保險業監管局
Insurance Authority

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CONDUCT IN FOCUS

Conduct in Focus

Conduct in Focus is a periodical publication which presents statistics and commentary on the complaints received by the Insurance Authority ("IA") and examines topical regulatory issues regarding the way in which insurance business is conducted.

In this edition we present statistics on the complaints received by the IA for the full year 2021, recommend best practice principles for complaints handling by insurers, examine problems which can arise when material facts are not disclosed when buying insurance and warn the public about a scam which the IA has come across when performing its role as one of the frontline regulators under the Mandatory Provident Funds Scheme Ordinance (Cap. 485).

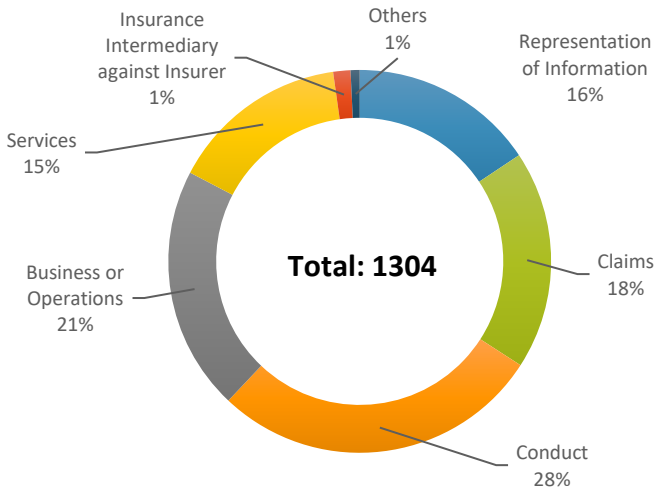
We do not in this edition (apart from here) mention COVID 19. All of us are already acutely aware of the pandemic. In times of adversity, however, insurance practitioners have always shown an uncanny ability to face down challenge, adapt and get on with it, by finding ways to provide service to policyholders and to continue to manage society's risks. Resilience is in the industry's DNA, as is the collective recognition that maintaining high standards of conduct, even in challenging times, is necessary to underpin trust in insurance. Conduct in Focus is here to assist with that important objective.

Peter Gregoire
Head of Market Conduct &
General Counsel

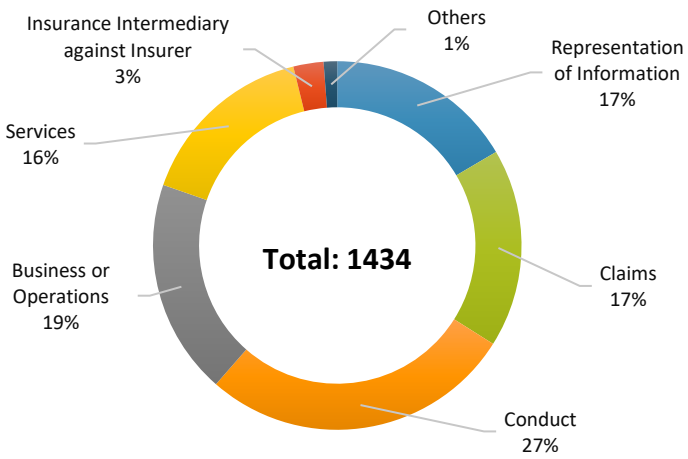
Complaint Statistics

1 January 2021 to 31 December 2021 vs prior year.

From 1st January to 31st December 2021



From 1st January to 31st December 2020



The IA received **1304**[1] complaints in 2021. In terms of category, the most significant number of complaints were received in the category of "conduct".

Explanation of Complaint categories

Conduct – refers to complaints arising from the process in which insurance is sold, the handling of client's premiums or monies, cross-border selling, unlicensed selling, allegations of fraud, allegations of forgery of insurance related documents, commission rebates and "twisting" (i.e. insurance agents inducing their clients to replace their existing policies with those issued by another insurer by misrepresentation, fraudulent or unethical means).

Representation of Information – refers to complaints relating to the presentation of an insurance product's features, policy terms and conditions, premium payment terms or returns on investment, dividend or bonus shown on benefit illustrations, etc.

Claims – refers to complaints in relation to insurance claims. The IA cannot adjudicate insurance claims or order payment of compensation. It can, however, handle complaints related to the process by which claims are handled (e.g. delays in processing, lack of controls or weaknesses in governance, areas of inefficiency in the claims handling process).

Business or Operations – refers to complaints related to business or operations of an insurer or insurance intermediary (e.g. cancellation or renewal of policy, adjustment of premium, underwriting decision, or matters related to the management of the insurer, etc.).

Services – refers to complaints regarding insurance related servicing by insurers or intermediaries, such as complaints related to the delivery of premium notice or annual statement, dissatisfaction with services standards etc.

[1] The IA received another 62 self-reported cases from insurers / intermediary firms in 2021 versus 60 in 2020, which are not included in the above statistics, which only include complaints made directly by members of the public to the IA.

Practice

How should insurers handle complaints?

The complaints statistics presented on the previous page show that the overall number of complaints received by the IA in 2021 declined by around 9% from 2020, albeit the broad mix of types of complaints remained similar.

A key change can also be seen in the IA's completion rate for handling complaints in 2021 versus 2020. In 2020, the IA received 1,434 complaints and handled 1,263 complaints to conclusion[2]. By contrast, in 2021 the IA received 1,304 complaints (as stated, a reduction of about 9% from 2020), but handled 1,550 complaints to conclusion (an increase of 22.7% from 2020).

The increase in the number of complaints handled to conclusion in 2021 versus 2020, may be partly due to improvements and efficiencies made in our complaints handling processes. These improvements aim to better focus the process on examining the merits of a complaint in a fair, objective and timely manner, with the twin aims of ensuring policyholders are protected and reinforcing high standards of conduct across the insurance market.

However, the improvement has also been enabled through engagement with insurers in the supervisory process, to encourage them to adopt best practice principles for their own complaints handling processes and in their dealings with the IA on complaints matters.

We take the opportunity in our Practice section in this edition to reiterate these best practice complaints handling principles.

Best practice principles for complaints handling by insurers

Complaints handling is a crucial part of how an insurer conducts business with its customers and is a key part of an insurer's governance and operations. The way in which an insurer handles its complaints can dictate its overall reputation for trust, customer-centricity and fair customer treatment. Complaints handling is, therefore, an important conduct issue for the IA and, indeed, any financial regulator. This is reflected in the Insurance Core Principles of the International Association of Insurance Supervisors which provide that fair treatment of customers is about achieving outcomes which include dealing with customer complaints and disputes in a fair and timely manner.

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[2] Concluded complaints include when the IA's complaints handling team decides, based on the available facts and evidence of the complaint, to transfer the case to the IA's enforcement team for consideration as to the appropriate enforcement or follow-up action to take. In 2021, 93 cases were transferred to the enforcement team versus 146* in 2020. Apart from this, the IA also concluded another 49 self-reported cases from insurers / intermediary firms in 2021, of which 32 cases were transferred to enforcement team; versus 39 in 2020, of which 34 were transferred to enforcement team.

* Among the 146 cases, 60 were against one licensed insurance agent related to the same allegation.

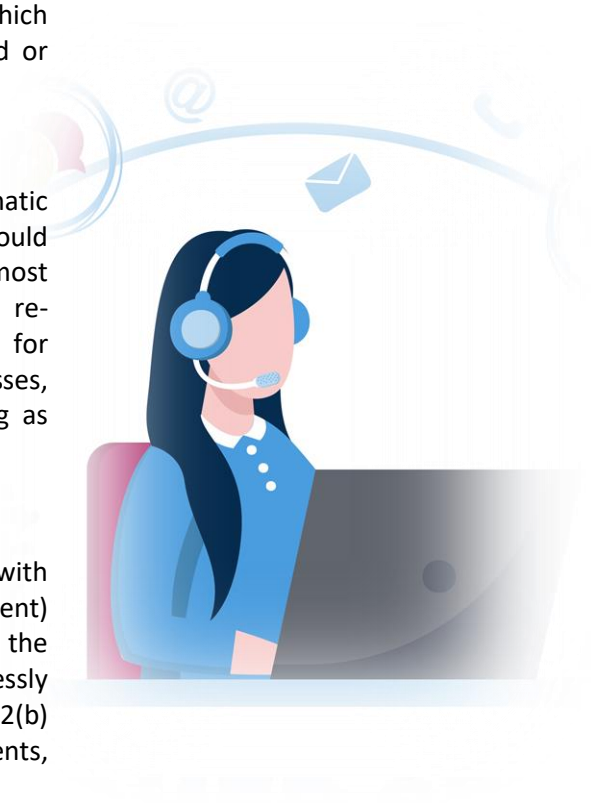
From the regulatory viewpoint, the best practice principles which the IA expects an insurer to embed in its complaints handling processes are as follows:

- **Principle 1 – Treating complainants fairly**
  An insurer should handle complaints against it or its licensed insurance agents in a timely manner and in a manner that treats complainants fairly.

- **Principle 2 – Impartiality and objectivity**
  An insurer should handle such complaints impartially and objectively, with the aim of identifying the issues underlying the complaint, finding out the facts related to the issues, and analyzing whether the grievances which are the subject of the complaint are substantiated or unsubstantiated.

- **Principle 3 – Identifying root causes**
  If grievances are substantiated, or other problematic issues are identified in the complaint, the insurer should rectify them (e.g. with the policyholder), and most importantly identify the root causes to prevent re-occurrence and, if this highlights the need for improvements in the insurer's controls or processes, make those improvements and implement training as necessary.

- **Principle 4 – Cooperating with the regulator**
  An insurer should respond to, cooperate and deal with the IA and other relevant regulatory (or law enforcement) authorities in the handling of complaints reported to the IA (or such other authorities). This principle is expressly stated in relation to agents in Section IX, paragraph 2(b) of the Code of Conduct for Licensed Insurance Agents, and the same implicitly applies to insurers.



Application of the best practice principles to non-conduct related complaints

One of the key functions of the IA is to ensure that insurers adopt proper standards of conduct in their dealings with policyholders and potential policyholders at all times. As such, even if a complaint against an insurer does not raise any regulatory conduct issues (for example, it is a pure contractual dispute or a servicing issue), the way in which the insurer handles the complaint is still a matter of regulatory concern and is subject to the IA's purview. The insurer should handle such complaints in line with standards of good conduct as reflected in the 4 best practice principles stated above.

Accordingly, when the IA receives a complaint which does not raise any issues about the insurer's conduct (such as a pure contractual dispute or a servicing issue), generally it will pass the complaint to the insurer to handle directly with the complainant. However, the IA expects the insurer to handle the complaint in line with the 4 best practice principles and may monitor the progress of the complaint to ensure this (by, for example, being asked to be copied in on the correspondence between the insurer and the complainant).[3]

Handling of conduct-related complaints

Where a complaint does raise an issue of regulatory conduct (for example, an allegation of misrepresentation by a licensed insurance agent of an insurer in relation to an insurance product at the point of sale), the IA's complaints handling team will, as a general rule, handle the complaint in line with our complaints handling processes. As part of these processes, the IA will gather the relevant facts and views on the case from the complainant, the insurer and any other person(s) whom the IA deems relevant, examine the merits of the complaint based on the totality of the information collated from a fair and objective perspective and reach a conclusion.

For these purposes, when asked to provide information and views on a conduct-related complaint by the IA, an insurer is expected to look into the case appropriately, gather the relevant information being sought and respond to the IA with the information and its views in a timely manner. The IA will expect the insurer, in giving its views, to do so objectively and impartially (in line with the best practice principles).

To assist insurers with this process, the IA has developed a template report which insurers can use for the purpose of providing information on complaints to the IA when required to do so. Please contact the IA's complaints handling team for the template at complaints@ia.org.hk if you require a copy.

Complaints as an indication of culture

The way in which an insurer handles complaints, is one of the most prominent indicators of an insurer's business culture and ethics and the way it treats its policyholders. For this reason, an insurer's complaints handling processes are one of the main focuses for the IA during its routine inspections and supervision of insurers.

As such, to ensure fair treatment of its customers, it is important that all insurers (and particularly their boards of directors) give sufficient prominence and attention to the way they handle complaints and ensure that their complaints handling processes are founded on the 4 best practice principles stated in this article.

[3] Where the complaint involves a claims dispute which falls within the jurisdiction of the Insurance Complaints Bureau ("ICB"), with the policy holder's consent, the IA may refer the complaint to the ICB for further handling (see later article on the IA's co-operation with the ICB). In this event, the insurer will be required to respond to and co-operate with the ICB in the handling of the complaint, in line with Principle 4 of the best practice principles.

The Insurance Authority's cooperation with the Insurance Complaints Bureau

The IA has wide powers to address misconduct under the insurance regulatory framework through proportionate supervisory action or appropriate disciplinary sanction. The IA's powers do not, however, extend to adjudicating whether a claim should or should not be paid under an insurance policy (in the same way, say, as a court would).

The Insurance Complaints Bureau ("ICB") provides an impartial dispute resolution mechanism which enables individual policyholders to resolve their claims disputes with insurers through (for example) impartial adjudication that is binding on the insurers which are its members.

In order to ensure that complainants have full opportunity to have their grievances considered in a fair and impartial manner, on 1 November 2021 the IA entered into a Memorandum of Understanding ("MoU") with the ICB, so that where the IA receives a claims-related dispute that falls within the ICB's jurisdiction (and where the policyholder's consent is provided), the IA can refer the case to the ICB for handling and resolution.

By entering into this MoU, the IA can continue to focus on upholding proper standards of conduct and sound business practices across the insurance market through its complaints handling work, whilst also ensuring complainants have the benefit of the ICB's trusted dispute resolution mechanism to address their claims related disputes. Through this cooperation, the IA and the ICB can ensure that complainants' grievances are considered efficiently and effectively by the appropriate body, thereby reinforcing trust in the insurance industry and upholding the principle of fair treatment of customers.

For further information on the IA's complaints handling processes, please go to our "website".

For further information on the ICB, please go to its website by clicking the icon:

ICB The Insurance Complaints Bureau 保險投訴局

Practice

Advising clients on the Duty of Disclosure

As the statistics for 2021 indicate, around 18% of complaints which the IA received concern disputes about whether a claim should be paid under an insurance policy. A small section of complaints included within this segment, involve situations where the insurer's basis for declining to pay the claim is that the policyholder failed to disclose a "material" fact at the time he or she applied to buy the insurance.

With these types of complaints, often the sole issue in dispute is whether or not the fact was indeed "material" and should have been disclosed. Sometimes, however, the complainant's allegation concerns the conduct of the licensed insurance intermediary and particularly the advice which the intermediary is alleged to have given to the complainant at the time the insurance policy was purchased.

For example, we have seen numerous complaints where the complainant asserts that he or she informed the licensed insurance intermediary of the "material" fact, but (for whatever reason) the material fact was not disclosed to the insurer in the application form. These cases serve as a vital reminder to licensed insurance intermediaries of the importance of their role in advising customers on the need to disclose all material facts at the time the customer applies for insurance and the importance of completing all information in the application form as fully and accurately as possible. This obligation is reflected in Standard and Practice 5.3 of the respective Codes of Conduct for Licensed Insurance Agents and Licensed Insurance Brokers.

Standard and Practice 5.3 in the Codes of Conduct

Disclosure in relation to a policyholder's obligations

When a client is making an application for insurance with the assistance of a licensed insurance agent/broker, the agent/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.

A number of these complaints involve claims under medical insurance policies, where the dispute concerns whether the policyholder should have disclosed to the insurer a particular medical condition at the time he or she applied for the insurance. The discovery of the non-disclosure of the medical condition may only have been made by the insurer at the time a claim is submitted under the insurance policy (through the claims handling process). The policyholder may then raise the suggestion that the particular medical condition was indeed discussed with the licensed insurance intermediary at the time of the application (and on occasion may be able to produce saved contemporaneous messages exchanged through WhatsApp or WeChat which demonstrate this). The complainant may assert that, despite being informed of the medical condition, the licensed insurance intermediary (for whatever reason) took the view that the condition did not need to be disclosed (because, for example, the intermediary took the view that the medical condition was not sufficiently serious or the complainant had recovered from the condition).

Examples

Here are some examples of the types of complaints we have seen in this respect:

- When applying for insurance, a prospective policyholder informed his licensed insurance intermediary of treatment he had received in the past for a particular medical condition. The intermediary asked whether the treatment had finished and whether there had been any follow-up treatment. The prospective policyholder answered that all treatment had finished and he did not need to receive any follow-up treatment. On this basis, the intermediary concluded that the medical condition was not material to disclose in the application form. Later, the policyholder's claim was declined because of the failure to disclose.

- A licensed insurance intermediary did not advise a prospective policyholder to disclose to the insurer, when applying for medical insurance, that her sons (the proposed insureds under the policies) had autism, because although they had been diagnosed with Autism Spectrum Disorder, they were high functioning and as such, in the intermediary's opinion, this was not material. The insurer disagreed and the policyholder faced problems in recovering claims under the policy.

- A licensed insurance intermediary noticed that his client, when filling in an application for insurance, had quite severe problems with her eyesight. The intermediary did not ask about this, however, and did not follow up with the client when he noted that the client had not disclosed any information about her eyesight in the application form. Later the policy was avoided because it was discovered the client had a long-standing eye disease.

These examples show licensed insurance intermediaries exercising judgement and giving opinions on what are, essentially, medical and health related matters. Licensed insurance intermediaries, however, are not expected to be medical experts and should be wary of the limits of their expertise. As a matter of practice, licensed insurance intermediaries should always err on the side of caution, by advising clients that it is better to disclose medical conditions (rather than not disclosing them) when applying for insurance. This is especially the case as the consequences of not disclosing matters which are later decided to have been material, can be catastrophic and (in a worst case scenario) result on the policyholder's insurance coverage being invalidated.

Insurer's controls and procedures

Insurers also have a vital role to play in this respect, by:

- reinforcing, through training, the message to their appointed licensed insurance agents of the need to err on the side of caution, when it comes to giving advice to clients on disclosing material facts;
- clearly stating the obligation to disclose material facts in plain and visible language in their application forms;
- providing hotline support and enquiry services for licensed insurance intermediaries and prospective policyholders, so that questions on specific medical conditions and whether they need to be disclosed can be addressed in real time; and
- being aware of their responsibility (and liabilities) as principals of their appointed licensed insurance agents, in respect of matters disclosed to and advice given by their agents (particular reference should be made to section 68 of the Insurance Ordinance (Cap. 41) in this respect).

It is also incumbent on insurers to keep their underwriting guidelines, and the actuarial and other data on which they base their guidelines and underwriting decisions, up to date, as insurers need to demonstrate (to comply with legislation such as the Disability Discrimination Ordinance, for example) that it is reasonable for them to rely on such data when it comes to underwriting decisions and considerations as to whether certain medical conditions are material to disclose. As an example, in a case concerning a declinature based on autism spectrum disorder (being one of the examples mentioned above) it may be incumbent on the insurer to demonstrate that the data and research underpinning its underwriting guidelines is not out of date.

Finally, insurers' attention is drawn to the *"Paper on Conduct of Business Risk and Its Management"* published by the International Association of Insurance Supervisors in November 2015 which contains useful guidance on positive indicators that show fairness, efficiency and transparency in claims practices. These positive indicators include where the insurer has in place a process to ensure that claims are assessed not only from a purely legal contractual perspective but also taking into account fairness considerations. It is these types of indicators that the Paper encourages supervisors like the IA to take into account when assessing an insurer's approach to mitigating conduct risk and the strength of the insurer's culture as part of the supervisory process.

Policyholder Corner

In Policyholder Corner, the Insurance Authority ("IA") provides practical guidance to the public on buying insurance or dealing with insurance matters based on lessons learned from the complaints it receives.

The importance of disclosing all "material facts" when buying insurance

Unlike most other types of contracts, an insurance policy is a contract based on the duty of utmost good faith. This duty of utmost good faith applies to all insurance policies.

The most important aspect of the duty of utmost good faith is the duty of disclosure which applies to a person looking to buy an insurance policy (i.e. a prospective policyholder).

The duty of disclosure means that a prospective policyholder before completing the purchase of an insurance policy, must disclose to the insurer all "material facts" about the risk which the person is looking to insure.

The historical reason underpinning this duty of disclosure, is that a prospective policyholder has all the relevant information in relation to the risk he is looking to insure, whereas the insurer has none. For example, a person looking to buy life or medical insurance knows what illnesses he has had in the past, whether he has any ongoing medical issues, what his lifestyle is like and what information was in his last health check-up. All of this is highly relevant to the risk he is looking to insure (i.e. the risk of him dying sooner than expected, or the risk of him needing medical treatment). The insurer, however, knows none of this information and needs the prospective policyholder to disclose it, so the risk can be assessed, the amount of premium can be estimated and a decision can be made as to whether or not to offer the insurance policy. As such, the law requires the prospective policyholder to be honest and make full disclosure to the insurer of all "material facts" relating to the risk.

Failing to disclose such "material facts" can have very serious consequences. It entitles the insurer to "avoid" the insurance policy. This means the insurer, on discovering the non-disclosure by the policyholder, can simply pay back the premium received and act as if the insurance policy never existed (thereby denying any claims made under the policy).

What is a "material fact"? The law provides that a fact is "material" if it "would influence the judgement of a prudent insurer in fixing the premium or determining whether he will take the risk".

In recent years, there has been a growing chorus of voices suggesting that the "duty of disclosure" has become increasingly outdated and is too weighted in favour of the insurer. After all, can a prospective policyholder really be expected to know what type of fact might influence a "prudent insurer"? Further, the remedy of avoiding the entire insurance policy in the event of a non-disclosure of a material fact is extreme (and the remedies should be more balanced). For these, and other, reasons certain jurisdictions have already taken steps to change this aspect of the law. That said, even with such changes, there generally remains an onus on policyholders to disclose certain facts to the insurer when applying for insurance.

For practical purposes, therefore, we offer this clear advice to policyholders when you are buying insurance:

If in doubt, please disclose!

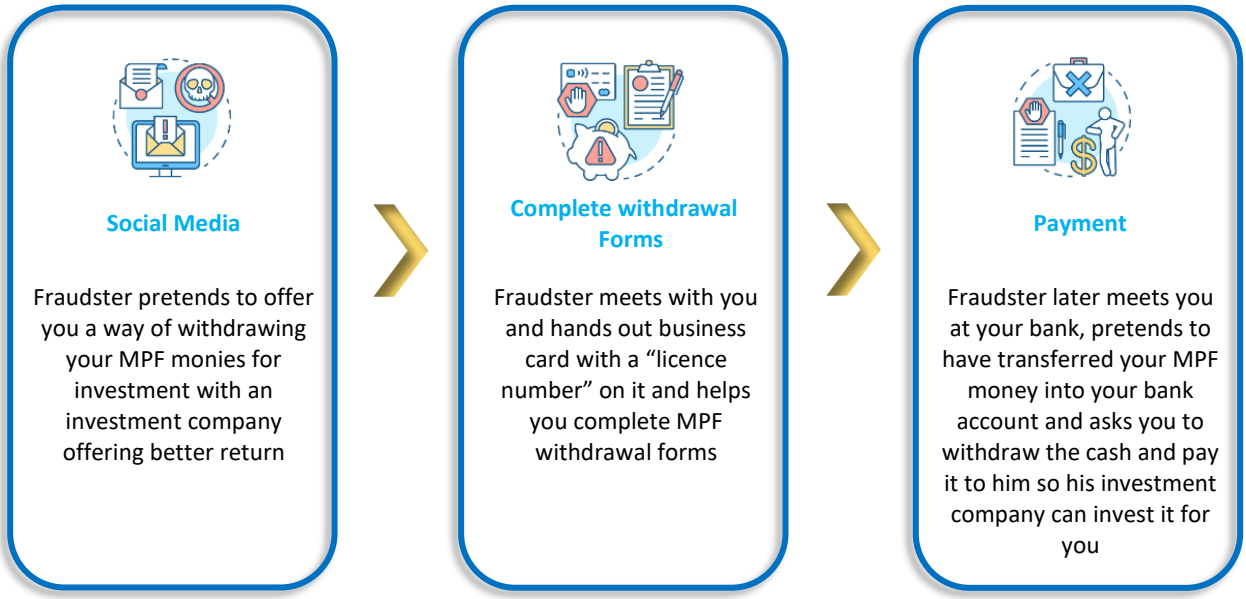
We cannot emphasize this enough. If there is any information about the risk for which you are seeking insurance, that you are unsure about whether or not to disclose (such as previous medical condition or treatment you have received), the best course of action is to disclose it. It is, after all, better to be safe than sorry!

MPF SCAM ALERT!

Did you know that, as well as being the regulator of the insurance industry, the IA also serves as the frontline regulator of registered Mandatory Provident Fund ("MPF") intermediaries who (a) carry on MPF sales and marketing activities incidental to their main insurance activities; and (b) are themselves regulated by the IA for the insurance activities they carry on?

As a frontline regulator, the IA investigates suspected non-compliances with performance requirements under the Mandatory Provident Fund Schemes Ordinance (Cap. 485) ("MPFSO").

In our work as frontline regulator we wish to draw the public's attention to the following scam, where potential fraudsters seek to impersonate MPF intermediaries for ill-gotten gain. Here is how the scam works:



A fraudster posing as an MPF intermediary advertises through social media pretending to work for an "investment company." The "investment company" purports to offer a service advising people how they can make a full withdrawal from their MPF account with their MPF provider (who the MPF intermediary represents) by completing forms falsely indicating their permanent departure from Hong Kong. The "investment company" can then invest the amounts withdrawn from the person's MPF account and obtain a better return.

The fraudster feigns authenticity when meeting any potential victim who responds to the advert, by producing a business card with a "licence number" on it and official-looking forms for the person to complete. Once the potential victim completes the forms, the fraudster allegedly submits the forms to the relevant MPF provider to complete the withdrawal process.

A week or so later, the fraudster arranges to meet the potential victim again at the victim's bank. The fraudster informs the potential victim that he has just transferred the withdrawn MPF monies to the victim's bank account. All the victim has to do is withdraw the amount in cash, and pay it over to the fraudster with a 10% service fee so the investment company can start investing the monies. Once the victim pays the money over, however, the fraudster disappears.

DON'T FALL FOR IT! REMEMBER:

- MPF intermediaries usually have to follow strict restrictions imposed by the MPF providers they represent in relation to using social media to advertise. So, if an advert on social media is offering something that is too good to be true, it usually is too good to be true. Don't respond to it!

- Contact the MPF hotline of your MPF provider or the Mandatory Provident Fund Schemes Authority ("MPFA"), to seek verification about any service being offered which appears to be suspicious.

- Check the registration number of the MPF intermediary (the "subsidiary intermediary") and the MPF provider he or she claims to represent (the "principal intermediary") from the Register of MPF Intermediaries on the MPFA's website, to ensure all the information is authentic. Again, consider contacting the MPF provider directly to verify the authenticity of the service, if you are suspicious.

- Always be suspicious if someone is asking you to pay over to a sum of money in cash. And as a general rule: never pay over cash to someone purporting to be an MPF intermediary. You could be putting your money at risk!

- If someone says they have transferred an amount to your bank account, check the transfer has gone through first.

- Fraudsters may also try to reach out to the public through other channels, such as cold calls, apart from social media.

The scam set out in this article involves the victims participating in potential illegal activity by making false declarations to withdraw monies from their MPF accounts. Fraudsters prey on this, believing that victims will be reluctant to report the fraud to the police. Always remember, that the best way to avoid these types of fraud is not to get involved in the first place.

Insurance Authority

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