Insurance Intermediaries Qualifying Examination

Travel Insurance Agents Examination

Study Notes

2021 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 insurance practitioner or 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

TABLE OF CONTENTS

- o - o - o -

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 against (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*: shifting a certain risk of loss from one party to another (e.g. purchase of insurance and contractual terms shifting the financial loss of pure risk);

- *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.

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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 the insurance industry, the position is made a little complex because an **Insurance Intermediary** may be described as an **Insurance Agent** (usually representing the insurer) or as an **Insurance Broker** (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. 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 ('IO') and of the Marine Insurance Ordinance.

3.1.3 Its Essential Criteria

For an 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' generally means the ***transfer of a right***.

In insurance, there are broadly **two types of assignment**: *assignment of the insurance contract (*or *insurance policy)* and *assignment of the right to insurance moneys (*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 moneys** (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 moneys, 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 moneys 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 moneys. 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** 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 does not have 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 types of insurance 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 salved.

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 types of non-marine property insurance 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 insurance which may be said to give a *commercial* rather than a *strict* indemnity. Some examples are as follows:

(a) *Reinstatement insurance* (or insurance 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, deprecation, 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.]

Subject to 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 life insurance is generally 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 insurance
(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 ("IO"), which specifies the various classes of business. The IO 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	*Life and annuity*	-	life insurance and annuity, excluding class C below
B	*Marriage and birth*	-	insurance contracts providing benefits payable on marriage or on the birth of a child
C	*Linked long term*	-	unit-linked life insurance and unit-linked annuity
D	*Permanent health*	-	essentially long term policies providing benefits for incapacity from accident or for ill-health (the policy is not normally cancellable by the insurer)
E	*Tontines*	-	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	*Capital redemption*	-	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	*Retirement scheme management category I*	-	group retirement scheme contracts providing for a guaranteed capital or return
H	*Retirement scheme management category II*	-	group retirement scheme contracts not providing for a guaranteed capital or return
I	*Retirement scheme management category III*	-	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	*Accident*	-	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	*Sickness*	-	policies providing benefits or indemnity for loss due to sickness or infirmity, but excluding class D above
3	*Land vehicles*	-	property insurance on vehicles used on land, including motor vehicles but excluding railway vehicles)
4	*Railway rolling stock*	-	property insurance on such vehicles
5	*Aircraft*	-	property insurance on aircraft
6	*Ships*	-	property insurance on ships
7	*Goods in transit*	-	property insurance on goods in transit, including **marine cargo**

8	*Fire and natural forces*	-	property insurance covering fire and some other perils (e.g. storm and explosion)
9	*Damage to property*	-	property insurance exclusive of classes 3-8 above
10	*Motor vehicle liability*	-	third party **Motor** insurance (including compulsory motor insurance)
11	*Aircraft liability*	-	covering liabilities for property damage or personal injury/death arising out of the use of aircraft
12	*Liability for ships*	-	covering marine liabilities for property damage or personal injury/death
13	*General liability*	-	liability insurance exclusive of classes 10-12 above; employees' compensation insurance is included here
14	*Credit*	-	covering loss to creditors from debtors' failure to pay debts
15	*Suretyship*	-	contracts of guarantee, including fidelity guarantee, performance bonds
16	*Miscellaneous financial loss*	-	any other classes of business (business interruption, loss of use, etc.)
17	*Legal expenses*	-	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 authorized *insurers* (including those which are professional reinsurers);

(b) number of licensed *insurance intermediaries*;

(c) number of persons *employed* in the industry;

(d) premium volume.

4.2.1 Authorized Insurers

As at 24 August 2021, 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 54 pure long term insurers were authorized, comprising 26 Hong Kong incorporated companies and 28 others (including 1 from the Mainland of China).

(b) **'Pure' General Business** (see **4.1.1** (b) above): 91 pure general insurers were authorized, comprising 60 Hong Kong incorporated companies and 31 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 authorized, comprising 10 Hong Kong incorporated companies and 9 others (none from the Mainland of China).

4.2.2 Licensed Insurance Intermediaries

As at 30 June 2021, there were 2,248 licensed insurance agencies, 89,345 licensed individual insurance agents and 26,338 licensed technical representatives ('agent'). In addition, there were 818 licensed insurance broker companies and 11,381 licensed technical representatives (broker) on the same date.

4.2.3 Persons Employed

The quadrennial Manpower Survey on the Insurance Industry in Hong Kong (commissioned by the Vocational Training Council) conducted in 2021. This survey concluded that the industry on 2 January 2021 had a workforce of 102,288 people. 76% of this workforce were mainly connected with Life Insurance (84% of these being insurance agents or technical representatives of insurance agents) and 24% 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 2020 (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$ 59,869 million, representing 2.21% of Hong Kong's Gross Domestic Product;

(b) the premiums for Long Term Business were as follows: HK$458,570 million of Individual Life In-Force Business office premium, HK$4,770.8 million of Group Life In-Force Business office premium, HK$9,439.8 million of contributions for Retirement Scheme In-Force Business transacted by insurers, HK$48,670 million of Annuity and Other In-Force Business office premium. The total premium (HK$521,451 million) represents 19.24% of Hong Kong's Gross Domestic Product.

4.3 INSURANCE INTERMEDIARIES

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) **Licensing/Registration/Authorization**: Before 23 September 2019, insurance intermediaries in Hong Kong were required by the Insurance Ordinance[1] to be formally registered with a self-regulatory organization or authorised directly by the insurance regulator (albeit in reality virtually all intermediaries chose the former route), as the case may be. With effect from 23 September 2019, all insurance intermediaries are instead required to be licensed directly by the Insurance Authority. (see **5.2.1** below).

(b) **Qualifications**: Before being licensed, an applicant must satisfy certain criteria. These will be considered in detail later. (see **Chapter 5**).

(c) **Role**: While insurance may be arranged *direct* with an insurer, i.e. without using an insurance intermediary, but this is not the norm, especially in Long Term Business. That said, more and more direct transactions of insurance business are seen in the local market. 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.

[1] On 26 June 2017, the Insurance Companies Ordinance (Cap. 41) was renamed the Insurance Ordinance (Cap. 41).

(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 MARKET ASSOCIATIONS/INSURANCE TRADE ORGANISATIONS

Some of the major market associations/insurance trade organisations in the Hong Kong insurance market are:

4.4.1 The Hong Kong Federation of Insurers ('HKFI')

(a) This organisation has already been mentioned, but 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..

(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) In the past, the HKFI also ran a self-regulatory organisation ('SRO') named the *'Insurance Agents Registration Board'* ('IARB'), which was established in January 1993. The IARB used 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. However, the IARB ceased to perform any self-regulatory functions on 23 September 2019 when the Insurance Authority took over the regulation of insurance intermediaries from all three SROs (see **5.2** below).

4.4.2 Professional Bodies of Insurance Brokers

Below are the two most renowned professional bodies of insurance brokers in Hong Kong:

(a) *the Hong Kong Confederation of Insurance Brokers ('HKCIB')*; and

(b) *the Professional Insurance Brokers Association ('PIBA')*.

Like the HKFI's IARB, the HKCIB and PIBA used to perform a self-regulatory function in relation to their members.

That role, however, ended when the new regulatory regime for licensed insurance intermediaries came into effect on 23 September 2019, with both of them continuing to play a vital role in representing their broker members. Specifically, they engage with the Insurance Authority on a regular basis, assist in making policy recommendations that will affect the local insurance broking industry and make relevant training available to their members.

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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. Below, we shall examine the various 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 of Hong Kong.

The policy objectives of setting up the new IA are to modernise the insurance industry regulatory infrastructure to facilitate the stable development of the industry, provide better protection for policyholders and potential policyholders, 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 old self-regulatory system administered by three SROs.

5.1.1 Insurance Ordinance ('IO')

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 IO, formerly entitled the Insurance Companies Ordinance ('ICO'), came into effect in 1983. The principal functions of the then Insurance Authority under the ICO were to ensure that the interests of policyholders and potential policyholders 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 new IA took over the statutory functions of the OCI to regulate the insurance industry of Hong Kong and the OCI was disbanded on the same date. The new regulator is also tasked to (i) regulate the conduct of insurance intermediaries through a licensing regime; (ii) promote the understanding by policyholders and potential policyholders 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.

Some of the major provisions of the IO concerning the regulation of insurers are outlined in **5.1.1a-f** 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 IO 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*.

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, 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 authorized insurer must be **fit and proper** to assume such a position. In addition, prior approval of the IA is required for an authorized 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 any controller or director 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 Authorized Insurers** (GL10), which sets out the minimum standard of corporate governance that is expected of authorized insurers. A high standard of corporate governance established by authorized 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 Hong Kong insurance market. GL10 covers all levels of management, and all functions (risk management, underwriting, claims, client servicing, audit, etc.), of an authorized 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 IO requires authorized 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'** (GL12). GL12 applies only where an authorized 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 IO). The reason why GL12 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.

GL12 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 all applicable laws. Specifically, insurers should give attention to the following:

(a) **Complaints**: proper procedures should be in place to deal with complaints against insurance agents.

(b) **Adequate Support**: insurers should ensure that insurance agents have adequate support to perform their duties efficiently.

(c) **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 become a member of the *Insurance Complaints Bureau* ('ICB') (see **5.1.3** below), which adjudicates insurance claims disputes between insurers and individual policyholders.

5.1.3 Insurance Complaints Bureau ('ICB')

The Insurance Complaints Bureau ('ICB') was inaugurated on 16 January 2018 to supersede The Insurance Claims Complaints Bureau ('ICCB') in providing an alternative dispute resolution mechanism to help resolve insurance-related disputes of a monetary nature arising from personal insurance contracts. Apart from maintaining the ICCB's service of adjudicating claim-related disputes, the ICB has launched a new mediation service to handle non-claim related insurance disputes of a monetary nature starting from 16 July 2018. It is worth noting that the ICB has no jurisdiction over insurance intermediaries' misconduct.

The ICB continues to have a compulsory membership of all authorized insurers carrying on personal insurance business in Hong Kong. The independence and impartiality of the ICB are partly reflected by the composition of its Board of Directors, of whom four – including the Chairman – come from outside the insurance industry and four from the insurance industry.

5.1.3a Composition and Powers of The Insurance Claims Complaints Panel

(a) Claim-related complaints that are filed with the ICB are actually adjudicated by the *Insurance Claims Complaints Panel* (the 'Complaints Panel'), which is led by an independent Chairman appointed by the ICB with the prior consent of the Secretary for Financial Services and the Treasury.

(b) Of the other four members on the Complaints Panel, two come from the insurance industry and two from outside.

(c) No fee is charged to the complainant, whether he wins his case or not.

(d) The Complaints Panel can make an award against an insurer up to **HK$1,000,000**, who has no right of appeal against an award. If the complainant is unsatisfied with the decision of the Complaints Panel, he may, however, seek legal redress.

(e) Further points on the powers of the Complaints Panel: The Articles of Association of the ICB stipulates that the Complaints 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 ICB. 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 Complaints Panel, in making a ruling, is empowered by the ICB Members to look beyond the strict interpretation of policy terms.

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*, 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 Complaints Panel.

5.1.3b Terms of Reference of the ICB's Services

Any complaint that the ICB sets out to handle should satisfy the following conditions:

For both claim and non-claim related complaints:

(a) the complaint is of a monetary nature;

(b) the claim amount/monetary value of the complaint does not exceed HK$1,000,000;

(c) the insurer concerned is an ICB member;

(d) the policy concerned is a personal insurance policy;

(e) the complaint is filed by a policyholder/policy beneficiary/ insured person/rightful claimant (e.g. an assignee);

(f) the insurer concerned has made its final decision on the claim/dispute;

(g) the complaint is filed with the ICB within 6 months from the day of notification by the insurer of its final decision;

(h) the complaint does not arise from commercial, industrial or third party insurance;

(i) the complaint is not subject to legal proceedings or arbitration.

For non-claim related complaints:

(j) the complaint is not about quality of service or an underwriting decision of an insurer; and

(k) the complaint is not related to investment performance, level of a fee, premium, charge or interest rate unless the dispute concerns an alleged non-disclosure, misrepresentation, incorrect application, negligence, breach of any legal obligation or duty or maladministration on the part of an insurer.

5.1.3c Non-claim Related Mediation Service

Where the parties concerned in dispute have failed to reach an amicable resolution despite the ICB's encouragement to do so, they may select a mediator from a list of qualified mediators with relevant experience and qualification that the ICB maintains for mediation service. With a jurisdiction limit of **HK$1,000,000**, the mediation service is free to complainants.

5.2 REGULATION OF INSURANCE INTERMEDIARIES IN HONG KONG

Taking effect on 23 September 2019, the **new regulatory regime for insurance intermediaries**, i.e. insurance agents and insurance brokers, superseded the old self-regulatory regime, which operated between 30 June 1995 and 22 September 2019. The self-regulatory regime, supported by the legislation contained in Part X of the Insurance Ordinance ('IO') (formerly known as the Insurance Companies Ordinance ('ICO')), required each insurance intermediary to be registered with and regulated by one of the three Self-Regulatory Organizations ('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 ('IA'), subsequent to taking over the functions of the Office of the Commissioner of Insurance ('OCI') on 26 June 2017 to regulate insurers, took over the regulation of insurance intermediaries from the three SROs on 23 September 2019 through a statutory licensing regime. In other words, as from 23 September 2019, the IA directly licenses and regulates all insurance intermediaries in Hong Kong.

Some details of the requirements of the new regulatory system are set out below, alongside an overview of the now-defunct self-regulatory system with references to the 'pre-amendment Ordinance' (meaning the ICO as in force immediately before the commencement date of the new regulatory system) as well as the 'new Ordinance' (meaning the IO as in force on the commencement date of the new regulatory system).

5.2.1 Basic Requirements of the Licensing Regime for Regulation of Insurance Intermediaries

Regulated under the now-defunct self-regulatory regime were appointed insurance agents and authorized insurance brokers - defined in the pre-amendment Ordinance - and their responsible officers, Chief Executives and technical representatives - defined in the SROs' respective codes of practice and the like. The pre-amendment Ordinance prohibited any person from being an appointed insurance agent and an authorized insurance broker at the same time, whether in relation to the same or different clients.

Under the new statutory licensing regime, which superseded the insurance agent/broker registration requirements, a **licence** granted by the IA is required for carrying on any 'regulated activity' in the course of business or employment or for reward, or for holding out to do so, subject to certain exemptions. It is important to understand that the relevant statutory provision does not distinguish between the carrying on of a regulated activity by an employee of an insurer and by a person who is not an employee of an insurer. Furthermore, an authorized insurer's statutory exemption from the licensing requirement does not extend to the insurer's agents. It follows that the direct sales staff of an authorized insurer who give advice on the coverage of the insurer's insurance products to policyholders as representatives of the insurer would need to obtain an individual insurance agent licence.

Each of the following is a **regulated activity** for the purposes of the licensing requirement:

- negotiating or arranging an insurance contract;
- inviting or inducing, or attempting to invite or induce, a person to enter into an insurance contract;
- inviting or inducing, or attempting to invite or induce, a person to make a '**material decision**'; and
- giving '**regulated advice**'.

A **material decision** refers to a decision made by the person entering into a contract of insurance and **regulated advice** is an opinion given in relation to any of these matters:

- the making of an application or proposal for an insurance contract;
- the issuance, continuance or renewal of an insurance contract;
- the cancellation, termination, surrender or assignment of an insurance contract;
- the exercise of a right under an insurance contract;
- the change in any term or condition of an insurance contract; and
- the making or settlement of an insurance claim.

The IO further provides that actively marketing insurance services to the public from a place outside Hong Kong falls within the scope of holding out to carry on a regulated activity.

Apart from empowering the IA to grant an applicant exemption from the licensing requirements, the IO also grants **exemption** from the licensing requirements **in relation to the giving of regulated advice** by the following classes of persons and where applicable, in the circumstances set out below:

- counsels, solicitors, certified public accountants, trust companies, actuaries;
- newspaper, television or radio broadcast, electronic communication to the public;
- the business of loss assessment, the business of settling claims on behalf of an authorized insurer;
- a company giving regulated advice to a 'specified company', i.e. a wholly owned subsidiary of the company, the sole shareholding company of the company, or a wholly owned subsidiary of that sole shareholding company;

- the discharge of only clerical or administrative duties for an authorized insurer or a Licensed Insurance Intermediary;

- an employee of any of the following authorized insurers carrying on a regulated activity in the course of employment: (a) an insurer authorized to carry on in or from Hong Kong reinsurance business only; and (b) a captive insurer; and

- an employee of an authorized insurer carrying on a regulated activity that only involves: (a) risk assessment; (b) determination of terms and conditions of insurance contracts; or (c) processing of any claim lodged under an insurance contract.

Under the new regime, there are the following **five types of licensees**:

- **Licensed Individual Insurance Agent**: an individual who has been granted a licence by the IA to carry on regulated activities in one or more lines of business (see **4.1.1**), as an agent of any authorized insurer;

- **Licensed Technical Representative (Agent)**: an individual who has been granted a licence by the IA to carry on regulated activities in one or more lines of business, as an agent of any licensed insurance agency;

- **Licensed Technical Representative (Broker)**: an individual who has been granted a licence by the IA to carry on regulated activities in one or more lines of business, as an agent of any licensed insurance broker company;

- **Licensed Insurance Agency**: a sole proprietor, partnership or company who/which has been granted a licence by the IA to carry on regulated activities in one or more lines of business, as an agent of any authorized insurer; and

- **Licensed Insurance Broker Company**: a company which has been granted a licence by the IA to carry on the regulated activity of 'negotiating or arranging an insurance contract' in one or more lines of business as an agent of any policyholder or potential policyholder and all other types of regulated activities in one or more lines of business.

Apart from the above five terms, the meaning of the following terms for the purposes of the new Ordinance should also be noted:

- **Licensed Insurance Agent**: a licensed insurance agency, a licensed individual insurance agent or a licensed technical representative (agent);

- **Licensed Insurance Broker**: a licensed insurance broker company or a licensed technical representative (broker);

- **Licensed Insurance Intermediary**: a licensed insurance agent or a licensed insurance broker; and

- **Regulated Person:** a licensed insurance intermediary, a responsible officer of a licensed insurance agency or licensed insurance broker company, or a person concerned in the management of the regulated activities carried on by a licensed insurance agency or licensed insurance broker company.

In relation to '**responsible officer**' as one type of regulated person, under the new Ordinance, each licensed insurance agency and licensed insurance broker company should have at least one responsible officer, and that all responsible officers should be licensed technical representatives (agent) or licensed technical representatives (broker) as the case may be. Besides, the appointment of a responsible officer requires the IA's prior approval.

As set out above, there are five types of insurance intermediaries that are required to hold a valid licence issued by the IA under the new licensing regime. In view of the large number of registered insurance intermediaries, the importance of a smooth transition from the old to the new regime to minimize possible disruption to insurance intermediaries' business and their service to existing policyholders cannot be over-emphasised. For the sake of such a transition, the IO provides **transitional arrangements for deemed licensees** (i.e. the existing insurance intermediaries validly registered with any of the SROs immediately before the commencement of the new regime – comprising registered insurance agencies, registered individual insurance agents, authorized insurance brokers, registered technical representatives, registered responsible officers and registered chief executives), so that they are deemed to be licensed by the IA for three years. The IA will, staggered over a three-year transitional period (beginning on 23 September 2019), invite the deemed licensees to submit applications to the IA for formal licences.

5.2.2 Authorized Insurer's Relationship with its Agents

Section 68 of the IO imposes vicarious liability on an authorized insurer for the acts of an insurance agent whom it has appointed and who has dealings with a client for the issue of a contract of insurance, or for insurance business relating to the contract. To be more specific, section 68(1) provides that if the person is appointed by the insurer as an agent, the insurer is liable for any act of the person in relation to those dealings, whether or not the act is within the scope of the person's authority.

If not for the above provisions, a dispute between an insured and an insurer as to for whom a licensed insurance intermediary has acted at the material time would have to be adjudicated on the basis of the relevant common law rule. In 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 in fact an agent of the insured for the act in question, even if he was at and about the material time running a business of insurance agency as opposed to insurance broking. In other words, this is a question of fact, rather than a question of law.

Contemplating the possibility of a person being appointed by more than one authorized insurer as an agent, giving rise to complicated issues of vicarious liability, other sub-sections of section 68 stipulate that:

- Where there is more than one appointing authorized insurer, those dealings relate to a particular line of business and only one insurer's appointment covers that line of business (the 'empowering insurer'), it is the empowering insurer who is liable.

- Where the appointments by more than one authorized insurer cover a particular line of business, those dealings relate to that line of business, and an act of the person is within the scope of his authority from one of those insurers (the 'empowering insurer'), it is the empowering insurer who is liable.

- Where the appointments by more than one authorized insurer cover a particular line of business, those dealings relate to that line of business, and an act of the person is within the scope of his authority from two or more of those insurers (the 'empowering insurers'), the empowering insurers are **jointly and severally liable**.

- Where the appointments by more than one authorized insurer cover a particular line of business, those dealings relate to that line of business, and an act of the person is not within the scope of his authority from any of those insurers, all those insurers are **jointly and severally liable**.

Nevertheless, an authorized insurer is not liable under section 68 for the act of the person if the following criteria are satisfied (subject to any other relevant factors that the court may take into account in considering a claim made under section 68):

- The act is not within the scope of the person's authority in relation to that insurer;

- The person disclosed that fact to the client before the client relied on the act; and

- The clarity and prominence of the disclosure was what a person would reasonably require for deciding whether to enter into any of the dealings covered by section 68.

5.2.3 Multiple Capacities of Licensed Insurance Intermediaries

The new Ordinance imposes the following **restrictions** in relation to the personnel of licensed insurance agencies, the personnel of licensed insurance broker companies, licensed technical representatives (agent) and licensed technical representatives (broker):

(a) **Personnel of Licensed Insurance Agencies**: Restrictions apply to the proprietor or partners of any licensed insurance agency, and to the directors or employees of any licensed insurance agency who manage or control any matter relating to a regulated activity of the agency, in that each of these individuals must not also be:

- the proprietor or a partner of another licensed insurance agency;
- a licensed individual insurance agent;
- a licensed technical representative (agent) of another licensed insurance agency;
- a licensed technical representative (broker);
- a director or employee of another licensed insurance agency who manages or controls any matter relating to a regulated activity of that other agency; or
- a director or employee of a licensed insurance broker company who manages or controls any matter relating to a regulated activity of that company.

(b) **Personnel of Licensed Insurance Broker Companies**: Each of the directors and employees of any licensed insurance broker company who manage or control any matter relating to a regulated activity of the company must not also be:

- the proprietor or a partner of a licensed insurance agency;
- a licensed individual insurance agent;
- a licensed technical representative (agent); or
- a director or employee of a licensed insurance agency who manages or controls any matter relating to a regulated activity of the agency.

(c) **Licensed Technical Representatives (Agent)**: They must neither act beyond the licensed insurance agency's scope of licensed business, nor be a licensed technical representative (agent) of another licensed insurance agency.

(d) **Licensed Technical Representatives (Broker)**: They must not act beyond the licensed insurance broker company's scope of licensed business.

5.2.4 Grant of Licence

(a) **Conditions for Grant of Licence**: The new Ordinance sets out the conditions for the grant of licence by the IA, **including 'fit and proper' criteria** for applicants for insurance intermediary licences. The 'fit and proper' requirement is ongoing and also applies to renewal of licences.

As regards firms (i.e. sole proprietorships, partnerships and companies), all of their controllers, partners and directors (where applicable) must also be fit and proper persons to be associated with the carrying on of regulated activities in the lines of business concerned. For such purposes, the term 'controller' is defined:

- in relation to a sole proprietorship, as an individual who ultimately owns or controls the carrying on of regulated activities by the sole proprietorship;

- in relation to a partnership, as an individual who is entitled to or controls, directly or indirectly, not less than 15% of the capital or profits of the partnership; is, directly or indirectly, entitled to exercise or control the exercise of not less than 15% of the voting rights in the partnership; or exercises ultimate control over the management of the partnership;

- in relation to a company, is a person who owns or controls, directly or indirectly, including through a trust or bearer share holding, not less than 15% of the issued share capital of the company; is, directly or indirectly, entitled to exercise or control the exercise of not less than 15% of the voting rights at general meetings of the company; or exercises ultimate control over the management of the company.

Below are the **major conditions** for grant of the different types of licences:

(i) **Licensed Insurance Agency**

- A sole proprietor, partnership or company may apply for an insurance agency licence;

- The sole proprietor, partners, or company (and its director(s)) must be a fit and proper person(s) to carry on regulated activities in the lines of business concerned;

- The controller, if any, is a fit and proper person to be associated with the carrying on of regulated activities in the lines of business concerned;

- The applicant is appointed as an agent by at least one authorized insurer; and

- The applicant is neither holding an individual insurance agent licence, an insurance broker company licence, a technical representative (agent) licence or a technical representative (broker) licence, nor applying for such a licence.

(ii) **Licensed Individual Insurance Agent**

- The individual applicant is a fit and proper person to carry on regulated activities in the lines of business concerned;

- The applicant is appointed as an agent by at least one authorized insurer; and

- The applicant is neither holding an insurance agency licence, a technical representative (agent) licence or a technical representative (broker) licence, nor applying for such a licence.

(iii) **Licensed Technical Representative (Agent)**

- The individual applicant is a fit and proper person to carry on regulated activities in the lines of business concerned;

- The applicant is appointed as an agent by a holder of or an applicant for an insurance agency licence; and

- The applicant is neither holding an insurance agency licence, an individual insurance agent licence or a technical representative (broker) licence, nor applying for such a licence.

(iv) **Licensed Insurance Broker Company**

- The company applicant and its director(s) must be fit and proper persons to carry on regulated activities in the lines of business concerned;

- The controller, if any, is a fit and proper person to be associated with the carrying on of regulated activities in the lines of business concerned;

- The applicant is neither holding an insurance agency licence nor applying for such a licence; and

- The applicant will be able to comply with the IA's requirements in relation to capital, net asset, professional indemnity insurance, etc.

(v) **Licensed Technical Representative (Broker)**

- The individual applicant is a fit and proper person to carry on regulated activities in the lines of business concerned;

- The applicant is appointed as an agent by at least one licensed insurance broker company, or by an applicant for an insurance broker company licence; and

- The applicant is neither holding an insurance agency licence, an individual insurance agent licence or a technical representative (agent) licence, nor applying for such a licence.

(b) **Responsibilities and Approval of Responsible Officer**: Each licensed insurance agency and licensed insurance broker company should appoint at least one responsible officer to supervise the carrying on of regulated activities and to ensure proper controls and procedures are in place for the purpose of compliance with the conduct requirements set out in section 90 of the IO. A responsible officer is **responsible** for using his best endeavours to ensure that the insurance agency or insurance broker company (as the case may be) has established and maintains proper controls and procedures for securing compliance with section 90 of the IO, which sets out conduct requirements for licensed insurance intermediaries.

Under the new Ordinance, the **conditions for the IA's approval of a Responsible Officer** include the following:

- He is a licensed technical representative (agent) or licensed technical representative (broker), or an applicant for a licence to be a licensed technical representative (agent) or licensed technical representative (broker), as the case may be;

- He will be fit and proper, whether solely or jointly with other responsible officers, to discharge responsibilities as a responsible officer; and

- He has sufficient authority, and will be provided with sufficient resources and support, for discharging responsible officers' responsibilities.

(c) **Determination of 'Fit and Proper'**: As said, 'fit and proper' criteria are among the conditions for grant of licence, renewal of licence or approval of responsible officers. In determining whether a person is a fit and proper person for the said purposes, the IA is required by the new Ordinance to have regard to the following matters in addition to any other matter that the IA considers relevant:

- His education or other qualifications or experience;

- Ability to carry on a regulated activity competently, honestly and fairly;

- His reputation, character, reliability and integrity;

- His financial status or solvency;

- Whether any disciplinary action has been taken against the person by the Monetary Authority ('MA'), the Securities and Futures Commission ('SFC'), the Mandatory Provident Fund Schemes Authority ('MPFA'), or any other authority or regulatory organization whether in Hong Kong or elsewhere which performs a function similar to those of the IA;

- If the person is a company in a group of companies, any information the IA possesses that relates to another company in the group, or to a controller or director of the person or of another company in the group;

- The state of affairs of any other business he carries on or proposes to carry on; and

- In relation to grant of insurance agency licence or insurance broker company licence or renewal of such a licence: any information the IA possesses that relates to:

    · any other person who is or is to be employed by or associated with the person for the purposes of carrying on regulated activities;

    · any other person who is or will be acting for the person in relation to the carrying on of regulated activities; or

    · the question as to whether the person has established effective internal control procedures and risk management systems to ensure its compliance with the IO.

Pursuant to section 133 of the IO, the IA has issued the **Guideline on "Fit and Proper" Criteria for Licensed Insurance Intermediaries under the Insurance Ordinance (Cap. 41)** (GL23) to outline the criteria and matters that the IA will normally consider in determining whether a person is fit and proper, which became effective on 23 September 2019. These criteria and matters are not intended to be exhaustive and the IA may take into consideration any other information which it considers relevant in assessing the fitness and properness of a regulated person. GL23 neither constitutes legal advice nor has the force of law.

The 'fit and proper' requirement is ongoing, and applies to any applicant for an insurance intermediary licence of any type or for the renewal of such licence, and to the controller(s), partner(s), director(s) (where applicable) and proposed responsible officer(s) (or current responsible officer(s) in the case of renewal of licence) of an applicant for an insurance agency licence or insurance broker company licence or for the renewal of such licence.

Besides, when deciding whether or not to impose, amend or revoke conditions on a licence or on an approval granted to an individual as a responsible officer under section 64ZG of the IO, the IA will take into account the fitness and properness of the applicants for a licence or renewal of licence, controller(s), partner(s), director(s) and responsible officer(s) (as the case may be).

The 'fit and proper' criteria set out in GL23 are divided into Criteria for Individuals and Criteria for Business Entities. Applicable to any individual who is required to be a fit and proper person, the **Criteria for Individuals** are matters to which the IA will have regard in determining whether an individual is a fit and proper person, with some of the matters differing in detail depending on whether he is an applicant for a licence (or a current licensee as the case may be) or a proposed responsible officer (or a current responsible officer as the case may be). The **Criteria for Business Entities** are matters which apply to any business entity – i.e. a sole proprietorship, partnership or company - which is, is applying to be, or is applying for a renewal of a licence to be, a licensed insurance agency or licensed insurance broker company.

GL23 further reminds licensed insurance intermediaries of their duties to comply with the relevant sections of the IO and with any rules, codes and guidelines made or issued under those sections. Any non-compliance will be taken into account in considering whether the licensed insurance intermediary concerned is a fit and proper person.

Below are the Criteria for Individuals and Criteria for Business Entities separately summarised:

Criteria for Individuals

(i) <u>Education or other qualifications or experience</u>

In considering the education or other qualifications or experience of a person applying to become an individual licensee, or a person who is proposed to be appointed as a responsible officer of a business entity which is, or is applying to be, a licensed insurance agency or a licensed insurance broker company, or applying for a renewal of such licence, the IA will take into account the nature of the functions or duties which the person will perform.

Individual Licensee

The individual applicant is expected to have attained any of the specified education or professional qualifications, and obtained a pass in the relevant paper(s) – depending on the line(s) of business concerned - of the Insurance Intermediaries Qualifying Examination (the 'IIQE').

The following are **some of the specified academic education or professional qualifications**:

(a) Level 2 or above in 5 subjects in the Hong Kong Diploma of Secondary Education Examination ('HKDSE'), including the following two compulsory subjects:

   A. a language subject which may either be Chinese Language or English Language; and
   B. Mathematics;

(b) Grade E or above in 5 subjects in the Hong Kong Certificate of Education Examination ('HKCEE'), including the following two compulsory subjects:

   A. a language subject which may either be Chinese Language or English Language; and
   B. Mathematics;

(For avoidance of doubt, combined examination results obtained in more than one sitting of the HKDSE and/or HKCEE are acceptable.)

(c) Diploma Yi Jin;

(d) International Baccalaureate Diploma;

(e) a diploma granted by a degree-awarding higher education institution established or registered under an Ordinance of Hong Kong considered acceptable by the IA;

(f) a diploma registered or exempt under the Non-local Higher and Professional Education (Regulation) Ordinance (Cap. 493), where the diploma, subject and institution are considered acceptable by the IA;

(g) an insurance qualification specified by the IA from time to time and published on the IA's website; or

(h) any other qualification considered by the IA to be equivalent to or higher than any qualification set out in the above paragraph (a) to (g) above (For example, a degree awarded by a higher education institution in Hong Kong or elsewhere is generally considered as acceptable.)

A person is **exempt from the specified education or professional qualifications** in relation to his application for an individual insurance agent licence, a technical representative (agent) licence or a technical representative (broker) licence, if (a) he was a 'specified person' (see the next paragraph) immediately before 23 September 2019 and regarded as having been granted a licence on that date, or was a specified person at any time within the two-year period immediately before that date; (b) he/she has not ceased to be engaged in insurance-related work in the insurance industry in Hong Kong for two consecutive years or more; and (c) he/she submits the application for such licence within the transitional period, i.e. the period of 3 years beginning on that date.

'**Specified person**' is defined in GL23 as:

- an Individual Agent registered with the IARB;

- a Technical Representative registered with the IARB;

- a Responsible Officer registered with the IARB;

- a Technical Representative registered with the CIB or PIBA; or

- a Chief Executive registered with the CIB or PIBA.

Exemption from certain IIQE papers is granted on the basis of the following:

- certain insurance, actuarial and professional qualifications listed in Annex 1 to GL23;

- being in the insurance intermediary business in Hong Kong immediately before 1 January 2000 and holding holding the Certificate of Proficiency in General Insurance Studies issued by The Hong Kong Federation of Insurers ('HKFI'); or

- possessing five years' proven experience in insurance business in Hong Kong within the six-year period immediately before 1 January 2000.

Annex 1, however, provides that **an individual's IIQE results may lapse** upon his/her cessation of or non-engagement in insurance practice for two or more consecutive years, unless he/she is exempt based on the possession of a specified insurance, actuarial, or professional qualification.

Responsible Officer

A proposed responsible officer is expected to have attained a **specified education or professional qualification**, that is to say: (a) a bachelor degree from a recognized university or tertiary educational institution; or (b) an insurance qualification specified by the IA from time to time and published on the IA's website; or (c) any other qualification considered by the IA to be equivalent to or higher than any qualification set out in (a) and (b) above.

A **proposed responsible officer of a licensed insurance agency** is **exempt** from the specified education or professional qualifications (see the previous paragraph) if he/she was: (a) a Responsible Officer registered with the IARB at any time before 23 September 2019, or (b) an Individual Agent or Technical Representative registered with the IARB at any time before 23 September 2019 and already possessed a minimum of 15 years' experience in insurance-related work in the insurance industry in Hong Kong on 23 September 2019.

Similarly, a **proposed responsible officer of a licensed insurance broker company** is **exempt** from the specified education or professional qualifications if he/she was: (a) a Chief Executive registered with the CIB or PIBA at any time before 23 September 2019, or (b) a Technical Representative registered with the CIB or PIBA at any time before 23 September 2019 and already possessed a minimum of 15 years' experience in insurance-related work in the insurance industry in Hong Kong on 23 September 2019.

In addition, a proposed responsible officer is expected to have and possess **experience** commensurate with the nature and scale of business of the licensed insurance agency or licensed insurance broker company concerned and with the level of responsibilities to be carried out. (Note: It is generally expected that a responsible officer should possess a minimum of 5 years' experience in the insurance industry, including at least 2 years of management experience. In assessing the relevance of the proposed responsible officer's industry and management experience, the IA will consider the role and functions to be undertaken by the person and whether the person's experience (gained in Hong Kong or elsewhere) will enable him to discharge the responsibilities required of a responsible officer.)

(ii) Ability to carry on a regulated activity competently and fairly

Individual Licensee

The matters relevant to the IA's assessment of the competence of an applicant include:

- where the individual is assuming responsibilities other than that relating to the carrying on of regulated activities, whether such responsibilities would give rise to a conflict of interest or otherwise impair his ability to carry on a regulated activity competently and fairly;

- whether the individual has been found by a court to be mentally incapacitated, or is detained in a mental hospital, under the Mental Health Ordinance (Cap. 136); and

- whether there is any evidence that the individual may be incompetent or negligent, which is indicated by the individual having been dismissed or requested to resign from any position or office for misconduct, incompetence, negligence or mismanagement.

The IA will consider whether he/she has satisfied the continuing professional development ('CPD') requirements set out in the Guideline on Continuing Professional Development for Licensed Insurance Intermediaries (GL24) issued by the IA. A failure to comply with the CPD requirements by a licensed insurance intermediary may affect his fitness and properness.

(iii) Reputation, character, reliability, honesty and integrity

Any Individual

The matters relevant to the IA's assessment of the reputation, character, reliability, honesty and integrity of the individual concerned include whether he/she:

- has failed to comply with or demonstrated unwillingness to comply with any requirements in relation to the carrying on of regulated activities;

- has been found by a court or another competent authority in Hong Kong or elsewhere to have committed fraud, an act of dishonesty or misfeasance;

- has been disqualified by a court in Hong Kong or elsewhere from being a director of a company;

- has been convicted of a criminal offence by any court in Hong Kong or elsewhere or is the subject of unresolved criminal charges in Hong Kong or elsewhere, which are of relevance to fitness and properness;

- has been refused or restricted from the right to carry on any trade, business or profession by any professional, trade or regulatory body in Hong Kong or elsewhere;

- has been censured, disciplined or publicly criticized by any professional, trade or regulatory body in Hong Kong or elsewhere;

- is the subject of an investigation and/or disciplinary action or proceeding conducted by any professional body established under any laws, regulatory authority or law enforcement agency in Hong Kong or elsewhere;

- has been dismissed or requested to resign from any position or office in Hong Kong or elsewhere for misconduct, negligence, incompetence or mismanagement;

- was a controller, director or partner of a business entity, in Hong Kong or elsewhere, which has been compulsorily wound up or has made any compromise or arrangement with its creditors or has ceased trading in circumstances where its creditors did not receive or have not yet received full settlement of their claims, either whilst the individual concerned was a controller, director or partner or within one year after the individual concerned ceased to be such a controller, director or partner;

- has, in connection with the formation or management of a business entity, been adjudged by a court or another competent authority in Hong Kong or elsewhere civilly liable for any fraud, misfeasance or other misconduct by the individual concerned to such a business entity or any members thereof; or

- has been a controller, director or partner of a business entity in Hong Kong or elsewhere, which,

    · with the consent or connivance of, or because of the neglect or omission by the individual concerned, has failed to comply with any requirements under any laws, or any rules, regulations, codes or guidelines made or issued under any laws, or any other regulatory requirements;

    · has been convicted of a criminal offence by any court in Hong Kong or elsewhere or is the subject of unresolved

criminal charges in Hong Kong or elsewhere, which offence or charges are of relevance to fitness and properness; or

· has been adjudicated by any court or other competent authority in Hong Kong or elsewhere civilly liable for any fraud, misfeasance or misconduct.

(iv) Financial status or solvency

Any Individual

The matters relevant to the IA's assessment of the financial status of the individual concerned include whether he/she:

- has entered into a voluntary arrangement with creditors or been adjudicated bankrupt by a court, or is currently subject to bankruptcy proceedings, in Hong Kong or elsewhere; or

- has failed to satisfy any judgment debt under an order of a court in Hong Kong or elsewhere.

(v) Other relevant matters

Individual Licensee

The individual concerned is required to be:

- a Hong Kong permanent resident; or

- a person who holds an appropriate immigration visa or permit which does not restrict that person from carrying on regulated activities in Hong Kong.

Criteria for Business Entities

(i) Ability to carry on a regulated activity competently and fairly

Licensed Insurance Agency
Licensed Insurance Broker Company

The IA expects a (proposed) responsible officer of the business entity concerned to:

- possess appropriate qualifications and experience (see the relevant requirements set out in the above section headed 'Criteria for Individuals'); and

- have sufficient authority for discharging his responsibilities set out in the IO and any rules, regulations, codes and guidelines made or issued under any Ordinances, and be provided with sufficient resources and support for discharging such responsibilities. (Note: In assessing the sufficiency of authority of the (proposed) responsible officer, the IA will consider the organizational structure, management responsibilities and seniority of the person within the licensed insurance agency or licensed insurance broker company concerned, and the nature and scale of regulated activities under the (proposed) responsible officer's supervision.)

In determining whether a business entity, which is, is applying to be, or is applying for a renewal of a licence to be, a licensed company agency or a licensed insurance broker company, is a fit and proper person to carry on regulated activities in a particular line of business, the IA will consider whether the (proposed) responsible officer(s) (as licensed technical representative(s) (agent) or licensed technical representative(s) (broker) as the case may be) are eligible to carry on regulated activities in the relevant line of business.

The business entity concerned should appoint at least one responsible officer to supervise the carrying on of regulated activities and to ensure proper controls and procedures are in place for the purpose of compliance with the requirements under the IO and other applicable regulatory requirements.

Under certain circumstances, the licensed insurance agency or licensed insurance broker company would be expected to appoint more than one responsible officer. In considering whether there is a sufficient number of responsible officers appointed by the business entity concerned, the IA will take into account, inter alia, the scale of business, nature of insurance services and products, and number of licensed technical representatives (agent) or licensed technical representatives (broker) (as the case may be) of the business entity concerned.

The IA will assess the competence of the business entity which is, is applying to be, or is applying for a renewal of a licence to be a licensed insurance agency or a licensed insurance broker company with regard to the following aspects (where applicable):

- Group companies and business entities carrying on other business:

    · (if the business entity is a company within a group of companies) any information relating to the group companies and their directors and controllers; and

- (if the business entity carries on or proposes to carry on business other than the business of carrying on of regulated activities) the nature and state of affairs of such business.

- Corporate governance:

  - whether the business entity has an adequate organizational structure with clear lines of responsibilities and authority;

  - whether the person(s) responsible for supervising the carrying on of regulated activities in the business entity's (proposed) lines of business possesses an appropriate range of knowledge, skills and experience that allows him to properly carry out his duties; and

  - whether there is a feasible business strategy in respect of the proposed line(s) of business which includes information on the insurance products to be marketed, services to be provided, target market clientele and sources of business.

- Internal controls and risk management:

  - whether the business entity has in place adequate and effective policies, procedures and controls concerning compliance with all laws, rules, regulations, codes, guidelines and other regulatory requirements relevant to the carrying on of regulated activities in its lines of business;

  - whether the business entity has identified the key risks and has developed strategies to mitigate such risks;

  - in the case of a business entity that also carries on or intends to carry on business other than insurance intermediary business, whether there are effective internal controls to ensure the interests of policyholders and potential policyholders will not be prejudiced; and

  - whether there are adequate and effective policies, procedures and controls in relation to the recruitment, training and supervision of staff to ensure that the persons who are employed by, or associated with, or act for the business entity in relation to the carrying on of regulated activities are and remain fit and proper and suitably qualified for the (proposed) lines of business.

(ii) Reputation, character, reliability, honesty and integrity

Licensed Insurance Agencies
Licensed Insurance Broker Companies

In respect of a business entity which is, or is applying for a licence, or is applying for a renewal of a licence, the matters relevant to the IA's assessment of the reputation, reliability and integrity of the business entity concerned include the following:

Whether the business entity concerned:

- has failed to comply with or demonstrated an unwillingness to comply with any requirements in relation to the carrying on of regulated activities;

- has been refused or restricted from the right to carry on any trade, business or profession by any professional, trade or regulatory body in Hong Kong or elsewhere;

- has been censured, disciplined or publicly criticized by any professional, trade or regulatory body in Hong Kong or elsewhere;

- is the subject of an investigation and/or disciplinary action or proceeding conducted by any professional body established under any laws, regulatory authority or law enforcement agency in Hong Kong or elsewhere;

- was a controller, director or partner of another business entity, in Hong Kong or elsewhere, which has been compulsorily wound up or has made any compromise or arrangement with its creditors or has ceased trading in circumstances where its creditors did not receive or have not yet received full settlement of their claims, either whilst the business entity concerned was a controller, director or partner or within one year after the business entity concerned ceased to be such a controller, director or partner;

- has been a controller, director or partner of another business entity in Hong Kong or elsewhere, which:

  · with the consent or connivance of, or because of the neglect or omission by, the business entity concerned, failed to comply with any requirements under any laws, or any rules, regulations, codes or guidelines made or issued under any laws, or any other regulatory requirements;

· has been convicted of a criminal offence by any court in Hong Kong or elsewhere or is the subject of unresolved criminal charges in Hong Kong or elsewhere, which are of relevance to fitness and properness; or

· has been adjudicated by any court or other competent authority in Hong Kong or elsewhere civilly liable for any fraud, misfeasance or misconduct;

- has a controller, director or partner who fails to meet any of (a) the criteria and matters set out in the section headed 'Criteria for Individuals' in respect of 'Reputation, character, reliability, honesty and integrity' or 'Financial status or solvency', or (b) the criteria and matters set out in the section headed 'Criteria for Business Entities' in respect of 'Reputation, character, reliability, honesty and integrity' or 'Financial status or solvency', as applicable.

(iii) Financial status or solvency

Any Business Entity

In respect of an any business entity, matters relevant to the IA's assessment of the financial status or solvency of the business entity concerned include the following:

Whether the business entity concerned:

- is subject to receivership, administration, liquidation or other similar proceedings;

- has entered into a scheme of arrangement with its creditors or failed to satisfy any judgment debt under an order of a court in Hong Kong or elsewhere; or

- has sufficient resources at all times for compliance with the financial requirements (e.g. capital, assets and liquidity requirements) applicable to it.

Note: However, for a business entity which is a sole proprietor or a partnership, the sole proprietor or each of the partners (as the case may be) is instead subject to the criteria and matters set out in the section headed 'Criteria for Individuals' in respect of 'Reputation, character, reliability, honesty and integrity' and 'Financial status or solvency'.

(iv) Other relevant matters

Licensed Insurance Broker Company

In respect of a company which is, is applying to be, or is applying for a renewal of a licence to be a licensed insurance broker company, the IA must be satisfied that the company concerned is or will be able to comply with the requirements in relation to capital, net assets, professional indemnity insurance, and the keeping of separate client accounts and proper books and accounts as set out in the IO and any rules made under section 129 of the IO.

The IA will normally not allow a person to be appointed as a responsible officer of more than one licensed insurance broker company unless the companies concerned belong to the same group of companies or have common shareholder(s), or there is any other justification acceptable to the IA. The IA will consider each application on a case-by-case basis.

5.2.5 Other Regulatory Measures

The new Ordinance gives the IA necessary powers for performing its statutory functions. The IA may **make rules** to, among others, require licensed insurance intermediaries to carry on business in a specified manner, and prescribe the qualifications and experience of, and training for, licensed insurance intermediaries. The IA may also **publish codes or guidelines** for giving guidance in relation to a matter relating to any of its functions, or in relation to the operation of a provision of the IO. Such codes and guidelines are not subsidiary legislation; non-compliance of any of them is not by itself a cause for judicial or other proceedings.

Below are some of the powers the IO gives the IA specifically:

(a) **Appointment by a Maximum Number of Authorized Insurers**: The IA has made the **Insurance (Maximum Number of Authorized Insurers) Rules** (the 'Rules') under sections 64I(1) and 129(1) of the IO for compliance by insurance agencies, individual insurance agents and insurers with effect from 23 September 2019. According to:

Rule 3, - Maximum Number of Authorized Insurers:
A person may be appointed as a 'licensed person' – a licensed insurance agency or licensed individual insurance agent - in carrying on a regulated activity for a maximum of 4 authorized insurers, of which no more than 2 can be insurers authorized to carry on long term business.

Rule 4, **General Principles**:
Applicable to the counting of the number of authorized insurers for the purposes of Rule 3, stipulates the following three principles:

- A licensed person is taken to be appointed by 1 insurer authorized to carry on general business if the licensed person is appointed by an authorized insurer as its agent to carry on regulated activities in general business only;

- A licensed person is taken to be appointed by 1 insurer authorized to carry on long term business if the licensed person is appointed by an authorized insurer as its agent to carry on regulated activities in long term business only; and

- A licensed person is taken to be appointed by 1 insurer authorized to carry on general business and by 1 insurer authorized to carry on long term business, if the licensed person is appointed by an authorized insurer as its agent to carry on regulated activities in both general business and long term business.

Rule 5, **- Principles for Appointments by Authorized Insurers in Group of Companies:**
Applicable to the counting of the number of authorized insurers for the purposes of Rule 3 where a licensed person is appointed as an agent to carry on regulated activities by 2 or more authorized insurers which are in the same group of companies, stipulates the following two principles.

- Where all those appointments are limited to either general business or long term business, but not both, the licensed person is taken to be appointed by 1 insurer authorized to carry on the line of business for which that licensed person is appointed; and

- Where those appointments are not limited to only general business or only long term business, the licensed person is taken to be appointed by 1 insurer authorized to carry on general business and 1 insurer authorized to carry on long term business.

Rule 6 Principles for appointments by members of Lloyd's:
It stipulates principles for appointments of licensed persons as agents by Members of Lloyd's to carry on regulated activities.

(b) **Powers of Inspection, Investigation and Imposing Disciplinary Sanctions**: The IA may in writing appoint a person as an **inspector** to conduct inspection for the purposes of ascertaining whether a licensed insurance intermediary is complying with, has complied with, or is likely to be able to comply with, a provision of the IO, a term or condition of a licence granted under the IO, etc. The IA may also direct or appoint its employees or other persons (all referred to as **investigators**) in writing to investigate a matter of suspected

contravention of a provision of the IO, suspected fraud, etc. The inspectors and investigators may require the answers, explanation, etc. given to them by those individuals who are the subjects of their inspection or investigations to be verified by statutory declarations.

If a person fails to comply with a requirement imposed by an inspector or investigator under the relevant provision of the IO, the inspector or investigator may apply to the Court of First Instance for an inquiry into the failure. The Court may order compliance by the person, and punish the person, and any other person knowingly involved in the failure, as if it had been a contempt of court.

(c) **Disciplinary Actions in respect of Regulated Persons**: Section 81 of the IO empowers the IA to take any of the actions specified thereunder in respect of any person who belongs to any of the specified classes of persons upon the happening of any of the events specified in relation to the classes of persons to which the person belongs. Further details are given below:

(i) The **grounds for exercising powers under section 81** include the following:

- The person, when being a regulated person, is/was guilty of 'misconduct', which is defined to mean:

  · a contravention of a provision of the IO;

  · a contravention of a term or condition of a licence granted under the IO;

  · a contravention of any other condition imposed under a provision of the IO; or

  · an act or omission relating to the carrying on of any regulated activity which, in the IA's opinion, is or is likely to be prejudicial to the interests of policyholders or potential policyholders or the public interest.

- The person, being a former or current responsible officer or a person concerned in the management of the regulated activities of a licensed insurance intermediary, is also to be regarded as guilty of misconduct if the insurance agency or insurance broker company concerned (as the case may be) is or was guilty of misconduct as a result of a conduct occurring with the consent or connivance of, or attributable to neglect on the part of, the person;

- The IA is of the opinion that the person is/was not a fit and proper person when being a regulated person, by taking into account, among other matters, the person's present or past conduct;

- Where the person is a licensed insurance intermediary that is an individual or partnership:

  · the individual or any of the partners enters into a voluntary arrangement with creditors, or has a bankruptcy order made against the individual or the partner, under the Bankruptcy Ordinance (Cap. 6);

  · the individual or any of the partners is convicted of an offence in Hong Kong or elsewhere, which in the opinion of the IA impugns the fitness and properness of the person to remain licensed;

  · the individual or any of the partners has been found by a court to be mentally incapacitated, or is detained in a mental hospital, under the Mental Health Ordinance (Cap. 136), which in the opinion of the IA impugns the fitness and properness of the person to remain licensed.

- Where the person is a licensed insurance intermediary that is a company:

  · where a receiver or manager of the property or business is appointed;

  · enters into a scheme of arrangement with its creditors;

  · goes into liquidation;

  · the person or any of the directors of the person is convicted of an offence in Hong Kong or elsewhere, which in the opinion of the IA impugns the fitness and properness of the person to remain licensed.

- Where any directors of the person has been found by a court to be mentally incapacitated, or is detained in a mental hospital, under the Mental Health Ordinance (Cap. 136) which in the opinion of the Authority impugns the fitness and properness of the person to remain licensed;

- Where the person is a licensed insurance intermediary that is a sole proprietorship, partnership or company of which any of the controllers of the person is convicted of an offence in Hong Kong or elsewhere, which in the opinion of the IA impugns the fitness and properness of the person to remain licensed; and

- Insurance Authority ('IA') may exercise any of the powers specified in (ii) below if a responsible officer of a licensed insurance agency or licensed insurance broker company is convicted of an offence in Hong Kong or elsewhere which in the opinion of the IA impugns the fitness and properness of the person to remain as a responsible officer.

(ii) The **powers** of the IA exercisable **under section 81** are as follows, depending on whether the person is a licensed insurance intermediary, responsible officer or regulated person:

- A licensed insurance intermediary:
  - to revoke or suspend the person's insurance intermediary licence for a period determined by the IA;

- Responsible officer:
  - to revoke or suspend the person's approval as a responsible office for a period determined by the IA;

- A regulated person:
  - to prohibit from applying to be licensed or being appointed as a responsible officer for a period determined by the IA;

  - to reprimand the person, publicly or privately; and

  - to order the person to pay a pecuniary penalty not exceeding HK$10,000,000 or 3 times the profit gained or loss avoided by the person as a result of the misconduct, or of the other conduct of the person which leads the IA to form the opinion that the person is/was not a fit and proper person, whichever is the greater.

(d) **Guideline on Exercising Power to Impose Pecuniary Penalty in Respect of Regulated Persons under the Insurance Ordinance (Cap. 41)** (GL22): The power of the IA mentioned in (c)(ii) above to impose pecuniary penalty is exercisable only after the IA has published guidelines, which are not subsidiary legislation, to indicate the way in which it proposes to exercise that power; and in exercising such power, the IA has had regard to the guidelines so published. Such a guideline was issued by the IA in July 2019 and took effect on 23 September 2019.

GL22 sets out the **considerations in exercising the IA's power to impose a pecuniary penalty**, as summarized below:

- The principal purposes of imposing a pecuniary penalty are:

  · to protect existing and potential policyholders and the public interest;

  · to promote and encourage proper standards of conduct of regulated persons;

  · to deter regulated persons who have engaged in misconduct from engaging in further misconduct and to deter other regulated persons from committing misconduct;

  · to deter regulated persons from doing any acts or omissions to do any act that would render them not fit and proper persons;

  · to deter licensed insurance agencies and licensed insurance broker companies from engaging a person who is not fit and proper to hold the position of technical representative, responsible officer, director or controller;

  · to sanction licensed insurance agencies and licensed insurance broker companies which engaged a person who was not fit and proper to hold the position of technical representative, responsible officer, director or controller; and

  · to prevent regulated persons guilty of misconduct from benefitting from the misconduct.

- The IA regards a pecuniary penalty as a more severe sanction than a reprimand, and a public reprimand as more severe than a private reprimand.

- As a matter of policy, the IA may publicize its decisions to impose a pecuniary penalty against a regulated person as it thinks fit.

- A pecuniary penalty should be effective, proportionate and fair. The more serious the conduct or the reason for which the regulated person is considered not to be fit and proper, the greater the likelihood that the IA will impose a pecuniary penalty and the amount of the penalty will be higher.

- When considering whether to impose a pecuniary penalty and the amount of the penalty, the IA will consider all the circumstances of the particular case and, subject to the overriding objective of

achieving the principal purposes of imposing a pecuniary penalty, take into account all relevant factors. GL22 sets out various non-exhaustive factors under the following four headings:

- the nature, seriousness and impact of the conduct;
- the behaviour of the regulated person since the conduct was identified;
- the previous disciplinary record and compliance history of the regulated person; and
- other relevant factors.

(e) **Conduct Requirements for Licensed Insurance Intermediaries and Certain Officers**: Sections 90, 91 and 92 of the new Ordinance set out the following conduct requirements for licensed insurance intermediaries, licensed insurance agencies and their responsible officers, and licensed insurance broker companies and their responsible officers, respectively ('statutory conduct requirements'):

(i) A **Licensed Insurance Intermediary** (i.e. a licensed insurance agent or a licensed insurance broker) when carrying on a regulated activity:

- must act honestly, fairly, in the best interests of the policyholder or potential policyholder, and with integrity;
- must exercise a level of care, skill and diligence that may reasonably be expected of a prudent person who is carrying on the regulated activity;
- may only advise on matters on which the intermediary is competent to advise;
- must have regard to the particular circumstances of the policyholder or potential policyholder that are necessary for ensuring that the regulated activity is appropriate to him;
- must make the disclosure of information to the policyholder or potential policyholder that is necessary for him to be sufficiently informed for the purpose of making any material decision;
- must use its best endeavours to avoid a conflict between the interests of the intermediary and those of the policyholder or potential policyholder, and disclose any such conflict to him/her;

- must ensure that the assets of the policyholder or potential policyholder are promptly and properly accounted for; and

- must comply with requirements prescribed by rules made by the IA under the specified sections.

(ii) A **Licensed Insurance Agency (or its Responsible Officer)** must:

- (Agency) establish and maintain proper controls and procedures for securing compliance with the conduct requirements set out in section 90 by the agency and its licensed technical representatives (agent);

- (Agency) use its best endeavours to secure observance with the said controls and procedures by its licensed technical representatives (agent);

- (Agency) ensure that its responsible officer has sufficient authority for carrying out the prescribed responsibilities set out below;

- (Agency) provide its responsible officer with sufficient resources and support for carrying out the prescribed responsibilities set out below;

- (Responsible officer) use his/her best endeavours to ensure that the agency has established and maintains proper controls and procedures for securing compliance with the conduct requirements set out in section 90 by the agency and its licensed technical representatives (agent); and

- (Responsible officer) use his/her best endeavours to ensure that the agency uses its best endeavours to secure observance with the controls and procedures by its licensed technical representatives (agent).

(iii) A **Licensed Insurance Broker Company (or its Responsible Officer)** must:

- (Company) establish and maintain proper controls and procedures for securing compliance with the conduct requirements set out in section 90 by the company and its licensed technical representatives (broker);

- (Company) use its best endeavours to secure observance with the said controls and procedures by its licensed technical representatives (broker);

- (Company) ensure that its responsible officer has sufficient authority for carrying out the prescribed responsibilities set out below;

- (Company) provide its responsible officer with sufficient resources and support for carrying out the prescribed responsibilities set out below;

- (Responsible officer) use his/her best endeavours to ensure that the company has established and maintains proper controls and procedures for securing compliance with the conduct requirements set out in section 90 by the company and its licensed technical representatives (broker); and

- (Responsible officer) use his/her best endeavours to ensure that the company uses its best endeavours to secure observance with the said controls and procedures by its licensed technical representatives (broker).

A failure to comply with any of these conduct requirements does not by itself render any person liable to any judicial proceedings. The IA may make rules requiring licensed insurance intermediaries to comply with the practices and standards, relating to the conduct of the intermediaries in carrying on regulated activities, that are specified in the rules.

(f) **Codes of Conduct for Licensed Insurance Intermediaries:** Under section 95(1) of the new Ordinance, the IA may publish codes of conduct, which are not subsidiary legislation and do not have the force of law, for giving guidance relating to the practices and standards with which licensed insurance intermediaries are ordinarily expected to comply in carrying on regulated activities. A failure on the part of a licensed insurance intermediary to comply with a code of conduct does not by itself render the intermediary liable to any judicial or other proceedings. Nevertheless, such failure may be taken into account in considering, for a provision of the IO, whether the intermediary is a fit and proper person to remain licensed.

Pursuant to section 95(1), the IA published the Code of Conduct for Licensed Insurance Agents ('Agents' Code') and the Code of Conduct for Licensed Insurance Brokers ('Brokers' Code'), which became effective on 23 September 2019. These are summarised below:

(i) **Code of Conduct for Licensed Insurance Agents**

The **aims** of the Agents' Code are threefold:

- Primarily, it promulgates the principles of conduct and related standards and practices with which licensed insurance agents are ordinarily expected to comply in carrying on regulated activities. These principles, standards and practices serve as the minimum standards of professionalism that licensed insurance agents should meet when carrying on regulated activities.

- Secondly, it supplements the duties and obligations which licensed insurance agents owe their principals (arising from their principal-agent relationship) by providing that they should comply with the requirements set out by their principals regarding their carrying on of regulated activities.

- Thirdly, it aims, in certain instances, to inform and explain the statutory conduct requirements in sections 90 and 91 (and in any rules made by the IA under section 94) of the IO with which licensed insurance agents are required to comply.

The Agents' Code sets out eight general principles which the IA believes to be the fundamental principles of conduct which licensed insurance agents should adopt and follow when carrying on regulated activities ('**General Principles**'). The Agents' Code goes on to further explain each General Principle and includes standards and practices relating to each General Principle (the '**Standards and Practices**').

In addition, the Agents' Code includes a section headed '**Corporate Governance and Controls and Procedures**', which sets out guidance on the practices and standards for corporate governance, controls and procedures which should be adopted by a licensed insurance agency in relation to the regulated activities carried on by the agency.

The Agents' Code sets out the fundamental principles of professional conduct which buyers of insurance are entitled to expect in their dealings with licensed insurance agents, reinforcing the bedrock of trust which serves as the foundation for a healthy, competitive and efficient insurance industry.

The Agents' Code does not have the force of law. A failure by a licensed insurance agent to comply with the Agents' Code shall not by itself render the agent liable to any judicial or other proceedings.

The IA may, however, take guidance from the Agents' Code in considering:

- whether there has been an act or omission relating to the carrying on of any regulated activity, which in the IA's opinion is or is likely to be prejudicial to the interests of policy holders or potential policy holders or the public interest;

- whether a licensed insurance agent is fit and proper to remain licensed;

- whether a licensed insurance agent or responsible officer of a licensed insurance agency has satisfied the statutory conduct requirements[2]; or

- any other matters under the IO to which the Agents' Code may be relevant.

The IA recognizes that licensed insurance agents differ in scale and complexity of business, that they utilize different channels to communicate and interface with policyholders and potential policyholders and that there may be different ways in which the General Principles, Standards and Practices, corporate governance and controls and procedures may be met or implemented. The IA will therefore take account of the relevant context, facts and impact of any matter in considering whether the provisions of the Agents' Code have been satisfied and, if not, whether to take any disciplinary action.

Neither the Standards and Practices nor the Corporate Governance, Controls and Procedures in the Agents' Code are exhaustive. The Agents' Code reflects a **principle-based approach**.

A summary of **the Agents' Code's** (including the General Principles (GP), Standards and Practices, and Corporate Governance and Controls and Procedures) is set out below:

General Principle 1 – Honesty and Integrity

A licensed insurance agent should act honestly, ethically and with integrity.

[2] In addition to the conduct requirements applicable to licensed insurance agents and/or their responsible officers as identified in sections 90 and 91 of the IO, these include the standards and practices specified in any rules made by the IA under section 94 of the IO with which licensed insurance agents are required to comply.

(GP1-related) Standards and Practices:

1.1 Accurate representations and presentation

(a) A licensed insurance agent should not mislead or deceive a client and should ensure that any representation made or information provided to a client about any insurers, insurance intermediaries or insurance products is accurate and not misleading or deceptive.

(b) A licensed insurance agent should not make inaccurate, misleading or deceptive statements or comparisons to induce a client to enter into an insurance policy or replace an existing insurance policy with another insurance policy.

(c) When advertising, marketing or promoting an insurance product, a licensed insurance agent should only use materials supplied or approved by its appointing insurer or appointing agency (as applicable).

(d) A licensed insurance agency should not use a name (including a registered name, trade name or brand name) that is likely to deceive, mislead or confuse a client. It should not use a name which may lead the public to believe that it is closely affiliated with an insurer, another insurance intermediary, or a well-known entity unless there is such close affiliation or it has the authority to use the name.

1.2 Compliance

(a) A licensed insurance agent should comply with:

(i) all laws which apply to the agent;

(ii) all rules, regulations, codes and guidelines administered or issued by the IA and applicable to the agent; and

(iii) all requirements of other regulatory authorities which apply to the agent in connection with the regulated activities carried on by the agent.

(b) A licensed insurance agent should cooperate with the IA and all other relevant regulatory authorities on any matters concerning the regulated activities carried on by the agent.

(c) A licensed insurance agent should comply with the duties under contract and at law in relation to the carrying on of regulated activities that it owes to its appointing insurer or appointing agency (as applicable). These would include, without limitation, the duty owed by a licensed insurance agency or a licensed individual insurance agent to obtain prior consent from its appointing insurer before accepting an appointment by another authorized insurer. A licensed insurance agent should also comply with the policies, procedures and other applicable requirements of its appointing insurers or appointing agency (as applicable) in relation to the carrying on of regulated activities.

(d) Where a licensed insurance agent is:

(i) wound up or adjudicated bankrupt by a court in Hong Kong or elsewhere;

(ii) convicted of a criminal offence (other than a minor offence[3]) in Hong Kong or elsewhere; or

(iii) disciplined by the Monetary Authority, the Securities and Futures Commission or the Mandatory Provident Fund Schemes Authority,

the agent should, as soon as reasonably practicable, report this to (i) the IA in writing, and (ii) its appointing insurer or appointing agency (as applicable) in a manner specified by the insurer or agency.

1.3 Harassment, Coercion or Undue influence

A licensed insurance agent should not harass, coerce or use undue influence to induce a client to enter into a contract of insurance or to make a material decision.

[3] "Minor offence" means an offence punishable by a fixed penalty under the Fixed Penalty (Traffic Contraventions) Ordinance (Cap. 237), the Fixed Penalty (Criminal Proceedings) Ordinance (Cap. 240), the Fixed Penalty (Public Cleanliness and Obstruction) Ordinance (Cap. 570), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) or the Motor Vehicle Idling (Fixed Penalty) Ordinance (Cap. 611), or an offence of similar nature committed in a place outside Hong Kong

1.4 Prevention of Bribery

(a) A licensed insurance agent should be familiar with and not contravene, and should ensure that its employees are familiar with and do not contravene, the Prevention of Bribery Ordinance (Cap. 201) ('PBO') and should follow all relevant guidance issued by the Independent Commission Against Corruption concerning matters in relation to the carrying on of regulated activities by the agent.

(b) Without limitation to 1.4(a) above, the PBO may prohibit a licensed insurance agent from:

(i) soliciting or accepting an advantage from a person as an inducement or reward for taking any action in relation to the affairs or business of his appointing insurer or appointing agency (as applicable), without first obtaining the requisite permission (i.e. permission which satisfies the requirements set out in section 9(5) of the PBO) from the appointing insurer or appointing agency (as applicable);

(ii) offering an advantage to another person who is an agent (as defined in the PBO) as an inducement or reward for that agent taking any action in connection with the affairs or business of that agent's principal, without the requisite permission (i.e. permission which satisfies the requirements set out in section 9(5) of the PBO) from the principal.

General Principle 2 – Acting Fairly and in Client's Best Interests

A licensed insurance agent should always treat clients fairly and act in their best interests.

(GP2-related) Standards and Practices:

2.1 Acting fairly, impartially and in client's best interests

(a) A licensed insurance agent, when conducting regulated activities in respect of a client, should:

(i) treat the client fairly; and

(ii) give suitable, impartial and objective advice to the client which takes account of the client's interests.

(b) A licensed insurance agent should only recommend insurance products which best meet the client's interests, from the range of insurance products offered by its appointing insurer or appointing agency (as applicable) which the agent is authorized to promote. In this respect, the insurance products which best meet the client's interests would be those that a reasonable licensed insurance agent would consider suitable for the client based on the client's circumstances.

2.2 Giving fair and impartial regulated advice in the client's best interests

(a) A licensed insurance agent should, prior to giving regulated advice:

(i) make such enquiries as are reasonable to obtain information relating to the client, to the extent such information is necessary in order for the agent to provide regulated advice; and

(ii) if it is reasonably apparent that such information is incomplete or inaccurate (e.g. if there are any inconsistencies in the information provided), make reasonable follow-up enquiries to obtain complete and accurate information.

(b) A licensed insurance agent, when giving regulated advice, should:

(i) take into account the information it has obtained from the client including the client's circumstances, and have a reasonable basis for the advice;

(ii) consider what available insurance products can reasonably meet the client's circumstances, when making a recommendation on an insurance product, based on the product range offered by its appointing insurer or appointing agency (as appropriate); and

(iii) provide the client with adequate information in order to assist the client in making an informed decision.

(c) The regulated advice given by a licensed insurance agent to a client should be advice that a reasonable licensed insurance agent would consider suitable for the client based on the information obtained from the client, including the client's circumstances.

General Principle 3 – Exercising Care, Skill and Diligence

A licensed insurance agent should act with due care, skill and diligence.

(GP3-related) Standards and Practices:

3.1 Meeting the standards expected of a reasonable and prudent licensed insurance agent

(a) A licensed insurance agent should always carry on regulated activities to a reasonable standard of care and skill and with due diligence. The reasonable standard of care, in this respect, is the standard expected of a prudent professional insurance agent carrying on regulated activities.

(b) Where a licensed insurance agent employs or engages another person to provide support to the agent in its carrying on of regulated activities, the agent should ensure the person has the integrity and competence to discharge the duties for which the person is employed or engaged and supervise the person diligently performing such duties. In so far as the person's work impacts the regulated activities carried on by the agent, the agent is and remains responsible for such activities.

3.2 Handling of application and claim forms

Where any application, claim or other forms which are required to be completed by a client, are being completed or submitted with the assistance of a licensed insurance agent, the agent:

(a) should inform the client that it is the client's responsibility to ensure the information provided in the form, or in the document(s) provided in support of the form, is accurate and complete;

(b) should not complete, amend or submit to the insurer concerned any such form without obtaining the client's agreement and confirming the completeness and accuracy of the contents with the client; and

(c) should not submit any such form to the insurer concerned if the agent knows that the form contains inaccurate information.

3.3 Carrying out client's instructions

A licensed insurance agent should take reasonable steps to carry out a client's instructions accurately and promptly, and notify the client as soon as practicable in case of any delay or failure to carry out the instructions.

3.4 Protecting client's privacy and confidentiality

(a) A licensed insurance agent should treat all information in relation to a client as confidential and should not use or disclose it other than:

(i) for the purposes of carrying on regulated activities for which such information has been provided;

(ii) with the written consent of the client; or

(iii) for the purposes of complying with any laws or regulations which apply to the agent and which require disclosure to be made.

(b) With regard to a client's personal data collected by a licensed insurance agent in the course of the carrying on of regulated activities, the agent must comply with the Personal Data (Privacy) Ordinance (Cap. 486) and should follow the related guidance issued by the Privacy Commissioner for Personal Data ('Privacy Commissioner') concerning collection, retention, use and security of personal data.

3.5 Record Keeping

(a) A licensed insurance agent should act in accordance with all requirements, policies and procedures of its appointing insurer or appointing agency (as the case may be) relating to the keeping of proper records concerning the regulated activities carried out on behalf of the appointing insurer or appointing agency (as the case may be).

(b) Where in accordance with the record-keeping requirements of a licensed insurance agent's appointing insurer or appointing agency (as the case

may be), such records are to be submitted by the agent to the appointing insurer or appointing agency (as the case may be), the agent should submit such records as soon as reasonably practicable.

3.6 Cooling-off period

If an insurance policy contains a cooling-off period provision, a licensed insurance agent should adhere to the following practices:

(i) before the client's application for the insurance policy is signed or (in the case of an application without a signature) before the application process for the insurance policy is completed, the agent should inform the client of his right to cancel the insurance policy during the cooling-off period and that the client should notify the insurer concerned during the cooling-off period if he wishes to exercise such right; and

(ii) if the agent is obliged to deliver the insurance policy to the client, he should deliver it as soon as reasonably practicable (and keep a record of the date of such delivery) so that the client will have sufficient time to review the insurance policy and reflect on his decision to purchase it before the expiry of the cooling-off period.

General Principle 4 – Competence to Advise

A licensed insurance agent should possess appropriate levels of professional knowledge and experience and only carry on regulated activities in respect of which the agent has the required competence.

(GP4-related) Standards and Practices:

4.1 Product knowledge

A licensed individual insurance agent and a licensed technical representative (agent) should have a good understanding of the nature and key features of, and the risks covered by and associated with, the different types of insurance products in respect of which he may carry on regulated activities.

4.2 Being clear about the limits of their knowledge

A licensed individual insurance agent and a licensed technical representative (agent) should not carry on regulated activities on matters in relation to which he lacks the specific skills or knowledge necessary for carrying on the relevant regulated activities. When in doubt, he should seek guidance from the appropriate personnel in the appointing insurer or the responsible officer or senior management in his appointing agency, as applicable.

General Principle 5 – Disclosure of Information

A licensed insurance agent should provide clients with accurate and adequate information to enable them to make informed decisions.

(GP5-related) Standards and Practices:

5.1 Disclosure in relation to identity and capacity

(a) A licensed insurance agent should provide the following information to its clients:

(i) the name (the registered name as well as the trade name, if any) of the agent;

(ii) the licence number of the agent;

(iii) the type of licence of the agent, i.e. individual insurance agent licence, insurance agency licence or technical representative (agent) licence;

(iv) the name of the appointing insurer or appointing agency (as applicable) of the agent; and

(v) where the agent is a licensed technical representative (agent), the name of the appointing insurer of the technical representative (agent)'s appointing agency.

(b) Where a licensed individual insurance agent or licensed insurance agency acts for more than one appointing insurer, the agent or agency as well as the licensed technical representatives (agent) appointed by the agency should clearly identify to the client which appointing insurer the agent or agency is representing in relation to each particular insurance transaction.

(c) A licensed insurance agent should provide the information in (a) and (b) above before or (if this is not feasible) as soon as reasonably practicable after commencing any regulated activity in relation to the client.

(d) A licensed individual insurance agent or a licensed technical representative (agent) should ensure the following information is correctly shown on his business card (including any digital business card) if a business card is distributed by the agent/technical representative for the purpose of carrying on regulated activities:

(i) the name as shown on his Hong Kong identity card or passport;

(ii) his licence number;

(iii) the type of licence; and

(iv) the name of his appointing insurer or appointing agency (as applicable).

5.2 Disclosure in relation to insurance products

(a) A licensed insurance agent should provide the client concerned with all relevant information on the key features of each insurance product recommended or arranged by the agent. The information should include:

(i) the name of the insurer concerned;

(ii) the major policy terms and conditions (e.g. coverage, policy period, conditions precedent, exclusions, warranties, and any other clauses which would reasonably be considered to adversely impact the client's decision to enter into the insurance policy);

(iii) the level of premium and the period for which the premium is payable; and

(iv) the fees and charges (other than premiums) to be paid by the client, if any.

(b) When comparing insurance products, a licensed insurance agent should adequately explain the similarities and differences between the products. Any comparison made should be accurate and not misleading (see also 1.1(b) above).

5.3 Disclosure in relation to policyholder's obligations

When a client is making an application for insurance with the assistance of a licensed insurance agent, the agent should explain to the client:

(i) the principle of utmost good faith and remind the client that non-disclosure of material facts or provision of incorrect information to an insurer may result in the insurance policy being invalidated or avoided or claims being repudiated by the insurer;

(ii) the sort of material facts which ought to be disclosed by the client to the insurer; and

(iii) any declaration which needs to be made by the client in respect of the application and give the client the opportunity to review it before the client signs or makes the declaration.

5.4 Disclosure in relation to a client referred by another person

(a) Where a client is referred to a licensed insurance agent by another person (referrer), the agent should, in addition to complying with the policies, procedures or requirements relating to referrals that its appointing insurer or appointing agency (as applicable) has in place and before arranging an insurance policy for the client, inform the client that:

(i) the agent will be responsible for arranging the insurance policy and, for this purpose, the client should only deal directly with the agent (i.e. the client should not deal with the referrer for arranging the insurance policy);

(ii) the referrer does not represent the agent and should have no involvement in the arrangement of the insurance policy;

(iii) the agent disclaims all liability for any advice in relation to the insurance policy given to the client by the referrer; and

(iv) premium for the insurance policy should be paid directly either to the insurer concerned or, if permitted (see Handling of premiums (8.1) under General Principle 8 – Client Assets), to the agent (but not to the referrer).

(b) 5.4(a) above does not apply where:

(i) the client is referred to a licensed insurance agency by its appointed licensed technical representative (agent); or

(ii) the referral is made to the licensed insurance agent by a licensed insurance broker (acting as agent of the client) for the purpose of arranging an insurance policy for that client with the agent's appointing insurer.

General Principle 6 – Suitability of Advice

A licensed insurance agent's regulated advice should be suitable for the client taking into account the client's circumstances.

(GP6-related) Standards and Practices:

6.1 Suitability assessment

(a) Before giving regulated advice, a licensed insurance agent should carry out an appropriate suitability assessment in relation to the client's circumstances. The objective of such suitability assessment is to ensure that a licensed insurance agent obtains sufficient information in relation to the client's circumstances on which to base its regulated advice to the client.

(b) To achieve the objective of a suitability assessment, a licensed insurance agent should:

(i) take reasonable steps to understand the client's circumstances;

(ii) consider the available insurance options in view of the client's circumstances;

(iii) take into account the client's circumstances when giving regulated advice to the client and have a reasonable basis for such advice; and

(iv) if a client does not provide information for the suitability assessment which is necessary for the licensed insurance agent to achieve the objective in 6.1(a) above, explain that the agent's regulated advice may not be suitable to address the client's circumstances unless such information is provided.

(c) The level of suitability assessment should be proportionate and reasonable, taking into account the client's circumstances and other factors such as the type of insurance product under consideration. Reference should also be made to the guidelines issued by the IA in relation to life insurance policies which set out specific requirements in relation to suitability assessments for these policies (e.g. financial needs analysis).

6.2 Recommendation

(a) The regulated advice given by a licensed insurance agent to a client (e.g. advice in relation to the making of an application or proposal for a contract of insurance) should be advice that a reasonable licensed insurance agent would consider suitable for the client based on the information obtained from the client, including the client's circumstances.

(b) If, after a licensed insurance agent has carried out a suitability assessment and provided regulated advice, the client insists on making a material decision contrary to the recommendation included in the advice which, in the agent's opinion, is not suitable for the client's circumstances, the agent should document and keep a proper record of:

(i) the recommendation made by the agent to the client;

(ii) the reasons given by the client (if any) to the agent for making a decision which does not follow the recommendation;

(iii) the explanation given by the agent to the client for considering the client's decision to be unsuitable; and

(iv) the fact that the decision is the client's own decision.

General Principle 7 – Conflicts of Interest

A licensed insurance agent should use the best endeavours to avoid conflicts of interests and when such conflicts cannot be avoided, the agent should manage them with appropriate disclosure to ensure clients are treated fairly at all times.

(GP7-related) Standards and Practices:

7.1 Avoiding potential conflicts of interest and providing transparency through appropriate disclosure of principal-agent relationship

To avoid potential conflicts of interest and to provide transparency on the role and functions of a licensed insurance agent, given that the agent is in the capacity of a representative of its appointing insurer or appointing agency (as applicable), the agent should disclose to the client the facts that:

(i) the agent is appointed by its appointing insurer or appointing agency (as applicable) to promote, advise on or arrange the insurance products offered by the insurer or agency (as applicable); and

(ii) the insurance products the agent can promote, advise on or arrange are limited to the insurance products offered by its appointing insurer or appointing agency (as applicable).

7.2 Disclosure of relevant restrictions arising from the agent's terms and conditions with its principal

Where a licensed individual insurance agent or licensed insurance agency acts for more than one authorized insurer, but the terms of the relevant agreement with or appointment by any of his or its appointing insurers restricts him or it from promoting, advising on or arranging particular insurance products on behalf of his or its other appointing insurers, the agent or agency (including the licensed technical representatives (agent) appointed by the agency) should disclose that restriction to the client and explain that, in line with the restriction, he or it will only be promoting advising on or arranging the insurance products of that particular appointing insurer.

7.3 Avoid allowing own interests to influence client's decision

Where a licensed insurance agent has another business or occupation, the agent should avoid any conflict arising between its interests in that other business or occupation and the interests of the client when carrying on regulated activities. In the event the agent is unable to avoid such conflict, it should disclose the conflict to the client as soon as practicable and, at all times, act fairly in relation to the client, placing the client's interests ahead of the agent's interests in that other business or occupation.

General Principle 8 – Client Assets

A licensed insurance agent should have sufficient safeguards in place to protect client assets received by the agent or which are in the agent's possession.

(GP8-related) Standards and Practices:

8.1 Handling of premiums

(a) A licensed insurance agent should only receive premium payments, where it is within the scope of the agent's authority granted by its appointing insurer or appointing agency (as applicable).

(b) If a licensed insurance agent is authorized to receive premium payments by its appointing insurer or appointing agency (as applicable), the agent should:

(i) handle the payments and disburse them to the appointing insurer or appointing agency (as applicable) in strict conformity with the requirements, controls and timing set out by its appointing insurer or appointing agency (as applicable);

(ii) safeguard any premiums received and not mix them with the agent's personal funds; and

(iii) maintain proper records of premiums received in accordance with the requirements and controls stated in (i) above.

(c) A licensed insurance agent should not receive premium payments by way of cash, unless:

(i) it is not reasonably feasible for the agent to accept payments by any other means; and

(ii) the appointing insurer or appointing agency (as applicable) of the agent authorizes the agent to receive cash payments, the payments are within the limits of such authority and handled strictly in accordance with the requirements and controls to which such authority is subject.

Corporate Governance and Controls and Procedures (Section IX of the Agents' Code)

A licensed insurance agency should have proper controls and procedures in place to ensure that the agency and its licensed technical representatives (agent) meet the General Principles, Standards and Practices set out in the Agents' Code.

Corporate Governance

A licensed insurance agency should establish and implement an organizational and management structure which includes adequate controls and procedures to ensure the interests of clients are not prejudiced. Such organizational structure should include clear roles and lines of responsibility and accountability of its senior management which underpins the objective of fair treatment of clients. The extent and scope of the agency's governance structure will depend on the nature, size and complexity of the business as well as the medium it uses for solicitation of business and the types of insurance it promotes, advises on or arranges.

Controls and Procedures

The requirements for controls and procedures that a licensed insurance agency is expected to adopt are set out under five headings:

- Compliance;
- Handling of complaints;
- Keeping of records;
- Reporting of incidents to the IA; and
- Accountability of the responsible officer and senior management.

(ii) **Code of Conduct for Licensed Insurance Brokers**

The **aims** of the Brokers' Code are twofold:

- First, it promulgates principles of conduct and related standards and practices with which licensed insurance brokers are ordinarily expected to comply in carrying on regulated activities. These principles, standards and practices serve as the minimum standards of professionalism that licensed insurance brokers should meet when carrying on regulated activities.

- Second, it aims, in certain instances, to inform and explain the statutory conduct requirements in sections 90 and 92 (and in any rules made by the IA under section 94) of the IO as they apply to licensed insurance brokers.

The Brokers' Code sets out eight general principles which the IA believes to be the fundamental principles of conduct which licensed insurance brokers should adopt and follow when carrying on regulated activities (the '**General Principles**'). The Brokers' Code goes on to further explain each General Principle and includes standards and practices relating to each General Principle (the '**Standards and Practices**').

In addition, the Brokers' Code includes a section headed '**Corporate Governance and Controls and Procedures**', which sets out guidance on the practices and standards for corporate governance, controls and procedures which should be adopted by a licensed insurance broker company in relation to the regulated activities carried on by the broker company.

The Brokers' Code sets out the fundamental principles of professional conduct which buyers of insurance are entitled to expect in their dealings with licensed insurance brokers, reinforcing the bedrock of trust which serves as the foundation for a healthy, competitive and efficient insurance industry.

The Brokers' Code does not have the force of law. A failure by a licensed insurance broker to comply with the Brokers' Code shall not by itself render the broker liable to any judicial or other proceedings.

The IA may, however, take guidance from the Brokers' Code in considering whether:

- whether there has been an act or omission relating to the carrying on of any regulated activity which in the IA's opinion is or is likely to be prejudicial to the interests of policyholders or potential policyholders or the public interest;

- whether a licensed insurance broker is fit and proper to remain licensed;

- whether a licensed insurance broker or a responsible officer of a licensed insurance broker company has satisfied the statutory conduct requirements[4]; or

- any other matters under the IO to which the Brokers' Code may be relevant.

The IA recognizes that licensed insurance brokers differ in scale and complexity of business, that they utilize different channels to communicate and interface with policyholders and potential policyholders and that there may be different ways in which the General Principles, Standards and Practices, Corporate Governance and Controls and Procedures may be met or implemented. The IA will therefore take account of the relevant context, facts and impact of any matter in considering whether the provisions of the Brokers' Code have been satisfied and, if not, whether to take any disciplinary action.

Neither the Standards and Practices nor the Corporate Governance, Controls and Procedures in the Brokers' Code are exhaustive. The Brokers' Code reflects a **principle-based approach**.

A summary of **the Brokers' Code** (including the General Principles (GP), Standards and Practices, and Corporate Governance and Controls and Procedures) is set out below:

General Principle 1 – Honesty and Integrity

A licensed insurance broker should act honestly, ethically, with integrity and in good faith.

(GP1-related) Standards and Practices:

1.1 Accurate representations and presentation

(a) When carrying on regulated activities, a licensed insurance broker should always act in good faith towards its client.

[4] In addition to the conduct requirements applicable to licensed insurance broker companies and/or their responsible officers as identified in sections 90 and 91 of the IO, these include the standards and practices specified in any rules made by the IA under section 94 of the IO with which licensed insurance broker companies are required to comply.

(b) A licensed insurance broker should not mislead or deceive a client and should ensure that any representation made or information provided to a client about any insurers, insurance intermediaries or insurance products is accurate and not misleading or deceptive.

(c) A licensed insurance broker should not make inaccurate, misleading or deceptive statements or comparisons to induce a client to enter into an insurance policy or replace an existing insurance policy with another insurance policy.

(d) Where a licensed insurance broker company develops its own advertising or marketing materials for use in carrying on regulated activities, it should ensure such materials contain only accurate information and are not disparaging, misleading or deceptive.

(e) A licensed technical representative (broker) should only use advertising or marketing materials supplied or approved by its appointing licensed insurance broker company.

(f) A licensed insurance broker company should not use a name (including a registered name, trade name or brand name) that is likely to deceive, mislead or confuse the client. It should not use a name which may lead the public to believe that it is closely affiliated with an insurer, another insurance intermediary, or a well-known entity unless there is such close affiliation or it has the authority to use the name.

1.2 Compliance

(a) A licensed insurance broker should comply with the following provisions applicable to the broker:

(i) all laws;

(ii) all rules, regulations, codes and guidelines which are administered or issued by the IA; and

(iii) all requirements of other regulatory authorities in connection with the regulated activities carried on by the broker.

(b) A licensed insurance broker should cooperate with the IA and all other relevant regulatory authorities on any matters concerning the regulated activities carried on by the broker.

(c) A licensed technical representative (broker) should comply with the requirements, policies and procedures in relation to the carrying on of regulated activities established by the licensed insurance broker company for which the technical representative is acting as agent.

(d) Where a licensed insurance broker is:

(i) wound up or adjudicated bankrupt by a court in Hong Kong or elsewhere;

(ii) convicted of a criminal offence (other than a minor offence[5]) in Hong Kong or elsewhere; or

(iii) disciplined by the Monetary Authority, the Securities and Futures Commission or the Mandatory Provident Fund Schemes Authority;

the broker should, as soon as reasonably practicable, report this to (i) the IA in writing and, (ii) where the broker is a licensed technical representative (broker), his appointing licensed insurance broker company in a manner specified by the broker company.

1.3 Harassment, Coercion or Undue Influence

A licensed insurance broker should not harass, coerce or use undue influence to induce a client to enter into a contract of insurance or to make a material decision.

1.4 Prevention of Bribery

(a) A licensed insurance broker should be familiar with and not contravene, and should ensure that its employees are familiar with and do not contravene the Prevention of Bribery Ordinance (Cap. 201) ("PBO") and should follow all relevant guidance issued by the

[5] "Minor offence" means an offence punishable by a fixed penalty under the Fixed Penalty (Traffic Contraventions) Ordinance (Cap. 237), the Fixed Penalty (Criminal Proceedings) Ordinance (Cap. 240), the Fixed Penalty (Public Cleanliness and Obstruction) Ordinance (Cap. 570), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) or the Motor Vehicle Idling (Fixed Penalty) Ordinance (Cap. 611), or an offence of similar nature committed in a place outside Hong Kong

Independent Commission Against Corruption concerning matters in relation to the carrying on of regulated activities by the broker.

(b) Without limitation to 1.4(a) above, the PBO may prohibit a licensed insurance broker company (including where it acts through its licensed technical representative (broker)) from:

(i) soliciting or accepting an advantage from a person as an inducement or reward for the broker company taking any action in relation to the affairs or business of a client of the broker company, without the broker company first obtaining the requisite permission from that client; or

(ii) offering an advantage to another person who is an agent (as defined in the PBO) as an inducement or reward for that agent taking any action in connection with the affairs or business of that agent's principal, without the requisite permission (i.e. permission which satisfies the requirements set out in section 9(5) of the PBO) from the principal.

General Principle 2 – Acting in Best Interests of Clients and Treating Clients Fairly

A licensed insurance broker should always act in the best interests of its clients and treat its clients fairly.

(GP2-related) Standards and Practices:

2.1 Acting in client's best interests and being impartial, objective and fair

A licensed insurance broker should:

(i) place the interests of clients before all other considerations;

(ii) treat the client fairly; and

(iii) give suitable, impartial and objective advice to its client which takes account of the client's interests.

2.2 Sourcing insurance products

(a) A licensed insurance broker should recommend insurance products which best meet its client's interests. In this respect, the insurance products which best meet the client's interests would be those that a reasonable licensed insurance broker would consider suitable for the client based on the client's circumstances.

(b) Before recommending an insurance product to a client, a licensed insurance broker should source a sufficient range of available insurance products, suitable to its client's circumstances, from a sufficient range of different insurers.

(c) A licensed insurance broker should not prejudice its client's selection of insurers by being unreasonably dependent on any particular insurer.

2.3 Giving fair and impartial regulated advice in client's best interests

(a) A licensed insurance broker should, prior to giving regulated advice:

(i) make such enquiries as are reasonable to obtain information relating to the client, to the extent such information is necessary in order for the broker to provide regulated advice; and

(ii) if it is reasonably apparent that such information is incomplete or inaccurate (e.g. if there are any inconsistencies in the information provided), make reasonable follow-up enquiries to obtain complete and accurate information.

(b) When giving regulated advice, a licensed insurance broker should:

(i) take into account the information it has obtained from its client including the client's circumstances, and have a reasonable basis for the advice;

(ii) consider what available insurance products can reasonably meet the client's circumstances, when making a recommendation on an insurance product, based on the insurance products sourced by the broker (see 2.2 above); and

(iii) provide the client with adequate information in order to assist the client in making an informed decision.

(c) The regulated advice given by a licensed insurance broker to a client should be advice that a reasonable licensed insurance broker would consider suitable for the client based on the information obtained from the client, including the client's circumstances.

General Principle 3 – Exercising Care, Skill and Diligence

A licensed insurance broker should act with due care, skill and diligence.

(GP3-related) Standards and Practices:

3.1 Meeting the standards expected of a reasonable and prudent licensed insurance broker

A licensed insurance broker should always carry on regulated activities to a reasonable standard of care and skill and with due diligence. The reasonable standard of care, in this respect, is the standard expected of a prudent professional insurance broker carrying on regulated activities.

3.2 Handling of application and claim forms

Where any application, claim or other forms which are required to be completed by a client are being completed or submitted on behalf of the client by a licensed insurance broker or with the assistance of the broker, the broker:

(i) should inform the client that it is the client's responsibility to ensure the information provided in the form, or in the document(s) provided in support of the form, is accurate and complete;

(ii) should not complete, amend or submit to the insurer concerned any such form without obtaining the client's authority and confirming the completeness and accuracy of the contents with the client; and

(iii) should not submit any such form to the insurer concerned if the broker knows that the form contains inaccurate information.

3.3 Carrying out client's instructions

(a) A licensed insurance broker should take reasonable steps to carry out a client's instructions accurately and promptly, and notify the client as soon as practicable in case of any delay or failure to carry out the instructions.

(b) Where a client terminates its appointment of a licensed insurance broker company, the broker company should provide all reasonable cooperation to bring the appointment to an end in an orderly manner.

3.4 Protecting client's privacy and confidentiality

(a) A licensed insurance broker should treat all information in relation to a client as confidential and should not use it or disclose it other than:

(i) for the purposes of carrying on regulated activities for which such information has been provided;

(ii) with the written consent of the client; or

(iii) for the purposes of complying with any laws or regulations which apply to the broker and which require disclosure to be made.

(b) With regard to a client's personal data collected by a licensed insurance broker in the course of the carrying on of regulated activities, the broker must comply with the Personal Data (Privacy) Ordinance (Cap. 486) and follow the related guidance issued by the Privacy Commissioner concerning collection, retention, use and security of personal data.

3.5 Record Keeping

(a) A licensed insurance broker company should keep proper records in relation to the regulated activities it carries out, so as to comply with the record keeping requirements of all laws, rules, regulations, codes and guidelines applicable to the broker company.

(b) A licensed technical representative (broker) should act in accordance with all requirements, policies and procedures of the licensed insurance broker company he represents relating to the keeping of proper records

established by the broker company in order for it to comply with 3.5(a) above.

3.6 Cooling-off period

If an insurance policy contains a cooling-off period provision, a licensed insurance broker should adhere to the following practices:

(i) before the client's application for the insurance policy is signed or (in the case of an application without a signature) before the application process for the insurance policy is completed, the broker should inform the client of his right to cancel the insurance policy during the cooling-off period and that the client should notify the insurer concerned during the cooling-off period if he wishes to exercise such right; and

(ii) if the insurance policy is delivered to the broker by the insurer concerned, the broker should deliver the insurance policy to the client as soon as reasonably practicable (and keep a record of the date of such delivery) so that the client will have sufficient time to review the insurance policy and reflect on his decision to purchase it before the expiry of the cooling-off period.

3.7 Assistance in relation to insurance claims

With regard to insurance claims made by a client:

(i) unless stated otherwise in the client agreement, a licensed insurance broker should (where requested by the client) provide the client with reasonable assistance in submitting any claim under an insurance policy which was negotiated or arranged by the broker on behalf of the client and pass on any relevant information received from the client in relation to the claim to the insurer concerned as soon as practicable; and

(ii) exercise due care to discharge all obligations in relation to the administration, negotiation and settlement of such claims to the extent that such obligations are within the scope of the broker's services stated in the relevant client agreement.

General Principle 4 – Competence to Advise

A licensed insurance broker should possess appropriate levels of professional knowledge and experience and only carry on regulated activities in respect of which the broker has the required competence.

(GP4-related) Standards and Practices:

4.1 Product knowledge

A licensed technical representative (broker) should have a good understanding of the nature and key features of, and the risks covered by and associated with, the different types of insurance products in respect of which he may carry on regulated activities.

4.2 Being clear about the limits of their knowledge

A licensed technical representative (broker) should not carry on regulated activities on matters in relation to which he lacks the specific skills or knowledge necessary for carrying on the relevant regulated activity. When in doubt, he should seek guidance from the responsible officers or senior management in his appointing licensed insurance broker company.

General Principle 5 – Disclosure of Information

A licensed insurance broker should provide clients with accurate and adequate information to enable them to make informed decisions.

(GP5-related) Standards and Practices:

5.1 Disclosure in relation to identity and capacity

(a) A licensed insurance broker should provide a client with the following information:

(i) the name (the registered name as well as the trade name, if any) of the broker;

(ii) the licence number of the broker;

(iii) the type of licence, i.e. insurance broker company licence or technical representative (broker) licence;

(iv) where the broker is a licensed technical representative (broker), the name of his appointing licensed insurance broker company; and

(v) the fact that the broker acts on behalf of the client in dealing with insurers on matters relating to insurance policies being procured by the client.

(b) Where a licensed technical representative (broker) acts for more than one licensed insurance broker company, he should clearly identify to the client which licensed insurance broker company he is representing in relation to each particular insurance transaction.

(c) A licensed insurance broker should provide the information in 5.1(a) and (b) above before or (if this is not feasible) as soon as reasonably practicable after commencing any regulated activity in relation to the client.

(d) A licensed technical representative (broker) should ensure the following information is correctly shown on his business card (including any digital business card) if a business card is distributed by the technical representative for the purpose of carrying on regulated activities:

(i) the name as shown on his Hong Kong identity card or passport;

(ii) his licence number;

(iii) the type of licence; and

(iv) the name of his appointing licensed insurance broker company.

5.2 Disclosure in relation to insurance products

(a) A licensed insurance broker should provide a client with all relevant information on the key features of each insurance product recommended or arranged by the broker. The information should include:

(i) the name of the insurer concerned;

(ii) the major policy terms and conditions (e.g. coverage, policy period, conditions precedent, exclusions, warranties and any other clauses which would reasonably be considered to adversely impact the client's decision to enter into the insurance policy);

(iii) the level of premium and the period for which premiums are payable; and

(iv) the fees and charges (other than premiums) to be paid by the client, if any.

(b) When comparing insurance products, a licensed insurance broker should adequately explain the similarities and differences between the products. Any comparison made should be accurate and not misleading (see also 1.1(c) above).

(c) Where a licensed insurance broker intends to give regulated advice on or arrange an insurance policy with an insurer which is not authorized by the IA, the broker should disclose to the client:

(i) the name and address of the insurer in the jurisdiction where the insurer has issued the policy and (if different) the jurisdiction where the insurer was incorporated;

(ii) the fact that the insurer is not regulated by the IA and is subject to different laws and regulations;

(iii) the financial standing of the insurer (e.g. whether the insurer has a credit rating and, if so, what the credit rating is); and

(iv) the governing law of the insurance policy and the jurisdiction in which disputes under the policy will be determined.

Where the client is an individual, the licensed insurance broker should also obtain written acknowledgement from the client of the disclosures in (i) to (iv) above, and keep a record of such acknowledgement.

5.3 Disclosure in relation to policyholder's obligations

(a) When a client is making an application for insurance with the assistance of a licensed insurance broker, the broker should explain to the client:

(i) the principle of utmost good faith and remind the client that non-disclosure of material facts or provision of incorrect information to an insurer may result in the insurance policy being invalidated or avoided or claims being repudiated by the insurer;

(ii) the sort of material facts which ought to be disclosed by the client to the insurer; and

(iii) any declaration which needs to be made by the client in respect of the application and give the client the opportunity to review it before the client signs or makes the declaration.

(b) When negotiating or arranging an insurance policy with an insurer on behalf of a client (i.e. prior to the insurance contract being entered into), a licensed insurance broker should:

(i) not make any false statements or mislead the insurer;

(ii) disclose to the insurer all material facts in relation to the insurance policy, which have been provided to the broker by the client; and

(iii) disclose to the insurer all material facts in relation to the prospective insurance policy of which the broker is aware.

5.4 Client agreements and terms of business with clients

(a) A licensed insurance broker company should enter into an agreement with a client, setting out in writing the terms and conditions of business on which the licensed insurance broker will carry on regulated activities for the client.

(b) The client agreement may be entered into:

(i) by the client signing the agreement which sets out the written terms and conditions;

(ii) by the client providing written consent to the broker's written terms and conditions of business (including by e-mail or other electronic mechanism); or

(iii) by conduct (with the broker company providing the client with its written terms and conditions of business for carrying on regulated activities for the client's review, and the client proceeding or continuing with the instruction to the broker company to carry on regulated activities, or otherwise indicating acceptance of such written terms and conditions of business, for example, by paying the premium for the insurance product arranged by the broker company).

(c) A copy of the client agreement should be provided to the client as soon as reasonably practicable and the broker company should keep a record of the client agreement.

5.5 Disclosure in relation to a client referred by another person

(a) Where a client is referred to a licensed insurance broker by another person (referrer), the broker should, in addition to complying with the policies, procedures or requirements relating to referrals that the licensed insurance broker company has in place and before arranging an insurance policy for the client, inform the client that:

(i) the broker will be responsible for arranging the insurance policy and, for this purpose, the client should only deal directly with the broker (in other words, the client should not deal with the referrer for arranging the insurance policy);

(ii) the referrer does not represent the broker and should have no involvement in the arrangement of the insurance policy;

(iii) the broker disclaims all liability for any advice in relation to the insurance policy given to the client by the referrer; and

(iv) the premium for the insurance policy should be paid directly to either the broker or the insurer concerned (and not to the referrer).

(b) 5.5(a) above does not apply where:

(i) the client is referred to a licensed insurance broker company by its appointed licensed technical representative (broker); or

(ii) a referral is made to a licensed insurance broker company in the context of the broker company being engaged by another insurance broker for the purpose of arranging an insurance policy for the client.

General Principle 6 – Suitability of Advice

A licensed insurance broker's regulated advice should be suitable for the client taking into account the client's circumstances.

(GP6-related) Standards and Practices

6.1 Suitability assessment

(a) Before giving regulated advice, a licensed insurance broker should carry out an appropriate suitability assessment in relation to the client's circumstances. The objective of such suitability assessment is to ensure that a licensed insurance broker obtains sufficient information in relation to the client's circumstances on which to base its regulated advice to the client.

(b) To achieve the objective of a suitability assessment, a licensed insurance broker should:

(i) take reasonable steps to understand the client's circumstances;

(ii) source a sufficient range of relevant insurance products available from a sufficient range of different insurers or explore other insurance options, and consider the available insurance options in view of the client's circumstances;

(iii) take into account the client's circumstances when giving regulated advice to the client, and have a reasonable basis for such advice; and

(iv) if the client does not provide information for the suitability assessment which is necessary for the licensed insurance broker to achieve the objective in 6.1(a) above, explain that its regulated advice may not be suitable to address the client's circumstances unless such information is provided.

(c) The level of suitability assessment should be proportionate and reasonable, taking into account the client's circumstances and other factors such as the type of insurance product under consideration. Reference should also be made to the guidelines issued by the IA in relation to life insurance policies which set out specific requirements in relation to suitability assessments for these policies (e.g. financial needs analysis). For example, for travel insurance, the suitability assessment may be conducted as a part of the applicable process (where the client's circumstances would be the trip details, the ages of the person's travelling, the length of the journey, etc.

6.2 Recommendation

(a) The regulated advice given by a licensed insurance broker to a client (e.g. advice in relation to the making of an application or proposal for a contract of insurance) should be advice that a reasonable licensed insurance broker would consider suitable for the client based on the information obtained from the client, including the client's circumstances.

(b) If, after a licensed insurance broker has carried out a suitability assessment and provided regulated advice, the client insists on making a material decision contrary to the recommendation included in the advice which, in the broker's opinion, is not suitable for the client's circumstances, the broker should document and keep a proper record of:

- the recommendation made by the broker to the client;

- the reasons given by the client (if any) to the broker for making a decision which does not follow the recommendation;

- the explanation given by the broker to the client for considering the client's decision to be unsuitable; and

- the fact that the decision is the client's own decision.

General Principle 7 – Conflicts of Interest

A licensed insurance broker should use the best endeavours to avoid conflicts of interests and when such conflicts cannot be avoided, the broker should manage them with appropriate disclosure to ensure clients are treated fairly at all times.

(GP7-related) Standards and Practices:

7.1 Avoiding potential conflicts of interest by providing appropriate disclosure in relation to remuneration

Where a licensed insurance broker company intends to arrange an insurance policy for its client and will receive remuneration from the insurer concerned, the broker company should, before arranging the insurance policy, provide adequate disclosure in relation to such remuneration to the client. Such disclosure should include information and be made in accordance with the manner stated in any rules, regulations, codes or guidelines administered or issued by the IA or other regulatory authorities.

7.2 Addressing potential conflicts of interest regarding relationships with insurers

If a licensed insurance broker has any association or affiliation with an insurer (such as, without limitation, a common shareholder, director and controller) and the licensed insurance broker intends to recommend an insurance product to a client which is offered by that insurer, then the broker should (prior to making the recommendation) disclose its association or affiliation with the insurer to the client.

7.3 Avoid allowing own interests to influence client's decision

(a) Where a licensed insurance broker has another business or occupation, the broker should avoid any conflict arising between its interests in that other business or occupation and the interests of the client when carrying on regulated activities. In the event the broker is unable to avoid such conflict, it should

disclose the conflict to the client as soon as practicable and, at all times, act fairly in relation to the client, placing the client's interests ahead of the broker's interests in that other business or occupation.

(b) Where another company in the same group of companies as the licensed insurance broker company is providing services in relation to an insurance policy in respect of which the broker is providing regulated activities, the broker should take steps to avoid or manage (through, for example, disclosure) any potential conflicts of interest which may arise, so as to ensure the client is treated fairly at all times.

General Principle 8 – Client Assets

A licensed insurance broker should have sufficient safeguards in place to protect client assets received by the broker or which are in the broker's possession.

(GP8-related) Standards and Practices:

8.1 Handling of client assets

(a) A licensed insurance broker company must handle client monies (and any other client assets received by the broker in the course of carrying on regulated activities) in strict compliance with the requirements stipulated in law and the relevant rules, regulations, codes and guidelines administered or issued by the IA, including without limitation:

(i) the requirements set out in Section 71 of the IO;

(ii) the requirements set out in the Insurance (Financial and Other Requirements for Licensed Insurance Broker Companies) Rules;

(iii) the terms and conditions of its client agreement with the client; and

(iv) the fiduciary duties it owes to its clients.

(b) A licensed insurance broker company should have sufficient controls and security in place to prevent unauthorized access to client assets.

Corporate Governance and Controls and Procedures (Section IX of the Brokers' Code)

A licensed insurance broker company should have proper controls and procedures in place to ensure that the broker company and its licensed technical representatives (broker) meet the General Principles, Standards and Practices set out in the Brokers' Code.

Corporate Governance

A licensed insurance broker company should establish and implement an organizational and management structure which includes adequate controls and procedures to ensure the interests of clients are not prejudiced. Such organizational structure should include clear roles and lines of responsibility and accountability of its senior management which underpins the objectives of acting in the best interests of clients and treating clients fairly. The extent and scope of the broker company's governance structure will depend on the nature, size and complexity of the business as well as the medium it uses for solicitation of business and the types of insurance it promotes, advises on or arranges.

Controls and Procedures

The requirements for controls and procedures that a licensed insurance broker company is expected to adopt are set out under six headings:

- Compliance;
- Insurance product and insurer due diligence;
- Handling of complaints;
- Keeping of records;
- Reporting of incidents to the IA; and
- Accountability of the responsible officer and senior management.

(g) **Insurance (Financial and Other Requirements for Licensed Insurance Broker Companies) Rules** (the 'Rules'): The Rules were made by the IA under the applicable provisions of the IO and came into effect on 23 September 2019 (the 'commencement date'). The Rules include certain transitional arrangements for 'specified insurance broker companies'. For the purposes of the Rules, the term 'specified insurance broker company' means a company which was immediately before the commencement date registered with an approved body of insurance brokers [which was an SRO under the old regulatory regime] as a member, and regarded as having been granted an insurance broker company licence on the commencement date under the transitional arrangements the IO provides for.

The Rules prescribe the following requirements applicable to licensed insurance broker companies:

(i) Share **Capital and Net Assets**: A licensed insurance broker company must at all times maintain a paid-up share capital of not less than HK$500,000 and net assets of not less than HK$500,000, with the calculation of the amount of net assets in accordance with the prescribed manner, subject to the following transitional arrangements applicable to specified insurance broker companies:

- HK$100,000 for the period that begins on the commencement date and ends on 31 December 2021; and

- HK$300,000 for the period that begins on 1 January 2022 and ends on 31 December 2023.

(ii) **Professional Indemnity Insurance** (PII): A licensed insurance broker company must maintain a PII policy that covers claims made against the company for liability arising from a breach of duty in the course of carrying on its regulated activities, subject to the following minimum limit of indemnity and maximum deductible amount prescribed in the Rules:

- **Limit of Indemnity**: Like the limit of indemnity for any one claim, that for any one policy period of 12 months must not be less than: (a) 2 times the aggregate amount of the company's insurance brokerage income in the 12 consecutive months immediately before the commencement date of the policy period, up to HK$75,000,000; or (b) HK$3,000,000 whichever is the greater.

  Nevertheless, in relation to a company which is in its first 12 months of operation as a licensed insurance broker company, the limits of indemnity must not be less than HK$3,000,000.

Furthermore, the policy must provide for at least one **automatic reinstatement** to the effect that, in the event of its limit of indemnity being reduced by a loss or claim, the limit of indemnity will be restored to an amount not less than the applicable minimum amount (as the case may be).

- **Deductible**: The deductible amount under a licensed insurance broker company's PII policy must not exceed 50% of the company's net assets as at the end of its financial year immediately before the commencement date of the policy period.

  The above requirement on deductible amount does not apply to a specified insurance broker company for the period that begins on the commencement date and ends on 31 December 2023.

  In relation to a company which is in its first 12 months of operation as a licensed insurance broker company, the deductible amount must not be more than 50% of the company's paid-up share capital as at the commencement date of the policy period.

(iii) **Keeping of Separate Client Accounts**: A licensed insurance broker company that receives or holds client monies must maintain at least one client account with an authorized institution in the name of the company and bearing the word 'client' in the account title. It must also give written notice to that authorized institution, stating that the client account is maintained by the company pursuant to section 71 of the IO; and keep proper records of the notice.

The **monies** which a licensed insurance broker company is required **to pay into a client account** as soon as practicable after receiving them include:

- monies received by the company from or on behalf of a policyholder or potential policyholder as premiums payable to an insurer under a contract of insurance arranged by the company;

- monies received by the company from an insurer, a reinsurer, an insurance intermediary or any other party for the purpose of or relating to the settlement of a claim under a contract of insurance;

- monies received by the company from or on behalf of a policyholder or potential policyholder for any purposes which are incidental to the carrying on of regulated

activities by the company in relation to the policyholder or potential policyholder; and

- the following types of monies arising from the ordinary transactions of the company's business of carrying on regulated activities:

  · premiums, renewal premiums, additional premiums and return premiums of all kinds;

  · claims and other monies due under contracts of insurance;

  · refunds to policyholders;

  · policy loans and associated interests;

  · fees, charges and levies relating to contracts of insurance; and

  · premium discounts, commissions and brokerage.

Licensed insurance broker companies must also perform **reconciliation of client accounts** at least once a calendar month. Nevertheless, this requirement does not apply to specified insurance broker companies for 6 months beginning on the commencement date.

(iv) **Keeping of Proper Books and Accounts**: A licensed insurance broker company must, in relation to its business which constitutes the carrying on of regulated activities:

- keep, where applicable, such accounting and other records (including records relating to the assets or affairs of the company's clients) as are sufficient to:

  · explain, and reflect the financial position and operation of, such business;

  · enable financial statements that give a true and fair view of its financial position and financial performance to be prepared from time to time;

  · account for all client monies that it receives or holds; and

  · demonstrate compliance by it with these Rules and that there is no contravention of certain specified provisions of the IO.

- keep those records in such manner as will enable an audit to be conveniently and properly carried out; and

- make entries in those records in accordance with applicable accounting standards.

A licensed insurance broker company is also required to keep all records in writing in the Chinese or English language or in such a manner as to enable them to be readily accessible and readily converted into written form in the Chinese or English language. In addition, it must retain the records that are required to be kept under the Rules for at least 7 years.

(v) **Submission of Audited Financial Statements**: A licensed insurance broker company must prepare the financial statements to be provided to the IA under section 73(1) of the IO in accordance with applicable accounting standards.

The financial statements so provided in relation to a financial year must include the company's:

- insurance brokerage income for the financial year distinguishing between general business and long term business;

- aggregate balances of cash held in its client accounts as at the end of the financial year; and

- insurance premiums payable as at the end of the financial year,

except for the audited financial statements of a specified insurance broker company for a financial year beginning before 1 January 2021.

Any document (except an auditor's report) provided under section 73(1) must be approved by the directors of the company, and signed by 2 of its directors on its directors' behalf or where it only have 1 director, by the director.

(vi) **Auditor's Report**: The auditor's report on the financial statements provided by a licensed insurance broker company under section 73(1)(d) of the IO in relation to a financial year must contain statements stating whether the financial statements, in the auditor's opinion, give a true and fair view of:

- the financial position of the company as at the end of the financial year; and

- the financial performance of the company for that year.

In addition, the auditor's report must contain statements stating whether, in the auditor's opinion, the company has continued to comply with the requirements under the Rules and the relevant provisions of the IO in relation to:

- the capital and net assets of the company;
- the PII taken out by the company;
- the keeping of separate client accounts by the company; and
- the keeping of proper books and accounts by the company,

as at the end of the financial year and 2 such other dates in the financial year as the auditor may elect, provided that the intervening period between those 2 dates must not be shorter than 3 months.

(h) **Guideline on Continuing Professional Development for Licensed Insurance Intermediaries (GL24)**

Pursuant to section 133 of the IO, the IA has published the Guideline on Continuing Professional Development for Licensed Insurance Intermediaries (GL24) with an aim to provide general guidance for the following **categories of persons to comply with the CPD requirements** set out therein:

- an individual licensee;
- an authorized insurer which appoints a licensed individual insurance agent;
- a licensed insurance agency which appoints a licensed technical representative (agent); and
- a licensed insurance broker company which appoints a licensed technical representative (broker).

GL24 has taken effect on 23 September 2019, save for the CPD hour requirements for individual licenses (required under paragraphs 3.1 and 3.3 of GL24) which will take effect from 1 August 2021 onwards.

GL24 is not intended to be exhaustive and does not constitute legal advice. Yet a **failure to comply** with any of the CPD requirements may adversely affect the fitness and properness of the person concerned and may result in a disciplinary action to be taken by the IA against that person.

GL24 sets out the requirements applicable to individual licensees and principals, respectively. In GL24, 'principal' means:

- in relation to a licensed individual insurance agent, an authorized insurer which appoints the licensed individual insurance agent;

- in relation to a licensed technical representative (agent), a licensed insurance agency which appoints the licensed technical representative (agent); and

- in relation to a licensed technical representative (broker), a licensed insurance broker company which appoints the licensed technical representative (broker).

Below are the key **CPD requirements for individual licensees** and **CPD requirements for principals**:

Individual Licensees

Subject to prescribed transitional arrangements, individual licensees, except for technical representatives (agent) licensed to carry on regulated activities in restricted scope travel business only, are required to attend any of the 8 types of **Qualified CPD Activities** (e.g. Approved CPD Activities (Type 1) and CPD Activities Organised by the IA (Type 7), etc.) to earn not less than 15 CPD hours in each Assessment Period (i.e. 1 August of a year - 31 July of the following year), including a minimum of 3 CPD hours related to a topic falling under 'Ethics or Regulations' in Annex 1 to GL24. In other words, the **enhanced CPD hour requirements** under the new regulatory regime represent an increase in the minimum aggregate number of CPD hours required from 10 (under the now-defunct self-regulatory regime) to 15, and the additional requirement to earn, among the aggregate CPD hours of 15, at least 3 CPD hours that are related to an 'Ethics or Regulations' topic.

Apart from prescribing a range of **topics** recognized as Qualified CPD Activities (e.g. local insurance (or related) legislation, regulatory aspects of insurance practice in Hong Kong, insurance, risk management, financial planning, ethics, etc., and any other topics the IA may add from time to time), GL24 also prescribes such details for Types 4 to 8 Qualified CPD Activities as topics, specified qualifications, examples of recognized professional bodies, etc. For the first time in Hong Kong's history of insurance regulation, **E-learning** became a recognized manner of participation in Qualified CPD Activities, subject to the restriction that an individual licensee may not earn more than 5 CPD hours for each Assessment Period through participation in E-learning Activities recognized as Type 1 or

7 Qualified CPD Activities (in aggregate)[6].

Subject to prescribed transitional arrangements, technical representatives (agent) only licensed to carry on regulated activities in **restricted scope travel business** are required to attend Qualified CPD Activities to earn not less than 3 CPD hours in each Assessment Period, and are not compulsorily required to attend Qualified CPD Activities related to 'Ethics or Regulations'. Under section 64ZZC(6) of the IO, 'restricted scope travel business', in relation to a travel agent that is a licensed insurance agency, means effecting a travel insurance policy (exclusive of an annual policy) that is tied to a tour, travel package, trip or other travel services arranged by the travel agent for its customers.

With effect from 1 August 2021 (instead of 23 September 2019), for individual licensees who are **newly licensed** in an Assessment Period, the minimum number of total CPD hours required for that Assessment Period varies according to the month in which the individual concerned is granted a licence; and whether he is a technical representative (agent) licensed to carry on regulated activities in restricted scope travel business only (in which case, depending on which month the license is granted, the minimum requirement ranges from 0, 2 to 3 CPD hours); or an individual licensee (other than a licensed technical representative (agent) (in which case, depending on which month the license is granted, the minimum requirement ranges from 0, 6 to 12 CPD hours, including a minimum of 3 CPD hours related to 'Ethics or Regulations' if the relevant license is granted within August 2021 - January 2022).

Individual licensees should comply with the CPD requirements so long as they remain licensed even when their licences are under suspension (for instance, they are not appointed by any principal). However, subject to the discretion of the IA, concessions may be granted to individual licensees in special circumstances (e.g. prolonged illness) which preclude their attendance or completion of Qualified CPD Activities. Only those Qualified CPD Activities which an individual licensee attend when he is licensed will count towards the total number of minimum CPD hour requirements specified in GL24.

[6] According to paragraphs 30 – 32 of Annex 1 to GL24, individual licensees can earn a maximum of 5 CPD hours for each CPD Assessment Period through participation in E-learning Activities that are recognised as Type 1 or Type 7 Qualified CPD Activities.

However, to facilitate the achievement of CPD hours and to encourage greater use of Elearning Activities, the maximum cap on the number of CPD hours that can be obtained through Type 1 and Type 7 E-learning Activities is increased from 5 CPD hours to 7 CPD hours for each Assessment Period. For details, see the interpretation notes relating to GL24 issued on 2 Aug 2021 by the IA.

Individual licensees should report to the IA the Qualified CPD Activities they have attended in each Assessment Period on a **CPD Declaration Form** in a prescribed format and manner no later than 2 months after the expiration of the relevant Assessment Period (i.e. by 30 September). Any CPD hours earned during an Assessment Period in excess of the total number of minimum CPD hours required cannot be carried forward to subsequent Assessment Periods. Individual licensees should also inform their principal(s) of the Qualified CPD Activities reported to the IA by the same deadline.

Individual licensees are required to properly retain sufficient **documentary evidence** of their attendance at or completion of all the Qualified CPD Activities reported to the IA on their CPD Declaration Forms for a minimum of 3 years after the expiration of the relevant Assessment Period. They should promptly produce such evidence to the IA for compliance check upon request.

Transitional CPD Arrangements for Individual Licensees

Annex 3 to GL24 sets out transitional CPD arrangements (or the minimum numbers of CPD hours required) for individual licensees for the period 23 September 2019 - 31 July 2021 for the following five categories of individual licensees:

- individual licensees (except for licensed technical representatives (agent) who are licensed to carry on regulated activities in restricted scope travel business only) who were registered with a former SRO immediately before 23 September 2019;

- licensed technical representatives (agent) who are licensed to carry on regulated activities in restricted scope travel business only and were registered with IARB immediately before 23 September 2019;

- individual licensees (other than licensed technical representatives (agent) who are licensed to carry on regulated activities in restricted scope travel business only) who are newly licensed by the IA between 23 September 2019 and 31 July 2020 (both days inclusive);

- licensed technical representatives (agent) who are newly licensed by the IA between 23 September 2019 and 31 July 2020 (both days inclusive) to carry on regulated activities in restricted scope travel business only;

- individual licensees who are newly licensed by the IA between 1 August 2020 and 31 July 2021 (both days inclusive).

Principals

A principal should ensure that each individual licensee appointed by it complies with the applicable CPD requirements.

It should also have in place adequate controls and procedures to monitor and ensure compliance with the CPD requirements by the appointed individual licensees. In this respect, the principal should request, check and verify the documentary evidence in support of the CPD Declaration Forms submitted to the IA by the individual licensees.

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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 Which of the following is a regulated activity for the purposes of the statutory licensing requirement for insurance intermediaries?

(a) printing an insurance policy; .....
(b) negotiating an insurance contract; .....
(c) giving advice on investing in insurance business; .....
(d) none of the above. .....

[Answer may be found in **5.2.1**]

Type 'B' Questions

3 Which of the following are required to have at least one responsible officer?

(i) licensed insurance institution;
(ii) licensed insurance agent;
(iii) licensed insurance agency;
(iv) licensed insurance broker company.

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

[Answer may be found in **5.2.1**]

4 In determining whether a person is a fit and proper person to be granted a licence to be a licensed individual insurance agent by the Insurance Authority (IA), the IA is required by the Insurance Ordinance to have regard to which of the following matters?

(i) his family background;
(ii) his nationality;
(iii) his education;
(iv) his reputation.

(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 **5.2.4(c)**]

[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:** insurance agents have to comply with the relevant provisions of the IO, and the rules made by and the codes and guidelines published by the IA under the IO.

(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. Given this contrast and the statutory imposition of vicarious liability on an insurer for the conduct of any person he has appointed as his agent (see **5.2.2**), 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 six data protection principles stipulated 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 kind 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 (source: website of the Office of the Privacy Commissioner for Personal Data):

(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) **Direct Marketing**: a new Part 6A of the Ordinance comprising provisions relating to use of personal data in direct marketing and provision of personal data for use in direct marketing has been introduced, with effect from 1 April 2013.

(i) **Interpretation of Part 6A:** in this Part,

Direct Marketing is defined to include the offering, or advertising of the availability, of goods, facilities or services through direct marketing means;

Direct Marketing Means means—

(1) sending information or goods, addressed to specific persons by name, by mail, fax, electronic mail or other means of communication; or

(2) making telephone calls to specific persons;

Marketing Subject, in relation to direct marketing, is defined to include any goods, facility or service offered, or the availability of which is advertised.

(ii) **Data user to take specified actions before using personal data in direct marketing**

A data user who intends to use the personal data of a data subject in direct marketing, or to provide it to others for use in direct marketing should inform the data subject of certain prescribed information (see below) and provide the data subject with a response channel through which the data subject may indicate whether he objects to the intended use or provision.

A data user who intends to use the data subject's personal data in direct marketing for his own purposes is permitted to provide the data subject with the prescribed information either **orally or in writing**. However, the provision of personal data (whether for gain or not) to another data user will be subject to the requirement that the data user should provide to the data subject **in writing** the prescribed information.

The prescribed information includes the kinds of personal data to be used or provided, the classes of marketing subjects in relation to which the data is to be used in direct marketing, and (where appropriate) the classes of persons to which the data is to be provided for direct marketing purposes. If the personal data is to be provided for gain, the data user must inform the data subject the data is to be so provided.

Presentation of the prescribed information by data users should be done in a manner that is easily readable and understandable.

(iii) **Grandfathering arrangement for pre-existing personal data**

The abovementioned requirements for a data user to notify the data subject of his intention to use the latter's personal data in direct marketing will not apply to personal data that the data user has, before the entry into force of the new provisions concerned, used in direct marketing in compliance with those requirements under the Ordinance that existed before. This grandfathering arrangement applies to use of any personal data of the data subject in relation to the same class of marketing subjects if any of the data subject's personal data has been so used before the commencement of the new provisions.

(iv) **Data user must not use personal data, or provide it to others for use, in direct marketing without data subject's consent or indication of no objection**

A data user can only use a data subject's personal data, or provide it to others for use, in direct marketing if he has provided the prescribed information and response channel to the data subject and received a reply from the data subject indicating that the data subject consents or does not object to the data user doing so.

Where a data user intends to use a data subject's personal data in direct marketing for his own purposes and provides the data subject with the prescribed information either **orally or in writing**, the data subject's reply to the data user indicating his consent or no objection may reciprocally be given either orally or in writing. If the reply is given orally, the data user must, before using the personal data in direct marketing, confirm **in writing** to the data subject within 14 days from the date of receipt of the reply, the permitted kind of personal data and the permitted class of marketing subjects.

Where a data user provides a data subject's personal data (whether for gain or not) to others for use in direct marketing, he must, before proceeding to provide the data, receive a reply **in writing** from the data subject indicating that the data subject consents or does not object to the data user doing so.

(v) **Data user must notify data subject when using personal data in direct marketing for the first time**

As before, a data user must notify a data subject of his opt-out right when using personal data in direct marketing for the first time. The maximum penalty for a contravention is a fine of HK$500,000 and imprisonment for 3 years.

(vi) **Data subject may require data user to cease to use personal data or provide it to others for use in direct marketing**

A data user must comply with a data subject's request at any time to cease to use the data subject's personal data in direct marketing.

A data user must comply with a data subject's request at any time to cease to provide the data subject's personal data to others for use in direct marketing, and to notify any person to whom the data subject's personal data has been so provided to cease to use the data in direct marketing.

(vii) **Penalty**

Contraventions of the requirements under the new regulatory regime are offences. For those contraventions that involve provision of personal data for gain, the maximum penalty is a fine of HK$1,000,000 and imprisonment for 5 years. For other contraventions, the maximum penalty is a fine of HK$500,000 and imprisonment for 3 years.

(f) **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 HK$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.

(g) **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 also a variety of offences under the Ordinance, including the offence of non-compliance with an enforcement notice that has been served by the PCPD.

(h) **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.

(i) **User-friendly Materials for Use by Data Users and Insurance Practitioners:** apart from the Ordinance, insurance practitioners are also 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) **Engagement of private investigators in insurance claims:** insurers may appoint private investigators to investigate suspicious claims. While private investigators are regulated by the Ordinance, insurers who appoint private investigators should pay attention to the issue of vicarious liability for the acts of their appointed private investigators.

(i) Lawful and fair means of collection: generally speaking, obtaining information covertly would not be considered fair means of collection of data. However, each case turns on its own facts and there may be special circumstances which justify particular means of collection. For example, collecting information about a claimant's activities by physical surveillance may be justified if there is reasonable suspicion of a fraudulent insurance claim of personal injury and there are no realistic alternatives to using such means of collection in seeking evidence of the suspected fraud.

(ii) Data is adequate but not excessive: in the course of investigating a suspected false claim of personal injury, for instance, data in relation to the claimant's private life which is unrelated to the claim should not be collected.

(d) **Collection and use of personal data in direct marketing:** the following examples highlight some of the areas to which insurance practitioners should pay attention:

(i) Lawful and fair means of collection: when an insurance practitioner changes job to work for another insurance institution, he should not make copies of the insurance policies or other information of his former customers from the records of his former principal/employer.

(ii) No change in purpose of use of data: In example (i) above, using a former customer's personal data for marketing products or services of the new principal/employer would unlikely be within the original purpose for which the data was collected by the former principal/employer.

(e) **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 take security safeguards and precautions in relation to the security of customers' personal data held by them or by their staff or agents, which should include the following:

(i) Secure transmission of documents containing personal data: 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. For example, 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'.

(ii) Insurance agents or representatives working at home or outside workplace: insurance agents and representatives often meet customers in public places, taking with them policies and other documents that contain the customers' personal data. During the process, they should ensure that the personal data is not seen, and conversations concerning sensitive customer information are not overheard by unrelated parties. On the other hand, insurance institutions should provide clear policies and guidelines to the relevant staff for handling customers' data outside the workplace.

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. Statistically, women live *longer* than men on average. From this, insurers may:

(i) charge a *lower* premium rate for *life insurance* 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 another serious medical condition, may present a very different risk from a person who is not disabled. 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

Unfair discrimination (such as appointing only either sex, unfairly denying promotion to either sex, refusing to employ the physically handicapped, sexual harassment and so on) is, quite rightly, not permitted by the anti-discrimination laws referenced in **6.3.1** above. Below are two examples of unfair discrimination with insurance:

(a) **Motor insurance**: charging higher premiums or imposing stricter terms on women simply because of a prejudice to the effect that women drivers are worse than men. (There have been statistics of accidents and driving convictions in certain countries which 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 generally defined as the abuse of entrusted power for personal gain. Enforced by the Independent Commission Against Corruption ("ICAC"), the Prevention of Bribery Ordinance (POBO) helps maintain a corruption-free environment that is conducive to efficiency and fair competition. It safeguards the interests of different stakeholders and protects principals against agents' abuses of authority for personal gain. Insurance practitioners are subject to the POBO and should comply with the law when transacting insurance business.

6.4.1 Major Provisions of the POBO

(a) **Offences and Penalty**

(i) Under Section 9(1) of the POBO, when conducting his/her principal's business or affairs, an agent should not solicit or accept any advantage without the permission of his/her principal. For example, an individual insurance agent accepted an advantage from a client for assisting the latter to conceal his pre-existing illness when applying for life insurance would be liable to the offence.

(ii) According to POBO, both offering and accepting any advantage constitute an offence. Therefore, the offeror of advantage as stated in (i) commits an offence under Section 9(2) of the POBO. In the above example, the client who offered the advantage to the insurance agent would be liable to this offence.

(iii) Section 9(3) of the POBO provides that any agent who, with intent to deceive his/her principal, uses any receipt, account or other document which is false or erroneous commits an offence. For example, an individual insurance agent used bogus insurance applications to deceive insurance company of commissions would be liable to the offence.

(iv) The maximum penalty for committing any of the above offences is imprisonment for 7 years and a fine of HK$500,000.

(b) **Elaborations on Key Elements**

(i) **Principal and Agent relationship:** In the context of the POBO, an "agent" includes any person employed by or acting for his/her "principal". Generally speaking, an individual insurance agent appointed by an insurer, a technical representative appointed by a licensed insurance agency, an insurance broker representing a proposer or policyholder, or any employee employed by a company is an "agent" of their respective "principals" and owe his/her

principal contractual and fiduciary obligations [7] . Insurance intermediaries or employees should obtain permission from respective principals for accepting any advantages in relation to the principals' affairs.

(ii) **Advantage:** The term "advantage" is broadly defined to include money, gift, loan, reward, commission, office, employment, contract, service, favour, the exercise of a duty, and forbearance from the exercise of a duty, etc. Even tips, "red packet money" and "tea money" are included irrespective of amounts. However, entertainment (i.e. food and drink consumed on the spot) is excluded.

(iii) **No defence for corruption:** Under Section 19 of the POBO, customs in any profession, trade, vocation or calling do not constitute a defence for bribery. It is also not a defence for the recipient to claim that "the act requested to be done was not actually carried out" as stated in Section 11 of the POBO. The offeror and the recipient of a bribe will commit an offence irrespective of whether or not the act of bribery has actually been carried out.

(iv) **Indirect bribery via third party:** Accepting or offering bribes indirectly through a third party is also against the law. As long as the purpose of offering the advantage is for inducing or rewarding the agent to do an act in relation to his principal's business, both the offeror and the recipient would commit an offence under the POBO.

(v) **Dealing with public servants:** Even with no corruption intention, insurance intermediaries should not offer any advantage to public servants while having business dealing with their organisations, as it would be an offence under Section 8 of the POBO. And if the offering of advantage to a public servant aims for a reciprocal act in abusing his/her official authority, it would be an offence under Section 4 of the POBO. Public servants include government officers and employees of public bodies.

[7] According to the Insurance Ordinance (Cap. 41), a licensed insurance agency is granted a licence to carry on regulated activities as an agent of its authorized insurer; whereas a licensed insurance broker company is granted a licence to carry on regulated activities as an agent of its policy holder or potential policy holder.

(vi) **Cross-boundary bribery:** If any part of the act of bribery, including offering, soliciting or accepting a bribe and agreeing on or processing the illegal deal, can be proved to have taken place in Hong Kong, both the offeror and recipient may be pursued under Section 9 of the POBO.

6.4.2 Report Corruption

In dealing with clients or other third parties, insurance intermediaries should uphold integrity, say no to corruption and guard against violating the POBO or other crimes. When encountering corruption, intermediaries are encouraged to report them to the ICAC so as to protect the company's and their own interests. ICAC's 24-hour report hotline: 25 266 366. All complaints will be handled in strict confidence.

6.4.3 Assistance from the ICAC

The ICAC has all along been working together with the insurance industry actively to prevent corruption and to uphold a high ethical standard amongst insurance intermediaries. The following resources and services are readily available for use by intermediaries and insurance companies:

(a) **Anti-corruption and Ethics Training:** The ICAC jointly arranges recognised Continuing Professional Development (CPD) training courses with various professional bodies where participants will be entitled to qualified CPD hours on completing the training. It also assists insurance companies with their anti-corruption activities for staff.

(b) **Dedicated Resources for Insurance Industry:** With a view to preventing corrupt conduct and promoting ethical practices, the Hong Kong Business Ethics Development Centre of the ICAC has produced a range of useful resources for the insurance industry, including the 'Online Learning Course for New Practitioners of Insurance Industry' dedicated to the candidates of the Qualifying Examination and insurance practitioners. The resources are available on the Centre's website for the insurance industry (https://hkbedc.icac.hk/insurance).

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 moneys.

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 actions. 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 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 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 section 77(1) of the IO.

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)

Assignment（轉讓） It generally means the transfer of a right. In insurance, there are broadly two types of assignment: **assignment of the insurance contract** (or insurance policy) and **assignment of the right to insurance moneys** (or insurance proceeds). **3.1.6**

Assignment of the Insurance Contract（保險合約的轉讓） It has the effect of passing the interest of the assignor in the contract wholly to the assignee, so 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. **3.1.6**

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

Automatic Reinstatement（自動恢復保障額） Where a liability policy provides for an aggregate limit (or 'limit per period'), any claim paid under the policy will have the effect of reducing the amount of cover available for the remainder of the policy period accordingly, unless the cover is reinstated (or restored) either by making a mutual agreement of reinstatement in the form of an endorsement or by triggering a pre-agreed automatic reinstatement clause. By way of illustration, under a liability policy subject to a limit for any one occurrence of $1m, a limit for any one period of $2m, and an automatic reinstatement provision for two reinstatements, the insurer might end up paying $6m cumulatively as the maximum for the whole policy period. **5.2.5**(g)

Average (in marine insurance)（海損（海上保險中的）） partial (i.e. non-total) loss. **3.4.7**(a) **Note**

Average (in non-marine insurance)（比例分攤（非海上保險中的）） 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 IO, 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 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 IO. **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**

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 IO (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)

Denial of Claims（拒絕賠付） 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)

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）） Emotional risk is the risk of being affected by grief and sorrow. **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）Equity is a set of rules originally established by the Chancery Court of England to mitigate the rigour of common law so as to achieve enhanced fairness. Equity prevails over 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 (Insurance)（忠誠保證（保險）） Fidelity guarantee insurance insures an employer against loss of money or property as a result of any act of fraud, theft or dishonesty by any person in the course of employment by the employer. **4.1.1**(b)

Financial (Risk)（財務上的（風險）） Financial risk is the risk of suffering a loss measurable in monetary terms. **1.1.1**(a)

Fit and proper（適當人選） 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**

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 IO. It consists of a very wide range of different types of insurance, with seventeen classes in the IO. **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**

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 relationship with the subject matter of insurance that gives the right to effect insurance on it. **3.1.1**

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

Insurance Agent（保險代理人） In insurance terminology, an insurance agent (or agent) is a person in the business of representing as agent in law one or more insurers to sell their insurance products.. **2.2**

Insurance Broker（保險經紀） In insurance terminology, an insurance broker (or broker) is a person in the business of representing a policyholder or potential policyholder in negotiating or arranging insurance between the policyholder or potential policyholder and an insurer, as agent in law of the policyholder or potential policyholder. **2.2**(a)

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. **5.1.3a**

Insurance Complaints Bureau（保險投訴局） With a membership of all authorised insurers carrying on personal insurance business in Hong Kong, its primary function is to help resolve both claim-related and non-claim related disputes of a monetary nature arising from personal insurance contracts, in the capacity of an adjudicator and mediator respectively. **5.1.3**

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 Intermediary（保險中介人） An insurance term meaning an insurance agent or insurance broker. **2.2**(a)

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 insurance and business interruption insurance. **3.1.4**(d)

Insurance Ordinance ('IO')（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**

I**nsured 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 Lloyd's 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 IO. 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)

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**

'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（履約保證書） 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）） The risk of dying or getting injured. **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） The powers that the IO gives the Insurance Authority (the IA) to take action in specified circumstances, for the purposes of executing the IA's functions under the IO. **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 in law acts. **2.2**(a)

Professional Indemnity Insurance ('PII')（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 authorized 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 authorized 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（純粹風險／純風險） A risk whose outcome is 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)

Regulation of Insurance Intermediaries（保險中介人的規管） Under the now-defunct self-regulatory regime, insurance intermediaries are required to be registered with and be regulated by one of the three former 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 took over the regulation of insurance intermediaries on 23 September 2019 from the SROs through a statutory licensing regime. **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)

Restricted Scope Travel Business（受限制的旅遊保險業務） Under section 64ZZC(6) of the IO, Restricted Scope Travel Business, in relation to a travel agent that is a licensed insurance agency— (a) means effecting a travel insurance policy that is tied to a tour, travel package, trip or other travel services arranged by the travel agent for its customers; and (b) does not include effecting an annual travel insurance policy. **6.2.5**(h)

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） A risk management tool that shifts a prescribed risk of loss from oneself to another party. **1.1.3**(c)

Salvage (in maritime law and marine insurance)（救助賞金／救助（海商法及海上保險中的）） 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（非海上保險中的）） 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 IO), 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**

Subsidiary Legislation（附屬法例）It means any proclamation, rule, regulation, order, resolution, notice, rule of court, bylaw or other instrument made under or by virtue of any Ordinance and having legislative effect, subject to the approval of the Legislative Council. **5.2.5**

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)

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. **3.3.2**(c)

Unit-linked（單位相連） In unit-linked insurance, 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 policy is linked to the value of the units held under the policy. **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)

INDEX

Codes of conduct for licensed insurance intermediaries	持牌保險中介人操守守則	**5.2.5**(f)
Collectability	收回應收賬款的能力	**5.1.1e**
Complaints and disputes	投訴及糾紛	**5.1.2e**
Composite (insurer)	綜合業務（保險人）	**4.2.1**(c)
Contract	合約	**2.1.1**
Contribution	分擔	**3.5**
Corporate governance	公司管治	**5.1.1d**
Damages	損害賠償	**3.2.6**(b)
Deductible	免賠額	**3.4.7**(b)
Deemed	當作	**2.2.1**
Directly or indirectly	直接或間接地	**3.3.4**(a)
Disability Discrimination Ordinance	《殘疾歧視條例》	**7.3.1**(b)
Double insurance	重複保險	**3.5.1**
Duties owed by agent to principal	代理人對委託人的責任	**2.2.4**
Duties owed by principal to agent	委託人對代理人的責任	**2.2.5**
Emotional (risk)	情緒上的（風險）	**1.1.1**(c)
Employees' compensation insurance	僱員補償保險	**4.1.1**(b)
Equal Opportunity	平等機會	**6.3.1**
Equity	衡平法	**3.5.1**
Excepted (excluded) peril	除外危險	**3.3.2**(b)
Excess	免賠額	**3.4.7**(b)
Executor	遺囑執行人	**3.1.4**(b)
‘Fair’ discrimination in insurance	保險中的「公平」歧視	**6.3.2**
Family Status Discrimination Ordinance	《家庭崗位歧視條例》	**6.3.1**(c)
Fidelity guarantee (insurance)	忠誠保證（保險）	**4.1.1**(b)
Fiduciary obligations	受信人責任	**7.5.1**(b)(i)
Financial (risk)	財務上的（風險）	**1.1.1**(a)
Fit and proper	適當人選	**5.1.1d**
Franchise	起賠額	**3.4.7**(c)
Fraud (Insurance)	（保險）詐騙	**6.5**
Fraudulent misrepresentation	欺詐性失實陳述	**3.2.5**(a)
Fraudulent non-disclosure	欺詐性不披露	**3.2.5**(c)
Fundamental risk	基本風險	**1.1.2b**(ii)
General business	一般業務	**4.1.1**(b)
General insurance	一般保險	**4.2.3**

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	《符合持續專業培訓計劃要求指引 — 適用於只登記從事受限制的旅遊保險業務的登記人士》	**5.2.2h**(e)
Guideline on Continuing Professional Development for Licensed Insurance Intermediaries (GL24)	《持牌保險中介人持續專業培訓指引》（指引24）	**5.2.5**(h)
Guideline on Exercising Power to Impose Pecuniary Penalty in Respect of Regulated Persons under the Insurance Ordinance (Cap. 41) (GL18)	《保險業條例》（第41章）有關向受規管人士行使施加罰款權力的指引》（指引18）	**5.2.5**(d)
Guideline on "Fit and Proper" Criteria for Licensed Insurance Intermediaries under the Insurance Ordinance (Cap. 41) (GL23)	《保險業條例》（第41章）有關持牌保險中介人"適當人選"的準則指引（指引23）	**5.2.4**(c)
Hong Kong Federation of Insurers ('HKFI')	香港保險業聯會（「保聯」）	**4.4**
Indemnity	彌償	**3.4.1**
(How provided)	（如何提供）	**3.4.4**
Insurable interest	可保權益	**3.1.1**
(When needed)	（何時需要）	**3.1.5**
Insurable risk	可保風險	**1.1.1**
Insurance agent	保險代理人	**2.2, 5.2.1**
Insurance Agents Registration Board ('IARB')	保險代理登記委員會（「登記委員會」）	**5.2.2a**(a), **5.2.2b**
Insurance Authority (IA)	保險業監管局	**5.1**
Insurance broker	保險經紀	**2.2**(a), **5.2.1**
Insurance Complaints Bureau ('ICB')	保險投訴局（「投訴局」）	**5.1.4**
Insurance Claims Complaints Panel (the 'Panel')	保險索償投訴委員會（「投訴委員會」）	**5.1.4a**
Insurance (Financial and Other Requirements for Licensed Insurance Broker Companies) Rules	《保險（持牌保險經紀公司的財務及其他要求）規則》	**5.5**(g)
Insurance intermediary	保險中介人	**2.2**(a)
Insurance intermediaries' duties to policyholders	保險中介人對保單持有人的責任	**6.1**
Insurance of legal rights	合法權利保險	**3.1.4**(d)
Insurance Ordinance ('IO')	《保險業條例》	**5.1.1**
Insured peril	受保危險	**3.3.2**(a)
Insurer	保險人	**1.1.2a**

Joint principal	共犯	**6.5**
Licensed individual insurance agent	持牌個人保險代理人	**5.2.1**
Licensed insurance agency	持牌保險代理機構	**5.2.1**
Licensed insurance agent	持牌保險代理人	**5.2.1**
Licensed insurance intermediary	持牌保險中介人	**5.2.1**
Licensed technical representative (agent)	持牌業務代表（代理人）	**5.2.1**
Licensed technical representative (broker)	持牌業務代表（經紀）	**5.2.1**
Licensed insurance broker	持牌保險經紀	**5.2.1**
Licensed insurance broker company	持牌保險經紀公司	**5.2.1**
Licensing regime	發牌制度	**5.2.1**
Life insurance	人壽保險	**4.1.1**(a)
Long term business	長期業務	**4.1.1**(a)
Loss prevention	損失防範	**1.1.3**(c)(iii)
Loss reduction	損失降低	**1.1.3**(c)(iii)
Material fact	重要事實	**3.2.3**
Mens rea	犯罪心意	**6.5**
Model agency agreement	標準代理合約	**5.2.2f**
'New for old' cover	「以新代舊」的保險保障	**3.4.8**(b)
Non-fraudulent misrepresentation	非欺詐性失實陳述	**3.2.5**(b)
Non-fraudulent non-disclosure	非欺詐性不披露	**3.2.5**(d)
Non-material fact	非重要事實	**3.2.3**(b)
Office of the Commissioner of Insurance ('OCI')	保險業監理處	**5.1**
Ordinary good faith	一般誠信	**3.2.1**
Paid-up capital (of authorized insurers)	繳足款股本（獲授權保險人的）	**5.1.1a&b**
Particular risk	特定風險	**1.1.2b**(i)
Pecuniary penalty	罰款	**5.2.5**(c)
Performance bond	履約保證書	**4.1.1**(b)
Peril	危險	**1.1.1 Note** 2, **3.3.2**
Personal Data (Privacy) Ordinance	《個人資料（私隱）條例》	**6.2**
Physical (risk)	身體上的（風險）	**1.1.1**(b)
Policy	保單	**2.1.1**
Policy limits	保單限額	**3.4.7**(d)
Powers of intervention	干預權力	**5.1.1f**
Prevention of Bribery Ordinance	《防止賄賂條例》	**6.4**
Primary functions of insurance	保險的主要功能	**1.2**(a)
Principal (in criminal law)	主犯（刑事法中的）	**6.5.1**

Principal (in law of agency)	委託人（代理法中的）	**2.2**(a)
Principal perpetrator	主犯	**6.5.1**
Privacy Commissioner for Personal Data	個人資料私隱專員公署	**6.2.1**(a)
Professional indemnity insurance ('PII')	專業彌償保險	**6.1.2**(c)
Proposal form	投保書	**3.2.2 Note** 1
Proposer	投保人	**2.2**(a)
Protection of personal data	保護個人資料	**6.2**
Proximate cause	近因	**3.3**
'Pure' general business	「純」一般業務	**4.2.1**(b)
'Pure' long term business	「純」長期業務	**4.2.1**(a)
Pure risk	純粹風險／純風險	**1.1.2a**(i)
Race Discrimination Ordinance	《種族歧視條例》	**6.3.1**(d)
Ratification	追認	**2.2.2**(b)
Regulated activity	受規管活動	**5.2.1**
Regulated advice	受規管意見	**5.2.1**
Regulated person	受規管人士	**5.2.1**
Reinstatement	恢復原狀	**3.4.4**(d)
Reinstatement insurance	重置保險	**3.4.8**(a)
Repair	修理	**3.4.4**(b)
Replacement	更換	**3.4.4**(c)
Responsible officer	負責人	**5.2.2a**(a)
Revocation	撤銷協議	**2.2.6**(b)
Risk	風險	**1.1**
Risk avoidance	風險避免	**1.1.3**(c)(iii)
Risk financing	風險融資	**1.1.3**(c)(iii)
Risk management	風險管理	**1.1.3**
Risk transfer	風險轉移	**1.1.3**(c)(iii), **1.2**(a)
Salvage (in maritime law and marine insurance)	救助賞金／救助（海商法及海上保險中的）	**3.4.5 Note**
Salvage (in non-marine insurance)	損餘（非海上保險中的）	**3.4.5**
Secondary participant	從犯	**6.5.1**
Secondary party	從犯	**6.5.1**
Section limit	保單部分限額	**3.4.7**(d)(ii)
Self-regulatory organisations ('SROs')	自我規管機構	**5.2**
Sex Discrimination Ordinance	《性別歧視條例》	**6.3.1**(a)
Single article limit	單一物件限額	**3.4.7**(d)(i)
Solvency margin	償付準備金	**5.1.1a**(b), **5.1.1c**

Speculative risk	投機風險	**1.1.2a**(ii)
Statutory classification of insurance	保險的法定類別	**4.1.1**
Subject matter of insurance	保險標的	**3.1.1**
Subrogation	代位	**3.6**
Subsidiary legislation	附屬法例	**5.2.5**
Sum insured	保額	**3.4.7**(d)
Suretyship	擔保	**4.1.1**(b)
Technical representative	業務代表	**4.2.2**
Termination of agency	終止代理關係	**2.2.6**
Third party	第三者	**2.2.1**
Tontine	聯合養老保險	**4.1.1**(a)
Tort	侵權	**3.2.6**(b)
Trustee	受託人	**3.1.4**(b)
Unfair discrimination in insurance	保險中的不公平歧視	**6.3.3**
Uninsured peril	不保危險	**3.3.2**(c)
Unit-linked	單位相連	**4.1.1**(a)
Utmost good faith	最高誠信	**3.2**
(breach of)	（違反）	**3.2.5 & 3.2.6**
(extension of common law duty)	（普通法責任的延伸）	**3.2.2 Note** 1
Valued policy	定值保單	**3.4.8**(c)
Vicarious liability	轉承責任	**2.2**(c)
Waive (a breach)	不追究（違反）	**3.2.2 Note** 2, **3.2.6**(c)
Warrant	保證	**3.2.2 Note** 1
Warranty	保證	**3.2.2 Note** 1, **5.1.2c**(b)(iii)

Representative Examination Questions

Answers

	QUESTIONS			
CHAPTER	**1**	**2**	**3**	**4**
1	(d)	(a)	(b)	(d)
2	(a)	(c)	(d)	
3	(c)	(a)	(d)	(a)
4	(d)	(b)		
5	(a)	(b)	(d)	(d)
6	(c)	(d)	(d)	(e)

Part II

Travel Insurance

TABLE OF CONTENTS

- o - o - o -

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 Complaints Bureau (ICB) (ICB was inaugurated on 16 January 2018 to supersede 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 then ICCB for adjudication. It is worth noting that the Insurance Claims Complaints Panel (Complaints Panel) of the then ICCB is empowered by its Articles of Association 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 then ICCB which is now The Insurance Complaints Bureau ("ICB") 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.*

Case 23 – All costs incurred to assist in the stabilization or to prevent further deterioration of a medical condition should be included as part of the medical expenses

The complainant took out a travel policy for her six-month trip to Europe. She sustained left knee injury while snowboarding in Germany during the second month of her trip. She was diagnosed by a local doctor as suffering from left knee cruciate ligament tear. Since her mobility was affected by the knee injury, she was admitted to a local hospital for arthroscopic operation. After the surgery, she was recommended to put on a knee brace and to receive follow-up consultations and physiotherapy.

The insurer offered to settle the medical expenses incurred by the complainant in Germany in full, but excluded the cost of knee brace since the item did not belong to a medical expenses.

It is stipulated in the provisions of the travel policy that "the insurer will indemnify the insured person against medical expenses, hospitalization charges, treatment expenses … necessarily incurred for continuous medical treatment outside Hong Kong… as a direct result of accidental bodily injury sustained by or sickness of the insured person occurring during the period of insurance".

Remarks*: the Complainants Panel noted that the travel insurance policy did not explicitly exclude the cost of knee brace. Since the complainant was recommended by her doctor to put on a knee brace after the surgery for stabilization, it thus formed part of her medical treatment.*

Case 24 – Insurer should be bound by the precedent to honour the claim

The complainant first effected an annual travel (overseas study) insurance policy for her son (the insured) in 2015 and the policy renewed automatically. The insured sustained vertebra pain while he was doing exercise at school. He received several consultations at a chiropractic clinic in August and September 2017. It was stipulated in the policy provisions that a referral letter must be obtained from a registered medical practitioner for receiving chiropractic treatment. As there was no referral letter, the insurer declined the claim for the medical expenses incurred.

Upon review of the claim history of the insured, the insurer found that it had wrongly settle his chiropractic expenses previously without asking for a referral letter. Due to the oversight, the insurer agreed in mid December 2017 to settle, on a without prejudice basis, the insured's chiropractic expenses incurred in August and September 2017, and at the same time, informed the complainant that it would not settle any further chiropractic expenses incurred in or after October 2017 if there was no referral letter.

The complainant subsequently filed another claim to the insurer for the insured's chiropractic expenses incurred from October to December 2017. Given that the chiropractic expenses was incurred in or after October 2017,

the insurer declined her claim. The complainant was not satisfied with the decision and emphasised that she was first informed by the insurer of the need to submit a referral letter in mid December 2017. If she had been notified earlier, she would have arranged her son to obtain a referral prior to seeking chiropractic treatments.

***Remarks**: the case was referred to three Honorary Secretaries and two of them recommended the insurer to honour the subsequent claim. They considered that the insurer's previous claims settlement would be deemed as a precedent which gave the compliant a message the chiropractic treatment was covered by the policy without the need of a referral letter.*

Case 25 – Number of Physiotherapy Treatment after return to HK

The Insured sustained a slip and fall accident during her trip to Australia. She consulted a local doctor the next day presenting with pain at elbows, legs and left buttock.

After return to Hong Kong, she sought consultation from a medical practitioner and was diagnosed as suffering from injuries to elbows, legs and lower back. She was then referred to have physiotherapy treatment. The Insured received a total of three medical consultations, one x-ray examination and 32 sessions of physiotherapy treatment during the three months following her return from Australia.

The insurer questioned about the frequency of the complainant's physiotherapy treatment and offered settlement less than the medical treatments Insured received.

The case was brought to the then ICCB which is now The Insurance Complaints Bureau ("ICB"). The Complaints Panel ruled that the insurer should settle the complainant's claim in full.

***Remarks:** to ascertain whether or not the medical treatments received by the insureds after return to Hong Kong are reasonable and directly related to the injuries happened abroad, the medical opinions given by the insured's attending doctor is critical.*

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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 26 – 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 27 – 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 28 - 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, 24-hours worldwide emergency assistance 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 29 - 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 then ICCB which is now The Insurance Claims Bureau ("ICB") after returning to Hong Kong.

The then 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 then 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 30 - 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 31 - 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 32 - 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 33 - 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 34 – 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 35 – 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, 6 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 36 - 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 37 – 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.

Some policies are extended to indemnify the monetary loss caused by unauthorized use of credit card in the event of loss of card during the trip ("Unauthorized Use of Credit Card") and Pays for replacement cost of accidental loss of travel documents and travel tickets ("Travel Document & Travel Ticket").

Unauthorized Use of Credit Card and Travel Documents

(b) Exclusions may include:

(i) any form of the plastic money (including any credit card, 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 38 – 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 39 – 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 40 - 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.*

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16 TRAVEL DELAY

This section will provide a benefit in a specified amount for each and every full consecutive hour, say, 6-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 41 – 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 42 - 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 43 – 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 44 - 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 then ICCB which is now The Insurance Claims Bureau ("ICB") 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.*

Case 45 – Travel Delay (change of port in a cruise trip)

A family joined a six-day cruise trip from Hong Kong to Okinawa via Guangzhou. Due to a typhoon approaching, the family was unable to embark the cruise ship which was scheduled to depart Kai Tai Cruise Terminal at 2:00pm on the scheduled departure day. The cruise company then arranged a shuttle buy at 11:00am to take them to Nansha, the next scheduled port of pickup. The family arrived Nansha at 6:30pm and boarded the cruise ship before 8:00pm on the same day.

According to the itinerary issued by the cruise company, the scheduled arrival time at Nansha Container Terminal was 6:00pm. Given that the family departed Hong Kong for Nansha at 11:00am by shuttle buy arranged by the

cruise company and arrived Nansha at 6:30pm, there was no departure delay and only 30-minutes arrival delay. Since the trip delay was less than six hours, the insurer declined the claim for travel delay benefit. Furthermore, the insurer indicated that changing of port should not be considered as a travel delay.

It is stipulated in the "Travel Delay Cover" of the travel insurance policy that "in the event that the public common carrier in which the insured person has arranged to travel is delayed for at least six hours from the departure or arrival time specified in the insured person's original itinerary as a result of … adverse weather conditions… the insurer will pay HK$300 for each and every full six hours of delay up to the maximum benefits as stated in the Table of Benefits…"

Remarks*: having duly reviewed all the information available, the Complaints Panel agreed that there was no delay in departure or arrival time for more than six hours and that changing of port was not regarded as a travel delay.*

Case 46 – Travel Delay (train suspension caused by typhoon)

The Insured took a trip to Tokyo where the train to Narita Airport was suspended due to typhoon. The delay hours were around 16 hours.

The policy stipulated that "in the event the insured's covered trip is delayed by a public common carrier due to adverse weather conditions… and the delay exceeds six consecutive hours from the time specified in the itinerary, the insurer will pay the amount of benefit stated… for each and every full six consecutive hours delayed, up to the maximum stated. The insured claim for additional hotel expenses under travel delay benefit. The insurer declined the claim on the ground of inadequate evidence as the certificate issued by the train operator did not state the actual delay hours.

The Insured made a complaint to the then ICCB which is now The Insurance Claims Bureau ("ICB"). The Complaints Panel ruled in favour of the Insurer who subsequently offered HK$600 (HK$300 x 2) to the complainant in respect of the travel delay benefit claim but not the hotel expenses claim.

Remarks: *when determining the merits of the cases, other than certificates issued by airlines or operators of public common carriers, the Complaints Panel also considers other valid evidence in support of the case like the local newspapers supporting the duration of train suspension in this case.*

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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 dated;

(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);

(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; and

(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.

(h) **Exclusions** may include:

(i) suffered from infectious disease or epidemic disease related to COVID-19 being classified as a pre-existing condition from 12 March 2020 onwards due to the declaration by the World Health Organisation.

Case 47 - 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 48 - 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 49 - 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 50 - 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) **Curtailment of trip**: Where the insured trip has commenced outside the place of origin but, because of the happening of any of the specified perils, has to be curtailed unavoidably, 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;

(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; and

(iii) suffered from infectious disease or epidemic disease related to COVID-19 being classified as a pre-existing condition from 12 March 2020 onwards due to the declaration by the World Health Organisation.

Case 51 - 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.*

Case 52 - Re-routing

A couple joined a six-day trip to Japan. Due to typhoon, they were informed by the airline that their original return flight departing Fukuoka to Hong Kong at 12:55pm was cancelled. The couple then decided to purchase tickets from another airline and took the flight which departed Fukuoka to Hong Kong at 8:30pm on the same day. The couple filed a claim for the additional ticket fares incurred under the "re-routing" benefit of the travel policy.

Since the route of the couple's original and re-arranged flights were the same, the insurer declined their claim for "re-routing" benefit but paid the travel delay claim up to the maximum benefit limit of HK$2,000 per person.

The Complaints Panel noted that there was no definition of "re-routing" in the policy. The literal interpretation of "re-routing" is "the act of choosing a different path for travel and/or to route or direct in a different direction".

Remarks*: since the couple took the same route to return Hong Kong from Fukuoka, the Complaints Panel agreed that their situation did not fulfil the meaning of "re-routing".*

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19 OUTBOUND TRAVEL ALERT

(a) **Outbound Travel Alert System**: The Security Bureau of the HKSAR 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 88 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.

Should there be public health reasons, based on the alert level as advised by the Food and Health Bureau, the Security Bureau will issue an OTA on countries/territories seriously affected by infectious diseases to help the public better understand the possible health risks.

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.

Case 53 – Terrorist Attack

The complainant took out a travel insurance policy for her family trip to Bangkok from 22 to 26 August 2015. Due to the bomb explosion which occurred in Bangkok on 17 August 2015 and the fact that the Security Bureau of the HKSAR issued a red Outbound Travel Alert for Bangkok the next day, the family finally decided to cancel their trip. As terrorism is one of the insured perils as stated under the "cancellation of trip" benefit of the travel policy, the complainant filed a claim to the insurer of the irrecoverable air tickets fares and the hotel cancellation fee.

The insurer considered that the bomb attack was not defined as "terrorist attack" under the policy. As the cause of the family's trip cancellation did not

fall within other insured perils as specified under the policy, the insurer declined the claim.

***Remarks**: the Complainants Panel noted that the government of Thailand did not announce the bomb attack incident as a "terrorist attack" and there was no individual or group claiming responsibility for this particular incident. Given that the cause of the incident was still unknow, the Complaints Panel agreed that the bomb incident in Bangkok on 17 August 2015 should not be regarded as a "terrorism".*

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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.

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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 Complaints Bureau ('ICB')**: Instead of resorting to arbitration in accordance with the arbitration provision, if any, or to legal action, an insured person may make a claim-related complaint against his insurer to the Insurance 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. The ICB has launched a new mediation service in 2018 to handle non-claim related insurance disputes which are of a monetary nature.

(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.

24.3 Choice of Travel Agent

There are 2 types of Travel Agents, namely Traditional Travel Agent and Online Travel Agent:

(a) Traditional Travel Agent

- According to the Travel Agents Ordinance, travel agents which carry on outbound or inbound travel business must first join Travel Industry Council of Hong Kong ("TIC") and then obtain a Travel Agent's Licence.

- If, however, a travel agent does not carry on either of these two kinds of business, it may choose to join the TIC without obtaining a licence. In other words, a TIC member may not be a licensed travel agent. Therefore, it is important to buy outbound travel services or products from licensed travel agents.

- For detailed information about whether a travel agent has a licence, visit the website of the Travel Agents Registry (*https://www.tar.gov.hk/cgi-bin/tarnew/licence.pl).*

(b) Online Travel Agent

- There are a growing number of online travel agents during the rapid development of e-commerce. When buying outbound travel services on the Internet, it is important to ensure the travel services are provided by licensed travel agents in Hong Kong.

- After making the payment on the Internet for outbound travel services provided by a licensed travel agent in Hong Kong, it is important to obtain a receipt with levy stamp from the licensed travel agent as soon as possible.

- Receipts of travel service products with levy stamps of the TIC enable the protection by the Travel Industry Compensation Fund (including the Package Tour Accident Contingency Fund Scheme).

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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)

INDEX

Representative Examination Questions

Answers

QUESTIONS

1	2	3
(a)	**(b)**	**(c)**

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