code as qualified for maintaining his registration status for another 12 months if he completes all 3 CPD hours for the assessment year within that assessment year.

(iii) **CPD Assessment**

The Guidance Note details how RPs' compliance with the CPD requirements is assessed. It is important for RPs to get familiar with the relevant provisions.

(iv) **Maintaining CPD records and Monitoring CPD Compliance**

The *Guidance Note* lays down responsibilities of responsible officers ('RO's), technical representatives ('TR's), insurance agents who have appointed TRs and all insurers to maintain CPD records. It also lays down responsibilities of insurance agents who have appointed TRs and all insurers to monitor CPD compliance.

(v) **Consequence of Non-Compliance**

In circumstances where an RP fails to meet the CPD requirements, his registration should be revoked for 3 months as a starting point by the IARB. Such RP should be required to complete all outstanding CPD hours at the time of re-registration.

In circumstances where an RP makes a false declaration in reporting his CPD hours, his registration should be revoked for 12 months as a starting point by the IARB. Such RP should be required to complete all outstanding CPD hours at the time of re-registration.

In circumstances where an RP fails to respond to a request of the IARB to produce proof of compliance with the CPD programme, his registration should be revoked for a specified period of time as determined by the IARB. The future application for registration of such RP will not be processed unless he can produce proof of compliance.

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Representative Examination Questions

Type 'A' Questions

- 1 In the general rules for the authorisation of insurers under the Insurance Ordinance, the requirement concerning **reinsurance** is that it must be:
- (a) adequate;
 - (b) sufficient to meet all liabilities;
 - (c) at least equal to the solvency margin;
 - (d) all be placed with Hong Kong reinsurers.

[Answer may be found in **5.1.1a**]

- 2 Under the Code of Practice for the Administration of Insurance Agents, which of the following boards may refer complaints against insurance agents to the relevant principals for investigation?
- (a) the Insurance Claims Complaints Board;
 - (b) the Insurance Agents Registration Board;
 - (c) the board of directors of the company which is an appointed insurance agent;
 - (d) none of the above.

[Answer may be found in **5.2.2d(c)(i)**]

Type 'B' Questions

- 3 Under the Code of Practice for the Administration of Insurance Agents, which of the following are permitted disciplinary actions against an insurance agent?
- (i) Issue a reprimand
 - (ii) Suspend the agent's appointment
 - (iii) Terminate the agent's appointment
 - (iv) Other action deemed fit by the IARB
- (a) (i), and (ii) only;
 - (b) (i), (ii) and (iii) only;
 - (c) (iii) and (iv) only;
 - (d) (i), (ii), (iii) and (iv).

[Answer may be found in **5.2.2d(c)(v)**]

- 4 Which of the following should be included in the Conduct of Insurance Agents for General Insurance Business and Restricted Scope Travel Business?
- (i) Give advice only when competent to do so
 - (ii) Identify himself before business discussions
 - (iii) Explain policy differences when making comparisons
 - (iv) Explain policy cover and ensure the client understands what he is buying
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- (a) (i) and (ii) only;
 - (b) (i), (ii) and (iii) only;
 - (c) (iii) and (iv) only;
 - (d) (i), (ii), (iii) and (iv).

[Answer may be found in **5.2.2**]

[If still required, the answers may be found at the end of this Part of the Study Notes.]

6 ETHICAL AND OTHER RELATED ISSUES

6.1 INSURANCE INTERMEDIARIES' DUTIES TO POLICYHOLDERS

6.1.1 Common Duties

At the outset, it must be remembered that insurance intermediaries may be either **insurance agents** or **insurance brokers**. Depending on the category involved, the duties towards policyholders may be different. Of course, there are areas which are common ground. These will include:

- (a) absence of *fraud*: this is a common obligation on all;
- (b) *fair and reasonable* behaviour: if not specifically covered by (a) above, then this standard must at least be expected when considering ethical issues;
- (c) take *no unfair advantage of clients*: especially of physical, mental or educational deficiencies (again, this must be a matter of basic ethics);
- (d) exert *no undue influence*: the role of the insurance intermediary is that of an adviser, not a persuader or enforcer;
- (e) all actions must be *legal*: the honourable insurance intermediary will not only keep to the *letter* of the law, he will observe the *spirit* of the law and good insurance practice;
- (f) where the duties are governed or required by *legislation*, it is important to know that a breach could involve **criminal** proceedings, with severe penalties.

All the above are virtually self-evident, but they are still important things to remember in the context of this Chapter. Specifically, there are other matters that should be borne in mind, according to whether the insurance intermediary is an insurance agent or an insurance broker.

6.1.2 If the Insurance Intermediary is an Insurance Agent

- (a) **Relationship**: an insurance agent's principal is normally the *Insurer*, not the *Insured*. As such, his primary responsibilities are to the insurer, although of course he is not exempt from the legal and ethical obligations discussed in **6.1** above.
- (b) **Minimum Requirements**: as discussed, all insurance agents must be appointed *in writing* and subject therefore to an **Agency Agreement** (see **5.2.2f**). Such an agreement must include certain minimum requirements. These will include a wide range of obligations towards both his Principal and the policyholder (or prospective policyholder). These may be reviewed in **5.2.2f**.

Note: Please **do** revise the passage suggested. We do not repeat the requirements here, but they are important and consist of knowledge that will be expected in your examination.

- (c) **Professional liability:** Tortious liability on the part of an insurance intermediary may to some extent depend upon the degree of knowledge/expertise expected of him, which in turn depends upon the nature of the skills he has professed for undertaking on behalf of the claimant the activity which has allegedly led to a loss to the claimant. As the typical insurance broker will hold himself out as being an insurance expert for the client, his duty of care to the client can be said to be onerous. By contrast, if an insurance agent has not professed to his clients special skills for undertaking an activity for them, he should be at a much lower risk of being held liable to them for incompetent performance of such activity. With in mind this contrast and the statutory imposition of vicarious liability on an insurer for his appointed insurance agents' conduct in prescribed circumstances, it is understandable that unlike an insurance broker an insurance agent is not statutorily required to buy and maintain professional indemnity insurance.

6.2 PROTECTION OF PERSONAL DATA

One of the consequences of the 'computer revolution' has been the fear that the speed, efficiency and capabilities of information technology will severely affect personal privacy. This has been a worldwide concern and many jurisdictions, including Hong Kong, have passed laws to safeguard the individual in this respect. The particular statute for Hong Kong is the *Personal Data (Privacy) Ordinance* (the 'Ordinance').

6.2.1 Features of the Ordinance

- (a) **Scope:** by international standards, this Ordinance is thorough, relating to personal data without distinguishing between automatic and manual personal data, and binding all persons and the Government as well. A body has been established under the Ordinance to oversee its application, namely *the Office of the Privacy Commissioner for Personal Data* ('OPCPD').
- (b) **Definitions:** the following terms are defined in the Ordinance:
- (i) 'data' - any representation of information (including an expression of opinion) in any document and includes a personal identifier;
 - (ii) 'personal data' - any data (including expressions of opinions)
 - (1) relating directly or indirectly to a living individual (data subject);

- (2) from which it is practicable for the identity of the individual to be directly or indirectly ascertained; and
 - (3) in a form in which access to or processing of the data is practicable.
- (c) **Data Protection Principles:** any person who controls the collection, holding, processing or use of personal data (data user) has to follow the fair information practices stipulated in the six data protection principles laid down in the Ordinance, as follows:

- (i) **Principle 1 - purpose and manner of collection of personal data:** it outlines the *lawful and fair* collection of personal data, also the information that the *data user* should give to the *data subject* when collecting personal data.

Example:

When insurance practitioners collect customers' personal data, they should provide the customers with a Personal Information Collection Statement (PICS) stating clearly the purpose of collecting the data, the classes of persons to whom the data may be transferred, the consequences of failing to supply the data, and the right of access to and correction of the data. The PICS should be attached to documents such as insurance application forms.

- (ii) **Principle 2 - accuracy and duration of retention of personal data:** the personal data should be *accurate, up-to-date* and kept *no longer* than necessary.

In particular, if a data user engages a data processor, whether within or outside Hong Kong, to process personal data on the data user's behalf, the data user should adopt contractual or other means to prevent any personal data that has been transferred to the data processor from being kept longer than is necessary for processing of the data. The term 'data processor' means "a person who (a) processes personal data on behalf of another person, and (b) does not process the data for any of the person's own purposes". For the Privacy Commissioner for Personal Data's ('PCPD') recommended means of compliance with the requirements, please see **6.2.1(d)** below.

Example:

If letters sent to a customer are always returned, it could be because of an inaccurate mailing address. Insurance practitioners should stop using that mailing address and update it.

- (iii) **Principle 3 - use of personal data:** unless the *data subject* gives consent, the personal data should only be used for the purposes for which they were collected, or a *directly related* purpose.

Example:

Under general circumstances, insurance practitioners are not allowed to disclose their customers' personal data to other companies for promotion of their products, unless prior prescribed consent has been obtained from the customer.

- (iv) **Principle 4 - security of personal data:** appropriate *security measures* should be applied to personal data (including data in a form in which access to or processing of it is not practicable) to ensure that personal data are protected against unauthorised or accidental access, processing, erasure, loss or use.

In particular, if a data user engages a data processor, whether within or outside Hong Kong, to process personal data on the data user's behalf, the data user should adopt contractual or other means to prevent unauthorised or accidental access to, processing, erasure, loss or use of, the data that has been transferred to the data processor for processing. For the definition of 'data processor', please see (ii) above. Please see 6.2.1(d) below for the PCPD's recommended means of compliance with the requirements.

Example:

When using window envelopes to mail documents containing customers' personal data, insurance practitioners should ensure that the customers' sensitive data (e.g. identity card number) does not show through the envelope window. If the letter is intended for the recipient only, insurance practitioners should consider marking "Private and Confidential" on the envelope and seal it.

- (v) **Principle 5 - information to be generally available:** *data users* should take all practical steps to ensure openness and transparency about their policies and practices in relation to personal data, the kinds of personal data they hold and the *main purposes* for which personal data is used.

Example:

Formulate and maintain a Privacy Policy Statement, stating the kinds of personal data held, purpose for using the personal data and its personal data policies and practices, which can be displayed on the website of the insurance practitioners' company.

- (vi) **Principle 6 - access to personal data:** *data subjects* have the rights of access to, and of correction of, their personal data.

Example:

A customer has the right to ask an insurer to supply a copy of the personal data contained in his insurance policy.

- (d) **How to Comply with Requirements of Data Protection Principles 2 and 4 where Processing of Personal Data is Outsourced to a Data Processor:** the PCPD recommends to data users the following means of compliance with the requirements:

- (i) **Through contractual means**

The primary means by which a data user may protect personal data entrusted to its data processor is through a contract. In practice, data users often enter into contracts with their data processors for the purpose of defining the respective rights and obligations of the parties to the service contract. To fulfil their obligations under data protection principles 2 and 4 where processing of personal data is outsourced to a data processor, data users may incorporate additional contractual clauses in the service contract or enter into a separate contract with the data processor.

The types of obligations to be imposed on data processors by contract are numerous, including the following:

- (1) Security measures required to be taken by the data processor to protect the personal data entrusted to it and obligating the data processor to protect the personal data by complying with the data protection principles;
- (2) Timely return, destruction, or deletion of the personal data when it is no longer required for the purpose for which it is entrusted by the data user to the data processor;
- (3) prohibition against any use or disclosure of the personal data by the data processor for a purpose other than that for which the personal data is entrusted to it by the data user;
- (4) the data user's right to audit and inspect how the data processor handles and stores personal data; and
- (5) consequences of breach of the contract.

(ii) **Through other means**

Sometimes, a data user may not be able to enter into a contract with its data processor to protect the personal data entrusted to it. The Ordinance provides flexibility by allowing the use of ‘other means’ of compliance. The term ‘other means’ is not defined in the Ordinance. Generally, data users may engage non-contractual oversight and auditing mechanisms to monitor their data processors’ compliance with the data protection requirements.

(iii) **Further good practice recommendations**

Further good practice recommendations are made by the PCPD to data users who engage data processors to process personal data on their behalf:

- (1) Data users should be transparent about their personal data handling practices and, when collecting personal data, make it plain to the data subjects, in clear and understandable language, that their personal data may be processed by data processors.
- (2) If the data processors are not situated in Hong Kong, the data users should make sure that their contracts are enforceable both in Hong Kong and in the countries in which the data processors are situated. The meaning of any technical and legal terms to be used in the contracts such as ‘personal data’, which may vary from one jurisdiction to another, should be clearly defined to suit compliance with the Hong Kong requirements.
- (3) Both data users and data processors should keep proper records of all the personal data that have been transferred for processing.
- (4) Before entrusting any personal data to data processors for system testing, data users have to consider whether use of anonymous or dummy data by data processors can equally serve the purpose.

(e) **Offence of Disclosure of Personal Data Obtained Without Data User’s Consent**

- (i) **Offences and penalty:** A person commits an offence if the person discloses any personal data of a data subject which was obtained from a data user without the data user’s consent, with an intent (a) to obtain gain in money or other property, whether for the benefit of the person or another person, or (b) to cause loss in money or other property to the data subject.

A person also commits an offence if he discloses any personal data of a data subject which was obtained from a data user without the data user's consent, and the disclosure causes psychological harm to the data subject.

The maximum penalty for either offence is a fine of \$1,000,000 and imprisonment for 5 years.

(ii) **Defence:** The Ordinance provides the following defence to any person charged with any of the offences:

- (1) he reasonably believed that the disclosure was necessary for the purpose of preventing or detecting crime;
- (2) the disclosure was required or authorised by or under any enactment, by any rule of law or by an order of a court;
- (3) he reasonably believed that the data user had consented to the disclosure; or
- (4) he disclosed the personal data for the purposes of a prescribed news activity or a directly related activity; and had reasonable grounds to believe that the publishing or broadcasting of the personal data was in the interest of the public.

(f) **Contravention of the Ordinance:**

Data subjects may complain to the PCPD about a suspected breach of the Ordinance and sue the wrongful data users for compensation for damage (inclusive of injured feeling) they have suffered as a result of a contravention of the Ordinance.

Complications are involved where an alleged breach occurred as a result of a data user's outsourcing of processing of a data subject's personal data to a data processor. The data processor is not directly liable to the data subject for infringing his personal data privacy. The aggrieved data subject may seek recourse from the data user, who is liable as principal for the wrongful act of its authorised data processor.

Where a complaint is brought by a data subject against a data user for its data processor's wrongful act or practice which has infringed his personal data privacy, the contract made between the data user and the data processor incorporating specific provisions on data protection can be admitted as evidence of the data user's compliance with data protection principles 2 and 4. The data user may also bring an action against the data processor by relying on any contractual terms that govern the data processor's obligations in data protection.

Apart from breaches of the Ordinance that may give rise to civil redress by data subjects, there are a variety of offences under the Ordinance,

including the offence of non-compliance with an enforcement notice that has been served by the PCPD.

- (g) **Exemptions:** The right to privacy is **not absolute**. Clearly, criminals have no right to expect total secrecy, and the normal conduct of business and social life in a community demand that some information can be generally or specifically available to those with a legitimate right to know. Exemptions from the Ordinance include:
- (i) a broad exemption for personal data held for *domestic* or *recreational* purposes;
 - (ii) exemptions on access by data subject for certain *employment-related* personal data held by their employers;
 - (iii) exemptions from the subject access and use limitation requirements where their application is likely to prejudice certain competing public or social interests, i.e. security, defence and international relations; prevention or detection of crime; apprehension, prosecution or detention of offenders; assessment or collection of any tax or duty; health; legal professional privilege; news activities; statistics and research; and human embryos, etc.
- (h) **User-friendly Materials for Use by Data Users and Insurance Practitioners:** apart from the Ordinance, insurance practitioners are advised to read the guidance notes and information leaflets issued by the relevant regulatory bodies for practical guidance on collection and use of personal data, including the following:
- (i) ‘How Insurance Practitioners Can Protect Their Customers’ Personal Data’ jointly issued by the OPCPD and the Hong Kong Federation of Insurers;
 - (ii) ‘Guidance on the Proper Handling of Customers’ Personal Data for the Insurance Industry’ issued by the OPCPD; and
 - (iii) ‘New Guidance on Direct Marketing’ issued by the OPCPD.

6.2.2 Insurance Applications

The above relate to society generally, of which insurance is of course a part. In order to assist the insurance industry in complying with the relevant requirements of the Ordinance when handling the collection, storage, use and security of customers’ personal data, and when handling customers’ data access requests, the PCPD has published a guidance note titled ‘Guidance on the Proper Handling of Customers’ Personal Data for the Insurance Industry’ (‘the Guidance Note’). Insurance practitioners should find the Guidance Note useful as it covers real work situations which they commonly encounter and which involve various key data protection compliance issues.

The following are some of the practical tips that the Guidance Note is applicable to insurance practitioners, including travel insurance agents:

- (a) **Collection of customers' medical data:** insurers often collect customers' medical data on an application for life or health insurance or in processing a claim under such insurance.
 - (i) No collection of excessive data: collection of excessive data is contrary to data protection principle 1. For example, in an insurance claim for medical expenses incurred in relation to an operation to remove a claimant's tonsils, it may not be necessary to collect medical data about a surgery performed on his knee ten years ago, unless the insurer can show the relevancy of the data to the claim.
 - (ii) Lawful and fair means of collection: as required by data protection principle 1, personal data should only be collected by means which are fair and not prohibited under any law. In general, obtaining information by deception or misrepresentation would not be considered fair means of collection of data.
- (b) **Collection of Hong Kong identity card ('HKIC') number and copy:** collection of an HKIC number (and other personal identifiers such as a passport number) and an HKIC copy is regulated by data protection principle 1 and the Code of Practice on the Identity Card Number and other Personal Identifiers ('PI Code') issued by the PCPD.
 - (i) HKIC number: a data user should not collect HKIC number (or other personal identifiers) of an individual unless authorised by law or permitted in the situations set out in paragraph 2.3 of the PI Code. For example, an insurer may require the HKIC number of a customer or beneficiary to ensure that an insurance claim is paid to the right person.
 - (ii) HKIC copy: insurance institutions should comply with paragraph 3.2 of the PI Code in collecting an HKIC copy. For example, an insurance institution may collect a copy of the identity card of an individual who is a life insurance customer, as proof of compliance with section 3 of Schedule 2 to Anti-Money Laundering and Counter-Terrorist Financing (Financial Institutions) Ordinance.
- (c) **Access to, storage and handling of customers' personal data by staff and agents:** in compliance with the requirement of data protection principle 4, insurance institutions should implement security safeguards and precautions in relation to the security of customers' personal data held by them or by their staff or agents. For instance, when transmitting documents containing personal data of customers, insurance institutions and insurance practitioners should ensure that the data is protected

against unauthorised or accidental access by unrelated parties. In the case of transmission by mail or via another person, sealed envelopes should be used, no sensitive data (e.g. HKIC number) is visible through the envelope window, and mail only intended for the eyes of the addressee should be marked 'private and confidential'.

For more examples, please refer to the Guidance Note.

6.3 ISSUES REGARDING EQUAL OPPORTUNITY

6.3.1 Legislation Addressing Discrimination

An **Equal Opportunities Commission** ('EOC') exists to implement four Ordinances, whose objectives are to eliminate discrimination on grounds of:

- (a) *sex, marital status or pregnancy* (the *Sex Discrimination Ordinance*, 1995);
- (b) *disability* (the *Disability Discrimination Ordinance*, 1995);
- (c) *family status* (the *Family Status Discrimination Ordinance*, 1997); and
- (d) *race* (the *Race Discrimination Ordinance*, 2008).

6.3.2 'Fair' Discrimination in Insurance

The insurance industry, like every other area of our society, must respect the law regarding anti-discrimination. That said, in the practice of insurance business, insurers will in certain circumstances differentiate between proposers in ways that are legitimate, insofar as that is permitted by the Ordinances mentioned above. An identical provision is contained in each of the first three Ordinances (not including the Race Discrimination Ordinance) to the effect that the treatment of a person in relation to insurance is not outlawed where the treatment (a) was effected by reference to actuarial or other data from a reliable source, and (b) was reasonable having regard to the data and any other relevant factors. The following are instances of 'discrimination' in insurance that are generally considered to be legitimate:

- (a) **Life insurance:** The premium charged for a life insurance is very much affected by the life expectancy of the life insured at the time the insurance is arranged. It is a biological fact that women, on average, live *longer* than men. From this, insurers may:
 - (i) charge a *lower* premium rate for *life insurances* on women than for men of the same age, health condition, etc., because on average the policy benefit will not be paid so soon and/or more premium payments are expected in the case of women; and
 - (ii) offer higher *annuity benefit payments* to men than to women of the same age, health condition, etc., because on average fewer payments will be made to men.

- (b) **Personal accident insurance:** A person with a disability, such as impaired eyesight or other serious medical condition, clearly represents a very different risk from a person with a normal healthy body. This difference could mean that insurers *decline* (refuse to insure) such persons, or impose various *underwriting measures* (higher premium, additional policy limitations, etc.).

6.3.3 Unfair Discrimination in Insurance

The conducts of discrimination that are common throughout our society (appointing only either sex, unfairly denying promotion to either sex, refusing to employ the physically handicapped, sexual harassment and so on) may happen in insurance situations as well. Below are two examples of unfair discrimination with insurance:

- (a) **Motor insurance:** charging higher premiums or imposing stricter terms on women because of the widely held male prejudice to the effect that women drivers are worse than men. (There have been statistics of accidents and driving convictions in certain countries which seem to suggest that the opposite is true!)
- (b) **Fire insurance:** refusing to grant household insurance to a woman on the grounds that she is divorced or a single parent.

6.4 PREVENTION OF CORRUPTION

Corruption is an individual's act of abusing his authority for personal gain at the expense of other people.

Administered by the Independent Commission Against Corruption ('ICAC'), the Prevention of Bribery Ordinance helps the business sector maintain an environment that is conducive to efficiency and fair competition. It protects principals against agents' abuses of authority for personal gain. Under Section 9(1) of the Ordinance, an agent (normally an employee), when conducting his principal's business or affairs, should not seek or accept an advantage without the permission of his principal. The offeror of advantage commits an offence under Section 9(2) of the Ordinance. Section 9(3) of the Ordinance provides that any agent who, with intent to deceive his principal, uses any receipt, account or other document which is false or erroneous commits an offence. Each of the offenders is subject to a maximum penalty of imprisonment for 7 years and a fine of \$500,000.

The ICAC offers free and confidential corruption prevention services to organisations. For example, Best Practice Packages covering a wide range of topics have been developed to provide both public corporations and private sector companies with user-friendly guidelines on plugging corruption loopholes. The ICAC also provides free, confidential corruption prevention advice to individual organisations.

To make insurance intermediaries better understand the importance of anti-corruption and ethics management, the ICAC offers a large variety of anti-corruption training courses and activities to the insurance industry. It has issued a booklet named the 'Practical Guide on Professional Ethics for Life Insurance Intermediaries' in collaboration with the Insurance Authority, the self-regulatory bodies of the insurance industry and various professional associations of insurance. The objectives are to enhance the vigilance of the life insurance industry against potential corruption and fraud, and to strengthen insurance companies' ability to manage the ethical conduct of their staff, so that the risks of violations of laws and regulations are reduced, contributing to long-term success.

Insurance intermediaries are encouraged to get familiar with the substance of the Ordinance, the best practices suggested by the ICAC (including the module on Verification of Insurance Claims), and the Practical Guide on Professional Ethics for Life Insurance Intermediaries, with a view to preventing corrupt conduct both within and outside their organisations. Other services of the ICAC should also be used as much as is necessary. In dealing with clients or other third parties, insurance intermediaries should guard against violating the Ordinance. Corruption cases should be reported to the ICAC in person, by phone or by letter.

6.5 PREVENTION OF INSURANCE FRAUD

Fraud is of course 'dishonesty' or 'cheating'. Since insurance is a process involving a high element of trust, there is ample scope for the dishonest person to take advantage.

Insurance fraud may take any of a large number of forms. Usually, we tend to associate the term with dishonest claims, from relatively 'small' matters, such as having a cheap watch stolen and saying that it was an expensive one, to elaborate swindles involving arson or faked death certificates. There have even been examples of large life insurance being arranged and then having the person concerned murdered for the insurance money.

Fraud, however, may arise at other than the claims level. Obtaining insurance by the deliberate falsification of material information, or knowingly hiding bad features, is equally fraud. Of course, this is a form of breach of utmost good faith (see **3.2** above), but often it is difficult to prove such things later.

Although fraud may be committed by anyone involved with insurance (policyholder, insurance intermediary or even the insurer), we shall concentrate on the customary understanding of the proposer or insured seeking an illegal advantage against the insurer. The comments below refer specifically to the role of the insurance intermediary in this subject area.

6.5.1 Beware of Becoming Partners in Crimes

Undoubtedly all of us know that we must refrain from carrying out criminal activities, or we may face criminal prosecution and even civil action. For instance, an insurance intermediary who misappropriates premiums that have been collected on behalf of his principal is liable to prosecution for theft, and to civil action by the principal to recover the stolen money and for damages such as loss of interests. It is also common knowledge that, apart from the actual perpetrator(s), a **secondary party** to the crime (see the next paragraph for its definition) is also punishable by law. However, a general knowledge cannot be assumed that the secondary party and the **principal perpetrator** (or just **'principal'**) can be equally responsible for the same crime. This **6.5.1** introduces the criminal law of secondary parties so as to enhance the ability of insurance intermediaries to identify potential criminal activities and to prompt them to take extra care in distancing themselves from such activities. It will be seen that the discussions here are not restricted to the offence of fraud and offences involving fraud, in view of the fact that the law of secondary participation is generally applicable to all offences.

Depending on the nature of participation, a participant in crime can either be in the capacity of a principal or a secondary party (alternatively known as **'secondary participant'** and **'accessory'**). Where there are more than one principal and they should be jointly responsible, they are also known as joint principals. A secondary party to an offence is one who aids, abets, counsels or procures the commission of that offence. Without going into details about these four legal terms, it is sufficient for the purposes of these Study Notes to mention that secondary participation almost invariably consists simply in assisting or encouraging the commission of the crime.

It surprises almost anyone who is new to this area of the law to know that it is generally immaterial whether a defendant is alleged to have participated in the crime as principal or as secondary party, as he is equally responsible either way. Not too many people, it is also believed, realise that participation by inactivity can be as culpable as participation by acting. Where the defendant has the right to control another person's actions and he deliberately refrains from exercising the right, such inactivity may constitute a positive encouragement to that other person to carry out an illegal act, and therefore an aiding, etc. Let us say, an insurance agent Mr Wong (who is an appointed insurance agent of Insurer A alone) solicits insurance business from a prospective client for Insurer B, with his up-line manager Miss Chiu (who is also an appointed insurance agent of Insurer A) standing by and watching. If Miss Chiu knows that Mr Wong is not an appointed insurance agent of Insurer B, then her failure to stop Mr Wong very likely constitutes aiding and abetting the commission of the offence under s 77(1) of the Insurance Ordinance.

The final aspect of the law of secondary participation to be discussed here is the mens rea (or guilty mind) of the defendant at the time of aiding, etc. that must be proved as one of the elements of the crime. Neither an intention to gain from the commission of the crime nor from the conduct of aiding, etc. is required. What is required is an intention to aid, etc., which conduct he knew to be capable of assisting or encouraging the commission of the crime. Such an intention, it should be noted, is not the same thing as an intention that the crime be committed. Let us say, an insurance intermediary issues to a client, at the request of the latter, an inflated premium receipt for a private car insurance policy, which receipt he realises might be presented to the latter's employer for the purposes of over-claiming living costs allowance. By so doing, the insurance intermediary can still be held to be an aider and abettor, even if he is indifferent whether the client cheats his employer by use of the bogus receipt as planned.

6.5.2 The Insurance Intermediary and Examples of Insurance Fraud

As stated, fraud takes many forms. We do not talk about deliberate collusion and dishonesty on the part of insurance intermediaries. The illegality and unethical nature of that is self-evident. Below are examples where the insurance intermediary may be approached or tempted to assist in insurance fraud:

- (a) **Arranging the insurance:** it often happens that the insurance intermediary possesses or is supplied with information which could have an adverse effect upon an application or proposal for insurance. This information could even mean that the risk is uninsurable. Under no circumstances should that information be omitted or misrepresented. Doing this with the intention of misleading the insurer is **fraud**.

Remember, by law and ethics, an insurance intermediary is *bound* to exercise the duty of utmost good faith in such matters, whatever the practical consequences for the proposed insurance.

- (b) **Fraudulent claims:** it is not the responsibility of the insurance intermediary to become a 'detective' or a 'law-enforcement officer', but there is a common duty not to assist fraud and to report evidence or suspicions of it. Concerning claims, this may mean suspicious circumstances, doubtful medical or other documentary evidence or even verbal communications which clearly indicate that all is not correct with a particular claim.

Note: A word of caution must be given. Fraud is a most serious matter and to allege it is something that must not be done lightly. It is the insurer's primary duty to investigate claims, and certainly only he can allege fraud. The insurance intermediary's role is to assist the insurer, and indeed the law, in resisting attempted fraud and in revealing fraud, but this is a matter of the greatest sensitivity, as will be readily appreciated.

6.5.3 Practical Steps in Preventing Fraud

As with all matters involving illegal activities, perhaps the most important advice in preventing fraud is firstly to be **aware** that it *can happen*. Of course, we must not become paranoid about this, but the possibility that it can arise is always a good beginning in fraud prevention. Additionally:

- (a) **Vigilance:** suspicious actions, like sudden increases in sums insured with no or inadequate explanation, apparently inordinate amounts of insurance, and so on, should put the insurance intermediary on guard.
- (b) **Diligence:** sometimes fraud can arise when records are inadequately kept or unnecessary delays occur. Keeping up to date with actions and record keeping is not only good business, it is an excellent fraud prevention exercise.
- (c) **Communication:** whether representing the insured or the insurer, the insurance intermediary should always keep in close touch with the insurer, especially where there may be suspicious circumstances.
- (d) **Integrity:** by law, contract and all recognised ethical behaviour, insurance agents and brokers have to maintain the highest moral standards. Remembering this at all times will almost automatically supply all necessary guidance in this area. Insurance agent, insurance broker or insurer, we are all the enemy of fraud.

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Representative Examination Questions

Type 'A' Questions

- 1 The Personal Data (Privacy) Ordinance for Hong Kong applies to:
- (a) the public sector only;
 - (b) the private sector only;
 - (c) both the public sector and the private sector;
 - (d) neither the public sector nor the private sector.

[Answer may be found in **6.2.1(a)**]

- 2 Legislation has been enacted in Hong Kong regarding equal opportunity. Which of the following are areas where discrimination may arise have been made the subject of an appropriate Ordinance?
- (a) sex;
 - (b) pregnancy;
 - (c) physical disability;
 - (d) all of the above.

[Answer may be found in **6.3.1**]

Type 'B' Questions

- 3 Which of the following are among the recognised principles of Data Protection?
- (i) Access to personal data
 - (ii) Security of personal data
 - (iii) Purpose and manner of collection
 - (iv) Information to be generally available to the data subject
- (a) (i) and (ii) only;
 - (b) (i) and (iii) only;
 - (c) (ii) and (iv) only;
 - (d) (i), (ii), (iii) and (iv).

[Answer may be found in **6.2.1(c)**]

[If still needed, the answers may be found at the end of this Part of the Study Notes.]

GLOSSARY

Abandonment (委付) A practice effectively restricted to marine insurance, whereby the assured surrenders all rights in the subject matter insured to the insurer, in return for a total loss settlement. **3.4.6**

Adequate Reinsurance (足夠的再保險) One of the requirements under the Insurance Ordinance for an insurer wishing to be authorised, or to remain to be authorised, in Hong Kong. **5.1.1e**

Administrator (遺產管理人) Put simply, he is a person appointed to manage the property of another. **3.1.4(b)**

Agency (代理關係) Principal and agent relationship. **2.2.1**

Agency by Estoppel (不容反悔的代理權) An application of the doctrine of estoppel to an agency situation is where a person, by words or conduct, represents or allows it to be represented that another person is his agent, in which case he will not be permitted to deny the authority of the agent with respect to anyone (third party) dealing with the agent on the faith of such representation. **2.2.3(d)**

Agent (代理人) A person acting on behalf of a principal. **2.2(a)**

Agreed Value Policy (約定價值保單) Property insurance where it is agreed at policy inception that the item(s) concerned have, throughout the currency of the contract, the value stated in the policy. Mostly used with items that tend not to depreciate, e.g. jewellery and antiques, and in marine insurance. **3.4.8(c)**

‘All Risks’ (「全險」) A form of property insurance cover where all causes of loss are insured unless specifically excluded. **1.1.1 Note 2**

Ancillary Functions of Insurance (保險的輔助功能) Indirect benefits, consequences and results of insurance (as opposed to its direct intentions and objectives). **1.2(b)**

Annuity (年金) A contract whereby an insurer promises to make a series of periodic payments (‘annuity benefit payments’) to a designated person (‘payee’) throughout the lifetime of a person (‘annuitant’) or for an agreed period, in return for a single payment or a series of payments made in advance by the annuity purchaser. Very often, the payee, the annuitant and the annuity purchaser are the same person. **4.1.1(a)**

Apparent Authority (表面權限) The authority of an agent may be apparent instead of actual, where it results from a manifestation of consent, *made to third parties* by the principal. This doctrine is distinct from the doctrine of estoppel in that it applies where an agent is allowed to appear to have a greater authority than that actually conferred on him, whereas the doctrine of estoppel applies where the supposed agent is not authorised at all but is allowed to appear as if he was. **2.2.3(b)**

Appeals Tribunal (上訴裁判處) A body of members nominated by The Hong Kong Federation of Insurers and confirmed by the Insurance Authority, to hear appeals by applicants in respect of applications for registration under the Code of Practice for the Administration of Insurance Agents or by any party who is the subject of any disciplinary or other action imposed by the IARB under the Code. The Tribunal's decision is final. **5.2.2d(d)**

Assignment of Policy (Insurance Contract) (保單(保險合約)的轉讓) The transfer of rights under a contract of insurance, whereby another person becomes the policyowner in respect of the same subject matter of insurance. **3.1.6**

Assignment of the Right to Insurance Money (收取保險金的權利的轉讓) The transfer of the right to insurance money to a third party, who then acquires the right to sue the insurer under the contract. **3.1.6**

Average (in marine insurance) (海損): partial (i.e. non-total) loss. **3.4.7(a) Note**

Average (in non-marine insurance) (比例分攤): a policy provision which imposes a penalty for under-insurance when a claim arises. **3.4.7(a)**

Bailee (受託保管人) A bailee of goods is a person taking possession of the goods with their owner's consent, where there is no intention to transfer ownership. **3.1.4(b)**

Breach (違反) Failure to fulfil an obligation, perhaps in connection with contractual terms, or related to agency relationship. **2.2.5(c)**

Captive Insurer (專屬自保保險人) It primarily underwrites its founder's own risks. The founder, or parent company, may be one company, several companies, or an entire industry. (Note: a captive insurer, more strictly defined in the Insurance Ordinance, is subjected to less stringent statutory supervision than an ordinary insurer.) **5.1.1b(d)**

Cash Payment (現金支付) A method of providing an indemnity, or paying the policy benefit. **3.4.4(a)**

Claim (索償／保險金要求) An insured's request for indemnity or policy benefit under his insurance. Alternatively, a claim made by a third party against the insured of a liability policy. **3.2.6 Note**

Claims (Denial of)(拒絕賠償或支付保險金) A section within the Code of Conduct for Insurers relates to guidelines to be followed when rejecting insurance claims. Broadly, these guidelines call for a fair and reasonable approach and good communication with the claimant as to the reasons for the denial, etc. **5.1.2c(b)**

Claims Outstanding (未決申索) Put simply, they are claims which, as at a particular date, remain unpaid. The term is defined in much greater detail in the Insurance Ordinance.

5.1.1c(a)(ii)

Classification of Risk (風險的類別) Categorising risks for a particular purpose. **1.1.2**

Code of Conduct for Insurers (《承保商專業守則》) Implemented by The Hong Kong Federation of Insurers in May 1999, this code lays down recommended practices for insurers. The code only applies to insurance for personal policyholders resident in Hong Kong, effected in their private capacity only. **5.1.2**

Code of Practice for the Administration of Insurance Agents (《保險代理管理守則》) Issued by The Hong Kong Federation of Insurers with the approval of the Insurance Authority in accordance with the provisions of the Insurance Ordinance, this has 7 parts (A to G) covering a wide range of expectations and requirements in the subject of administration of insurance agents. **5.2.2**

Collectability (收回應收賬款的能力) Whether or not arranged reinsurance is likely to prove effective (i.e. whether the reinsurers can or will pay their shares of loss). It in fact is not a technical term. **5.1.1e**

Complaints and Disputes (投訴及糾紛) This important topic is given guidelines and recommended practices in the Code of Conduct for Insurers, and includes such matters as the existence of appropriate structures for receiving and dealing with complaints, both internally and externally. **5.1.2e**

Composite (Insurer) (綜合業務(保險人)) Originally designating an insurer which transacted more than one type of business, the term now is likely to mean an insurer which transacts both types of insurance business as per the Insurance Ordinance (i.e. Long Term Business and General Business). **4.2.1(c)**

Contract (合約) A legally enforceable agreement. **2.1.1**

Deemed (當作) Treated as. **2.2.1**

Damages (損害賠償) Money claimed by a claimant from a defendant as compensation for harm alleged to have been done to the claimant by the defendant. **3.2.6(b)**

Duties owed by Agent to Principal (代理人對委託人的責任) Responsibilities deemed to apply, or individually specified, such as obedience to legitimate orders, the exercise of due care and skill, etc. **2.2.4**

Duties owed by Principal to Agent (委託人對代理人的責任) Corresponding responsibilities deemed to apply, or individually mentioned, such as payment of agreed remuneration, etc. **2.2.5**

Emotional (Risk) (情緒上的 (風險)) An uncertainty that leads to grief and sorrow if realised. **1.1.1(c)**

Employees' Compensation Insurance (僱員補償保險) Compulsory insurance in Hong Kong which relates to the statutory liability of an employer to pay specified compensation in respect of an employee's death or injury arising out of and in the course of his employment. **4.1.1(b)**

Equal Opportunity (平等機會) A concept that has received particular legislative attention in Hong Kong, with Ordinances passed with a view to eliminating discrimination on various grounds, such as sex, marital status, disability, race, etc. **6.3.1**

Equity (衡平法) That body of rules formulated by the courts to supplement the rules and procedure of the common law. **3.5.1**

Excepted (Excluded) Peril (除外危險) A cause of loss excluded by the terms of the insurance (e.g. suicide under a personal accident insurance), or by statutory provisions. **3.3.2(b)**

Excess (免賠額) A policy provision requiring the insured to bear the first amount, up to the prescribed amount, with each and every claim; in other words, the insurance is only liable 'in excess' of the prescribed amount. **3.4.7(b)**

Executor (遺囑執行人) Person named in a will whom the testator wishes to administer the estate. **3.1.4(b)**

Fair Discrimination in Insurance (保險中的「公平」歧視) Justified differential practices adopted by insurers to meet the realities of situations, e.g. charging men more premium in life insurance than women of the same age, health condition, etc. Thus, this is no breach of the relevant anti-discrimination legislation. **6.3.2**

Fidelity Guarantee(忠誠保證) An insurance guarantee to a person against the dishonesty of another person (perhaps, an employee of the first person). **4.1.1(b)**

Financial (Risk) (財務上的(風險)) An uncertainty producing a loss measurable in monetary terms if realised. **1.1.1(a)**

Fit and proper (適當的人選) A common phrase in regulatory instruments, indicating that the individual occupying or wishing to occupy a certain position is suitable and acceptable from a regulatory point of view. **5.1.1d, 5.2.2e**

Fitness and Properness of Registered Persons (登記人士的適當人選準則) A range of requirements and limitations concerning the criteria for this subject are contained in Part E of the Code of Practice for the Administration of Insurance Agents. **5.2.2e**

Franchise (起賠額) A rare policy provision whereby the insured is not covered for any loss not exceeding or attaining the specified franchise, but is covered in full if the loss exceeds or attains the franchise, depending on the wording used. It could be related to a time, rather than an amount, so that (for example) no hospitalisation compensation or benefit is payable for less than three days' stay, but compensation for the full period is payable for longer stay. **3.4.7(c)**

Fraud (Insurance) ((保險)詐騙) Fraud against the insurer is possible in a number of ways. These could involve the insurance intermediary, concerning the arrangement of the insurance or in connection with a claim. **6.5**

Fraudulent Misrepresentation (欺詐性失實陳述) A breach of utmost good faith, arising from the fraudulent provision of false or inaccurate material facts. **3.2.5(a)**

Fraudulent Non-Disclosure (欺詐性不披露) A breach of utmost good faith, arising from a fraudulent omission to provide a material fact. **3.2.5(c)**

Fundamental Risk (基本風險) That type of risk whose causes are outside the control of any one individual or even a group of individual, and whose outcome affects large numbers of people. **1.1.2b(ii)**

General Business (一般業務) One of the two major divisions of insurance classified under the Insurance Ordinance. It consists of a very wide range of different types of insurance, with seventeen classes in the Insurance Ordinance. **4.1.1(b)**

General Insurance (一般保險) Another term for General Business, denoting insurance other than long term insurance. **4.2.3**

Group of Companies (保險公司集團) For the purposes of clause 22(b) of the Code of Practice for the Administration of Insurance Agents, the term means that the relationship between the companies is that of ‘subsidiary’ and ‘holding company’ or they are the subsidiaries of another company, with ‘subsidiary’ and ‘holding company’ having the meanings attributed to them by Sections 2(4)-(7) of the Companies Ordinance. **5.2.2c(d)(iii)**

Guidelines on Handling of Premiums (《代理人應如何處理客戶保費指引》) The Insurance Agents Registration Board has published this set of guidelines, recommending the method of payment of premiums. **5.2.2h(b)**

Guidelines on Misconduct (《違規行為指引》) Another set of guidelines issued by the Insurance Agents Registration Board, recommending procedures and appropriate actions to avoid potential losses arising from misrepresentation and forgery, etc. **5.2.2h(a)**

Guidelines on the Effective Date of Registration of Insurance Agents, Responsible Officers and Technical Representatives (《保險代理、負責人及業務代表的登記生效日期指引》) These include reference to the fact that holding oneself out to be an insurance agent, Responsible Officer or Technical Representative, before being registered by the Insurance Agents Registration Board is an offence against the Insurance Ordinance or a breach of the Code of Practice for the Administration of Insurance Agents. **5.2.2h(c)**

Hong Kong Federation of Insurers (‘HKFI’) (香港保險業聯會(「保聯」)) The central market body, representing majority of the authorised insurers in Hong Kong. A major objective of the HKFI is to promote and advance the interests of insurers and reinsurers transacting business in Hong Kong, and its mission statement further states that the HKFI exists to promote insurance to the people of Hong Kong and build consumer confidence in the insurance industry. **4.4**

Indemnity (彌償) An exact financial compensation, restoring the insured to the same financial situation he occupied immediately prior to the loss. A standard understanding of all insurances except life and personal accident (but its application or non-application may be modified by contractual terms). **3.4.1**

Indemnity (How Provided) ((如何提供)彌償) Exact compensation to the insured may be provided by a cash payment, by repair or replacement, or by reinstatement. The non-marine practice is that this will be at the insurer's option. **3.4.4**

Insurable Interest (可保權益) The legal right to insure. The relationship with the subject matter of insurance that gives the right to effect insurance. **3.1.1**

Insurable Risk (可保風險) A threat of loss that meets the necessary criteria for feasible insurance cover. **1.1.1**

Insurance Agent (保險代理人) An agent in an insurance contract, usually representing the insurer and remunerated by commission on the premium paid. **2.2**

Insurance Agents Registration Board ('IARB') (保險代理登記委員會) The body set up by The Hong Kong Federation of Insurers to register insurance agents and to handle complaints against insurance agents pursuant to the Code of Practice for the Administration of Insurance Agents. **5.2.2a(a), 5.2.2b**

Insurance Broker (保險經紀) An insurance intermediary who arranges insurance on behalf of the intended or actual insured. Remunerated by commission (or brokerage) paid by the insurer. **2.2(a)**

Insurance Claims Complaints Bureau (保險索償投訴局) Has a membership of all authorised insurers underwriting personal insurance in Hong Kong. Its primary function is to handle complaints from personal policyholders, in respect of claims affecting personal insurances. **5.1.4**

Insurance Claims Complaints Panel (保險索償投訴委員會) Consisting of an independent Chairman and four members, only two of which are nominated by The Hong Kong Federation of Insurers, the Panel may hear and adjudicate on claim-related complaints from personal policyholders. No fee is involved for the policyholder, win or lose. **5.1.4a**

Insurance Intermediaries (保險中介人) In Hong Kong these consist of insurance agents (usually representing the insurer) and insurance brokers (usually representing the insured). Separate regulatory rules and provisions apply to each group. **2.2(a)**

Insurance Intermediaries' Duties to Policyholders (保險中介人對保單持有人的責任) With this topic, there are common areas for both insurance agents and insurance brokers. In addition there will be separate requirements upon each, the former especially involving the requirements of the agency agreement. **6.1**

Insurance of Legal Rights (合法權利保險) Also called pecuniary insurance, this covers the infringement of rights or the loss of future income, e.g. fidelity guarantee and business interruption insurance. **3.1.4(d)**

Insurance Ordinance (保險業條例) This is the legislation for regulating the Hong Kong insurance industry. It is formerly known as the Insurance Companies Ordinance (Cap. 41). 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). **5.1.1**

Insured Peril (受保危險) A cause of loss insured by the policy. An insured peril must always be involved before a valid claim can arise. **3.3.2(a)**

Insurer (保險人) That party to an insurance contract who carries the risk. Insurers usually are corporations, though individual insurers are also found in the London market. **1.1.2a**

Life Insurance (人壽保險) The major type of Long Term Business and forming the leading class of insurance, by premium volume, in Hong Kong. **4.1.1(a)**

Long Term Business (長期業務) One of the two major divisions of insurance, as per the Insurance Ordinance. The dominant categories within this division concern life insurance contracts. It is ‘long-term’ because policies are normally not annual contracts, but last for a number of (sometimes many) years. **4.1.1(a)**

Loss Prevention (損失防範) The lowering of the frequency of identified losses. **1.1.3(c)(iii)**

Loss Reduction (損失降低) The lowering of the severity of identified losses. **1.1.3(c)(iii)**

Management of Insurance Agents (保險代理人管理) Forming Part IV of the Code of Conduct for Insurers, this section provides guidance on various relevant issues, including registration, complaints, adequate support, etc. **5.1.2d**

Material Fact (重要事實) A fact that would influence the judgement of a prudent underwriter as to the acceptance of a risk or the premium on which it is to be accepted. **3.2.3**

Model Agency Agreement (標準代理合約) A principal must appoint an insurance agent under a written agency agreement, which must at least meet the minimum requirements of The Hong Kong Federation of Insurers' model agency agreement, as outlined in Part F of the Code of Practice for the Administration of Insurance Agents. **5.2.2f**

‘New for Old’ Cover (「以新代舊」的保險保障) Claims settlements are not subject to deduction for wear and tear, depreciation, etc. An expression found mostly with personal lines property insurance, with some items (e.g. clothing) not subject to this provision. **3.4.8(b)**

Non-fraudulent Misrepresentation (非欺詐性失實陳述) A breach of utmost good faith, arising when one party innocently or negligently gives to another party an inaccurate or untrue representation of a material fact. **3.2.5(b)**

Non-fraudulent Non-Disclosure (非欺詐性不披露) A breach of utmost good faith, arising when one party innocently or negligently fails to give to another party material facts. **3.2.5(d)**

Ordinary Good Faith (一般誠信) The common law duty not to lie or deliberately mislead the other party in a contract. However, this duty does not require the disclosure of all facts known, but only in response to specific questions. **3.2.1**

Paid-up Capital (實繳股本) Shares for which no amount remains ‘on call’ (i.e. all the money due for them has actually been paid to the company). **5.1.1a&b**

Particular Risk (特定風險) A risk where the consequences are potentially of *limited* application, i.e. affecting *relatively* few people or a relatively small area (although the consequences for those concerned may be fatal or very serious). **1.1.2b(i)**

Performance Bond (履約保證) A guarantee that a construction contract will be carried out. **4.1.1(b)**

Peril (危險) The cause of a loss. This is important in connection with the application of proximate cause. **1.1.1Note 2, 3.3.2**

Physical (Risk) (身體上的(風險)) An uncertainty resulting in death or injury if realised. **1.1.1(b)**

Policy (保單) A written/printed instrument most often issued to an insured as an evidence of the insurance contract. **2.1.1**

Policy Limits (保單限額) Policy provisions which determine the maximum amount of insurance recovery, e.g. sum insured. **3.4.7(d)**

Powers of Intervention (干預權力) The statutory ‘teeth’ given to the regulatory authorities to take action in appropriate circumstances. The options available range from various restrictions and limitations to liquidation of the insurer concerned. **5.1.1f**

Primary Functions of Insurance (保險的主要功能) The direct objectives and intentions of insurance, e.g. transferring risk and compensating losses. **1.2(a)**

Principal (委託人) The person for whom an agent acts. **2.2(a)**

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, loss or damage caused through their negligence. **6.1.2(c)**

Proposal Form (or Application Form) (投保書) A standard form on which a proposer of insurance is required to supply the insurer with material information.

3.2.2 Note 1

Proposer (投保人) A prospective insured who completes a proposal form when seeking insurance; may also be known as an applicant. **2.2(a)**

Protection of Personal Data (保護個人資料) A subject of international importance, with the advances in computer technology. The specific legislation dealing with the issue in Hong Kong, which includes any applications in insurance, is the Personal Data (Privacy) Ordinance. **6.2**

Proximate Cause (近因) The dominant or effective reason for a loss, which must be ascertained to determine whether that loss constitutes a valid claim under an insurance contract or not. **3.3**

‘Pure’ General Business (「純」一般業務) When an authorised insurer in Hong Kong is described as doing **‘Pure’ General Business**, that means it transacts only general (not long term) business. **4.2.1(b)**

‘Pure’ Long Term Business (「純」長期業務) When an authorised insurer in Hong Kong is described as doing **‘Pure’ Long Term Business**, that means it transacts only long term (not general) business. **4.2.1(a)**

Pure Risk (純風險) An uncertainty that can only result in either a loss or no change. **1.1.2a(i)**

Ratification (追認) A retrospective act of adopting a contract or a transaction by someone who was not bound by it originally because it was entered into on his behalf but without his authority. **2.2.2(b)**

Register of Insurance Agents (保險代理登記冊) A register to be maintained by the Insurance Agents Registration Board, as prescribed by the Insurance Authority and available for public inspection at The Hong Kong Federation of Insurers' office or website. **5.2.2d(a)**

Registered Person (登記人士) A person who has been registered under the Code of Practice for the Administration of Insurance Agents as either an Individual Agent; an Insurance Agency, a Responsible Officer of an Insurance Agency; or a Technical Representative of an Individual Agent or Insurance Agency. **5.2.2a(a)**

Regulation of Insurance Intermediaries (保險中介人的規管) Under the current self-regulatory regime, insurance intermediaries are required to be registered with and be regulated by one of the three self-regulatory organisations ('SROs'), namely the Insurance Agents Registration Board (IARB), the Hong Kong Confederation of Insurance Brokers (CIB) and the Professional Insurance Brokers Association (PIBA). The Insurance Authority established under the Insurance Companies (Amendment) Ordinance 2015 will eventually take over the regulation of insurance intermediaries from the SROs through a statutory licensing regime in the next stage.

5.2

Reinstatement (Property insurance) (恢復原狀(財產保險)) As a method of providing an indemnity, it means the restoration of the insured property to the condition it was in immediately before its destruction or damage. **3.4.4(d)**

Reinstatement Insurance (重置保險) Property insurance where the settlement basis for claims is effectively 'new for old' (i.e. no deduction for depreciation, etc.) if the damage is reinstated (or made good). **3.4.8(a)**

Replacement (更換) A method of providing an indemnity, by the insurer providing a substitute item for the one lost/damaged. **3.4.4(c)**

Responsible Officer (負責人) More fully defined in the Code of Practice for the Administration of Insurance Agents, such a person is responsible for the conduct of an insurance agency business. **5.2.2a(a)**

Revocation (撤銷協議) The cancellation of an agency agreement by either party (which must be subject to legal and specific contractual terms). **2.2.6(b)**

Risk (風險) Uncertainty concerning a potential loss. **1.1**

Risk Avoidance (風險避免) Elimination of the chance of loss of a certain kind by not exposing oneself to the peril. **1.1.3(c)(iii)**

Risk Financing (風險融資) No matter how effective the loss control measures an organisation takes, there will remain some risk of the organisation being adversely affected by future loss occurrences. A risk financing programme is to minimise the impact of such losses on the organisation. It uses tools like: risk assumption, risk transfer other than insurance, self-insurance, insurance, etc. **1.1.3(c)(iii)**

Risk Management (as used by insurers) (風險管理(保險人所運用的)) Ways and means of improving the insured loss potential of risks that are insured. **1.1.3**

Risk Management (not as used by insurers) (風險管理(不屬於保險人所運用的)) In banking and other financial service areas, the reference is to the control of speculative risks. As a separate field of knowledge and discipline, it refers to the identification, quantification and methods of dealing with all types of risk, pure and speculative. **1.1.3**

Risk Transfer (風險轉移) Finding another party to promise in advance to bear the consequences of one's exposure to risk. **1.1.3(c)(iii)**

Salvage (in maritime law and marine insurance): This term is used to mean (a) (救助賞金) a reward payable to a person (salvor) who has successfully rescued ships or other maritime property from perils of the sea, pirates or enemies by the property owners, or (b) (救助) such a rescue. **3.4.5 Note**

Salvage (in non-marine insurance) (損餘): what is left of the subject matter of insurance, following damage, e.g. the wreck of a car, which may still have some scrap value. **3.4.5**

Section Limit (部分限額) A policy provision limiting the amount payable under a particular section of the policy. **3.4.7(d)(ii)**

Single Article Limit (單一物件限額) A property policy provision stipulating that the policy liability in respect of any one article should not exceed a specified sum called the 'single article limit', unless separately subject to its own sum insured. **3.4.7(d)(i)**

Solvency Margin (償付準備金) The extent to which assets exceed liability. Insurers in Hong Kong must have a solvency margin which does not fall below the 'relevant amount' (minimum required sum) at all times. **5.1.1a(b)**

Speculative Risk (投機風險) A risk which offers the possibilities of gain and loss. **1.1.2a(ii)**

Statutory Classification of Insurance (保險的法定類別) The categorisation of insurance classes in accordance with statute (the Insurance Ordinance), which broadly divides insurance into Long Term Business and General Business. **4.1.1**

Subject Matter of Insurance (保險標的) Where the **Subject Matter of Insurance** is lost, damaged, injured, or the like, the insurance policy will pay the insured according to the extent to which his interest in it will have been affected. It can be property, the person, potential liability or legal right. **3.1.1**

Subrogation (代位) The common law principle allowing an insurer to acquire and exercise for his own benefit any recovery rights the insured may possess against third parties in respect of the loss for which the insurer has indemnified the insured. **3.6**

Sum Insured (保額) The limit of the insurer's liability under the policy. **3.4.7(d)**

Suretyship (擔保) A suretyship contract is one whereby the surety is obliged to pay the obligee in the event of the principal's failure to fulfil an obligation to the obligee. It is the principal who pays the contract price. **4.1.1(b)**

Technical Representative (Insurance Agent's) ((保險代理人的)業務代表) More fully defined in the Code of Practice for the Administration of Insurance Agents, such a person (not being an insurance subagent) provides advice to actual or potential policyholders on insurance matters for an insurance agent, or arranges contracts of insurance in or from Hong Kong on behalf of that insurance agent. **5.2.2a(a)**

Technical Representative (Insurance Broker's) ((保險經紀的)業務代表) More fully defined in the Minimum Requirements Specified for Insurance Brokers, such a person provides advice to actual or potential policyholders on insurance matters for an insurance broker, or negotiates or arranges contracts of insurance in or from Hong Kong on behalf of an insurance broker for actual or potential policyholders. **4.2.2**

Termination of Agency (終止代理關係) An agency relationship may be brought to an end on various grounds, including mutual consent. **2.2.6**

Third Party (第三者) A person, not being the insured or the insurer, who might be involved in a claim as a claimant against the insured or a potential source of subrogation. **2.2.1**

Tontine (聯合養老保險) An unusual type of Long Term Business, where the policy benefit is payable to the last survivor of a specified insured group of persons. **4.1.1(a)**

Tort (侵權) The law of tort is notoriously difficult to define. In simple words, it is a kind of civil wrong (especially negligence) giving rise to a possible claim against the wrongdoer. It is the most important source of subrogation rights of insurers. **3.2.6(b)**

Trustee (受託人) A person who is holding property on trust for another. **3.1.4(b)**

Unfair Discrimination in Insurance (保險中的不公平歧視) This relates to the application of different terms which are not justified by the technical merits of the risk, e.g. charging higher premiums for women drivers in motor insurance. **6.3.3**

Uninsured Peril (不保危險) A cause of loss which is not specifically excluded from policy cover, but it is not specifically included either, e.g. raining under a standard fire policy. Damage from an uninsured peril may be recoverable, if proximately caused by an insured peril, e.g. water damage caused in fighting a fire.

Unit-linked Business (or Linked Business) (單位相連業務(或相連業務)) The policyowner's contributions (after deductions for expenses and premiums) are used to buy 'units' in an investment fund, so that the value of the product is linked to the value of the units. **4.1.1(a)**

Utmost Good Faith (最高誠信) The common law duty upon both parties in an insurance contract to reveal all material information to the other party, whether or not such information has been specifically requested. **3.2**

Valued Policy (定值保單) A valued policy – a policy effected on a valued basis – is commonly issued in marine insurance. A sum called 'agreed value' is specified in the policy, which will be taken as the value of the subject matter insured throughout the currency of the policy. **3.4.8(c)**

Vicarious Liability (轉承責任) A person's liability at law for the acts and omissions of another, e.g. the principal, in respect of his agent's actions. **2.2(c)**

Waive (a breach) (不追究 (違反)) Effectively an 'act of forgiveness', where a breach of policy condition or other contractual requirement is disregarded – actively or passively - by the aggrieved party, so that the contract remains unaffected by the breach. **3.2.2 Note 2, 3.2.6(c)**

Warrant (保證) To make a formal declaration as to the truth and accuracy of information supplied. **3.2.2 Note 1**

Warranty (保證) An absolute undertaking by the insured to do, or to refrain from doing, some specified thing(s), or an absolute affirmation as to the truth and completeness of information supplied. **3.2.2 Note 1, 5.1.2c(b)(iii)**

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Part II

Travel Insurance

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1 INTRODUCTION

Part II of the Study Notes is about the practice of travel insurance in Hong Kong. To a beginner in travel insurance, this is a subject that will take them quite some effort to master, because travel insurance is indeed composed of a large variety of insurance, which differs much in practice from one another. At any rate, if you would pick up and read any one travel insurance policy that is available in the local insurance market, you will find that the provisions applicable to any one policy section do not share too many features with those applicable to any other policy sections. In face of such difficulties, what can be and will be done here is find out and describe the practice commonly found in the local market.

At the bottom of most Chapters of these Study Notes, you will find actual cases of 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 these 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 Insurance Claims Complaints Bureau (ICCB), and the rest concern claims disputes that were ultimately settled between the claimants and the insurers without being referred to the ICCB for adjudication. It is worth noting that the Insurance Claims Complaints Panel (Complaints Panel) of the ICCB is empowered by the Articles of Association of the ICCB to look beyond the strict interpretation of policy terms in making a ruling. In addition, as far as good insurance practice is concerned, the Complaints Panel relies heavily on the expected standards set out in *The Code of Conduct for Insurers* (see 5.1.2 of Part I of these Study Notes), with particular reference to ‘Part III: Claims’.

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2 TRAVEL INSURANCE AGENTS

A new category of insurance agents, “travel insurance agents”, has been introduced in 2006 to the Insurance Intermediaries Quality Assurance Scheme in order to enable travel agents’ registrations as travel insurance agents and their staff members’ registrations as responsible officers or technical representatives, so that they can sell and actively promote travel insurance to their clients and be subject to regulation.

Only travel agents licensed under the Travel Agents Ordinance and their staff members are allowed to be registered as travel insurance agents and responsible officers or technical representatives respectively.

Travel insurance agents are only allowed to represent their principals in respect of Restricted Scope Travel Business, which is defined in the Code of Practice for the Administration of Insurance Agents as: “effecting and carrying out contracts of travel insurance tied to a tour, travel package, trip or other travel services which the same travel agent arranges for his clients, excluding any annual travel insurance policies or any travel insurance policies for tours, travel packages, trips or other travel services which the travel agent does not arrange for his clients”. Needless to say, where a traveller does not feel at ease with a travel insurance policy’s low limit of indemnity applying to a precious watch with which he is going to travel, and therefore wants to effect a full value “all risks” policy on it, a travel insurance agent will not be allowed to sell such a policy. That is because even if the proposed property all risks insurance is related to a tour or travel package which the travel insurance agent is arranging, it is not at all “travel insurance”.

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3 BASIC FEATURES OF TRAVEL INSURANCE

- (a) **Package policy:** a travel insurance policy can be said to be a package policy because of its features that are described below.
- (i) It is a single policy document representing more than one type of insurance. At any rate, a travel insurance policy covers all four types of subject matter of insurance, namely property, the person, liability and pecuniary interests.
 - (ii) It has pre-determined restrictions in cover, limits of liability, etc.
 - (iii) Whilst a travel insurance policy is divided into sections, with each section providing specifically defined cover, they are not rated separately. In other words, the insurer quotes premium for the whole policy, rather than for individual sections.
 - (iv) The insurer is not keen to modify a travel insurance plan so as to suit the specific needs of a particular proposer, exceptions not being unknown (see 7(c)(i) for examples of extensions of cover granted upon request). For instance, a proposer cannot go without a particular section in return for a discount off the premium. Nor can he have the limit of indemnity for, say, the personal money section raised, even if he is willing to pay an increased premium. Such inflexible practice is attributed to the need for a simple operation procedure for the sake of efficiency and cost effectiveness, which will ultimately benefit both the consumer and the service provider.
- (b) **Single or multi- insured person:** in addition to himself, a proposer of travel insurance may name as insured persons his spouse and/or any of their children below a specified age, who is or are travelling with him.
- (c) **Single or multi- trip:** Travel insurance policies are mostly taken out for a certain “trip” – a journey from the place of origin to the destination(s) and back - although insuring a one way trip is also possible. An annual travel insurance policy may also be taken out to cover an unlimited number of trips, for the sake of convenience or cost effectiveness. (It is worth repeating here that a travel insurance agent is not allowed to sell annual policies.)

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4 DOCUMENTATION

- (a) **Application:** on a travel insurance application form, the applicant is required to identify himself and the person(s) to be insured, and to specify the trip to be insured and the plan of insurance to be purchased (see **6(a)**).
- (b) **Certificate of insurance or insurance policy:** on accepting a proposal, the insurer or its agent will issue to the insured a certificate of insurance or an insurance policy. Either of these two types of document together with the attached provisions serves the same, important function of proving the existence of an insurance contract between the insured and the insurer.

Either of the documents is divided into sections, each providing a specific type of cover. It contains both general provisions (i.e. provisions that apply to all the sections) and sectional provisions (i.e. provisions that apply to one or more but not all of the sections). The following is a list of the sections often found in travel insurance policies (or travel insurance certificates) available in Hong Kong, details of which can be found in **Chapters 7 – 19** of this Part:

- (i) Personal accident benefits
- (ii) Medical expenses
- (iii) Hospital benefit
- (iv) Emergency services
- (v) Baggage and personal effects
- (vi) Baggage delay
- (vii) Personal money
- (viii) Loss of travel documents
- (ix) Personal liability
- (x) Travel delay
- (xi) Loss of deposit or cancellation of trip
- (xii) Curtailment of trip
- (xiii) Outbound travel alert.

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5 INSURED TRIP

The insured trip may be defined as one from the place of origin specified on the certificate of insurance to the planned destination(s) within the territorial limits (or geographical limits) (e.g. “Asia”, “Worldwide”, “Worldwide except Canada and the United States of America”, or the like) prescribed on the certificate of insurance, and then back to the place of origin. It should be noted that even a “Worldwide” policy will exclude travels in, to or through any of the countries specified for such limitation.

The certificate will also specify a maximum duration for the trip so that any event which happens on a date beyond the maximum duration will not be covered. Having said that, it is not rare for a travel insurance policy to provide for a free, automatic extension of the maximum duration for, say, 10 days, in the event of an unavoidable temporal extension of the insured trip.

The policy may further specify in greater detail the commencement and termination of the insured trip, distinguishing between a cancellation cover and all other cover. For instance, it might be stipulated that the insurance other than the cancellation cover commences on the departure of the insured person from his residence or office (whichever event happens later) and terminates on his return to his residence or office (whichever event happens earlier), provided that the insurance will not commence more than 12 hours prior to the time of departure from the international departure point in the place of origin, and will terminate 12 hours after the insured person has returned to the place of origin in the event that he has yet to reach his residence or office when that 12 hour period expires. Alternatively, the insured trip could be more narrowly defined on an ‘immigration counter to immigration counter’ basis. On the other hand, cancellation cover typically commences when a certificate of insurance is issued and terminates on the planned departure date.

Regarding the purposes of a trip, it could be important for certain travellers to make sure that the policy to be purchased covers travel for business purposes as well as travel for pleasure.

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6 RATING AND UNDERWRITING

- (a) **Rating:** Travel insurance premium is typically fixed according to the maximum duration of cover and the territorial limits. Of course, the premium will be higher where one or more of the insured's family members are also covered than where he is the only insured person. Besides, different scales of premium apply to different plans offered by the same insurer, where such plans offer different amounts of benefits and limits of indemnity.
- (b) **Underwriting:** Single trip risks are not individually underwritten, so that, for instance, the insurer will not inquire about the medical history of the person to be insured, which it will definitely do when underwriting a separate medical risk. (In other words, underwriting in travel insurance is virtually restricted to proposals for annual policies.) This practice is reflected by the simple design of application forms, which do not ask about material facts (such as the medical history of the person to be insured) other than the identification particulars of the trip to be insured, the age of the person to be insured, and so on.

Regarding disclosure of material facts, it is important to note that the mere fact that a proposal form does not ask about a particular fact which is material will not alter the legal position that a proposer is legally required to actively disclose all material facts, failure of which will entitle the insurer to avoid the contract.

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7 PERSONAL ACCIDENT BENEFITS

- (a) **Basic cover:** where any of the specified events of bodily injury happens, the relevant amount of benefit will be payable in accordance with the schedule of benefits, provided that the bodily injury was ‘caused solely and directly by accidental, violent, external and visible means during the currency of the policy, and sustained within one year of the accident’. (Note: the exact wording used will vary from one insurer to another.) This cover may possibly be restricted to an accident occurring outside the place of origin, so that an accident happening to the insured person when he is travelling back home from the airport in the place of origin will be uninsured.

Where more than one of the insured events of bodily injury result from the same accident, payment will only be made for that event which carries the greatest amount of payment. Besides, where a benefit becomes payable to an insured person under this section, payment will not be made to him thereunder in respect of another accident.

Some policies provide for a double payment under this section where the required accident happens whilst the insured person is travelling in a private car, in a coach arranged by a travel agency, or purely as a fare-paying passenger in a ‘common carrier’ (which term may be defined as a public conveyance licensed to carry passengers. Some double indemnity cover in addition includes bodily injury (as defined) that the insured person suffers while being an innocent victim in a robbery or attempted robbery.

- (b) **Insured events:** the insured events of bodily injury may comprise the following:
- (i) death;
 - (ii) loss of both eyes, two limbs, or one eye and one limb;
 - (iii) loss of one eye or one limb;
 - (iv) loss of hearing in both ears;
 - (v) loss of speech;
 - (vi) permanent total disablement; and
 - (vii) third degree burns (**note:** second degree burns might also be covered).

Some of the above terms may be defined in the following manner:

- (i) *Permanent total disablement:* the total inability to engage in any gainful occupation of any kind for a continuous period of at least 12 months, at which time there is no reasonable hope of improvement. Where the insured person does not have a gainful occupation at the time of the accident, the policy may provide for substitution of the term ‘normal daily duties’ for ‘gainful occupation’, so that an insured housewife and the like will not be deprived of this head of cover.

- (ii) *Loss of limb*: physical separation at or above the wrist or ankle, or a permanent loss of use of the limb.
 - (iii) *Loss of eye*: total, irrecoverable and irremediable loss of sight in the eye.
 - (iv) *Loss of hearing*: permanent and irrecoverable loss of hearing rendering the insured person deaf in both ears irremediable by surgical and other means of treatment.
 - (v) *Loss of speech*: total and irrecoverable loss of speech irremediable by surgical and other means of treatment.
 - (vi) *Third degree burns*: full thickness skin destruction due to burns.
 - (vii) *Second degree burns*: damage to both the epidermis and the underlying dermis due to burns.
- (c) **Exclusions**: there are a number of these and they may be considered under various headings:
- (i) *Hazardous activities*, such as dangerous sports (mountaineering, winter sports, etc.) and aviation other than as a fare-paying passenger. (Note: some plans do cover a couple of dangerous sports subject to restrictions, e.g. (1) scuba diving down to a depth of not more than 40 metres from the surface is covered; (2) winter sports and underwater activities are covered for reduced amounts of benefits/limits of liability. Individual insurers might be ready to grant extensions of cover for selected sports at additional premiums upon request. Some only exclude engaging in professional sports in return for income or remuneration.)
 - (ii) *Anti-social activities*, which will include suicide, deliberately self-inflicted injury and abuse of alcohol or drug.
 - (iii) *Other exclusions*, for example, injury as a consequence of disease.
- (d) **Age-related limitations**: the cover granted to any insured person who is beyond a specified age range, e.g. age 18 - 75, is normally reduced to a specified amount or proportion of benefit.

Case 1 – Duty to disclose claims history when applying for insurance

The insured was entitled to 41 days' sick leave as a result of a work accident. He then submitted an accident claim for total temporary disablement benefit.

The insurer's scrutiny disclosed that the insured had received a total of 22 days and 46 days accident benefit from another insurer for the injuries that he respectively suffered two months and six months prior to the issue of insurance cover to him. However, he did not mention his past claims on the policy application. The Complaints Panel dismissed the claim on being convinced by the evidence that it was a deliberate attempt on the part of the

insured not to reveal his claim history in order to secure the insurance cover.

Remarks: this case illustrates the materiality of the proposer's claims history and is relevant to each and every section of a travel insurance policy. In making the above decision, the Complaints Panel seemed to be attaching importance to the existence of fraud on the part of the insured when he was proposing for the insurance.

Case 2 - Definition of “total and permanent disability” for purposes of personal accident cover

A woman, who worked as a cleaning staff member in a secondary school, twisted her back while she was cleaning the classroom windows. She was admitted to hospital and the diagnosis was prolapsed intervertebral disc with sciatica. Due to this mishap, she was unable to carry on her duties and was forced to leave her job.

Her policy defined “Total and Permanent Disability” as “disability that prevents the insured from doing any work, occupation or profession to earn or obtain any wages, compensation or profit, and that such disability should last for not less than six months in duration”. Since she had been rendered unable to do any gainful occupation, the insurer granted her “Total and Permanent Disability” compensation for more than three years. After three years of physiotherapy, her attending doctor confirmed that she had become able to walk and move around without any aid and to be engaged in a sedentary job which would involve no bending of the back. The insurer therefore considered that her latest condition failed to fulfil the policy definition of “Total and Permanent Disability” and stopped further payment.

Accepting the professional opinions of the insured's attending doctor, the Complaints Panel was of the view that the insured was not excluded from performing work of any type. It, thus, resolved to endorse the decision of the insurer to reject the claim.

Remarks: the scope of “total and permanent disability” insured by the subject policy was not wide enough to cover the subject disability.

Case 3 - Definition of “total and permanent disability” for purposes of accident rider to life policy

The insured, who was a fireman, had been suffering from chronic low back pain and bilateral knee pain since early 1998. An x-ray photo of the lumbosacral spine revealed degenerative changes. His employment contract with the Fire Services Department was terminated in July 1999 because the Medical Board had assessed him to be unfit to continue working as a fireman. The insured believed that his condition had met the policy definition of Total and Permanent Disability and submitted a claim for waiver of premiums.

According to the policy definition, Total and Permanent Disability means “the life insured is unable to engage in any gainful occupation as a result of sickness or injury”. The insurer declined his claim on the basis that a medical report had confirmed that the insured could work and walk unaided without functional limitation. Moreover, the Fire Services Department had confirmed that the insured’s particulars had been circulated to other government departments in search of alternative employment.

Having noted the above, the Complaints Panel was of the view that whilst the disability had resulted in the insured being unable to continue his old occupation as a fireman, it did not prevent him from engaging in another gainful occupation. As such, it supported the insurer’s decision to decline the waiver of premium claim.

Remarks: this case concerns applying a restrictive definition of “total and permanent disability” for the purposes of an accident rider to a life insurance policy. This is also relevant to the personal accident section of a travel insurance policy.

Case 4 – Injury must have been accidental 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.

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, and 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 ‘accidental’ injury.

Case 5 – Definition of ‘accident’ for purposes of personal accident insurance

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 accident claim was upheld.

Remarks: this case involves applying a specific definition of ‘accident’.

Case 6 – Personal accident claimant must prove happening of ‘accident’

A construction worker sustained left wrist sprain injury as a result of moving heavy construction materials at work. Although his attending doctor confirmed that swelling and tenderness were noted on his wrist after the incident, a physical examination revealed no sign of visible bruise or wound. The insurer refused to meet his claim for Total Temporary Disablement benefit, on the grounds that the wrist injury was not a direct and independent result of an accident as evidenced by a visible bruise or wound on the body.

Apart from the insured’s personal account of the alleged accident, there was no objective proof of the incident’s happening. The Complaints Panel was not convinced that there was sufficient evidence to support a case of genuine injury and requested further information from the insured.

The insured produced to the Complaints Panel a letter from his employer stating that on the date of the incident, the insured was asked to carry some demolished wooden materials to a designated site some distance away. The insured having gone for a long time, his supervisor went looking for him and found him on the site with an injured left wrist. He was then sent to hospital.

Having gone through the fresh evidence from the insured’s employer, the Complaints Panel was of the view that a genuine accident had taken place resulting in the insured’s left wrist injury. Despite the lack of visible bruise

or wound, the Complaints Panel ruled in favour of the insured and awarded him the disablement benefit.

Remarks: whilst a 'visible bruise or wound' would be a strong evidence of the happening of an accident, the Complaints Panel was clearly of the view that other types of evidence could alternatively be accepted.

Case 7 - Proof of 'accident' for purposes of claiming under accident rider to life policy

The policyholder had been working as a bus driver for nearly 20 years. One day while he was driving a bus, he braked hard in order to prevent his vehicle from colliding with a car which had suddenly cut into his lane, and suffered a back injury as a result. He was given 99 days' sick leave and submitted a claim for accident benefit under his life policy.

The insurer refused to meet the claim as the policyholder's injury was not evidenced by any visible bruise or wound on the body. In addition, the insurer had learnt from the policyholder's employer that the policyholder had already taken over 100 days of sick leave in the past five years due to lower back pain.

The Complaints Panel, having considered the policyholder's long history of lower back pain, came to the view that there was insufficient proof that the cause of his back problem was accidental, and therefore decided to uphold the insurer's decision.

Remarks: the Complaints Panel was making reference to the insured's medical history in determining whether his injury had been caused by an accident. This approach is also applicable to the personal accident section of a travel insurance policy.

Case 8 - 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 from 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, instead of 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.

Case 9 – 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 emphasised 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'.

Case 10 – Claims provision requiring notification of accident

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: it is normal for a non-marine insurance policy to require notification of loss within a time limit. Whilst it is important for a claimant to satisfy such a requirement, a mere failure on his part to do so might not suffice to enable the insurer to repudiate the claim, the policy wording used and whether or not that has caused prejudice to the insurer being among the considerations.

Case 11 – Personal Accident Section requires ‘accidental injury’

The insured having died during her journey in Tibet, the insured’s father claimed Personal Accident Benefit, alleging that the death was due to an accidental injury.

On the terms of the policy, Death Benefit was only payable if death resulted solely from an Injury caused by an Accident. The causes of the death as shown on the insured’s death certificate were acute altitude stress, acute high altitude pulmonary edema and acute altitude brain edema. On the bases that the cause of the death was classified as a sickness (not an Injury) and the incident was foreseeable in high altitude environment (and thus did not constitute an Accident), the insurer rejected the claim.

Not being convinced by such arguments, the insured’s father complained to the ICCB and the Consumers’ Council, which ultimately concluded that the insurer’s decision was appropriate.

Remarks: just as its name implies, personal accident cover requires the happening of an accident. In addition, a typical travel insurance policy requires that the insured person must have been injured as a result.

Case 12 – Identifying proximate cause of injury in applying exclusion

The insured lost the sight of one eye in a serious car accident in the Gulf region at a time when the region had been declared a war zone. The insurer had to consider whether the policy exclusion of “losses arising out of war (whether declared or not), invasion, act of foreign enemies, civil wars” could apply to the insured’s claim for disablement.

Evidence suggested that it was a mere traffic accident not in consequence of war, even though there was combat in the areas nearby. Therefore the insurer decided that the war exclusion was not applicable and paid the claim.

Remarks: the insurer was resting its decision on an application of a rule of proximate cause to the war exclusion.

Case 13 - Personal Accident Section requires ‘accidental injury’

The insured had sustained a fatal injury on his journey in Beijing. It was reported to the insurer that the insured had had a fall in a hotel’s swimming pool. Feeling no abnormality after the fall, the insured did not report the incident to the hotel. With developed headache and vomiting four days after the incident, the insured was admitted to the hospital. Following two craniotomies done in Beijing, the insured was repatriated to Hong Kong and eventually died from intracerebral haemorrhage.

Personal Accident Benefit was payable under the policy for accidental death, in relation to which “Accident” was defined as “an event occurring entirely beyond the Insured Person’s control and caused by violent, external and visible means”. Following an extensive investigation, the insurer repudiated liability on the grounds that the cause of the death was not an “Accident” but an illness.

It was medical experts’ opinion that in the case of head injury caused by external means leading to haemorrhage in the brain, haemorrhage could be found in both the meninges and the spaces among them. Given that the area in which haemorrhage was detected in the subject case was confined to the right thalamus without any signs of haemorrhage in the areas of the arachnoid, it transpired that the haemorrhage was not caused by external means. The opinion was consistent with the findings of the attending physicians in Beijing and Hong Kong that there was no sign of trauma whereas the haemorrhage was spontaneous and related to primary hypertension not in relation to an accidental fall.

Relying on the expert opinion, the insurer rejected the claim.

Remarks: *it could be complicated to determine whether an injury has been caused by an accident within the meaning of the personal accident section.*

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8 MEDICAL EXPENSES

- (a) **Basic cover:** Indemnity will be provided for expenses of medical treatment whether as in-patient or out-patient necessarily incurred outside the place of origin and during the insured trip, as a result of an illness or accidental bodily injury contracted or sustained during the insured trip. Should *follow-up* medical expenses be incurred within, say, 6 months, after the insured person's return to the place of origin, reimbursement will also be made, for which purposes such expenses are usually defined as including Chinese medicine practitioner's fees, Chinese bonesetter charges and acupuncturist charges up to certain limits.
- (b) **Limits of indemnity:** Indemnity for hospitalisation expenses is usually limited to a specified amount per day of hospital confinement. Another limit exists for follow-up medical expenses incurred in Hong Kong. Besides, there is normally an aggregate limit for payments made under the section.
- (c) **Exclusions** will include:
- (i) Pre-existing (i.e. prior to insurance) conditions and disabilities;
 - (ii) Birth control and infertility treatment;
 - (iii) Cosmetic surgery;
 - (iv) Routine medical examinations and check-ups; and
 - (v) Treatment that in the opinion of the attending medical practitioner can be reasonably delayed until the insured person returns to the place of departure.
 - (vi) Treatment that is not substantiated by a written report by the medical practitioner.

Case 14 – Proposer is obliged to disclose material facts he knows or should know

A woman sustained ovarian cyst three months after taking out a medical insurance policy. The attending doctor's pathology report stated that "specimen contains compressed ovarian tissue and a cyst with recent and old haemorrhage". The insurer asserted that "old haemorrhage" meant that "bleeding had occurred in the past" and the insured should have known about it before she took out the policy.

The Complaints Panel saw no evidence which suggested that the insured previously had any knowledge of the concerned ailment. Further a medical practitioner gave evidence that there was only a 50% chance that the insured knew of her previous condition. In view of these, the Complaints Panel resolved the doubt in the insured's favour and made an award to her.

Remarks: the Complaints Panel was applying the 'balance of probability' standard of proof in determining whether the insured knew of her pre-existing medical condition when effecting the policy. This case is relevant to the medical expenses and hospital benefit sections of a travel insurance policy in relation to the proposer's duty to disclose material facts at the proposal stage.

Case 15 – Proposer is obliged to disclose material facts he knows or should know

A woman submitted a hospitalisation claim for the removal of a left ovarian dermoid cyst. Upon investigation, the insurer discovered that the woman had undergone laser treatment for retinal degeneration two months prior to her application for insurance. The insurer therefore rejected the claim and rescinded the policy on grounds of material non-disclosure.

The Complaints Panel had to consider whether the non-disclosed fact was material enough for the insurer to rescind the policy or not. Further enquiries revealed to the Complaints Panel that the woman had her first laser treatment to her eyes three years before her insurance application, receiving further medical treatments of the eyes at later dates. Given that the woman had a long history of eye problem, the Complaints Panel considered the insurer's rejection of the claim on grounds of non-disclosure appropriate.

Remarks: this case concerns the determination of whether a certain material fact has been known to the proposer, and is relevant to the medical expenses and hospital benefit sections of a travel insurance policy.

Case 16 - Proposer is obliged to disclose material facts he knows or should know

The insured suffered from stomach carcinoma and was admitted to hospital for 13 days. He then submitted a claim for daily hospital cash benefit.

The insurer's investigation revealed that prior to the issue of insurance cover to him, the insured had received treatments on and off for enteritis, TB and ulcer syndrome for more than 20 years but had failed to mention these on the policy application. In the event, the insurer rejected the claim on grounds of material non-disclosure.

For his part, the insured claimed that he had forgotten about these illnesses because of the absence of unusual symptoms in the past 10 years. He reinforced this point by producing his doctor's medical report which stated that all his ailments had only lasted for a short period of time and were symptomatic and not serious.

Accepting the insured's argument that his afflictions were of a minor nature and had occurred a long time earlier, the Complaints Panel concluded that the insurer's decision to repudiate the policy was somewhat severe and awarded 13 days of hospital cash benefit to the insured.

Remarks: the Complaints Panel seemed to be suggesting that on the facts of the case repudiation of the claim would be out of proportion to the nature of the breach (if any) of the duty of disclosure on the part of the insured. This case is relevant to the medical expenses and hospital benefit sections of a travel insurance policy.

Case 17 – How ‘material’ must a ‘material fact’ be

A woman was admitted to hospital for treatment for thyrotoxic goitre nine months after she had effected a medical policy in October 1998. The insurer found that she had sought medical consultation for anaemia in 1994 and got on-and-off allergic skin rashes between 1991 and 1997. As these facts had not been disclosed on the application form, the insurer rejected her hospitalisation claim and rescinded the policy on grounds of non-disclosure of material facts.

The woman emphasised that she had recovered from anaemia and did not need to take medication for at least three years. To substantiate her argument, she produced a letter from her attending physician, confirming that her haemoglobin levels in March 1995 and October 1997 respectively were normal. As for her skin rash, the woman alleged that it was only a common allergy and not of a serious nature.

The Complaints Panel learned from a medical report that prior to her policy application, the woman’s haemoglobin content was normal while her anaemia and allergic skin rash were mild and infrequent. In the end, the Complaints Panel was not convinced that the non-disclosed facts were material enough to have affected the underwriting decision of the insurer, and therefore ruled in the favour of the insured.

Remarks: to be ‘material’, a fact must be capable of influencing the underwriter’s decision. This case is relevant to the medical expenses and hospital benefit sections of a travel insurance policy.

Case 18 – Travel insurance policy only recognises “Registered Medical Practitioners”

Having twisted his left ankle while playing football, the insured consulted several doctors and received physiotherapy treatments. He submitted claims for reimbursement of medical expenses under his personal accident policy.

The insurer settled most of his medical expenses but refused to reimburse the medical expenses charged by a doctor who is a chiropractor on the grounds that a chiropractor is not a “Registered Medical Practitioner” as defined in the policy.

Although chiropractors are professionals, they are neither qualified by a degree in western medicine nor registered in Hong Kong under the Medical

Registration Ordinance. As the chiropractor failed to fulfil the policy definition of “Registered Medical Practitioner”, the Complaints Panel ruled that the insurer was not liable for the chiropractor charges.

Remarks: it is normal for a travel insurance policy to define “Registered Medical Practitioner” for the purposes of its medical expenses cover.

Case 19 - Commencement of medical expenses cover

The insured became ill while travelling to the Hong Kong International Airport, and diverted to a hospital for consultation, continuing with the trip afterwards. On his return, he submitted a claim for medical expenses, which the insurer rejected.

The policy defined the insured trip as commencing only when the insured leaves the Hong Kong Immigration Counter, and required that the insured sickness should be contracted and commence during the insured trip outside Hong Kong. Not being satisfied that all these requirements have been met, the insurer denied the claim.

Remarks: while the cover provided by some sections commences right after the insured has left his home or office, the other sections require that the insured event should happen at a time beyond a further, prescribed point.

Case 20 - Injury must have been sustained outside place of origin for purposes of medical expenses cover

The insured’s departure time was delayed for 14 hours due to aircraft problems. During the interval, the insured returned home but unfortunately twisted her leg when alighting from a taxi.

The insurer paid Travel Delay Benefit but declined her claim for Medical Expenses.

Although the policy did provide that “The insurance cover of all sections commences on the departure of the Insured Person from his residence or office”, its Medical Expenses Benefit Section provided that “This Insurance provides reimbursement of eligible expenditure for medical treatment arising from bodily injuries or sickness and or disability contracted or sustained outside the Place of Origin (defined as “Hong Kong”) during the Period of Insurance”. As the insured twisted her leg on her way back home within the geographical area of the Place of Origin, the insurer did not accept that the claim for medical expenses fell within the Medical Expenses Benefit cover.

Remarks: while the first provision above stipulated the commencement of the policy in general, the second provision went on to specify the circumstances in which medical expenses benefits would be paid, which clearly did not include injuries sustained in Hong Kong.

Case 21 - Injury must have been sustained outside place of origin for purposes of medical expenses cover

Without having had any abnormalities during his two week trip to Malaysia, the insured started to have fever two days after returning to Hong Kong. He was first diagnosed as suffering from flu by a general physician, and subsequently confirmed to have contracted atypical pneumonia by a specialist, who recommended hospitalisation.

As the policy only covered “bodily injuries or sickness and or disability contracted or sustained outside the Place of Origin during the Period of Insurance”, the insurer initially considered declining the claim for medical expenses in view of the facts that the insured had had no complaint of any discomfort nor had he consulted a physician while abroad, and that the symptom emerged only after his return.

Nevertheless, when medical expert opinion was obtained which affirmed that the atypical pneumonia would have an incubation period of 10 to 14 days prior to emergence of symptoms, the insurer accepted that the illness was contracted during the period of insurance and thus paid the claim.

Remarks: it is common knowledge that symptoms may appear only days after a particular disease has been contracted.

Case 22 - Injury must have been sustained outside place of origin for purposes of medical expenses cover

Prior to boarding, the insured had a slip in the departure hall of the airport in Seoul on the last day of his trip. For this he received no immediate treatment because he thought that the injury was minor and the plane was due to take off. On arrival in Hong Kong, the insured started to have increasing pain around the waist and pelvis. He consulted a physician the following day.

The policy covered only “bodily injuries or sickness and or disability contracted or sustained outside the Place of Origin during the Period of Insurance” and his claim for Medical Expenses was initially rejected in the absence of any incident report or overseas medical receipt evidencing that the injury had been sustained outside the Place of Origin.

Nevertheless, the insurer reconsidered and admitted the claim at a later date upon receipt of the tour leader’s statement affirming that he had witnessed the incident, and in view of the fact that it was not a condition precedent to policy liability that medical treatment had been sought on the spot.

Remarks: while it is expected that an injured insured should receive medical treatment as soon as possible, the circumstances of the accident may be such that that is not reasonably practicable until he has returned to the place of origin.

9 HOSPITAL BENEFIT

Apart from indemnifying the insured person for medical expenses under the medical expenses section, it is usual for a travel insurance policy to provide hospital cash allowance, which is a specified amount for each day of hospital confinement, subject to an aggregate limit per insured person and a time franchise. Like the medical expenses section, the hospital benefit section requires that the hospitalisation should have resulted from an illness or accidental bodily injury contracted or sustained during the insured trip, and is subject to similar exclusions (see **Chapter 8**).

Case 23 – Certain purposes of hospital confinement are excluded from hospital benefit cover

An insured broke her leg as a result of falling downstairs and was admitted to the Queen Mary Hospital (QMH). The diagnosis was periprosthetic fracture of the right femur. Open reduction of femur with internal fixation and bone grafting for femur were then performed. After staying in the QMH for 16 days, she was transferred to the MacLehose Medical Rehabilitation Centre (MMRC) for active training and physiotherapy treatment on her doctor's referral.

The insurer settled 16 days' hospital cash benefit for the insured's hospitalisation in the QMH, but refused to pay cash benefits for the remaining 78 days' stay in the MMRC. Despite the fact that the insured was referred to the MMRC by a physician, the insurer maintained that her confinement in the MMRC did not satisfy the policy definition of Hospital Confinement, which specifically excluded "any confinement for the purpose of nursing, convalescent, rehabilitation, extended care or rest facilities".

The Complaints Panel noted from the MMRC's discharge summary that the insured's confinement in the MMRC was merely for rehabilitation purpose and thus endorsed the insurer's decision to decline to pay the 78-day hospital cash benefits.

Remarks: this case, although about a medical insurance policy, is equally relevant to a travel insurance policy. Both the medical expenses and hospital benefit cover of a travel insurance policy is subject to specific exclusions.

Case 24 – To qualify for hospital cash allowance hospitalisation must be necessary

A woman was admitted to hospital for treatment for right buttock mass. Although the Magnetic Resonance Imaging (MRI) performed showed a superficial lump, she did not undergo any operation and was discharged the next day.

The insurer declined her hospitalisation claim on the grounds that the MRI could be effectively performed on an outpatient basis, hospitalization being unnecessary.

The Complaints Panel noted that the insured's buttock mass was very near to a nerve end and the lump might be constricting the nerve. It was the insured's attending physician who had recommended immediate admission to the hospital for diagnostic tests needed to decide whether prompt excision was necessary or not. When the MRI result showed only a superficial lump with no compression on nearby nerves, the excision plan was cancelled. In the circumstances, the Complaints Panel was satisfied that hospitalisation was necessary although MRI could be done in an outpatient facility. It therefore ruled in favour of the claimant and awarded her the hospitalisation benefit.

Remarks: in making the decision, the Complaints Panel seemed to be putting emphasis on the judgment of the attending physician in determining whether the diagnostic tests on an inpatient basis were necessary. This is applicable to both the medical expenses and hospital benefit cover of a travel insurance policy.

Case 25 - To qualify for insurance payment hospitalisation must be 'medically' necessary

The insured was admitted to hospital for low back pain experienced for over a month. Magnetic Resonance Imaging (MRI), x-ray examination and other laboratory tests were performed during her hospitalisation. The diagnosis being a mild prolapsed intervertebral disc, she was discharged the next day.

The insurer rejected her hospitalisation claim on the grounds that the hospitalisation had not been necessary and the tests could have been effectively done on a day care basis. More importantly, the policy excluded hospitalisation primarily for diagnostic scanning, x-ray examination or physical therapy only.

The Complaints Panel noted that the insured was advised by her attending doctor to be admitted to hospital for MRI, which might help to rule out any space occupying lesion inside the spinal cord, and for treatment of severe pain. However, the hospital bill made the Complaints Panel doubt if medication or treatment had been given to the insured on a day-to-day, controlled basis during her hospitalisation. Having sought further details from the attending doctor, the Complaints Panel found that the insured was recommended to have the MRI performed in a hospital because the MRI bookings in the outpatient clinic were full.

The Complaints Panel was of the view that the said hospitalisation was for the convenience of the insured and her doctor rather than due to emergency medical needs. As such, it was inclined to believe that the insured's hospitalisation was not medically necessary and thus upheld the insurer's decision to reject the claim.

Remarks: the requirement for 'medical necessity' is applicable to both the medical expenses and hospital benefit cover of a travel insurance policy.

10 EMERGENCY SERVICES

This section provides free, around-the-clock emergency services under several heads, including emergency evacuation, repatriation for medical care, repatriation of remains or ashes, and burial and funeral expenses. The insured person is advised to travel with a copy of the certificate of insurance, which bears the emergency hotline telephone number. It must be noted that should emergency services be arranged by the insured person without the approval of the insurer or its authorised representative, no reimbursement of the expenses so incurred will be made unless, for reasons beyond the insured person's control, the required notification to the insurer or its authorised representative could not have been made in an emergency medical situation.

- (a) **Emergency evacuation:** If the insured person sustains bodily injury or becomes ill during the insured trip and outside the place of origin so that immediate treatment is required but adequate medical facilities are not available in the locality, the insurer or its authorised representative will, upon notification of such circumstances, organise an emergency evacuation of the insured person to the nearest adequate medical facility (which may happen to be located in the place of origin) at the cost of the insurer, subject to no monetary limit. The insured expenses are chiefly expenses of transportation, medical services and medical supplies.

Disputes over whether or not 'immediate treatment' is required in particular circumstances sometimes arise. Some policy wording provides that it is for the assistance services provider named in the policy to judge the medical necessity. Of course, it is natural for the provider to seek medical practitioners' opinions in cases of difficulty.

- (b) **Compassionate visit:** Some travel insurance plans will provide indemnity up to a specified amount for reasonable additional travel ticket and/or accommodation necessarily incurred by one adult immediate family member (as defined) or one traveling companion of the insured person to travel over or stay behind, to be with and/or take care of the insured person, as a result of death of, serious injury (as defined) to or serious sickness (as defined) of the insured person occurring during the insured trip. Such cover is subject to a proviso that it can only be utilised once during the insured trip
- (c) **Return of unattended children:** A travel insurance policy may provide that in the event that any of the insured person's dependent child(ren) who is below a specified age, is travelling with the insured person and is left unattended overseas by reason of death of the insured person occurring during the insured trip, or of an accidental bodily injury to or sickness of the insured person occurring during the insured trip and resulting in hospital confinement for more than, say, 3 days, it will pay up to a specified amount for the reasonable additional accommodation and travelling expenses incurred for returning the child(ren) back to Hong Kong.

- (d) **Repatriation of remains or ashes:** In the event that the insured person dies during the insured trip, the insurer will arrange repatriation of the mortal remains to the place of origin at its cost, subject to no monetary limit.
- (e) **Burial and funeral expenses:** These expenses are normally payable up to a specified sum if the insured person dies during the insured trip.
- (f) **Exclusions:** Among others, expenses of treatment that can be reasonably delayed until the insured person returns to the place of origin are excluded from this section. This is the reason why the term ‘emergency’ is used to name the cover.

Case 26 - Exclusion of pre-existing condition from emergency services cover

The insured felt dizzy during her journey and was diagnosed as suffering from hypertension and tonsillitis. According to the attending doctor, the insured’s dizziness was due to high blood pressure and she should stay in hospital to have her blood pressure lowered and stabilised.

She requested that the insurer arrange an emergency evacuation. However, as the medical information obtained revealed that she had been suffering from hypertension for about ten years and hypertension was specifically excluded from the policy, the insurer turned down her request.

Believing that her high blood pressure was due to tonsillitis and being dissatisfied with the insurer’s decision, she complained to the ICCB after returning to Hong Kong.

The ICCB ruled that unless the insured could prove that her condition was not related to her hypertension, the insurer could maintain its denial of her claim.

Remarks: it was apparently the view of the ICCB that the insurer had satisfactorily proved that the insured’s condition was due to hypertension.

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11 BAGGAGE AND PERSONAL EFFECTS

- (a) **Basic cover:** This section provides indemnity for loss of or damage to baggage or personal effects owned by the insured person which was caused by an insured peril during the insured trip, subject to a limit per article or per pair or set of article, and to a limit per insured person.
- (b) **New for old:** Some policies provide ‘new for old’ cover, possibly restricted to articles not older than one year. In the absence of a ‘new for old’ provision, deductions will be made for wear and tear and depreciation from payments made under this section.
- (c) **Exclusions:** Below are some common exclusions:
- (i) some types of property, such as foodstuffs, animals, plants, antiques, jewellery, mobile phones, spectacles, consumables, money and documents;
 - (ii) confiscation by order of any Government or Public Authority;
 - (iii) baggage sent in advance;
 - (iv) baggage left unattended in a public place;
 - (iv) breakage of or damage to fragile articles;
 - (v) losses not reported to the police authority within, say, 24 hours; and
 - (vii) mysterious disappearance of property.

Case 27 - 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: this case was about motor insurance claims. Similar disputes may arise in travel insurance where, for instance, following the repair of an old camera necessitated by an insured accident, a claim is submitted for the full repair cost, unless the subject policy contains a 'new for old' provision.

Case 28 - Exclusion of 'fragile articles' from baggage and personal effects cover

The insured included in his checked-in baggage for his return flight a glass ornament he bought during his trip in the Czech Republic. It was found damaged upon arrival in Hong Kong.

The insured submitted an insurance claim for the damage, which was denied on the basis that fragile articles were specifically excluded from the cover.

Remarks: normally insurers treat articles made of glass as 'fragile articles' for the purposes of such an exclusion clause.

Case 29 - Personal Effects Section provides indemnity

The insured found his checked-in suitcase damaged on his return to Hong Kong. He reported the damage to the airline and claimed the cost of repairing the damaged suitcase. The insured also made an insurance claim for the same damage.

On being notified that the airline had already had the damaged suitcase repaired and returned to the insured, the insurer refused to pay the claim on the following grounds:

1. the Baggage and Personal Effects cover was subject to an exclusion of loss of or damage to property which functions normally after it has been fixed or repaired by the Common Carrier; and
2. no double indemnity should be provided.

Remarks: what the personal effects cover provides is 'indemnity', not 'benefit'.

Case 30 - Limit of liability per set of personal effects

The insured was paid for the loss of a digital camera and its memory card a sum of HK\$3,000, the article limit under the policy, which provided that “the limit of the Company’s liability for each item pair or set shall be HK\$3,000. Camera body, lenses and accessories will be treated as a set”.

The insured argued that the article limit was not applicable because the camera and the memory card were purchased under different invoices and therefore should not be treated as a set.

The insurer maintained its decision to pay only a sum of HK\$3,000 on the following grounds:

1. Although the memory card was detachable from the camera, it could not be used independently of the camera nor could the camera function without insertion of the memory card.
2. Apparently, the memory card was an accessory to the camera and the two items should be treated as a set.

Remarks: the policy did provide in unambiguous wording that “camera body, lenses and accessories will be treated as a set” for the purposes of applying the article limit.

Case 31 – What is included in a set of articles for purposes of article limit

In a similar case, the insured was paid for the loss of a digital camera and a flash a sum equal to the article limit. Likewise the insured argued that they were separate items.

Upon the manufacturer’s verification that the flash lost was an independent item with separate battery and stand and could function independently for various uses, the insurer accepted that it was not an accessory to the camera notwithstanding that it could be connected to the camera for flash synchronisation, and paid for the loss of the flash without applying the article limit.

Remarks: this insurer was apparently of the view that an item would not be an ‘accessory’ to a camera for the purposes of the article limit provision, only if its functions (or major functions) could be performed while it is not being connected to the camera.

Case 32 – Baggage and personal effects cover is subject to ‘care of property’ provision

The insured placed her holdall on a seat before alighting from a tour coach with the group for sightseeing. Although the coach driver was supposed to have stayed behind attending to the coach and the belongings of the group members, he left for a break. When he returned, he found that the coach had been broken into and that most of the members’ belongings including the insured’s holdall were gone.

Although the policy provided that “The Insured Person shall observe ordinary and proper care for the safety of the property” and that “The insurance does not cover loss of any baggage that is left behind or unattended in a public conveyance or a public place”, the insurer accepted that it had not been practicable for the insured to carry the holdall all along and, also, it was common for tourists to place their belongings in a coach when they left for sightseeing.

While the insured had left her holdall behind in the coach, it was not left unattended but was indeed put under the driver’s care and custody. Based on this, the insurer considered that the insured had duly observed her duty of ordinary and proper care. Furthermore, as the loss was unforeseeable and occurred entirely beyond the insured’s control, the omission of the driver should not be a bar to the insured’s right of recovery under the policy.

The claim was paid in the end.

Remarks: in determining whether the insured had complied with the ‘care of property’ provision, the insurer considered how reasonably or otherwise the insured had conducted herself in the circumstances of the case.

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12 BAGGAGE DELAY

- (a) **Insured Peril:** Where the insured person has been temporarily deprived of his baggage for a period of at least (or more than), say, 10 hours after arriving at the destination because of delay or misdirection in delivery, this section will pay up to a limit per insured person the cost of recovering the baggage or the costs of the consequent purchases of essential items of toiletries or clothing. As an alternative to providing indemnity, a policy may pay the insured person a specified amount subject to a time franchise.

It is interesting to note that it is not a common practice to expressly qualify the insured 'delay or misdirection in delivery' as one done by a common carrier. Suppose a traveller proceeds to his hotel without waiting for his delayed baggage at the destination airport, and asks the hotel to send someone to the airport to pick up the baggage for him. Further suppose that the traveller does not get back his baggage until 12 hours after his arrival at the airport (assuming that the applicable time franchise is 10 hours), and that evidence shows that the airline has merely caused a delay of 2 hours, the further delay of 10 hours having been caused by the hotel's misdirection in delivery. In these circumstances, it will be vital to determine whether or not the Baggage Delay Section also covers 'delay or misdirection in delivery' by a third party who is not a common carrier.

- (b) **Time of Expenditure:** It is not an express requirement that the costs be incurred at a time when the time franchise has expired.
- (c) **No Double Payment:** Where a loss falls within the scope of the Baggage and Personal Effects Section as well as that of the Baggage Delay Section, a proviso will operate to allow claiming under only one of these two sections.
- (d) **Exclusions** may include:
- (i) delay not certified by the airline or tour operator; and
 - (ii) delay arising from detention or confiscation by customs or other law enforcement officials.

Case 33 - Baggage delay covered on a named perils basis

The insured joined a 5-day tour to Thailand and purchased an insurance policy through the travel agency. When he arrived at the Bangkok Airport, his baggage was found to have been lost due to an unknown reason. A few days later, the luggage was found and returned to the insured by the airline.

The insured claimed against the insurer for reimbursement of expenses of purchasing requisites. However, from the airline's irregularity report, the insurer discovered that the delay to the insured's baggage was attributed to its having been "wrongly taken by other passengers." This cause of loss was not considered by the insurer to have constituted "misdirection in delivery by the common carrier", the peril insured by the baggage delay section. On this basis, the insurer rejected the claim.

Remarks: the baggage delay cover is normally on a named perils basis, rather than on an all risks basis.

Case 34 – Reimbursement under Baggage Delay Section for emergency purchases of 'essential items of toiletries or clothing'

After arrival at the airport in Paris, the insured could not reclaim the stroller she carried on the journey for her baby. She had already purchased a new stroller when the airline arranged delivery of her stroller to her 17 hours after her arrival.

The policy covered "emergency purchases of essential items of toiletries or clothing consequent upon temporary deprivation of baggage for at least 6 hours from the time of arrival at destination abroad due to delay or misdirection in delivery". Despite a delay of over 6 hours and an apparently imminent need for the purchase of a new stroller, the claim for baggage delay was rejected on the grounds that the stroller replaced was not an 'essential item of toiletries or clothing'.

Remarks: in addition to requiring a 'temporary deprivation of baggage', the baggage delay cover was restricted to emergency purchases of 'essential items of toiletries or clothing' and did not include 'any baggage'.

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13 PERSONAL MONEY

- (a) **Basic cover:** Loss of personal money (the term ‘money’ may be defined as: cash, bank notes, cheques, travellers’ cheques and money orders) caused by theft, robbery or burglary is covered, subject to a limit per insured person.
- (b) **Exclusions** may include:
- (i) credit cards, Octopus cards, etc.;
 - (ii) losses not reported to the police authority within 24 hours of the loss;
 - (iii) loss of travellers’ cheques not immediately reported to the local branch or agent of the issuing organisation; and
 - (iv) mysterious disappearance.

Case 35 – Theft

While waiting at the baggage reclaiming carousels of the Bangkok airport, the insured discovered that he had left his wallet on the plane. He notified the airline of this, who then located the wallet on the plane. Unfortunately the money in the wallet was gone.

The policy would indemnify the insured “against losses of personal money in the form of banknotes, cash or travellers’ cheques directly resulting from theft, robbery or burglary”. The insured’s insurance claim for loss of money was declined on the grounds that the loss, instead of being a direct result of theft, was attributable to his leaving the wallet behind.

Remarks: this insurer was apparently of the view that loss of money could not have been caused by theft for the purposes of the personal money cover where that has been preceded by lack of care on the part of the insured.

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14 LOSS OF TRAVEL DOCUMENTS

- (a) **Basic cover:** This section will pay up to a limit 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) during the insured trip and outside the place of origin, and the costs of travel or accommodation incurred in arranging such replacement documents.
- (b) **Exclusions** may include:
- (i) A loss which has not been reported to the police within 24 hours of the discovery of the loss, or for which a police report has not been obtained;
 - (ii) Mysterious disappearance of documents;
 - (iii) The cost of replacing travel documents or visas which are no longer needed for completing the trip.

Case 36 – Insurer will not pay ‘extraordinary’ expenses of replacing lost travel documents

The insured lost his Re-entry Permit to the Mainland of China. As an application for a replacement Permit would entail a processing time of 12 working days, and presumably the insured had an instant need to travel to the Mainland, he, in addition to an ordinary Re-entry Permit, applied for an “Express” Temporary Permit, which would only require 5 working days for processing. The insured then submitted claims for the amounts of HK\$560 and HK\$200, being the respective processing fees for the two documents.

While the policy “reimburses the Insured Person for the cost of obtaining replacement of passports, air tickets and travel documents”, the insurer was of the view that such costs shall be confined to the actual replacement cost of the travel document lost and that the cost for obtaining an “Express” Temporary Permit was additional and irrecoverable under the policy. Hence, it only paid HK\$560.

Remarks: the insurer was apparently of the view that the insurance contract had only contemplated the replacement of a normal travel document, and any special circumstances of the insured in which an express document might be needed had never been among the insured events.

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15 PERSONAL LIABILITY

- (a) **Basic cover:** This section will indemnify the insured person up to a limit (of indemnity) against liability for accidental bodily injury of a third party or accidental loss of or damage to a third party's property occurring during the insured trip. It will also pay the relevant legal costs and expenses whether they be defence costs incurred with the insurer's written consent or costs awarded against the insured person. Depending on the wording used, such legal costs and expenses are payable either in addition to or subject to the said limit.
- (b) **Exclusions** may include:
- (i) Employers' liability (or employees' compensation);
 - (ii) Own damage: Liability for loss of or damage to property belonging to, or in the care custody or control of, or held in trust by, the insured person;
 - (iii) Contractual liability: This term in the context of liability insurance means legal liability assumed by an insured under an agreement, which would not have attached to him but for this agreement; and
 - (iv) Liability arising from ownership, possession or use of conveyance, firearms or animals;
 - (v) The insured person's liability to an immediate family member.

Case 37 - Handling claims from third parties

Having damaged a crystal table lamp belonging to a hotel, the insured satisfied the hotel's claim for the cost of replacing the table lamp without referring the claim to the insurer.

The insurance policy provided that the insurance "does not cover any liability, loss or claim ... where the Insured Person or his authorised representative has admitted liability or entered into any agreement or settlement without notifying and obtaining the prior written consent of the [insurance] Company". The insurer argued that the insured had breached this policy condition by admitting liability and paying compensation to the hotel without notifying the insurer and obtaining its prior written consent. Furthermore, the insurer was of the view that had the hotel's claim been referred to it, it could most probably have achieved through negotiation a more reasonable amount of compensation.

Finally, despite the alleged breach of policy condition, the insurer decided to pay the claim on an ex gratia basis after due consideration of the instant dilemmatic situation in which the insured found himself after the damage.

Remarks: the insurer is seen to have settled the claim pragmatically.

16 TRAVEL DELAY

This section will provide a benefit in a specified amount for each, say, 5-hour period of travel delay, provided that the delay has been for at least, say, 6 hours. Such delay must have been caused by an insured peril, such as adverse weather condition, natural disaster, terrorism, industrial action, hi-jack, mechanical derangement of aircrafts or other conveyances. For cover against issuance of outbound travel alert, please see Chapter 19.

The types of delay covered may include both departure delay and arrival delay, or be restricted to a specified one. It should be noted that even in the case of a policy covering both types of delay, the claimant is required by a policy provision to opt for benefits for either departure delay or arrival delay.

As an alternative to travel delay benefit, the claimant may claim for reasonable costs of alternative transportation arrangements where necessary as a result of the delay, up to a specified amount.

Some travel insurance plans gives the claimant the alternative of claiming an indemnity up to a specified amount for expenses which were paid in advance and amounts for which he is legally liable, all of which are not recoverable from any other source, in case he decides to cancel the insured trip on grounds of departure delay for at least, say, 10 hours due to an insured peril, such as adverse weather condition, natural disaster, terrorism, industrial action, hi-jack, mechanical derangement of aircrafts or other conveyances. Such alternative cover may appear under the ‘loss of deposit or cancellation of trip’ section, instead of the ‘travel delay’ section.

In addition, cover for travel delay is very likely to be subject to a proviso that the insurance must have been purchased before any media announcement of a strike affecting the common carrier concerned. Besides it is subject to several exclusions, including those which in effect exclude delay arising from the insured person’s default (for example, the insured person’s failure to check in according to the itinerary supplied to him is excluded).

Case 38 – Two possible types of travel delay

Two insured persons joined a group tour to the Mainland of China, and were scheduled to travel by a direct flight to Shenyang. After take-off, the flight was diverted to Beijing due to heavy snow. As a result, the insured persons were caused a 14-hour delay to the flight on arrival in Shenyang.

The insurer did consider that the inclement weather condition that had caused the flight delay was indeed a named peril insured under the Travel Delay section of the policy. However, this policy only covered “departure delay”, meaning that the period of delay was to be calculated from the original scheduled departure time of the Common Carrier to the actual departure time.

As the flight departed without any delay, the insurer rejected the claim (for arrival delay).

Remarks: it is important to distinguish between departure delay and arrival delay because not every policy covers both kinds of delay.

Case 39 - Travel delay covered on a named perils basis

The insured was about to fly back to Hong Kong as the last leg of his journey. Having arrived at the airport, he received the airline's announcement that the departure of his flight was to be postponed due to aircraft rotation.

The insured submitted an insurance claim for travel delay, which was rejected on the grounds that the cause of the delay, aircraft rotation, was not among the insured perils, which were: inclement weather condition, natural disaster, equipment failure, hijack, and strike by employees of the Common Carrier.

Remarks: the travel delay cover is normally on a named perils basis, rather than on an all risks basis.

Case 40 – Travel delay cover subject to time franchise

The insured couple had experienced travel delays during their trip to the USA and Canada with three flights as follows:

1. Chicago/Vancouver 15 July - delayed for 4 hours and 26 minutes
2. San Francisco/Las Vegas 22 July - delayed for 2 hours and 26 minutes
3. San Francisco/Hong Kong 26 July - delayed for 1 hour and 16 minutes

The policy contained a franchise provision which read as follows: "The period of delay is in excess of 6 hours in duration, which is effective from the scheduled commencement of a trip until the trip recommences on the first available alternative transportation offered by the carrier". The couple's claims for delay were rejected as the three scheduled flights in question were each delayed for less than 6 hours and did not recommence one after the other.

Remarks: the insurer considered the three scheduled flights in question as independent of each other, so that the respective periods of delay must not be aggregated for the purposes of the franchise provision.

Case 41 - Itinerary useful for proving travel delay

The insured could not travel from Barcelona to Milan by train due to the railway labour's strike. She did not resort to other means of transport and stayed in Barcelona for 11 days until the strike ended, and then rescheduled her journey, postponing the return date from 16 June to 3 August.

Travel Delay Benefit under the policy was payable "in the event the flight or other public transportation in which the Insured Person has arranged or scheduled to travel is delayed during the insured journey due to serious weather conditions, industrial action, hi-jack, technical or other mechanical derangement of aircraft or conveyances and the cancellation or postponement of the flight or vessel due to such derangement is entirely beyond the Insured Person's control".

Although there had been an industrial action, the insured failed to submit satisfactory evidence to prove that she had been affected by it. The Eurailpass that she possessed allowed her to travel on board the Euro trains any time within the prescribed period, and that was probably the reason why she could not produce to the insurer an acceptable itinerary to prove that she had arranged or scheduled to travel on board the trains delayed or cancelled. On these grounds, her claim was declined.

Furthermore, the insured was found to have purposely prolonged the journey and deferred the return date by 48 days. All subsequent delays were also not covered as they were no longer beyond the insured's control and fell beyond the period of insurance.

The insured made a complaint to the ICCB and the Complaints Panel ruled in favour of the insurer.

Remarks: *those who travel on Eurailpasses may face a difficult burden of producing an acceptable itinerary in the course of proving travel delay.*

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17 LOSS OF DEPOSIT 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, this section will indemnify the insured person for such loss, up to a specified amount. Examples of the usual insured perils include the following:

- (a) Death or sickness of or injury to the insured person or his immediate family member (as defined), travelling companion or close business partner (as defined) within, say, 90 days, before the planned departure date which disables any of them from making the insured trip;
- (b) Unexpected outbreak of riot or civil commotion at the destination within, say, one week, before the planned departure date;
- (c) Unexpected outbreak of an epidemic at the destination within, say, one week, before the planned departure date;
- (d) The insured person's failure to immediately notify travel agencies, tour operators or common carriers of the necessity to cancel the travel arrangement because of an insured event of death, sickness or injury (see (a) above); and
- (e) The insured person's attendance on a jury, appearance in court under a witness summons, or compulsory quarantine within a specified period before the planned departure date;
- (f) Damage to the insured person's principal home in Hong Kong arising from fire, flood or burglary within, say, one week before the planned departure date and requiring the insured person's presence in Hong Kong on the planned departure date for the purposes of police investigation into the incident;
- (g) Outbound travel alert (see Chapter 19).

This section provides that the insurance is purchased before the insured person becomes or should become aware of any circumstances that are very likely to cause the insured trip to be cancelled.

Case 42 - Trip cancellation covered on a named perils basis

The insured had enrolled in a cruise tour. One day prior to the scheduled commencement, the travel agent informed the insured that the tour had been cancelled due to the cruise company's operation.

The insured submitted an insurance claim for cancellation of trip, which was rejected as cancellation due to operational reasons is not an insured peril. The insurer further explained that the cause of the cancellation must be among the

named perils, such as death, serious sickness or injury of the insured or his family member, the insured person's attendance on a jury or appearance in court under a witness summons, and unexpected epidemic, riot or civil commotion at the planned destination.

Remarks: the trip cancellation cover is normally on a named perils basis, rather than on an all risks basis.

Case 43 - Exclusion of pre-existing conditions from 'Loss of Deposit or Cancellation' cover

On July 11, 2004, the insured registered for a tour to Japan scheduled to commence on July 24, 2004. Failing to turn up for the trip because of Palpitation (sickness), the insured claimed reimbursement from the insurer for the forfeited tour fee.

The insured's medical records showed that he had received treatment for a heart condition related to his Palpitation on June 19, 2004. Further, the sickness was diagnosed before the day he registered for the tour and effected the insurance. As a result, the insurer declined the claim on the basis of the 'pre-existing conditions' exclusion.

Remarks: the trip cancellation cover is subject to a 'pre-existing conditions' exclusion.

Case 44 - Trip cancellation is normally covered on a 'named perils' basis

Owing to the Malaysian government's refusal of Hong Kong people's entry during the period of the SARS outbreak, the insured cancelled his trip to Malaysia and filed an insurance claim for his resultant loss.

While the policy would indemnify the insured against loss of irrecoverable tour fares paid in advance, the cover was subject to the occurrence of any of the named perils of:

1. death, sickness or accident medically serious enough to cause an inability of the insured to travel;
2. death, serious sickness or accident afflicting the insured's immediate family members, close business partners or travelling companion;
3. the insured person's attendance on a jury, appearance in court under a witness summons, or compulsory quarantine; and
4. serious damage to the insured's home requiring his attendance.

As the cause of the insured's loss was not among the named perils, the insurer rejected the claim.

Remarks: trip cancellation cover is normally on a 'named perils' basis rather than on an 'all risks' basis.

Case 45 - Exclusion of pre-existing conditions from 'Loss of Deposit or Cancellation' cover

The insured effected an insurance certificate on 2 April but then cancelled her trip due to serious illness of his father on 4 April.

On the basis of the policy proviso that the losses “should not arise from medical or physical conditions or other circumstances affecting the Insured Person, or immediate family members or travel companion, close business partner of the Insured Person known to exist at the time of issue of the Insurance Certificate”, the claim was initially declined as the patient’s renal failure was a chronic disease in existence at the time of the issue of the insurance certificate.

Further investigation by the insurer revealed that the patient had been suffering from a renal disease and was required to receive haemodialysis treatment regularly at the hospital. The follow-up treatment on 4 April, two days prior to the commencement of the insured’s journey, was a regular pre-appointment which would not have prompted the insured to cancel the scheduled journey, and her father’s condition only deteriorated in the course of the haemodialysis treatment.

The insurer accepted that despite the patient’s history of renal disease, such circumstances would not have prevented the insured from travelling until the patient’s condition deteriorated on 4 April. As the circumstances of renal failure were not known to exist at the time of the issue of the insurance certificate, the claim was reconsidered and finally admitted.

Remarks: the insurer was apparently of the view that for the purposes of the 'pre-existing conditions' proviso, the conditions that matter are those which at the time of the issue of the insurance certificate will prompt a reasonable insured to cancel the journey.

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18 CURTAILMENT OF TRIP

- (a) **Curtailement 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, this section will indemnify the insured person for loss of pre-paid travel fare or accommodation expenses, and any additional costs of returning to the place of origin.

The insured perils will normally include death or sickness of or injury to the insured person or his immediate family member (as defined), travelling companion or close business partner (as defined) which disables any of them from continuing with the trip, hi-jack of aircrafts or conveyances, unexpected outbreak of an epidemic or of riot or civil commotion, natural disasters, damage to the insured person's principal home in Hong Kong arising from fire, flood or burglary, and issuance of an outbound travel alert (please read Chapter 19).

- (b) **Rearrangement of trip:** Where the insured trip has commenced but, because of the happening of any of the specified perils (see (a) above for examples of the insured perils), has to be re-routed, this section will indemnify the insured person for any additional travelling and accommodation expenses incurred after the commencement of the insured trip and outside the place of origin.

Payments under this section are subject to an aggregate limit per insured person, and a proviso that the insurance is purchased before the insured person is aware of any circumstances that are very likely to cause the insured trip to be curtailed or re-routed.

- (c) **Exclusions** may include:
- (i) bankruptcy, liquidation or default of travel agencies, tour operators or common carriers; and
 - (ii) the insured person's failure to immediately notify travel agencies, tour operators or common carriers of the necessity to curtail the trip because of the death or sickness of or injury to an immediate family member or close business partner of the insured person.

Case 46 - Reasonable expenses consequent upon curtailment of trip

The insured curtailed her trip after sustaining bodily injury in a traffic accident in Singapore. She purchased an executive class air ticket for her return on the immediately available flight, alleging that an economy class air ticket was not available unless she would take the second available flight, which would depart about an hour later.

The insurer only agreed to pay the cost of an economy class air ticket for two reasons. Firstly the policy provided that “the insurance indemnifies additional public transportation expenses returning to the Place of Origin (based on economy class fare for any transportation media)” in the event of curtailment. Secondly, in light of the insured’s medical condition, there was no imminent need nor was it medically necessary to upgrade the air ticket if the ensuing flight would depart only one hour later.

Remarks: for the purposes of the cover for curtailment of trip, the insured is normally expected to travel on economy class air tickets.

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19 OUTBOUND TRAVEL ALERT

- (a) **Outbound Travel Alert System:** The Security Bureau of the Hong Kong Government has been implementing an Outbound Travel Alert (OTA) System since October 2009, which aims to help people better understand the risk or threat to personal safety in travelling to 85 countries (exclusive of the Mainland of China, Taiwan and Macau) that are the more popular travel destinations for Hong Kong residents (HKRs). When there are signs of threat in a place that may affect the personal safety of HKRs, the Security Bureau will assess and consider the need to issue an OTA, taking into account such factors as the nature (e.g. whether it is targeted at travellers), level and duration of the threat.

There are three possible OTAs, namely amber OTA, red OTA and black OTA, which represent signs of threat, significant threat and severe threat respectively.

- (b) **Outbound Travel Alert (OTA) Cover:** All travel insurers in Hong Kong are now providing OTA cover as part of the standard travel insurance cover they offer, in response to the introduction of the OTA System by the Security Bureau. Such cover operates by naming the issuance of a black OTA by the Security Bureau for the planned destination as an insured peril under the sections on ‘loss of deposit or cancellation of trip’ and ‘curtailment of trip’, with or without a separate section on OTA. In addition to this, some plans include the issuance of a red OTA for the planned destination as an insured peril under the section on travel delay.

While it could be argued that as a reasonable precaution, an insured person should refrain from making a planned departure where a black OTA has already been issued prior to the planned departure, some travel insurance policies specifically require insured persons to cancel their trips in such circumstances, in return for full refunds of any premiums paid.

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20 LIMITATIONS AND EXCLUSIONS

- (a) **Various types of limitations:** Apart from the limitations and exclusions that apply to particular sections, there exist limitations and exclusions that apply to all sections. Some of the usual sectional limitations and sectional exclusions have already been discussed under the appropriate section heads.

The commonest limitations found in travel insurance include exclusions, limits of indemnity, excesses, time franchises, the contribution clause and the non-contribution clause. The possible limitations can be classified into those that apply only to indemnity insurance and those that apply to both indemnity and benefit insurances. The first category of limitations includes the contribution clause and non-contribution clause. Time franchises and general exclusions are examples of the second category of limitations.

- (b) **Pro rata average clause:** It is worth noting that the pro rata average clause, which is almost without exception incorporated into all non-marine property insurance policies, and which operates in the event of underinsurance by restricting policy liability on a pro rata basis according to the degree by which the sum insured at the time of the loss falls short of the value of the property insured at that time, is unknown in travel insurance. Instead the travel insurance policy provides indemnity in full for property loss up to a specified monetary limit.

- (c) **General Exclusions:** They may include the following:

- (i) War and war-like operation;
- (ii) Nuclear risk;
- (iii) Terrorist act, unless stated as being an insured peril under any of the policy section;
- (iv) Insured's breach of government prohibition or regulation;
- (v) Insured's failure to take precautions following warning through or by general mass media of intended strike, riot, civil commotion, natural disasters or epidemic;
- (vi) Insured's failure to take reasonable steps to safeguard his property or prevent injury; and
- (vii) Expenses recoverable from any other sources, other than those recoverable under this policy's Hospital Benefit Section, Personal Accident Section, Baggage Delay Section (under which benefit instead of indemnity is provided), or Travel Delay Section. (An exclusion so worded will have the effect of excluding expenses payable under any other policy that covers the insured's interests.) It is also typical for a travel insurance policy to provide that where an insured person is covered by more than one travel insurance policy issued by the insurer for the same trip, only the one that provides the greatest amount of cover will apply.
- (viii) Travel that is made against the advice of a medical practitioner or for the purposes of obtaining medical treatment.

21 CLAIMS

- (a) **Claims procedure:** Like insurance policies of most other classes, a travel insurance policy lays down claims procedures, which the insured person is required to follow right from the moment that an event happens which may possibly give rise to a claim under the policy. The procedures of claims under different sections are somewhat different, with some common features like the requirements of notification of accident and of completion of a claim form.

Put simply, the claims provisions require the insured person to do something or not to do something. The first category of claims provisions includes a notification provision, a provision requiring the completion and submission of a claim form, and those that require documentary evidence of the happening of an insured event and of the amount of loss. Documents of proof that a travel policy may specifically require include receipts for purchases of the items that have been lost or damaged, a copy of a statement to a police authority reporting wilful damage or loss of money or personal effects, and a copy of a statement to an airline claiming for loss of baggage.

The most important provision that bans the doing of something is the one that requires the insured person not to admit liability to a third party without the insurer's written consent – a breach of this provision will very likely compromise a subsequent defence in court against that third party's claim and thus allow the insurer a contractual right to deny the insured person's claim under the personal liability section.

- (b) **Arbitration:** It is possible for a travel insurance policy to provide for arbitration as a means to settle a claims dispute between the insured person and the insurer. Such a provision requires that any arbitration should commence not later than, say, one year from the date that the insurer disclaims liability, failure of which will render the claim inadmissible. In the absence of an arbitration provision, the policy will usually specify a limit of, say, three years for instituting legal proceedings against the insurer.
- (c) **Insurance Claims Complaints Bureau:** Instead of resorting to arbitration in accordance with the arbitration provision, if any, or to legal action, an insured person may make a claims-related complaint against his insurer to the Insurance Claims Complaints Bureau, an objective of which is to facilitate the settlement or withdrawal of such a complaint by making awards or by other appropriate means.
- (d) **Settlement options:** The baggage and personal effects section usually provides that the insurer may settle an insurance claim by cash or by any one of the prescribed methods, which can be repair, replacement or reinstatement. Where the policy has not prescribed any settlement options, the insurer is legally obliged to settle a valid claim by payment of cash. Regarding settlement by cash, it should be noted that although it is the normal practice in indemnity insurance to *reimburse* the insured for insured losses, travel insurers pay for emergency services direct to the service providers.

22 BENEFICIARIES

When applying for travel insurance, the applicant will be asked to designate a beneficiary, who is to receive death benefit under the Personal Accident Section when that is payable. Of course, the applicant may choose to designate himself or nobody as the beneficiary – in either of these events, the death benefit will be paid to his estate.

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23 MISCELLANEOUS GENERAL PROVISIONS

Apart from those provisions that have been discussed above, there remain some provisions that apply to the whole policy, which include the following:

- (a) **Premium non-refundable:** Unlike the normal practice with most types of general insurance, a travel insurance policy does not provide for its cancellation by either party. On the contrary, it usually provides that once a policy or certificate of insurance is issued, no premium refund will be made.
- (b) **Age limits of insured persons:** Cover is restricted to those insured persons who fall within a specified age range, e.g. 6 weeks to 85 years. Instead of denying cover to persons falling beyond a specified age range, some policies reduce the amounts of benefits/limits of liability to be made available to such persons under their personal accident benefits, medical expenses, and hospital benefit sections by a specified proportion. In addition, children under, say, 18 years of age must be accompanied by an adult insured person when travelling.
- (c) **Reasonable care:** Whilst *careless or negligent* conduct of the insured person is tolerable so far as claims are concerned, losses arising from his *reckless or deliberate* conduct will be irrecoverable.
- (d) **Assignment:** An assignment provision may be included to require the insurer's written consent to a purported assignment of interest in the insurance contract or to require the giving of a written notice of such an assignment to the insurer, for it to be valid.

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24 HANDLING OF CONTINGENCIES

Should the insured traveller be caught in a contingency, how he will react will have insurance claims implications. It will be best if he has a copy of his insurance policy at hand when travelling. Where the full policy wording is not around, it is advisable to assume the widest scope of cover and the most stringent terms when deciding on what steps to take to preserve his right to make an insurance claim. For instance, in the event of a delay to a flight, he should still retain the relevant boarding pass and any correspondence issued by the airline concerned advising of the delay, its reason, etc. if he is not sure of the exact insured perils of the delay cover. Besides, it is also advisable to assume a policy requirement for a loss of money or personal effects to be reported to the local police at the first available opportunity.

24.1 Common Contingencies

- (a) **Flight Delay or Cancellation:** In the event of a flight delay or cancellation, the traveller (or the tour escort) should investigate into the feasibility of substituting overland transport means for the delayed or cancelled flight. It should be noted that the insurer would require that any additional costs to be incurred as a result must be necessary and reasonable in the circumstances. In addition, the insured traveller is expected to act as if uninsured so that he should, for example, seek the airline's agreement to bear all the resultant costs, even where they fall within the scope of cover of his policy. Any unrecovered balance of such costs, if insured, will be recoverable under the insurance policy's Travel Delay Section or Cancellation Section, as the case may be.

Sometimes the original airline will arrange a substitute flight. It should be noted that the insurer expects the insured person not to reject an offer of such an arrangement unreasonably. For instance, a particular insurer may consider it unreasonable for the insured person to purchase an executive class ticket on the immediately available flight at the expense of the insurer, if the airline has expressed willingness to allow the insured person to fly free on an economy-class flight which is scheduled to depart an hour later than the immediately available flight.

- (b) **Accident during a Flight:** Should the traveller be injured on an airplane, he (or the tour escort) should notify the flight attendants of this. Better still, a written report on the incident should then be obtained from the airline as independent verification of what had happened to him and when. His own account of the incident will be no substitute for such a report for the purposes of making a claim for personal accident benefit.
- (c) **Theft during a Flight:** In the case of a theft loss occurring during a flight, the traveller should notify the flight attendants of this, and report the case to the police at the flight destination and obtain a copy of the police report. This report is normally required for making a claim for loss of personal effects or personal money. If for any reason a police report is not available, a written report on the incident from the airline may possibly help.

- (d) **Injury Sustained in a Hotel:** Should the traveller be injured within the boundaries of a hotel wholly or partly because of the hotel's fault, he should try to claim compensation from the hotel. It should be noted that even in circumstances where the hotel is seen to be blatantly at fault for the injury, there is no guarantee that it will agree to pay or fully pay for it, so that the injured traveller may possibly have to pursue a claim against the hotel and/or an insurance claim for personal accident benefit after his return to Hong Kong. Therefore, if possible, the injured traveller should obtain a report on the incident from the hotel and retain all the relevant receipts for medical treatment and the like, for the purposes of subsequent claims.
- (e) **Theft in a Hotel:** The traveller should report a theft loss happening in a hotel to the hotel manager and then to the police. A copy of the police report should be obtained. This report is normally required for making a claim for loss of personal effects or personal money. If, for any reason, a police report is not available, a written report on the incident from the hotel may possibly help.
- (f) **Damage to Hotel Property:** If, in the course of checking out from a hotel, the traveller is alleged to have damaged an item of hotel property, he should discuss with the hotel manager how to resolve the liability issue, with the aim of minimising his loss. It is important to note that reaching a settlement agreement with a third party without the insurer's prior written consent will, in relation to a claim under a Personal Liability Section, constitute a *technical* breach of that policy condition which requires the insured person not to admit liability to a third party without the said consent. That said, this can be a good opportunity for the insurer to acquire renown as a reputable insurer by taking a pragmatic approach in such a matter by disregarding the technical breach in handling the insured traveller's subsequent claim, if the insured person is seen to have acted reasonably in minimising the loss as if he were uninsured.
- (g) **Loss of Baggage:** In the event of such a loss, the insured traveller should note that his policy may require, under the Baggage and Personal Effects Section, that this be reported to the local police immediately.
- (h) **Loss of Personal Effects or Travel Documents:** In the event of such a loss, the insured traveller should report this to the police in the area and obtain a copy of the statement made. This statement is normally required for making a claim for loss of personal effects.
- (i) **Sickness:** Where the insured traveller is ill and seeks medical attention, it is important to obtain receipts for the resultant expenses and medical reports for the purposes of claims for medical expenses or hospital benefit.
- (j) **Personal Accident:** Where the insured traveller was injured in an accident, he should obtain relevant reports and receipts and any other documentary evidence for the purposes of subsequent claims for personal accident benefits, medical expenses or hospital benefit.

- (k) **Death:** In the event that the insured person dies during the insured trip, the policy will normally arrange the repatriation of the mortal remains to the place of origin at its cost, possibly up to a specified amount.
- (l) **Non-delivery of Baggage:** In the event of non-delivery of baggage from the airline, the insured traveller should seek from the airline a receipt for reporting of loss and, unless the place of origin has been reached, articles of everyday use (such as toothpaste, toothbrush and comb). It should be noted that where articles of everyday use have been provided to him so that it is no longer necessary for him to spend money on such items, no insurance indemnity for baggage delay will be provided.

24.2 Package Tour Accident Contingency Fund Scheme

Funded by the Travel Industry Compensation Fund, this Scheme provides financial relief to outbound travellers on package tours who are injured or killed in accidents whilst touring abroad, in the form of ex gratia payments for:

- (a) medical expenses incurred in the place of accident outside Hong Kong;
 - (b) expenses incurred in the place of accident outside Hong Kong for funeral or return to Hong Kong of the remains or ashes of the deceased; and
 - (c) expenses incurred by relatives for compassionate visits to the place of accident;
- subject to respective maximum amounts.

For the purposes of the Scheme, an “outbound traveller” means a person who has paid a travel agent an inclusive price for an outbound travel service comprising any two or all of the following:

- (a) carriage (by land, sea or air transport) from Hong Kong to places outside Hong Kong;
- (b) accommodation outside Hong Kong;
- (c) arrangements for an activity outside Hong Kong.

- o - o - o -

Representative Examination Questions

Type “A” Questions

- 1 Which of the following is the most usual document that is used to prove the existence of a contract of travel insurance?
- (a) certificate of insurance;
 - (b) notice of insurance;
 - (c) open cover;
 - (d) none of the above.

[Answer may be found in **Chapter 4(b)**]

- 2 Which of the following statements regarding underwriting in travel insurance is true?
- (a) the underwriting practice in travel insurance is more stringent than in commercial insurance;
 - (b) single trip risks are not individually underwritten;
 - (c) each section of a travel insurance policy is underwritten individually;
 - (d) all of the above.

[Answer may be found in **Chapter 6(b)**]

Type “B” Questions

- 3 Which of the following are among the basic features of the type of travel insurance that a travel insurance agent is allowed to sell?
- (i) Each section of a travel insurance policy is rated separately.
 - (ii) Package policies are issued.
 - (iii) The policy must not be an annual one.
 - (iv) A travel insurer is normally willing to modify a travel insurance policy to suit the needs of a particular client.
- (a) (i) and (ii) only;
 - (b) (i), (ii) and (iii) only;
 - (c) (ii) and (iii) only;
 - (d) (iii) and (iv) only.

[Answer may be found in **Chapter 3**]

[If still required, the answers may be found at the last page of this Part.]

GLOSSARY

Arbitration (仲裁) A legally recognised method of resolving a dispute in a less formal, more private, manner than litigation. Often a subject covered by policy conditions. **21(b)**

Excess (免賠額(或自負額)) A contractual provision requiring the insured to be responsible for up to the stated figure or proportion in respect of each and every claim **20(a)**

Permanent Total Disablement (永久及完全殘疾) Can be defined as the total inability to engage in any gainful occupation of any kind for a continuous period of at least 12 months, at which time there is no reasonable hope of improvement. Where the insured person does not have a gainful occupation at the time of the accident, the policy may provide for substitution of the term ‘normal daily duties’ for ‘gainful occupation’. **7(b)**

Pro Rata Average Clause (比例分攤條款) 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. **20(b)**

Second Degree Burns (二級燒傷或燙傷) Can be defined as damage to both the epidermis and the underlying dermis due to burns. **7(b)**

Single Trip (單次旅程) A travel insurance policy is often taken out for a particular trip – i.e. from the place of origin to the destination(s) and then back to the place of origin. **3(c)**

Third Degree Burns (三級燒傷或燙傷) Can be defined as full thickness skin destruction due to burns. **7(b)**

Time Franchise (起賠期限) A franchise is a policy provision whereby the insured is not covered for any loss not exceeding or attaining the specified franchise, but is covered in full if the loss exceeds or attains the franchise, depending on the wording used. It could be related to a time, rather than an amount, so that (for example) no hospitalisation compensation or benefit is payable for less than three days’ stay, but compensation for the full period is payable for a longer stay. **20(a)**

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Representative Examination Questions

Answers

QUESTIONS

1

2

3

(a)

(b)

(c)

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