

CHAPTER 3

PRACTICE OF UNDERWRITING

Learning Outcomes

When you have completed this chapter you should be able to:

- explain the purpose of an insurance proposal;
- define indemnity, contribution and subrogation;
- describe the process of arranging cover from the application, to the payment of premium;
- describe what factors are taken into consideration when underwriting a domestic insurance;
- explain when premium is payable for short term insurance and the different methods of payment;
- list the parts of the short term policy; and
- describe what is contained in each part of the policy.

TERMINOLOGY

Here are the definitions of some of the concepts used in this Chapter.

Indemnity

Short term insurance policies are policies of indemnity. This simply means that the insured is put back in the financial position he was in prior to the loss. He cannot make a profit from a loss.

Contribution

If the insured cannot make a profit, what would happen if he had two policies covering the same risk? Could he claim from both?

The answer is that there is a contribution condition written into the short term policy. This means that each insurer would pay his rateable share of any loss. This is further discussed under claims settlement.

Subrogation

If a client insures his car and someone else crashes into it, he would be able to claim from his policy and also from the third party who caused the damage. He would again be profiting. Subrogation changes this.

When an insurer pays out a claim, at common law there is a subrogation right. This means that once the claim is paid the insurer can sue the third party who caused the damage, for the amount of money paid out to the insured, or for repairs or replacement.

The delay could prejudice the insurer and therefore the policy has a subrogation clause, which allows the insurer to start the recovery immediately.

In this chapter we look at how a domestic proposal for insurance is underwritten, and examine why certain questions are important. We will also consider premium payment and the legislation which governs it amongst other things.

3.1 ESSENTIAL ELEMENTS OF A CONTRACT

This study unit is partially based on notes compiled by Prof Robert Vivian, Department of Business Economics, University of the Witwatersrand.

In terms of the general law of contract, at least the following must exist for a valid contract to come into existence:

- there must be agreement or consensus between the parties (offer and acceptance);
- the agreement must be made within the limits of the parties' contractual capacity (competent parties);
- the performance on which they agree must be possible and lawful (legal object);

- the prescribed formalities, if any, must be complied with (legal form); and
- both parties must exchange consideration.

These requirements are not peculiar to legislation pertaining to insurance legislation but are general requirements for all contracts.

OFFER AND ACCEPTANCE - THE PROPOSAL FORM

The rules of establishing agreement by offer and acceptance apply to the insurance contract. When a contract is negotiated, one party offers certain terms, conditions or price. The other party then accepts or rejects the offer. Both parties must understand what the other means and be sure of the intentions of the other party.

EXAMPLE

You offer to buy a motor car and the contract includes the installation of a radio.

The seller agrees to sell you the car and to include the radio in the purchase price.

The offer is accepted, so there is consensus.

The insurance proposal form plays an important role in the offer and acceptance required for the contract to come into being. The insurer invites the public to do business, and the insured offers to be insured. The offer is submitted on an application form known as a proposal. Insurers invariably contract on their own fixed terms, and the applicant proposes that the insurer issue a policy as usual. The insurance company's use of a proposal form is not to be construed as an offer by that insurance company to the insured, but rather as an invitation to do business.

The content of the proposal form greatly depends on the class of insurance cover that is being arranged. For example: In the case of a life policy, questions concerning a person's age and health are relevant, and in the case of a fire policy, questions about a person's solvency may well be relevant.

Generally, the proposal form covers items such as the status of the person, and details of the risk which the insurers are being asked to insure.

EXAMPLES of the information insurers require

- Insuring a building. The proposal form would probably require information on the building's construction and occupation of the premises.
- Life policies. The insurer would probably want to know something about the habits of the person to be insured (eg whether he drinks or smokes).

- Motor policies. The insurer would probably want information on the person's driving history, criminal actions, and criminal claims arising from driving and related violations.

An important question contained in most proposal forms is the claims experience of the proposer. All material facts have to be disclosed to the insurer, including the number of previous claims by the insured, and whether any previous insurance claims had been declined. The insurer decides on the basis of this proposal form whether to accept the risk and, if so, at what premium. Many proposal forms conclude with a declaration by the proposer that the information he has given is the truth, and that this information forms the basis of the proposed contract. The information is then incorporated by way of a reference in the policy.

As we have indicated, the proposal form constitutes the offer to be insured, and once accepted, the insurance normally follows. Sometimes the insurance is urgently required before the insurer has had the opportunity to study the proposal form and make a decision. In these circumstances it is possible to arrange temporary insurance.

The proposal form has more than one purpose. The following are the six main functions of a proposal form:

1. **to elicit information** - the main use of proposal forms is to provide the information underwriters need to decide whether to accept the proposal, and if so, at what price and on what terms. Standardised forms are easier for the applicant and make underwriting more efficient;
2. **to make a legal offer** - as we have said, a valid offer must be made before a contract can be concluded. The completion of a proposal form often constitutes the legal offer by the proposer, although offers can also be verbal;
3. **to elicit a quotation** - sometimes a proposal form is completed as a request to the insurer for a quotation on price and terms. The insurer's quotation is then the legal offer;
4. **to describe the cover available** - many proposal forms summarise the cover available in terms of the insurance contract;
5. **to advertise** - proposal forms also advertise other products available from the insurer; and
6. **to establish a warranty** - the wording and declaration in an insurance proposal form often warrant the truth of the answers in the form.

PARTIES MUST BE COMPETENT

In South Africa, certain categories of people are unable to enter into a contract - they do not have contractual capacity. For example:

- people under the age of 18 have a limited right to enter into contracts;

- people who are mentally ill cannot enter into contracts; and
- insolvent people have a limited capacity to enter into a contract.

AGREEMENT MUST BE LAWFUL (LEGAL OBJECT)

The insurance contract must be lawful. The general rule is that all agreements are lawful unless prohibited by statute or common law. Agreements are prohibited by common law if they are against public policy.

EXAMPLE

A contract to rob a bank is not a legal contract. No contract can be legally enforced if the agreement concerned for something illegal.

Insurance and wagering agreements

The fact that the agreement has to be lawful is of particular importance to insurance law because of the similarity between an insurance contract and a wager contract. In common law, wagering contracts are not illegal as such, but are unenforceable. You have to be able to distinguish between wagering agreements and insurance contracts. This distinction is usually based on the concept of "insurable interest".

Statutory prohibitions

A number of statutory prohibitions are of importance to insurance contracts. Remember that we indicated in the study unit on the regulation of insurance that only registered insurers may contract insurance business.

Common law

The risk that is insured must not be illegal or contrary to public morality.

LEGAL FORM

As a rule, no special form is required to conclude a contract and insurance follows this rule. The insurance contract, like other contracts, comes into existence as soon as the parties have agreed to its essential terms. In terms of common law, neither the issuance of a policy nor the payment of a premium is therefore essential for concluding a contract. A written document is not necessarily required, but in practice a policy document is usually issued. Stamp duty used to be payable on both short and long term policies, but is no longer payable on short term insurance contracts.

CONSIDERATION

"Consideration" is what each side promises to do. In insurance policies, the consideration is defined as payment of the premium. In South African law, unlike English law, there does not have to be a consideration for the contract to be valid. However, the policy wording usually states that payment must be made. This modifies the law, but only for that particular contract.

3.2 SPECIAL LEGAL CHARACTERISTICS OF INSURANCE CONTRACTS

In addition to the legal principles that apply to all the contracts discussed in the previous section, some legal principles are unique to insurance contracts.

These principles will give you a foundation for understanding the different processes and specific applications of insurance.

3.2.1 INDEMNITY

The principle of indemnity is the most fundamental principle in insurance law. No evidence exists that it has ever been seriously challenged in Court since its introduction more than 100 years ago.

"Indemnity" means that the insured is financially restored to the same position he was in before the loss.

In indemnity insurance contracts, the insured is entitled to recover the actual commercial value of what he has lost during the event against which he has been insured.

Indemnity insurance includes insurance against damage (and the consequences of such damage) to property and insurance against legal liability claims. It includes fire and perils, motor vehicle, burglary, public liability, plate glass and marine insurance.

Generally, the operative clause in the property and liability policy specifically limits the liability of the insurer to indemnifying the insured. The preamble to a policy may for example read as follows:

In consideration of the payment of the premium by or on behalf of the insured, the company... agrees to indemnify or compensate the insured...

A number of important consequences follow from the indemnity requirement, including subrogation, contribution and determining the value of the loss.

The object of indemnity is therefore to place the insured in the same position after the loss as immediately before the event. He is not to be placed in a better position. The insurer may discharge its obligation to indemnify the insured in a number of ways, for instance by cash, replacement, reinstatement or repair.

EXAMPLE

You have a house which catches fire and burns down. The insurer indemnifies you by rebuilding the house to the same size and style as it was prior to the fire. The house cannot be a better or a worse design or a different size.

If your car is damaged, the insurer indemnifies you by repairing the damage to the car and by restoring the car to its original condition.

NON-INDEMNITY INSURANCE

We can measure the value of a car or a house, but how can we place a value on a person's life? How can we say that the life of one person is more valuable than the life of another? The answer is that we cannot. Some insurance contracts are therefore non-indemnity contracts. The amount due to the insured in terms of this contract need not bear any relation to the actual loss the insured suffered. These contracts include life insurance, personal accident and sickness insurance. A person can insure his life for R1 million and this amount need not bear any relation to the calculated pecuniary value of his life as such.

A number of consequences that arise from the requirements of indemnity do not apply to non-indemnity insurance contracts. These include subrogation, contributions between co-insurers, the time when insurable interest must exist, and the rules for determining the measure of the loss.

GENERAL PRINCIPLE OF INDEMNITY

The insurer's liability is limited to the "real and actual" value of the loss suffered during the event insured against. It cannot exceed either the amount insured or the amount of the insurable interest, and if it exceeds either or both of these the amount has to be reduced to correspond with the smaller item. In other words, the insured cannot make a profit from his loss, or, as is sometimes said, is not entitled to double indemnity.

Indemnity does not imply that the insured will be indemnified for the full extent of his loss under a policy. An insured who stands to be indemnified in terms of a fire policy, is therefore not entitled to be indemnified for the loss of profits or against liability claims that may arise as a consequence of the fire. Loss of profits would have to be insured under a separate insurance policy, and the liability exposure would have to be insured in terms of liability insurance.

MEASURE OF INDEMNITY

Although the principle or concept of indemnity may be clear, its application is fraught with theoretical and practical difficulties. The parties can avoid the theoretical difficulties to some extent by concluding a valued policy or by incorporating a reinstatement clause in the policy.

REINSTATEMENT POLICIES

Policy conditions may allow for the reinstatement of the damaged premises or equipment, usually at the discretion of the insurer. It may not be possible to reinstate the property, particularly if an old building is to be replaced by a new one. Aspects such as upgraded fire regulations may apply, which may result in additional costs.

NEW FOR OLD

An insured might prefer not to be indemnified, in the strict sense of the word, against the loss suffered, but would prefer that his old asset be replaced with a new one. If a television set is for example stolen, the insured would rather have a new television set. Strictly speaking, if this is permitted, the insured is placed in a better position than before the loss occurred. This is not necessarily a violation of the principle of indemnity, since no general principle demands that the loss has to be determined in terms of the market value of the asset.

Valued policies

It is not always possible to assign an indemnity value to every asset. In some instances (for example, the insurance of jewellery or works of art), when the asset has a stable value, it is possible to insure on a valued basis. In the event of total loss, the insured sum will be paid out.

3.2.2 UTMOST GOOD FAITH

As pointed out, an insurance company needs sufficient information on the risk it insures. This information is provided by the insured. When a person provides this information, it is called "acting in good faith".

The insurer relies on the information provided by the person applying for insurance. The law places a positive duty on the applicant to disclose all matters material to the risk. The person seeking insurance cover is likewise placing his faith in the insurer, and the insurer is obliged to disclose material facts to the prospective insured. By law, the parties to an insurance contract should deal with each other in good faith. One consequence of this good faith requirement is the duty to disclose.

This duty is not common to all contracts. As a general rule, there is no need in most commercial contracts for the parties to disclose information which is not requested. The idea is that people should make the best bargain without actually misleading each other. The legal principle governing such contracts is the *caveat emptor* (ie Latin for "let the buyer beware"). This principle encourages every person to obtain the best deal for himself, but clearly such a principle does not allow one party to refrain from fully informing the other party to a contract.

The insurance contract differs from a normal commercial contract in that it recognises a duty to deal in good faith. This implies that the insurer has a right to avoid the contract not only if the proposer has misrepresented a material fact, but also if the proposer failed to disclose such a material fact. The implication of the duty of good faith is therefore the duty to disclose.

Insurance contracts are among the few that are not contracts of *caveat emptor* but of *uberrimae fidei* (ie "utmost good faith").

WHY IS GOOD FAITH NECESSARY?

It is important for the proposer to act in good faith when he provides details of the risk to the underwriter because

- the underwriter uses the facts to decide on the premium, the terms and conditions, and even whether to accept the risk; and
- the insured should pay his fair share into the common pool (This can only happen if he acts in good faith.)

DUTY OF DISCLOSURE AND THE TEST FOR MATERIALITY

Non-disclosure could mean hardship for the insured. They have paid their premiums and have placed their faith in the insurance company and the Insurance contract to protect them against ruin. However, they can never be sure that they have indeed secured protection because once the claim arises, the insurer may allege that they had not disclosed all the material facts. Indeed, the insurer does not even have to examine factual issues until the claim arises.

It is important that the insured are aware of what must be disclosed. In English law, certainly as far as marine insurance is concerned, a fact is material if it would influence the judgment of the prudent insurer in fixing the premium or accepting the risk. If this test is to be applied, the insurer has to ask itself which facts a prudent insurer would regard as material. However, this test is too harsh on the insured. Another test which has been suggested is that of the reasonable insured.

In the case of *President Versekeringsmaatskappy Beperk v Trust Bank van Afrika Beperk*, it was held that the test of whether information should be disclosed was whether the reasonable person (not the reasonable insurer or insured) would consider what information should be conveyed to the prospective insurer so that it could decide whether to accept the risk or charge a higher than normal premium.

It is difficult, though, to define a "reasonable person". What is reasonable to one person may not be reasonable to another, and this will probably still be argued in the Courts for a long time.

EXAMPLES of disclosure

There has been no reference yet to any "doctrine" as such. I would say prior definition is required. The duty of good faith, which is the basis of the duty of disclosure, is probably best explained by a number of examples. Bear in mind that the duty of disclosure depends largely on individual facts and circumstances and the type of insurance.

The following are examples of when the duty of disclosure applies:

- the fact that a policy has been cancelled, or the fact that, a previous proposal has been declined, or the fact that the renewal of previous policies has been refused, are all plainly matters which should be disclosed;

- the character of the insured ought to be disclosed. The fact that a proposer for fire insurance has had previous fires suggests carelessness or an increased moral hazard on the part of the insured or their servants, or that the insured has made an unfair or excessive claim, or is fond of litigation, and these are all material facts that should be disclosed;
- it may be material for the insurer to know whether the insured is insolvent; and
- the risk experience of the proposer maybe material.

Examples of material facts that have to be disclosed for various classes of insurance	
Fire	<ul style="list-style-type: none"> • the process carried out at the premises • the location of the premises • other businesses that operate from the same premises
Theft	<ul style="list-style-type: none"> • the type of stock and protection against burglary • the location of the premises
Personal	<ul style="list-style-type: none"> • the occupation of the insured
Accident	<ul style="list-style-type: none"> • the fact that the insured windsurfs as a sport
Motor	<ul style="list-style-type: none"> • what the vehicle is used for
Insurance	<ul style="list-style-type: none"> • the fact that the vehicle is driven by the insured's son who is 18
All classes	<ul style="list-style-type: none"> • previous claims experience

CRITICISM OF DISCLOSURE

The concept of "the duty to disclose" has been the subject of comments by leading insurance writers in South Africa and in other parts of the world,

The definition of "materiality" has also been criticised. It has been suggested that the definition of materiality be changed to what a reasonable insured would disclose rather than what he would consider material. The movement in South Africa towards the "reasonable person", instead of the reasonable insurer, corresponds with the considered opinion in most parts of the Western world.

FACTS THAT NEED NOT BE DISCLOSED

Not all facts are material. Some facts need not be disclosed in the absence of enquiry. The following circumstances need not be disclosed unless called for in the proposal form:

- Circumstances that diminish the risk for the insurer.

EXAMPLE

The fact that there is a trained fire crew on the premises.

- A circumstance that is known or presumed to be known to the insurer.

EXAMPLE

The fact that the winters in Gauteng are dry and that there is a high incidence of veld fires.

- Matters of common notoriety or knowledge, which the insurers are presumed to know, and matters which an insurer in the ordinary course of business ought to know.

EXAMPLE

The fact that a person has high blood pressure has to be disclosed, but the fact that hypertension increases the chance of heart failure is assumed to be known to the insurer and therefore need not be disclosed.

- The existence of other insurance.

EXAMPLE

The fact that a person also has other policies covering his life need not be disclosed.

DURATION OF THE DUTY TO DISCLOSE

The duty to disclose continues throughout the negotiations and terminates when the contract is concluded. Material facts that come into the proposer's possession before the contract is signed, or facts that were previously immaterial but become material due to changed circumstances, must be disclosed. Once the contract has been concluded, however; the proposer is not obliged to disclose further material facts unless he is contractually obliged to do so.

In indemnity insurance, the duty to disclose attaches to renewal of the contract to the same extent as it does to the original contract. Renewal is a new contract for a defined period which entirely replaces the expired contract.

The position is different for an ordinary life policy. The life assurance contract is a continuing contract and the insured has a right to keep this contract in existence by paying premiums when they are due. As the renewal is not a "new contract", no fresh duty to disclose arises. The fact that there cannot be a duty to disclose on the anniversary of a life policy is self-evident, because the anniversary is not a new contract. If a new contract were to arise, it would mean that the insurance company can refuse to renew the policy if the person has contracted some terminal disease. In this case life policies would be useless. If the insured failed to disclose all the material facts and a loss occurs, the insurer may

- reject liability for the claim;

OR

- in serious cases the policy may be cancelled.

3.2.3 CAUSE OF LOSS (PROXIMATE CAUSE)

"Proximate cause" means the active, efficient cause that sets a train of events in motion that brings about the result, without the intervention of a force started and working actively from a new and independent source. As a general rule, the loss or damage must have been caused by the peril that was insured against. An insurance claim does not succeed unless the loss or damage is proximately caused by the peril insured against.

Establishing the legal connection between cause and event is a problem in many branches of law and in the law of insurance as well. Which events legally caused which result is an extremely difficult legal problem to prove.

Proximate cause in insurance law has been at issue in a number of South African court cases, and the South African Courts have referred to English insurance law in deciding individual cases.

3.2.4 SUBROGATION

Subrogation literally means "to stand in the place of". It is the right of one person to stand in the place of another person and to avail himself of all the rights and remedies of that other person.

The origin and scope of subrogation are controversial. However, subrogation is a consequence of indemnity; they go hand in hand.

An early English case is that of *Mason v Sainsbury*. In this case rioters had wrecked an insured house. The insurers paid the claim. The insured also had a claim against the local administrative district authority in terms of the Riot Act of 1714. The insurers were held entitled to recover from the district authority in the name of the insured.

The two aspects of subrogation can be seen from this case. Firstly, the insured have two possible claims open to them, but because of the principle of indemnity, they are not allowed to be placed in a better position than if the loss had not occurred. Therefore, they cannot expect to recover and (if they have recovered) retain the amount of their loss from both parties. In short, the insured cannot make a profit from their loss or, as it is often expressed, they are not entitled to double indemnity.

Secondly the insurer, having paid the claim, secures the right to enforce the rights of the insured against the third party. In short, the insurer acquires the right to take action against the third party. The full and absolute meaning of the word "subrogation" is to be used, namely that the insurer is placed in the position of the insured. Subrogation expresses the insurer's right to be placed in the insured's position so as to be entitled to the advantage of all the insured's rights and remedies against third parties. Subrogation clearly rests on the principle that no one should profit from a loss.

This principle applies to all contracts of indemnity insurance (for example, fire insurance), whether the loss is total or partial. However, this principle does not apply to non-indemnity insurance (for example, life or general personal accident insurance).

3.2.5 CONTRIBUTION

When two policies are in force, each pays its rateable proportion of a loss. This is known as "contribution".

People are often doubly insured. They could, for example, have insured their house with two separate insurers. After the loss, the position of the two insurers is governed by the principle of contribution. Clearly the overriding principle, that of indemnity, ensures that the insured cannot recover more than they lost. Therefore, they cannot recover the full amount from both insurers, since this double amount would exceed the amount permitted in terms of the indemnity principle.

The fact that a person may not receive double indemnity does not mean that he may not take out double insurance. People who wish to insure their property with more than one insurer, can do so. An insurer who wishes to avoid the possibility of double insurance can deal with a position of double insurance in terms of the contract.

The principle of contribution therefore means that if people are insured by more than one insurer, they may seek to recover their indemnity from all or any of the insurers. These insurers then have the natural right to claim from their co-insurers a pro rata portion of the amount they have paid in fulfilment of the indemnification.

The result is a circuitous process in which the insured first claims in full from one insurer, leaving this insurer to subsequently claim a rateable contribution from other insurers. To avoid this circuitous procedure, policies commonly contain what is known as a "contribution condition". This condition provides that, if at the time of the loss another insurance policy covers the loss or part of it, the insurer shall not be liable for more than its rateable portion. The net effect of this clause is that the insured person can only claim up to the rateable proportion of the loss from each insurer. Because of this right, it is customary for insurance policies to contain a specific condition dealing with contribution and co-insurance.

EXAMPLES of contribution

You have insured your house for R150 000 with insurer A. You transfer your bond to another bank and take out insurance on the house with company B for R200 000. You do not cancel the insurance with company A. Your house is flooded and the damage amounts to R30 000.

How will the insurance policies respond to your claim?

Policy from company A	R150 000
Policy from company B	R200 000
Total insured sum	R350 000
Loss	R30 000

The loss adjuster determines that underinsurance does not apply.

The actual value of your house is: R150 000

The formula for adjusting the loss is:

Company A:

$$\frac{\text{Sum insured by Company A}}{\text{Total of all policies}} \times \frac{\text{Loss}}{1}$$

$$\frac{R150\,000}{R350\,000} \times \frac{R30\,000}{1}$$

$$= R12\,857$$

Company B:

$$\frac{\text{Sum insured by Company B}}{\text{Total of all policies}} \times \frac{\text{Loss}}{1}$$

$$\frac{R200\,000}{R350\,000} \times \frac{R30\,000}{1}$$

$$= R17\,143$$

Company A will pay R12 857 and Company B will pay R17 143 of the loss of R30 000.

3.2.6 AVERAGE

"Average" deals with underinsurance. In terms of common law, the general rule is that a person who underinsures his property is entitled to the full amount of his loss, whether total or partial, subject to the maximum limit of the policy.

EXAMPLE

If a house worth R100 000 is insured for R80 000 and is damaged by fire to the extent of R50 000, the insured can be indemnified up to the total cost of the loss, R50 000 in this case.

We therefore see that in terms of common law, a person can underinsure his property and still receive the full amount of the loss, provided that the loss does not exceed the limit of the insurance.

For partial losses, this is obviously unfair to the insurer since the insurer has calculated the premium on R80 000 whereas the exposure is greater at R100 000. Most asset policies contain an average clause, derived from marine insurance law, to deal with this situation.

AVERAGE IN MARINE INSURANCE

Marine insurance is considerably older than other forms of insurance and the rules are more clearly developed. In marine insurance, if a person underinsures, he is deemed to be his own insurer for the uninsured balance. The matter is governed by Section 81 of the Marine Insurance Act of 1906, which reads:

"Where the insured is insured for an amount less than the insurable value or, in the case of a valued policy, for an amount less than the policy valuation, he is deemed to be his own insurer in respect of the uninsured balance."

EXAMPLE

If a ship has an insurable value of R600 000 but is insured for only R500 000, then the insured is deemed to be his own insurer for the R100 000. If the ship is damaged to the extent of R300 000, the insurer is only liable for R250 000 ($5/6 \times 300\ 000$). Therefore if the insured underinsures, he cannot recover the full value of the loss.

AVERAGE CONDITIONS IN POLICIES

It has been suggested that underinsurance is grounds on which the insurer may avoid the policy. This could be because of failure to disclose or breach of warranty. It is, however, more common for the insurer to insert and invoke the so-called "average clause".

Because of the possibility of a person's underinsuring himself, it is normal for asset-based insurance policies to deal with average as an insurance condition. To prevent underinsurance and enable the insurer to earn a higher premium, asset policies such as fire policies commonly contain a condition which provides that, if at the time of the loss the sum insured is less than the value of the property, the insured is to be considered an insurer for the difference, and must accordingly bear a rateable portion of the loss.

Therefore, as a general rule, in an asset loss, the person who is underinsured bears a proportion of the loss. This situation is normally expressed by the following formula:

$$(\text{Value insured}/\text{value at risk}) \times \text{loss sustained}$$

Various clauses exist in practice. Some policies contain what is known as the "two-thirds rule", which makes the insured his own insurer to an extent of two thirds of the value of his loss.

Another common clause is the "excess clause". Its effect is that the insured carries a portion of the loss. This clause determines that the insured has to bear a fixed amount of the loss. In the case of a motor policy, this could be an amount of R200 for each loss.

AVERAGE AND LIFE POLICIES

"Average" does not apply to life insurance. Reference to an "under-average" life would therefore have its normal meaning of "average", in the sense that the health or some feature of the person under consideration was in some particular way subnormal. In this case special underwriting considerations would arise.

3.2.7 FRAUD, NON-DISCLOSURE AND MISREPRESENTATION

NON-DISCLOSURE AND THE LAW OF CONTRACT

The historical position of the law of contract is that it is one of utmost good faith. The general principles of the law of contract also deal with fraud and misrepresentation and failure to disclose. Because the general principles of contract deal with these, it is questionable whether a need exists for a specific doctrine of utmost good faith. Non-disclosure and fraud can therefore be analysed in terms of the rules which govern the law of contract, without having to develop a specific law relating to insurance contracts.

FRAUD

Fraud clauses and misrepresentation clauses are common to all contracts, and it is therefore unnecessary to consider fraud in insurance in great detail. The fraud may take place at various times during the transaction. Although fraud may apply when the contract is entered into, it more commonly occurs when a claim is instituted.

MISREPRESENTATION

Historically, misrepresentation has not been of particular importance in the insurance context. This is partly because of the extreme width of the duty to disclose material facts, as discussed above. Cases have frequently failed to distinguish between the two defences of failure to disclose in insurance law and misrepresentation as a contractual requirement. Indeed, it appears to be standard practice for an insurer to plead both defences where possible. While this maybe conceptually unsatisfactory, it is well established. It is rationalised that it is part of the insured's duty of good faith to answer questions correctly on the proposal form.

PREMIUMS

The premium is an essential part of the general requirements of an insurance contract. There cannot be an insurance contract unless the premium has been agreed upon. The agreement may be expressed or implied. The actual payment of the premium is not necessary for conclusion of the contract. As long as the parties have agreed that a premium will be paid, it is possible for an insurance contract to come into being.

Although it is not a requirement in common law that the premium must be paid before the insurance cover becomes operative, it is normally a condition of the insurance policy. In some cases, (for example, South African Special Risks Insurance Association or SASRIA cover) no cover exists until the premium has been paid.

3.3 PARTS OF THE POLICY

A short term policy document has a number of sections, each with a different purpose. The parts are:

- the Heading;
- the Preamble or Recital Clause;
- the Operative Clause;
- the Exceptions;
- the General Conditions;
- the Disclosure Notice; and
- the Policy Schedule; this is the part which differs in each policy and contains the client's details.

3.3.1 HEADING

This simply contains the name of the insurer and the head office address. This is the registered address used in terms of the Companies Act. There may also be the Company's logo or some form of decoration.

3.3.2 PREAMBLE

This gives the names of the parties to the contract. The preamble also states that the proposal is the basis of the contract. It will normally carry a premium payment condition which effectively means that the contract only comes into force when the insured has paid the premium. In South Africa, there is no legal need for a consideration to be paid for a contract to be legal, however the policy document modifies this legal rule, by having this clause.

3.3.3 OPERATIVE CLAUSE

The operative clause is where the insurer agrees to pay a claim when a loss, which is covered in terms of the policy wording, occurs.

3.3.4 EXCEPTIONS

The insurer cannot be expected to cover anything and everything. In most policies there will therefore be some kind of exceptions if the premium is to be economical and fair.

For example, riot and strike is excluded in a normal policy. In South Africa it must be covered by a SASRIA policy, and there is a similar arrangement, called NASRIA, that operates in Namibia. For other territories, insurers may be prepared to extend cover under the policy.

3.3.5 GENERAL CONDITIONS

Each section of the policy will have its own conditions, but there will also be general conditions. The purpose of the Conditions is to:

- tell the insured what he must do in certain circumstances; and
- state what insurers will do in certain circumstances.

EXAMPLES of General Conditions

The following are examples of general conditions contained in a policy.

General Condition	Function
Subrogation Clause	This allows the insurer to take over the insured's rights before the claim is settled.
Contribution Condition	This is where there is more than one policy in force.
Fraud clause	This states that if the claim is fraudulent there will be no cover.
Claims procedure	What the insured must do if there is a claim.

Cancellation clause	<p>This condition states what the insured or the insurer must do if they wish to cancel the insurance.</p> <ul style="list-style-type: none"> • Normally the insured can cancel with immediate effect. • The insurer usually has to give 30 days' notice if it wishes to cancel an annual policy during the period of insurance. • A monthly policy can be cancelled (lapsed) from the following month. <p>This can vary between insurers and the individual policy should be checked.</p>
---------------------	---

3.3.6 POLICY SCHEDULE

This is the part of the policy which makes it personal to each client. It contains full details of:

- the risk;
- the insured;
- the period of insurance;
- any excess or first amount payable;
- the policy number; and
- any special terms and conditions which apply to this particular policy.

The policy will also state that the printed policy wording and the schedule must be read as a whole and not separately.

3.3.7 DISCLOSURE NOTICE

As per the regulatory requirement it is necessary to include a disclosure notice with every policy document and schedule. This notice must include:

- name and contact details of the product supplier;
- the contractual relationship between the product supplier and the FSP;
- names and contact details of the product suppliers compliance and complaints departments;
- any conditions or restrictions imposed on the FSP by the product supplier;

-
- any ownership interest of the product supplier in the FSP and the extent thereof; or
 - whether the FSP receives more than 30% of their total remuneration from the product supplier.

Disclosures about the FSP itself should include:

- the name, registration number and contact details of the FSP;
- details of the legal and contractual status of the FSP;
- contact details of the relevant compliance department of the FSP;
- any restrictions or conditions imposed on the FP in terms of its authorisation and licence;
- whether the FSP holds the relevant professional indemnity or fidelity cover or not; and
- any existence of a specific exemption the FSB has applied, where applicable.

3.4 INSURABLE INTEREST

Just as in long term insurance, insurable interest is essential if cover is to be issued. However, the application of this in short term insurance is somewhat different.

Insurable interest is the legally recognised relationship between the insured and the financial loss that he suffers following a loss. You can insure only those things with which you have a legally recognised financial relationship. For example, you can insure your house against fire because if it burns down you will suffer a financial loss.

Legally recognised relationships are:

- owners and joint owners of property;
- mortgages and mortgagors;
- bailees (those who legally hold other peoples' property);
- agents; and
- executors and trustees who can insure the property for which they are legally responsible.

WHEN MUST INSURABLE INTEREST APPLY?

This differs according to what class of insurance it is applied to, as shown below:

Class of insurance	Insurable interest must be present
General (fire, accident and motor classes)	<ul style="list-style-type: none"> • When the policy is issued • At the time of the loss; and • At the renewal of the policy
Marine insurance	<ul style="list-style-type: none"> • At the time of the loss
Long term insurance (life and pensions type business)	<ul style="list-style-type: none"> • When the policy is issued

The need for insurable interest is probably the single most important difference between an insurance contract and a wager.

3.5 INSURABLE AND UNINSURABLE RISKS

3.5.1 FUNDAMENTAL RISK

Fundamental risks affect large parts of society or even of the world, and are regarded as commercially uninsurable. These are risks that are outside the control of a person or a group of people. They normally affect a large number of people and the loss is often catastrophic.

EXAMPLES

- Earthquakes;
- War;
- Riot;
- Famines; or
- Economic recession and unemployment.

Fundamental risks can be caused by social, political or natural factors.

Suppose, for example, that a cement manufacturer is thinking of exporting its surplus production to a foreign country. There is nothing they can do to prevent a war or recession in the country, but they must take into account the risk of this happening and destroying their market.

Often the Government or State insurance covers these types of risks as their effect is widespread.

The South African Special Risks Association (SASRIA) is a company that was specifically created by the Government to provide insurance against the fundamental risks of political riot and strike.

3.5.2 PURE AND SPECULATIVE RISK

A pure risk involves two outcomes. Either there is no loss or there is a loss. Pure risk cannot involve a possible profit.

EXAMPLE

- When you drive to work in the morning you either have a car accident or you don't.
- Your house either burns down or it doesn't.

Insurance is concerned primarily with pure risks.

Speculative risks, on the other hand, are normally taken in the hope of some gain and the provision of insurance may act as a distinct disincentive to effort. For example, if it was possible to insure the profit that a person hoped to gain from an enterprise, then there would be little incentive for some people to do anything to generate the profit. No personal effort to secure the profit would still result in profit, because the policy would pay up in the event that no profit was generated.

However, as practice is changing and the division between pure and speculative is becoming more blurred as time passes. Take the case of the credit risk which is usually listed under the heading of speculative risks. The goods have been sold on credit in the hope that a gain will result, but a form of credit insurance is available which will meet some of the consequences should the debtor default.

However, insurance is not normally available for those risks where the outcome can be a gain. Speculative risks are entered into voluntarily, in the hope that there will be gain. There would be very little incentive to work towards achieving that gain if it was known that an insurance company would pay up, regardless of the effort expended by the individual. Using the terminology of hazard, we could say that there would be a very high risk of moral hazard.

We should, however, be clear that the pure risk consequences of speculative risks can be insured against and that more people involved in risk and insurance are being asked to handle speculative risks.

EXAMPLE

A speculative risk, which may become a pure risk, is bad debt. Profit is made on a venture or sale, which is a speculative risk. The subsequent collection of the debt or the non-collection can result in a loss, therefore fitting the definition of pure risk.

The pure risk consequences of speculative risks are certainly insurable, but not the speculative risk itself.

EXAMPLE

The marketing of a new line in clothing. The risk that the new line will sell or not is clearly a speculative one. It is a risk knowingly entered into in the hope of financial gain. This, after all, is the very essence of business activity.

However, the risk that the line will not sell is not the only risk to which the enterprise is exposed:

- the factory in which the garments are to be made could be damaged;
- designs could be stolen; and
- suppliers of essential materials could have fires or other damage resulting in them being unable to supply the raw material.

All of these risks are pure risks which are insurable, but they arose directly from the decision to take the speculative risk in the first place.

We are not saying that all pure risks are insurable, just that speculative risks are normally not.

3.5.3 PARTICULAR RISK

A particular risk is one which affects individuals and which arises from individual causes which can be identified.

EXAMPLES

- Thieves break into your home and goods are stolen. This is a particular risk because it affects only you and your family (not society as a whole).

Other examples would be;

- a fire breaking out at a factory,
- the explosion of a boiler; or
- a motor car accident.

In general, risks which are not particular fall into the fundamental class.

3.5.4 INSURABLE RISK

In order for a risk to be insured, there are certain basic rules that must be met. They are generally as follows:

- the cause of the loss must be accidental or fortuitous;
- there must be insurable interest;
- the risk must be one of a number of similar risks; and
- the insuring of the risk must not be against public policy. An example of this would be the risk involved in a company treating its' staff badly and incurring fines from the CCMA.

When we are insuring something, it is not really the article itself that we are insuring, but rather the cost of replacing or repairing the item. This is what is meant by a financially measurable risk.

3.6 PROPOSAL FORM

3.6.1 TO HAVE OR NOT TO HAVE

At one time companies insisted on a completed proposal form, as it is legally recognised as the basis of the contract. Today, however, it is becoming increasingly common for the broker to send in details of the risk by way of an e-mail or through the internet, effectively completing the proposal online³. This is particularly true in commercial and corporate insurance, where the proposal effectively becomes a survey of the risk.

This makes sense as a company with perhaps twelve premises to be insured would have to fill in huge amounts of paperwork, before they could get cover.

In the personal lines market it is much more usual to see the completed proposal form. Call centres and telephone closings are also used. This has the same effect as a written proposal. The proposer's replies to questions are voice logged, and the insurer can refer to them at any time in the future.

3.6.2 GOOD FAITH AND DISCLOSURE

There are two distinct ways that contracts can differ legally. Contracts undertaken in the normal course of business are generally based on the premise of caveat emptor or let the buyer beware, but contracts of insurance are based on a different concept - *uberrima fides* or good faith.

One must appreciate that in all business dealings one undertakes some form of contract, even if most of these are simply oral.

³ Of course, most direct underwriters also do not use a proposal form as such but collect the required details over the 'phone.

However, if it can subsequently be proved that the seller deliberately withheld information from the buyer that would in all likelihood have affected his decision to buy the buyer will have recourse, if necessary, to the courts. Should this not be the case it is only where the seller provides some form of warranty that there is a possibility of a comeback.

The cooling off period applies only to any credit agreement entered into, or cases where there is a specific law enforcing a cooling off period, such as with insurance policies in South Africa. However, based on the principles of common law a purchaser will be able to apply to the courts in the event of deliberate fraud or misrepresentation of the facts.

Note that that ignorance of the facts cannot and will not be accepted as a valid defence. One is expected to be aware of what one signs or agrees to at all times and, as is often repeated, "Ignorance is no excuse in the eyes of the law."

The very nature of an insurance contract requires that the seller (the proposer) provides the buyer (the insurer) with all the facts at his disposal. Nondisclosure or misrepresentation of any of the facts will give the insurer the right to claim that the policy was void ab initio (from the beginning).

The duty of disclosure was highlighted in the well known case of *Carter v Boehm (1766)* where Lord Mansfield stated the rule and the reasons for it.

"The duty of disclosure is imposed by law (ex lege) and it is not based upon an implied term of the contract of insurance. It does not flow from the requirement of bona fides, nor from the special circumstances of insurance law, being only an example of the application of general principles, especially relating to misrepresentation."

Over the years this has led to a certain amount of confusion as to whether insurance contracts are contract of *uberrima fides* (utmost good faith) or contracts of *bona fides* (good faith). The often quoted case of *Mutual and Federal Insurance Company Ltd. v Oudtshoorn Municipality (1985)* finally cleared up this confusing principle. The Appellate Division decided that utmost good faith was an impractical concept since there can only be good faith or bad faith.

A person may be less than honest but cannot be more than honest and utmost good faith was declared to be meaningless in South African law. With a contract *uberrima fides* it was accepted that there was an obligation placed on the proposer to disclose all that he knows, and the hiding of any material circumstance, whether the proposer thought it was relevant or not, would allow the insurer to void the contract from inception.

The implication of this court ruling resulted in the conclusion that the principle of *uberrima fides* placed too heavy a responsibility on the proposer. Further rulings have resulted in what is today known as the reasonable man test. The reasonable man test is equally important to long term as well as short term business.

It is also important to note that the FAIS Code of Conduct focuses on the insurance representative's duty to make disclosure to the proposer or client.

REASONABLE MAN TEST

While the basis of *uberrima fides* is still applicable in principle to any proposal for insurance it is now generally accepted that the test to the validity of the contract will be determined by the reasonable man test. The proposer is expected to provide an insurer with all the relevant information required that a reasonable man would know to be material to the risk.

It will be no excuse to state that facts were not disclosed because it was thought that they were not important or material. If a reasonable man would have recognised the facts to be material, the proposer is expected to also have recognised this. This does not mean that every proposer now needs to be an underwriter.

The emphasis is on what a reasonable man would consider to be necessary. Unfortunately there does not seem to be a clear definition of what is considered to be a reasonable man. Where this has been put to the test the opinion of a person with an average intelligence and some form of tertiary education is considered adequate. A knowledge of insurance usually disqualifies the person as the opinion of a layman is what is wanted.

However, one must appreciate that the nature of the subject matter of insurance, and the circumstances pertaining thereto, are facts particularly within the knowledge of the insured.

The insurer is not generally aware of these facts unless informed thereof by the insured.

While a proposer can inspect the terms and conditions provided by the insurer before final acceptance of the contract an insurer is at a disadvantage as it cannot examine all aspects of the proposed insurance which are material. Only the proposer knows, or should know, the relevant facts about the risk being proposed.

The law is also clear that the questions set out in a proposal form do not necessarily define the limits of what is material for the insurer to know. Further facts that must therefore be disclosed include:

- those which would indicate that the risk is greater than would be expected from its class;
- those which would tend to make the amount of the loss greater than normal;
- previous loss and claims history;
- previous application of penalty terms (loadings) or restricted cover (exclusions) imposed by other insurers;
- the fact that the insured had absolved a third party from what would be normal legal liabilities, therefore depriving the insurer of potential subrogation rights (only applicable to short term contracts); and
- any medical information that could materially affect the assessment of the risk, whether the condition was referred to in the medical questions or not (mostly only applicable to long term contracts).

EXAMPLE

The extent of the duty to disclose is well illustrated in the case *Pickering vs. Standard General Insurance Co. Ltd.* The insured, although he had correctly answered questions on the proposal form regarding his health, had been aware of the possibility that he may have been an epileptic. Even though it was later established that he did not suffer from epilepsy, the court ruled that there had been a suspicion that he may have. He should have disclosed this fact to the insurer.

Non-disclosure is seen by insurers to be a form of moral risk. However, the trend in both the rulings of the Ombud and Legislative decisions of late has tended to go against this basic concept and increasingly it has become necessary to show that the issue directly led to the claim, as we can see from the recent court ruling below.

Insurance :: Claim for damages

Hollely v Auto & General Insurance Co Ltd
[2008] JOL 21182 (W)

Case Number:	04/31731
Judgment Date:	01/10/2007
Country:	South Africa
Jurisdiction:	High Court
Division:	Witwatersrand
Bench:	PA Meyer AJ

Summary:

The plaintiff's motor vehicle, which was insured against damage by the defendant, was damaged beyond repair in a motor vehicle accident. The defendant repudiated plaintiff's claim under the policy of insurance.

It was held that the main issue was whether the defendant was entitled to avoid or to repudiate the plaintiff's claim for compensation under the policy by virtue of the fact that the plaintiff had failed to disclose that he had been involved in a motor vehicle collision prior to the one in respect of which the claim was lodged.

The fact that such information was not disclosed in itself did not justify the repudiation of the plaintiff's claim. The defendant bore the onus of proving that the test for materiality as enacted in the amended Section 53(1) of the Short Term Insurance Act 53 of 1998 was satisfied.

The court found that the evidence established that the non-disclosure of the plaintiff's previous collision and insurance claim, had the effect of inducing the defendant to take on the risk at a much lower premium.

3.6.3 FUNCTION OF THE PROPOSAL

The proposal serves a number of functions, not the least being, as we said, the basis of the contract. If nothing else, probably one of the most important facts is that it reminds you of all the questions that you must ask, to enable you to underwrite the risk correctly.

Below there is an example of a completed proposal. It is from no specific company and is a guideline as to the type of questions asked.

XYZ INSURANCE COMPANY (PTY) LTD	
Agent:	New Wave Brokers
Full Name of Proposer:	Gregory John Marshall and Jane Elizabeth Marshall
Postal Address:	38 Cedarwood Drive, Orange Grove, Johannesburg, 2192
Physical Address:	The same as the postal address
Age of Proposer:	Gregory 27 and Jane 25
Occupation of Proposer:	Gregory - Computer Programmer Jane - Legal Secretary
Details of any Claims in the last three years:	No claims - never had insurance previously
Name of Previous Insurers and Policy Number:	N/A
Have you ever had insurance declined or special terms imposed?	No
Date on which insurance is to commence:	Immediately
Signature of Proposer:	G Marshall & J Marshall Date: 14 February 2007
We hereby declare that the information contained in this proposal is true and acknowledge that this proposal shall form the basis of the insurance contract.	
Please complete the details of the risk on page 2 and 3 of this proposal form.	
Page 1	

DETAILS OF RISKS TO BE INSURED

BUILDINGS	<p>HOUSEOWNERS (Buildings)</p> <p>Address at which risk is situated: 38 Cedarwood Drive, Orange Grove, Johannesburg</p> <p>Walls Made of: Brick Roof made of: Thatch Sum Insured: R980 000</p> <p>Is SASRIA cover required (Yes or No): Yes</p> <p>Is there a Bond over the Property: Yes</p> <p>Name of Bond Holder: First National Bank</p>
CONTENTS	<p>HOUSEHOLDERS (Contents)</p> <p>Address at which risk is situated: 38 Cedarwood Drive, Orange Grove, Johannesburg</p> <p>Walls made of: Brick Roof made of: Thatch</p> <p>Total value of goods to be insured: R190 000</p> <p>Is there any outstanding finance on the goods to be insured? No</p> <p>Do all opening windows have burglar proofing: No, the bathroom window has none</p> <p>Do all external doors have grille gates: No, the sliding door in the lounge has no security gate</p> <p>Will the house be left unoccupied during the day? Yes, we both work</p> <p>Will the house be left unoccupied for more than 60 days in any one year? Yes, we are going away for three months to America</p> <p>Total value of gold, silver, precious metals and jewellery is covered up to a total value of 30% of the sum insured for contents. Any in excess of this must be declared to the company and additional premium paid.</p> <p>Is SASRIA cover required for this section: Yes</p>

ALL RISKS	ALL RISKS SECTION	
	Description of goods to be insured	Sum insured
	ITEM 1: Wearing apparel and personal effects	R10 000
	ITEM 2: Contact lenses	R1 500
	ITEM 3: Diamond Ring	R9 500
	ITEM 4: Camera and equipment	R6 000
	ITEM 5: Becker car radio/CD	R8 000
MOTOR	MOTOR SECTION	
	Vehicle to be Insured:	Make: Volkswagen Model: VW Jetta 1.8GL
	Year of Manufacture: 2006	Cover(tick one): YCOMP TPFT TP only
	Colour: Blue	Engine No: unknown Chassis No: unknown
	Market Value: R75 000	Is cover required for a radio: No, see All Risks
	Name of usual driver: Mrs Jane Marshall	ID No: 8308030208104
	Year licence acquired: 2002	Has the licence ever been endorsed? No
	Vehicle Use:	Going to and from work and over weekends for pleasure/family use
	Are you entitled to a claim free group?	Have been driving for 5 years and never had an accident
	Is there any finance outstanding on the vehicle?	Yes
	If so name of finance company:	Wesbank
	Is SASRIA cover required for the vehicle?	Yes
Page 3		

Recap

The principle is that each insured is required to pay in his fair share to the insurance pool, according to the risk.

Page one of the proposal

Page one of the proposal asks the general type questions about the insured and their family. These include:

- occupation - certain categories of occupation are unattractive from an insurers point of view. They could involve long hours of work, or an unusual amount of travelling, for example;
- details of previous claims - this gives the insurer an idea as to whether or not the risk is better or poorer than normal; and
- insurance declined or terms imposed - this is to find out if the insured has been turned away by other insurers.

Page two of the proposal

This is where they start to ask details of the risk. As you can see the various sections of the policy require different information. For the purposes of this course the important ones are:

- construction of the dwelling - if it is anything other than standard construction an additional premium is normally charged. Inferior construction increases the risk. Standard construction: the private dwelling built of brick, stone, concrete, and roofed with slates, tiles, metal, asbestos, or concrete;
- burglar proofing and grille gates - unfortunately, due to the high incidence of crime in South Africa, insurers will be very reluctant to give cover if the premises does not have adequate protections. Some companies insist on a burglar alarm with armed response for high sums insured;
- house occupied during the day - premises that are not occupied all day are more at risk from a theft point of view; and
- unoccupied for 60 days or more - an additional premium is due if the house is left unoccupied for more than 60 days, but again the risk is increased from a theft point of view. Further details as to when the planned trip is to take place should be obtained.

Some companies will not give cover to a proposer who is going on holiday in the very near future. This is because the client often takes out insurance whilst away during a high risk period and cancels it as soon as he comes home, when the risk is less. This is selection against the insurance company.

Page three

Under the All Risks section the client has asked for cover for among other things:

- diamond ring - R9 500; and
- camera and equipment - R6 000.

These descriptions are totally inadequate. The client should supply full details, including serial numbers, valuation certificates and even a jeweller's inspection certificate for high valued items.

If there is a loss the client is going to have to supply proof that he owned the item and that it really did exist. It would not be the first time that a client has claimed for an article they did not own.

Remember, however, that if the client gives incomplete information, it is the underwriter's responsibility to ask for it.

Motor section

The full details of the vehicle and the driver are asked for. The main point of interest in this particular proposal is the fact that the driver has been driving for five years and has never had an accident. Does this entitle them to a claim free group?

The answer is no, because they stated they have never had insurance before. This means they could not have had a claim. In practice the client may have always had a company car and he may have had no accidents in this. If he can prove this and substantiate it with a letter from the company, he might be allowed a certain amount of no claims bonus - a discount on the premium. In this example it seems that something is wrong, since the car was under finance from Wesbank and insurance would most likely have been compulsory.

The engine and chassis numbers need to be obtained.

SASRIA

Throughout the proposal you will see the question is "Is SASRIA required". This refers to the South African Special Risks Insurance Association which covers risks in South Africa against loss or damage arising from riot strike and civil commotion, whether politically or non-politically motivated. For example, rioting took place at Megawatt Park and, more recently, in the streets of Cape Town and Johannesburg.

The insurer does the administration, such as making out the insurance coupon on behalf of SASRIA and administering claims, but the premiums are paid over to SASRIA, and SASRIA settles any claims.

3.7 PROCEDURE

Now that the proposal has been completed, the underwriter will use it to work out premium and terms and conditions. We will look at each section and draw up a quote to enable you to see how it is done.

3.7.1 HOUSEOWNERS

Under this section we take

- | | | | |
|-------------------|------------------|-----------|-------|
| • the sum insured | R980 000 | | |
| • area | Johannesburg | Base Rate | 0,15% |
| • construction | brick and thatch | Loading | 1,0% |

Total rate for the houseowners section 1,15%

Premium due R11 270 per annum = R939,16 per month.

The sum insured should be based on the cost of:

- rebuilding the premises, including clearing the site. If you have ever seen a house burnt to the ground, you will know that there is a lot of work to be done before any rebuilding work can take place; and
- the market value of the house should not be used, as this means that the insured is not paying the correct share into the insurance pool. The contract is to reinstate the property to the condition it was prior to the loss, so it is necessary to insure for re-building costs, including architects' fees and debris removal.

3.7.2 HOUSEHOLDERS

Under this section we take into account the following:

- | | | | |
|----------------|--------------|-----------|------|
| • sum insured | R190 000 | | |
| • area | Johannesburg | Base rate | 1,5% |
| • construction | thatch | Loading | 1% |

Total rate for householders section 2,5%

Premium for the householders section R4 750 per annum = R395,83 per month.

Other considerations would be to:

- restrict the policy and exclude theft cover until such time as the insured has installed a grille gate on the sliding patio door and burglar bars on the bathroom window; and
- the underwriter should also state the thickness of bar required and the type of lock for locking the grille gate. This would normally be at least a five lever lock.

SUM INSURED - HOUSEHOLDERS

The short term policy is normally one of indemnity. It is putting the insured back in the position he was in prior to the loss. This can cause a financial problem. Imagine:

- you are an insured;
- your house is flooded by the washing machine overflowing; and
- your 5 year old carpets are damaged by this.

How is the insurance company going to replace your 5 year old carpet? There are a couple of options, namely

- find out the cost of new carpets and deduct an amount for wear and tear. You are not happy with this though, because the assessor wants to deduct 50% and you say no way, they still had years of life left in them;
- they could take new carpets and lay them down in their offices for a week and let all the staff walk over them so that they are worn, just like your old ones. You know your answer to that suggestion; or
- they can replace your carpets, with new ones of the same quality - but perhaps your sum insured does not allow for this. So what is the answer?

The policy can be issued on a new for old basis. As long as the sum insured is adequate and reflects the new replacement cost of the insured's household contents there is no problem.

INVENTORY

To help the insured to reach the correct figure, an inventory form is included with most personal lines proposal forms. It requires the client to go from room to room and take note of all his possessions and the cost of them. He may have to find out the price of an article, but on the whole it is easier to find out the new price of an item, than to reach agreement on how much that nine year old refrigerator is worth.

Some insurers also make use of an evaluation service by which a person might come to the property to do an inventory. This will provide insurers with a correct sum insured.

Inflation

We are all too well aware of the effects of inflation and to help the client, the insurer will have a built in inflation margin. This means that, at each renewal, the sum insured under the householders and homeowners section of the policy will be increased by an amount in line with the rate of inflation. A monthly policy (see later) will be increased at each annual anniversary date.

This provision can be deleted if the client wishes, but he will run a serious risk of becoming underinsured, unless he watches prices and adjusts his policy accordingly.

3.7.3 ALL RISKS

Each of the items under the all risks section will have a separate rate applied. For example

- | | | |
|--|------|-----|
| • wearing apparel and personal effects | rate | 3% |
| • contact lenses | rate | 10% |
| • diamond ring | rate | 3% |
| • camera and equipment | rate | 5% |
| • Becker car radio/CD | rate | 15% |

The rates are normally a standard company rate for that type of article. They are applied to the sum insured for that item.

As regards wearing apparel and personal effects, this is an item that covers articles normally worn on a daily basis by the insured, whilst he is at work or out and about. There is normally a limit per item, of usually about R500 and certain types of articles are excluded, such as fur coats and sporting equipment.

As mentioned previously the underwriter should ask for a full description of the items insured and in the case of the ring a valuation would normally be required.

3.7.4 MOTOR

The representative will give the client a quotation based on the information supplied on the proposal but there is also further information that needs to be obtained, regarding the engine and chassis numbers, whether the vehicle has an alarm, immobiliser or tracking device fitted. Clarification also needs to be obtained regarding the non-insurance over the past five years, if the vehicle has outstanding finance.

Vehicle details:

Year and model:	2006 Volkswagen Jetta 1.8GL
Retail value:	R75 000
Finance house:	Wesbank

Main driver details:

Name	Mrs Jane Marshall
Age/ID of regular driver:	28 years
Claim free group:	0
No of years licence held:	5

Cover Details:

Cover:	Comprehensive
Motor Liability:	Yes
Basic Excess:	R2 500
Class of Use:	Private & Professional
Roadside Assistance:	Yes
SASRIA:	Yes

Vehicle Security:

Alarm/immobiliser: Yes
Overnight Parking: Locked Garage

Optional Extensions:

Car Hire: 30 days
Credit Shortfall: No

Rate: 4.5% = R312.50 per month.

ISSUING THE POLICY

The underwriter will give the client, or broker the quotation and advise them of the terms and conditions which are to apply, such as the additional protections, and the need for the valuation.

If the client is happy the underwriter will go on risk, except for the theft cover. This will be excluded until such time as the insurers are advised that the risk improvements have been carried out.

A policy document will be issued by the insurance company and forwarded to the client, via a broker if he has one.

BUSINESS POLICY

The procedure for issuing a business policy will be slightly different in that there is not usually a proposal form.

- The broker will request a quote either over the phone, or when the insurance company's representative visits the broker.
- The quote will be given with the various terms and conditions.
- If necessary a company surveyor will inspect the prospective client's premises, to check the housekeeping and protections.
- The underwriter will negotiate with the broker and, when completed, the underwriter will go on risk.

The broker will send in closing instructions, the signed debit order and deposit the premium, if necessary.

- A policy is issued and sent to the broker who in turn will ensure it is given to the client.

CONCLUSION

In the next section we look at the effect the Short Term Insurance Act has and the various ways of collecting premium and how they affect the client's policy.

3.8 PREMIUM COLLECTION

3.8.1 SHORT TERM INSURANCE ACT

The Short Term Insurance Act lays down certain rules with regard to the collection of premium for short term insurance.

In terms of Section 45, and Part 4 of the regulations of the Short Term Insurance Act, any intermediary who collects or handles premium on behalf of an insurer, must furnish a guarantee for an amount of 30% of the annual premiums he collects per year based on a minimum guarantee of R100 000 and a maximum of R100 000 000⁴.

The Guarantee was introduced in response to the business operations of certain brokers collapsing, with a consequent loss of premiums.

SAIA handles the Intermediary Guarantee Facility Ltd, which underwrites guarantees for brokers. Alternatively, security can be provided by a bank or other financial institution.

Maximum rates of commission are also set by the Act of;

- motor - 12,5%; and
- all other classes - 20%;

Commission is only payable when the premium has been paid to the insurer, except that the premium may be paid over net of commission.

3.8.2 RULES FOR PAYING OVER PREMIUM

The Short Term Insurance Act also regulates the time the intermediary has in which to pay over premiums that have been collected. The Act stipulates that intermediaries:

- must have written authorisation from the insurer to handle premiums;
- must pay over premiums received within 15 days after the end of the month in which they were received;
- must provide a monthly statement of premiums received and commission due; and
- may deduct commission and any refunds, and pay the insurer net of commission.

3.8.3 WHEN PREMIUM IS DUE

In insurance practice, premiums are due:

⁴ The maximum Section 45 guarantee amount increased from R50 million to R60 million in 2008 and was progressively increased by R10 million each year until it reached R100 million in 2012.

- in the case of a new policy, on the inception date of the policy;
- in the case of an endorsement, or a marine declaration, on the first day of the month following the date upon which documentation is issued by the insurer to the policyholder concerned; or
- in the case of the renewal premium, this is the same as new business. The premium is therefore due on or before the renewal date, but natural persons (individuals) must be allowed at least 15 days' grace.

3.8.4 METHODS OF PAYMENT

Premiums for a policy can be paid in different ways. They are:

- the premium can be paid annually. This method is still used by businesses and personal lines clients. However, because of economic reasons it is becoming less popular. More people are paying by monthly debit order;
- monthly payment by debit order. It is virtually unheard of for a short term insurer to accept payment via cheque or cash for a monthly policy; and
- some insurers have a half-yearly or quarterly payment system, whereby the client pays in two or four instalments.

3.8.5 MONTHLY PREMIUM PAYMENTS

There are two types of monthly policy. They are the annual policy paid monthly and the true monthly policy with an anniversary date each year. The main difference between them is the fact that any changes in the company's underwriting philosophy affect the first only at the next annual renewal date, but the second immediately. This is set out in the table below.

Area of Difference	Annual Policy	Monthly Policy
Collection of premium	The premium is annual, but paid in monthly instalments.	The premium is a monthly one.
Premium increases and underwriting changes	These are reviewed only once a year.	If the company increases its rates the premium increases from the next collection date. Any underwriting changes also come into effect immediately.
Usual classes of business	This is common to the commercial and business market.	This is very common in the personal lines market.

3.8.6 NON-PAYMENT OF PREMIUM

In short term insurance the client has no period of grace, as he has in the long term market. The premium is due on a certain date and must be paid by then. However, if the policyholder is a natural person (individual), the insured must be allowed at least 15 days' grace for the payment of renewal premiums. For monthly policies this applies from the second month of the policy.

Premiums paid to an accredited intermediary (credit agent) are deemed to have been received by the insurer. The insured is covered by the policy, even if the broker then fails to pay the insurer.

However with monthly payments there can be a problem in that the bank can be slow in returning an unpaid debit order. It has happened that insurers have paid claims, only to have the debit order returned as unpaid, after the claim has been paid. In this instance the insurer would be within its rights to ask for the claim settlement money back, but normally they will ask for the premium to be paid.

3.8.7 WHEN COVER CEASES - DEBIT ORDER POLICIES

The policy wording and/or the debit order form which the client signs, tells the client when premium is due. It is normal for insurers to re-submit an unpaid debit order for a double debit but should this be rejected, the policy will be cancelled from the first month the premium was due. However if the debit order is returned as payment stopped, the policy is cancelled immediately.

The effective date of the cancellation will be the due date of the first returned debit order.

EXAMPLE

- Premium is payable on 28 March.
- This premium is in respect of April as the policy is payable in advance.
- Date of cancellation if debit order returned will be 1 April.

3.8.8 CONCLUSION

The collection of premium in short term has wide-ranging consequences. The type of collection can affect the terms of the insured's policy whether monthly or annual amendments.

The collection of premiums paid over by intermediaries can be an administrative burden, with accounts departments within the insurance company receiving monthly bordereaux, which must be reconciled with outstanding premiums. It is very important for these statements to be monitored very carefully. Premiums should never be allowed to remain overdue without some action being taken.

Chapter Reference List

Vivian, Prof R, Notes, Department of Business Economics, University of the Witwatersrand.

Marine Insurance Act, 1906

Short Term Insurance Act, 1998 (Act no 53 of 1998)

QUESTIONS ON CHAPTER 3

Revision questions

Work through these revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. Do executors and/or trustees have an insurable interest in the property for which they are legally responsible?
2. When must insurable interest be present for marine insurance?
3. Are speculative risks generally insurable?
4. What is the function or purpose of the insurance proposal?
5. What information is contained in the typical insurance policy schedule?

Written questions

Attempt these questions after you have completed this chapter and its revision questions. Suggested answers to these questions are at the end of this book.

1. Short term insurance policies, on the whole, are policies of indemnity. Explain what this means and why contribution and subrogation are linked to this principle.
2. Explain how the Short Term Insurance Act regulates the handling of premiums and the amount of intermediary commission.
3. The short term policy is made up of various sections, one of which is the schedule. Describe what is contained in the schedule.
4. Explain the difference between a true monthly policy and the annual policy that is paid monthly. How does it affect the client?
5. Describe the factors which are taken into consideration when underwriting a householders policy.

CHAPTER 4

RENEWALS

Learning Outcomes

When you have completed this chapter you should be able to:

- describe the renewal process from receipt of the advance list until the dispatch of the renewal documents;
- list the steps taken in the renewal process by the underwriter, representative and client; and
- describe the steps necessary for the issue of SASRIA at renewal of a policy.

One of the major differences between short term insurance and long term insurance is the fact that the short term policy is a contract which is normally in force for one year only. At the end of this period the insurer and insured have the option to renegotiate the contract and renew the policy if they wish to, or if nothing changes the policy continues for another year on an annual renewal basis.

Long term contracts are normally for a longer period and the insurer does not have the right to cancel cover, except where the insured has not paid the premium or where no disclosure of a material fact is discovered at the time of a claim.

In this chapter we will look at the procedure followed by all the parties and the responsibilities of each of the parties, during a renewal process.

4.1 RENEWAL LISTING

4.1.1 RENEWAL LISTING

A short term insurance policy is renewable annually.

Approximately two months before the renewal date, the underwriter will receive a listing of policies due for renewal. This is called the advance listing.

This is usually a report from the insurance company's data base or client listing.

Therefore a policy with a renewal date of 1 July will be on the advance listing in April/May. The list is normally produced towards the end of a month.

4.1.2 EXPLANATION FOR THE ADVANCED LISTING

The renewals are listed this far in advance to allow the underwriter time to consider:

- the claims experience for the policy;
- the rate being charged; and
- the current terms and conditions.

It also gives the underwriter time to decide on whether or not he wants to invite renewal. If he decides not to renew, the representative will need time to try and place the cover elsewhere.

4.2 CLAIMS EXPERIENCE

From the client's claims experience, the underwriter will consider;

- the number of claims, and
- the size or value of the claims

which have been paid by, or reported, to the company in the last three years.

The underwriter will use the last three years claims experience, if the account has been with the company long enough. If it is relatively new, they will use the number of years that are available.

4.2.1 DETERMINING TRENDS

Why is it important for the underwriter to draw conclusions from three years of claims?

If you only look at one year it will give you an unbalanced perspective. The insured may have had one very bad year. Three years will give a better idea if there is a trend in the claims experience.

By looking at the claims you will see if,

- the insured claims on a regular basis;
- the insured is always putting in very small claims; or
- the insured may also have had a number of burglary losses and may need risk improvements.

Experience helps an underwriter to pick up and consider trends which can be seen from the claims experience. These trends could relate to:

- a particular client;
- a geographical area; or
- a particular or pure risk.

4.2.2 CONCLUSIONS REACHED

The underwriter will use the claims experience to judge if the premium is adequate. He will also check to see if the terms and conditions need amending. It may be that the excess is inadequate and needs to be increased, or the client needs to implement further safety features.

If the claims are very bad, he may decide not to offer renewal terms. The policy would then lapse, which means that the policy is cancelled at renewal.

4.3 OPTIONS

4.3.1 RATES BEING CHARGED

When looking at the rate being charged, the underwriter will decide if the rates should be:

- increased;
- decreased; or
- left as they are.

Unfortunately, because of the level of claims insurers are experiencing, there are seldom rate decreases. Crime is a big problem and this is reflected in the number of hijackings and thefts that are reported every year to insurers. This in turn, affects the rates that clients are being charged.

The claims experience will affect the premium charged, particularly on a business policy. The personal policies within an insurer's portfolio are normally subject to standard rates.

4.3.2 TERMS AND CONDITIONS

Each policy is issued with certain terms and conditions.

The underwriter may have put a clause in the policy which said,

"... theft cover is subject to all external doors and windows having burglar proofing".

At renewal, however, the underwriter may see that there have been a number of burglaries, or a number of small claims. The underwriter may then exercise one of the following options:

- amend the first amount payable;
- ask for risk improvements; or
- request a survey to be carried out.

4.4 SURVEY

In some cases insurers are prepared to meet the additional cost of a professional surveyor, either employed by the insurer or an external consultant, to assess the risk in more detail. This is especially common on larger commercial risks.

4.4.1 SURVEY OPTION

If the underwriter decides to call for a survey,

- a surveyor from the insurance company will visit the insured premises;
- he will take down full details of the protections, housekeeping and any other details he feels are important. He will draw a plan of the premises noting all doors and windows, and may also take photographs;
- these allow the underwriter to look at the premises;
- a report will be produced which outlines features of the risk for the underwriter; and
- the underwriter will assess these features and decide which may improve the risk and which could worsen the risk.

The surveyor is the eyes and ears of the underwriter. His findings will influence the underwriter's renewal terms and conditions. He also has experience of safety measures, fire protections and related subjects. The surveyor is not there to catch the client out, but to give professional advice, which assists the insured and the insurer.

4.4.2 CONCLUSION

Surveys are useful at renewal, but could also be requested:

- prior to inception of the risk;
- following a loss, as the loss adjuster may highlight some adverse feature; and
- for the large risk, as a risk measurement or physical inspection depending on the processes involved, or area concerned.

4.5 SOUTH AFRICAN SPECIAL RISKS INSURANCE ASSOCIATION (SASRIA)

At renewal, as at inception the question of SASRIA cover needs to be addressed.

The regulations governing the operation of SASRIA are very specific and if they are not adhered to strictly, SASRIA will not meet any claim which may arise.

4.5.1 SASRIA COVER

- SASRIA cover is not automatically given. If an insured wants the cover, it must be requested on or before inception or renewal date of the underlying policy.
- For all classes of insurance, except motor, there must be an underlying policy which has fire as one of the perils.
- The request must be in writing and can be faxed through to the insurers.

The insurer then has 30 days in which to issue the coupon. This is merely an administrative period for insurers to issue the coupon. Once requested, the coupon must be paid for. In terms of the SASRIA regulations the coupon cannot be cancelled.

SASRIA will not backdate cover more than six months after the request for SASRIA cover, or the inception date of the SASRIA cover, whichever is the later.

4.6 RENEWAL

4.6.1 RENEWAL CYCLE

Renewal negotiations and discussions can take a great deal of time. For the broker and insurer this process is repeated every month of the year, for different clients with some months having large numbers of policies to be reviewed and renewed.

The larger accounts are renewed in the same way. Although the renewal involves more work and more negotiations, the procedure is basically the same.

Here we will briefly look at the renewal documentation from the perspective of the:

- insurer;
- broker; and
- insured.

4.6.2 INSURER'S PERSPECTIVE

When the underwriter has reviewed the policy the new rates, terms and conditions are recorded in the system.

Most personal policies have an Automatic Inflation Margin written into them. This is so that inflation does not undermine the validity of the sum insured. This margin adjusts the sum insured to ensure that it keeps pace with inflation, usually about 6% per month. The sum insured on householders and houseowners sections will therefore be increased by this amount.

The client does not have to accept this increase, but must take care not to underinsure.

4.6.3 BROKER'S PERSPECTIVE

PROCEDURES

The staff in a broker's office do not normally wait for the insurers to send them the documentation. They usually have their own data base and run a list of all renewals for a particular month approximately two months in advance.

When they receive the insurer's renewal notices, these must be compared with the brokers list to ensure that they have documents for every client whose policy is due for renewal. If they do not receive the documents, they must contact the insurer and ask for the terms and conditions.

If the underwriter advises them that the company does not want to renew a certain policy, the broker will have to try to place the business elsewhere. The procedure they would then follow would be the same as for a new business.

ADDITIONAL ROLES FOR THE BROKER

The broker will check all the rates, terms and conditions to see that they are fair and will renegotiate with the insurer, if necessary. When satisfied, the broker will either write, phone or visit the client to discuss renewal.

4.6.4 INSURED'S PERSPECTIVE

Unfortunately, the man in the street tends to view insurance and insurers suspiciously. There are many reasons for this, but the main one is probably the poor service which they have received from all sectors of the market. Insured's often get sold cover that they do not need, or excesses and terms are imposed without the insured's knowledge.

The insured is also not without blame. The average person does not read his policy document when he receives it. An additional problem in South Africa is language. Most insurance contracts are in English or Afrikaans which, for the bulk of South Africans, is a second or third language at best. The level of language and style of language is also not user friendly. Legal jargon and insurance jargon can confuse a client.

The Consumer Protection Act seeks to address this.

ROLE OF THE INSURED

When the broker contacts or visits the client, it is up to the insured to advise the broker of any changes he requires in the cover such as:

- increased sums insured;
- extensions of cover required; or
- reductions in cover,

must all be advised by the client.

The broker can only advise the client on what is available. The broker should have checked on premiums with other companies. This information must be available to the client.

It is important to realise that the cheapest is not always the best. Insurance should be bought on the basis of:

- the best cover;
- terms and conditions available; and
- not necessarily the cheapest price.

When all the negotiations are finished, the broker will go back to the insurers and advise them of any changes required.

PAYMENT OF THE RENEWAL PREMIUM

If cover is to continue, the renewal premium should be paid by the client on, or before the renewal date of the policy. Today many clients pay by debit order on a monthly basis. These clients still have an annual anniversary where cover is reviewed.

REVISED SCHEDULES

Once the insurer has been advised of the changes in the risk details, and the policy has been amended, a revised schedule is then sent to the client.

This schedule must be sent if the terms and conditions of the policy have been amended. We said before that the policy is only evidence of the contract, but with changes in the contract, the schedule is proof of these changes. It is offer and acceptance again.

The revised schedule replaces the one in the policy document and details the cover for the next period of insurance.

CONCLUSION

The renewal cycle is a time-consuming and demanding job from both the insurer and the broker's point of view. It is however a very important job which needs skilled handling.

The one other process which must be carried out at renewal which we have not discussed, is the placing of the reinsurance. We deal with this aspect in the next chapter, which is devoted to the short term reinsurance practice.

Chapter Reference List

www.sasria.co.za

QUESTIONS ON CHAPTER 4

Revision questions

Work through these revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. How frequently are short term policies typically renewed?
2. What is the purpose of an advanced listing?
3. If the claims history of a particular person is very bad, can the insurer refuse to offer renewal of the policy?

Written questions

Attempt these questions after you have completed this chapter and its revision questions. Suggested answers to these questions are at the end of this book.

1. The underwriter tries to review at least three years claims experience. Explain why he does not use one years claims only.
2. Explain the steps necessary for the issuing of SASRIA, with particular reference to the effect late requests, or late issuing may have for the different parties.
3. Describe the survey process and what information can be obtained from it.

CHAPTER 5

SHORT TERM REINSURANCE PRACTICE

Learning Outcomes

When you have completed this chapter you should be able to:

- explain who the parties to reinsurers are;
- explain the difference between treaty and facultative reinsurance;
- describe the two types of proportional reinsurance;
- explain the advantages and disadvantages of quota share reinsurance;
- list the reasons for using quota share reinsurance;
- explain the operation of a surplus treaty;
- calculate a surplus treaty placement;
- explain non-proportional reinsurance;
- explain the operation of stop loss reinsurance;
- explain excess of loss and catastrophe excess of loss;
- explain what is meant by layering in excess of loss; and
- list the advantages of layered reinsurance.

As in the long term market, short term insurers use reinsurance to help eliminate large fluctuations in the underwriting results, and to allow them to accept larger risks than they would otherwise be able to. In the short term market, treaties are negotiated annually and there are various types of treaty which protect the company in different ways. In this chapter we are going to look at the different types of reinsurance used in short term.

When insurers place reinsurance business with a reinsurer they receive commission on the business placed. Generally the reinsurance commission is on a scale similar to that used by the insurer in paying a broker, although the amount could be higher, unless the business is seen by the reinsurer to be not that attractive.

5.1 REASONS FOR AND THE IMPORTANCE OF REINSURANCE

As the term indicates, "reinsurance" represents insurance of the insurer. It is defined as the shifting of risk or part of the risk by a primary insurer, called the "ceding company", to another company, called the "reinsurer". The part of the risk retained by the ceding company is called the "line or retention", and the portion reinsured is the "cession".

There are four main reasons why an insurer would want to transfer its business to a reinsurer:

- reinsurance enlarges the ceding company's financial capacity to accept risk;
- reinsurance stabilises profits and evens out losses;
- reinsurance reduces the ceding company's reserve requirements; and
- reinsurance offers a way for an insurer to retire from underwriting a given segment of its insurance business.

5.2 CLASSES OF REINSURANCE

There are two classes of reinsurance, namely proportional (participating) and non-proportional (non-participating) reinsurance. In proportional reinsurance, the reinsurer pays a fixed percentage of total claims. In the case of non-proportional reinsurance, the reinsurer pays only losses above an agreed amount. This amount varies, depending on the claim size.

5.3 PROPORTIONAL REINSURANCE

In proportional reinsurance the whole of a risk is split in some ratio between a cedant and the reinsurer:

- the cedant is the insurance company placing the risk; and
- the reinsurer is the company accepting that part of the risk.

The reinsured is bound to cede and the reinsurer bound to accept a pre-determined fixed share of each and every risk that falls within the scope of the treaty.

5.3.1 SHARING

In proportional reinsurance, the reinsurer has a specific fixed interest in a risk. In return for the proportion of the risk carried by the reinsurer, it will receive the same proportion of the original premium for the risk. When a claim occurs it will be shared between the cedant and the reinsurer in the same proportion again, irrespective of the size of the claim.

5.3.2 TREATY OR FACULTATIVE

Proportional reinsurance can be on a facultative or treaty basis.

- **Facultative** - each risk must be negotiated with the reinsurer separately; they can accept or decline the business.
- **Treaty** - all business which falls within certain parameters can be placed to the treaty without individual authorisation and the reinsurer must accept.

5.3.3 TREATY NEGOTIATIONS

In short term insurance it is normal for treaties to be negotiated each year. The negotiations normally take place around August or September, so that the new arrangements are in place by 1 January.

5.3.4 RECORDING

It may be that the cedant has to pass details of individual cessions to reinsurers. If this is the case then a bordereaux will list details of cessions and be passed to reinsurers regularly. This is an open treaty.

Most, however, operate on the basis of trust between cedant and reinsurer, where the reinsurer is never advised of the individual risks, but is merely paid over the premium. These are blind treaties.

5.3.5 TYPES OF PROPORTIONAL TREATY

There are many different types of treaty in short term insurance which include:

- quota share treaty; and
- surplus treaty.

5.4 QUOTA SHARE TREATY

A quota share treaty is an agreement whereby the cedant is bound to cede and the reinsurer is bound to accept a fixed proportion of every risk underwritten in the class of business to which the treaty relates.

NET RETENTION AND CEDED PERCENTAGES

Quota share treaties are normally expressed as percentage arrangements. For example, a 50%, or 80% Quota Share. The figure quoted is the amount passed to reinsurers, with the difference between 100% and that quoted being the net retention of the cedant.

EXAMPLE

80/20% Quota share treaty

Cession to treaty = 80%

Reinsured retention for his net account = 20%

Therefore R100 premium would be apportioned as follows:

- reinsurer receives $R100 \times 80\% = R80$
- reinsured retains $R100 \times 20\% = R20$

A R70 claim would be apportioned as follows:

- reinsurer pays $R70 \times 80\% = R56$
- reinsured retains $R70 \times 20\% = R14$

MONETARY LIMIT

Normally there is a maximum amount to which the reinsurer will accept, over this they are not committed. This could be expressed as:

- quota share treaty to accept 75% of every risk insured, not exceeding R1 000 000 on any one risk.

This limits the quota share reinsurers to an exposure of R750 000 for any one risk. The limit is R1 000 000 for any one risk which is the gross retention - cedant and reinsurer combined.

CEDANT RESTRICTION

It is normal for there to be a restriction on the quota share treaty which prevents the cedant from reinsuring its net retention in some other way.

In order to ensure that the cedant is prudent in their underwriting, it is necessary for them to have a financial interest in the risk. If the cedant has no financial exposure then it would probably not worry about the type of risk being accepted.

VERY IMPORTANT

One of the most important things to remember on quota share is that the ceding office must reinsure the agreed percentage of every risk falling within the scope of the treaty.

5.4.1 REASONS FOR QUOTA SHARE

Reasons for agreeing a quota share treaty may include:

- a new insurance company who needs a significant amount of reinsurance protection until it has gained experience and has established credibility. It may find this is the only type of reinsurance protection it can obtain;
- an existing insurer who branches into another field or for the new class of business it may look to a quota share treaty;
- following significant underwriting losses, an insurer may find this is the only type of treaty it can negotiate; or
- a company, which is a subsidiary of a larger insurance group, may use an inter-group quota share treaty to pass business may within the organisation.

ADVANTAGES

It is simple to operate from the cedant's point of view:

- there is no selection against the reinsurer as they get a share of all accounts;
- the commission rate is normally higher for the cedant; and
- the reinsurer will normally make more profit on a quota share treaty because it gets an equal share of good and bad business

DISADVANTAGES

- The cedant has no choice but to cede business which it could have normally kept for its own account.
- The cedant has to keep a set percentage, not an amount of any one risk. It therefore will have high exposures and low exposures, even though the net retention is a specific percentage.
- The cedant can only put those risks that fall within the parameters of the treaty to the treaty. It will therefore have risks which it cannot put to the treaty and necessitates the placing of facultative reinsurance.

EXAMPLE of a quota share treaty

You insure your house with a newly formed insurance company. In order to ensure that it does not incur too great a loss, the insurance company arranges a 70% quota share treaty. Your house is valued at R300 000 and the contents at R100 000. The total insured sum is R400 000.

The reinsurance company retains 70% of the total risk (= R280 000) and the insurance company retains 30% (= R120 000). The reinsurance company receives 70% of the premiums and the insurer receives 30%.

As you can see, everything is proportionally divided.

5.5 SURPLUS TREATY

A surplus treaty is an arrangement whereby only the amount of excess of the cedant's normal capacity for a particular risk is ceded to the reinsurers and not a fixed proportion of every risk.

When negotiating the treaty, the insurer will advise the reinsurer as to the pattern of acceptance limits it uses.

EXAMPLE

Type of risk	Line or Retention (R)
Office Block	100 000
Supermarket	80 000
Warehouse	60 000
Tannery	35 000

Woodworker	20 000
Plastics extruder	7 500

HAZARD

In this case, the peril insured against is fire. The hazards are factors that increase the risk of fire. The office block is obviously much less hazardous than the premises that carry out plastic extrusion work. The insurer can therefore keep a greater proportion of the office risk for its own retention.

MAXIMUM RETENTION

The underwriter will have guidelines for all the different types of risk and will have underwriting limits for each. These are the maximum retention that the insurer wants to hold. In the example of a pure particular risk, the underwriter may decide to keep even less than the maximum retention.

5.5.1 REINSURERS' SHARE

The reinsurers base the amount they wish to hold, on the net retention of the insurer. In the surplus treaty the reinsurers' retention is expressed as a number of lines, so you would see reference to a nine line treaty, or five line treaty.

This simply means that the reinsurer is taking nine times what the insurer is holding.

EXAMPLE

Five line treaty;

- cedant holds R250 000;
- reinsurer can take R1 250 000;
- gross retention which direct insurer can write to R1 500 000.

It is important to remember to add the reinsurers' and the direct insurer's share together in order to obtain the gross retention.

INSURER'S REDUCED RETENTION

When the direct insurer decreases his net retention, then the reinsurers' line would be based on this reduced retention and not the normal net retention.

EXAMPLE

Type of Risk	Normal Retention	Reduced Retention	Reinsurer retention	Gross Retention
Plastics risk	R7 500	R5 000	R25 000	R30 000

INCREASED CAPACITY

The insurer may still not have enough capacity to write risks he is offered. He can arrange a second surplus treaty which will normally have fewer lines, but when the first surplus is used up, it can be utilised to increase capacity.

EXCLUDED RISKS

The surplus treaty will have certain types of risk excluded, for example petrochemical risks could be excluded from a surplus treaty under fire insurance. It is normal to have a surplus treaty in the fire department of the commercial insurer.

EXAMPLE

An insurer has been offered a risk by a broker and needs to decide if it can hold it or if it must look for facultative reinsurance.

- The business of the client is manufacturers of Thatch Lapas;
- sum insured under fire section R1 000 000;
- insurer's net line R200 000;
- it is a nine line treaty.

Net	Reinsurer can hold nine lines	Gross Retention	Sum Insured
R200 000	R1 800 000	R2 000 000	R1 000 000

The underwriter can accept the risk.

What happens if the insurer decides to reduce their retention due to the poor housekeeping at the premises and the fact that the nearest fire brigade is 100km away?

Net	Reinsurer can hold nine lines	Gross Retention	Sum Insured
R75 000	R675 000	R750 000	R1 000 000

The underwriter is R250 000 short of the sum insured. He therefore must either place facultative, or if he has a second surplus treaty he may use it.

5.5.2 OTHER RISKS

When calculating the amount of his retention, the underwriter must also be aware of other risks (clients) insured with his company that may share the premises of the insured. This will affect the amount of his exposure and therefore the amount of reinsurance he needs.

He must also take into account the different types of cover the insured requires. If the insured has fire, loss of profits and office premises cover, they all have perils in common with one another, and the underwriter would normally add them together and use the accumulation to ascertain his exposure.

EXAMPLE

- Fire sum insured R1 000 000
- Loss of Profits sum insured R1 500 000
- Office premises sum insured R50 000
- Total sum insured R2 550 000
 - Net line R200 000
 - Nine line treaty R1 800 000
 - Gross capacity R2 000 000

Over-exposed by R550 000.

The insurer may have an increase in capacity when there is loss of profits cover. The net retention might then be increased by up to 50%. Therefore, in the example above, the capacity would be:

- net line R200 000;
- 50% increase - R100 000;
- new net line R300 000;
- nine line treaty R2 700 000;
- gross capacity R3 000 000.

This is not a market standard but varies with individual companies and is dependent upon the terms they negotiate with reinsurers.

5.5.3 CONCLUSION

In concluding it is important to note the following facts:

- the second surplus is normally only used when the first surplus has been exhausted;
- a cedant will establish treaties with enough capacity to cope with the vast majority of its risks;
- the amount of retention for the different classes of risk in an account vary;
- each underlying risk is unique and there will be vast differences in sums insured;
- the surplus treaty is very flexible in that the underwriter can keep up to a maximum, but can keep less if required; and
- as with any reinsurance treaty the underwriter should use it wisely and not expose it to poor quality risks. If he does so and his treaties perform badly he could find himself with reduced capacity or unfavourable commission terms, the following year.

EXAMPLE of a surplus treaty

Assume that an insurer's line or net retention is R60 000. If a nine-line treaty can be arranged with a reinsurer, the total amount that can be accepted will be R600 000 (R60 000 by the insurer and R540 000 by the reinsurer).

If we use the previous example of your house valued at R300 000, the insurance company will retain R60 000 on your house and R240 000 will be reinsured. The reinsurer does not take nine times the insurer's share - this is the maximum it will take. If the amount is smaller, the insurer can still retain its share and the balance goes to the treaty.

5.6 NON-PROPORTIONAL REINSURANCE

In non-proportional reinsurance the degree of exposure, the premium and the amount of any loss are not shared proportionately, hence the term non-proportional.

The cedant will underwrite its retention as a form of first-loss insurance. It will bear losses up to a certain figure. Reinsurers will deal with the balance of any loss above the figure, usually with an upper limit for their own involvement.

INCREASED USE

Non-proportional covers have grown in popularity in recent years because:

- they are simple to operate;
- they are relatively inexpensive to purchase; and
- they allow the reinsurer to charge a specific rate rather than having to take a proportion of the cedant's original premium.

This reinsurance may be used to protect the insurer against:

- the effect of individual large losses;
- accumulation of losses arising from a single event; and
- large losses on a whole account or class of business.

They constitute a vital part of the insurer's reinsurance programme.

TYPES OF NON-PROPORTIONAL REINSURANCE

There are different types of non-proportional reinsurance and they can be facultative or treaty and are:

- stop loss;
- excess of loss; or
- catastrophe excess of loss.

5.6.1 STOP LOSS REINSURANCE

STOP LOSS

In this type of reinsurance, an insurer tries to protect a certain class of business from severe fluctuations in results, where losses exceed premiums by an unacceptable level in any one period.

This form of reinsurance is generally used for specific classes of insurance, such as hail, which vary greatly from year to year.

EXAMPLE

The insurer has a stop loss treaty for 90% of any excess of claims over 70% of premium in any one year up to 100% then,

- the insurer has R20 000 000 premium income for 2010;
- the losses are R18 000 000.

What will the stop loss pay, if anything?

- 70% of the premium = R14 000 000
- claims = R18 000 000
- therefore the claims have exceeded the limit by R4 000 000;
- the stop loss will pay 90% of this excess amount;
- the treaty will pay R3 600 000.

IMPORTANT FACT

To encourage insurers to underwrite properly and to prevent the taking on of poor quality business, stop loss should never be written to 100% of the excess losses. The insurer still has a financial interest to ensure that the treaty is not over exposed.

PREMIUM BASED

As the cover is premium-based, the insurer will have to give the reinsurer a fairly accurate estimate of the premium it will write in the forthcoming year.

To protect themselves, however, the reinsurer will normally put an upper limit on the amount they wish to reinsure.

For this reason an insurer will arrange layers of stop loss cover with,

- first layer to pay the amount by which the aggregate loss ratio exceeds 90%, subject to a limit of 20% of the net premium income, or R60 000 000, whichever is the lesser;
- second layer stop loss cover by which the aggregate loss ratio exceeds 110%, subject to a limit of 30% of the net premium income, or R90 000 000, whichever is the lesser; and
- estimated net premium income for the year is R250 000 000.

In other words:

Estimated Premium	First layer	Second layer
R250 000 000	20% = R50 000 000 or R60 000 000 whichever is the lesser	30% = R75 000 000 or R90 000 000 whichever is the lesser

With these limits therefore the insurer is protected if his premium income from this class of business should go up as high as R30 000 000 and the reinsurer is protected as he knows his maximum losses.

PERFECT REINSURANCE

Stop loss is sometimes referred to as the perfect reinsurance. It protects the cedant from all losses great and small from whatever source, because all claims are incorporated in the loss ratio.

However, even with the restrictions we have mentioned above, reinsurers are reluctant to offer stop loss protection. When it is given, it is an expensive form, resulting in a large transfer of premium if it is to give the cedant the cover it requires.

5.6.2 EXCESS OF LOSS

We saw that Stop Loss reinsurance dealt with classes of insurance, whereas excess of loss is for individual risks.

MAXIMUM AMOUNT

Here the insurer is concerned with the maximum amount he wishes to pay in the event of a single risk and a single claim. When the claim exceeds this amount, the reinsurer will pay the excess amount. For large sums insured the cover can be arranged on a layered basis, with various reinsurers covering the different layers.

EXAMPLE

The underwriter is asked to cover a fidelity guarantee risk with a sum insured of R10 000 000. Fidelity guarantee insurance is a contract indemnifying employers against pecuniary losses on account of forgery, defalcation and fraudulent conversion by employees. The underwriter decides:

- he only wants to retain R1 000 000 for his net account. This is because his head office have set this as the maximum exposure they wish due to the high hazard involved;
- he therefore must place R9 000 000 on excess of loss basis. He has no treaty and reinsurers are not prepared to do the reinsurance on a proportional basis;
- he manages to place the layers as follows, at the premiums reflected:

Layer	Sum Insured	Premium
Total Exposure	R10 000 000	R1 000 000
Deductible (net to insurer) first layer	R1 000 000	balance left after reinsurers paid = R525 000
second layer	R2 500 000	R200 000
third layer	R3 000 000	R155 000
fourth layer	R3 500 000	R120 000

PREMIUM

The premium varies for each layer as the reinsurers participating in the higher levels will only have to pay, when a very large loss happens.

5.6.3 CATASTROPHE EXCESS OF LOSS

Excess of Loss can be a treaty or a facultative form of reinsurance. It can be arranged as a treaty for individual risks, or it can be arranged to cover a catastrophe type risk.

The Natal floods that occur from time to time are an example of a catastrophe. Insurers accept risks on the basis of individual events happening. Occasionally things go wrong and a natural disaster causes havoc. The losses from one disastrous flood, or earthquake, or like event could cause serious financial difficulties for a short term insurer. To protect themselves they therefore arrange catastrophe treaties.

LAYERS

The cover would again be on a layered basis. The two major considerations when arranging the cover are:

- at what point will the reinsurance cover begin; and
- how far will the protection go?

The amount kept by the cedant before excess of loss is called the priority or the deductible. The amount carried by reinsurers is sometimes called the security.

STARTING LEVEL

The insurer must decide at what point they will need the cover to begin. They may feel that they could afford to pay as much as five times the net line before they would require catastrophe cover. Therefore if they have a net line of R1 000 000 they may feel that losses up to an amount of R5 000 000 would be okay. They now have a starting point for their catastrophe cover.

MAXIMUM LOSSES LIKELY

They must decide what the worst case scenario would be. This is quite difficult, but it is something the insurer has to judge from;

- past experience;
- changing weather patterns;
- population growth; and
- the increase in housing density.

We will assume that they decide that on 100 times their net retention. They therefore need to arrange catastrophe excess of loss up to a limit of R100 000 000. In diagrammatic format:

Security	R95 000 000
Deductible	R5 000 000

In Practice

In practice it would be on a layered basis.

Fourth layer - R30 000 000 excess R70 000 000
Third layer - R40 000 000 excess R30 000 000
Second layer - R20 000 000 excess R10 000 000
First layer R5 000 000 excess R5 000 000
Deductible R5 000 000

LAYER INVOLVEMENT

The first layer therefore only becomes involved when a catastrophe exceeds R5 000 000 and so on through the different layers. The final layer only becomes involved when claims have exceeded R70 000 000.

Advantages of layering

This process of splitting into layers has advantages for both the cedant and the reinsurer, such as:

- reinsurers are much happier with a defined range of exposure;
- cedants are more likely to be able to place the cover;
- as the higher layers are more remote from losses then the premium for the cover will be cheaper; and

- for the same reason, reinsurers are able to accept larger amounts in these higher layers.

CONCLUSION

Reinsurance is a very important factor for the underwriter to consider. It can be the difference between financial soundness or liquidation for his organisation and in turn, his own employment.

QUESTIONS ON CHAPTER 5

Revision questions

Work through these revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. Is a quota share treaty a proportional treaty?
2. If an insurer arranges a nine line surplus treaty and its own retention is R5 000 000, up to how much cover can it write under the treaty?
3. What kind of reinsurance arrangement is sometimes referred to as the perfect reinsurance?
4. What are the advantages of layering in reinsurance arrangements?

Written questions

Attempt these questions after you have completed this chapter and its revision questions. Suggested answers to these questions are at the end of this book.

1. Explain the difference between facultative and treaty reinsurance.
2. Explain the advantages of layered reinsurance.
3. An underwriter is asked to underwrite a plastic extrusion plant. The sums insured are:
 - Fire R10 000 000
 - Loss of Profits R15 000 000

She has a net line of R1 000 000 and can take an additional 50% if the risk involves Fire and Loss of Profits. She has a nine line surplus treaty.

Calculate what her gross retention is and what facultative reinsurance she will have to place, if any.

4. Explain the reasons for using a quota share treaty.

CHAPTER 6

CLAIMS PROCEDURES

Learning Outcomes

When you have completed this chapter you should be able to:

- list the three basic requirements for a claim to be valid;
- define the concept of proximate cause;
- explain the operation of proximate cause;
- explain who the burden of proof rests with under differing circumstances;
- define what prescription is;
- describe the different prescription periods;
- describe the four basic methods of settling a claim;
- explain the different methods of dispute resolution in claims;
- define what an ex-gratia payment is and explain why subrogation and contribution do not apply;
- define average, why it applies and demonstrate the use of the average calculation; and
- describe the steps which are taken or can be taken by an insurer after a loss has been settled.

6.1 NOTIFICATION OF A CLAIM

Almost all policies require the insurer to be notified immediately of an event that could give rise to a claim. The insured frequently have to provide full particulars within a stipulated period, say seven, fifteen or thirty days. Notifying the insurer as soon as possible is essential so that a full investigation of the circumstances can be initiated. If this notification is tardy, evidence may become unavailable, or witnesses' recall of the incident may become muddled. It is usually in the insured's interest to obtain assistance from the insurer's claims officials or of independent loss adjusters to help prevent additional loss and to speed up the start of repairs. Although notification should be in writing, this requirement may be waived and the insurer will act on a verbal communication.

A claim form is usually sent to the claimant for completion to elicit pertinent information regarding the insured, the place of loss, the nature of the loss, the time of the loss, a description of the property and its value at the time, and particulars of other insurance policies (except life policies) that cover the insured event.

6.2 CLAIMS DEPARTMENT

We like to say that "claims are the shop window of insurance". However, this is also the area where disagreement and controversy arises most often. When a claim arises the client has possibly suffered the trauma of an accident, or burglary and they need empathetic treatment and efficient service. A claims negotiator must be able to handle the client's claims in a sensitive and professional manner.

6.2.1 CLIENTS' RESPONSIBILITY

Many clients do not read the policy documentation sent to them and in some instances, clients do not understand the policy wording. Claims settlement is often delayed when supporting documentation is not forthcoming but this is can be overcome by the appointment of an assessor who will be willing to assist the client by obtaining the necessary quotations.

6.2.2 CLAIMS NOTIFICATION

A claim is usually notified to insurers either by fax, telephone, or via e-mail. Normally, the client will notify their broker, if any, and the broker will then liaise with the insurance company.

Most insurers insist that notification of a claim should take place within a set number of days or specified period after the incident taking place. The actual period for notification varies according to the class of insurance and from insurer to insurer. This is explained in the prescription period later on.

Usually, the claims negotiator will register a claim against the insured's policy on their in-house computer system or complete a telephonic advice of a claim, which is used as a reference by the claims negotiator. Some Brokers still use a claim form which will be sent to the insured. Details will include:

- full details of the insured and policy number;

-
- date of the loss;
 - full details of how and where the loss occurred;
 - the damage caused;
 - was any other party involved;
 - where the claim form is to be sent; and
 - in the case of a motor accident, the full details of the driver, car and where the vehicle can be inspected.

The form will also have a space to record the date of the advice, and the name of the negotiator who took down the details. The claims negotiator uses this information to help decide whether or not a claim is valid. There are really only three questions that need answering though. We look at them in the next section.

6.3 VALID CLAIM

6.3.1 DETERMINING THE VALIDITY OF A CLAIM

The claims negotiator can decide whether a claim is valid by asking:

- is there a policy in force that covers the item lost or damaged?
- is the proximate cause an insured peril?
- have the policy terms and conditions been complied with?

POLICY IN FORCE

When a client reports a claim to either his insurer or broker, the first step in the process is for the insurer or broker to check that a policy is in force and that the premium is paid.

The claims negotiator will then check on:

- insured's details;
- cover details;
- terms and conditions which apply; and
- excess information.

PROXIMATE CAUSE

This is a fundamental principle in short term insurance. In an insurance contract it is necessary to state the perils that are covered or excluded, so that all parties to the contract know exactly what is covered and what is not.

It is necessary therefore to examine the cause of loss in some detail, because the insurer is liable only for losses proximately caused by an insured peril.

LEGAL DEFINITION

The legal case which is used as a standard on proximate cause is *Pawsey v Scottish Union and National (1908)* where the judge expressed this as follows:

Proximate cause means the active, efficient cause that sets in motion a train of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

DOMINANT CAUSE

The proximate cause is not necessarily the first or last cause, it is the dominant cause. This means that there is a direct link between the proximate cause and the result, with the power of the cause being such that at each stage in the chain of events, the following event can be predicted until the final result takes place.

The concept of proximate cause is not without contention and there have been many legal cases to determine the cause of events. The following examples may illustrate this point.

Gaskarth v Law Union (1876)

- There was a fire at the premises.
- A wall was left standing and was in sound condition.
- A subsequent gale force wind blew the wall down.

The court held that the damage was not caused by fire but by the subsequent gale force wind.

Isitt v Railway Passengers Assurance Co (1899)

- The insured fell and dislocated his shoulder;
- he was confined to his room and reduced to a condition of debility and unusual susceptibility to cold;
- he caught a cold, which developed into pneumonia and died a month later; and

- the court held that the effects of injury caused by the accident were the cause of death.

The court stated that the proper direction to a jury would be:

"Do you think that the circumstances leading up to the death, including the cold which caused the pneumonia, were the reasonable and natural consequences of the injury and of the conditions under which the assured had to live in consequence of the injury?"

If you find that no foreign cause intervened and that nothing happened except what was reasonably to be expected under the circumstances, you may have to find that death resulted "from the effects of the injury" within the meaning of the policy."

Original Peril Still Operating

The crucial factor therefore appears to be whether or not the original peril was still operating and was the dominant cause of the loss. In the Gaskarth case the wall was secure after the fire. In the Isitt case the insured was ill in bed because of the accident and it was because of the fact that he was in bed that he developed pneumonia which killed him.

Points to remember

In the case of *Alston v Marine & Trade (1964)* the court stated that the cause would be regarded as superseding where:

- its intervention brings about harm different in kind from that which would otherwise have resulted;
- the results after the event appear to be extraordinary rather than normal in the light of the circumstances at the time of its operation;
- it operates independently of any situation created by the original cause and is not an act done as a normal response to such a situation; and
- it is due to the act of either a third person or the victim.

Burden of Proof

- The insured must prove that the loss was caused by a peril against which he holds insurance.
- If the insurer wishes to claim that an exception operates it is up to the insurer to supply the proof.

-
- If the insured wishes to claim that only part of the loss comes within the exception, the burden of proof then reverts to him.

Rules for the Application of Proximate Cause

- The risk insured against must actually take place.
- Further damage to the subject-matter due to attempts to minimise a loss already taking place, is covered.
- No new act must intervene - *Novus actus interveniens*.
- Last straw cases. In the instances where the original peril has meant that loss was more or less inevitable, the original cause will be the proximate cause even though the last straw comes from another source.

Conclusion

The decision as to whether or not the proximate cause is an insured peril, is an extremely important one in short term insurance. Wrong decisions can cost the company money, even if the mistake is discovered later, it can be very difficult to reverse.

TERMS AND CONDITIONS

Compliance with the terms and conditions of the policy is not always easily verified at the first intimation of the loss. The claims negotiator's first priority is to establish:

- that there is a policy covering the subject of the loss; and
- the cause of the loss is an insured peril.

The claims negotiator will then, depending on the size of the loss, appoint a loss adjuster, or request a fully completed claim form and supporting documentation.

LOSS ADJUSTER

The insurer will appoint a loss adjuster for claims over a specific amount. This monetary level will normally be decided by the management of the company. When a loss adjuster is appointed, he will:

- require full details of the cover under the policy;
- contact the client and arrange to meet him;
- investigate the circumstances of the loss and it is here that he will ensure that the terms and conditions have been complied with;
- organise quotations and liaise with repairers; and

- send a final report to the insurer, who will then accept, or reject liability for the loss.

If no loss adjuster is appointed, then the claims clerk must check all the documentation to ensure that he has enough information to decide on the company's liability.

CONCLUSION

Once these three points have been considered the claim can be processed and settled. The process is to establish the insurer's liability. To settle the claim, however, it is important that the client supply all documentation required by the insurer and in the next section we describe the process of indemnifying the insured.

6.4 INDEMNITY

6.4.1 FINANCIAL LOSS

Insurance covers the amount of the financial loss that the insured suffers when there is an insured event. The insured pays a premium based on the amount of the financial risk. The amount of this financial risk is the sum insured or limit of indemnity depending on the class of business.

- Sum insured is used when the amount of any loss that could occur is already known, for example, homeowners insurance.
- Limit of indemnity is used when the amount of the loss will only be known after the event, for example, legal liability insurance.

6.4.2 INDEMNITY

The purpose of short term insurance is to put the insured back in the same financial position he was in prior to the loss.

The insured cannot make a profit if he is adequately insured. This is called indemnity.

6.4.3 INDEMNITY VERSUS COMPENSATION

In short term insurance not all policies are policies of indemnity. It is relatively easy to put a price on a diamond ring, a house, or motor car. Even in liability cover the amount of the award made by the court is the measure of indemnity. But it is impossible to put a price on human life and limb.

This is why the Personal Accident policy is a policy of compensation and not indemnity. In this case, the sum insured is agreed at the outset and, in the event of an accident or death from accidental means, this is the amount that will be paid to the insured.

6.4.4 UNDERINSURANCE

To indemnify the insured, the sum insured on the policy must be adequate, or he is not paying his fair share into the premium pool. If the client is underinsured average will be applied when a loss occurs. The insured is considered his own insurer for that part of the risk that is underinsured.

AVERAGE

The premium that the insured pays is based on the amount of financial risk or value at risk.

What happens if the insured does not advise the insurer of the correct value at risk?

If he says that it is lower than it should be, he will not be paying enough premium. When this happens we say that the insured is under insured. If there is a loss then we apply what is called average.

Average Applied

Average is applied using the following formula:

$$\frac{\text{Sum Insured}}{\text{Value at risk}} \times \text{Loss} = \text{Settlement}$$

PRACTICAL EXAMPLE

A practical example of the application of average is:

- Tom has a house and the sum insured is R2 000 000;
- the cost to rebuild the house following a fire is R3 000 000;
- there is a fire and the cost of repairs is R600 000.
- Settlement is -

$$\frac{\text{R2 000 000}}{\text{R3 000 000}} \times \text{R600 000} = \text{R400 000}$$

Average applies only to policies of indemnity. It is important to note that average does not apply to policies of compensation.

6.4.5 BETTERMENT

It sometimes happens that the insured is in a better position after a loss than he was prior to the loss. An example would be if a set of partly worn tyres is stolen from the insured's car, and insurers replace these with brand new tyres. This is known as betterment. In conforming with the principle of indemnity, the Insured might be asked to contribute a proportion of the cost of replacement.

This practice does vary from insurer to insurer, as many householder's policies are now issued on new replacement value. It is therefore very important to insure for the full replacement cost.

6.5 METHODS OF SETTLING CLAIMS

6.5.1 FOUR METHODS

The four basic methods of settling claims are:

- cash settlement;
- replacement;
- repair; or
- reinstatement.

The method chosen varies between classes and individual claims. The one chosen should be the one which is best for both the client and the insurance company.

CASH SETTLEMENT

The preferred method of settlement is by an EFT but a cheque may still be issued in some instances.

REPLACEMENT

Insurers can often obtain better replacement prices than a client can. This is simply because of the volume of business transacted by the insurer. It is therefore sometimes better for the insurer to replace the lost or damaged article. With jewellery and electrical goods insurers can often get discounts of up to 30%.

With glass claims this is the usual method of settlement.

REPAIR

This is where the insurer has the article repaired and settles the account.

This is the most common method of settlement in motor insurance. The client pays the repairer his excess and the insurance company settles the remainder of the account.

REINSTATEMENT

This is usually used in settling fire claims.

After a fire, the building is rebuilt on the premises, or if necessary at alternative premises. The new building is built to the same specifications as the building which was destroyed and it is therefore as far as possible the same.

CONCLUSION

With the different methods of settling a claim there is no hard and fast rule as to which method should be used for a particular class of insurance. It has become common practice to use one method over another depending on the circumstances.

The main aim should be to ensure that the client and the insurer should each be reasonably satisfied at the end of the negotiations, without either party being allowed to prejudice the settlement.

Remember that one unhappy client will give you 100 times the publicity that one happy client will.

6.6 CLAIMS DISPUTES

When handling claims, disagreements can happen. Reasons for these disagreements include:

- the insurer may allege that the contract was breached;
- the insurer may say that the loss is not covered; or
- the amount of the settlement may be a source of disagreement.

6.6.1 RESOLUTION OF DISPUTES

Disputes may be resolved in three different ways. These are:

- negotiation;
- litigation; or
- arbitration.

NEGOTIATION

Negotiation is the most common way of handling disputed claims. This process will normally involve the:

- broker,
- insured; and
- insurer.

Discussions are held until an amicable agreement is reached.

LITIGATION

Litigation involves legal proceedings and is costly. It should be viewed as a last resort. If an insurer repudiates liability however, it may be the only option open to the insured.

What do we mean when we say the insurer repudiates liability? This is when an insurer tells the insured that the loss is not covered, because the terms and conditions have not been complied with. It is not a repudiation of liability if the item is not on the policy. This would simply be no cover. This causes a great deal of confusion for claims clerks.

If the insurer repudiates liability, an insured normally has three months in which to start legal proceedings against the insurer. In the standard policy wording the period is 6 months.

Insurers do not go to court lightly and will usually only use this route where the amount is substantial or where there is a legal precedent at issue.

In the case of a claim from a third party, insurers will take over any defence and handle in the insured's name by means of subrogation.

ARBITRATION

Arbitration is a process whereby an independent party is appointed to hear both sides of the argument. Arbitration can only be used to resolve problems of quantum, which is the amount of the settlement.

The arbitrator should be someone who is acceptable to both parties. If the process has been conducted in a legally recognised way, the arbitrator can give a decision which will be binding on both parties. There is no specific person who is an arbitrator. It could be a person with a legal background or the Short Term Ombudsman and it must be someone whom both groups trust and respect.

The hearing is not conducted in a court of law, but the arbitrator can get advice on any points of law which may come up.

6.6.2 EX-GRATIA PAYMENTS

In insurance there are times when a claim is not covered for technical reasons, or where there has been a genuine misunderstanding. If this is unfair to the insured, the company will pay either the full loss or part of it. This is called an ex-gratia payment.

This is normally a decision which is made at management level, and is often for business reasons.

EXAMPLE

Perhaps the insured has a large amount of business with the company and he will move the business if the claim is not paid. Imagine a client who has a premium of R500 000 per annum. If you repudiate liability for a claim of R1 000 he may just move the business. This may seem unfair but it is a business decision.

An ex-gratia payment is not an indemnity payment and therefore subrogation and contribution cannot be applied.

An ex-gratia payment for one claim does not mean that the same loss will be covered in future. An ex-gratia payment is made without prejudice by insurers and therefore does not affect future claims payments.

SHORT TERM OMBUDSMAN

With the setting up of this office, in many cases the claims negotiation process can be handled in a speedier manner, thereby avoiding a complex legal process with the Ombud effectively overseeing the arbitration process.

6.7 PRESCRIPTION PERIOD

There are various prescription periods to be understood.

NOTIFICATION

Short term policies require prompt notification of any occurrence likely to give rise to a claim. Sometimes this must be within a set time period; other policies say as soon as reasonably possible but then there must be a good reason for the delay.

This is a condition precedent to liability. If not met, insurers are entitled to repudiate the claim.

Imagine if the insured advised insurers of a burglary one year after the loss. The cost of replacement would probably be higher, and the insurer has not had the opportunity to:

- investigate the loss;
- ask for risk improvements; or
- take other steps.

If it were a liability claim, insurers would lose the opportunity to investigate the circumstances, and perhaps get witness statements.

FINAL SUBMISSION OF CLAIM

There is a limited period for the final submission of the claim. In the standard policy wording, this is two years, but some policies have shorter periods.

LEGAL PROCEEDINGS

If the claim is repudiated by insurers, the insured has a limited period in which to institute legal proceedings against them.

RECOVERY FROM THIRD PARTIES

Apart from the policy prescription periods, there are statutory prescription periods that apply particularly to recoveries from third parties. The normal prescription period is three years.

GOVERNMENT CLAIMS

In claims involving the SANDF, SAPS, and Government and semi-government organisations, prompt notification is required of the intention to claim against them. Expert legal advice should be obtained, as prescription periods vary.

6.8 POST LOSS ACTION

6.8.1 AFTER THE LOSS

When a claim has been settled the claims department must notify the underwriting department to ensure that:

- cover is continued; or
- the premium is adjusted.

When a claim has been settled, the claims negotiator will notify the underwriting department who will then take certain steps. These could involve:

- a post loss survey;
- a reduction or deletion of a no claims bonus or claim free group;
- reinstatement of the sum insured; or
- deletion of the lost item.

These issues are the focus below.

POST LOSS SURVEY

We have mentioned in previous chapters the role of the surveyor. Before new business is taken on a surveyor may be sent out to check protections and risk details. This is particularly true in commercial insurance. In recent years however it has become more common for insurers to survey personal lines.

This is not surprising if one looks at the high sums insured and the potential for losses in personal lines.

Following a claim an insurer may decide to carry out a survey, particularly if a loss adjuster advised that there was a problem area and if no survey had been carried out, when the policy was first taken up by the insured.

Based on this survey, risk improvements could be called for, to prevent further losses.

REDUCTION OF NO CLAIM BONUSES

For certain classes of insurance, a no claims bonus (NCB) or claim free group (CFG) is allowed. This means the insured receives a discount for the number of years without a claim. When a claim occurs, the NCB or CFG must be reduced or disallowed.

It is therefore important that the claims clerk advises the underwriter, who will reduce the NCB or CFG from renewal if an annual policy or from the month following the claim in a monthly policy. The premium charged will normally increase.

The recent trend has been away from no claim bonuses to a system of refunding a percentage of the premiums paid if no claims are submitted.

While this could be seen in a more positive light by clients, there is also some opinion that this is not as favourable financially as the no claim bonus system.

REINSTATEMENT OF THE SUM INSURED

When the insured suffers a loss, the sum insured is reduced by that amount. In some classes of insurance if cover is to continue, the sum insured must be reinstated and put back at the amount it was before the loss.

An example helps explain this process.

EXAMPLE

- Ted has a café and he has R200 000 theft cover.
- On Tuesday night thieves broke into the shop and stole R150 000 worth of goods. He put in new locks and advised his insurer of the loss.
- On Wednesday night the shop was broken into again and they stole R10 000 worth of goods.
- Ted has contacted his broker because he is worried that the second loss won't be covered fully because his sum insured was nearly used up the first time.

Ted's broker is able to reassure Ted that everything is okay. There is automatic reinstatement on his policy. So when the first loss happened, the sum insured was reinstated back to the original amount.

Ted will now have to pay a pro rata premium from the date of loss up to the renewal date on the policy.

Calculation to reinstate the sum insured

The mathematics of it are as follows:

Sum Insured	R200 000
Loss no 1	R150 000
Balance left of sum insured	R50 000

Pro rata premium must be paid on R150 000 to put the sum insured back to R200 000, and again on the second loss of R10 000.

Pro rata means a corresponding portion of the premium, calculated on the amount of the loss and the period from the date of the loss until next renewal date. For a monthly policy, this might be a matter of only a few days, and insurers would probably waive the additional premium.

DELETION OF AN ITEM

When the insurer has paid out for a total loss of an item, it must be deleted from the policy.

- This often happens under a motor policy where a vehicle is a write off, uneconomical to repair or beyond repair.
- In all risks insurance, an article which is lost or stolen would need to be deleted.

Items are normally only deleted from sections where they are specified in the policy.

CONCLUSION

From this section, it is noted that there must be a continual interaction between the claims and underwriting departments in a short term insurance company. Each department relies heavily on the other so that they can function efficiently and effectively.

We said that the claims department is the shop window of the company but, if this is so, the underwriting department must ensure that the policy is issued correctly and efficiently. If this does not happen the claims department will be unable to process claims correctly.

QUESTIONS ON CHAPTER 6

Revision questions

Work through these revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. What are the three important questions that need to be asked by the claims negotiator when evaluating a claim?
2. Define indemnity in insurance in your own words.
3. Name the four different methods that an insurer can use to settle claims under the principle of indemnity.
4. When would litigation be a feasible option for an insurer to settle claims disputes?
5. What is the purpose of a post-loss survey?

Written questions

Attempt these questions after you have completed this chapter and its revision questions. Suggested answers to these questions are at the end of this book.

1. Define proximate cause and explain its operation.
2. Describe the four methods of settling a claim and give an example of when each is most likely to be used.
3. Explain why subrogation and contribution do not apply to an ex-gratia payment.
4. Describe the various steps an insurer can take following a loss.
5. Explain the concept of average and give an example of how it is applied.