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Insurance, legal and regulatory

IF1

2022
STUDY TEXT

Insurance, legal and regulatory

IF1: 2022 Study text

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Using this study text

Welcome to the **IF1: Insurance, legal and regulatory** study text which is designed to support the IF1 syllabus, a copy of which is included in the next section.

Please note that in order to create a logical and effective study path, the contents of this study text do not necessarily mirror the order of the syllabus, which forms the basis of the assessment. To assist you in your learning we have followed the syllabus with a table that indicates where each syllabus learning outcome is covered in the study text. These are also listed on the first page of each chapter.

Each chapter also has stated learning objectives to help you further assess your progress in understanding the topics covered.

Contained within the study text are a number of features which we hope will enhance your study:

Activities: reinforce learning through practical exercises.

Be aware: draws attention to important points or areas that may need further clarification or consideration.

Case studies: short scenarios that will test your understanding of what you have read in a real life context.

Consider this: stimulating thought around points made in the text for which there is no absolute right or wrong answer.

Examples: provide practical illustrations of points made in the text.

In-text questions: to test your recall of topics.

Key points: act as a memory jogger at the end of each chapter.

Key terms: introduce the key concepts and specialist terms covered in each chapter.

Refer to:

Refer to: extracts from other CII study texts, which provide valuable information on or background to the topic. The sections referred to are available for you to view and download on RevisionMate.

Reinforce: encourages you to revisit a point previously learned in the course to embed understanding.

Sources/quotations: cast further light on the subject from industry sources.

On the Web: introduce you to other information sources that help to supplement the text.

At the end of every chapter there is also a set of self-test questions that you should use to check your knowledge and understanding of what you have just studied. Compare your answers with those given at the back of the book.

By referring back to the learning outcomes after you have completed your study of each chapter and attempting the end of chapter self-test questions, you will be able to assess your progress and identify any areas that you may need to revisit.

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Note
Website references correct at the time of publication.

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Examination syllabus

Chartered Insurance Institute

Insurance, legal and regulatory

Objective

To provide knowledge and understanding of the basic principles of insurance, including the main legal principles related to insurance contracts, the main regulatory principles related to insurance business and the key elements to protect consumers.

Summary of learning outcomes		Number of questions in the examination*
1.	Understand the nature and main features of risk within the insurance environment.	9
2.	Know how to apply the main features of risk and risk management to a given set of circumstances.	2
3.	Understand the main features of insurance.	8
4.	Know the structure and main features of the insurance market.	14
5.	Understand contract and agency.	9
6.	Understand the principle of insurable interest.	5
7.	Understand the principle of good faith.	11
8.	Understand the doctrine of proximate cause and its application to non-complex claims.	2
9.	Understand the principle of indemnity and how this is applied to contracts of insurance.	7
10.	Understand the principles of contribution and subrogation.	4
11.	Understand the main regulatory and legal requirements applicable to the transaction of insurance business.	15
12.	Understand consumer protection and dispute resolution.	6
13.	Know the main methods of preventing, handling and resolving consumer complaints.	4
14.	Understand the CII Code of Ethics and be able to apply the principles to non-complex scenarios.	4

* The test specification has an in-built element of flexibility. It is designed to be used as a guide for study and is not a statement of actual number of questions that will appear in every exam. However, the number of questions testing each learning outcome will generally be within the range plus or minus 2 of the number indicated.

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Important notes

- Method of assessment: 100 multiple choice questions (MCQs). 2 hours are allowed for this examination.
- This syllabus will be examined from 1 January 2022 until 31 December 2022.
- Candidates will be examined on the basis of English law and practice unless otherwise stated.
- Candidates should refer to the CII website for the latest information on changes to law and practice and when they will be examined:

1. Visit *www.cii.co.uk/qualifications*
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1. Understand the nature and main features of risk within the insurance environment.

1.1 Describe the concepts of risk and risk perception.
1.2 Explain the risk management function and process.
1.3 Describe the various categories of risk.
1.4 Explain the types of risk that can be insured and the types of risk that cannot.
1.5 Describe the components of risk.
1.6 Understand the relationship between frequency and severity and how they are applied.
1.7 Explain the difference between a peril and hazard as they relate to insurance.

2. Know how to apply the main features of risk and risk management to a given set of circumstances.

2.1 Apply the main features of risk and risk management to different sets of circumstances/scenarios.

3. Understand the main features of insurance.

3.1 Explain the need for insurance.
3.2 Explain the basis of insurance as a risk transfer mechanism.
3.3 Describe how insurance benefits policyholders and society in general.
3.4 Explain the term coinsurance and how this is used in two distinct ways in the insurance market.
3.5 Describe what is meant by dual insurance and self-insurance.
3.6 Describe the main classes of insurance.
3.7 Explain the purpose of Insurance Premium Tax.
3.8 State the current rates of Insurance Premium Tax and how it is collected.

4. Know the structure and main features of the insurance market.

4.1 Describe the structure of the insurance market and the five main groups of people.
4.2 Describe the main categories of insurer in terms of ownership.
4.3 Explain the structure of the Lloyd's market and main features.
4.4 Describe the London Market.
4.5 Describe the distribution channels used for the selling of insurance.
4.6 Explain the purpose of reinsurance.
4.7 Describe the key roles of professionals in insurance.
4.8 Explain the main functions of the principal market organisations.

5. Understand contract and agency.

5.1 Describe the essential elements of a valid contract.
5.2 Explain conditional and unconditional acceptance of a contract.
5.3 Describe consideration which supports the contract.
5.4 Explain how contracts can be cancelled or terminated.
5.5 Describe methods of creating an agent/principal relationship.
5.6 Describe the duties of an agent and the duties of a principal.
5.7 Explain the consequences of an agent's actions on the principal.
5.8 Describe what should be included in a Terms of Business Agreement (TOBA) between insurers and intermediaries.

6. Understand the principle of insurable interest.

6.1 Define insurable interest and its components.
6.2 Explain the timing of insurable interest.
6.3 Explain how insurable interest can arise.
6.4 Explain the application of insurable interest to property and liability insurance contracts.

7. Understand the principle of good faith.

7.1 Explain the principle of good faith and how this applies to contracts of insurance.
7.2 Explain how the duty of fair presentation operates in insurance policies and how it can be altered in terms of the policy.
7.3 Define material circumstances.
7.4 Identify and distinguish between physical and moral hazards in relation to a proposal.
7.5 Explain an insurer's right to information.
7.6 Explain material circumstances that do not require disclosure.
7.7 Explain the consequences of non-disclosure or a breach of the duty of fair presentation.

8. Understand the doctrine of proximate cause and its application to non-complex claims.

8.1 Explain the meaning of proximate cause.
8.2 Apply proximate cause to scenarios that relate to non-complex claims.

9. Understand the principle of indemnity and how this is applied to contracts of insurance.

9.1 Define the principle of indemnity.
9.2 Explain the settlement options available to insurers which will provide the insured with the necessary indemnity.
9.3 Identify and distinguish between indemnity and benefit policies.
9.4 Explain what is meant by agreed value policies, first loss policies and new for old cover.
9.5 Calculate a non-complex claim payment, subject to the pro rata condition of average.

10. Understand the principles of contribution and subrogation.

10.1 Explain the principle of contribution and when and how it applies to the sharing of claim payments between insurers in straightforward property cases.

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10.2 Explain the principle of subrogation and why it may or may not be pursued in simple circumstances.

11. Understand the main regulatory and legal requirements applicable to the transaction of insurance business.

11.1 Explain the reasons for compulsory insurance and describe the types of insurances which are compulsory in the UK.

11.2 Explain the application of the Consumer Rights Act 2015 in relation to insurance contracts.

11.3 Explain the Contracts (Rights of Third Parties) Act 1999 in relation to insurance contracts.

11.4 Explain the role of the financial services regulators in the authorisation, supervision and regulation of insurers and intermediaries.

11.5 Describe the financial services regulatory principles for businesses and the Financial Conduct Authority and Prudential Regulation Authority's regulation of individuals in broad outline.

11.6 Explain the importance of the fair treatment of customers and positive customer outcomes.

11.7 Describe the consequences of non-compliance – discipline and enforcement.

11.8 Explain the requirements for reporting, record keeping and training and competence.

11.9 Describe the scope and effect of the Insurance: Conduct of Business sourcebook (ICOBS) in broad outline.

11.10 Describe the solvency requirements for insurers and intermediaries and financial services regulatory risk-based capital requirements in broad outline.

12. Understand consumer protection and dispute resolution.

12.1 Describe the main provisions of the current data protection legislation.

12.2 Describe the main provisions of the current Money Laundering Regulations and their application to insurers and intermediaries.

13. Know the main methods of preventing, handling and resolving consumer complaints.

13.1 Describe the financial services regulatory requirements in relation to handling complaints.

13.2 Explain the services provided by the Financial Ombudsman Service.

13.3 Describe the main provisions of the Financial Services Compensation Scheme, including the range of activities falling within its scope.

14. Understand the CII Code of Ethics and be able to apply the principles to non-complex scenarios.

14.1 Explain the five main principles in the CII Code of Ethics.

14.2 Apply the main principles in the CII Code of Ethics and identify positive and negative indicators of ethical behaviour to non-complex scenarios.

Reading list

The following list provides details of further reading which may assist you with your studies.

Note: The examination will test the syllabus alone.

The reading list is provided for guidance only and is not in itself the subject of the examination.

The resources listed here will help you keep up-to-date with developments and provide a wider coverage of syllabus topics.

CII study texts

Insurance, legal and regulatory. London: CII. Study text IF1.

Books and eBooks

Insurance law: an introduction. Robert Merkin. London: Routledge, 2014.*

Insurance law in the United Kingdom. 3rd ed. John Birds. The Netherlands: Kluwer Law International, 2015.

Insurance theory and practice. Rob Thoyts. Routledge, 2010.*

Bird's modern insurance law. 10th ed. John Birds. Sweet and Maxwell, 2016.

MacGillivray on insurance law: relating to all risks other than marine. 13th ed. London: Sweet & Maxwell, 2015.

The Insurance Act 2015: a new regime for commercial and marine insurance law. Malcolm Clarke, Baris Soyer (eds.). Abingdon: Informa, 2016.

Periodicals

The Journal. London: CII. Six issues a year.

Post magazine. London: Incisive Financial Publishing. Monthly. Contents searchable online at *www.postonline.co.uk*.

Reference materials

Concise encyclopedia of insurance terms. Laurence S. Silver, et al. New York: Routledge, 2010.*

Dictionary of insurance. C Bennett. 2nd ed. London: Pearson Education, 2004.

Financial Conduct Authority (FCA) Handbook. Available at *www.handbook.fca.org.uk/handbook*.

Prudential Regulation Authority (PRA) Rulebook Online. Available at *www.prarulebook.co.uk*

* Also available as an ebook through eLibrary via *www.cii.co.uk/elibrary* (CII/PFS members only).

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Examination guide

If you have a current study text enrolment, the current examination guide is included and is accessible via Revisionmate (*www.revisionmate.com*). Details of how to access Revisionmate are on the first page of your study text. It is recommended that you only study from the most recent version of the examination guide.

Exam technique/study skills

There are many modestly priced guides available in bookshops. You should choose one which suits your requirements.

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IF1 syllabus quick-reference guide

Syllabus learning outcome		Study text chapter and section
1.	**Understand the nature and main features of risk within the insurance environment.**	
1.1	Describe the concepts of risk and risk perception.	*1A*
1.2	Explain the risk management function and process.	*1B*
1.3	Describe the various categories of risk.	*1D*, *1F*
1.4	Explain the types of risk that can be insured and the types of risk that cannot.	*1D*, *1F*
1.5	Describe the components of risk.	*1C*
1.6	Understand the relationship between frequency and severity and how they are applied.	*1C*
1.7	Explain the difference between a peril and hazard as they relate to insurance.	*1C*
2.	**Know how to apply the main features of risk and risk management to a given set of circumstances.**	
2.1	Apply the main features of risk and risk management to different sets of circumstances/scenarios.	*1A*, *1B*, *1C*, *1E*
3.	**Understand the main features of insurance.**	
3.1	Explain the need for insurance.	*1G*
3.2	Explain the basis of insurance as a risk transfer mechanism.	*1A*, *1G*, *1H*
3.3	Describe how insurance benefits policyholders and society in general.	*1G*
3.4	Explain the term coinsurance and how this is used in two distinct ways in the insurance market.	*1I*
3.5	Describe what is meant by dual insurance and self-insurance.	*1J*
3.6	Describe the main classes of insurance.	*1K*
3.7	Explain the purpose of Insurance Premium Tax.	*2L*
3.8	State the current rates of Insurance Premium Tax and how it is collected.	*2L*
4.	**Know the structure and main features of the insurance market.**	
4.1	Describe the structure of the insurance market and the five main groups of people.	*2A*
4.2	Describe the main categories of insurer in terms of ownership.	*2B*
4.3	Explain the structure of the Lloyd's market and main features.	*2C*
4.4	Describe the London Market.	*2D*
4.5	Describe the distribution channels used for the selling of insurance.	*2E*, *2F*, *2G*
4.6	Explain the purpose of reinsurance.	*2H*
4.7	Describe the key roles of professionals in insurance.	*2I*
4.8	Explain the main functions of the principal market organisations.	*2J*, *2K*
5.	**Understand contract and agency.**	
5.1	Describe the essential elements of a valid contract.	*3A*
5.2	Explain conditional and unconditional acceptance of a contract.	*3B*
5.3	Describe consideration which supports the contract.	*3C*
5.4	Explain how contracts can be cancelled or terminated.	*3E*, *3D*

Syllabus learning outcome		Study text chapter and section
5.5	Describe methods of creating an agent/principal relationship.	*3F*
5.6	Describe the duties of an agent and the duties of a principal.	*3F*
5.7	Explain the consequences of an agent's actions on the principal.	*3F*
5.8	Describe what should be included in a Terms of Business Agreement (TOBA) between insurers and intermediaries.	*3G*
6.	**Understand the principle of insurable interest.**	
6.1	Define insurable interest and its components.	*4A*
6.2	Explain the timing of insurable interest.	*4B*
6.3	Explain how insurable interest can arise.	*4C*
6.4	Explain the application of insurable interest to property and liability insurance contracts.	*4D*
7.	**Understand the principle of good faith.**	
7.1	Explain the principle of good faith and how this applies to contracts of insurance.	*5A*
7.2	Explain how the duty of fair presentation operates in insurance policies and how it can be altered in terms of the policy.	*5B*
7.3	Define material circumstances.	*5C*
7.4	Identify and distinguish between physical and moral hazards in relation to a proposal.	*5C*
7.5	Explain an insurer's right to information.	*5B*
7.6	Explain material circumstances that do not require disclosure.	*5D*
7.7	Explain the consequences of non-disclosure or a breach of the duty of fair presentation.	*5E*, *5F*, *5G*
8.	**Understand the doctrine of proximate cause and its application to non-complex claims.**	
8.1	Explain the meaning of proximate cause.	*6A*, *6C*
8.2	Apply proximate cause to scenarios that relate to non-complex claims.	*6B*
9.	**Understand the principle of indemnity and how this is applied to contracts of insurance.**	
9.1	Define the principle of indemnity.	*7A*, *7B*, *7C*, *7F*
9.2	Explain the settlement options available to insurers which will provide the insured with the necessary indemnity.	*7A*
9.3	Identify and distinguish between indemnity and benefit policies.	*7A*
9.4	Explain what is meant by agreed value policies, first loss policies and new for old cover.	*7D*
9.5	Calculate a non-complex claim payment, subject to the pro rata condition of average.	*7F*
10.	**Understand the principles of contribution and subrogation.**	
10.1	Explain the principle of contribution and when and how it applies to the sharing of claim payments between insurers in straightforward property cases.	*8A*, *8B*
10.2	Explain the principle of subrogation and why it may or may not be pursued in simple circumstances.	*8C*, *8D*, *8E*, *8F*, *8G*
11.	**Understand the main regulatory and legal requirements applicable to the transaction of insurance business.**	
11.1	Explain the reasons for compulsory insurance and describe the types of insurances which are compulsory in the UK.	*9A*
11.2	Explain the application of the Consumer Rights Act 2015 in relation to insurance contracts.	*11B*

Syllabus learning outcome		Study text chapter and section
11.3	Explain the Contracts (Rights of Third Parties) Act 1999 in relation to insurance contracts.	*9B*
11.4	Explain the role of the financial services regulators in the authorisation, supervision and regulation of insurers and intermediaries.	*10F*, *10G*
11.5	Describe the financial services regulatory principles for businesses and the Financial Conduct Authority and Prudential Regulation Authority's regulation of individuals in broad outline.	*10A*, *10B*, *10C*, *10D*
11.6	Explain the importance of the fair treatment of customers and positive customer outcomes.	*7E*, *10A*, *10B*, *10C*, *10D*
11.7	Describe the consequences of non-compliance – discipline and enforcement.	*10E*
11.8	Explain the requirements for reporting, record keeping and training and competence.	*10G*, *10H*, *10I*, *11D*
11.9	Describe the scope and effect of the Insurance: Conduct of Business sourcebook (ICOBS) in broad outline.	*10H*
11.10	Describe the solvency requirements for insurers and intermediaries and financial services regulatory risk-based capital requirements in broad outline.	*10F*
12.	**Understand consumer protection and dispute resolution.**	
12.1	Describe the main provisions of the current data protection legislation.	*11A*
12.2	Describe the main provisions of the current Money Laundering Regulations and their application to insurers and intermediaries.	*10J*
13.	**Know the main methods of preventing, handling and resolving consumer complaints.**	
13.1	Describe the financial services regulatory requirements in relation to handling complaints.	*11E*
13.2	Explain the services provided by the Financial Ombudsman Service.	*11F*
13.3	Describe the main provisions of the Financial Services Compensation Scheme, including the range of activities falling within its scope.	*11G*
14.	**Understand the CII Code of Ethics and be able to apply the principles to non-complex scenarios.**	
14.1	Explain the five main principles in the CII Code of Ethics.	*11C*
14.2	Apply the main principles in the CII Code of Ethics and identify positive and negative indicators of ethical behaviour to non-complex scenarios.	*11C*

Introduction

IF1 ***Insurance, legal and regulatory*** provides an overview of the general insurance market and its key elements. It will help you to develop a knowledge and understanding of the basic principles of insurance, the main regulatory principles relating to insurance business and the key measures in place to protect consumers.

We begin by looking at the concept of risk, the different types of risk that exist and how insurance acts as a risk transfer mechanism. As well as exploring which risks are insurable and the main classes of insurance we also look at the increasingly important area of risk management and how risks are controlled. This is now a major focus for insurance firms.

The structure of the insurance market is complex and information flows between the various players who interact in providing products and services to clients. As well as understanding the nature of insurance and the operation of the insurance market there are a number of special legal principles that apply to insurance contracts of which you need to acquire a sound knowledge. The legal aspects of insurance are considered in relation to English law although some insurance contracts may be subject to other jurisdictions, especially if they are designed to provide cover for risks in overseas territories.

Over the years more and more legislation has been introduced into English law to protect insurance buyers, particularly consumers (rather than commercial buyers). A number of EU directives have also been introduced which have resulted in new or amended legislation and have played an important role in shaping the regulatory environment for insurance firms.

We look in detail at the form that statutory regulation takes in the UK, examining the two regulatory bodies responsible for general insurance, the Prudential Regulation Authority (PRA) and Financial Conduct Authority (FCA), and their respective roles and approach to supervision. We also look at the rules that govern the activities of general insurance firms, including their conduct when selling and administering general insurance contracts.

As part of this study text we review some of the key consumer protection mechanisms that exist and examine the roles of the Financial Services Compensation Scheme (FSCS) and Financial Ombudsman Service (FOS).

Finally we look at some of the ethical standards which apply to individuals operating in the general insurance market including considering the Chartered Insurance Institute's Code of Ethics, which is designed for insurance and financial services professionals.

Contents

1
Risk and insurance

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C Components of risk	*1.5*, *1.6*, *1.7*, *2.1*
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E Features of insurable risks	*2.1*
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H Pooling of risks	*3.2*
I Co-insurance	*3.4*
J Self-insurance	*3.5*
K Classes of insurance	*3.6*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- list the main components of risk;
- describe how risk is perceived;
- state the function of risk management;
- describe the process of risk management;
- demonstrate how insurance relates to risk;
- identify the categories into which risks are divided;
- compare insurable and uninsurable risks;
- describe the relationship between frequency, severity, risk and insurance;
- distinguish the terms peril and hazard as they relate to insurance;
- describe how insurance operates as a risk transfer mechanism;
- describe how the common pool operates;
- describe how insurance benefits policyholders and society;
- describe what is meant by co-insurance, dual insurance and self-insurance; and
- describe the main classes of insurance.

Introduction

In this chapter, we will look at the concept of risk and how it is perceived, as well as the different categories of risk. We will go on to explain how insurance acts as a risk transfer mechanism and how the common pool works. This chapter will also introduce the main classes of insurance.

Key terms

This chapter features explanations of the following terms and concepts:

Attitude to risk	Co-insurance	Dual insurance	Equitable premiums
Financial risks	Fortuitous events	Fundamental risks	Hazard
Homogeneous exposures	Insurable interest	Law of large numbers	Particular risks
Peril	Pure risks	Risk management	Self-insurance
Speculative risks			

A Overview of risk and risk transfer

The term '***risk***' is used in various ways in the insurance marketplace and, to develop a better understanding of how it applies in different contexts, we need to look at each of these in turn. Examining the term in its everyday sense soon reveals our first problem: there is no universally recognised definition for the term.

A1 Risk perception

If you were to ask a person in the street what the term 'risk' means to them you are likely to receive a wide variety of answers – everything from a business owner being concerned about the possibility of recession to parents' worries about the dangers faced by their children. Yet others may identify the risks inherent in running a business, perhaps the demand for their products or obsolescence issues. The list of risks that we face is almost endless.

In a personal sense we all take decisions based upon an assessment of risk. Most of this is carried out informally. We assess the likelihood of rain occurring and decide whether to take an umbrella with us when we leave our home in the morning. There may be some data involved (a weather forecast from a reliable source) or we may have merely looked out of the window to make a judgment about the likelihood of rain. This informality may be acceptable in 'low risk' situations where the ultimate calamity is something like wet clothing. In other contexts, however, we need better measurement tools, especially where the potential for loss is significant.

Example 1.1

An individual's perception of a particular risk can be significantly different from another's. For example, a lot of people will be more concerned about the risk of being involved in an airplane crash than the possibility of a serious road traffic accident, even though the risk of the latter occurring is significantly higher. This can in part be explained by the element of control involved in driving, and therefore the perception that the individual has control over the outcome.

However, someone that has recently been involved in a motor accident may in fact have an inflated view of the risk of it occurring again, as a result of their own personal experience.

Risk measurement and the means of attempting to deal with the risks we face are collectively termed **risk management**. In a commercial context this is often a well-defined and scientific process, attempting to answer questions such as 'How much will it cost if things go wrong?' and 'What are the chances of the risk becoming a reality?' We will deal with these issues in greater detail later in IF1.

Most individuals make less precise calculations in their personal lives, preferring instead to simply protect against those things that seem capable of inflicting financial disaster, such as fire or theft.

A2 Definition of risk

Consider the following statements, each giving a different slant to the term 'risk':

- The possibility of an unfortunate occurrence.
- Doubt concerning the outcome of a situation.
- Unpredictability.
- The possibility of loss.
- The chance of gain (such as hoped-for benefit from a gamble or investment strategy).

Whichever definition we choose, we need to recognise the elements of **uncertainty** and unpredictability or, in some of our definitions, danger. The term often implies something that we do not want to happen. As we shall see later, not every type of risk is insurable.

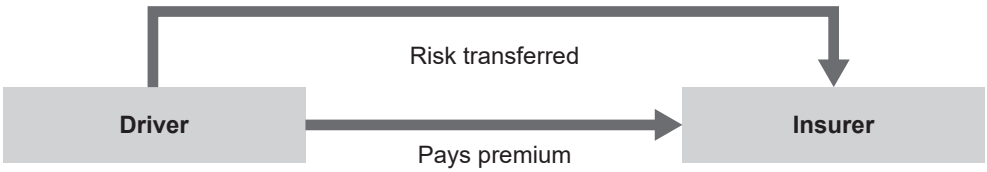
Just think for the moment about owning a car. There are many risks associated with this, including:

- the risk that the car will be stolen;
- the risk of a car accident with or without injury to the driver;
- the risk of injuring others as a result of a car accident; and
- the risk of damage to the car caused by another driver.

Each of these represents a risk so far as the owner is concerned. In each case it is possible to insure (transfer) the risk. This is done by the owner paying a known premium to an insurer in return for the insurer accepting the future unknown cost of the insured risk. The insurer does this by promising to pay for loss, damage or liability as defined by the policy terms (see figure 1.1). Insurance therefore is a means of transferring the risk.

The accepting of an unknown future potential risk by an insurer for an agreed premium is a way of defining insurance as a **risk transfer** mechanism. It brings peace of mind to the insured because they have replaced the uncertainty of possible future loss with the certainty of the agreed premium. We consider this aspect later in the chapter.

Figure 1.1: Risk of causing injury while driving a car



A3 Other meanings of the term 'risk'

Although this section is devoted to risk in its generic sense, there are three other ways in which the term is used in the marketplace:

- The first refers to the ***peril*** or contingency that is insured – the fire risk, the theft risk and so on.
- The second use of the term relates to the thing (or liability) actually insured. In this context the 'risk' could be a factory or a manufacturer's liability to the public.
- When an underwriter quotes for 'a risk' an even wider definition is implied. The underwriter will mean both the thing insured, such as the property itself, and the range of contingencies or scope of cover required.

A4 Attitude to risk

Each person's attitude to risk is different, therefore we all respond to risk in a different way. Some people are willing to carry certain risks themselves and are termed **risk-seeking**, while others lean more towards being ***risk-averse***, feeling happier minimising the risk they are exposed to (perhaps by transferring the risk, as in insurance). Very few individuals are in a position to evaluate, with any accuracy, the risks to which they are exposed. However, as

we shall now see, many companies attempt to achieve this as part of their risk management process.

Question 1.1

Which of these terms describes an individual who is keen to remove risk where possible?

a. Risk unhappy. ☐

b. Risk-averse. ☐

c. Risk-seeking. ☐

d. Risk confident. ☐

B Risk management

There is a continuing trend towards taking control and developing a formal strategy for managing the various risks that affect businesses. The appointment of risk managers in industry and commerce is now commonplace. Many are members of the **Association of Insurance and Risk Managers in Industry and Commerce (Airmic)**. This organisation has been influential in setting standards in areas of risk management and, with other organisations, has published a Risk Management Standard that has been widely adopted.

Often, insurance is bought because certain aspects of cover are compulsory, such as third party motor insurance. Alternatively, it may be that another party has a financial interest in the item to be insured; for example, if an individual buys a house with a mortgage, a mortgage lender may insist insurance is taken out on the property.

Commercial risk management

Commercial organisations often take a much more analytical view when deciding what to insure, attempting to answer questions such as 'How much will it cost if things go wrong?' and 'What are the chances of the risk becoming a reality?'

The focus of good risk management is the identification and treatment of defined risks and it should be a continuous and developing process embedded in a firm's strategy. It should address methodically all the risks surrounding the firm's current, past and future activities.

Commercial risk management is important for several reasons:

- It reduces the potential for loss by identifying and managing **hazards**.
- It gives shareholders a greater degree of confidence in a company's ability to manage its risks.
- It provides a disciplined approach to quantifying risks.

Be aware

Many risk managers are members of the **Association of Insurance and Risk Managers in Industry and Commerce (Airmic)**. This organisation has been influential in setting standards in areas of risk management and, with other organisations, has published a Risk Management Standard that has been widely adopted.

In order to make informed decisions about the risks that a business faces, there are three key steps in the risk management process:

- risk identification;
- risk analysis; and
- risk control (including the possibility of risk transfer).

Let's look at these in more detail.

B1 Risk identification

Risk identification involves discovering the threats that may already exist, and the potential threats that may exist in the future. Not all of these risks will be insurable but they must all be

managed. For the retail shop, petty theft and shoplifting may be real risks and will need to be managed in some way or funding set aside to cover their costs. For many conventional risks, an insurer may become involved in helping to identify existing and potential risks through carrying out a physical examination or survey. Insurers also play a role in relation to risk control when they provide reports following the survey.

B2 Risk analysis

Risk managers will examine past data to evaluate or analyse the risk. For example, they can look at the past loss patterns of, say, motor accidents involving drivers under the age of 25, and so predict what is likely to happen in the future for drivers who fall into this category. Equally, patterns of reported accidents in the accident register may be analysed for future trends. Insurers will look at many of the same elements when considering the rating of a risk.

B3 Risk control

If the risk is seen to have the potential for adverse consequences, some course of action should be put in place to control, reduce or even eliminate the risk. Elimination is the most effective, but may be costly or impractical. For example, if a manufacturer carries out some paint spraying activity that is highly hazardous, it may be possible to outsource that part of the process and in so doing eliminate that element of the risk. The elimination of risk, or even its reduction, will always be subject to the test of whether the cost of doing so is reasonable compared to the cost of the feared event happening.

There are various aspects to the controlling of risk:

Physical control measures	For example, putting specific locks on the doors of a factory to reduce the theft risk.
Financial control measures	Such as transferring the risk by either taking out insurance or by contract (e.g. arranging for a security firm to accept responsibility for cash whilst in its control).
Developing a good risk culture	Key to improving risk awareness and managing risk. This can be achieved by educating employees or clients on how to avoid or reduce risks.

Depending on what they were designed for, internal controls are usually categorised as detective, corrective or preventative.

- **Detective controls** detect errors or irregularities that may have occurred.
- **Corrective controls** correct errors or irregularities that have been detected.
- **Preventative controls** keep errors or irregularities from occurring in the first place.

Insurers often assist commercial policyholders in the area of loss prevention and control. They do so by imposing requirements and making recommendations designed to improve the risk, following the completion of a survey. These are important parts of the surveyor's report and will either be aimed at improving the risk to an acceptable standard from the insurer's point of view, or will offer premium reduction as an incentive for worthwhile risk improvements. Insurers may also offer risk management training, guidance or other literature to help their policyholders avoid or manage risk.

Insurers have started to use more advanced technological capabilities to actively manage policyholder risks, for example through the provision and monitoring of leak detection devices as part of a property insurance proposition. The National Cyber Security Centre has been central to development of research that supports the management of cyber risks and further developing security capabilities at a national level.

In a wider context, insurers are involved in researching areas of loss prevention and control. A good example of this is the work carried out on their behalf by the **Fire Protection Association (FPA)**. The kind of work this body undertakes includes:

- researching new materials and methods of construction and seeing how they behave in a fire;
- providing rules that set standards of construction;
- reporting on new industrial processes and machinery; and
- providing rules for the construction, installation and operation of fire extinguishing appliances, e.g. sprinkler systems.

Motor insurers also rely on Thatcham Research Centre for testing vehicle safety and security systems, and for testing seats for whiplash protection. The emergence of autonomous vehicles has become a crucial part of Thatcham Research Centre's work.

The National Cyber Security Centre has been central to development of research that supports the management of cyber risks and further developing security capabilities at a national level.

Fraud is a key risk that insurers also need to manage and mitigate, and this has resulted in the creation of various industry bodies and databases for use in the recording and detection of fraudulent activity. As an example, the **Motor Insurance Anti-Fraud and Theft Register (MIAFTR)** was formed through the participation of **Association of British Insurers (ABI)** member companies to combat the increasing number of **fraudulent claims**. The register records all details of vehicles and motorcycles that become total losses arising from any cause, including fire and theft. Third party and insured losses are also recorded, and the information is available to all companies as well as the Lloyd's Corporation. Insurers that place information onto the register relating to a new claim will be advised if the vehicle, claimant or the claimant's address matches existing data that is already present on the register. Even if fraud is not discovered, previous claims may be disclosed that had not been advised by policyholders when they took out their policy. Other examples include the Claims and Underwriting Exchange (CUE), the National Fraud Database, and the Insurance Fraud Register.

The **Loss Prevention Research Council**'s risk-based research and other initiatives also help insurers to develop crime- and loss-control solutions.

Question 1.2

A factory installing sprinklers into its premises is an example of which activity?

a. Risk transfer. ☐

b. Risk modelling. ☐

c. Risk control. ☐

d. Risk analysis. ☐

C Components of risk

In order to gain a deeper understanding of the meaning of risk, we must now take a closer look at the various components of risk. These include:

- uncertainty;
- level of risk; and
- peril and hazard.

C1 Uncertainty

Uncertainty about the future is at the centre of risk. If we always knew exactly what was going to happen, there wouldn't be any risk. Because we don't, we can't be certain of anything.

C2 Level of risk

Risk is assessed by insurers in terms of **frequency** (how often something might happen) and **severity** (how costly it would be if it did happen).

Consider this…

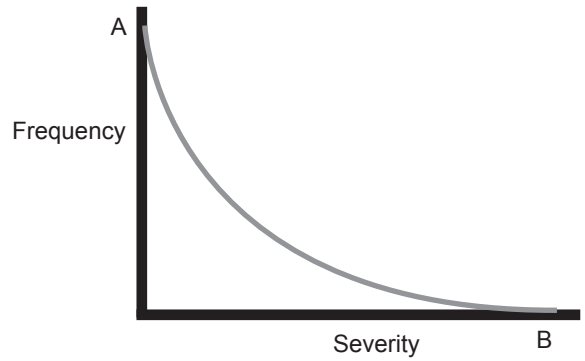
Imagine a house by a river that is known to flood. No-one knows if the river will overflow again, but because the river is prone to flooding, the risk to the house is increased. Now imagine a second house, 100 metres up a hill from the river. This house is less likely to be at risk from flooding because of its position. But what about severity?
Imagine that the house further from the river is much larger. It should be insured for a far greater amount because of the potential severity of loss, damage or destruction.

Frequency and severity will both be part of an insurer's risk assessment, but the relationship between them varies.

High frequency and low severity
An example or high frequency and low severity of loss could be motor insurance, which usually entails a large number of small claims, for things like dented bumpers and cracked windscreens.

Low frequency and high severity
This describes a small number of events resulting in very high costs, such as aircraft accidents and oil spillages.

Figure 1.2: Relationship between frequency and severity



The left-hand side of the graph at point 'A' shows the high frequency/low severity claims which, based on the law of large numbers, tend to be predictable.

The right-hand side of the graph at point 'B' shows the low frequency/high severity claims, which are difficult to predict owing to their random nature.

The relationship between these two dimensions is inverse, so as one increases in prominence the other decreases, and vice versa. An insurer will often base its decisions on how much of a risk it can prudently accept on factors relating to frequency and severity. Insurers have various ways of dealing with a risk that is offered to them where the amount involved exceeds their normal acceptance limits.

C3 Peril and hazard

This is the final aspect of risk and it relates to the cause of losses. But what is the difference between the two terms?

- A ***peril*** can be defined as that which gives rise to a loss.
- A ***hazard*** can be defined as that which influences the operation or effect of the peril.

At first, the distinction between the two may not be that obvious. However, the following example should help.

Example 1.2

Consider someone smoking a cigarette in a house that's insured against fire. Drop the cigarette and it could start a fire. The fire itself is a peril. The act of smoking in the house is the hazard – it affects the likelihood of a fire in the house.

Here are some other examples of peril:

Explosion	This is the event insured against, which may give rise to loss.
Lightning	When it occurs, this natural peril can result in damage.
Collision	Whether between ships, aircraft or vehicles.
Dishonesty	Either employees or external parties stealing from a company, for example.

C3A Physical and moral hazard

Physical hazard relates to the physical characteristics of the risk and includes any measurable dimension of the risk. Examples include the following:

Security protection at a shop	The greater the security protection, the better the physical hazard level as it may even prevent a loss altogether.
The construction of the property	The higher the standard of building construction, the better the physical hazard for fire and similar risks, as the building will be more resistant to damage.
The age of a proposer and type of car for motor insurance	These are factual, measurable factors.

Moral hazard arises from the attitude and behaviour of people. In insurance, this is usually the conduct of the insured. Moral hazard also arises from the conduct of the insured's employees and that of society as a whole. For example:

Carelessness	A driver's lack of care can increase the chance of an accident happening and its severity.
Dishonesty	A person who has previously made fraudulent or exaggerated claims represents a poor moral hazard.
Social attitudes	A person who regards insurance fraud as acceptable and not immoral.

The way in which a business is run is also an example of moral hazard. For example, careless or lax management in a factory represents poor moral hazard. This is clearly something relating to attitude and behaviour, but it may be evident because of unguarded machinery or a lack of control of smoking by employees, for example.

We must guard against the tendency to jump to the conclusion that there is an adverse moral aspect to a risk merely because the risk is an obviously heavy one. For example, a fireworks factory represents a very heavy fire risk, but it does not follow that there is a poor moral aspect to the risk.

Equally, a young driver who is driving a high-performance car certainly represents a poor physical hazard. Statistics show that a disproportionately high number of accidents are caused by young drivers. The car itself will be in a high rating group because of its value and performance. These two aspects are physical because they are measurable. It is, of course, possible that some other factor may point towards poor moral hazard – perhaps a poor claims history or serious motoring convictions.

Explosion	The storage of dangerous chemicals or not ensuring that there is no smoking in certain areas.
Lightning	The construction of any buildings struck by the lightning or the inadequacy of any lightning conductors being used.
Collision	The hazards are in relation to speed, behaviour, extent of training for example. Having a relaxed attitude to the speed limit as a driver is an example of bad moral hazard.
Dishonesty	Factors such as poor security in place or inadequate operational controls. A lax corporate attitude to security is an example of bad moral hazard.

Question 1.3

A fireworks factory is inspected by insurers and found to have excellent safety protocols and good training for the staff. What are the protocols and training examples of?

a. Good moral hazard. ☐

b. Poor moral hazard. ☐

c. Good physical hazard. ☐

d. Poor physical hazard. ☐

D Categories of risk

Be aware
Not all risks are insurable – we look at uninsurable risks in *Uninsurable risks* on page 1/12.

In a general insurance context, insurable risks can be grouped as follows:

- financial risks;
- pure risks; and
- particular risks.

D1 Financial risks

For a risk to be insurable the outcome of an adverse event must be measurable in financial terms. Most general insurances are compensatory in nature, as we shall see later. This means that the value placed on the loss is not determined in advance.

Let us look at some examples of ***financial risks*** to help us understand this concept:

- **Accidental damage to a motor car**: the financial value of the risk is the cost of repairing or replacing the vehicle.
- **Theft of property**: the financial value of the risk of theft of an item of jewellery is its current market value. This is measurable in financial terms. It would not include sentimental value because, as we have seen, this is not precisely measurable in financial terms.
- **Loss of business profits following a fire**: this risk is measurable since comparisons can be made to similar trading periods to devise a fair estimate of the loss to be paid by the insurer as compensation.
- **Legal liability to pay compensation for personal injury to others**: the courts measure the value of damages applicable for the loss of a leg, for example against compensation payments made previously in similar situations. Usually a standard formula is applied to calculate damages that will take account of financial circumstances as well as the injury itself.

D1A Benefit policies

Important exceptions to this general rule are personal accident and sickness policies. This is because there is no way of valuing precisely, for instance the loss of a life or sight so these policies are taken out in order to provide pre-agreed amounts in the event of an accident or sickness. They are known as ***benefit policies***. Similar considerations apply to life insurance policies or twins insurance where for a one-off payment you can chose a lump sum which is only paid in the event that twins are born.

D2 Pure risks

Pure risks are those where there is the possibility of a loss but not of gain, and where the best that we can achieve is a break-even situation. Travelling home in a car is a good example. The best that we can hope for is a safe arrival. The possibility exists however, that there might be an accident and the car damaged or someone injured. It is these types of risk that are generally insurable.

Consider this…
Think of two pure risks to which a company or individual might be exposed.

You may have already thought of these, but here are some examples of pure risks:

- **The risk of fire**: it could damage or destroy property or cause an interruption to the running of the business, both are measurable in financial terms.
- **The risk of machinery breakdown**: this could lead to actual damage or business interruption.
- **The risk of injury to employees at work**: if such injury is caused by the negligence of the company, a court may award damages and costs. These are measurable in financial terms.

D3 Particular risks

Particular risks are localised or even personal in their cause and effect. Sometimes the cause may be more widespread (e.g. a storm over a whole region), but the effect is localised or even related to an individual. Not all properties in the region will have been damaged.

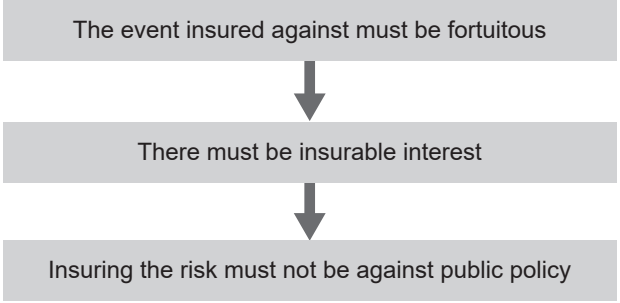
Again, to help us understand let us look at some examples of particular risks:

- **A factory fire**: this would cause localised damage to the factory and possibly to its surroundings, but would not affect the whole community.
- **A car collision**: damage to the vehicles and any third-party liability are localised events affecting relatively few individuals.
- **Theft of personal possessions from a home**: an event that only affects an individual or family.

We have established that only certain classifications of risk are insurable: those that are financial, pure and particular. There are certain other things that need to be in place for a risk to be insurable.

E Features of insurable risks

For a risk to be insurable, the following features must be present:



E1 A fortuitous event

To be insurable, the occurrence must be a **fortuitous event**, i.e. accidental or unexpected. In contrast, a non-fortuitous loss is a policyholder who deliberately damages their car. Not all elements of loss or damage may be fortuitous.

Consider this…
Two apartments are burgled within the same week. The first apartment was properly locked and the burglar managed to force open a window in order to steal contents from the apartment. The second apartment had keys left in the door and several large windows open, which allowed the burglar to enter the property and steal the contents. Which of these two losses could be described as fortuitous? Which of these losses are likely to be paid by insurers?

E2 Insurable interest present

Refer to
See chapter 4 for more on insurable interest

Insurable interest is the legally recognised financial relationship between the insured and the object or liability that is being insured. For example, you can insure against the theft of your own car because you suffer financial loss if it is stolen.

E3 Not against public policy

It is commonly recognised in law that contracts must not be against public policy or go against what society considers to be the right or moral thing to do. Insurers should not, therefore, cover risks that are against public policy.

For example, it would be against public policy to insure the risk of incurring a fine for a criminal offence. The risk may appear to have all the features of an insurable risk, as the event may be considered fortuitous (accidental) and the insured has an insurable interest, since they suffer financial loss as a result of the fine. However, it is clearly unacceptable to be able to insure against paying a fine, because the fine's purpose is to punish the individual. Providing insurance for it may encourage people to break the law.

Consider this…
Think of another risk which would be against public policy. What would be the effect on an insurer's professional reputation if it were to insure such risks?

E4 Homogeneous exposures

Given a sufficient number of exposures to similar risks, known as ***homogeneous exposures***, the insurer can forecast the expected frequency and likely extent of losses. This is achieved by using the **law of large numbers**, a theory that determines that predictions become more accurate as the base of data used increases in size. In the absence of a large number of homogeneous exposures, the task is more difficult, as patterns and trends are more difficult to determine.

Whereas fortuitous loss, insurable interest and not being against public interest are absolute requirements for a risk to be insurable, the concept of homogeneous exposures is an ideal and there are occasions when an insurer will need to use less than fully reliable historical data when fixing premiums.

Example 1.3
A fire insurer receives a proposal for a timber warehouse situated in a busy city. In order to arrive at an appropriate premium for the proposed risk, the insurer considers the likely level of losses based on past experience of a large number of similar risks situated in the same area.

F Uninsurable risks

In contrast to the insurable risks outlined in *Categories of risk* on page 1/9, there are risks which cannot be insured, namely:

- non-financial risks;
- speculative risks; and
- fundamental risks.

F1 Non-financial risks

A **non-financial risk** is one where the outcome is not measurable in monetary terms. No value can be placed on the outcome.

Examples:

- **Choosing a new house**. The risks associated with deciding on a particular house are not easily measurable in financial terms. These risks include style, accommodation, location and personal taste.
- **Deciding on a school for a child**. Decision-making may include academic performance, social integration and sports performance.
- **Loss of enjoyment of a holiday**. There can be no value attached to the enjoyment of an activity or a holiday.

There may be financial implications in each example but the outcome is not measurable in financial terms. For this reason, such risks are not insurable.

F2 Speculative risks

These are often referred to as 'business risks' but they are also associated with gambling. ***Speculative risks*** may involve three possible outcomes; loss, break-even or gain. Insurers do not insure speculative risks, since they are undertaken voluntarily, in the hope that there will be a gain. The risk element would be completely removed if the insured knew that the insurer would cover any losses.

Examples:

- There are major risks involved in pursuing a particular marketing strategy for, say, a new brand of confectionery. If it fails, losses may be massive, but a successful strategy can result in a huge gain. Such a risk cannot be insured and the business must bear the full risk of a loss or gain outcome.
- Investing in a company on the stock exchange may produce good dividends and capital appreciation or, if the company fails, may result in a loss of the complete investment. The risk of failure cannot be insured.

It should be noted that the pure and particular aspects of a speculative risk may be able to be insured. Take our first example. If the confectionery manufacturer purchased expensive machinery on which to produce a new type of chocolate bar, the risk of the machinery being damaged by fire or stolen is insurable, even though it has been bought primarily in the hope of achieving a profit as a result of increased sales.

F3 Fundamental risks

Fundamental risks are those which arise from a cause outside the control of any one individual or group of individuals and their effects are usually widespread. The loss associated with them is often catastrophic. Such risks may arise out of social, economic, political or natural causes.

Examples:

- economic recession;
- war;
- earthquake; and
- famine.

However, fundamental risks may have particular consequences for individuals which can be insured. So, although it is not possible to insure against the general effects of economic recession, insurance is available which would cover mortgage payments in the event of the insured becoming unemployed.

Earthquake is listed here as a fundamental risk, but we need to qualify this. It is correctly classified as fundamental but it is insurable in areas that pose no great likelihood of loss. For instance, there is no problem in obtaining cover in the UK. However, this may not be the case in California or Japan which are subject to a much greater loss potential.

Similar considerations apply to storm damage which can be difficult to obtain in parts of the USA adjacent to the Gulf of Mexico, although such cover is freely available in other parts of the world.

Consider this…
Think about some of the widespread natural disasters, wars and economic recessions of the past 15 years. What might the claims impact have been on the insurance industry?

G Benefits of insurance

Insurance has existed for a very long time, offering financial protection against the possibility of suffering a misfortune or loss.

But do we really *need* it? This question is frequently asked, particularly when the insurance renewal notice arrives. Whether an individual wants insurance depends on four factors:

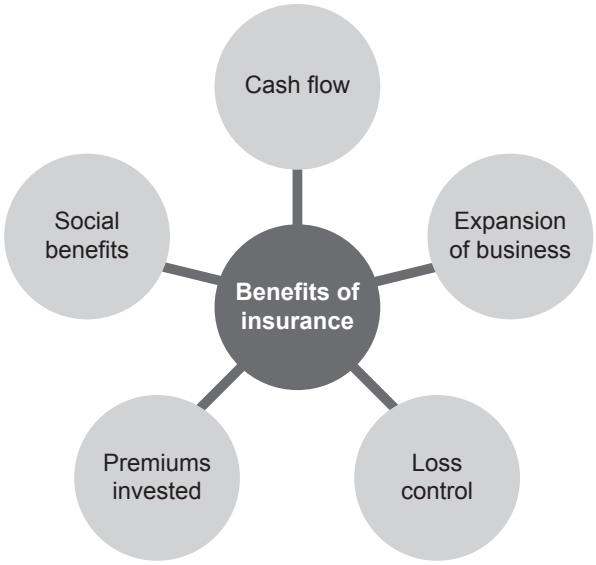
- their attitude to the potential risk;
- whether insurance for the risk is a legal requirement;
- the price they are prepared to pay for the peace of mind insurance gives; and
- whether they feel they have a choice about insuring the risk.

Insurance enables the risk of financial loss to be transferred in a variety of ways.

Examples include:

- The large unknown financial risk that an individual faces of their home burning down, for example, is transferred to the insurer and replaced by the much smaller and certain cost of the premium.
- The unknown and potentially unlimited financial risk of a claim for personal injury against an individual following a road traffic accident, which without insurance could lead to bankruptcy.
- For people travelling abroad, there is security in knowing that you are covered for the costs of having to return home early to illness, or for having your medical costs covered whilst you are in a foreign land.
- A business providing vehicle repair services may be unable to operate in the event that its premises were damaged by flooding. With uncertainty as to how long it would take to get up and running again, commercial insurance with business interruption cover provides peace of mind to the owners of the business.

Insurance brings many benefits to policyholders, and to society as a whole. In addition to peace of mind, and the enabling of risk transfer, there are some other key benefits to be aware of:



- **Improved cash flow** – money does not have to be kept in reserve for potential losses, which frees up capital and therefore improves cash flow.
- **Expansion of business** – enterprise is encouraged, since insurance makes it easier for new businesses to start or for existing businesses to invest, innovate and expand.
- **Loss control** – is improved. Insurers have an interest in reducing the frequency and severity of losses, not only to enhance their own profitability but also to contribute to a general reduction in the economic waste which follows a loss. Also, the policyholder suffers less business interruption and consequential inconvenience as the effects of the loss are minimised or ideally, do not occur at all.
- **Premiums invested** – premiums can be invested to earn interest. Money is held until claims have to be paid. This creates a 'premium reserve'.
- **Social benefits** – such as encouraging business activity and helping to keep people in employment. Most commercial insurance policies will offer a business interruption element which covers wages and the loss of trading income during a period of business interruption and recovery.

H Pooling of risks

The basic principle of insurance is that the losses of the few are met by the contributions of the many. An insurance company gathers together relatively small sums of money from people who want to be protected from similar kinds of perils. The insurer sets itself up to operate a **common pool**.

In fact, insurers operate a number of separate pools for different classes of insurance. Contributions, in the form of premiums from all those insured, go into this pool. Out of the pool come payments to compensate the losses of the few.

These contributions, or premiums, must be large enough in total to meet the losses in any one year and, in addition, must cover the costs of operating the pool and provide an element of profit for the insurer. The insurer endeavours to make sure that the premium which each insured pays is fair in relation to the risk that they introduce to the pool.

Consider this…
Think of a policyholder who owns a large mansion and another who owns a small apartment. Both require home insurance, though it is likely that the mansion will be considered a larger risk than the flat, so the policyholder will be required to pay more premium into the common pool.

H1 Law of large numbers

Applying the ***law of large numbers*** to insurance enables the insurer to predict the final cost of claims in any one year fairly confidently. This is because insurers provide cover for a large number of similar risks and the final number of actual loss events (claims) tends to be very close to the expected number.

This enables the insurer to calculate likely losses and thus charge a fixed premium so that the insured knows the costs for the year, irrespective of the number or size of their own particular losses. Nevertheless, competitive pressures and the business imperative to grow or defend market share can affect the level of premium requirement put forward to the client.

H2 Equitable premiums

To operate a pooling system successfully, a number of pools must be set up, one for each main group of risks. For example, an individual pool for, say, motor insurance and another for household insurance must be set up. Each person wishing to join the pool must be prepared to make an equitable (fair) contribution to that pool.

When deciding on ***equitable premiums*** (fair contributions), insurers take into account the different elements of risk brought to the pool by each of the policyholders. These are often referred to as discrimination factors. Arriving at a premium is a complex process and the correct assessment of risk is extremely important. The correct assessment will ensure that a fair premium is charged, and a fair profit can be made. This is the task of an underwriter when considering an individual risk.

Question 1.4

When pooling risk, insurers use the law of large numbers to make reliable:

a. Claims payment predictions. ☐

b. Investment return predictions. ☐

c. New business predictions. ☐

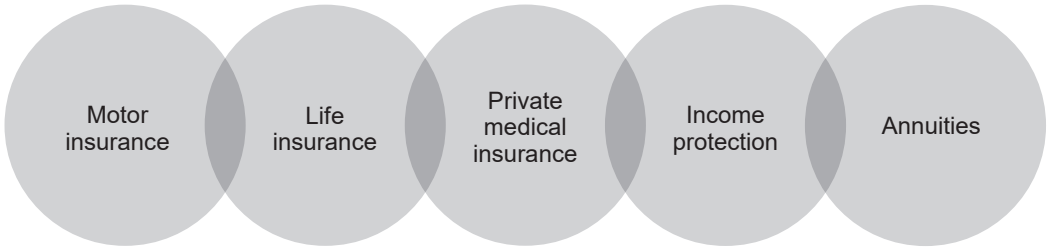
d. Premium income predictions. ☐

H2A EU Gender Directive

At the start of 2011, the Court of Justice of the European Union (CJEU) ruled that insurers could no longer use gender as a premium calculation tool or in determining which benefits could be offered. This ruling followed a legal assertion by a Belgian consumer group named **Test-Achats** that the practice contravened the wider European principle of gender equality. The effect of this was that insurers had to change their pricing models by 21 December 2012.

Be aware
The EU Gender Directive was transposed into UK law by the **Equality Act 2010 (Amendment) Regulations 2012**.

The ruling affects:



In the case of motor insurance, women traditionally benefitted from lower car insurance premiums than men. Although insurers can no longer use gender as a rating criteria, there is

some evidence women continue to enjoy cheaper car insurance due to better claims history and less exposure to high risk occupations.

There are some examples of gender-related insurance practices which are allowed under the Directive and were, therefore, not affected by the Test-Achats ruling. Generally, it is still possible to reflect physiological differences between men and women in questions and tests, and when interpreting medical results. For example, medical tests are not necessarily the same for men and women and it remains possible to use different tests by gender for insurance screening when necessary for mammograms or prostate screening. Insurers are also allowed to collect information on gender status and ask questions about gender-specific diseases, for example a woman's family history of breast cancer.

I Co-insurance

Part of an insurer's job is to manage the pool of money from which valid claims are to be paid. Each insurer will therefore decide upon the maximum limits of acceptance for particular categories of risk. For commercial property insurances this will probably be a range of acceptance limits, depending upon the trade being carried on in the premises and usually linked to different construction standards. For example, an insurer will be comfortable accepting a higher sum insured for an office risk than for a plant where plastics are manufactured.

So what happens when a risk is offered to an insurer but the amounts at risk are greater than the insurer's retention limits for that category?

The insurer has two choices:

- decline to offer insurance for the risk; or
- find a way of sharing the risk with others – one of the principal ways of doing this is ***co-insurance***.

'Co-insurance' is used in two distinct ways in the insurance market:

- risk sharing between insurers; and
- risk sharing with the insured.

Reinsurance
Insurers occasionally come together to form a pool and agreeing to jointly underwrite particular risks. This is known as reinsurance and usually designed to cover catastrophic risks such as terrorism or earthquakes. We will look at reinsurance in *Reinsurance* on page 2/19.

I1 Risk sharing between insurers

In this context, co-insurance is a risk-sharing mechanism which applies mainly, but not exclusively, in the London Market (including Lloyd's).

For property insurance in particular, an insurer may agree the rating and terms to be applied with other insurers ('co-insurers') and issue a collective policy. Each insurer receives a stated proportion of the premium and pays the same proportion of any losses that occur. The 'lead office' is the first named insurer in the policy and invariably carries the largest share of the risk, and they are also responsible for issuing the documentation. Each time a change is required the leading office issues closing instructions to each of the co-insurers, advising them of the proposed change and requesting their agreement.

Although the lead office carries out these functions on behalf of the other insurers, each insurer is separately liable to the insured for their proportion of any claim that becomes payable. The policyholder has a direct contractual relationship with each individual co-insurer. It is as if each had issued a policy for its own share.

In the event of a claim, the lead office will settle losses, within agreed defined limits, on behalf of the co-insurers and recoup the sums from them afterwards although for substantial losses, say in excess of £50,000, a payment is made to the policyholder by each co-insurer and sent to the leading office for onward transmission to them.

The system is time-consuming to administer, but has the benefit of being entirely transparent as far as the policyholder is concerned.

Similar sharing mechanisms operate within the London Market through Xchanging Insure Services. The broker will often undertake many roles, including the collection of amounts due from co-insurers. Brokers may also be involved in settling losses on an insurer's behalf, but this will depend upon any delegated authority granted by the insurer.

I2 Risk sharing with the insured

The term 'co-insurance' is also used in relation to the amount of a risk that the insured may retain. A small fixed sum retained by the insured is called an '**excess**'; a large fixed sum tends to be called a '**deductible**'. However, where an insured is responsible for a substantial proportion of each loss, either through choice (in order to reduce premiums) or by necessity (as part of an insurer's terms for accepting the risk), the term co-insurance is used. An amount might be expressed as 'Co-insurance 25%', which would mean that the insured would pay 25% of each claim under the policy.

One benefit of risk sharing for insurers is that the policyholder is deterred from making small claims. They may also take more care to prevent damage or loss occurring if they are likely to be financially impacted.

Dual insurance

The term dual insurance is used when there are two or more policies in force which cover the same risk. This usually occurs inadvertently where an aspect of cover provided as part of a package overlaps with a primary cover that has intentionally been purchased to deal with a particular eventuality.

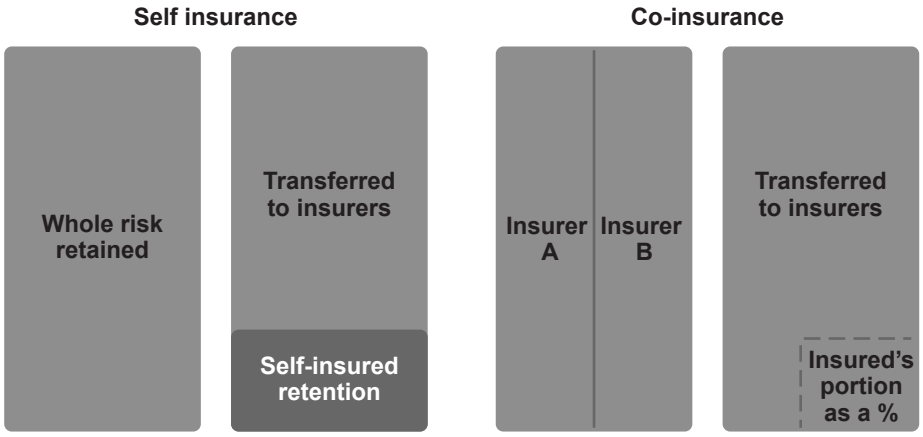
For example, a travel policy may be purchased before a holiday that includes some cover for personal effects that are already covered under the personal possessions section of the individual's household contents policy.

Special rules apply to such situations, and in chapter 8 we will look more closely at what happens when there are two or more policies covering the same risk.

J Self-insurance

The term ***self-insurance*** means that an individual or company has decided not to use insurance as the risk transfer mechanism, but to carry the risk themselves. For example, a company that has a number of shops and a predictable pattern of small claims for glass breakages might set aside a regular sum each month to fund these losses.

The term can also be used when referring to the part of a loss that the insured retains, although in this context it usually applies to substantial sums. For example, a manufacturing company takes a decision to self-insure the first US$50,000 of each property loss that it suffers. The amount is called the ***retention***.



K Classes of insurance

When working in the insurance market, insurers will refer to personal lines insurance and commercial lines insurance.

Personal lines insurance protects a policyholder from loss or damage to personal property or from damages for which the policyholder may be held personally responsible.

Commercial lines insurance protects a business from loss of its business property or damages for which the company may be held liable.

K1 Motor insurance

Insuring motor vehicles and liabilities arising out of their use is the most significant compulsory insurance in the UK. The principal types of motor insurance are motor insurance, motorcycle insurance, commercial motor insurance and motor trade insurance.

Personal motor insurance and home insurance are the most common types of general insurance and motor and home can include elements of property and casualty cover. Property cover pays for loss to the policyholder's property, while casualty cover pays for damages for which the policyholder is held liable.

Example 1.4
Miguel accidentally drives his car into the side of a building owned by someone else. His insurance will pay for the damage to the vehicle through its property coverage, and for damage to the building through its casualty coverage.

Larger commercial motor risks are considered very much on their own claims history and are referred to as fleet-rated risks.

K2 Home insurance

This covers buildings and/or contents (usually on a 'new for old' basis) against a wide range of perils, including fire, additional perils and theft. Valuables and personal effects are also covered, as is public liability cover. A number of optional extensions are available including accidental damage cover.

K3 Travel insurance

This covers individuals travelling within a country or overseas, and is available in 'single trip' or 'annual multi-trip' policies. Such insurance covers, for example, injury, death, medical expenses, loss of luggage/personal possessions/money and cancellation charges.

K4 Pet insurance

This is primarily designed to help cover vet costs if a pet is ill, gets injured or has an accident. In addition to vet fees, a pet insurance policy will typically cover:

- the purchase price if a pet dies due to an accidental injury; and
- an element of third party liability cover, usually applicable to dogs only, for injury to third parties or damage to their property.

K5 Health insurance

There are a number of different types of insurance related to personal health:

Personal accident	Cover in the event of accidental death or bodily injury.
Sickness	Cover for an inability to work due to sickness.
Private medical insurance	Cover for individuals who seek medical treatment outside the National Health Service (NHS) when they are ill.
Short-term income protection	Designed to pay an agreed monthly amount during a short period (usually 12 months) when an individual can't work because of an accident, sickness or redundancy. On making a claim, the policyholder has to wait a set number of days before receiving a monthly payment. The payments continue until the policyholder returns to work, or – if they don't return to work – for a maximum period (typically one or two years).
Critical illness	Cover in the event of the diagnosis of a defined range of serious illnesses.

Payment protection insurance (PPI)

PPI is slightly different from income protection cover, as it is designed to cover monthly loan and credit card payments, as opposed to replacing a percentage of the insured's income. Payouts will typically be made directly to the insured's creditors, rather than the insured.

Under Financial Conduct Authority (FCA) rules PPI policies cannot now be sold as a single premium contract, which effectively prevents them being sold as direct add-ons to a loan that is taken out. This is because of poor selling and advice practices in the past. We will cover these in greater detail in *Application of PRA and FCA rules* on page 10/8.

K6 Liability insurance

This is insurance to cover the legal liability to pay compensation and costs awarded against the insured in favour of another party, in respect of death, injury, disease, loss or damage sustained by that party. Examples are as follows:

Employers' liability	Insurance to compensate the insured in respect of their legal liability to pay damages to any employee arising out of bodily injury, disease, illness or death received in the course of employment by the insured. Like motor insurance, this is made compulsory by law.
Public liability	Insurance to compensate the insured in respect of claims from third parties (i.e. members of the public or companies) for accidental bodily injury or damage to their property due to the insured's negligence or that of their employees.
Products liability	Covers legal liability for third-party bodily injury or property damage caused by products, goods or services sold or supplied.
Directors' and officers' liability	Covers personal legal liability incurred by individual directors and officers for financial loss resulting from their negligence or failure to fulfil statutory responsibilities.
Professional indemnity	Protects a person acting in their professional capacity against claims that might be made alleging that injury or loss has resulted from their negligent actions or advice.

K7 Commercial property insurance

Property insurances cover risks to actual property. The main types of cover available are briefly mentioned here.

Perils and 'all risks' policies	These are issued to cover material property such as buildings, contents and stock. Policies tend to be issued either on the basis of building up cover by adding different perils or, as in the case of all risks policies, by defining the cover by its exclusions rather than adding more and more contingencies.
Engineering/breakdown	Covers explosion, breakdown or accidental damage to plant, which is generally grouped under the following headings: This is generally grouped under the following headings: • boilers and pressure plant; • engine plant; • electrical plant; • lifting machinery; • miscellaneous plant; and • computers. Many of these items need to be inspected regularly by a competent person as a legal requirement. Consequently, inspection contracts often accompany these covers.
Glass	Policies cover destruction of or damage to all fixed glass (and may be extended to include lettering on glass), on an 'all risks' basis. It may also extend to cover damage to the contents of the window.
Livestock	Insurance of livestock (horses, cattle etc.) against death through accident or disease, and against theft and unexplained disappearance. Policies for horses may also be extended to cover riding tack/equipment.
Money	Money insurance is on an 'all risks' basis, covering all risks of loss or destruction of or damage to money in transit, on the insured's premises during business hours (and for modest amounts out of a safe outside business hours), in a bank night safe etc. The term 'money' is defined widely. Cover may include fixed payments if members of staff suffer injury or damage to their clothing when a robbery takes place.

K8 Pecuniary insurance

Pecuniary means 'relating to money' and pecuniary insurance covers intangibles such as income, revenue or value. Some classifications will include 'money insurance' under this heading.

Examples are as follows:

Fidelity guarantee	The word 'fidelity' implies the 'faithful or loyal performance of a duty'. The financial results of a lack of fidelity, arising from the dishonesty or disloyalty of a company's employee(s), can be insured against. Therefore, such insurance covers the risk of losing money or stock, by the fraud or dishonesty of a person holding a position of trust.
Legal expenses	Insurance for individuals, families and businesses to enable them to meet the cost of seeking legal advice or pursuing/defending civil actions.
Credit	Credit is the system of buying or selling goods or services without immediate payment being made. Credit insurance covers businesses against the risk of non-payment, whereby the seller ensures that if their debtors (buyers) fail to meet their obligations, the seller can recoup their losses.
Business interruption	Insurance against losses due to an interruption in business occurring immediately after, and in consequence of, an interruption to the business usually arising from material damage or disease. Cover is in respect of the actual loss of earnings of the business, adjusted for business trends, plus the increased costs associated with the business recovery.
Political risk	Insurance that can be taken out by businesses against the risk that revolution or other political conditions will result in a loss.

Guaranteed asset protection (GAP)	This insurance was originally sold to cover the 'gap' between the amount paid out by a motor insurance policy and the amount still to be repaid on the finance that was taken out to buy the vehicle (where that amount was larger).

K9 Marine and aviation insurance

Marine
Marine insurance covers three main areas of risk: physical damage to the ship or goods (cargo), liabilities incurred to other parties and loss of income.

- **Marine hull** insurance covers physical damage to the ship, its machinery and equipment and some limited liability insurance in case of contact with other vessels.
- **Marine cargo** insurance covers loss or damage to goods.
- **Marine freight** insurance covers the sum paid for transporting goods or for vessel hire.

Aviation
Aviation insurance covers both loss of or damage to the aircraft (hull) and legal liability to third parties and passengers (liability). Specialist covers such as aviation products and personal accident policies for aircrew are also insured in the aviation market. However, aviation cargo is covered under a marine policy. **Satellite insurance** is a specialised branch of aviation insurance.

K10 Combined or packaged policies

A combined or packaged insurance policy is one that brings together a number of different types of cover or a range of risks/perils under one policy. Examples are:

Commercial package	Marketed under a variety of trade names these policies are designed to provide a range of covers automatically for particular trade sectors, e.g. shopkeepers, hoteliers, hairdressers. The cover is relatively inflexible and it would not be possible to exclude different sections. The packaging has been carefully researched so that the majority of those in the particular trade are catered for. The packaging is usually offered at very favourable rates.
Commercial combined	These policies pre-date the package policies and were originally introduced to cater for small business risks, such as traders and shopkeepers, where more than one type of insurance is required. Nowadays they tend to be issued either for risks that are not eligible for package arrangements or where greater tailoring is required. Such policies may bring together for example, fire, business interruption, theft, money etc. The benefit of having these various types of insurance within one policy is that a single renewal notice and premium payment is made. There is also some modest premium saving as a result of insuring several classes in one document. The policy is really a 'shell' into which different covers may be placed. As these insurance products, which are largely aimed at small to medium sized business, have become more commoditised, insurers have developed 'eTrade' portals through which brokers can place risks online, without having to pick up the phone. These are usually hosted by a software house, which provides the technology to support eTrade activities for multiple insurers, or alternatively via an insurer's own extranet.

Question 1.5

Insurance cover can usually be purchased in the UK to protect against:

a. An investment loss on the stock market. ☐

b. Dishonesty of an employee. ☐

c. Failure of a business venture. ☐

d. War damage to a domestic property. ☐

Key points

The main ideas covered by this chapter can be summarised as follows:

Overview of risk and risk transfer

- Risk has an element of uncertainty, unpredictability and sometimes danger.
- The term risk is used in a number of different ways in the insurance market and can mean the peril or contingency that is insured, the thing (or liability) actually insured or both the thing insured and the range of contingencies or scope of cover required.
- Individuals can be either risk-seeking or risk-averse.
- The primary function of insurance is to act as a risk transfer mechanism; that is to transfer a risk from one person, the insured, to another, the insurer. The insured exchanges a large unknown financial risk for a much smaller certain premium.

Risk management

- The primary function of insurance is to act as a risk transfer mechanism, that is to transfer a risk from one person, the policyholder, to another, the insurer. The policyholder exchanges a large unknown financial risk for a much smaller certain premium.
- Risk management seeks to identify, analyse and control risk.
- Risks can be controlled by physical means (taking measures to decrease the likelihood of a feared event happening) or by financial means (transferring the risk to another by insurance or by contract). They can be controlled by improving risk awareness through cultural behaviour and training.

Components of risk

- The insurer will consider the frequency with which a risk occurs, and the severity of its impact when it does, when deciding how much of a risk can be prudently accepted.
- A peril is that which gives rise to a loss and a hazard is that which influences the operation or effect of the peril. Hazard can be physical or moral.

Features of insurable risks

- In order to be insurable, risks must be financial (i.e. their impact be capable of financial measurement), pure (i.e. not speculative) and particular (i.e. localised and personal in their impact).
- An event insured against must be fortuitous or unforeseen, there must be insurable interest and insuring against it must not be against public policy. Generally, too, there must be homogeneous exposures.

Pooling of risk

- Pooling of risk is the principle that the losses of the few are paid for by the premiums of the many.
- The law of large numbers means that where there are a large number of risks covered, the actual number of losses occurring tends to be very close to what was expected.
- Each person contributing to the pool must pay a fair premium based on the amount of risk they bring.

Benefits of insurance

- Insurance brings peace of mind for the policyholder and a number of economic benefits to both businesses and society at large.

Risk sharing

- An insurer can deal with a risk that is too large through either co-insurance or reinsurance.

Key points

- Co-insurance often describes where the carrying of a risk is shared between two or more insurers.
- It can also refer to the case where the insured agrees to retain part of the risk themselves.
- Dual insurance is the existence of two or more policies covering the same risk.
- Self-insurance is where the policyholder decides to carry the risk themselves by setting aside funding.

Classes of insurance

- Personal lines insurance protects a policyholder from loss or damage to personal property or from damages for which the policyholder may be held personally responsible.
- Commercial lines insurance protects a business from loss of its business property or damages for which the company may be held liable.
- The main types of general insurance are home, motor, travel, commercial property and liability.
- There is also a range of general insurance related to the health of a person, such as personal accident, sickness, medical insurance, payment protection, indemnity and critical illness.

Question answers

1.1 b. Risk-averse.

1.2 c. Risk control.

1.3 a. Good moral hazard.

1.4 a. Claims payment predictions.

1.5 b. Dishonesty of an employee.

Self-test questions

1. For a risk to be insurable it must be:
   a. Financial, speculative and particular. ☐
   b. Fundamental, pure and particular. ☐
   c. Financial, pure and particular. ☐
   d. Fundamental, financial and pure. ☐

2. Homogeneous exposures are:
   a. Similar risks which help set premium levels. ☐
   b. Identical risks which help set premium levels. ☐
   c. Identical risks which help determine a pattern. ☐
   d. Similar risks which help determine a pattern. ☐

3. Gary is starting a mobile bicycle repair business. He is concerned about the threat of local competition. He should be aware that this is not insurable as it is a:
   a. Pure risk. ☐
   b. Speculative risk. ☐
   c. Financial risk. ☐
   d. Non-financial risk. ☐

4. What are the three steps to managing risks?
   a. Risk identification, risk monitoring and risk avoidance. ☐
   b. Risk identification, risk analysis and risk control. ☐
   c. Risk highlighting, risk analysis and risk monitoring. ☐
   d. Risk highlighting, risk analysis and risk avoidance. ☐

5. An intruder alarm in a workshop is an example of a:
   a. Physical control measure. ☐
   b. Preventative control measure. ☐
   c. Material control measure. ☐
   d. Financial control measure. ☐

6. The pool of insurance premiums must be large enough to meet the losses in any one year plus the:
   a. Costs of operating the pool and an element of profit. ☐
   b. Costs of operating the pool. ☐
   c. Anticipated losses in the following year. ☐
   d. Costs of operating the pool and an element of contingency. ☐

7. Mi Casa Home Insurance has issued a collective co-insurance policy with two other insurance firms for a local construction company. It is **true** to say that:

   a. The construction company only has a direct contractual relationship with Mi Casa. ☐

   b. Mi Casa decides the terms and rating to be applied. ☐

   c. Mi Casa is solely responsible for settling any claims made. ☐

   d. The construction company has a direct contractual relationship with each of the insurers. ☐

8. A taxi firm that regularly puts an amount of money aside to cover the costs of accidental damage is an example of:

   a. Co-insurance. ☐

   b. Dual insurance. ☐

   c. Self-insurance. ☐

   d. Reinsurance. ☐

9. A car mechanic has an accident at work and seeks damages from the garage owner. This claim is **most** likely to paid by the garage owner's:

   a. Public liability insurance. ☐

   b. Employers' liability insurance. ☐

   c. Property insurance. ☐

   d. Accident and sickness insurance. ☐

10. Income protection provides:

   a. Fixed benefits in the event of accidental death or bodily injury. ☐

   b. Fixed benefits in the event of an accident, illness or loss of job. ☐

   c. Payments for inability to work due to sickness only. ☐

   d. Payments in the event of diagnosis of a serious illness. ☐

You will find the answers at the back of the book

2
The insurance market

Contents	Syllabus learning outcomes
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C Lloyd's	*4.3*
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E Intermediaries	*4.5*
F Insurance marketing and distribution	*4.5*
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Learning objectives

After studying this chapter, you should be able to:

- discuss the operation and structure of the insurance market;
- explain the features of different types of insurance company;
- describe the structure and main features of the Lloyd's and London markets;
- describe the different distribution channels used for buying and selling insurance;
- describe the basic purpose of reinsurance;
- describe the functions of underwriters, claims personnel, loss adjusters, loss assessors, actuaries, risk managers and compliance officers;
- describe the main functions of the major market associations, professional bodies and trade bodies; and
- describe the functions of the Motor Insurers' Bureau (MIB).

Introduction

The insurance market is a truly global market with buyers and sellers in every country. Many buyers of insurance are multinational companies operating in many countries, and their suppliers of insurance (the insurers) are frequently also multinational, operating on a global scale.

There are some restrictions on this apparently 'perfect' market. Some parts of the world insist on risks within the country concerned being placed with a domestic or specific insurer, or with an insurer authorised by the State to underwrite that form of insurance in that country. For example, employers' liability insurance in the UK must be placed with an authorised insurer, while in some provinces of Canada the liability aspects of motor insurance must be insured with the provincial government agency.

Example 2.1

A single modest-sized household insurance risk is placed directly with an insurer in the same territory: the insurer retains the whole of the risk premium and is responsible for every valid claim. The supply chain here appears very short and many risks around the world will be placed on this basis. However, even in this apparently compact arrangement we may find that there are complicating factors that tell us something about the nature of the market. Let us assume that the insurer, when considering its whole household account, is concerned that there are many risks in the same geographic area. This could mean that, although individually the risks are all modest in size, collectively they present a high potential exposure for a single incident caused by, say, the peril of flood.

The insurer may therefore seek some protection for this accumulation of flood exposures. This can be done by means of reinsurance. To access this part of the market, the insurer may employ the services of a reinsurance broker. The broker may organise the reinsurance in a different territory from that of the original risks. The reinsurer, when considering its own accumulations of exposure, may decide to exchange part of its portfolio of flood risks in one area with those insured by another reinsurer that covers flood risks in different parts of the world. This can be achieved through mechanisms called catastrophe exchanges.

From this example we can clearly see that elements of what appeared to be a simple, straightforward local risk have become part of a much wider international arrangement. The risk has been shared with a number of other parties. If this is what can occur even with the most straightforward of risks, it is not difficult to imagine how the larger, more complex risks will often be spread around this global market. The multinational company that has a presence in many different territories may have very complex arrangements for their insurances, involving the local insurance market, the international insurance market and the reinsurance market. There may be a number of different intermediaries involved at different stages in the process.

Fortunately, modern communications allow business to be conducted at times and places convenient to the insured, intermediary and insurer. There are of course still certain recognised centres for insurance, including the London Market which offers worldwide capacity through Lloyd's, the International Underwriting Association of London (IUA) and the company market in general.

Key terms

This chapter features explanations of the following terms and concepts:

Actuaries	Bancassurance	Claims personnel	Compliance officers
Consolidators	Distribution channels	Insurers	Intermediaries
Lloyd's	London Market	Loss adjusters	Loss assessors
Managing agent	Price comparison websites	Reinsurance	Takaful
Underwriters			

A Market structure

The insurance market is made up of five main components:

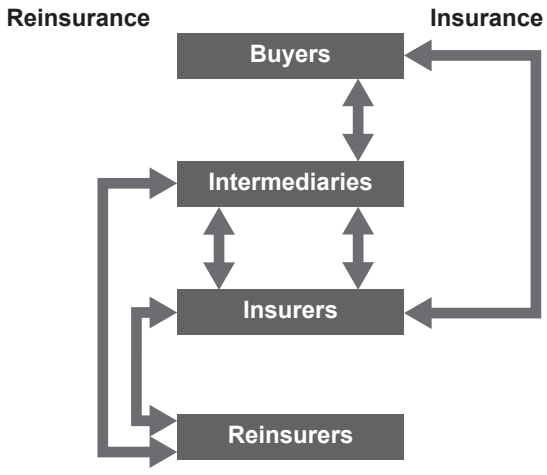
- Buyers (policyholders/insureds).
- Insurers (sellers).
- Intermediaries (those who bring buyers and sellers together).
- Comparison websites (aggregators).
- Reinsurers (a further means of spreading risks).

Consider this…

Think of any market you are familiar with and identify the different ways sellers compete with one another. Would competition in this market differ from competition in the insurance market? If so, in what ways?

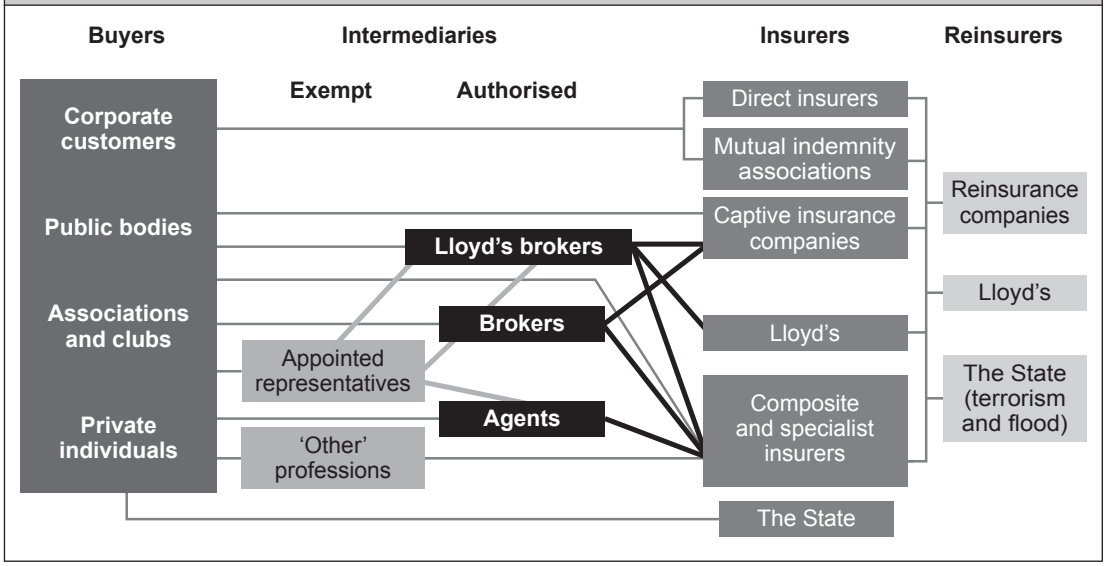
All of these different groups of people communicate with each other and with the many other people who work in or around the insurance market. This interaction is easily illustrated by the diagram shown in figure 2.1.

Figure 2.1: Information flow



Let us now expand figure 2.1, so we can take a closer look at the people who may be included under the main headings of buyers, intermediaries, insurers and reinsurers (figure 2.2).

Figure 2.2: Interaction



A1 Buyers

The buyers of insurance may be divided into five main types:

- Private individuals.
- Companies.
- Partnerships.
- Public bodies.
- Associations and clubs.

A1A Private individuals

Many people buy insurance in their private capacity. Household buildings and contents insurance will be high on the list, though motor insurance will tend to be the major item of insurance expenditure for most individuals. Many other types of cover are purchased by individuals.

A1B Companies

The range covered by this category of 'buyer' extends from the very largest multinational corporation with a multi-million pound worldwide premium spend to the self-employed sole trader working from home. Unlike partnerships, limited liability companies have a separate legal existence from those who own the company.

A1C Partnerships

Partnerships do not have a separate legal existence, each of the partners being jointly and severally liable. They are most commonly found in the medical, veterinary and legal professions and their insurance needs, especially in the area of professional negligence (the giving of poor professional advice that leads to loss), tend to be catered for by specialist schemes.

A1D Public bodies

Public bodies are major buyers of insurance and include local authorities and schools. In some cases, they may be large enough to have set up their own insurance fund through which they insure some risks, while turning to the insurance market to cover other risks. Some public bodies are exempt from compulsory insurance requirements. Police forces, for example, do not have to insure their motor vehicles. However, most exempt bodies still choose to insure risks where there is a real catastrophe potential – which would include the liability for personal injury in connection with the use of motor vehicles.

A1E Charities, associations and clubs

There are many charities, associations and clubs that will have some insurance needs. Whether it is the local football club or the local stamp collecting society, the management

team or organisers will usually buy insurance cover for liability risks and damage to owned property. They may also act for members by arranging group covers or schemes.

In legal terms these are 'unincorporated associations' and have special requirements because, theoretically, each member is liable for the association's actions. This is why, when policies are issued for such organisations, you will see that the insured's name tends to be expressed as 'The committee and members for the time being of…'.

B Insurers

Any company wishing to transact insurance in the UK must be authorised to do so by the **Prudential Regulation Authority (PRA)** and the **Financial Conduct Authority (FCA)**.

The PRA must be satisfied that the applicant complies with its conditions. In particular, insurance companies are required to maintain defined levels of solvency margins. (A company's solvency margin is the difference between its assets and its liabilities.)

Insurers may be distinguished from one another in terms of ownership and function.

The FCA's strategic objective is to make sure that the relevant markets function well, which includes the role insurers play in the insurance marketplace.

Refer to
The roles and objectives of both regulators are discussed further in Chapter 10.

B1 Types of insurer as defined by ownership

There are a number of categories of ownership:

- Proprietary companies.
- Mutual companies.
- Captive companies.
- Protected cell companies.
- Lloyd's.

We will now examine these in more detail.

Refer to
Lloyd's explained in *Lloyd's* on page 2/8

B1A Proprietary companies

Most of the insurance companies in this group are registered under the **Companies Act 1985**. These companies are owned by shareholders who, in buying shares, contribute to the share capital of the firm. Therefore, company profits, after expenses and reserves, belong to the shareholders.

Proprietary companies are limited liability companies. This means that a shareholder's liability for the company's debts is limited to the nominal value of the shares they own (the originally stated face value of the shares). Some are publicly quoted companies with a share value stated in the recognised financial exchanges. This applies to many of the 'household names' in insurance. They have the letters 'plc' after their name. Even these companies may choose to operate under a brand: for example, Direct Line Group operates under various brands, including Direct Line, Churchill, Privilege and Green Flag for roadside assistance, and Royal and Sun Alliance plc continues to operate under the 'MORE TH>N' banner.

However, some insurance companies operating in the sector are private limited companies whose shares may be owned by a few shareholders, or sometimes by only a single shareholder. Their shares are not available to the general public. In the UK such companies have the designation 'Ltd' after their names. Limited companies are more commonly small- to medium-sized insurance intermediaries rather than insurers, simply because of the large amount of capital required by insurers to conduct business.

B1B Mutual companies

In contrast to proprietary companies, mutual companies are owned by the policyholders. The policyholders share in the profits of the company by way of lower premiums. In theory, these policyholders are liable for any losses made by the company. However, in reality, mutual companies are limited by guarantee, with a policyholder's maximum liability usually limited to their premium. There has been a trend for insurers owned in this way to demutualise, which means they then become proprietary companies.

B1C Mutual indemnity associations

Mutual indemnity associations are self-managed pools of insurers and, similarly to mutual companies, also owned by their policyholders. They are primarily active in marine insurance, where Protection and Indemnity Associations (known as 'P&I clubs') insure certain aspects of marine hull liability. The contribution ('call') is set initially and further calls are possible depending upon the overall results.

B1D Captive insurers

A captive is an insurance company established by its parent company or group (usually a large corporation) that provides insurance coverage primarily, if not solely, to that parent company.

Captive insurance is a tax-efficient method of transferring risk and has become more common in recent years among the large national and international companies. The tax efficiency arises in two ways:

- Premiums payable to the captive may be tax deductible at source.
- The captive will be established in a territory with a favourable tax rate that will apply to any trading profits. Many captives operate from offshore locations such as the Republic of Ireland, the Channel Islands, Bermuda and the Isle of Man because of such favourable tax regimes.

Apart from tax efficiency, there are other incentives. These include:

- the ability to get the full benefit of the group's risk control techniques by paying premiums based on its own experience;
- avoiding the payment of extra premium designed to meet the direct insurer's overheads; and
- obtaining a lower overall risk premium level by being able to place certain risks in the reinsurance market with its flexible products and lower overheads.

Captive insurers do not offer insurance to the general public.

Protected cell companies (PCCs)
In 1997 Guernsey created a new kind of captive insurer, the **protected cell company (PCC)**, that 'ring fenced' the assets of the participating cells and allowed them to operate as distinct insurance entities. Since then PCC regulations have been introduced in a number of other countries/areas, including Bermuda, Barbados, Gibraltar, Malta and the Isle of Man. Gibraltar and Malta are able to offer the facility throughout the EU via EU 'passporting' provisions.

A PCC is a special type of captive insurer that operates in two parts with a core and an unlimited number of cells. It 'ring fences' the assets of the participating cells and allowed them to operate as distinct insurance entities.

A PCC operates in two parts with a core and an unlimited number of cells. A PCC is a single legal entity, which has a single board of directors that manages the affairs of the PCC as a whole. The PCC's articles usually empower the directors of the company to create cells at their discretion simply by resolving to create a new cell.

- Each prospective cell owner must enter into a cell management agreement with the PCC board and will be bound by the PCC's memorandum and articles of association.
- Entry to the PCC is subject to approval by the PCC board who will require details of the proposed business plan and will agree the parameters within which the cell is to operate.
- A PCC files a single annual return, but regulatory approval is required for the business plan of each cell.

- PCCs have many uses and are not just used as risk transfer vehicles. Some insurers use their PCCs to offer 'captive' facilities to clients and some to offer niche products where conventional cover is expensive or unavailable.
- There are a number of benefits to using a PCC, including the minimum establishment and administration costs, and their creation in territories with favourable tax rates that will apply to any trading profits.

B2 Types of insurer as defined by function

So far we have classified companies according to their form of ownership. However, in terms of the marketplace it is more relevant to classify them by function or type.

Composite companies	These accept several types of business (called classes of business) and represent the major part of the company market.
Specialist insurers	These tend to issue policies for only one class of business.

Composite insurers usually accept property, casualty, motor, accident, life and marine business as well as other types of insurance. With mergers and acquisitions, the six largest composite groups account for over 60% of general premium income written by UK insurers. Specialist insurers, on the other hand, have expertise in one particular niche area and so they form a valuable addition to the market but in a narrow area.

B3 Takaful insurance companies

Takaful is a type of insurance that has its roots in the Islamic financial services industry. The model has been developed over a period of time and is based on the rulings of Sharia law on financial and commercial transactions. It works on the principle that in any transaction risk and profit (and loss bearing) should be shared between the participants.

The reason for this business development is to meet a specific customer group, namely insurers and intermediaries with a need for products to meet their particular religious principles.

Under Islamic (Sharia) law, traditional insurance policies are seen by Muslims to be contrary to some of the fundamental principles of Islam. This is because they involve:

- **Gharar** (**uncertainty**) – Islamic law forbids sales where there is risk to the buyer, unless the risk is of a normal or reasonable proportion. Some believe that traditional insurance policies do not remove uncertainty because how much and when, if at all, a policy will pay out remains uncertain.
- **Maisir** (**gambling**) – traditional insurance policies are seen to be a sort of gambling because some policyholders receive payouts while others do not. Gambling is forbidden under Islamic law.
- **Riba** (**interest**) – Islamic rules also forbid making money from money, such as through interest. Wealth can only be made through the trade of assets and investments.

Takaful is an Arabic word meaning 'guaranteeing each other'. Takaful insurances embrace the Islamic principles of:

- mutuality and cooperation;
- shared responsibility;
- joint indemnity;
- common interest; and
- solidarity.

Takaful 'insurance' products need to be approved by Islamic scholars to ensure they are compliant, and many providers consult special Sharia advisory committees during the development process.

While Takaful insurance has been in existence for over 30 years, it was only in 2005 that a major high-street bank became the first to offer Islamic insurance policies for buildings and contents. The sector has seen strong and steady growth since then.

B4 The State

In the UK the Government's preferred method of ensuring adequacy of insurance coverage is to legislate to make certain insurances compulsory. However, the State acts as an insurer in a number of different areas, predominantly in welfare benefits and pension provision. It also acts as a guarantor (a kind of reinsurer) to the insurance sector for terrorism risks and flood risks.

Question 2.1

Which type of insurance company does **not** provide insurance to members of the general public?

a. Captive. ☐

b. Composite. ☐

c. Mutual. ☐

d. Proprietary. ☐

C Lloyd's

Lloyd's is **not** an insurer, but an entity providing the infrastructure for the placing of risks in its own market. It also acts as a partial regulator for those organisations offering insurance within that marketplace.

The **Corporation of Lloyd's** oversees and supports the wider market, ensuring that it operates efficiently and keeps its reputation as the key market for large scale, specialist insurance and reinsurance. The regulatory roles includes the agreement of business plans every year, setting minimum standards for performance (and monitoring compliance with them) and also providing some central shared services such as the international trading licences.

Syndicates are the groups of private individuals (also known as "names") or corporate members who actually carry the risks (they provide the financial backing). Each syndicate outsources the day-to-day running of the insurance business to an organisation known as a ***managing agent***. Their responsibilities include employing the underwriters and claims adjusters, and liaison with Lloyd's as well as other regulators. Managing agents are companies established to manage one or more syndicates on behalf of the members that will provide the capital. Lloyd's managing agents are dual-regulated, meaning they have to be approved by the PRA to carry on PRA-regulated activities and any business conduct activities are regulated by the FCA. At the end of 2010, there were 50 managing agents.

In 1990 the market's business was written by 401 syndicates, but there were 76 as of 31 December 2020. By allocating capital support to each syndicate each year, the members govern the amount of business that each syndicate can underwrite each year – the syndicate capacity. Lloyd's capacity continues to increase and Lloyd's is focused on remaining attractive to investors in the future.

A **members' agent** is effectively a form of specialist financial adviser. They specifically advise potential individual members on the advantages and disadvantages of investing in the Lloyd's market, syndicate selection and performance, reserve requirements and compliance issues. They also act as a communication channel between the member and the various managing agents running the syndicates in which the member has invested, receiving the regular reports on the profits (or not) made by the syndicate. There are currently only four active members' agents. These firms are approved by the FCA and by Lloyd's specifically to advise on Lloyd's syndicate participation.

A potential corporate capital member can use a members' agent if they wish, however the vast majority do not, usually because they are more sophisticated investors and/or are supporting a syndicate managed within the same corporate structure.

On the Web
www.lloyds.com

C1 Transacting insurance at Lloyd's

The Lloyd's market is centred around a modern, purpose-built building in the heart of the City of London. Each syndicate has a space on the trading floor with desks and chairs, still referred to as 'boxes' reflecting the original style of furnishing, and traditionally brokers have approached them there to negotiate their contracts.

Although many brokers operating in the London Market are known as Lloyd's brokers, it is not a requirement to hold this status in order to transact business in the Lloyd's market. Many brokers however like to hold this status as a brand benefit to them particularly with overseas clients.

To become a Lloyd's broker, a broking firm (who could be based overseas) must firstly be fully regulated by their own regulator (so in the UK, the FCA) and must then satisfy certain requirements set by Lloyd's about capability, understanding of the market and ability to transact business using the central market systems.

Most risks are not placed using a proposal form but using a **Market Reform Contract (MRC)** (still known as a '**slip**') and there is a strict set of rules in place regarding the nature and content of this document particularly as this document can then be used as the evidence of the final contract, rather than a formal policy being issued.

Traditionally, much of the business at Lloyd's was still transacted by face-to-face negotiation with brokers visiting the underwriters either in their offices or in the Underwriting Room in the Lloyd's building. However in recent years, in a drive towards better operational efficiency, increasing steps have been taken to encourage the market to start placing business electronically using one of a number of systems that were developed for Lloyd's, both by the market itself and also by commercial software providers. This has not been a complete success with some parts of the market being very resistant to change!

The impact of the COVID-19 pandemic was fundamental as Lloyd's closed the Underwriting Room and brokers and insurers also closed their offices. This forced every corner of the market to use the electronic systems, with email as an emergency backup, or face not being able to transact business.

However, the market did not grind to a halt and business – even the more complicated risks – was placed and renewed successfully during the periods of closure before the Underwriting Room and wider Lloyd's building reopened.

The vast majority of business placed into the Lloyd's market will involve a broker who will obtain a quotation from an underwriter recognised as a 'leader' in a particular class of business. The underwriter will indicate the percentage share that they will accept and the terms that apply. Subsequently, the broker will approach other underwriters and will 'fill' the slip by obtaining signatures for the shares that they are each willing to accept.

The term underwriter comes from the days of the Lloyd's coffee shop where merchants would put details up on a board of their next adventure for which they were seeking support. If anyone was prepared to invest in their adventure they would add their name under the details – hence 'underwriter'. The noise of the name being added also led to the use of the term 'scratch' for the signature, or initials and date that an underwriter adds to the slip/Market Reform Contract.

Many risks written in the Lloyd's market are large and have high financial exposures. This means that it is not generally possible (or sensible) for a single underwriter to accept 100% of a risk. Each underwriter that the broker approaches will accept a percentage share. This sharing of the risk between a number of insurers is known as subscription underwriting.

Once the slip is fully placed (in other words, the percentages accepted by each underwriter total the amount of cover required, usually 100%) the information about the risk (including a copy of the slip/market reform contract, details of the insurers, the premium to be paid and any applicable taxes) is submitted by the broker to an organisation called **Xchanging**.

Xchanging manages central risk data capture and money movement systems for the entire London Market (so both Lloyd's and companies). Xchanging personnel will capture the

details of the risk on their database and overnight messaging every night populates the insurers databases. Additionally, Xchanging will manage the collection of the net premium from the broker and the distribution to the appropriate Lloyd's and London company market insurers (insurance companies operating within the London Market outside of Lloyd's – see *The London Market* on page 2/11).

In order to pay the premium, the broker collects the gross premium from their client and pays it via Xchanging, less the agreed commission (also known as **brokerage**).

If a formal policy document is required by either Lloyd's insurers or London company market insurers for sending to a client, this can be requested from Xchanging who will prepare it on the insurer's behalf.

Not every risk placed in Lloyd's requires the support of more than one underwriter. Motor insurance is a good example of a class of business where the insurance will be placed with a single underwriter, who will accept the whole of the risk. For this type of business there also tends to be a standard policy wording which will be sent to every customer without having to be specially prepared and signed.

C2 Limited and unlimited liability

The original 'names' investing in the Lloyd's market were people who, having demonstrated a certain level of financial wealth, provided capacity for insuring risks. They did so by guaranteeing their shares of losses up to the full extent of their own personal fortune. This is what is meant by **unlimited liability** and was and is a very onerous commitment.

Problems arose because the entry requirements were relatively low in terms of the net worth that had to be demonstrated, and the application could be supported by a bank guarantee on the main residence of the prospective Member. Particularly in the 1980s there was a boom in house values so reasonably modest properties were valuable enough to meet the requirements.

Additionally, membership of Lloyd's was often given as a retirement present to employees who themselves did not have the net worth behind them. Historically because of healthy investment returns the pure underwriting losses of the 1960s and 1970s had been neutralised and the market was seen as a very appealing investment vehicle, never having actually lost money.

In the late 1980s there was a serious of major losses to hit the market, including hurricanes and the Piper Alpha oil rig disaster in the North Sea. In addition the problems with asbestos and ongoing pollution were beginning to manifest. The losses to hit the market were catastrophic and the names were faced with substantial requests for funds that many of them just did not have leading to many situations of bankruptcy and other hardships.

The Lloyd's market went through a period known as Reconstruction and Renewal which involved putting all the business from the 1993 year and prior into a specialist reinsurer known as Equitas. What was also changed was the investment framework of the market to welcome corporate capital, as well as to introduce limited liability for any new individual members.

This corporate capital was introduced so that the resources of a new type of investor could help strengthen the capital base of Lloyd's. Corporate members have limited liability for their share of the risks accepted. The proportion of capital from individuals in the market has dramatically decreased since 1994, so that in 2019 only 9.8% of Lloyd's capacity was provided by private capital – both unlimited and limited. Those who were unlimited liability members before the problems and wanted to remain were able to, but any new individual members now all have limited liability in the same way as the corporate capital members.

Question 2.2

Which individuals provide financial backing for Lloyd's syndicates?

a. Underwriters. ☐

b. Names. ☐

c. Managing agents. ☐

d. Member agents. ☐

D The London Market

Lloyd's represents only a part of the much wider London insurance market, which itself is a distinct, separate part of the UK insurance and reinsurance sector. The main providers in this market are insurance and reinsurance companies (many of whom are members of the **International Underwriting Association of London (IUA)**, Lloyd's syndicates, Lloyd's service companies (who effectively operate as branch offices of the syndicates in places such as Singapore and Dubai), and protection and indemnity clubs (mutual insurers which deal in marine liability risks). Much of the business is conducted internationally, including significant insurance and reinsurance arrangements.

The London Market is the place where many sizeable or complex industrial risks from all over the world are placed. This market in general, and perhaps the Lloyd's market in particular, has been a focus for placing very unusual risks and is arguably unique in the world in this respect.

To give you an indication of its size, Lloyd's gross written premium income for the year 2010 was £35.5 billion (source: Lloyd's *Annual report 2020*). It is not possible to be precise about figures for the London Market because some of the insurers that operate in this market do not produce separate sets of figures for this aspect of their overall operations.

D1 Contract certainty

One of the main ingredients of a valid contract (of insurance or otherwise) is a meeting of minds – so that there can be no ambiguity or potential for disagreement between the parties as to the terms of the deal that they have done.

Historically, the London Market was not particularly good at ensuring that the documentation evidencing the deals being done was complete and accurate, notwithstanding the financial size of those deals. Problems arising after the point of contract (e.g. during claims) were often negotiated out or litigated between the parties.

However, the 2001 terrorist attacks on the World Trade Center led to many claims being made on various types of insurance contract written at least in part in the London Market. Issues were found with incomplete documentation which led to many years of highly expensive litigation between clients, insurers and reinsurers about the relatively simple topic of what deal(s) had actually been done. As well as the time and costs involved, there was a certain reputational impact as well.

The UK regulators at the time were not very impressed and issued a simple challenge – insurers had to ensure that a large proportion of their contracts were certain at the time they were entered (generally when the underwriter accepted a share of the risk). This clarity centred around the details of the deal itself, and the final share of the risk that the insurer was accepting.

The concept is known as ***contract certainty***.

The following definition for contract certainty has been agreed within the London Market:

> Contract certainty is achieved by the complete and final agreement of all terms between the insured and insurers by the time they enter into the contract, with contract documentation provided promptly thereafter.

Contract certainty does in fact involve three distinct but equally important elements:

- Certainty as to the details of the contract that has been agreed.
- Certainty as to the final share of the risk that each insurer has agreed to take – an underwriter's original written line (or share) that they agree to take might well be proportionately reduced or "signed down" by the broker if the risk is popular and many insurers want to participate. It is their final signed line which insurers need to have in their records as soon as possible.
- The provision of contractual documentation to the client promptly, i.e. within 30 calendar days for commercial customers, or seven working days for consumers.

If a broker is involved in the placement, then both the broker and the underwriters share the responsibility for making sure that contract certainty is achieved, and both parties should carefully check all the documentation (for example the slip/market reform contract) for ambiguity/contradiction or missing information.

E Intermediaries

The structures and functions of intermediaries vary according to the status of the intermediary and the terms of the business agreement with the insurance provider. However, there are some general rules which we will summarise here.

An insurance intermediary is an agent, but many insurance intermediaries perform a wider range of functions than simply bringing the two parties (the insured and the insurer) together. In broad terms we can distinguish between the functions of independent intermediaries and other intermediaries, who are more clearly linked to one or more product providers. In legal terms an ***agent*** is one who is authorised by one party, termed the ***principal***, to bring that principal into a contractual relationship with another, termed the ***third party***.

Refer to
Law of agency covered in more detail in *Agency* on page 3/8

The FCA is the regulator for all aspects of insurance sales, advice and conduct (in addition to the authorisation and monitoring of intermediaries). The rules that relate to intermediaries also apply to insurers in connection with their mediation activities, i.e. their advice, promotion and sales functions, and complaints handling.

Under FCA rules all 'persons' (and this includes firms) engaged in insurance mediation activities must be either directly authorised by the FCA or exempt. To be exempt means the intermediary must adopt the status of an **appointed representative (AR)** or **introducer appointed representative (IAR),** or be a member of a professional body that has equivalent rules to those of the FCA, termed a **designated professional body**. Broadly speaking this means that an authorised person/firm will take responsibility for the activities of ARs and IARs.

In addition to these, the **Insurance Distribution Directive (IDD)**, implemented in October 2018 (see *Insurance Distribution Directive (IDD)* on page 10/27 for more information), introduced a new category of intermediary: the **ancillary insurance intermediary (AII)**. An AII is person that distributes insurance on an ancillary purpose, and whose principal professional activity is not insurance distribution. This could include travel operators that sell travel insurance as part of their services, but not as a main part of their business.

E1 Authorised persons

An **authorised person** is an individual or firm authorised by the FCA to engage in regulated activities.

An intermediary, whether a sole trader or a company, wishing to offer insurance must apply for direct authorisation by the FCA, unless they have decided that the status of appointed representative is more appropriate for them.

Once authorised, a firm is bound to abide by all FCA rules. These rules are demanding, particularly in terms of financial accounting, training and competence, and reporting requirements. Consequently, since their introduction there has been a great deal of consolidation in the market place through sales and acquisitions. In addition, umbrella

organisations have been created that are known as **broker networks**. These vary in their structure, but one model for this is that the umbrella organisation becomes the authorised person and each ‘member’ of the network becomes an appointed representative, thus availing itself of the centralised facilities.

The FCA rules are in addition to any legal duty of trust that an agent owes to a principal.

E2 Appointed representatives

An **appointed representative (AR)** may be an individual or a company that is appointed by an authorised person (the principal) under the terms of a contract. An AR may be acting for an insurer or for an intermediary that is itself directly authorised by the PRA or FCA. The contract which sets out the terms of business between the parties (called an Appointed Representative Agreement) determines the AR’s role and responsibilities. The key feature is that the principal takes responsibility for the AR’s activities in carrying on the business of the principal.

An AR may act for more than one principal, provided that there is a suitable contract in place with each one. Although there is no regulatory restriction regarding the number of appointments held, market practice has effectively imposed a modest limit. This is because of the complexity of operating under many different contractual arrangements with different authorised persons. If a principal appoints an AR that is already acting for another firm, the principal must enter into a written multiple principal agreement with every other principal the AR may have.

As a category, ARs include organisations with a non-insurance main occupation, such as motor garages, freight forwarders, and associations who sell relevant insurance products to their members. They may also be full-time insurance agents that have decided to become ‘tied’ to one or more insurers rather than become authorised directly themselves.

Once appointed as an AR, the authorised person they are acting for is responsible for ensuring they abide by all FCA rules in relation to any regulated activities they perform. The authorised person must, therefore, have adequate oversight arrangements in place over the AR.

Principals in the past have not always been able to demonstrate efficient control measures and this was highlighted by an FCA Thematic review, 'TR16/6 Principals and their appointed representatives in the general insurance sector', conducted in July 2016.

The review found significant shortcomings with principal firms' understanding of their regulatory obligations. It identified that insurers could not demonstrate enough control and oversight of their AR activities. As a result, the FCA took intervening action with five firms who took part in the review, limiting their appointed representative activities.

E3 Introducer appointed representatives

An **introducer appointed representative (IAR)** is one whose scope of appointment by the authorised person/firm is limited to effecting introductions and distributing what are termed 'non-real time financial promotions' – in other words supplying such things as brochures and proposal forms. The principal is responsible for the actions of its IARs, but a less demanding regime applies. For example, the FCA's training and competence rules, which apply to ARs, do not apply to IARs.

We can see that this type of appointment would suit many who wish to act as a marketing channel for an insurer (or authorised intermediary). Individuals and firms who provide no advice, but simply act as a shopfront for an insurer’s products, fall into this category.

E4 Lloyd’s insurance brokers

It is worth pointing out at this stage that the term ‘broker’ is frequently used in the insurance market. At one time it was necessary to be formally registered to use this term. Nowadays, in practice it tends to be only those offering truly independent advice that use the term in their titles. The FCA makes no distinction between the term ‘broker’ and ‘independent intermediary’.

However, although the term ‘broker’ may be freely used in the market, it is the Council of Lloyd’s that registers insurance broking firms to act as **Lloyd’s brokers**. This title has been retained, even though access to Lloyd’s has been granted to a wider range of intermediaries

by virtue of the Legislative Reform (Lloyd's) Order 2008. To be registered, brokers must satisfy the Council as to their expertise, integrity and financial standing. Once appointed, the words 'and at Lloyd's' may be used on letterheads and name plates. The requirements of Lloyd's are in addition to those of the FCA for authorised persons. However, Lloyd's no longer has its own separate code of conduct for Lloyd's brokers, relying instead on the FCA rules for authorised persons.

An intermediary that is not itself a Lloyd's broker and does not wish to pursue the new direct routing possibilities, may access the Lloyd's market by using the services of a Lloyd's broker. This effectively creates a chain of supply. In these circumstances the Lloyd's broker is termed a 'wholesale' broker and the originating intermediary a 'sub-broker' or 'producing broker'.

E5 Services provided by intermediaries

In the market, the main distinguishing feature of an independent intermediary, which includes Lloyd's brokers, is the fact that the intermediary is acting on behalf of the client when placing business, not on behalf of the insurer in introducing the business. The expertise of the independent intermediary is, in part, demonstrated by recommending the most appropriate insurer with which to place the risk.

The intermediary must be capable of offering advice on the basis of a fair analysis of the market. This does not mean that they do so in every case. However, there is an obligation under FCA rules to make available a list of product providers if the market has not been fully explored and only a restricted number of insurers approached.

Remuneration from the insurer is traditionally a percentage of the premium payable, though increasingly there is a tendency in larger commercial insurance for intermediaries to charge a fee for their services instead (in which case they would rebate the commission to the client or agree a net premium with the insurer).

The services that intermediaries provide for their clients vary considerably. All independent intermediaries:

- decide the best market in which to place the risk;
- negotiate terms and conditions initially and for mid-term changes;
- provide advice to the client regarding the detail of the policy wording;
- review client needs;
- negotiate renewals; and
- advise the client on the validity of claims.

There are further services that may be provided and these will be specified in the Terms of Business Agreement (TOBA) with the client. They include:

- risk management advice;
- assisting with the presentation of claims; and
- assisting in recovering any uninsured losses.

What we have considered so far are services provided to clients. Other functions may be carried out by the intermediary on behalf of insurers, depending upon the TOBA with the insurer. These could include:

- collecting the premium;
- committing the insurer to cover the risk (if authorised);
- settling claims on behalf of the insurer (if authorised); and
- issuing motor, or other cover notes to give evidence of cover.

If an intermediary operates as the AR of an insurer, they may only give advice in relation to that insurer's products. They do not, therefore, carry out the wider functions that relate to the suitability of different markets. However, they continue to have a responsibility to match a client's demands and needs with suitable products from within their principal's range or from any wider product range available to them if they are the AR of more than one insurer.

They may also carry out functions relating to mid-term alterations and renewals. For these purposes they are acting on behalf of the insurer from whom they receive their authorisation.

They may carry out any function, if they are authorised to do so by the insurer. This will be set out in the TOBA between the insurer and the AR.

On the other hand, an intermediary may operate as the AR of an independent intermediary, that is itself an authorised person. In this circumstance they may carry out the wider functions that relate to the suitability of different markets, if authorised to do so by their principal. The terms of authority will be contained in the contract between the intermediary and the AR.

E6 Consolidation of the insurance sector

In recent years there has been considerable consolidation in the insurance broking sector. This has relevance to our consideration of the way in which the market operates.

There are many reasons for this consolidation, including the difficulty that many smaller intermediaries have encountered in coping with regulation. Other reasons relate to the age profile of many principals within the sector and pressures on rates that inevitably led to reduced earnings.

Consolidation has taken a number of different forms.

E6A Broker networks

One way in which the market has consolidated is through **broker networks**. One business model used is that of an organisation, authorised by the FCA, offering AR status to those joining the network. This means that firms who join retain ownership of their own broking firm but acquire access to centralised services, which may include accounting, training and development and other aspects of compliance. The network itself benefits from greater purchasing power in negotiations with insurers and there may be cost savings arising from the greater critical mass of the overall organisation.

This is not by any means the only model. There are other networks where all firms are individually authorised by the FCA but join together in a formal alliance. This may be to access a defined range of centralised services from the ‘senior’ firm in the alliance or to obtain more favourable terms from insurers.

E6B Consolidators

A further development in the market has been the emergence of ***consolidators***. These are companies that are growing by the formal acquisition of others within the marketplace. Insurers will naturally wish to transact business with such companies, both because of their present size and their growth potential. However, some consolidators will demand preferential rates and/or enhanced commission for the volume business they are able to offer them. Such consolidation could lead to significant changes in the sector.

Some consolidations are blurring the traditional boundaries between insurers and intermediaries. For example, one major insurer has acquired a significant-sized insurance broking firm in recent years. The same largest consolidator just mentioned has both broking interests and an underwriting agency arm.

In the Lloyd’s market the Legislative Reform (Lloyd’s) Order 2008 has removed the ‘divestment rule’ (this is where broking and underwriting activities must be completely separated), paving the way for more acquisitions and mergers. In doing this, the Government is relying upon the effectiveness of FCA rules that insist on conflicts of interest being managed and mitigated effectively.

F Insurance marketing and distribution

According to the Chartered Institute of Marketing, 'marketing' means the management process which identifies, anticipates and supplies customer requirements efficiently and profitably.

In insurance terms, the marketing process involves making decisions on product, price, promotion and place (the latter two involving distribution). Together these are sometimes referred to as the **marketing mix**.

The distribution of insurance is a very important component of the marketing mix, so far as insurance companies are concerned. This is because the choice of distribution channel will affect pricing and may even impact upon the shape of the product or its presentation. The

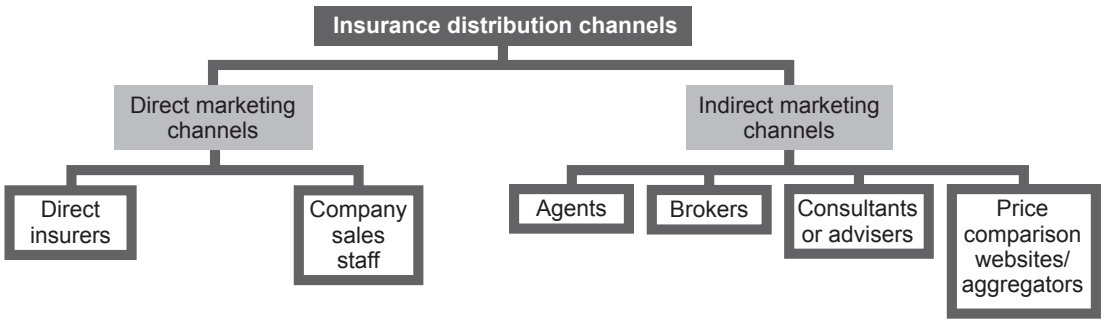
distribution channels used for insurance can be divided into two main types: **direct** and **indirect** channels.

Direct – employees of the insurer sell the insurance products or direct mailing techniques and websites are used to promote sales.

Indirect – intermediaries paid by the insurer to promote products on the insurer's behalf.

Consider this…
Think about the other marketing variations that could be affected by the distribution channel used.

The choice of distribution will determine the type of advertising used, e.g. whether it is to be aimed at intermediaries or the general public. It will also have an impact on costs relating to staff, premises and IT equipment. The following diagram illustrates this point more clearly.



Insurers have to select the most effective channels for product promotion and distribution, and these channels have many competing features. Equally, from a buyer's perspective, there are significant benefits and drawbacks to purchasing insurance through direct and indirect channels.

F1 Direct marketing channels

The last diagram shows that, in addition to direct insurers, 'company sales staff', who will often sell a range of policies, play a role in the direct marketing of insurance. Common direct marketing methods include targeted mailings, telephone calls and social media messaging directed at those categories of individual likely to purchase the product on offer. The mailings are focused in many different ways, e.g. to the 'over 50s', to those owning a particular model of car, those in designated job types and so on. Some companies have chosen to sell only online or over the telephone; many private motor insurers fall into this category. Their other methods of promoting their products and services are television, radio, newspaper/magazine advertising and through social media channels.

F1A Benefits and drawbacks

Benefits:

- Where products are marketed directly to the public, without involving paid sales staff, there will be reduced costs for insurers (as they do not pay commission to intermediaries). These savings can be passed on to the customer through more competitive premiums.
- The customer can purchase insurance quicker and more easily. This means that immediate cover can be obtained over the internet or telephone, subject to return of a pre-printed proposal confirmation form or statement of facts duly signed or simply relying upon the recorded voice responses to questions.
- The insurer can control the customer experience, and make improvements to its service quickly without having to engage a third party.

Refer to
Refer to *Price comparison websites* on page 2/18 for more on price comparison websites

Drawbacks

- Only one company's product is available, unless the customer makes several telephone calls or reviews quotes on a price comparison website.
- Although savings are made by not having to pay an intermediary, there is usually a significant advertising and promotion cost that has to be passed on to customers and included in the premiums.
- No independent advice is available regarding suitability and no independent assistance available in the event of a claim (this is, to an extent, balanced by the regulatory obligation that insurers have to treat customers fairly at each stage of the value chain for an insurance product).

F2 Indirect marketing channels

From an insurer's perspective there are many reasons why indirect marketing channels could be beneficial. The intermediary will earn commission, so there is an incentive to sell the product on the insurer's behalf and the insurer benefits from any promotional activity. The insurer must decide what type of intermediary will be appointed. If it chooses to use an AR or IAR, the insurer will, broadly speaking, be responsible for their actions in relation to advice and sales. However, the insurer will be aware of the extent to which an AR is tied to the insurer by virtue of any agreements with other product providers. They must be aware of these under FCA rules. Often, there is no competing insurer or product as far as such intermediaries are concerned, because they choose to tie themselves to a single insurer.

Independent intermediaries will provide advice to their client (the buyer) about a whole range of things, such as the best premiums available in the marketplace, the range of cover and on the extent to which the product they are recommending meets their client's demands and needs. They may also provide other services to the insured, such as assistance in completing a claim form or advice if a dispute concerning a claim arises. For many insurers this is a helpful aspect. The responsibility for advice rests upon the independent intermediary. The insurer must ensure that the intermediary is fully briefed on the scope and nature of the product. FCA rules identify a specific range of features that must be provided by the insurer and ultimately to the client.

Complex commercial insurances are particularly suited to this kind of arrangement.

F2A Schemes and delegated authority

Many insurers delegate authority to intermediaries to act on their behalf. Under a delegated authority arrangement, the intermediary can be authorised to issue cover, provided that new business or changes to existing policies fall within defined criteria. Some **delegated authority schemes** (often called '**binders**') give a great deal of flexibility to the intermediary within defined limits. Often the policy wording will have been specially negotiated to fit a particular category of client, e.g. haulage contractors, warehouse keepers and hoteliers.

The attraction of these schemes for insurers is a flow of business arising from the tailored wording. There may also be an agreement on rating, but some schemes rely upon individual rates being provided by the insurer upon receipt of proposal information. From the intermediary's point of view there can be the ability to grant immediate cover, an ease of operation, and sometimes profit-sharing provision, if the results of the scheme are good.

A managing general agent (MGA) is a specialist type of intermediary who also has delegated authority to act for one or more insurers. MGAs are intermediaries that perform functions ordinarily handled only by insurers, such as marketing, binding cover, underwriting and pricing, appointing agents and loss adjusters, and handling claims. MGAs benefit insurers by the specialist expertise they have to offer in their niche areas, and MGAs are able to distribute and service insurance products while using the capacity provided by insurers.

F3 Bancassurance

Bancassurance describes the arrangement between a bank and an insurance company whereby insurance products are sold to the bank's customers – traditionally through its bank branches. It is sometimes described as a distribution channel for insurance products, but

bancassurance is a business that involves a bank and an insurer, which may use several distribution channels to achieve its goal.

The first bancassurance operations were established in Europe and have led to several mergers and acquisitions across continents. The momentum has been building outside Europe in recent years, as countries seek to replicate this success in their own financial markets.

Bancassurance offers the following advantages for banks and insurance:

- Access to each party's 'scale efficiencies' (those benefits that a company enjoys purely as a result of operating on a large scale).
- Lower risk to the business (through access to alternative sources of customer/products).
- Access to previously unavailable resources (from the other party's company).
- Improving 'value chain efficiency' (deriving the most added value from the product development process, which shows business efficiency).
- Opportunities for joint product development (pooled resources can reduce cost and time for each party).
- Access to one another's brands and reputations in their respective sectors.
- Market development (increased percentage share of the available customers).

G Price comparison websites

Brokers and other intermediaries have traditionally searched the market for the most competitive quotation for a client. In the personal insurance area, many have subscribed to quote engines that will provide a range of quotations from those with whom they hold agency appointments.

However, the internet has facilitated different ways of comparing insurance prices. It has led to the development of consumer-focused ***price comparison websites*** **(PCWs)**, or 'aggregators'.

A price comparison website uses web-based extraction tools to collect and analyse ('aggregate') information from different data sources. Aggregation is the term used for information retrieval for goods and services on the internet. In theory, this may be with or without the permission or knowledge of the underlying data sources.

Within insurance, price comparison websites tend to rely upon cooperation with brokers and insurers to access their pricing for different risks. They aim to work with a number of direct insurers and intermediaries, delivering a service to the proposer whereby the completion of one question set provides quotations from a number of insurance providers. The proposer can then approach that company and purchase their insurance at competitive rates.

Example 2.2

Aliyah has just moved into a rental property and wants to take out insurance for her contents. As she does not want to spend time checking individual insurers' products, she uses price comparison website XYZ.com. To generate quotes from a number of insurers and brokers, Aliyah goes through an application process on the XYZ.com website, which has been designed to capture the data required for a number of providers.

Once she has completed this, XYZ.com provides a list of insurance products, with details of the provider, the price, and some high-level information regarding the policies. She may decide to choose one of the quotes straight away based on the price, or there may be other variables for her to consider before deciding, such as different excesses and additional elements of cover, in which case there may be further steps to go through before she can take out the policy.

One site claims that it gives the consumer a list of direct links where they will be able to get genuine, correct, real-time motor quotes from a range of household names.

Critics of the sites, however, point out that the imperative to save time and effort in submitting personal details by limiting the number of questions, may affect the accuracy of quotations. The results can be confusing as they are not always a true reflection of the

ultimate cost of insurance, once fuller details are submitted. It can also be difficult to compare cover or terms offered by various providers.

Price comparison websites can, and do, cut across traditional boundaries. Direct insurers, for example, by definition deal directly with the public, but the prices of many direct companies may be accessed through the sites. It should be noted that some direct insurers, such as Direct Line, have refused permission to be included in comparison websites, and they emphasise this in their advertising campaigns (although some of Direct Line Group's other brands, Churchill and Privilege, are sold through comparison websites – this arguably demonstrates the imperative for insurers to consider this option as part of their distribution strategies).

The emergence and growth of price comparison websites has changed the landscape of the insurance market. This is because they are consumer-focused price comparison mechanisms rather than distribution channels.

H Reinsurance

Just as individuals, corporations and public bodies may feel the need to transfer risk, so too do insurers. They achieve this by using the services of reinsurers that specialise in accepting business originally underwritten by insurers. Reinsurance may be on an individual risk basis, an event basis or on a portfolio (wide range) of risks covering losses from the operation of some catastrophe peril, for example.

Refer to
Risk transfer for insurers considered in *Co-insurance* on page 1/16.

H1 Purpose of reinsurance

We could start by asking 'Why reinsure at all?' Each insurer could decide to insure only those risks that it was able to accept within its own defined limits. This approach, however, could carry its own problems:

- What about several losses to different insured risks that are all connected in some way, e.g. storm damage to many insured properties at once?
- What about very large losses, e.g. a massive explosion or terrorist attack?
- What about the cumbersome nature of risk sharing if it is all is done by each insurer taking a small direct share or even sharing by means of co-insurance?

An insurer is able to reinsure a risk that it holds because it stands to lose financially as a result of any claim payment. The insurer is therefore able to pass any (or all) of the risk to another insurer as reinsurance. Although in theory the whole of an individual risk could be reinsured, this would make no sense, so insurers reinsure only part of a risk that they hold. In this way reinsurance may be used to share losses on a risk-by-risk basis.

One of the big differences between co-insurance and reinsurance is the fact that when an insurer places part of a risk with a reinsurer, the insured need not know that this has happened. Indeed it is rare for the insured to be aware of such arrangements. It follows that there is no contractual relationship between the original insured and the reinsurer. If a claim occurs the insured will look to the insurer to meet the loss in full; any subsequent recovery of reinsurance monies is entirely a matter for the insurer to pursue.

In summary the purpose of reinsurance is to:

- smooth peaks and troughs in the trading results;
- protect the portfolio (class of business);
- provide improved customer service; and
- provide support for insurers entering new areas of business.

Let us look at these now in greater detail.

Consider this…
What type of catastrophe perils might a UK insurer wish to reinsure against?

H1A Smoothing peaks and troughs

Insurers are keen to ensure that their trading results each year show gradual trends, rather than huge peaks or deep troughs. Investors prefer to see stability in insurance companies. Reinsurance helps by spreading the cost of very large losses over a period of time. In their pricing, reinsurer(s) will certainly require increases where there are adverse trends, but will not try to recoup a very large payment all in one go. Instead they will spread the cost over a number of years so this has the effect of smoothing out the highs and lows.

H1B Protecting the portfolio

It is possible to arrange reinsurance on a single known risk. When insurers do this it is known as **facultative reinsurance**. However, it is equally important for insurers to protect the pool of accumulated funds from the effects of very large losses or a series of losses arising from a single cause. This is a type of catastrophe reinsurance and could apply to, for example, weather-related claims.

Insurers arrange facilities to enable them to place a range of risks that fall within agreed criteria. These arrangements are called treaties. It is also possible for reinsurance to be effected to protect the portfolio (class of business) as a whole. Some specialist treaties are geared to pay out if the overall loss ratio (premiums v. claims) exceeds a certain figure. There are many different types of arrangement, some of which provide a means of sharing risks in agreed proportions and others that protect against losses exceeding agreed amounts. The detail of these goes beyond the scope of this syllabus.

H1C Improving customer service

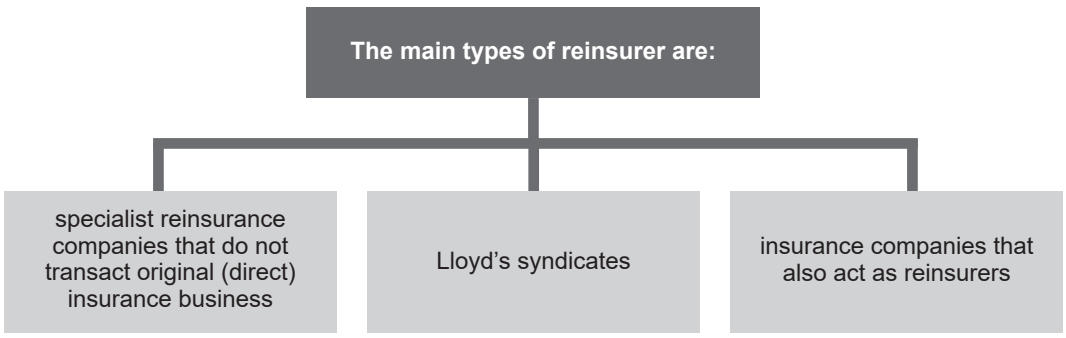
The practice of each insurer accepting only its own net share is one that would very quickly create significant problems for the placing of insurance risks. The extra capacity provided, particularly by treaty arrangements, enables insurers to accept much more than their own net capacity. This makes the placing of risks much easier, especially for those independent intermediaries that place extremely large risks.

H1D Entering new business areas

When insurers decide to begin to underwrite a new class of business they must register their intention to do so with the PRA. Once agreed, they will usually need to have the support of reinsurers. Special arrangements exist for such situations that provide an automatic facility, and therefore extra capacity, while an insurer is gaining experience in a particular class of business.

H2 Types of reinsurer

Reinsurers are often limited liability companies with substantial amounts of paid-up capital, sometimes in excess of £100 million, due to the high risk attached to the business. However, there are some reinsurers that have far less capital, meeting only minimum statutory requirements. Many smaller reinsurance companies operate in specialist classes of business. Captives usually only offer cover to companies owned by the same parent company.

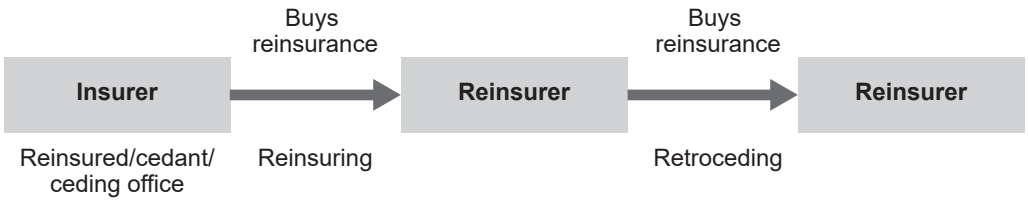


Reinsurers accept risks either directly from the insurer (also known as the reinsured) or through a reinsurance broker. They provide reinsurance for:

- insurance companies;
- Lloyd's syndicates; and
- other reinsurers.

Reinsurers are included in this list, as they too seek to transfer some of their risks to other reinsurers. This is called **retroceding** and the risk placed in this way a **retrocession**.

The insurer who buys the reinsurance cover is known as the **reinsured**, **cedant** or the **ceding office**.



Reinsurance is an international business, and insurers usually spread their risks over a number of reinsurance companies at home and abroad. Many Lloyd's syndicates also buy and sell reinsurance. The UK reinsurance market transacts most of its business in the City of London. The two main reinsurance centres are:

- Lloyd's; and
- the **International Underwriting Association** of London **(IUA)**.

The IUA is responsible for representing its member companies, the provision of information services and research. The IUA is not itself an insurer. It is the largest representative organisation for international wholesale insurance and reinsurance companies in the world.

The organisation and most member companies are represented in the **London Underwriting Centre** (**LUC**) in the City of London. One of the LUC's most public functions is to produce clause wordings for the London Market, notably for marine insurance. Many of these are adopted internationally.

I Insurance professionals

Within the insurance marketplace there are a number of key roles. We continue our look at the market by considering the particular functions of the professionals employed there.

I1 Underwriters

Insurance, as noted in chapter 1, is a common pool; the contributions of many people are put into the pool and the losses of the few are met from it. In essence, the task of ***underwriters*** is to manage the pool as effectively and profitably as possible.

The main functions of the underwriter are to:

- assess the risks that people bring to the pool;
- decide whether or not to accept the risk (or how much of it to accept);
- determine the terms, conditions and scope of cover to be offered; and
- calculate a suitable premium to cover expected claims, provide a reserve, meet all expenses and provide a profit.

An underwriter may be a:

- person employed by an insurance company to make decisions on acceptance and premiums, and to apply the company standards;
- employee of an insurance broker, appointed representative or MGA servicing a delegated underwriting authority;
- Lloyd's underwriter, who accepts the whole or part of a risk offered on behalf of Lloyd's members and receives all or a portion of the premium paid in return for agreeing to meet that proportion of each loss; or
- term used to describe an insurance company itself, fulfilling the role of an underwriter because it accepts risks.

Refer to
See *International Underwriting Association of London (IUA)* on page 2/25.

I2 Claims personnel

An efficient claims department, staffed by competent and professional ***claims personnel***, is vital to ensure the proper management of an insurance company's funds. The role of claims personnel is to:

- deal quickly and fairly with all claims submitted;
- distinguish between real and fraudulent claims;
- determine the realistic cost of a claim prior to payment (**reserving**);
- determine whether others, e.g. loss adjusters and approved repair networks, need to be involved; and
- settle claims with the minimum of wastage (e.g. expenses).

I3 Loss adjusters

Loss adjusters are experts in processing claims from start to finish and **acts for the insurer**. Straightforward small claims are usually negotiated and settled by an insurer's in-house claims staff. However, in the case of larger claims or complex policy wordings, the services of a loss adjuster will be used. They:

- investigate the circumstances surrounding a claim;
- determine whether and to what extent the policy covers the loss;
- facilitate any emergency measures, e.g. for the protection of property;
- negotiate amounts claimed;
- negotiate with any specialist suppliers; and
- make a recommendation for settlement to the insurer.

The insurer will then consider the amount and, if satisfied, offer this sum to the insured.

Their aim is to negotiate a settlement, within the terms of the policy, which is fair to both the insurer and the insured. Chartered loss adjusters are members of the Chartered Institute of Loss Adjusters (CILA). Loss adjusters are independent, professionally qualified persons. Invariably, their fees are met by the insurers who instruct them.

Refer to
Refer to *Chartered Institute of Loss Adjusters (CILA)* on page 2/28

I4 Loss assessors

Loss assessors are expert in dealing with insurance claims and **act for the insured/ policyholder**, preparing and negotiating claims on their behalf.

Consider this…
Think about the differences between loss adjusters and loss assessors, to make sure that you are clear about their roles.

I5 Surveyors and those providing forensic services

Surveyors carry out a variety of functions on behalf of insurers, many of which are relevant to risk assessment. However, in this section we will concentrate on the surveyor's role and that of other professionals in relation to claims.

Forensic analysis is best known in crime scene investigation, where it is used to discover and assess supporting physical evidence. In principle, experts will employ similar techniques in insurance claims situations to determine the exact causes of loss or damage. Insurers will employ specialists for different investigative areas.

These areas are very wide ranging and include:

- establishing the 'seat' of a fire and its origins (i.e. where and how it started);
- gathering evidence to suggest fraud or a deliberate act (e.g. multiple fires);
- determining whether any fire accelerant was used;
- determining whether any lack of maintenance contributed to the damage;
- determining the proximate cause of a loss;
- establishing evidence that suggests that a policy exclusion operates (e.g. the involvement of employees in theft from a firm);
- establishing whether a car had previous damage or engine failure before a fire occurred; and
- examining accounting documentation in relation to a business interruption claim (refer back to *Pecuniary insurance* on page 1/20).

You will note a similarity between some of these roles and the tasks performed by loss adjusters. However, those undertaken by forensic experts tend to be more specialist and their advice may be sought when initial investigation of the circumstances surrounding a loss gives cause for concern. (It is worth noting that many firms offer what they describe as 'forensic services' to policyholders. These include claims handling and management services, independent advice, a review of the adequacy of insurance arrangements, accountancy and dispute resolution services.)

A surveyor's role (linked to a claims situation) may involve:

- giving advice on the immediate action necessary following a loss (e.g. employing a night watchman);
- making recommendations as to any underwriting action necessary (e.g. reduction in theft cover until premises are again adequately protected); and
- establishing whether previously advised requirements made by the insurer have been complied with.

I6 Actuaries

Actuaries may be defined as a professionally qualified persons who apply probability and statistical theory to problems of insurance, investment, financial and risk management, and demography.

Actuaries have for many years been associated with life insurance companies, applying mortality statistics and time value of money techniques to determine the adequacy of funds to meet future liabilities. They are also employed by non-life insurance companies.

Techniques applied by actuaries will include the probability of loss and the prediction of claim numbers and future values. Actuaries have a key role to play in pricing and reserving methodology within an insurance company.

The company's actuarial function has a key role to play in meeting **Solvency II** requirements.

Refer to
See *Authorisation and regulation of insurers* on page 10/15

I7 Risk managers

For many years, there has been a steady move by firms towards taking control of, and developing a formal strategy for managing, the various risks that affect businesses. For insurers, this approach has been necessary to demonstrate to the regulator their ability to comply with the Solvency II risk-based capital requirements.

Where this is a formalised function within an organisation, particularly a large or diverse company, specialist **risk managers** or risk management teams are appointed. Many risk managers are members of the trade associations, the **Institute of Risk Management (IRM)** and the **Association of Insurance and Risk Managers in Industry and Commerce (Airmic)**. You can find further information about these organisations in *Institute of Risk*

Management (IRM) on page 2/29 and *Association of Insurance and Risk Managers in Industry and Commerce (Airmic)* on page 2/29 of this chapter.

The functions of risk managers may be summarised as follows:

- The systematic identification, analysis and economic elimination or control of risks that threaten the business.
- Providing guidance on best practice in these areas to management.
- The transfer of appropriately identified risks by contract or insurance.

Consider this…
In what ways could a risk manager reduce the risk of fire in a company which prints newspapers?

I8 Compliance officers

In regulating the insurance and financial services sector, the PRA and FCA have prescribed a number of key roles that must be performed by a director or senior manager in financial services companies (including insurers and those involved in insurance mediation). One such role is carrying out the compliance oversight function. The person performing this job is known as a ***compliance officer*** and must report to the governing body (usually the board of directors) of the authorised company. The exact scope of the duties of a compliance officer will vary from one company to another. However, their main role is to ensure that their firm abides by the rules and regulations set down by the regulator. As we shall see, the FCA has issued detailed conduct of business regulations and guidance in a series of Sourcebooks, which together form the FCA Handbook.

The role is vital to insurers and intermediaries because there are serious consequences of failing to abide by legal or regulatory requirements. The range of functions undertaken by a compliance officer will usually include:

- communicating the company's policy to members of staff, setting up any associated training;
- completing regular reports on governance, finance and complaints for the FCA;
- reviewing all stages of the business processes to ensure that they are appropriate and compliant;
- maintaining the company's compliance manual; and
- performing the role of money laundering reporting officer as required by regulation.

Depending upon the size of the company, the compliance officer's role may be a 'hands on' role or it may involve oversight of some of the functions, with the work being carried out by other individuals. It is permissible for the tasks themselves to be carried out by an external compliance consultant. However, the responsibility and accountability of the compliance officer within the company cannot be delegated.

I9 Internal auditors

These work within firms to monitor and evaluate how well risks are being managed, the business is being governed and internal processes are working. They provide an independent and objective assessment of the effectiveness and efficiency of a company's operations, specifically its internal control structure. Unlike external auditors, they look beyond financial risks and statements to consider wider issues such as the organisation's reputation. Internal auditors also advise management on how to improve systems and processes.

Refer to
See *Authorisation and regulation of insurers* on page 10/15

Under the **Solvency II** regime internal auditors have a key role to play in assessing the reliability of financial reporting and compliance with laws and regulations.

J Market organisations

In this section we will outline the membership and main functions of the principal trade associations and professional bodies within, or related to, the insurance profession.

J1 Association of British Insurers (ABI)

The **ABI** is the largest of the insurance market associations. Formed in 1985, its has over 200 member companies that include UK insurers and foreign insurance companies operating in the UK.

It is engaged in a wide variety of work, including the gathering of relevant market statistics, framing of codes of practice and playing a major role in public relations, creating a greater awareness of the role of insurance. The ABI also confers with the Government on matters of interest to its members.

The objectives of the ABI are to:

- get the right people together to help inform public policy debates, engaging with politicians, policymakers and regulators at home and abroad
- be the public voice of the sector, promoting the value of its products and highlighting its importance to the wider economy;
- help encourage consumer understanding of the sector's products and practices; and
- support a competitive insurance industry, in the UK and overseas.

The ABI's work falls under two councils: the General Insurance Council and the Life Insurance Council. Much work has been carried out by these councils on fire prevention, liability, fraud, motor accidents and life underwriting over the years.

Activity
Visit the ABI website (*www.abi.org.uk*). Focusing on one line of business (e.g. motor, home), try to identify some of the key issues on the ABI's agenda, and consider their approach to influencing change across the industry.

J2 International Underwriting Association of London (IUA)

The **IUA** is the world's largest representative organisation for international and wholesale insurance and reinsurance companies. It came into being on 31 December 1998 as a result of the merger of The Institute of London Underwriters (ILU), representing marine companies, and the London Insurance and Reinsurance Market Association (LIRMA), representing non-marine insurance and reinsurance interests.

The IUA exists to protect and strengthen the business environment for its member companies operating in or through London. It is a company limited by guarantee which has a chief executive and is governed by an elected board, mainly comprised of senior market figures. Much of the business of member companies is centred upon the LUC in the City of London.

The IUA aims to:

- improve London's process efficiency and increase its business attractiveness;
- promote expertise and innovation in underwriting and claims; and
- influence public policy and compliance.

On the Web
www.iua.co.uk

J3 British Insurance Brokers Association (BIBA)

BIBA is the major non-statutory trade association for insurance intermediaries, with a membership of just under 2,000 regulated firms. Its code of conduct emphasises the need to:

- abide with all relevant laws, principles and regulations;
- act with integrity and honesty;
- act in the best interests of each client; and
- act with skill, care and diligence.

BIBA seeks to maintain and improve the highest standards of business behaviour and to protect and enhance the interests of its members for the benefit of the general public.

Its key roles include:

- promoting members' views on proposed legislation;
- encouraging and provides training within the broking profession;
- nominating members to sit on joint committees;
- encouraging links with partner members from the leading insurance companies; and
- liaising with outside bodies, including regulators, the Government and the ABI.

On the Web
www.biba.org.uk

J3A London Market Regional Committee (LMRC)

The position regarding representation of London market brokers is currently slightly complex. Up until the end of 2008 BIBA operated through a virtually autonomous trade body representing the interests of Lloyd's brokers operating in the London and worldwide insurance and reinsurance markets. This was the London Market Insurance Brokers' Committee (LMBC), which was the only representational body at the time. However, the LMBC was disbanded at the beginning of 2009.

In June 2009, BIBA announced the formation of the **London Market Regional Committee (LMRC)** as a replacement of the old LMBC. As a body it was integrated into BIBA's existing regional committee structure.

The LMRC consulted with members on the areas they wanted the committee to address in order to develop its strategy and objectives. It intends to maintain a lobbying role and to represent the sector to the FCA, Europe, the UK Government and other stakeholders. It aims to work with other London Market bodies, including the London and International Insurance Brokers' Association (LIIBA), on areas of mutual interest and to avoid duplication of work.

J4 London and International Insurance Brokers' Association (LIIBA)

LIIBA is an independent trade body, representing the interests of insurance and reinsurance brokers operating in the London and international markets. It effectively took on the role performed by the LMBC from 1 January 2009. There is a clear overlap between the LMRC and the LIIBA.

LIIBA's mission is to ensure that 'London remains where the world wants to do business by continuing the transformation of market processes and maintaining the highest professional standards'. LIIBA's key priorities are to:

- represent members' interests to the Government, the regulators, the EU and international bodies to establish a proportionate regulatory framework;
- modernise the London Market's business processes to be competitive and efficient, delivering an improved client service;
- support members with regard to legislative and technical changes; and
- strengthen relationships with Lloyd's, the LMA and the IUA on a range of market issues.

On the Web
www.liiba.co.uk

J5 Lloyd's Market Association (LMA)

The **LMA** provides representation, information and technical services to underwriting businesses (i.e. managing agents) in the Lloyd's market. It was formed by merging five formerly separate organisations that were 'class of business-specific'. All managing and members' agents are members and are actively involved in the association's work, participating on its board, committees or business panels. The LMA has key partners: the LIIBA, the LMRC and the IUA.

Refer to
Refer back to *Lloyd's* on page 2/8 for the role of managing agents

The stated purpose of the LMA is to identify and resolve issues which are of particular interest to the Lloyd's underwriting community, and working in partnership with the Corporation of Lloyd's and other partner associations to influence the course of future market initiatives.

Through associate membership (available to trading partners of Lloyd's managing agents or members' agents) the LMA offers an information service to brokers, lawyers and similar businesses connected with Lloyd's.

As part of its service to members, access is provided to insurance policy wordings. These carry the LMA's Copyright.

Activity
Go to the LMA website (*www.lmalloyds.com*) and research any class of business which you are interested in. See what the LMA groups are doing in relation to market reform, new wordings and education.

J6 Managing General Agents' Association (MGAA)

The **MGAA** was formed with an elected board in February 2012 to give the insurance industry a better understanding of what an MGA is and what they contribute to the industry. It represents its members' interests and sets best practice guidelines as well as seeking to improve the sector's professionalism, stability and competitiveness.

On the Web
www.mgaa.co.uk

J7 Chartered Insurance Institute (CII)

The **CII** has been at the forefront of insurance education and professionalism for over 100 years. Since the turn of the 21st century, membership has risen from 65,000 to over 125,000 throughout the UK and overseas.

The CII's examination programmes and membership services ensure that members are equipped with the knowledge and understanding of insurance needed to perform their roles effectively.

The CII's activities are extensive and include:

- setting a high standard for members in its code of conduct (see appendix 2 for the CII Code of Ethics);
- promoting professional growth;
- offering a range of qualifications and the means to study for these;
- specialist societies for continuing education and development;
- faculties for different professional interest groups;
- training in technical subjects;
- library and information services;
- specialist publication production;
- careers information service;
- insurance education development overseas; and
- local institute educational and social programmes.

On the Web
www.cii.co.uk

J8 Chartered Institute of Loss Adjusters (CILA)

As we have already seen, loss adjusters are impartial claims specialists. Those who are members of the **Chartered Institute of Loss Adjusters (CILA)** must operate under the terms of a code of conduct. The CILA was set up under a Royal Charter and it is a leading authority on insurance claims issues. The Institute is recognised worldwide and embodies core values of education, examination and professional standards.

The code of conduct states that members must at all times preserve impartiality. To maintain standards, the CILA has its own complaints handling mechanism.

The membership of the Institute consists of individual loss adjusters, rather than the firms that employ them. The CILA provides training and professional qualifications (including associateship and fellowship) and encourages the sharing of technical information.

As a result of developments in the market, some members are now employed within insurance broking firms, insurance and reinsurance companies, risk and claims management companies, and also corporations and major policyholders.

On the Web
www.cila.co.uk

J9 Institute and Faculty of Actuaries (IFoA)

The **Institute and Faculty of Actuaries (IFoA)** is the UK's only chartered body dedicated to actuaries and has a membership of more than 12,000 fellows, associates, affiliates and student members. For practical purposes they operate as a single entity.

The profession's formal planning operates at two levels. The corporate plan is agreed each year by the joint Faculty and Institute councils. This sets the strategic direction and activity for a five-year period, identifying specific priorities to be delivered during the current year.

The Institute provides manuals of actuarial practice and issue guidance notes in particular areas. In common with other professional bodies, the IFoA operates standards of conduct, practice and ethics. This is designed to ensure quality and consistency in the application of actuarial skills for the benefit of the public, and to protect the reputation of the profession. Its other functions are to:

- provide education and encourage the development and sharing of knowledge and research in actuarial science;
- demonstrate and promote to the public and business the benefits of actuarial skills; and
- provide membership services and foster a sense of belonging.

On the Web
www.actuaries.org.uk

J10 Institute of Risk Management (IRM)

The **IRM** was founded in April 1986 to meet growing demand for a diploma course in risk management. The course offered one of the first qualifications with universal benefit for students working in risk management in any sector: industry, commerce, academia or elsewhere.

The **IRM** was founded to meet growing demand for a diploma course in risk management.

In 2005 the IRM launched the introductory International Certificate in Risk Management to complement the existing diploma-level qualification. The IRM now delivers general and specialist training courses, events, a topical risk management magazine and a variety of other work to support the professional development of risk professionals around the world.

The IRM actively works with partner organisations to develop new educational programmes, thought leadership and continuing professional development.

On the Web
www.theirm.org

J11 Association of Insurance and Risk Managers in Industry and Commerce (Airmic)

Airmic was formed in 1963 and promotes the interests of corporate insurance buyers and those involved in risk management and insurance for their organisation. Members include company secretaries, finance directors, internal audit, and risk and insurance managers.

Membership can be either on an individual or corporate basis. Members come mainly from multinational businesses, including around three-quarters of FTSE 100 companies. Medium-sized and smaller enterprises, charities and public-sector organisations (such as universities and local authorities) are also represented.

Airmic supports its members:

- through training and research;
- by sharing information;
- through a diverse programme of events;
- by encouraging best practice; and
- by lobbying on subjects that directly affect risk managers and insurance buyers.

As well as providing information and networking opportunities (including an annual conference, lectures, seminars, monthly newsletter and a series of around 50 Airmic Academy workshops a year), Airmic also presents the Association's views to Government, regulators, other market bodies and the EU.

On the Web
www.airmic.com

J12 Insurtech UK (IUK)

InsurTech UK (IUK) was newly formed as a trade body in 2019 and aims to position the UK as a leading force in technological innovation in the insurance sector. It represents the interests of a range of business types operating in the sector – in particular, those that describe themselves as 'insurtech' companies. These can generally be split into insurance distributors (e.g. managing general agents (MGAs) and brokers) and technology suppliers (e.g. policy administration system providers, data analytics specialists and claims automation solutions).

While the body is at an early stage of its development, it has grown quickly, and now has over 100 members. It is aimed at positioning the UK as a leading force in technological

innovation in the insurance sector and has been active in engaging the Government on a range of issues.

IUK's membership reflects the diverse nature of this group, from MGAs built on technology which enables the fast design and launch of new product offerings across personal and commercial lines, providers of usage-based insurance for gadget insurance, new distribution platforms, through to specialist providers of external data and analytics (data enrichment services).

K Motor Insurers' Bureau (MIB)

The **MIB** was established in 1946 as a private company, limited by guarantee. Its purpose was to enter into agreements with the Government to compensate the victims of negligent, uninsured or untraced motorists. It supports the principle that innocent victims of road accidents should not be left without compensation, simply because of inadequate or non-existent motor insurance policies.

The MIB's objectives are to:

- reduce the level and impact of uninsured driving in the UK;
- compensate victims of uninsured and untraced drivers fairly and promptly; and
- provide first class data asset management and specialist claims services.

The MIB functions under two separate agreements with the government: the Untraced Drivers' Agreement and the Uninsured Drivers' Agreement.

Untraced Drivers' Agreement	Uninsured Drivers' Agreement
• Applies to the provision of compensation for personal injury or death, plus property damage in limited circumstances. • Property damage claims are only considered where the vehicle is identified, but the driver cannot be traced.	• Is concerned with third-party personal injury or third-party property damage, when there is no motor insurance policy in force.

The MIB's obligations are linked to the compulsory insurance requirement of the **Road Traffic Act 1988**, so the protection provided is limited to where there is a legal requirement to insure.

The MIB has a Green Card Section, the role of which is to identify and correspond with overseas (mainly European) motor insurers regarding claims involving UK nationals.

The Bureau is financed by a levy on authorised motor insurers in the UK.

On the Web
www.mib.org.uk

L HMRC and insurance premium tax

Insurance premium tax (IPT) is levied by the Government on general insurance premiums in the UK. There are two main rates:

- A standard rate of 12%.
- A higher rate of 20% for travel insurance and some vehicles, and domestic and electrical appliances.

Most long-term insurances, together with reinsurance and insurance on ships, aircraft and goods-in-transit (internationally), are exempt from IPT. Premiums for risks located outside the UK are also exempt, but they may be liable to similar taxes imposed by other countries. IPT is collected by the insurer in addition to the policy premium and shown separately in the policy documentation. Insurers must account to **HM Revenue & Customs (HMRC)** quarterly for tax that is due.

Key points

The main ideas covered by this chapter can be summarised as follows:

Market structure

- The insurance market is made up of buyers, intermediaries, aggregators, insurers and reinsurers.

Insurers

- Propriety companies are limited liability companies, owned by their shareholders and registered under the Companies Act 1985.
- Mutual companies are owned by their policyholders.
- A captive insurer is a tax-efficient and cost-effective way of transferring risk.
- A protected cell company provides a cost-effective platform for a diverse range of conventional insurance and other applications.
- Composite insurers accept several types of business, whilst specialist insurers accept only one.

Lloyd's

- Lloyd's is not an insurer but an organisation providing facilities for the placing of risks in its market.
- The risks are carried by syndicates, who appoint managing agents who employ an underwriter to accept risks on the syndicate's behalf.
- Business is usually placed by means of a Market Reform Contract ('slip'), containing details of the risk.
- Generally a broker takes the slip to a lead underwriter at Lloyd's who indicates what percentage of the risk they are willing to accept and on what terms.
- Other underwriters are then approached to fill the slip until all the risk has been covered.

London Market

- The main providers in the London market are insurance and reinsurance companies, Lloyd's syndicates, Lloyd's service companies and Protection and Indemnity clubs.
- Many of the insurance and reinsurance companies are members of the IUA.
- Many sizeable, complex and unusual risks are placed in the London Market.

Intermediaries

- Intermediaries are agents and an agent is one who is authorised by the principal to bring that principal into a contractual relationship with a third party.
- The FCA regulates all aspects of insurance sales and advice and all who carry out such activities must be either authorised or exempt.
- An intermediary can choose to be either regulated directly (i.e. to be an authorised person) or to be an appointed representative or introducer appointed representative (i.e. to be exempt).
- The services that intermediaries provide for their clients vary and depend on what sort of intermediary they are (e.g. whether they are an independent intermediary or an agent of an insurer). They also provide services to insurers.
- There has been considerable consolidation within the broking sector. This is either through the development of broker networks or the growth of consolidators.

Insurance marketing and distribution

- Distribution of insurance products can either be direct, i.e. the insurer's employees sell the products, or indirect, i.e. intermediaries are paid by the insurer to promote products on their behalf.

Key points

- Many insurers delegate some authority to intermediaries to act on their behalf.

Price comparison websites

- A price comparison website (PCW) collects and analyses information from different data sources to provide an online service to those wishing to compare prices on a particular insurance product.

Reinsurance

- Reinsurance is the way that insurance companies insure the risks they have accepted. They may wish to do this to increase their capacity for a particular risk or to protect their portfolio from the impact of many associated small losses or the effects of a very large potential loss.
- Reinsurers can purchase insurance for the risks they have accepted – this is known as retroceding.

Insurance professionals

- An underwriter assesses the risk that people bring to the pool and decides whether to accept it and on what terms. They will then calculate a suitable premium.
- The role of claims personnel is to deal quickly, fairly and cost effectively with all claims, while distinguishing between real and fraudulent claims. They also assess how much the claim will cost so that an adequate reserve is set aside prior to payment.
- A loss adjuster is an independent expert in handling large or complex claims, and is appointed by the insurer to act in this capacity.
- A loss assessor is an expert in dealing with insurance claims and is appointed by the insured to assist them in negotiating a claim with the insurer.
- An actuary applies probability and statistical theory to problems of insurance, investment, financial and risk management and demography.
- The role of the risk manager is the systematic identification, analysis and economic elimination or control of risks that threaten a business.
- A compliance officer is responsible for ensuring that a firm complies with all legal and regulatory requirements.

Market organisations

- The ABI is the principal body representing insurers carrying on business in the UK.
- The IUA is the world's largest representative organisation for international and wholesale insurance and reinsurance companies. It exists to protect and strengthen the business environment for its members operating in and through London.
- BIBA is the major trade association for insurance intermediaries.
- The LMRC is the arm of BIBA representing the interests of Lloyd's and other brokers in the London insurance and reinsurance markets.
- The LIIBA is a trade body representing the interests of brokers in the London and worldwide insurance and reinsurance markets.
- The LMA provides representation, information and technical services to underwriting businesses in the Lloyd's market.
- The MGAA is a trade body for MGAs. It represents their interests and sets best-practice guidelines.
- The CII is the professional body for those who work in insurance and is at the forefront of insurance education and professionalism.
- The CILA is the professional body for loss adjusters. Its members must operate under its code of conduct.
- The IFoA has more than 12,000 fellows, affiliates and student members.
- The IRM offers qualifications and training for risk management professionals and provides information and networking opportunities.

Key points

- Airmic is a trade association that promotes the interest of corporate insurance buyers and those involved in risk management.
- Insurtech UK (IUK) represents the interests of businesses that define themselves as 'insurtechs', and has as its primary aim the positioning of the UK as a leading force in technological innovation in the insurance sector

Motor Insurers' Bureau (MIB)

- The MIB has two agreements with the government designed to provide compensation for the victims of uninsured or untraced motorists: the Untraced Drivers Agreement and the Uninsured Drivers Agreement.

Question answers

2.1 a. Captive.

2.2 b. Names.

Self-test questions

1. Within the Lloyd's market, risks are placed by means of a:
   a. Market risk contract. ☐
   b. Market reform contract. ☐
   c. Note. ☐
   d. Risk reform contract. ☐

2. Jacqui is an insurance broker. She is **most** likely to be remunerated by:
   a. A fixed advice fee. ☐
   b. Commission based on the sum insured. ☐
   c. An ongoing advice fee. ☐
   d. Commission based on the premiums charged. ☐

3. Ahmar has signed an agency agreement with Kent Regal Ltd. It is **true** to say that:
   a. He can act for Kent Regal Ltd in bringing them into legal relationships with others. ☐
   b. Any contracts he enters into will not be binding on Kent Regal Ltd. ☐
   c. Any contracts he enters into will not be binding on the insured. ☐
   d. He must act solely as a representative of the insured. ☐

4. Sulla, an independent intermediary, is placing business for new clients. Her services are **least** likely to include:
   a. Decisions on the best market in which to place the risk. ☐
   b. Actions on behalf of the insurer. ☐
   c. Advice relating to policy wording. ☐
   d. Negotiating initial terms. ☐

5. An indirect marketing strategy would mean that an insurer would distribute their products via:
   a. Insurance brokers. ☐
   b. Company sales staff. ☐
   c. Newspaper advertising. ☐
   d. The internet. ☐

6. A client who has obtained a motor insurance quote from a price comparison website should be aware that:

   a. Price comparison websites are always more expensive than insurance brokers. ☐

   b. Price comparison websites act in the best interests of the insurer. ☐

   c. They must pay a fee to the price comparison website for its service. ☐

   d. The true cost may be higher once fuller details are submitted. ☐

7. The purpose of reinsurance is to:

   a. transfer all of the cost to a third party. ☐

   b. smooth peaks and troughs in the trading results. ☐

   c. enable claims to be settled quickly. ☐

   d. reduce the cost for the client. ☐

8. Insurance premium tax (IPT) applies to:

   a. Insurers' premium income. ☐

   b. Life insurance premiums only. ☐

   c. Some general insurance premiums. ☐

   d. All insurance premiums. ☐

9. Aaron works for a large insurance company. His work involves reviewing business processes and communication of company policy to staff members. He is **most** likely to be a:

   a. Compliance officer. ☐

   b. Loss adjuster. ☐

   c. Claims handler. ☐

   d. Risk manager. ☐

You will find the answers at the back of the book

3
Contract and agency

Contents	Syllabus learning outcomes
Introduction	
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B Offer and acceptance	*5.2*
C Consideration	*5.3*
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F Agency	*5.5*, *5.6*, *5.7*
G Terms of business agreements (TOBAs)	*5.8*
Key points	
Question answers	
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Learning objectives

After studying this chapter, you should be able to:

- define a contract and apply the definition to an insurance contract;
- list the essentials of a valid contract;
- compare conditional and unconditional acceptance;
- state how contracts of insurance can be terminated;
- apply the rules of consideration to contracts;
- describe the ways of creating an agency;
- describe the relationship between the agent, insurer and insured;
- describe the ways by which agency may be terminated; and
- describe the areas that should be included in a terms of business agreement between an insurer and an intermediary.

Introduction

So far, we have considered the nature of insurance and the operation of the insurance market and, by now, you should be quite familiar with these two topics. In this chapter, we shall start to deal with the legal principles that apply to insurance. Here we shall look at contract law and examine the special legal principles that apply to insurance contracts.

The legal aspects of insurance are considered in relation to English law. English law comes from many sources. These include legislation (Acts of Parliament and statutory instruments), judicial precedent (court decisions in previous cases), custom and EU law.

Much of English law has developed from cases being heard in courts and the judgment given, based upon the facts of the case. Generally speaking, once a principle has been established, it is followed in other court cases where similar circumstances apply. This is what we mean by the term judicial precedent. In the following sections, where case law has contributed to the establishment of legal principle, we will refer to the case and a give a brief summary of it.

You will see references to claimants and defendants whenever we give details of legal cases. The claimant is the party who brings an action in court against the defendant. You should be aware of the details of the case, where given, but you do not need to learn the year of the case.

The **terms of business agreement** (**TOBA**) is one of the key documents prompted by the previous regulator, the Financial Services Authority (FSA). Prior to its introduction, there were agency agreements in force dealing with the contractual relationship between insurer and intermediary, but the TOBA is a much more comprehensive document. You should note that there are other TOBAs detailing the duties and responsibilities of intermediaries and their clients towards each other. These are often coupled with service level agreements and are beyond the scope of this course.

Key terms

This chapter features explanations of the following terms and concepts:

Agency	Agency by agreement	Agency by consent	Agency by necessity
Agency by ratification	Agent	Breach of warranty	Cancellation
Consideration	Contract certainty	Contract law	Express authority
Fraudulent acts	Implied authority	Offer and acceptance	Principal
Terms of business agreement (TOBA)	Third party	Void ab initio	

A Contract law

The English law of contract is essentially a law of bargains. It is concerned with the relationship between two parties, one of whom agrees to perform a certain act if and when the other party performs a certain act.

Smith and Keenan's *English Law* defines a contract as 'an agreement, enforceable by law, between two or more persons to do, or abstain from doing, some act or acts, their intention being to create legal relations and not merely to exchange mutual promises'.

Applying this definition to insurance, it may be said that an insurance contract is an agreement, enforceable by law, between insurer and insured. The insured agrees to pay a premium to the insurer and abide by the terms and conditions of the policy. In return, the insurer agrees to pay to the insured a sum of money or something of monetary value, on the happening of a specified event.

How do both parties enter into this legally binding agreement and what conditions must be satisfied by both parties to ensure that the contract is a valid one?

First, let us look at the essentials of a valid contract and then at the way in which an insurance contract differs from other commercial contracts.

A1 Essentials of a valid contract

To ensure that a valid and enforceable contract is formed an agreement must satisfy certain criteria.

Offer and acceptance	+	Consideration

There are other important elements to a valid contract. These are not included in the syllabus but are listed here for completeness:

- Intention to create legal relations.
- Capacity to contract.
- *Consensus ad idem* (genuine meeting of minds).
- Legality of purpose.
- Possibility of performance.
- Certainty of terms.

Contract certainty
The issue of contract certainty became central to the London Market following challenges around coverage in the wake of the terrorist attacks on the World Trade Center in 2001. The approach taken by the London Market is detailed in *Contract certainty* on page 2/11).

A contract may be declared invalid or set aside if it is missing any of these essentials. Legally, it is said to be ***void ab initio*** (from the beginning).

All parties to a contract must act in good faith. They must not mislead one another. However, except for the seller's legal duty to comply with recognised product quality standards, it is for the buyer to satisfy themselves regarding the quality of the product.

Only in certain circumstances is a document necessary and a simple contract does not need to be evidenced in writing. Insurance policies are simple contracts. It follows that a policy does not have to have been issued for cover to exist. However, clauses spelling out the specifics of a contract could be used by one party to demonstrate the other party had fully understood a contract and their role in it if they had signed the document or indicated acceptance of its terms.

B Offer and acceptance

A contract comes into existence when one party makes an offer which the other accepts unconditionally. This statement seems straightforward enough and the following sections show how offer and acceptance works in practice.

B1 Unconditional acceptance

It is easier to see how unconditional acceptance works by looking at an example. Let us consider the following conversation.

Bill (from ABC Insurer): 'On the basis of your proposal form I can offer you cover, subject to driving being restricted to the named persons you have listed, for £350.'

Tom: 'I accept.'

In this example, Tom's acceptance does not alter any of the terms of Bill's offer. The acceptance is said to be unconditional. A contract is formed, subject to the other essential elements (listed in *Essentials of a valid contract* on page 3/3) being present. To be effective, acceptance must be the final and unqualified agreement to the offer.

B2 Conditional acceptance

If new terms are introduced, the so-called acceptance (Tom's reply in the example) becomes a new offer (a counter-offer) which is open to be accepted or rejected by the person who made the original offer (in the example, Bill).

Now consider an alternative response by Tom.

Bill (from ABC Insurer): 'On the basis of your proposal form I can offer you cover, subject to driving being restricted to the named persons you have listed, for £350.'

Tom: 'I accept, so long as I can have 'any driver' cover.'

In this case, a contract has not been formed as Tom has not unconditionally accepted the offer. Not until Bill accepts Tom's counter-offer, without further conditions, is a contract formed. A counter-offer operates as a rejection of the original offer.

Example 3.1

in the case of ***Hyde v. Wrench*** **(1840)**, the defendant, Wrench, offered to sell his farm to the claimant, Hyde, for £1,000. The claimant in turn offered £950, which was refused. The claimant later increased his offer to £1,000, but this was also refused by the defendant.

It was held that there was no contract because the counter-offer acted as a rejection of the original offer to sell at £1,000.

Consider this…

Ellen has lost her dog and has offered a reward for its safe return. Jayne finds and returns the dog. Jayne is not aware of the reward. Do you think Ellen is contractually bound to pay Jayne a reward?

B3 Postal acceptance

The general rule is that the contract is made when the acceptance is received by the offeror (person making the offer). However, where the parties have agreed to use the post as the method of communication, acceptance is complete at the point when the letter of acceptance is posted.

This rule applies even if the letter is delayed, or is lost or destroyed in the post and never reaches the offeror – established in the case of ***Household Fire Insurance Co. v. Grant*** **(1879)**.

In this case Grant applied for shares in the Household Fire Insurance company. The insurance company properly posted the letter accepting his offer, but it never arrived. The court decided that the offer had been accepted when the acceptance was posted, so there was a valid contract.

Consider this…

Judy posts a letter to Jim accepting his offer to sell her his car. She changes her mind. Do you think she can withdraw the acceptance by telephoning Jim?

B4 Offer and acceptance in practice

Let us now bring together everything we have learnt so far about offer and acceptance and see how it works in an insurance situation.

Example 3.2

Katie accepts the tenancy of a flat in a block owned by Lonchester Council. She buys some furniture, carpets and curtains mainly using her credit card. She is concerned about the risk of damage by fire, theft and other perils mentioned in the insurance company's prospectus.

Katie gives Newflat Insurance details of the risk to be insured. It responds by quoting a premium of £100 which is an offer to Katie. She accepts the premium by notifying the insurer and the insurer is then 'on risk' (another use of the term 'risk', which in this context means that there is now a contract with Katie and any losses covered by the policy, which occur from that point onwards, will be met).

In some cases insurers allow their agents to accept liability on their behalf even before all the formalities have been settled.

We shall now consider the essential element of consideration, which is necessary to ensure that a valid contract is formed.

C Consideration

Contracts must be supported by consideration to be valid. But what exactly is consideration?

It was defined in ***Currie v. Misa*** **(1875)** as:

> Some right, interest, profit or benefit accruing to one party, or some forbearance, detriment, loss or responsibility given, suffered or undertaken by the other.

Consideration may be described, simply, as each person's side of the bargain which supports the contract. The payment of money is a common form of consideration for one of the parties, although, as we can see from the above definition, not the only form. Parties can exchange promises to perform certain acts in the future or promise to do something in return for the act of another. Their promises and actions are the consideration supporting the contract.

Question 3.1

Jane offers to supply filing cabinets to Pam who accepts the offer. What further action is required in order that a legally enforceable contract exists between them?

a. The terms of their agreement need to be written down. ☐

b. Another person needs to witness their agreement. ☐

c. The filing cabinets need to be delivered to Pam. ☐

d. Pam needs to agree to pay Jane for the filing cabinets. ☐

D Renewal of insurance contracts

Once an insurance contract has been concluded it is expected to continue until the agreed expiry or renewal date. Some insurances are designed for short periods – travel insurance, for example. Others such as motor, casualty or home insurance are renewable contracts that will continue, typically, for one year and the insurer usually offers terms for renewal at the end of that period. There is no obligation upon the insurer to offer renewal terms.

However, the fair treatment of customers principle and ICOBS imply that the insurer must alert the customer to the fact that cover will expire.

A firm must take ensure that a customer is given appropriate information about a policy in good time and in a comprehensible form so that the customer can make an informed decision about the arrangements proposed.

(ICOBS 6.1.5)

Policy renewal should be offered ‘in good time’, which is determined by the point in the renewal process at which the information may be most useful.

New regulatory rules were introduced by the FCA in April 2017 that require insurers and intermediaries selling retail general insurance products to:

- disclose the previous year’s premium on renewal notices (accounting for mid-term adjustments where relevant);
- include text to encourage consumers to check their cover and shop around for the best deal at each renewal; and
- identify consumers who have renewed with them four consecutive times, and give these consumers an additional prescribed notice encouraging them to shop around.

These changes reflect the findings of an FCA consultation on consumer treatment by firms at renewal, and the lack of competition that has resulted from this. The FCA found that price increases were not transparent at renewal and that long-standing customers were paying more than new customers for the same insurance product. As a result, consumers often defaulted to renew products that were not good value or had become unsuitable for their changing needs.

A further thematic review was undertaken in 2018, 'TR18/4: Pricing practices in the retail general insurance sector: Household insurance', which identified the same issues relating to firms' pricing practices. Following this review, a further consultation and market study took place in 2020 to investigate the issues identified in more detail and the FCA published the 'General Insurance pricing practices' market study in September 2020. The market study identified again that when it comes to renewal pricing, home and motor insurance are not working well for customers.

Be aware

New rules will come into force on 1 January 2022 which place a greater responsibility on insurers to ensure fair pricing when renewing insurance contracts.

While the full content of this review is beyond the scope of this unit, students should be aware of the importance of fair pricing when renewing insurance contracts and the impending ban on "price walking" (charging long-standing customers less competitive and more expensive premiums than new customers) for general insurance contracts.

E Cancellation of insurance contracts

There are some situations in which either the insurer or the insured will wish to cancel cover during the currency of the policy. This will be governed by the written terms and conditions in the policy. In some cases where insurance is purchased at a distance, the policyholder has a ‘cooling off’ period whereby they have an automatic right to cancel within a specific timescale. This is the right imposed by regulation rather than English law as explained in *Policyholder’s rights* on page 3/7.

E1 Insurer’s rights

Most general insurance policies have a cancellation condition. This allows the insurer to cancel, provided that a letter is sent to the insured's last known address (usually by recorded delivery or registered post), giving 14 days' notice of cancellation. The period of notice is not standard; some insurers state 10 days, others 30 days. If the insurer invokes this cancellation condition a pro rata return premium is sent to the insured, representing the unexpired portion of the risk.

It is rare to find an insurer doing this but it could happen. Examples would be if there has been difficulty with a claims settlement and the insurer feels that the insured has acted unreasonably and certainly if the insured has been guilty of fraud in connection with a claim

(although as we see later, if the insured has acted fraudulently the insurer may not be obliged to return the premium).

E2 Policyholder's rights

A consumer has a right to cancel without penalty and without giving reason for most insurances purchased at a distance, for example over the internet or by phone. The main exception is travel and baggage insurance and other policies for less than one month. A consumer must exercise the right within 30 days for a payment protection contract or 14 days for any other. The FCA rule satisfies the **Distance Marketing Directive** requirements for the cancellation of distance contracts. When a consumer exercises the right to cancel they may only be required to pay, without any undue delay, for the service actually provided by the firm in accordance with the contract. However, no amount can be charged by the insurer for the cancellation of a payment protection contract.

It is less common for the policyholder to have cancellation rights where cover has been purchased face to face. Some insurers permit this in their wordings, even allowing a proportionate return of premium. Insurers are entitled to charge for the cover already provided and the generally accepted norm is to pro rata the premium based on the number of days the policy was in force. In addition, the insurer can, and usually does, charge a flat fee for the cancellation of the policy to cover their administrative costs. It is best practice to set these costs out in the policy wording or accompanying sales literature. Insurers must take care that these rates do not appear to be 'unfair' as this could be to the detriment of the consumer and in contravention of the **Unfair Terms in Consumer Contracts Regulations 1999 (UTCCRs)**.

Under the **Deregulation Act 2015**, where a policy is cancelled mid-term the policyholder is no longer required to return the certificate of motor insurance or make a statutory declaration or any statement acknowledging the policy has ceased to have effect (and not doing so ceases to be an offence). This change came into effect on 30 June 2015.

E3 Other means of terminating contracts of insurance

As with any other contracts, termination may be as a result of the fulfilment of the contract or as a result of some problem in relation to the contract.

E3A Fulfilment

In insurance this would mean the total loss of the subject-matter. For example, if a car insured under a private car policy is burnt out so that it effectively ceases to exist, the policy is automatically terminated. An insurer could choose to allow a substitute vehicle to be insured and will usually do so within a reasonable period. If not, the policy is terminated.

E3B Voidable contracts

There are circumstances in which one party to a contract may set it aside. It is said to be voidable at their option. This may arise under insurance policies where the insured is in breach of a policy condition that places a continuing requirement upon them. An example would be where the insured is required to maintain equipment in efficient working order. Where the insured has not done so, the insurer may treat the policy as void.

However, you must distinguish this type of situation from one in which the insured fails to fulfil a condition relating to a claim. In this case the insurer may have the right to avoid paying the particular claim, but the policy will remain in force.

An insurer may be able to avoid the contract entirely setting it aside *ab initio* as a consequence of non-disclosure or misrepresentation of information by the policyholder.

There may also be situations where the policy has never been in force. This would arise where there was no recognised insurable interest at the outset. In such cases the policy is automatically void. This does not really amount to a termination since the contract has never been in force.

E3C Breach of warranty

There are situations where an insurer's liability is automatically discharged. A warranty is a term in an insurance contract which according to the **Marine Insurance Act 1906 (MIA 1906)** must be exactly and literally complied with by the insured, whether material to the risk

or not. Departure from the exact requirements, even for reasons of necessity, constitutes a breach.

Breach of a warranty will discharge the insurer from liability under the policy automatically without the need for the insurer to terminate the contract unless the insurer opts to waive the breach and continue the insurance. Although the insurer is 'off risk' from the date of the breach this does not affect claims prior to that date. Depending on the nature of the warranty and the breach, the insurer might be discharged from liability *ab initio* (from the beginning of the contract).

Refer to
See *Insured's duty of disclosure – non-consumer insurance* on page 5/3, for impact of Insurance Act 2015

Changes introduced by the **Insurance Act 2015 (IA 2015)** mean that since August 2016 a breach of warranty no longer automatically terminates the contract. The insurer will have no liability for losses occurring or attributable to something occurring during the period of suspensions, but will be liable for losses occurring after a breach has been remedied. This is a complete change from the harsh situation of automatic discharge if there was a breach even if not material to the risk.

E3D Fraudulent acts

Current law distinguishes between claims which go to the heart of the contract and use of fraudulent means to increase otherwise valid claims.

Under IA 2015, insurers can elect to terminate an insurance contract with effect from the time of a 'fraudulent act', without a return of premium.

If a fraudulent claim is made the insurer:

- is not liable to pay the claim;
- can recover any amounts already paid for the claim; and
- can also choose to terminate the contract from the date of the fraudulent act.

If the insurer chooses to terminate the contract, it:

- can refuse liability for all matters occurring after the date of the fraudulent act; and
- do not have to return any premiums.

Different rules apply for group insurances. If the fraud is committed by one of the benefiting individuals under the contract then the insurer's actions do not affect the other individuals benefiting from the contract.

F Agency

In law an ***agent*** is one who is authorised by a ***principal*** to bring that principal into a contractual relationship with another, a ***third party***. In general contract law the agent will often not have any continuing duty once the contract has been concluded.

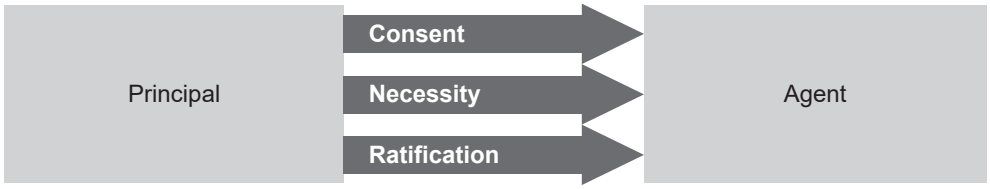
F1 Contracts and the agent

Most commercial insurance contracts and some personal insurance contracts result from the activity of an intermediary who negotiates on behalf of the parties involved. We discussed the different types of intermediary that are in the market in *Intermediaries* on page 2/12.

In law, however, everyone who acts on behalf of another person is an agent. If we allow someone to act for us, or even if we allow them to say that they are acting for us without denying the fact, we will probably have to accept responsibility for whatever is done on our behalf.

F2 Methods of creating an agent/principal relationship

There are three ways in which the relationship of principal and agent can arise:



F2A Agency by consent

Refer to
TOBAs examined in *Terms of business agreements (TOBAs)* on page 3/12

The most usual way of creating a relationship between principal and agent is by consent, also known as an ***agency by agreement***. Both parties enter into a legally enforceable agreement. This is usually by means of express appointment where the terms of the appointment are written down. It is by far the most common method used in insurance. Insurers will issue a **terms of business agreement** (**TOBA**) to each agent stating the terms and conditions of the appointment, the extent of the agent's authority and how money is to be handled and accounted for. In addition, intermediaries will issue a TOBA to their client setting out the services they are offering and the responsibilities of both parties.

It is also possible for an agency relationship to be created by consent in an implied way. This could be the case where work is undertaken and a commission paid but nothing is written down. An agency may therefore be created by consent in either an express or an implied way.

F2B Agency by necessity

This arises where a person is entrusted with someone else's goods and it becomes necessary to act in a certain way in order to preserve the property in an emergency.

F2C Agency by ratification

Ratification refers to a situation where an agent acts without authority, but the principal accepts the act as having been done by the agent on their behalf. The principal's agreement after the event is their **ratification** and they are bound by the contract to the third party. Where this occurs the principal must ratify the whole contract and is not able to vary its terms or pick and choose which elements to accept. This could occur where the agent has no authority at all or is acting outside the terms of an agency agreement.

Consider this…
An agent gave an insured temporary cover for insurance, as they had done in the past. Unfortunately, this cover was given despite a previous warning from the insurers that cover was no longer available for risks of this type. A loss occurred before the insurers realised that cover had been given by the agent on their behalf.
Do you think that the insurers have to indemnify the insured?

F3 Relationship of agent to principal

In most cases, an agent represents only one of the contracting parties. Independent insurance intermediaries are an exception to this general rule because they may, at different times, act for the insured and insurer. For those who have been granted AR status by an insurer, their actions are, broadly speaking, the responsibility of the insurer on whose behalf they operate.

F3A Agent of the insured

An independent intermediary is considered to be the agent of the insured when:

- giving advice on cover or the placing of insurance, or helping arrange the insurance; and
- giving advice to the insured on how to make a claim or assisting them with it.

F3B Agent of the insurer

An independent intermediary is considered to be the agent of the insurer when:

- an insurer authorises an intermediary to receive and handle proposal forms on its behalf and confirm cover;
- the intermediary surveys and describes the property on the insurer's behalf;
- the intermediary has authority to collect premiums and does so; or
- an insurer authorises an intermediary to pay claims.

Question 3.2

An insurance broker recommends and arranges an insurance policy for the client and collects the premium for the insurer. The broker subsequently advises the client on how to make a claim. At what point in this scenario is the insurer the broker's principal?

a. Recommendation of the policy. ☐

b. Arrangement of the policy. ☐

c. Collection of the premium. ☐

d. Advising of the claim. ☐

F4 Duties of an agent

An agent has the following duties to their principal:

Obedience	One of the prime duties owed by an agent to their principal is the duty to obey instructions. If the agent fails to comply, they are liable to be sued by their principal for damages.
Personal performance	As a general rule, an agent must perform the duties imposed on them by the agency. The special nature of the relationship between principal and agent means that they cannot delegate their duties to someone else (although purely mechanical tasks may be delegated). In practice, an agent for the placing of an insurance risk may be a company. The particular individual who meets with the client is not expected to carry out all the negotiating and placing functions: it is often market practice for these to be given to specialists in the company.
Due care and skill	A person must exercise due care and skill in the performance of all acts done in the course of their duty as an agent. An independent intermediary is a person who claims to be a specialist in insurance and must, therefore, offer a higher standard of ability than someone whose main profession is not insurance.
Good faith	An agent's relationship with their principal is one of trust. It follows that they must not allow their own interest to conflict with their duties towards their principal. There is a higher level of duty owed in insurance contracts and this will be discussed in detail in chapter 5. Agents must not accept bribes or secret commissions. In the case of insurance, it is customary for the insurer to pay a commission to intermediaries. The level of this commission need only be disclosed to a client when requested by them. However, any additional commission received, such as profit commission, would need to be disclosed automatically to the client.
Accountability	An agent must account to their principal for all money they receive on their behalf and must keep a proper record of all transactions.

F5 Duties of a principal

A principal has the following duties to their agent:

Remuneration	The agent has a right to the remuneration agreed by their principal or, if none has been fixed, to a reasonable remuneration as is customary or appropriate. For insurance transactions the remuneration usually consists of commission, and to earn this the agent must prove that they were the effective cause of any transaction. In short, an agent has not 'earned' their commission until a contract has been signed.
Indemnity	Subject to any express terms in the agency agreement, an agent has a right to claim from their principal an indemnity against all expenses or loss incurred when acting on the principal's behalf.

F6 Undisclosed principal

In most situations it is clear that an agent is acting not on their own behalf, but on behalf of a principal. However, English law permits an agent to act for an undisclosed principal while seeming to act on their own behalf.

The agent must have authority to act on behalf of the undisclosed principal at the time the contract is made for it to be effective. In other words, the terms of the agency agreement must be clear between the principal and agent.

F7 Consequences of an agent's actions

The consequences of an agent's actions on the principal will depend on the particular circumstances. Influential factors will be the extent of the agent's authority, i.e. whether there is actual authority, apparent authority or no authority.

F7A Actual authority

Actual authority may be express or implied.

Express authority arises from the terms of an agency agreement, which may be oral or in writing. As already indicated, it would be unusual for this to be oral in an insurance context; all terms would be expressed in a TOBA.

Implied authority may be of two kinds. If the agent has to undertake a certain action in order to carry out express instructions, they will have implied authority to do so. So, for example, if an agent needs to travel to a particular place to carry out the principal's instructions, the travel costs will be met without any need to have specific agreement on this aspect.

F7B Apparent authority

It is unlikely that a third party will be aware of the extent of an agent's authority. Since the third party is often in no position to make any judgment about the extent of such authority, the situation is catered for in law by what is termed 'apparent' authority. There are different situations in which it may arise in an insurance context.

There is a helpful summary of how apparent authority arises in ***Gloystarne & Co Ltd v. Mr G S Martin*** **(2000)**, an Employment Appeal Tribunal case:

> Putting the point alphabetically, B does not become A's agent in dealings with C, nor does B acquire authority from A to act on A's behalf in relation to C by way only of what B says to C. If that was the case, principals could have agents completely unknown to them and over which they had no control. Rather the case is that B becomes A's agent in dealings with C by reason, in general, of what A says to C on the point or whether A conducts himself to C in some way that reflects on the possibility of B's agency.'

In general we can say that if an agent has never been appointed, but claims to act on behalf of a principal, this will not create a binding contract with the principal. It requires the principal's conduct to indicate that the agent is acting on their behalf.

However, an agent may have been validly appointed, but is not permitted to carry out certain tasks. In this case, the way to determine if a contract is valid is whether the action carried out by the agent is of a kind that is usual in that trade or profession.

Example 3.3
Let us assume that an insurer has provided an intermediary with a motor cover note book (used by the intermediary to issue cover) and an agent's guide as to the type of risks that may be accepted. The intermediary provides a client with a quotation for a motor insurance and issues a cover note on behalf of the insurer. The client assumes the intermediary has the necessary authority to perform all these functions as they are usual for the profession. If the intermediary indicates acceptance of the risk, but for some reason it is beyond the authority limits granted by the insurer, a valid contract would nonetheless be created, as they will have been acting with ostensible authority.

Be aware
Even if the actions of an agent bind the principal to the contract, an agent acting outside their authority will be liable to the principal for their actions.

F8 Termination of agency

An agency may be terminated in a number of ways. The most common are by:

- mutual agreement by the principal and the agent;
- the agency being withdrawn by the principal or given up by the agent; or
- the death, bankruptcy or insanity of either party.

Consider this…
One of the major problems in insurance is how the cancellation of an agency can be brought to the attention of all existing and possible future third parties.

Think of some reasons why the cancellation of an agency could cause problems for an insurer.

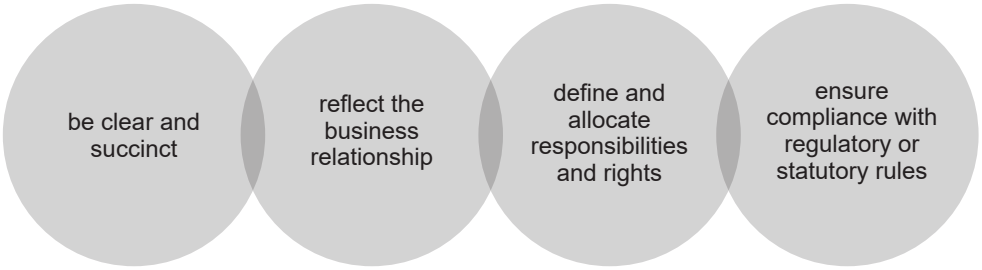
It is important that a principal notifies all relevant parties when an agency is terminated. The rule of apparent authority can apply for some time after termination and unscrupulous former agents may continue to commit their principal to further agreements. Insurers may find themselves bound to contracts entered into by an agent who no longer has any authority to act on their behalf.

G Terms of business agreements (TOBAs)

Insurers and intermediaries alike have tended to develop bespoke TOBAs reflecting their particular methods of doing business. Model TOBAs have been produced by a number of market associations on behalf of their members. The ABI has given guidance on insurer TOBAs.

G1 General requirements

All TOBAs should:



G2 Status

This should include an obligation on the broker to advise the insurer of their regulatory status and of any change to that status. If there are restrictions on the classes of business to which the TOBA applies this should also be clearly stated.

G3 Commission

Any scale of rates should be clearly stated and updated from time to time. If commission is variable this should be stated, together with any minimum notice period for changes. The date when commission is due and payable should also be given.

G4 Material information

This relates to the need for prompt passing of information by the intermediary to the insurer. The ABI recommends that it should be made clear that an intermediary provides all material information to the insurer as agent of the policyholder. The only exception to this is where the insurer has granted the intermediary delegated authority to act on its behalf.

G5 Premiums and credit

This section must deal with the responsibility for the credit risk in relation to premiums both paid and refunded while in the hands of the broker.

An insurer who agrees to a 'risk transfer' arrangement under the FCA rules accepts full responsibility for the premium even though it is not physically transferred to them until later. Some insurers grant this facility to the brokers with whom they deal. (However, it is not universal practice to permit risk transfer throughout the whole of a supply chain, where more than one broker is involved.)

Where risk transfer is granted, the TOBA will specify the type of trust bank account permitted to hold the premiums.

This section will also specify terms of credit and the responsibilities for cancelling or recovering documentation in the event of any breach by the policyholder. The broker's obligation to release all statutory documentation, such as motor insurance and employer's liability certificates, will also be covered in this section.

G6 Claims money

This section will specify whether the insurer or the broker is to bear the credit risk in relation to claims money held by the broker.

G7 Broker/client relationship

The ABI suggests that under this heading insurers should consider including a non-solicitation clause, effectively barring the insurer from acquiring business, currently placed through the broker, on a direct basis for a period of five years. This element of guidance is a suggestion only.

G8 Direct administration arrangements

This section clarifies that the insurer's role in dealing directly with the policyholder is limited to fulfilment of regulatory or contractual responsibilities. In other words, it reaffirms that the usual situation is for the insurer to deal with the policyholder via the intermediary. Direct contact between insurer and policyholder will occur only as provided for in the policy, elsewhere in the TOBA or where required by regulation.

G9 Claims

Notification via the broker or direct should be specified.

G10 Termination

This section will specify the arrangements for termination where there is no fault (usually by mutual agreement or specified notice period) and also where there is fault. The latter is a more extensive list that tries to anticipate the types of situation in which one party would expect to have the right to serve notice on the other.

Broadly speaking, the areas covered are:

- suspicion of fraud or dishonesty;
- change of regulatory status;
- administration arrangements causing prejudice to policyholders;
- failure to remedy a breach of the TOBA within an agreed timescale;
- irredeemable breach of the TOBA; and
- bankruptcy or receivership.

The insurer will also wish to include its right to cancel for failure to pay monies due, or on the death of the broker if the broker is a sole trader.

G11 Regulatory requirements

All TOBAs should themselves be compliant and should include terms requiring compliance with all other applicable regulatory and legal requirements, such as anti-bribery and money laundering obligations, and local regulatory and legal requirements where the intermediary is outside the UK.

G12 Additional sections

Accounting procedures	This will clarify who prepares the accounts and terms of settlement.
Assignment options	Assignment is the transfer of rights under the terms of a contract. If this is permissible, the terms should be specified.
Arbitration options	The appointment of an arbitrator or other expert may be specified in the event of a dispute.
Variation of terms	Any variation (subject to the appropriate notice period) will be sent by recorded delivery to the last known address.
Signature	Both parties will sign the document.
Authority	If any delegated authorities have been granted, the terms should be specified (including premium handling, claims handling and subagent arrangements).
Indemnity	If included, this would provide an indemnity to each party in the event that the other party acted outside the terms of the TOBA or their respective authority limits.
Other clauses	A list of other clauses, such as *force majeure* (effectively major things outside a party's control), are specified here. One of these is opting out of the **Contracts (Rights of Third Parties) Act 1999**. Refer to *Contracts (Rights of Third Parties) Act 1999* on page 9/5 for more on the 1999 Act.

G13 Other TOBAs in the market

Separate TOBAs are created for business dealings between intermediaries and their clients and between brokers and their subagents or co-brokers (this is where more than one broker acts for a client). There will be some common elements, but also some elements uniquely focused on the different relationships. The 'client' TOBA may well contain a service level agreement (SLA) indicating precisely what services are being provided and to what standard. The scope of these is beyond the IF1 syllabus.

Key points

The main ideas covered by this chapter can be summarised as follows:

Contract law

- A contract is an agreement, enforceable by law, between two or more persons to perform a certain act or abstain from doing so – their intention being to create legal relations and not merely to exchange mutual promises.
- Two important criteria for a valid and enforceable contract are:
  - offer and acceptance; and
  - consideration.
- To be effective, acceptance must be the final and unqualified agreement to the offer.
- Consideration may be described, simply, as each persons side of the bargain which supports the contract.

Termination of contracts of insurance

- Most general insurance policies have a cancellation condition allowing the insurer to cancel the contract, after due notice, with a pro rata return of premium.
- A consumer has a right to cancel, without penalty and without giving reason, most insurance policies purchased at a distance as long as they do so within 30 days for a payment protection policy or 14 days for any other type of policy.
- Some insurers also permit the insured to cancel other insurance contracts while retaining the right to charge for the cover already given at their short period rates.
- A contract of insurance can be terminated by fulfilment or made voidable – for instance by the insured's breach of a policy condition imposing a continued requirement on them.
- Under the Insurance Act 2015 an insurer may elect to terminate a contract in response to a fraudulent act.

Agency

- In law an agent is one who is authorised by a principal to bring that principal into a contractual relationship with another, a third party.
- An agent–principal relationship can arise by consent, necessity or ratification. Authority can be express or implied.
- In insurance an independent intermediary may, at different times, act for each party to the contract.
- An agent has the following duties to the principal:
  - obedience;
  - personal performance;
  - due care and skill;
  - good faith; and
  - accountability.
- An agency may be terminated by mutual consent, by either party or by the death, bankruptcy or insanity of either party.

Terms of business agreements (TOBAs)

- All TOBAs should be clear, succinct, reflect the business relationship, define and allocate responsibilities and rights and ensure compliance with regulatory and statutory rules.

Question answers

3.1 d. Pam needs to agree to pay Jane for the filing cabinets.

3.2 c. Collection of the premium.

Self-test questions

1. A valid contract **must** include:
   a. Signed documentation. ☐
   b. A written offer. ☐
   c. A legal disclaimer. ☐
   d. Consideration. ☐

2. Sanjeev requires house insurance. He has spoken to an insurer over the telephone who has offered him a policy with an excess of £500. Sanjeev accepts the policy but requests an excess of £250. In contract terms, Sanjeev's acceptance represents:
   a. A counter offer. ☐
   b. An offer. ☐
   c. Unconditional acceptance. ☐
   d. Agreement. ☐

3. Katie is selling her car for £2,000. May offers her £1,800, which Katie refuses. Legally, a contract has not been formed between Katie and May because:
   a. Katie's refusal of the counter offer acts as a withdrawal of the original offer. ☐
   b. Katie and May did not sign a contract. ☐
   c. May's counter offer acts as a rejection of the original offer. ☐
   d. May offered less than Katie was prepared to accept. ☐

4. Colin buys home contents insurance, having received a quote through the post which he is happy with. Acceptance of the quote will be complete when:
   a. A letter of acceptance is received. ☐
   b. A letter of acceptance is posted. ☐
   c. The policy is put on risk. ☐
   d. Colin receives confirmation from the insurer. ☐

5. Within insurance, consideration will typically be the:
   a. Value of the claim paid by the insurer. ☐
   b. Disclosure of all relevant facts at the outset by the insured. ☐
   c. Initial terms for the insurance issued by the insurer. ☐
   d. Premium paid by the insured. ☐

6. Joe and Maggie have been told that their insurance policy doesn't have a right to cancel. What type of policy is it?

   a. Travel insurance with a term of less than a month. ☐

   b. Motor insurance with a term of less than a month. ☐

   c. Payment protection insurance. ☐

   d. Critical illness insurance. ☐

7. Tolu has buildings insurance but has not adhered to a warranty on the policy. In the event of a claim, the insurer would:

   a. Be able to avoid the claim and cancel the policy from the outset. ☐

   b. Be liable but would be able to only pay a set proportion of the claim. ☐

   c. Not be liable for claims resulting from this, but will be liable for losses occurring after a breach has been remedied. ☐

   d. Be able to make a discretionary payment of an amount it feels is reasonable. ☐

8. If an independent intermediary completes a property survey for an insurer, they would be considered to be a(n):

   a. Principal for the insurer. ☐

   b. Principal for the property owner. ☐

   c. Agent for the property owner. ☐

   d. Agent for the insurer. ☐

9. Firdale Insurance Ltd has asked one of its agents to carry out a property survey 50 miles away. The agent carries out the survey and charges the mileage costs back to the insurer. The costs will be met because:

   a. The agent has implied authority. ☐

   b. Agency agreements always allow for mileage costs. ☐

   c. The agent has limited authority. ☐

   d. The principal is always liable for the actions of their agent. ☐

10. All agency agreements should:

    a. Set out the requirements and responsibilities for just the agent. ☐

    b. Define and allocate the responsibilities and rights of each party. ☐

    c. Set out the requirements and responsibilities for just the principal. ☐

    d. Set out the broad principles and conduct requirements that each party will be subject to. ☐

You will find the answers at the back of the book

4
Insurable interest

Contents	Syllabus learning outcomes
Introduction	
A Definition of insurable interest	*6.1*
B Timing of insurable interest	*6.2*
C Creation of insurable interest	*6.3*
D Application of insurable interest	*6.4*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- define insurable interest;
- describe when insurable interest needs to exist;
- explain when insurable interest commonly arises in various classes of insurance;
- describe how insurable interest may be created; and
- apply the concept of insurable interest to property and liability policies.

Introduction

In this chapter we shall examine insurable interest and its place in insurance. It is one of the elements necessary to create a valid insurance contract.

Key terms

This chapter features explanations of the following terms and concepts:

Common law	Financial value	Insurable interest	Legal relationship
Statute	Subject-matter		

A Definition of insurable interest

Insurable interest is the legal right to insure arising out of a financial relationship recognised at law, between the insured and the subject-matter of insurance.

A1 Features of insurable interest

The following features of insurable interest may help to clarify the definition:

- ***subject-matter***;
- ***legal relationship***; and
- ***financial value***.

We will also need to consider some related terms to clarify other aspects of insurable interest. These are:

- insurers' insurable interest; and
- anticipated insurable interest.

Consider this…

Do you have insurable interest in:

- a house you are purchasing, prior to the exchange of contracts?
- a watch you are holding as security for a loan?
- a car which has been sent to your garage for repair?

You have no insurable interest in the first case, As the buyer you have no legal interest in the property, until there has been an exchange of contracts (at which point, both parties will have an insurable interest).

There is an insurable interest in both the second and third case:

- You may be liable to pay for or replace the watch if it is damaged when the loan is repaid.
- The owner will require compensation from you if the car is lost or damaged.

A1A Subject-matter

The term 'subject-matter' is used in two ways: the subject-matter of the insurance and the subject-matter of the contract.

Subject-matter of insurance	The item or event insured. The most obvious examples are cars, houses, valuables or factory stock or liability for acts of negligence. Any type of property or any event which may result in a loss of legal right or the creation of a legal liability. The subject-matter can be any type of property or any event which may result in a loss of legal right or the creation of a legal liability. Under a household policy the subject-matter can be the building, furniture and other contents or the creation of liability, for example when a tile that should have been secured falls off a roof and injures a passer-by.
Subject-matter of the contract	The financial interest a person has in the subject-matter of the insurance, as defined in the case of ***Castellain v. Preston* (1883)**.

A1B Legal relationship

The relationship between the insured and the subject-matter of the insurance must be recognised in law. An example of a legal relationship is ownership. If there is no legal relationship, there is no insurable interest (for example, a thief can have no insurable interest in stolen goods nor indeed can one friend have an insurable interest in another's possessions, unless they are in their possession for safekeeping).

A1C Financial value

The insurable interest in the subject-matter of insurance must have a financial value. Unlike many other types of contract that may be concerned with performance or some other obligation, insurance contracts are always concerned with a financial interest or value. We will look at the measurement of the value later.

Activity
Think about yourself or a member of your family and note down what insurable interests you or they might have through owning or being responsible for something.

A1D Insurers' insurable interest

Insurers share risks with other insurers. They are able to do this because they themselves have an insurable interest in the risks that they have assumed. They reinsure with other insurers (or reinsurers) part or all of a risk that they hold; the subject-matter of the contract being the insurer's financial interest in the original insurance (the possibility of financial loss to the insurer if there is insured liability, loss or damage).

We will look at anticipated insurable interest in *Anticipated insurable interest* on page 4/3.

B Timing of insurable interest

When must insurable interest exist? The answer to this question varies according to the class of insurance business. Although IF1 is not primarily concerned with life insurance or marine insurance, they are shown here to demonstrate the fundamental differences between different classes of insurance.

B1 Anticipated insurable interest

The expectation of acquiring insurable interest at some time in the future (however certain) may not be enough to create insurable interest in general non-marine insurances.

This is illustrated in the case ***Lucena v. Craufurd* (1806)**, where the judge said:

> …suppose the case of the heir at law of a man who has an estate worth £20,000 who is ninety years of age, upon his death bed intestate, and incapable from incurable lunacy of making a will, there is no man who will deny that such an heir at law has a moral certainty of succeeding to the estate, yet the law will not allow that he has any interest, or anything more than a mere expectation.

B2 Timing for different classes of insurance

There are different laws which govern when the timing of insurable interest is required for different classes of insurance and we will now examine these in detail.

B2A Marine insurance

The **Marine Insurance Act 1906 (MIA 1906)** was a codifying Act (bringing together and updating all previous legislation on the subject).

It stated that any marine insurance contract was void in the absence of insurable interest at the time of any loss.

The Act contains the following on the timing of insurable interest:

Section 6 When interest must attach

The assured must be interested in the subject-matter insured at the time of the loss though he need not be interested when the insurance is effected;

Provided that where the subject-matter is insured "lost or not lost", the assured may recover although he may not have acquired his interest until after the loss, unless at the time of effecting the contract of insurance the assured was aware of the loss, and the insurer was not.

We can assume the timing for insurable interest for this class of insurance as 'not required but reasonably expected' at the time of entering the contract and 'required' at the time of loss excluding in the circumstance of this exception as stated within the Act.

Be aware

The **Marine Insurance (Gambling Policies) Act 1909** made it a criminal offence to effect a marine policy where either there is no insurable interest, or where there is no reasonable expectation of such an interest.

B2B Life insurance

Prior to the **Life Assurance Act 1774**, a practice had developed of effecting life insurance policies on another person's life (by a disinterested party) simply as a form of wager. This 'mischievous form of gaming' was made illegal by the Act.

So, if at the time of effecting a policy on someone's life, there is no insurable interest on the part of the person effecting the policy, the Act means that the policy is void. In other words, there must be an insurable interest at inception of a life policy. The Act also specified that the name of the person effecting the policy had to be shown and they may only recover the value of their interest. However, there need be no valid insurable interest at the time of a claim (***Dalby v. The India and London Life Assurance Company* (1854)**)

The Act itself introduced some uncertainty by specifically excluding its application to insurances on 'ships, goods or merchandises', leaving some room for debate regarding insurances on buildings, for example. The courts have treated motor insurances (where there is some cover for damage to the vehicle itself) as 'goods'.

B2C General insurance

The **Gaming Act 1845** extended the requirement for insurable interest beyond life insurance contracts. This Act made all contracts of gambling or wagering null and void. The effect of this legislation upon a general insurance policy taken out where there is no insurable interest was to treat such contracts as a gamble, and therefore of no effect.

This legislation was repealed by the **Gambling Act 2005** which came into force in 2007. The 2005 Act repealed the legislation by stating:

> The fact that a contract relates to gambling shall not prevent its enforcement.

However, general insurance contracts are contracts of indemnity so, applying the principle of indemnity, a party to a general insurance contract can only recover the amount of their loss or other fixed amount as agreed with the insurer at the time a loss occurs.

Example 4.1

George has agreed to purchase a new car on Thursday from a main dealer. He arranges an insurance policy (which covers damage to the car and third-party liabilities) effective from Thursday and has been issued a cover note as evidence of cover by the insurer. When George turns up at the garage at the appointed time, the car is not ready because the garage, when carrying out the pre-sales check, discovered that oil was leaking and certain parts needed renewing. They tell George that regrettably this will take a couple of days. He can collect the car on Saturday.

Disappointed, George agrees to this as he is still keen to purchase the car. He does nothing about the insurance because it hardly seems worth changing things for the sake of two days, and he picks the car up on the Saturday.

The terms of the Life Assurance Act 1774 do not apply to this insurance (the car is treated as 'goods' and therefore exempt), but technically the policy was effected before George had an insurable interest. He did not become the owner until two days after he effected the policy. If we were to use the rule strictly, we arrive at the unreasonable conclusion that the policy is null and void – this would clearly be a nonsense.

The statement of the judge in ***Williams v. Baltic Assurance Association*** **(1924)** tends to add weight to this conclusion. He said:

> There is no real support for the broad proposition that an interest must subsist at the time the policy is taken out

It is not a straightforward area of law. We must therefore temper our general rule regarding insurable interest at inception with the fact that there is generally no absolute requirement for actual insurable interest at inception.

In addition, general insurance policies that are contracts of indemnity are subject to the rule that insurable interest must exist at the time of the claim. This is because of the compensatory nature of such policies. The claimant has, by definition, suffered no financial loss if they had no legal financial interest at the time of the claim.

B3 Summary of timing

The effect of the legislation for different classes of insurance is to produce distinct rules for each category:

Life insurance contracts	Insurable interest must exist at inception but need not exist at the time of a loss.
Marine insurance contracts	Insurable interest must exist at the time of a loss but need not exist at inception, provided that there is a reasonable expectation of interest.
General insurance contracts	A general rule that insurable interest must exist both at inception and at the time of a loss, though some connection other than a full insurable interest may be sufficient at inception.

We have now discussed the principle of insurable interest and have seen when insurable interest must be present if an insurance contract is to be enforceable at law. We will now consider the different ways in which insurable interest can arise.

Question 4.1

As a general rule, when must insurable interest first exist in order for a private motor insurance policy to be enforceable at law?

a. At the time of the quotation. ☐

b. On completion of the proposal form. ☐

c. At inception of the policy. ☐

d. At the time of a claim. ☐

Insurable Interest Bill

The English and Scottish Law Commissions published a draft Bill in May 2016 to reform insurable interest law in the UK, which it described as antiqued and overly restrictive.

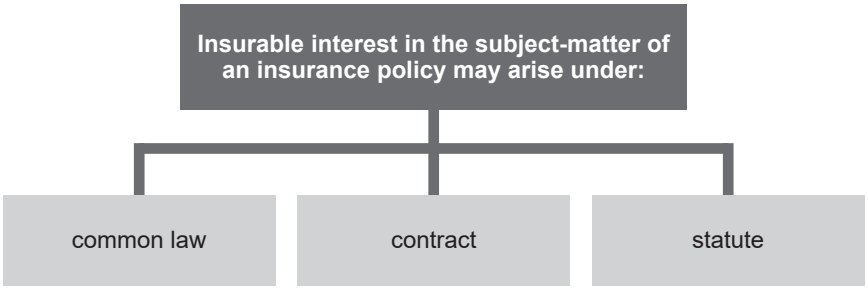
It stated that current insurance laws were restrictive and prevents insurers from selling economically and socially useful insurance products that people want to buy including life insurance for loved ones.

Initially, the draft bill proposed changes to the laws of insurable interest in both life and non-life insurance contracts, but following stakeholder consultation to the 2016 draft bill, and a lack of demand from the market to reform the laws of insurable interest in non-life insurance contracts, a revised draft of the bill was published in June 2018 to focus on the reform of insurable interest for life insurance (and other insurances relating to human life) only.

The draft bill's intention is to reform insurable interest in life insurance by broadening its concept, to include the following:

- Providing that individuals have an automatic insurable interest in cohabitants, not just spouses or civil partners;
- Extending insurable interest to cover children and grandchildren, so that they could lawfully be covered under travel or health policies;
- Confirming in law that pension trustees and other administrators of group schemes have an insurable interest in the lives of the members of the group – this would ensure that employers' life and health policies have the full support of the law;
- Allowing for trustees of private trusts to purchase life insurance bonds if the settlor or truster of the trust would have had the necessary insurable interest to do so.

C Creation of insurable interest



C1 Common law

We all owe duties to each other and have certain rights under common law. These give rise to insurable interest. The most straightforward is ownership. If we own something, we stand to lose financially if it is lost or damaged. Equally, if we cause someone injury through our negligence, there is a financial aspect to this that gives us an insurable interest.

C2 Contract

There are situations in which we accept greater liabilities than those imposed by common law. These occur when we enter into a contract that gives us greater responsibilities. A landlord is normally liable for the maintenance of the property they own. However, the landlord may make the tenant liable, under the terms of the lease. The imposition of these responsibilities, or potential liabilities, creates an insurable interest.

C3 Statute

There are a few statutes (Acts of Parliament) which impose a particular duty on, or grant some benefit to, certain groups of people, thus creating or modifying insurable interest. Examples of statutes imposing duties are the **Settled Land Act 1925** and the **Repair of Benefice Buildings Measure Act 1972**.

Where these statutes apply they make tenants responsible for the upkeep of the buildings they occupy. This gives the tenants an insurable interest in the building.

Statutes modifying insurable interest
There are also statutes which restrict liability and therefore restrict insurable interest. For example, the **Carriage of Goods by Sea Act 1971** limits the liability of a carrier to a specific amount, and therefore their insurable interest. Other examples of statutes restricting insurable interest are the **Hotel Proprietors' Act 1956**, **Carriers Act 1830** and **Trustee Act 1925**.

D Application of insurable interest

Now we have a clear understanding of the principles and features of insurable interest and how it may arise, let us consider its application to property and liability insurance contracts.

D1 Property insurance

This is probably the easiest type of insurable interest to identify. It generally arises out of ownership, where the insured is the owner of the subject-matter of insurance. There are also instances where insurable interest arises when the insured is not the full owner of the subject-matter, for example:

- **Part or joint owners**. A person who is a joint or part owner of certain property has an insurable interest up to the limit of their financial interest. However, as they are considered a trustee for any money that may be paid in the event of a claim, which may exceed their actual interest, a joint or part owner can insure the property for its full value.
- **Agents**. Where a principal has insurable interest, their agent can insure on their behalf.
- **Bailees**. Where someone holds property on a temporary basis on behalf of the legal owner, they are a bailee. They have an insurable interest in the property, since if it is damaged or stolen they may have to replace it. Examples of bailees include shoe repairers, garage owners and dry cleaners.
- **Tenants**. When someone is a tenant of a property, they are not the owner of it but have an insurable interest in it. This is because in the event of damage to the property, the tenant may be liable for the cost of repairs.

Bailees' and tenants' interests are in respect of possible liability.

Shareholders in a limited company do not have an insurable interest in the company's property. Their interest in the company is limited to the value of the shares that they own and does not extend to the physical property owned by the company.

Consider this…
What do you think is the extent of insurable interest of:

- a mortgage lender in the borrower's property?
- a joint owner of a caravan?

In the first case, it is the extent of the mortgage. In the second case, it is the extent of the interest in the caravan. However, a joint owner is treated as a trustee for the other owner and may insure to the full value of the caravan.

D2 Liability insurance

Under common law a person has insurable interest to the extent of any potential legal liability that they may incur to pay damages awarded by a court and other costs.

Our definition of insurable interest included not only loss and damage but also potential liability. This could arise under common law where, for example, a person may be liable for injuring someone else through the careless use of an umbrella. This incident may give rise to a potential award by a court plus a claimant's legal costs. The potential liability and costs are capable of being insured.

Key points

The main ideas covered by this chapter can be summarised as follows:

Definition of insurable interest

- Insurable interest is the legal right to insure arising out of a financial relationship recognised at law, between the insured and the subject-matter of insurance.
- The main features of insurable interest are subject-matter, legal relationship and financial value.

Timing of insurable interest

- When insurable interest must exist depends on the class of insurance.
- For life insurance it must exist at inception.
- For marine insurance it must exist when a claim is made.
- For general insurance it must exist when a claim is made and usually at inception, though actual insurable interest at the time of inception is not absolute.

Creation of insurable interest

- Insurable interest can arise at common law, under contract or under statute.

Application of insurable interest

- With property insurance, insurable interest usually arises out of ownership, although certain others, who are not the full owner, can also have an insurable interest.
- A person has insurable interest to the extent of any potential legal liability that they may incur to pay damages awarded by a court and other costs.

Question answers

4.1 c. At inception of the policy.

Self-test questions

1. What must exist for there to be insurable interest?
   a. Subject-matter, ownership and financial value. ☐
   b. Subject-matter, ownership and financial loss. ☐
   c. Subject-matter, legal relationship and financial value. ☐
   d. Subject-matter, legal relationship and financial loss. ☐

2. Dorothy and James are getting married and have taken out insurance for their wedding day. In terms of insurable interest, their wedding day is the:
   a. Legal relationship. ☐
   b. Subject-matter. ☐
   c. Financial value. ☐
   d. Risk. ☐

3. If an insurance company wants to reinsure part of a risk they hold, their financial interest in the original insurance is known as the:
   a. Subject-matter of insurance. ☐
   b. Anticipated insurable interest. ☐
   c. Legal liability. ☐
   d. Subject matter of the contract. ☐

4. A couple arranged a joint life insurance contract shortly after they were married. They divorced five years later. It is **true** to say that the contract is:
   a. Still enforceable because insurable interest existed at inception. ☐
   b. Not enforceable because insurable interest no longer exists. ☐
   c. Still enforceable but only if either partner remarries. ☐
   d. Only enforceable until the point they are divorced. ☐

5. Aiden sold his car to his friend Darren. Two weeks later Darren had an accident in the car causing significant damage. As Aiden had not cancelled his original insurance policy he submitted a claim on Darren's behalf. His claim was refused because:
   a. He was only covered for third party fire and theft. ☐
   b. He had no financial interest in the car at the time of the claim. ☐
   c. Darren was not a named driver on the policy. ☐
   d. His claim amount exceeded the cover on the policy. ☐

6. Which class of insurance requires the existence of insurable interest at both inception and at the time of a loss?
   a. Level term assurance. ☐
   b. Marine insurance. ☐
   c. An endowment plan. ☐
   d. General insurance. ☐

7. Insurable interest can be created by:
   a. Ownership, contract and court order. ☐
   b. Ownership, contract and legislation. ☐
   c. Ownership, agency agreement and legislation. ☐
   d. Ownership, contract and agency agreement. ☐

8. A dry cleaners has an insurable interest in the garments they clean and is therefore referred to as a(n):
   a. Bailee. ☐
   b. Tenant. ☐
   c. Agent. ☐
   d. Part owner. ☐

9. Why does a tenant have insurable interest in the property they live in?
   a. They own the property for insurance purposes. ☐
   b. They act as an agent for the owner. ☐
   c. They may be liable for the cost of repairs. ☐
   d. They are treated as part owners for insurance purposes. ☐

10. Robert is effecting an insurance policy on behalf of another party. Robert is not the owner of the property but he is able to arrange insurance because he is a(n):
   a. Bailee. ☐
   b. Principal. ☐
   c. Agent for the other party. ☐
   d. Tenant. ☐

You will find the answers at the back of the book

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5

Good faith and disclosure

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Learning objectives

After studying this chapter, you should be able to:

- define good faith;
- explain how good faith applies to contracts of insurance;
- describe the duty of disclosure and give examples of breach of this duty;
- describe the duty not to make a misrepresentation in consumer insurance contracts;
- describe the duty to make a fair presentation of risk and how it arises;
- describe the ways in which insurers may limit their entitlement to disclosure of information;
- define a material circumstance and describe its importance; and
- describe the consequences of non-disclosure, misrepresentation or a breach of the duty of fair presentation.

Introduction

Many contracts involve the purchase of a tangible product. A purchaser can inspect a tangible item at the time they buy to check that it is good value. Provided that the seller does not mislead them (for example, by showing a sample that is unrepresentative of the actual product), the law expects the purchaser to satisfy themselves about the obvious properties of the product being bought.

There are some obvious difficulties when trying to apply this principle to insurance contracts, which have until recently been treated as contracts of **utmost good faith**. This meant, in simple terms, that the insurer and insured both had a duty to deal honestly and openly during their contractual relationship. This is still largely the case, although the law has been modified to reflect the imbalance of bargaining positions between insurers and insureds, with the rules for disclosure set out in the **Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA)** for consumer contracts, and the **Insurance Act 2015 (IA 2015)** for non-consumer contracts.

On the Web
The full content of CIDRA and IA 2015 can be found at *www.legislation.gov.uk*.

Key terms

This chapter features explanations of the following terms and concepts:

Compulsory insurances	Disclosure	Duty of fair presentation	Good faith
Material circumstances	Misrepresentation	Non-disclosure	

A Principle of good faith

Insurance contracts are subject to the principle of good faith.

Good faith means that disclosure must be made in a reasonably clear and accessible manner, and material representations of fact, expectation or belief must be 'substantially correct'.

This means that the parties to a contract must volunteer material information in all negotiations before the contract comes into effect.

The principle applies equally to both the proposer and the insurer throughout the contract negotiations. However, it applies rather differently to each party. It is the proposer who has the duty to disclose all **material circumstances** about the risk to the insurer. The nature of the subject-matter of the insurance contract and the circumstances surrounding it are facts known mainly by the insured.

The insurer on the other hand must be entirely open with the proposer in other ways. The insurer cannot introduce new non-standard terms into the contract that were not discussed during negotiations, neither can the insurer withhold the fact that discounts are available for certain measures that improve a risk (such as the fitting of an intruder alarm for household contents insurance).

Be aware
You may hear your colleagues refer to good faith as 'utmost good faith'.

B Duty of disclosure

It has, historically, been implicit in all insurance negotiations that there is a duty to disclose material circumstances. The duty of disclosure was treated as particularly important at the proposal stage, before the contract comes into existence. At common law, once the policy is in force the duty of disclosure would be revived at each renewal date, and insurers would often add specific policy terms to make the disclosure requirement a continuing one.

When considering what should be disclosed, customers would be expected to ask themselves "What is a material circumstance?" and provide this information.

The definition, which is still relevant today, is taken from s.18(2) of the **Marine Insurance Act 1906 (MIA 1906)**:

> Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk.

In this section, we look at the how the law has been modified to a position which reflects the different levels of knowledge of risk and the balance of bargaining powers for consumer and commercial policyholders.

B1 Insured's duty of disclosure – consumer insurance

The **Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA)** came into force on 6 April 2013. CIDRA removes the common law duty on consumers to disclose any information that a prudent underwriter would consider material and replaces this with a duty to **take reasonable care not to make a misrepresentation**.

CIDRA applies to **consumers** and not to business/commercial insurance (the Insurance Act 2015 alters commercial contracts of insurance.). Under CIDRA a consumer is someone who takes out insurance 'wholly or mainly for purposes unrelated to the individual's trade, business or profession'. This is wider than the FCA definition of consumer which is 'any natural person acting for purposes outside his trade, business or profession'.

CIDRA replaces the duty on consumers to volunteer information before taking out insurance, with a duty to take reasonable care to answer insurers' questions fully and accurately. It also sets out a Statutory Code clarifying the law of agency relationship, provisions for group schemes and the insurance taken out on the life of another. Other provisions in the Act include safeguards preventing insurers from including terms in insurance contracts which put the insured in a worse position in respect of pre-contract disclosure and representation than the legislation will permit. One example is the banning of 'basis of contract clauses' which are sometimes found on proposal forms and warrant the truth or accuracy of the statements and make them the basis of the contract.

There have been a number of consequences of this legislation for intermediaries and insurers who have had to change their documentation, websites and ways of working. Insurers in particular have had to make sure they ask specific questions of their potential policyholders, and intermediaries have had to amend their terms of business agreements as well as consider how their agency relationship with the policyholder may impact them.

> **Consider this…**
> Are consumers subject to the duty of good faith, either at the point of sale of an insurance product or at renewal?

B2 Insured's duty of disclosure – non-consumer insurance

The **Insurance Act 2015 (IA 2015)**, which came into force on 12 August 2016, extends much of the legislation set out in CIDRA to non-consumer insurance contracts.

B2A Good faith

IA 2015 states that 'any rule of law permitting a party to a contract of insurance to avoid the contract on the ground that the utmost good faith has not been observed by the other party is abolished'. It also states that 'any rule of law to the effect that a contract of insurance is a contract based on the utmost good faith is modified to the extent required by the provisions of this Act and the Consumer Insurance (Disclosure and Representations) Act 2012'.

The concept of good faith continues, but the absolute remedy of avoidance in the case of a breach no longer exists.

B2B Duty to make a fair presentation

IA 2015 changes the obligations on the parties during placement as a new duty of fair presentation applies to non-consumer contracts.

The Act states that the 'insured must make to the insurer a fair presentation of the risk'.

A fair presentation of the risk is defined as one:

- which makes disclosure of every ***material circumstance*** which the insured knows or ought to know, or disclosure which gives insurers sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances;
- which makes the disclosure in a manner which would be reasonably clear and accessible to a prudent insurer; and
- in which every material representation as to a matter of fact is substantially correct and every material representation as to a matter of expectation or belief is made in good faith.

This is a substantial change – the onus shifts from the insured to the insurer, which is assumed to know information that would be expected of it. Insurers, therefore, have to take responsibility for asking questions and probing for information about a risk.

The new duty of fair presentation applies before the contract of insurance is entered into. However, as the Act also deals with issues relating to breaches of duty during any variation process, it can be interpreted that the duty continues through the life of the contract.

B2C Measure of the insured's and insurer's knowledge

IA 2015 sets out what an insured or insurer should know or is expected to know.

Insured
An individual insured knows only:

- what is known to them as an individual; or
- what is known to one or more of the individuals who are responsible for their insurance.

A 'non-individual' insured knows only what is known to one or more of the individuals who are:

- part of the senior management (those who play significant decision-making roles about the organisation of insured activities); or
- responsible for the insured's insurances.

An insured is not deemed to know confidential information that is known to an individual employed by their agent, where that information has been obtained by the individual from a source unconnected with the insurance in question.

The measure of what the insured ought to know is defined as: 'what should have been revealed by a reasonable search of information available to the insured (whether the search is conducted by making enquiries or by any other means)'.

Information can be held in the insured's organisation or by any other person such as the agent.

The Act specifically states that knowledge includes those things that an insured suspects and about which they would have had actual knowledge, but for deliberately refraining from confirming/enquiring about the information. Insureds should not therefore turn a blind eye to issues they have suspicions about.

Insurer
An insurer knows something only if it is known to one or more individuals who participate on behalf of the insurer in the decision as to whether to take the risk, and if so on what terms (whether the individual does so as the insurer's employee or agent, as an employee of an agent or in any other capacity).

An insurer ought to know something only if:

- an employee/agent of the insurer knows it and ought reasonably to have passed on the relevant information to the individual making the decision whether or not to take the risk; or
- the relevant information is held by the insurer and is readily available to an individual making the decision whether or not to take the risk.

An insurer is presumed to know:

- things which are common knowledge; and
- things which an insurer offering insurance of the class in question in the field of the relevant activity would reasonably be expected to know in the ordinary course of business.

Knowledge of both the insured and insurer includes matters that an insured or insurer suspects and about which they would have had actual knowledge but for deliberately refraining from confirming them or enquiring about them.

B2D Agent's duty

In non-consumer (business) insurance the insurer can seek remedy for the breach of the fair presentation of the risk if the insured's agent breaches the duty. Section 4 of IA 2015 regulates this principle in its provision that what is known to the person who is responsible for the insured's insurance is attributed to the insured.

In common law, a person is responsible for the acts of their agent and so a careless or reckless misrepresentation by an agent is treated as if it had been made by the principal. This principle is maintained in consumer insurance by CIDRA, which states 'Nothing in this Act affects the circumstances in which a person is bound by the acts or omissions of the person's agent' (s.12(5)).

Under CIDRA, an intermediary is to be considered to be the **insurer's agent** if the intermediary:

- is the appointed representative of the insurer;
- collects information from the consumer with express authority from the insurer to do so; or
- has authority to bind the insurer to cover and does so.

In all other cases it is presumed that the agent is the **consumer's agent** unless, in light of the relevant circumstances, the consumer proves otherwise.

B3 Insurer's duty of disclosure – non-consumer insurance

The insurer also has a duty of disclosure to the insured. In order to fulfil this duty, the insurer must also behave with good faith, by, for example:

- notifying an insured of a possible entitlement to a premium discount resulting from a good previous insurance history;
- only taking on risks which the insurer is registered to accept (avoiding unenforceable contracts); and
- ensuring that statements made are true: misleading an insured about policy cover is a breach of good faith, shown in ***Kettlewell v. Refuge Assurance Company* (1909)**.

Question 5.1

To whom does the principle of duty of disclosure apply in contracts of insurance?

a. The proposer only. ☐

b. The insurer only. ☐

c. Both the insurer and proposer. ☐

d. An interested party. ☐

B4 Effect of FCA rules

Financial Conduct Authority (FCA) rules require insurers and intermediaries to provide sufficient information about the contract before its conclusion so that a prospective customer can make an informed decision about whether to buy it or not.

One element of the information that must be disclosed to a client or prospective client is a statement of their demands and needs. There is flexibility in the way that this may be done, but the responsibility lies with the adviser to show how the demands and needs are met by the product(s) offered. The fulfilling of this requirement implies that there is a comprehensive fact gathering exercise that must be undertaken, placing the onus for establishing the facts upon the adviser.

The FCA imposes restrictions on rejecting claims where consumers have failed to disclose information to insurers or have misrepresented facts. For this reason, the FCA requires firms to ensure a customer knows what they must disclose by:

1. explaining to the customer the responsibility of consumers to take reasonable care not to make a misrepresentation and the possible consequences if a consumer is careless in answering the insurer's questions or if a consumer recklessly or deliberately makes a representation;
2. explaining to a commercial customer the duty to disclose all circumstances material to a policy, what needs to be disclosed and the consequences of any failure to make such a disclosure;
3. ensuring that the commercial customer is asked clear questions about any matter material to the insurance undertaking; and
4. asking the customer clear and specific questions about the information relevant to the policy being arranged or varied.

The rules are generally more onerous on insurers of personal and private policies, but what about commercial insurers and their duty of disclosure? Insurers of commercial risks have the option of applying these more rigorous standards in their dealings with commercial clients, though there is no obligation upon them to do so, providing they can demonstrate that they are treating their customers fairly. In some areas, such as gathering information material to the risk, it is clearly in their best interests, for example, to ensure that they ask appropriate questions on the proposal form and provide clear details of the policy cover provided.

B5 Disclosure post-contract

B5A At inception

Under both common law and recent law reforms, the duty of disclosure starts when negotiations begin and ends when the contract is formed (at inception). From that point until renewal negotiations take place there is no requirement for the insured to declare material circumstances, unless these affect the policy cover.

For example, if the value of property increases or a car is sold and another purchased it is clear that the insurer must be advised because the policy requires a specific endorsement to accommodate the change in risk. However, a policyholder does not need to disclose a conviction for fraud (which would be a material fact for all general insurance policies) until the following renewal. The exception would be if there was a specific policy condition which extended the duty so that it became a continuing one.

Consider this…
A motor policy was taken out in respect of a small van. While the policy was in force, the insured joined an amateur band and the van was then used to transport equipment and some band members. Do you think that the insured should notify the insurers of this change, and if so, when and why?

Once the insurance starts from that point until renewal negotiations take place there is no requirement for the insured to declare material information, unless this affects the policy cover. For example, if a vehicle changes under a motor policy the new vehicle must be declared and noted on the policy. In this case the new occupation would not need to be declared until renewal unless the policy contains a condition which extends the duty so that it becomes a continuing one.

B5B On renewal

On the renewal of a policy, the insured's duty of disclosure is revived for general insurance (i.e. non-life) policies.

All general insurance policies, such as fire, theft, liability and certain marine and aviation policies, are contracts that are renewable, usually after twelve months. When the contract ends it is customary to offer renewal terms. If accepted, a new contract is formed. The duty of disclosure is revived during the period of negotiation and applies as for new contracts.

It is important that you distinguish between the requirements for short-term policies and those for long-term policies (such as life and pensions policies). Once the requirements for disclosure have been met in the negotiations leading up to the inception of a long-term contract, the duty of disclosure ceases. Once the policy is in force, even if a material circumstance, such as the life insured's health, changes, it does not need to be declared. The only requirement for the policy to continue is that the insured pays the premiums when they fall due.

B5C Continuing requirement

Insurers are often concerned that their rights at common law are limited because they do not need to be advised of certain material mid-term changes to a risk that they insure. They deal with this situation in different ways for different classes of insurance. Not all insurers adopt the same approach but the following will illustrate some of the issues.

Commercial property insurance	A policy condition requires continuing disclosure of removal to another location, or circumstances that increase the risk of damage.
Motor insurances	There is usually an onerous policy condition that requires continuing disclosure of all material changes by the insured, during the currency of the policy.
Public liability insurance	The continuing requirement for disclosure for this class of business arises from the fact that insurers tightly define 'the business' of the insured in the policy. This means that the insured must notify any extension of activities for cover to apply. A condition requiring ongoing disclosure of material circumstances may be coupled with this.

B5D On alteration

During the term of a general (non-life) policy, it may be necessary to change the terms of the policy. The insured may wish to increase the sum insured, change the description of the property or add another driver to a motor policy. Where a change results in the need for an endorsement to the policy, the duty of disclosure is revived in relation to that change.

B5E Limitation of an insurer's right to information

In many cases it is the completion of a proposal form by the proposer that brings about insurance. The insurer constructs the proposal form with the intention that it will draw out all the relevant information relating to the risk. However, even if a specific question is not asked, the duty of disclosure means that the proposer must still disclose any information that is material unless they are a 'consumer' as defined under CIDRA. Following the implementation of IA 2015, non-consumer customers are only under a duty to make a fair presentation of the risk (unless the insured and the insurer have contracted out of this provision of the Act). If the parties have contracted out of this provision then all material

circumstances must be disclosed whatever questions are posed by the insurer as the principle of good faith still applies.

Refer to
Duty of fair presentation explained in *Duty to make a fair presentation* on page 5/4

If a question is asked, but the proposer only provides partial information in response and the insurer does not seek further details, then the insurer is deemed to have waived its rights regarding this information. The proposer is not considered to have failed to disclose a material fact in these circumstances. This applies to answers left blank on proposal forms or a vague description of a business. It is up to the insurer to follow up with appropriate further questions.

Consider this…
A question on a proposal form asks the proposer for details of previous losses within the last five years. The proposer answers the question by saying 'see your records'.
Would the insurers have a right to decline to pay a claim if the records, which they had not consulted, subsequently showed a claim within the five-year period?

Even though such losses might well be material information, the insurer has limited what it regards as material information and thus waived its right to the information.

If an insurer clarifies what they mean by a ‘material circumstance’ by defining exactly what is required in answer to a question on a proposal form, they are unable at a later date to claim that they required wider or further disclosure. In effect, they cannot claim that there has been a failure to disclose something material. This will be the case in any situation where the insurer has requested what they regard as relevant information relating to a defined period.

When there has been a breach of the duty of good faith by the insured (subject to the exceptions noted above), the insurer will generally have the right to avoid the policy. Timing will vary depending upon the circumstances. If an insurer chooses not to invoke the right to avoid the policy, they may simply waive their right and treat the policy as remaining in force.

However, insurers must exercise care because their conduct may prevent them from claiming that a breach of the disclosure duty has occurred. For example, if an insurer knows that the insured failed to disclose a material circumstance in discussions leading up to inception of the policy, the insurer has the option to avoid the contract *ab initio* (from the beginning). However, the insurer must not act in a way that suggests that they have waived their right to avoid the contract. Such an action could be writing to the insured invoking a seven-day cancellation clause. It is clear that in doing this the insurer accepts that the policy is in force up to the date of cancellation. The insurer has thus waived its right to avoid the policy on grounds of ***non-disclosure*** at a later date. The effect of this would be that, should a claim occur between inception and the cancellation date, the insurer could not avoid payment of the claim on the grounds of non-disclosure.

The remedies available to insurers for misrepresentation or a breach of the duty to make a fair presentation are described in *Remedies available to insurers under CIDRA* on page 5/12 and *Remedies available to insurers under IA 2015* on page 5/13 of this chapter.

C Material circumstances

The **Insurance Act 2015 (IA 2015)** states that ‘a circumstance or representation is material if it would influence the judgement of a prudent insurer in determining whether to take the risk and, if so, on what terms’.

Examples include:

- special or unusual information relevant to the risk;
- any particular concerns which lead the insured to request insurance to cover the risk; and
- anything which those concerned with the class of insurance and field of activity in question would generally understand as being something that should be dealt with in a fair presentation of risks of the type in question.

As we have discussed, under IA 2015 the duty of disclosure of material circumstances is required from **both** parties when forming a new insurance contract. It is revived both at renewal of the contract and during an alteration.

There is an ongoing requirement for notification of material changes which would affect policy cover. Many insurers will also include **policy endorsements** – which form part of the contract – that place responsibility on the insured to notify of all material changes.

Activity

Review a commercial policy wording from an insurer you work for or are familiar with. What conditions do this insurer include for a change of material circumstance during the period of the contract?

Question 5.2

A bookseller has a property insurance contract with Surebuild.

The contract was based on the bookseller's premises at the time of inception. The building was of brick and slate construction and had a rebuild value of £400,000.

Two months after policy inception, the bookseller decides to move address.The construction materials of its new premises are wood with a thatched roof. Additionally, due to the successful growth of the bookseller's business, the new premises are much larger and have a rebuild value of £800,000.

Are these material circumstances which the bookseller should disclose to Surebuild as soon as possible or should it wait until the next policy renewal?

C1 Features of material circumstances

The courts test whether a circumstance is material by looking at it from a prudent insurer's point of view. They do not consider the insured's point of view or that of the particular insurer involved.

Example 5.1

The construction of a building would be a material circumstance in respect of a commercial fire policy. Other factors that a prudent insurer would consider might include occupancy, previous loss record, previous insurance record and heating arrangements.

C2 Material circumstances in non-life proposals

In general, material circumstances relate to either physical hazard or moral hazard. We have already defined physical and moral hazard in chapter 1. Legal cases today rarely concern physical hazards, as specific questions to establish this information are invariably included on the proposal form. Moral hazard is less likely to be the subject of specific questions on the proposal form.

C2A Physical hazard

Let us look at some examples of material circumstances that concern possible physical hazards in relation to non-life proposals:

- **Fire insurance**: construction of the building, nature of use, heating and electrical system.
- **Motor insurance**: age and type of car, age of driver, whether full licence held, previous accidents, the area where the vehicle is kept and the use to which it is put.
- **Theft insurance**: nature of stock, its value and nature of security precautions.

C2B Moral hazard

The following examples of material circumstances relating to moral hazard apply to non-life insurance. They relate either to the insurance history of the insured or to their personal history or attitude:

- **Insurance history**: previous refusals to insure (declinatures) by other insurers; previous claims history if any indication of suspected fraud or exaggeration.
- **Personal history**: criminal convictions, a lack of good management of business premises, excessive or wilful carelessness.

The case of ***Roselodge v. Castle*** **(1966)** examines the nature of moral hazard (personal history) in the context of an application for insurance. In this case, McNair, J. ridiculed the insurer's suggestion that the fact that the proposer was caught stealing apples at the age of twelve would be material to an application for insurance many years later.

D Circumstances that do not need to be disclosed

The duty on the non-consumer insurance proposer to disclose material circumstances is in some ways a heavy one. However, some circumstances can be considered 'material' but do not need to be disclosed. This is either because the insurer ought to know them or could find them out. Section 3(5) of the Insurance Act 2015 states that the following circumstances do not need to be disclosed:

Information that lessens the risk	It would be unusual not to advise the insurer of circumstances that lessen the risk. This is because they are matters that usually have the effect of producing a lower premium or better cover. Nevertheless, there is no requirement to disclose such facts. **Example**: the fitting of an intruder alarm to improve a theft risk.
Information the insurer knows	Under IA 2015, the insurer is deemed to have knowledge where information is known to one or more individuals who act for the insurer in reaching a decision on whether to take on a particular risk and on what terms.
Information the insurer *ought* to know	Where an employee or agent of the insurer has knowledge of the material circumstance, and ought reasonably to have passed it on to individual(s) involved in decisions on whether to take on the particular risk (and on what terms), the insurer will be treated has having ought to have known it. This would also include circumstances which should have been identified as part of a reasonable survey which the insurer has had carried out, but where the surveyor misses something which transpires to be material – this is because the insured has no way of knowing what the surveyor may or may not have noted during a visit.
Information the insurer *is presumed* to know	The insurer is presumed to know things which are common knowledge, or which an insurer offering insurance of a particular class would be reasonably be expected to know in the ordinary course of business. **Examples**: • the existence of a state of war; • a particular area being subject to natural catastrophes, subsidence, hurricane or flood; • industrial processes that are standard for a particular trade.
Information waived by the insurer	This would include where the proposer has not answered a question on a proposal form, or has just inserted a dash. If the insurer does not follow this up, it is considered to have waived its right to that information. It cannot claim non-disclosure in the future. This would also include circumstances which are linked to but outside the scope of specific questions raised by the insurer. **Example**: if an insurer asks for details of all claims that have occurred in the last three years, there is no need to disclose claims that occurred more than three years ago, even if they are material.

D1 Spent convictions

The **Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO)**, which amends the **Rehabilitation of Offenders Act 1974**, came into force on 10 March 2014 in England and Wales.

Under the new system, rehabilitation periods for community orders and custodial sentences comprise the period of the sentence plus an additional specified 'buffer' period, rather than all rehabilitation periods starting from the date of conviction as was the case under the previous regime.

The rehabilitation periods have changed to:

Custodial sentences:	
Sentence length	**New rehabilitation period is the period of sentence plus the 'buffer' period which applies from the end of the sentence**
0–6 months	2 years
6–30 months	4 years
30 months – 4 years	7 years
Over 4 years	Never 'spent'
Non-custodial sentences:	
Sentence	**Buffer period (will apply from end of the sentence)**
Community order & Youth rehabilitation order	1 year
Fine	1 year (from date of conviction)
Conditional discharge, referral order etc.	Period of order

As with the previous scheme, the above periods are halved for persons under 18 at the date of conviction (except for custodial sentences of up to 6 months where the buffer period will be 18 months for persons under 18 at the date of conviction).

On the Web

GOV.UK information on the changes: *bit.ly/2xkpZfj*.

Question 5.3

When considering a proposal for a fire insurance policy on a property, what information is **not** typically considered to be material?

a. Details of any mortgage secured on the property. ☐

b. The materials used to construct the building. ☐

c. The purpose for which the building will be used. ☐

d. Whether or not the risk premises are under the sole occupation of the proposer. ☐

E Consequences of misrepresentation by consumers

So far we have considered the nature of material circumstances, those that need to be disclosed and the consequences of non-disclosure. But what happens if information is stated wrongly, or exaggerated? **Non-negligent** misrepresentation of a material circumstance by a consumer will be considered unreasonable grounds for refusing to pay a claim. The test to be applied, therefore, is whether that consumer has acted reasonably in providing the information.

The rules that apply are therefore similar to those for non-disclosure. Slightly different words are used, but the intention is the same. It is really a reinforcement of the fact that a proposer

need only answer to the best of their knowledge or belief. However, where a proposer deliberately or recklessly answers wrongly, the insurer will be entitled to avoid the policy *ab initio*. The misrepresentation must concern a fact not an opinion, and must otherwise meet the conditions outlined earlier relating to non-disclosure.

Example 5.2
The following are examples of misrepresentation in insurance:

- A proposer for theft insurance says that the premises are protected by a burglar alarm when they are not.
- A proposer for motor insurance declares that their car has not been modified in any way when it has.
- A proposer for an appliance insurance declares that the appliance is under five years old when it is ten years-old.

E1 Remedies available to insurers under CIDRA

The **Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA)** replaces the duty on consumers to volunteer the information before taking out insurance, with a duty to take reasonable care to answer insurers' questions fully and accurately. Consequently, it is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer. The Act sets out proportionate remedies insurers are able to use if the misrepresentation is a 'qualifying misrepresentation'.

If the misrepresentation is deemed a reasonable mistake based on the type of insurance contract and the clarity of the insurers' questioning, then the insurer may have to pay a claim. Whether or not a consumer has taken reasonable care not to make a misrepresentation is to be determined in the light of all the relevant circumstances. The following are examples of things which may need to be taken into account:

- The type of consumer insurance contract in question and its target market.
- Any relevant explanatory material or publicity produced or authorised by the insurer.
- How clear, and how specific, the insurer's questions were.
- In the case of a failure to respond to the insurer's questions in connection with the renewal or variation of a consumer insurance contract, how clearly the insurer communicated the importance of answering those questions (or the possible consequences of failing to do so).
- Whether or not an agent was acting for the consumer.

A dishonest misrepresentation is always to be taken as showing lack of reasonable care.

Remedies are available to the insurer if the misrepresentation is a **qualifying misrepresentation**. That is, it was either deliberate, reckless or careless. A qualifying misrepresentation is deliberate or reckless if the consumer:

- knew that it was untrue or misleading, or did not take care whether or not it was untrue or misleading; and
- knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.

If a qualifying representation is found to be deliberate or reckless, the insurer:

- may avoid the contract and refuse all claims; and
- can keep any premiums paid, unless it would be unfair to the consumer to retain them.

A qualifying misrepresentation is careless if it is not deliberate or reckless. If there was a careless misrepresentation, that is that the consumer 'failed to take sufficient care to understand what the insurer wanted to know or to check the facts', then the insurer will be able to apply a compensatory remedy. This would be based on what the insurer would have done if it had known the correct information, such as applying a relevant exclusion, refusing to offer terms at all or applying an increased premium. In the event of the latter, the claim may be proportionately reduced by the amount the policyholder would have been obliged to pay under the terms of the contract if the information had been disclosed at inception (the approach to proportionate reduction this will be the same as that set out below for IA 2015 in *Original placement* on page 5/13).

F Consequences of a breach of the duty of fair presentation

For non-consumer contracts, unless the insurer has contracted out of the duty to make a fair presentation of the risk an insurer will only be able to avoid a policy if the insured has made a deliberate or reckless breach. In other cases the insurer will have to respond more proportionately.

F1 Remedies available to insurers under IA 2015

An insurer has a remedy for breach of duty of fair presentation only if the insurer shows that, but for the breach of duty:

- it would not have entered into the contract of insurance at all; or
- it would have done so only on different terms.

A breach that triggers a remedy is called a **qualifying breach**. The two categories of breach are:

- deliberate or reckless; or
- neither deliberate nor reckless.

The insurer has to show that the breach was deliberate or reckless. A deliberate or reckless breach means that the insured:

- knew that it was in breach of the duty of fair presentation; or
- did not care if it was in breach of that duty.

Actual remedies are contained in Schedule 1 of IA 2015. Different remedies are available depending on when the breach occurred; i.e. at the time of the original placement or when the contract was varied.

F1A Original placement

If a breach was deliberate or reckless insurers may avoid the contract, refuse all claims and do not have to return the premium.

For all other breaches that were not deliberate or reckless the remedy depends on the impact:

- If the insurer would not have entered into the contract at all they can avoid it and refuse all claims – but they must return the premium.
- If the insurer would have entered into the contract, but on different terms (not related to the premium), then the contract will be treated as if those terms applied unless the insurer chooses not to apply them.

If the insurer would have entered into the contract, but charged a higher premium (irrespective of other terms), then claims can be reduced proportionately. This concept is similar to average, where a calculation is made on the premium received as contrasted to the premium which should have been charged.

'Reduce proportionately' in this scenario means that the insurer need pay on the claim only x % of what it would otherwise have been under an obligation to pay under the terms of the contract (or, if applicable, under the different terms provided for by IA 2015) where:

$$x = \frac{\text{premium actually charged}}{\text{higher premium}} \times 100$$

Example 5.3

A motor insurer agreed to accept an insurance proposal for a risk where the proposer did not disclose driving convictions as he mistakenly thought they were spent. The premium charged was £590, but had the insurer known about the conviction the premium would have been £720.

The insured's vehicle was damaged, and he made a claim. The cost of repairs was £300. You can use the formula above to proportionately reduce the claim: divide the premium charged (£590) by the amount the premium should have been (£720) times 100. This equals 81.94%. So the adjusted claim amount is 81.94% of £300, or £245.82.

F1B Variations of contracts

Under IA 2015, if a breach was deliberate or reckless the insurer can put the insured on notice that the contract will be treated as terminated from the time when the variation was made, and premiums do not have to be returned.

If the breach was not deliberate or reckless, and the premium either stayed the same or increased as a result of the variation:

- If the insurer would not have agreed to the variation at all, the insurer can treat the contract as if the variation never happened, but must return any applicable premium charged for the variation.
- If the insurer would have agreed to the variation, but on different terms including the premium, then the contract will be treated as if those terms now applied and if the insurer would have charged a higher premium then any claim will be reduced proportionately.

'Reduce proportionately' in this scenario means that the insurer need pay on the claim only x % of what it would otherwise have been under an obligation to pay under the terms of the contract (or, if applicable, under the different terms provided for by virtue of the Act) where:

$$x = \frac{\text{premium actually charged}}{\text{higher premium}} \times 100$$

P is either the:

- total premium the insurer would have charged (either the increased premium or the amount the premium should have been reduced by); or
- original premium.

Where an insurer wishes to avoid the contract, refuse all claims and retain the premiums the burden of proof is on the insurer to demonstrate that they can use this remedy.

Insurers may apply these remedies retrospectively and can revisit previously agreed claims if a breach is discovered later.

Question 5.4

Khalil makes a claim of £500 for baggage stolen from his car. The insurer had given Khalil a discount on his premium because the vehicle was being kept in a locked garage overnight; however, the insurer discovered that the vehicle was being kept in a public car park when the theft occurred.

Khalil had arranged the insurance for his daughter and had not checked with her when asked a direct question by the insurer about where the vehicle was stored; he assumed it would be stored in the garage. The property was rented, and as the garage was full of stored furniture the vehicle was parked in the nearest public car park.

The insurer charged a premium of £800, but it should have been £1,000 if the discount for overnight garaging had not been applied. What amount will the insurer have to pay for the stolen baggage?

a. £500. ☐

b. £425. ☐

c. £400. ☐

d. £450. ☐

F2 Breach of warranty

The **Marine Insurance Act 1906** provides that a warranty must be exactly complied with whether material to the risk or not.

Immediate termination of the contract of insurance for breach of a warranty (even where the breach was for only a short period of time) was widely considered to be unduly harsh. Under IA 2015, breach of warranty will no longer automatically terminate the contract. Instead, an insurer's liability will be suspended from the time of the breach. The insurer will have no liability for losses occurring or attributable to something occurring during the period of suspension, but will be liable for losses occurring after a breach has been remedied. This is a complete change from the harsh situation of automatic discharge if there was a breach – even if the breach was not material to the risk.

If a loss occurs and the term has not been complied with, the insurer cannot rely on non-compliance to exclude, limit or remove liability if the insured can show that the non-compliance did not increase the risk of the actual loss that occurred in the circumstances that it occurred. This puts the insured in a better position as it brings a materiality link into the warranty concept, but the burden is on the insured to show that the breach in no way increased the risk leading to any loss actively suffered.

IA 2015 refers to material terms as being terms of the contract which, if complied with, would tend to reduce the risk of one of more of:

- particular kinds of loss;
- losses at a particular location; and
- losses at a particular time.

G Compulsory insurances

There are certain insurances which are required by statute and this impacts on an insurer's rights following a breach of the duty of disclosure. The most common example is **motor insurance** (third-party personal injury and third-party property damage). The **Road Traffic Act 1988** prohibits the insurer from avoiding liability on the grounds of certain breaches of good faith.

Exactly the same rules of disclosure apply to motor insurance contracts as to other non-life classes of insurance. However, the law is primarily concerned that the innocent victims of road accidents should be adequately compensated, and this aim would be defeated if an insurer could avoid paying claims on the grounds of non-disclosure. Insurers must therefore meet all claims for personal injury and property damage made compulsory under the legislation. Once they have done so, they then have a right of recovery against the insured. They will usually seek to recover what they can in such circumstances.

Example 5.4

Trevor insured a van for domestic use. A couple of months later, he installed six additional seats, without notifying the insurer of this modification. Trevor took twelve friends to a concert in it, and an accident occurred as a result of careless driving and the overloading of the vehicle.

In this scenario, although Trevor was in breach of his insurance policy, and regardless of the amount of the passenger injury claims, the insurer is not allowed to set the claim aside. It is unlikely that Trevor will be able to afford to pay such a claim personally, although the insurer will certainly try to recover its outlay from him.

Consider this…

Assume the driver in this example was badly injured as well. Could they claim against the policy for their own injuries?

They couldn't, because the driver is the policyholder and cannot claim against themselves for negligence. If they wished to claim under the personal accident section of the policy, the insurer would refuse to deal with this claim because of the deliberate recklessness.

Key points

The main ideas covered by this chapter can be summarised as follows:

Principle of good faith

- Good faith as a positive duty to disclose, accurately and fully, all information material to the risk being proposed, whether requested or not.

Duty of disclosure

- The insured has a duty of disclosure in both consumer and non-consumer insurance.
- The insurer also has a duty of disclosure to the insured.
- Policy wordings can modify the duty of disclosure, making it a continuing one.
- The duty of disclosure revives at renewal automatically, regardless of any policy provision.
- An insurer who fails to further investigate unanswered questions or inadequate or unclear information is deemed to have waived their right to it and cannot subsequently claim non-disclosure.
- An insurer is estopped from avoiding a policy *ab initio* if their previous behaviour suggests they have waived that right.

Material circumstances

- A material circumstance is one which would influence the judgment of a prudent insurer in fixing the premium or determining whether they will take the risk.
- Certain information, though material, does not need to be disclosed.

Consequences of misrepresentation by consumers

- FCA rules state that insurers will not refuse to meet a claim from a consumer on the grounds of misrepresentation of a fact material to the risk, unless misrepresentation is negligent.
- There are specific remedies available to insurers where the policyholder is a 'consumer' as defined by CIDRA.

Breach of the duty of fair presentation

- IA 2015 introduces a new duty of fair presentation for non-consumer contracts.
- Specific remedies are available to insurers for breaches of the duty of fair presentation.

Compulsory insurances

- There are certain insurances which are required by statute and this impacts on an insurer's rights following a breach of the duty of disclosure.

Question answers

5.1 c. Both the insurer and proposer.

5.2 As soon as possible, as they are material circumstances which affect policy cover.

5.3 a. Details of any mortgage secured on the property.

5.4 c. £400.

Self-test questions

1. A life insurance policyholder has suffered two strokes but has not informed the insurer of her change of health. This is because:
   a. The duty of disclosure ends at inception of the policy. ☐
   b. The duty of disclosure only applies at the policy renewal date. ☐
   c. The duty of disclose never applies to life insurance contracts. ☐
   d. Her health is not relevant information. ☐

2. Janette, a motor insurance policyholder, has been diagnosed with epilepsy. It is **true** to say that:
   a. As long as she was diagnosed after inception, she has no duty of disclosure. ☐
   b. Her epilepsy is relevant information and she has a duty to disclose this to her insurer. ☐
   c. It is her choice whether she informs her insurer. ☐
   d. She only has a duty of disclosure if directed to do so by her GP. ☐

3. Why might an insurer require continuing disclosure for public liability contracts?
   a. To ensure changes to business activity are notified. ☐
   b. To ensure premiums can be increased. ☐
   c. To avoid lengthy discussions at renewal. ☐
   d. To identify opportunities for cross selling. ☐

4. Susie has completed a proposal form for building and contents insurance. She has only provided partial information as she cannot recall full details of a claim she made last year. The insurer asks no further questions and the policy is put on risk. In this example:
   a. The policy is null and void and any future claim will be refused. ☐
   b. Any claim may be reduced as a result of the missing information. ☐
   c. Susie is considered to be in breach of contract. ☐
   d. The insurer is deemed to have waived its rights regarding the missing information. ☐

5. When Sakon applied for his motor insurance, he disclosed that there was a family history of illness in response to a question on the proposal form. The insurer took no further action. In the event of a claim, it is **most** likely that the claim would be:
   a. Met in full as Sakon had provided enough information on the proposal. ☐
   b. Declined as Sakon hadn't supplied full information. ☐
   c. Met in full as Sakon's insurer had not sought further details. ☐
   d. Subject to Sakon having to provide further information at the time of the claim. ☐

6. Material circumstances are those which:

a. Are important to a prudent underwriter in determining the nature of the risk, this being determined at the sole discretion of the underwriter. ☐

b. Directly relate to the insurance policy. ☐

c. Influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms. ☐

d. Are relevant to the insurance policy, as determined by an average person of average intelligence. ☐

7. When applying for an insurance policy, a proposer is under an obligation to disclose any material circumstances. This would include:

a. Matters of law. ☐

b. Information which the insurer ought to know. ☐

c. Information that is outside the scope of the specific questions asked by the insurer. ☐

d. Details of the proposer's circumstances that relate to the insurance being applied for. ☐

8. BB Insurance Ltd have received a claim on a buildings insurance policy where the insured had deliberately and fraudulently failed to disclose details of existing subsidence. Had this been disclosed, insurance cover would not have been offered. As a result, BB Insurance Ltd are **most** likely to:

a. Refuse the claim, set the whole contract aside, and retain the premium. ☐

b. Pay the claim and continue the policy, but refuse future claims relating to subsidence. ☐

c. Refuse the claim, cancel the policy and refund the premiums paid. ☐

d. Pay the claim and continue the policy as before. ☐

9. An insurance claim is settled even though the insurer is aware that information had been fraudulently misrepresented when applying for it. The type of insurance policy is **most** likely to be:

a. Home contents insurance. ☐

b. Compulsory motor insurance. ☐

c. Buildings insurance. ☐

d. Medical expenses insurance. ☐

10. An insurer is obliged to settle a claim even though there was a breach of good faith at the outset that, had they known, would have meant they otherwise would not have entered into the contract. This is because they have received a claim:

a. For personal injury with a compulsory excess. ☐

b. Where it is not possible to apportion blame. ☐

c. For third party injury and property caused by moral hazard. ☐

d. For third party injury and property made compulsory by statute. ☐

You will find the answers at the back of the book

6
Proximate cause

Contents	Syllabus learning outcomes
Introduction	
A Meaning of proximate cause	*8.1*
B Application to simple claims	*8.2*
C Modification by policy wordings	*8.1*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- define proximate cause;
- distinguish between insured, excepted and uninsured perils; and
- apply the principle of proximate cause to simple insurance claims.

Introduction

In this chapter we shall look at the causes of loss and how these relate to the cover provided under a policy. We will then go on to apply the principles to straightforward claims situations.

When a loss occurs, and the insured makes a claim for loss or damage, the insurer decides whether to meet the claim by asking the following questions:

- Is the insurance contract in force?
- Was the loss caused by an insured peril?

Answers to both these questions can usually be found by checking policy records and the claim form. Sometimes, however, it is not clear what actually caused the loss. In these circumstances insurers look at the loss, at all the possible causes and at the relationship between them, before deciding whether the claim is valid and so making a payment.

Key terms

This chapter features explanations of the following terms and concepts:

Dominant cause	Excluded perils	Insured perils	Modification by policy wordings
Proximate cause	Uninsured/unnamed perils		

A Meaning of proximate cause

Often the cause of a loss is straightforward and there is no need for a long investigation. A fire caused by an electrical fault is easy to establish. If a policy covers the peril of 'fire' the claim will be payable. If two cars are in collision, their respective policies will respond, to the extent that blame is apportioned, for both third-party personal injury and third-party property damage (any insured own damage will also be met, provided the policy is a comprehensive one). There may need to be a lot of discussion about the apportioning of blame but there is no doubt that the policies will respond because the cause is covered.

However, there are occasions when the cause of the loss is not so easily defined, either because there is a chain of events or there is more than a single cause. In such cases we need rules to guide the way in which insurers should deal with such losses. This is when insurers apply the doctrine of **proximate cause**.

An insurance policy covers a particular loss caused by an insured peril. Insurers look first at the relationship between the peril and the loss to establish the proximate cause of the loss. They must then decide whether or not the cause (peril) is insured, before paying the claim.

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.

(***Pawsey v. Scottish Union and National*** **(1907)**)

The proximate cause of an occurrence is always the **dominant cause** and there is a direct link between it and the resulting loss. A single event is not always the direct cause of a loss: a loss sometimes occurs following a train of events.

A good way to picture the relationship between cause and effect is to imagine a row of dominoes, all standing. Imagine the first domino is pushed over, knocking the second which in turn knocks over the third and so on until they have all fallen down. The push of the first domino sets in motion the chain of events which brings about the fall of the last domino. If we take the fall of this last domino to represent a loss, then the push of the first domino is, therefore, the proximate cause of the loss.

Imagine, however, that one of the dominoes does not fall as a result of the first domino falling. Instead it is pushed by an onlooker. In this case the chain of events stops and the intervention of a new force, independent from the original chain of events, becomes the cause of the last domino falling. It is, therefore, the new proximate cause of the loss.

Question 6.1

The proximate cause of a loss will always be the:

a. Dominant cause. ☐

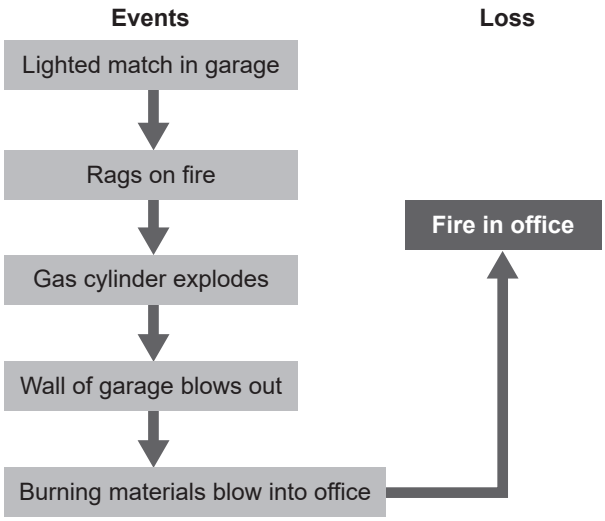
b. First cause. ☐

c. Last cause. ☐

d. Only cause. ☐

Figure 6.1 below sets out the chain of events for a more complex, real-world scenario.

Figure 6.1: A complicated chain of events



We can see clearly that the match being lit is the proximate cause in this scenario.

Example 6.1

Yi-Ling's home is damaged after a serious water leak during a period of heavy rain. Upon inspection of the property, the appointed loss adjuster concludes that the leak was caused by earlier damage to the roof, with water causing damage over an extended period of time, and which resulted from Yi-Ling's failure to maintain the property.

It is likely that an insurer would treat the failure to maintain as the proximate cause, and the claim would therefore be declined due to the lack of an insured peril (it is also likely that the failure would amount to a breach of a policy condition) – see *Nature of perils* on page 6/4 regarding the nature of perils.

However, we must be careful not to over-simplify the question of causation. Let us look again at the definition of proximate cause that we highlighted from the case of Pawsey earlier. We could argue that it only works where causes occur 'in a straight line' and one result leads neatly to the next. Many situations involve several causes to a greater or lesser extent.

In the case of ***Leyland Shipping v. Norwich Union Fire Insurance Society* (1918)**, Lord Shaw stated that 'causation is not a chain but a net', going on to describe the proximate cause as 'proximate in efficiency'. This is particularly important as we consider more complex claims where there may be more than one contributing cause, and the causes may be insured, uninsured or excepted perils. These claims are beyond the scope of the IF1 syllabus.

A1 Identifying the cause

In many cases, common sense can be applied to determine the proximate cause of a loss by looking at cause and effect.

We can see this in operation in the case of ***Marsden v. City & County Insurance Company* (1865)** as described in example 6.2.

Example 6.2

A shopkeeper insured their plate glass shop window against loss or damage arising from any cause except fire.

Fire broke out in a neighbour's property and a mob gathered as a result. The mob then rioted and broke the plate glass. It was held that the riot and not the fire was the cause of the loss. It was not inevitable that a crowd would gather and then riot after the fire and so the damage was not the inevitable result of the fire.

A2 Nature of perils

Once the insurer has established the proximate cause of the loss, it must check whether the peril is covered by the policy. Perils can be classified as follows:

Insured perils	Those named in the policy as covered.
Excepted/excluded perils	Those named in the policy as specifically not covered.
Uninsured/unnamed perils	Those perils not mentioned at all in the policy.

Insurers will decide whether or not a straightforward claim is valid by establishing which of these categories the proximate cause of the loss falls into. It is only necessary to find the proximate cause of a loss where the events before the loss are not all insured perils.

If they are all insured, the loss is covered. However, it may be necessary to determine which peril caused a loss if different levels of excess apply to different perils in the chain.

Consider this…

A fire in a neighbour's house spreads to a boundary wall. The following day a storm occurs and the wind blows down the wall. What do you think is the proximate cause of the loss?

It is likely that the fire would be considered the proximate cause of the loss. However, any significant time delay would point to storm being the dominant (and therefore proximate) cause. This example is based on the case of ***Gaskarth v. Law Union* (1876)**.

Even if only one event in the chain leading to the loss is an excepted peril, the rule must still be applied to establish whether that peril was the proximate cause of the loss. If it was, then the insurer is not liable for the damage.

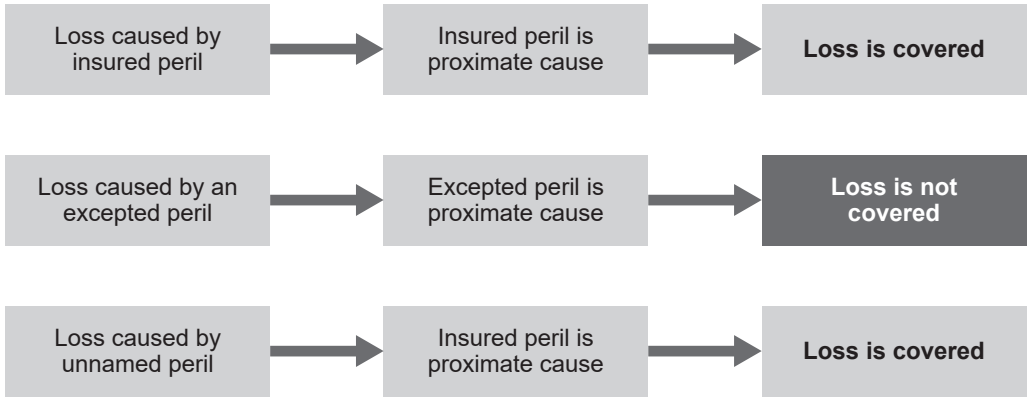
If the loss is due to an uninsured or unnamed peril, say water damage caused by putting out a fire, then insurers are liable if the proximate cause was an insured peril. In *Modification by policy wordings* on page 6/6, we shall look at how these rules can be modified by policy wordings.

Consider this…

A storm blew down the wall of a timber building which, when it fell, broke electrical wiring. The broken wiring short-circuited and caused a fire in the timber building. The fire brigade was called and the water they used to put out the fire and to cool neighbouring buildings caused damage to the unburnt contents of the timber building and to the neighbouring buildings.
What is the proximate cause of the water damage to the unburnt contents of the timber building and the neighbouring buildings?

There is a direct line of causation between the storm, the collapse of the wall, the burning damage and water damage. Therefore, the storm is the proximate cause of the water damage.

Figure 6.2: Summary of the nature of perils



B Application to simple claims

In this section, we shall look at proximate cause in relation to the Association of British Insurers (ABI)'s recommended standard fire policy. We shall also see how the rule is modified by policy wordings and how remote and concurrent causes affect recovery.

As we have already seen, there are two things that need to be considered when deciding if a loss is covered:

- Which perils are clearly stated as covered by the policy?
- Which perils are clearly not covered by the policy (the excepted perils)?

In appendix 1, you will find the ABI standard fire policy (material damage). We will use this document to consider how cover and proximate cause operate in practice. This policy wording has been developed for the market and is adopted as a basis for providing fire insurance by most general insurers. Lloyd's has its own version of a standard policy with slightly different wording, providing marginally wider cover for explosion.

Activity

Turn to appendix 1. Think about how the ABI standard fire policy (material damage) applies to the fire described in *Nature of perils* on page 6/4.

You may also want to mark the appendix and refer to it as you study the next section.

In the scenario just mentioned, the proximate cause of the loss is the storm. However, as we look backwards down the chain of events from the ultimate damage to the contents, we can see that the water damage caused by the firefighters was as a direct result of the fire. The cause of the fire, the storm, was not an excepted peril, it was simply unnamed. The outcome would have been different if the original (proximate) cause had been an excepted peril: in this case none of the claim would have been payable, whether fire damage or extinguishment costs, because of the operation of an excepted peril.

Consider this…

An earthquake overturned an oil stove and the spilt oil caught fire. The burning oil set fire to the building which set fire to a second building. Sparks and burning embers, blown in a breeze, set fire to a third building and eventually, 500 metres away from the first fire, a building was set alight by its neighbouring building.
What is the proximate cause of the last fire? Would the loss be covered under the terms of the standard fire policy (material damage) shown in appendix 1.

The proximate cause of the fire is the earthquake. The case is based on ***Tootal Broadhurst Lee Company v. London and Lancashire Fire Insurance Company*** **(1908)** where earthquake was excluded and the insurers were held not to be liable for the damage.

C Modification by policy wordings

The wording used in the policy can modify the doctrine of proximate cause. In the ABI standard fire policy provided as an appendix to IF1, look at the difference between the wording used to exclude damage by war risks (General Exclusion 1) and that applying to nuclear assemblies and components (General Exclusion 2).

In General Exclusion 1, we see that the definition of war has been widened to include 'whether war be declared or not'. However, only damage directly related to war risks will be excluded. If war is a remote or incidental cause, then losses otherwise insured, will be paid. Compare this to General Exclusion 2, where the use of such words as 'indirectly caused by', or even more generally 'contributed to by', would exclude remote or even incidental causes linked to nuclear risks.

This has an application to all classes of insurance. For example, an insurer becomes aware that a proposer for personal accident insurance has a continuing back injury. They may well decide that they will only provide cover if it excludes 'any injury caused by, contributed to by, or exacerbated by…' the particular back complaint. This would mean that even unconnected causes would be excluded, if the existence of the back complaint leads, for example, to the person being off work for longer.

It is important to check the precise wording of exclusions to establish the way in which the proximate cause of a loss is dealt with.

In the case of ***Oei v. Foster*** **(1982)**, the claimant's wife caused a chip pan fire in a house that they had borrowed. She claimed against their personal liability insurer as she was legally liable for the damage caused. The judge stated that the insurers were not liable to pay because the policy excluded liability 'arising directly or indirectly from … ownership or occupation of any land or building'. This was wide enough to include the borrowing (and therefore occupation) of the damaged building.

Question 6.2

Julie has a car accident, sustains mild injuries and requires is injured medical treatment. She is taken to hospital where she dies due to an infection caught at the hospital. What is the proximate cause of her death?

a. The car accident. ☐

b. The infection. ☐

c. Driving. ☐

d. Her stay in hospital. ☐

Key points

The main ideas covered by this chapter can be summarised as follows:

Proximate cause

- Proximate cause can be defined as 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.
- Perils can be classified as insured, excepted/excluded and uninsured/unnamed. It is the category into which the peril deemed to be the proximate cause of the loss falls, which dictates how the insurer will respond to the claim.
- The doctrine of proximate cause can be modified by policy wordings and it is important to check the precise wordings of exclusions in deciding how they impact on any claim.

Question answers

6.1 a. Dominant cause.

6.2 b. The infection.

Self-test questions

1. When identifying proximate cause, it is **true** to say that:
   a. Proximate cause is the only cause of a resulting loss. ☐
   b. There is always a direct link between proximate cause and resulting loss. ☐
   c. Proximate cause is the last cause of a resulting loss. ☐
   d. Proximate cause only occurs when there is a single event. ☐

2. Bad storms have caused heavy branches from surrounding trees to blow into the road at a busy crossroads. During the night, before the branches can be moved, a motorist has an accident at the crossing. The proximate cause of the accident is the:
   a. Storm. ☐
   b. Branches. ☐
   c. Delay in moving the branches. ☐
   d. Motorist. ☐

3. Following a party in a busy bar, partygoers spill out onto the street and a fight breaks out. During the commotion a shop window is smashed. Later that evening stock from the shop is stolen. The proximate cause of the theft is the:
   a. Party. ☐
   b. Broken window. ☐
   c. Revellers. ☐
   d. Fight. ☐

4. The principle of proximate cause is applied when there is:
   a. Only one cause. ☐
   b. No identifiable peril. ☐
   c. More than a single cause. ☐
   d. No known cause. ☐

5. Tracey's garden shed has been damaged by a fallen tree from her neighbour's garden. The tree fell during heavy storms. What is the proximate cause of the damage to Tracey's shed?
   a. The storm. ☐
   b. The fallen tree. ☐
   c. The neighbour's failure to secure the tree. ☐
   d. Tracey's failure to protect her shed. ☐

6. The shop window of a newsagents has been smashed and, although the premises were insured for glass breakages, the claim has been refused. This is **most** likely because the proximate cause of the loss was:

   a. Not the dominant cause. ☐

   b. An insured peril. ☐

   c. An unnamed peril. ☐

   d. An excluded peril. ☐

7. An unnamed peril is:

   a. The policy as not covered. ☐

   b. Not mentioned in the policy. ☐

   c. Specifically excluded in the policy. ☐

   d. Specifically mentioned in the policy. ☐

8. James has insured his painting and decorating tools against loss, theft and accidental damage. The policy does not mention loss as a result of fire. This would be referred to as an:

   a. Excluded peril. ☐

   b. Insured peril. ☐

   c. Uninsured peril. ☐

   d. Excepted peril. ☐

9. A shop owner's stock was water damaged following an attempt to put out a fire that resulted from an electrical fault. The policy did not cover water damage but the claim was paid because:

   a. Water damage was an excepted peril. ☐

   b. The proximate cause was an insured peril. ☐

   c. Fire damage was an excepted peril. ☐

   d. The proximate cause was water damage. ☐

10. An excepted peril is:

    a. The policy as covered. ☐

    b. Not mentioned in the policy at all. ☐

    c. Linked directly to the proximate cause. ☐

    d. Named in the policy as specifically not covered. ☐

You will find the answers at the back of the book

7
Indemnity

Contents	Syllabus learning outcomes
Introduction	
A Definition of indemnity	*9.1*, *9.2*, *9.3*
B Application of indemnity	*9.1*
C Measuring indemnity	*9.1*
D Modifying indemnity	*9.4*
E Speed of indemnity – Enterprise Act 2016	*11.6*
F Limiting factors	*9.1*, *9.5*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- define indemnity;
- explain how indemnity applies in policies and how it is measured and achieved;
- describe how indemnity is modified by agreed value and first loss policies;
- identify circumstances where claimants may receive more than an indemnity settlement;
- describe situations when claimants may receive less than an indemnity settlement; and
- describe how the Enterprise Act 2016 protects policyholders.

Introduction

In this chapter we will discuss the concept of indemnity in relation to insurance contracts. We will consider how the concept applies and how it is modified.

When an insured peril causes a loss, the insured submits a claim to their insurer for the loss. The insurer checks the validity of the claim and then, if valid, accepts it, agreeing to meet their obligation under the terms of the insurance contract. The actual settlement or the amount payable by the insurer depends on a number of factors, including the nature of the cover, the extent of the cover, policy excess and any conditions limiting the amount payable. Most short-term (non-life insurance) contracts are contracts to indemnify the insured in the event of loss, i.e. to pay the claim or indemnity. They are called short-term policies because the insurer has the option of inviting renewal at the end of each period of insurance.

Key terms

This chapter features explanations of the following terms and concepts:

Agreed value policies	Average	Benefit policies	Betterment
Day one reinstatement	Deductible	Excess	First loss policies
Indemnity	New for old cover	Pro rata condition of average	Reinstatement
Reinstatement memorandum	Replacement	Settlement	Sum insured
Underinsurance	Valued policy		

A Definition of indemnity

Indemnity is financial compensation sufficient to place the insured in the same financial position after a loss as they enjoyed immediately before the loss occurred.

The importance of the principle of indemnity was emphasised by Brett, LJ, in the case of ***Castellain v. Preston*** **(1883)**:

> The very foundation, in my opinion, of every rule which has been applied to insurance law is this, namely that the contract of insurance contained in a marine or fire policy is a contract of indemnity and of indemnity only…and if ever a proposition is brought forward which is at variance with it, that is to say, which either will prevent the assured from obtaining a full indemnity, or which gives the assured more than full indemnity, that proposition must certainly be wrong.

A1 Benefit policies

Policies providing fixed benefits are not policies of indemnity. These policies are known as ***benefit policies*** and mainly cover accident and sickness.

There is no way that a price can be placed on the loss of a limb or of sight, so the principle of indemnity cannot apply. In the event of a claim, a defined amount or benefit will be paid.

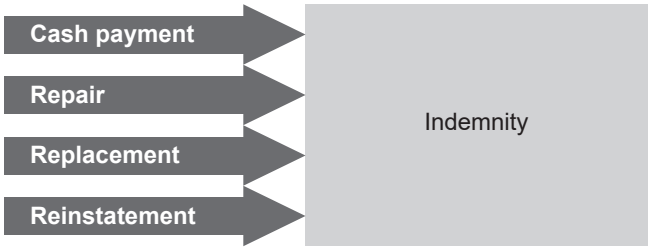
You should note, however, that insurers do try to take account of an individual's circumstances and earnings, when agreeing to insure weekly benefits for temporary disablement. They do so because they do not wish the policy benefits to act as an incentive for the insured to remain off work longer than necessary. Apart from life, pensions, annuity and investment contracts, policies that fall into the category of benefit policies include:

- personal accident;
- sickness;
- critical illness;
- payment protection indemnity;
- hospital cash plans;
- permanent health; and
- elements of travel insurance.

A2 Options available to insurers

Now we have established that not all contracts of insurance are policies of indemnity, we will consider the vast majority that do seek to provide exact financial compensation. For any type of property insurance (and this would include the 'own damage' section of motor policies), although the insured is entitled to receive indemnity (within the limits of the ***sum insured*** as stated in the policy), there are different ways of providing indemnity.

There are several ***settlement*** options open to an insurer which will provide the insured with the necessary indemnity:



The options available apply only if they are stated in the policy. If they are not, the insured has a legal right to financial compensation. These options have their origins in insurers wanting to find the most economical way of providing indemnity. For example, in the past, though not so much nowadays, insurers would have arrangements with some major jewellers. They would then be able to replace very expensive jewellery at a discount. They would often do this rather than pay out the 'insurance valuation' price – which they may have considered an inflated figure provided by a valuer. Historically too, insurers would sometimes arrange for the repair of carpets that were damaged. With the advent of '**new for old**' type covers this has diminished, but in the past many items were 'repaired' by insurers.

Although these options have historical significance, there are some helpful aspects to them which mean that insurers have found it useful to retain these options. Indeed some applications are even on the increase. Effectively the options have remained the same but the practical applications have changed.

A2A Cash payment

For many years, most insurance claims have been settled by the payment of money by the insurer directly to the insured. This is still the case, particularly with commercial insurances. However, for personal insurances (in particular, home insurance) there has been, since the 1990s, a growing trend for insurers to use the replacement option through nominated retail chain stores or their own supply chains. This will be looked at in more detail in *Replacement* on page 7/4, but it is worth noting here what happens if the item offered by the insurer is not wanted by the insured.

Many insurance companies now have close relationships with retailers, and the insurer's bulk buying power often means they can get quite large discounts, often as much as 20%, when purchasing goods.

Example 7.1

An insurer receives a claim for a damaged television, which the insurer can replace on a like for like basis for the insured.

A replacement television would usually cost £1,000. However, the nominated retailer has agreed that it will give the insurer a 20% discount, meaning the insurer can provide indemnity to its policyholder for £800.

If the insured decides that they do not want a replacement, but would rather have a cash settlement, the insurer will only be required to pay to the insured the amount they would have paid the retailer; i.e. the discounted sum. Let us apply that to the example we have just considered to see how this works.

Example 7.2
The insurer offers its policyholder the opportunity to receive a new television directly from the household name retailer. The policyholder rejects this outright and demands a cash payment. The insurer agrees and sends the policyholder a cheque for £800 (being £1,000 minus the 20% discount they would have received from the nominated retailer).

However, the Financial Ombudsman Service has indicated that where policyholders do wish to have a replacement they should be allowed to choose where they purchase this and they are entitled to a cash settlement if they cannot find an acceptable alternative. In these circumstances, the insurer would not be entitled to reduce the cash settlement to take account of the discount it would have received, had the policyholder bought the replacement from one of its nominated suppliers.

The settling of claims for certain types of insurance always involves the payment of money. These types include money insurance, fidelity guarantee, business interruption, loss of rent and liability policies. In the case of liability insurance, payment is made to the wronged party, not to the insured (although the insured is being indemnified for their liability).

A2B Repair

Where it is possible, insurers may opt to repair any damage to an insured item. In this way they can provide indemnity, perhaps at a lower cost than the insured might achieve, because of the negotiating power of a large organisation. The most common example is in motor insurance claims.

Example 7.3
Gary's car is involved in a collision. He notifies his insurer which arranges for the damage to be repaired at a garage they have approved. The insurer pays the garage directly, rather than paying money to Gary.

In this scenario, the 'approved' or 'recommended' repairer will provide the insurer with guarantees in relation to workmanship and hourly rates, as well as the provision of courtesy cars, in return for a flow of business from the insurer. Some insurers have taken this further and developed their own networks of vehicle repairers, ensuring that they can control costs and the end-to-end claims process in the majority of claims for damage to the insured's car.

Consider this…
Apart from motor vehicles, think of another example where insurers might wish to repair rather than make a cash settlement.

A2C Replacement

The most common example of ***replacement*** as a means of providing indemnity is glass insurance. Quick replacement means further losses are minimised, such as when shop front windows are smashed.

As we have seen, replacement is also often used as a means of settling household property losses. On these occasions the policyholder simply orders a replacement item from one of the household name retail stores and the item is paid for by the insurer.

The use of nominated retailers by insurers brings them several benefits:

- The discounts that they receive mean lower claims costs.
- Using the replacement option can prevent or at least minimise fraudulent claims, because, in most cases, a fraudster will be looking for easy cash from an insurance claim rather than goods.

- Customer experience is improved by the use of quality retailers. For example, the insured will have a new television delivered to their door and the bill will be paid direct by the insurer.

Other situations in which insurers may opt for replacement are:

- car write-offs where the car is less than a year old; and
- losses relating to items of jewellery if the insurer can obtain a worthwhile discount from a jeweller.

A2D Reinstatement

Reinstatement is the fourth way that an insurer can provide indemnity. Reinstatement means that the insurer agrees to restore a building (or piece of machinery) that has been damaged by an insured peril.

However, this is not a popular option with insurers. The reason for this is that, unless the policy specifies otherwise, they are bound to reinstate the property so that it is largely in the same condition it was before the loss. In any event they are their own insurers of the risk during the period of reinstatement. Also, once they choose to reinstate, they lose the certainty that the sum insured will be the maximum they have to pay out. This is reasonable, since the insurer can hardly insist on reinstatement and then, once the sum insured is exhausted, stop work regardless of whether the building is completely restored by then or not.

The distinction between repair and reinstatement may not be immediately obvious. Reinstatement applies only to buildings (and occasionally machinery), and is concerned with bringing the property back to its pre-loss condition. To achieve this purpose the insurer effectively takes occupation of the premises (or what is left of them) to reinstate. The option to repair does not carry with it the 'occupation' aspect, or the same level of project management by the insurer as required for reinstatement.

B Application of indemnity

Property policies and liability policies are contracts of indemnity because a value can be placed on the subject-matter insured. This principle also applies to pecuniary insurances, such as business interruption. You should note that life and personal accident policies are not contracts of indemnity as the insured cannot be restored to the same financial position after a loss.

B1 Property insurance

As a practical example of indemnity cover in respect of property insurance, imagine a fire which destroys part of a school. Calculating the value of the loss may be a problem since equipment and facilities are likely to be worth less than the original purchase price. Where equipment is completely destroyed, the measure of indemnity is the **replacement cost** less an allowance for wear and tear. In the case of partial damage, indemnity is the **repair** cost less an allowance for wear and tear. This is very much a theoretical starting point. Most property policies incorporate some form of 'new for old' cover.

Refer to
Refer to *New for old cover* on page 7/9 for details of 'new for old' cover

B2 Liability insurance

A liability policy provides indemnity to the insured in respect of their legal liability to pay damages and claimant's costs. The policy does not define the financial value of the indemnity, as this is often left to the courts to decide. However, it does lay down the elements to be included in an indemnity settlement. There will always be a limit to how much the policy will pay in the event of a claim, and this will be stated in the policy (with the exception of motor liability insurance causing injury or death, which is unlimited).

Question 7.1

Roy takes out two personal accident policies. The first policy provides £25,000 cover for loss of limb. The second policy provides £30,000 cover for loss of limb. What is the total amount that Roy will receive in the event of a valid loss of limb claim?

a. £25,000. ☐

b. £27,000. ☐

c. £30,000. ☐

d. £55,000. ☐

C Measuring indemnity

In this section, we will see how insurers measure indemnity for different classes of insurance.

Our starting point must be the financial value of the subject-matter of the insurance, but how is this financial value calculated? In the absence of policy conditions modifying the position, in property insurance, the value of the subject-matter of the insurance is its value at the time and place of loss. However, as we shall see, it is usual for policy conditions to apply which alter this position. We start by looking at different categories and types of insurance and considering the standard cover provided by them, before examining possible extensions.

Example 7.4

Simon was preparing a meal in the kitchen when the front doorbell rang. When he finally returned to the kitchen, it was full of smoke. A pair of kitchen gloves had caught fire from one of the gas rings. The resulting fire had spread to curtains. Simon managed to put out the fire by using a wet tea towel.
Simon claimed £3 for the gloves, £70 for the curtains and £2 for the tea towel; the cost of the items two years previously.

In the absence of any new for old cover the insurers would have agreed to pay Simon the full replacement purchase price, less a deduction for wear and tear and depreciation.

C1 Marine insurance

In a ***valued policy*** (which is the same as an **agreed value policy**), the insurable value is agreed between the insured and the insurer. The insurable value in an unvalued policy must be calculated using the formula in the **Marine Insurance Act 1906 (MIA 1906)**. Thus, in both kinds of policy, there is an identifiable insurable value, effective from the start of the period of insurance (policy inception), and which is unaffected by subsequent market price variation. It usually corresponds with the sum insured.

C2 Property insurance

The measure of indemnity for property is its value at the date and place of loss. This is a very broad guideline and we must look at the different types of property insurance in order to understand how the principle operates in specific cases.

C2A Buildings

Basic cover

This basic cover is referred to in the market as an 'indemnity' settlement, to distinguish it from reinstatement (see below). Insurers calculate the indemnity for loss of, or damage to, buildings as the cost of repair or reconstruction at the time of loss. They make an allowance for any improvements that may result from the repair or reconstruction; for example, new plumbing or new decoration. This is termed ***betterment***. It is very unusual for buildings to be insured on this basis. Insurance on reinstatement conditions is much more common.

Reinstatement conditions

This is an extension of the principle of indemnity. Cover applies on the basis, not of a discounted sum reflecting wear and tear, but the full reinstatement value at the time of

reinstatement. There are several different types of insuring clause, the most common of which are the ***reinstatement memorandum*** and ***day one reinstatement***.

Reinstatement memorandum	• The most important aspect of insurances subject to the reinstatement memorandum is that the sum insured must represent the full value at the time of reinstatement. • The insured pays a premium based upon the higher amount, although this particular clause allows a margin for error in estimating the sum insured. It states that the insured value must be at least 85% of the actual value otherwise claim payments will be reduced. • This still leaves the insured with a problem if the claim amount exceeds the 85% figure, since insurers will not pay more than the sum insured in the event of a loss. • Reinstatement must be carried out without delay, although the insured is given flexibility about where and how reinstatement takes place.
Day one reinstatement	• The insured is required to state the reinstatement amount on the first day of the cover. • Insurers provide an automatic uplift to allow for inflation (usually an extra 50% of the 'declared value') but only charge a modest increase for this inflation element (15% of the premium). • The reinstatement figure at day one is relatively easy to establish. Because of this, the day one value must be accurate. • There is no 15% margin for error as there is with the reinstatement memorandum.

Example 7.5

ABC Ltd owns a factory. It wishes to insure the building on a basis that provides that in the event of loss or damage, the building will be put back to the same condition without any deduction being made for 'wear and tear'. This rules out a policy based solely on an indemnity settlement, but still leaves a choice to be made about the exact basis of cover.

ABC could decide that it wishes to insure on the basis of the reinstatement memorandum. Let us assume that the rebuilding cost today is £1m. ABC will need to decide how long reinstatement is likely to take. It will then need to estimate the full impact of this time period on the inflation of building costs. This is because it will need to set a sum insured that will be adequate at the time of reinstatement. ABC is confident that rebuilding, even following a substantial loss, could be completed within eighteen months. Consequently, it may consider that an inflationary element of 20% is the maximum that needs to be catered for. It would, therefore, set the rebuilding sum insured at £1.2m and pay a premium based upon this figure.

In the event of a loss, provided that the actual reinstatement value is no more than £1.412m, average will not be applied because its sum insured represents 85% of this amount.

Given these assumptions, ABC is far better advised to opt for the 'day one' reinstatement arrangement. The figure that it needs to declare is £1m, to which an automatic uplift of 50% will be applied. This is far more than its estimate of what it requires. The premium is increased by 15%, so producing a lower premium than the equivalent reinstatement memorandum arrangement. Average (which we look at in detail in *Limiting factors* on page 7/10) will only apply if the 'day one' figure is inadequate (but no margin for error is permitted).

You can see from this that different rebuilding periods or estimates of future inflation will affect the policyholder's decision regarding the most appropriate arrangement, but for most, the 'day one' option provides the better solution.

C2B Household goods

Basic cover

In general, indemnity is based on the cost of replacing the items at the time of loss, subject to a wear and tear deduction.

New for old cover

New for old cover is more popular and almost universally used within the UK. It modifies the principle of indemnity by making no allowance for wear and tear. Most insurers retain the

deduction for wear and tear for items of household linen and clothing, but apply cover for all other items on a 'new for old' basis. This is justified by setting the sum insured to represent the full replacement cost of the household goods and the premium paid reflects this. However, it does extend the principle of indemnity.

C2C Machinery and contents

Basic cover
The starting point for the measurement of indemnity depends on whether there is a ready second-hand market for the item:

- When there is a ready second-hand market, indemnity is the cost of the second-hand item plus carriage or installation costs.
- When there is no second-hand market, indemnity is the cost of repair or replacement less an allowance for wear and tear, if applicable.

Again it is important to emphasise that this is the starting point for considering property covers. In practice this very limited form of cover is rare.

Reinstatement conditions
Like buildings insurances, covers for machinery and contents (other than stock) also tend to be on a reinstatement basis. This modifies the principle of indemnity. The reinstatement memorandum is a common method of insuring such items and day one reinstatement is also possible. Again, it is important for you to note that the sum insured must be calculated on the same basis as the proposed settlement formula.

C2D Cash settlements under reinstatement conditions

One of the key elements of reinstatement conditions is the fact that in order to benefit from the cover the insured must actually reinstate.

If no reinstatement takes place, the insured is entitled only to a settlement based upon strict indemnity. This means that wear and tear and depreciation will be taken into account.

C2E Stock

This may be considered under two headings:

Manufacturers' stock in trade	Wholesalers' and retailers' stock in trade
This stock generally consists of raw materials, work in progress and finished stock. Indemnity value is the cost of raw materials, at the time and place of loss, plus labour and other costs incurred in respect of work in progress and finished stock.	Indemnity here is the cost of replacing the stock, at the time of the loss, including the costs of transport to the insured's premises and handling costs. It is not possible to insure stock on any kind of reinstatement basis.

In both cases, the insured is not entitled to payment in respect of any potential profit element on sale of stock. This is one of the aspects that is catered for by a business interruption policy.

One of the difficulties in measuring stock losses (whether for manufacturers or wholesalers) is that the stock may not have a definite constant re-sale value. In addition, some stock may be obsolete. Items may be unfashionable or be superseded by a more sophisticated model and, therefore, be difficult to sell. In these cases, settlement must be made to maintain the insured's financial position, not to improve it. This may mean paying only the market value where this is less than raw materials plus the costs defined above.

C2F Farming stock

In the case of livestock and produce, the local market price is the basis of indemnity. Farming stock is different from other types of stock, as the insured is entitled to receive any potential profit on sale. This is because the market price is both the buying price and selling price at any time and there is no way of separating out the profit element.

C3 Liability insurance

In liability insurance indemnity is measured as the amount of any court award (or more commonly, negotiated 'out of court' settlement) plus the costs and expenses arising in connection with the claim. Where the insurer agrees that other expenses can be incurred these are included in the amount payable. An example of such additional expenses would be paying for specialist medical treatment for an injury.

D Modifying indemnity

We have already seen some ways in which the principle of indemnity can be modified by agreement between the parties. There are others that allow the insured to get either more or less than a strict indemnity settlement. The principle of indemnity is modified in ***agreed value policies*** and ***first loss policies***.

D1 Agreed value policies

In agreed value policies the value of the subject-matter of the insurance is agreed at the start of the contract and the sum insured is fixed accordingly. This value will be reviewed at each renewal. In the event of a claim, the value need not be proved at the time of the loss.

Agreed value, or 'valued' policies are common in marine insurance. They may at times also be used when insuring works of art and other objects, such as vintage motor cars, whose true value may become a matter of dispute at the time of a claim. It is common to confine the agreed valuation to total losses and to provide that partial losses are settled as if the policy was unvalued; that is, on an indemnity basis. If the policy wording does not restrict the agreed value to total losses, then partial losses will be dealt with on a proportionate basis.

D2 First loss policies

There are occasions when the insured believes that the full value of the insured property is not really at risk, in other words a total loss or even a very substantial loss seems impossible. In this case the insured may request that their policy has a sum insured that is less than the full value. Where insurers agree to this it is known as a 'first loss' policy.

Example 7.6
Substantial amounts of stock are stored in a warehouse and may potentially be totally destroyed by fire. However, it may be physically impossible to remove all the stock from the warehouse in the course of a theft without using many lorries. The insured's assessment of the situation is that there is no need to insure the full value for theft cover.

However, the insurer's view of the maximum amount realistically at risk is often similar to the insured's estimate. Consequently, the insurer will have calculated the premium for the full value taking these factors into account. It follows, therefore, that insurers generally only give very modest discounts on the 'full value' premium for risks insured on this basis. The reason for this is that there may only be a slight reduction in their maximum exposure and they must still pay all individual claims up to the first loss figure.

D3 New for old cover

This type of cover usually applies to household contents policies. Commercial property risks that are insured on a reinstatement basis can also be placed in the same category. Each represents an attempt to replace at current costs.

Example 7.7
In 2012, Mark inherited a painting from his great-aunt. An expert valued the painting at £4,000–£5,000 and Mark took out an agreed value policy with his insurers for £5,000. In 2014, a painting by the same artist and of the same quality sold at auction for £8,000. Shortly after, thieves break into Mark's home and steal the painting.

The policy that Mark has with his insurers is an agreed value policy. Therefore, the insurer is only liable to pay Mark the value that was agreed, i.e. £5,000.

How the insurer will respond to a claim for damage will depend on the policy. If the agreed value is restricted to total losses then the partial loss will be settled on an indemnity basis. If the policy does not restrict the agreed value to total losses then the claim for damage will be settled on a proportionate basis.

E Speed of indemnity – Enterprise Act 2016

The **Enterprise Act 2016** was passed on 4 May 2016 and gives policyholders a legal right to claim damages in the event of a late payment. Under previous law damages for late payment of claims were not recoverable from insurers. Policyholders could only recover what was owed under an insurance contract but not any additional losses they had suffered due to delay in payment to them.

The law, which is an amendment to the Insurance Act 2015, applies to every (re)insurance policy placed or renewed on or after 4 May 2017, if it is subject to the laws of England and Wales, Scotland, or Northern Ireland.

Retail and smaller commercial customers had some access to redress in the event of late settlement of claims via the Financial Ombudsman Service (FOS). For example, complainants could be awarded interest in respect of delayed settlements where the complaint was considered justified. However, neither eligible nor non-eligible complainants had any legal right to compensation.

The Act amended the Insurance Act 2015 by adding an implied term into every contract of insurance that insurers must pay any sums due to their insured within a '**reasonable time**' (the 'implied term'). If a valid claim is not paid within a reasonable time, the insured will be entitled to enforce payment of the claim and pursue a claim for damages.

The Act permits (re)insurers a 'reasonable time' to investigate and assess each claim. What constitutes a 'reasonable time' will depend on the relevant circumstances and the Act provides examples of matters which may need to be taken into account, including:

- the type of insurance;
- the size and complexity of the claim;
- compliance with relevant statutory or regulatory rules or guidance; and
- factors outside the insurer's control.

The Act also provides that insurers will not be in breach of the provisions merely by failing to pay the claim all the while that a genuine dispute is continuing.

Under the Act claims against (re)insurers will be time-barred unless they are made no later than one year from the date on which the insurer has paid all the sums due in respect of the claim. There are, however, some safeguards that have been built in to avoid spurious claims. A key one is that the loss has to be foreseeable. For example, an insurer would be able to foresee that a delay in paying for a broken machine in a busy factory would lead to production losses whereas losses arising from a delay in paying a landlord for reimbursement of a broken boiler in a property that had been empty and unused for many years might not be foreseeable.

While parties to a non-consumer policy are permitted to contract out of the provisions the (re)insurer must meet strict 'transparency requirements'. The (re)insured's attention must be brought to the disadvantageous term before the contract is entered into and the term must be clear and unambiguous as to its effect. If the requirements are not met, the term will be void.

The Act also provides that a term seeking to contract out of the late payment provision will also be void if an insurer 'deliberately or recklessly' fails to pay out in a reasonable time. The Act suggests that a breach will be 'deliberate or reckless' if the insurer does not pay a claim and either knows it is in breach of the requirement to pay an insurance claim in a reasonable time or did not care whether or not it was in breach.

Insurers will not be able to contract out of these provisions in consumer contracts.

F Limiting factors

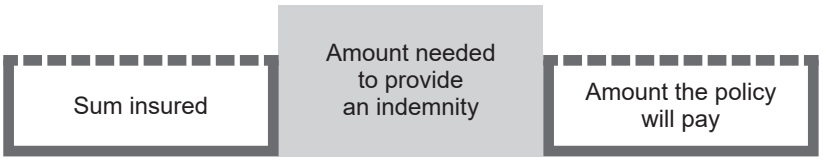
There are a number of situations where insurers may provide less than a full indemnity. This may be either because of the insured's choice of policy cover (as in the case of a first loss policy), because of poor insurance arrangements or because full cover was not requested. Policy terms may also restrict the insured's entitlement to a full indemnity.

We will now consider how the sum insured, the application of ***average***, **excesses** and **deductibles** limit the operation of the principle of indemnity.

F1 Sum insured

The maximum amount that can be recovered under a property insurance policy is limited to the sum insured. In liability policies, the maximum amount that can be recovered is the indemnity limit plus agreed costs. If, following a loss, the amount needed to provide indemnity is greater than the sum insured, the insured's recovery is limited to the sum insured (figure 7.1).

Figure 7.1: Insured's recovery limited to sum insured



Some policies have no limit stated, for example there is no limit for third-party personal injury cover in a motor policy. In such cases indemnity is restricted only by the amount of the court award (or the amount agreed in an out of court settlement).

F2 Inner limits or item limits

There are many policies that contain limits within the overall sum insured. The most common of these is a household contents policy. There is usually a single item limit (for gold, silver or similar items) of 5% of the sum insured. There may also be an overall limit for such items of, say, one-third of the total contents value; a separate limit for cash in the home and so on. Each of these may act as a limiting factor if the true value exceeds the limits stated.

Let us take an example from commercial insurance. Under a business interruption policy insured damage caused at specified suppliers will be subject to a financial limit. In fact, in most classes of insurance there are monetary limitations for specified items or categories.

Example 7.8

Following a fire in the insured's home a picture, valued at £3,500 at the time of the loss, was destroyed. If the total sum insured was £35,000, it is possible that the insured would not receive full indemnity for the picture.

There could be a limit on works of art of, say, 5% of the sum insured. Using a limit of 5% in this example, the indemnity would be:

5% × £35,000 = £1,750

This is lower than the market value of the picture destroyed in the fire. The insured has not, therefore, received a full indemnity.

F3 Average

We have said that in property insurance, the amount payable by an insurer is limited to the sum insured under the policy. This sum insured is the total value declared by the insured. It is this figure that is used to determine the premium. We have already seen that equitable premiums are central to the concept of pooling risks.

If, when taking out their policy the insured understates the value of the subject-matter of the insurance, there is said to be ***underinsurance***. The intention is that everyone who contributes to the pool pays a premium that is based on the full value of the subject-matter of the insurance. It would not be equitable to accept a risk into the pool that is based on less than the full value, as the premium charged would be too low. However, insurers cannot check that the sum insured is adequate every time they take on a new risk. Instead, they limit their liability by applying a policy term known as the **average condition**. In effect, this term means that the insured is considered to be their own insurer for the amount they have chosen not to insure, if there is underinsurance at the time of any loss. It means that even partial losses will be shared in proportion to the amount of underinsurance.

The formula used to calculate a claim payment, subject to the ***pro rata condition of average***, uses:

$$\frac{\text{sum insured}}{\text{value of goods at risk}} \times \text{loss}$$

The average condition is usual in commercial property policies and in virtually all household policies. It cannot apply to liability insurances.

Example 7.9

Hugh Brown & Co. had a fire in their shop and claimed for a loss of £600. The loss adjuster, instructed by the insurers, was satisfied that the loss claimed was correct but reported that the insured's accounts showed that there was £10,000 of goods in stock but only an £8,000 sum insured under the policy. Therefore, he adjusted the loss and recommended settlement as follows:

$$\frac{\text{sum insured}}{\text{value of goods at risk}} \times \text{loss}$$

$$\frac{£8{,}000}{£10{,}000} \times £600 = £480 \text{ to be paid}$$

Be aware

An insurer would only pay the total sum insured under a policy if the insured suffered a total loss.

Question 7.2

Mr Smith's garage buildings are valued at £200,000 and insured for £150,000 under a policy which is subject to average. If he suffers a £50,000 insured loss, how much will his insurers pay?

a. £12,500. ☐

b. £33,333. ☐

c. £37,500. ☐

d. £50,000. ☐

F3A Variations in conditions of average

The principle that losses will be paid in proportion to what the insured has decided to set as a sum insured applies to most property insurance policies. However, insurers vary their approach in different circumstances.

Special condition of average

You will recall that the basis of indemnity for farming stock is its market value, despite the fact that this includes the insured's profit margin. Insurers also take a more flexible view of the application of average for farmers and apply the special condition of average to agricultural produce and livestock. This is because the value of both may fluctuate significantly. In the case of agricultural produce this is particularly the case around harvest time. The effect of the clause is to state that if the value at the time of loss represents at least 75% of the actual value, average will not be applied. The condition does not apply to items that relate solely to growing crops, fences, gates and boundary walls, household goods or overhead cables or poles. The standard 'average' condition applies to such items. (There may also be an option for the insured to insure for the 'forward price' of produce. In this case, in the event of loss or damage, the value could not be ascertained until the forward date chosen has been reached.)

Two conditions of average

These conditions are designed to apply to contents or stock, the insurance of which is arranged on a floating basis (in more than one location), where specific insurance also

applies. The effect of the wording is first of all to state that 'average' applies. However, it goes on to state that if there is a more specific insurance for the items insured at any of the locations, only the excess value will be used to check whether average applies.

Example 7.10
An insured has a fire policy covering stock in warehouses A, B and C for a total value of £250,000 and another separate insurance for stock in warehouse B of £50,000.

A loss occurs and at that time the total value of the stock is £280,000. When settling the loss under the floating policy, the figure of £50,000 is deducted from the total value. This leaves £230,000, which means that the sum insured of £250,000 is adequate and average would not apply.

F4 Excess; deductible

An ***excess*** is an amount that is deducted from each claim and is paid by the insured. Some excesses are voluntary. This means that the insured receives some premium reduction for agreeing to carry the excess. They may alternatively be compulsory, such as the excesses that apply to UK motor insurance policies for damage to the insured vehicle when young or inexperienced drivers are in charge of the vehicle.

Combinations of voluntary and compulsory excesses are possible, and motor insurance provides us with a good example of this. A policyholder may opt to carry a voluntary excess. In the event of a claim involving a 'young' driver, the voluntary and the compulsory excesses are added together and the total figure deducted from the own damage claim.

There is a lack of consistency in the market regarding the use of the term ***deductible***. Historically, a deductible was a large excess – and this remains one of its definitions today. This would be the case where a commercial organisation agrees to meet the cost of any claim falling within the policy terms, up to the stated value of the deductible. It works in broadly the same way as an excess for claims that exceed the deductible amount (the policyholder paying the amount of the deductible and the insurer paying the balance, subject to any policy limits). However, it is often linked to a risk management process and is a means of retaining risks up to a certain size within an organisation. The precise way in which it may operate in conjunction with policy limits should be clearly stated in a policy wording. The variations in the market are beyond the scope of this course.

When a deductible does represent a very large sum, for which the insured accepts responsibility under a material damage or business interruption policy, there tends to be a 72-hour time limit for the defining of 'any one event'. This is important when considering weather-related claims that may occur over a period of time. It means that the deductible applies only once in such circumstances.

What may confuse you is the fact that sometimes the two terms 'excess' and 'deductible' appear to be used interchangeably in the market. This blurring of boundaries has been influenced by the fact that in parts of the world, most notably in the USA.

In general, policies that contain an excess will pay up to the policy limit over and above the excess. However, where the policy refers to a deductible, this amount is deducted from the limits. Even this usage is not universal, but it serves to distinguish the terms as a general rule. It is always necessary to refer to the policy wording for clarity.

If there is underinsurance or any other policy term that limits or reduces a loss, and an excess or deductible applies to the same loss, the excess or deductible is deducted last of all.

Consider this…
Why might an insurer allow a reduction in your motor insurance premium if you voluntarily agreed to pay the first £150 of each claim?

You would remove the need for the insurer to become involved in claims for very small amounts, which could still be very costly to administer, and would reduce the size of payment of any claim that exceeds £150.

Key points

The main ideas covered by this chapter can be summarised as follows:

Definition of indemnity

- Indemnity is financial compensation sufficient to place the insured in the same financial position after a loss as they enjoyed immediately before the loss occurred.
- Not all insurance policies are policies or indemnity. Some, e.g. personal accident policies, are benefit policies, as it is impossible to put a financial value on something like the loss of a limb.
- Indemnity can be provided through a cash payment, repair of the damaged item, replacement or reinstatement.

Application and measurement of indemnity

- For property insurance the measure of indemnity is the cost of repair or replacement at the time of the loss, less an allowance for wear and tear.
- For liability insurance the measure of indemnity is the damages and claimants costs awarded by a court (or arising from an out of court settlement).
- For marine insurance a valued or agreed value policy means that the insurable value is agreed between the insurer and insured and does not fluctuate with the market.

Modifying indemnity

- It is possible to extend the principle of indemnity for property insurance through the use of reinstatement conditions and new for old cover.
- Agreed value policies modify indemnity by fixing the value of the subject-matter of the insurance at inception. It is then not necessary to prove value on loss.
- A first loss policy limits the sum insured to an amount that the insured feels is the maximum potential loss where this is not the full value of the subject-matter of the insurance.

Enterprise Act 2016

- The Enterprise Act 2016 protects policyholders if the insurer does not settle valid claims within a reasonable time.

Limiting factors

- The maximum that can be recovered under any policy is the amount agreed to be the sum insured or the indemnity limit.
- There may be inner limits or item limits to the sum insured within the policy.
- In cases of underinsurance the average condition is applied whereby only that part of the loss that is proportionate to the sum insured is paid.

Question answers

7.1 d. £55,000.

7.2 c. £37,500.

Self-test questions

1. A home insurance policy does not state any specific settlement options. In the event of a claim, the policyholder is therefore:
   a. Legally entitled to financial compensation. ☐
   b. Legally entitled to reinstatement. ☐
   c. Only entitled to repair. ☐
   d. Only entitled to replacement. ☐

2. Reinstatement is a settlement option which:
   a. Replaces the subject matter with one of the same condition. ☐
   b. Restores the subject matter to the same condition it was in before the loss. ☐
   c. Provides a cash payment to the value of the subject matter. ☐
   d. Repairs the subject matter to its original condition. ☐

3. Property and liability policies are contracts of indemnity because:
   a. They are long term, non-renewable contracts. ☐
   b. A value can be placed on the subject matter insured. ☐
   c. They only offer cash settlement options. ☐
   d. They provide fixed benefits. ☐

4. The sum insured on a property insurance is defined as the full value at the time of reinstatement with a 15% margin for error. This is an example of:
   a. A reinstatement memorandum clause. ☐
   b. Basic cover. ☐
   c. Betterment. ☐
   d. Day one reinstatement. ☐

5. When calculating the indemnity value of a manufacturer's stock, it will be defined as the cost of raw materials at the time and place of loss, plus:
   a. Labour and costs of all stock, including lost profit. ☐
   b. The retail price of all stock. ☐
   c. Labour and the retail price of all stock less a deduction for wear and tear. ☐
   d. Labour and costs in respect of work in progress and finished stock. ☐

6. For which type of stock is the insured entitled to receive any potential profit on sale?
   a. Household goods. ☐
   b. Farming stock. ☐
   c. Manufacturer's stock. ☐
   d. Wholesaler's stock. ☐

7. If an insured does not wish to insure the full value of their stock for theft, they are **most** likely to need a(n):
   a. New for old policy. ☐
   b. Agreed value policy. ☐
   c. First loss policy. ☐
   d. Fixed value policy. ☐

8. A claim for £2,000 has been made on a household contents insurance policy which has a sum insured of £25,000. The policyholder may receive less than £2,000 if:
   a. The item claimed for cannot be replaced. ☐
   b. The policyholder has already made a claim on the policy. ☐
   c. There is a single item limit. ☐
   d. It is an agreed value policy. ☐

9. China Industries are claiming £2,000 following a break in at their warehouse. The loss adjuster has applied the average condition as the accounts show goods in stock of £10,000, whereas the sum insured is £7,500. What would the final settlement amount be?
   a. £2,000. ☐
   b. £2,500. ☐
   c. £2,666. ☐
   d. £1,500. ☐

10. If an insured values the subject matter of the insurance at less than the actual value, there is said to be:
   a. Underinsurance. ☐
   b. An average condition. ☐
   c. Reinsurance. ☐
   d. A deductible. ☐

You will find the answers at the back of the book

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8

Contribution and subrogation

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Question answers	
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Learning objectives

After studying this chapter, you should be able to:

- explain the concept of contribution;
- state how contribution applies to insurance contracts;
- explain what is meant by subrogation;
- list the circumstances in which insurers can exercise their rights of subrogation; and
- explain the way in which insurers acquire rights in relation to total loss settlements and salvage.

Introduction

There are some situations in which an insured may have in place more than one policy covering a particular loss or liability. Circumstances may also arise where the policyholder has insured a risk but the loss, when it happens, is caused by the actions of someone else. Consequently, not only is the policyholder protected by the insurance, they also have the potential to recover damages from the third party. In the first case we need to look at the rules that apply where there is some kind of dual insurance (the principle of ***contribution***); in the second we need to see how the insured's rights of recovery are passed on to the insurer (the principle of ***subrogation***).

Underlying both these principles is the principle of indemnity, which relates to exact financial compensation. This means that the insured is not entitled to profit from a claim settlement.

Key terms

This chapter features explanations of the following terms and concepts:

Common insurable interest	Common peril	Common subject-matter	Contribution
Independent liability method	Non-contribution clause	Precluded subrogation rights	Rateable proportion
Salvage	Subrogation	Tort	

A Contribution

When we examined the principle of indemnity, we said that when settling a loss, the intention was to place an insured in the same financial position they enjoyed immediately before the loss. We also said that the insured cannot recover more than the financial loss suffered.

The insured can take out as many insurance policies as they wish, provided that there is no fraudulent intent. But what happens when there is double insurance with more than one valid policy of indemnity in force? Can an insured recover under both policies and hence receive more than they actually lost?

From our study of the principle of indemnity, we know that an insured should not be able to recover, in total, more than the amount lost by claiming under both policies. The insured can only recover the total amount of a loss sustained, regardless of the number of policies held.

Let us consider an insured who holds two policies. If they then make a claim on only one of the insurers and receive indemnity from it, the other insurer has avoided its financial responsibility to them. The insurer that paid the claim has taken full financial responsibility for the loss. It is this possibility that gives rise to the principle of contribution, which seeks to share the burden of the loss fairly among all insurers who cover the loss.

Dual insurance

There are many situations where dual insurance exists. This means that two types of insurance provide cover in the event of loss.

Examples of dual insurance include the following:

- An 'all risks' policy and a travel insurance policy both covering travel and possibly the same property whilst abroad.
- The household contents policy and the personal effects section of a motor policy both covering personal effects whilst in a motor vehicle.
- A homeowner taking out a household buildings policy and not remembering that among the items agreed with the mortgage lender was the effecting of a policy with another insurer.
- A specific warehouse stock policy and a 'floating' policy covering stock over several warehouses: both covering the same stock.

A1 Contribution condition

Contribution supports the principle of indemnity, and so it exists whether stated in a policy document or not. However, if there is no specific policy condition, the insured is entitled to claim the whole amount from any of the insurers liable to pay. They will then leave that insurer to recover appropriate shares from the other insurers. Therefore, insurers customarily include a contribution condition in their policies. This condition restricts the insurer's liability to its ***rateable proportion*** or **rateable share** of a loss.

Activity
Look again at the standard fire policy given in appendix 1. Find the contribution condition and see how it is worded.

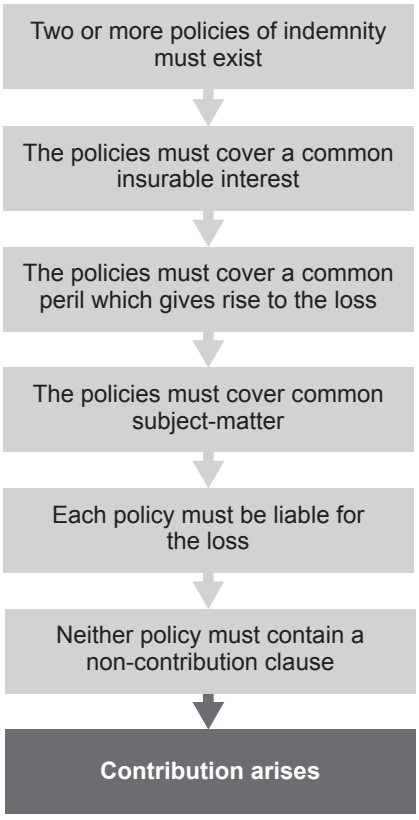
The effect of the condition is to compel the insured to make a claim under each valid policy for the sum for which each insurer is liable, if they wish to receive a full settlement.

A2 Definition of contribution

Contribution is the right of an insurer to recover part of a claim payment where two or more polices cover the same interest, the same risk and are in force when the loss occurs.

A3 How contribution arises

Under common law, the following requirements must be satisfied before contribution arises:



It is only necessary for the insurable interest, peril and subject-matter to be common to all policies. There is no requirement for the policies to be identical but there does need to be some overlap between one policy and another. We will now look more closely at the requirements of:

- common insurable interest;
- common peril; and
- common subject-matter.

A3A Common insurable interest

Contribution only applies where the policies cover a common interest in the subject-matter. In other words, the insurable interest is the same (owner, user, bailee etc.). This principle was established in the case of ***North British and Mercantile v. Liverpool and London and Globe* (1877)**, known as the ***King and Queen Granaries*** case.

In this case, a merchant had deposited grain at a granary owned by Barnett. By virtue of the custom of his trade, Barnett had insurable interest in the grain and had insured it. The owner had also insured it to cover his own interest in it.

The grain was damaged by fire and Barnett's insurers paid the whole claim. They then sought to recover from the owner's insurers. However, it was held that, as the two insureds' interests were different, one as bailee and one as owner, contribution did not apply. Barnett's insurers bore the whole loss.

This raises the question of whether both parties may claim under their policies if the interests in the same loss are different. In theory, both insureds could recover but, in practice, the insurance market has reached an agreement to protect itself from paying out twice on the same loss.

Example 8.1
Before going on holiday, Andy purchased travel insurance and, while he was away, his camera (worth £500) was stolen. At that time, he also had in force an 'all risks' policy covering personal items.
Andy can only claim a **maximum** amount of **£500 under either policy** as he cannot recover more than his loss.

If policy cover for each policy was the same he would be able to claim **£250 from each policy** as this represents the proportion which each policy would contribute.

However, if an average condition was included in the policy then this would reduce the amount payable.

A3B Common peril

The peril which causes a loss must be common to both contracts. Let us consider a situation where we have two policies: one covering dishonesty and the other covering dishonesty, fire and burglary. These can be brought into contribution where the loss is due to dishonesty. However, this is not the case where the loss is due to fire only, since this peril is not common to both policies. The insurer covering fire bears the burden for the loss in these circumstances.

A3C Common subject-matter

For contribution to apply, each insurer must provide cover in respect of the subject-matter of insurance which suffers loss or damage. This is frequently some form of property, but could equally relate to a legal liability.

B Applying the contribution principle

B1 Rateable proportion

We have seen that insurers contribute to a claim on the basis of what is termed a rateable proportion.

Rateable proportion is the share of any claim that an insurer pays when two or more insurers cover the same risk, usually in proportion to the respective sums insured. There are two possible ways of determining the rateable proportion of a claim.

B1A By sum insured

One method of calculating the rateable proportion of a loss is by apportioning it in line with the **sums insured** under each policy.

The rateable proportion is calculated using the formula:

$$\frac{\text{policy sum insured}}{\text{total sum insured (all policies)}} \times \text{loss}$$

Example 8.2

Look again at the standard fire policy given as appendix 1. Find the contribution condition and see how it is worded.

Policy A sum insured:	£10,000
Policy B sum insured:	£20,000
Total sum insured:	£30,000

$$\frac{\text{policy sum insured}}{\text{total sum insured (all policies)}} \times \text{loss}$$

The proportion of the claim paid by policy A is:

$$\frac{10{,}000}{30{,}000} = 1/3$$

Policy B pays:

$$\frac{20{,}000}{30{,}000} = 2/3$$

This method of assessing contribution is used for property policies which are not subject to average and which have identical subject-matter. However, the sum insured method ignores the fact that different restrictions, such as average (or an excess), may apply to each policy.

Question 8.1

Colin's cottage is valued at £100,000 and is covered by two fire insurance policies with identical terms and conditions. The first policy has a sum insured of £50,000 and the second policy has a sum insured of £100,000. A fire causes damage costing £60,000 to repair. Once contribution has been agreed between the insurers, how much will be paid by the first policy?

a. £20,000. ☐

b. £25,000. ☐

c. £30,000. ☐

d. £50,000. ☐

B1B By independent liability

An alternative method for calculating each insurer's share of a loss is the ***independent liability method***. This method calculates the amount payable under each policy as if no other policy existed and the insurer was alone in indemnifying the insured. The loss is then shared in proportion to the independent liabilities of the two policies.

This method is used where property policies are subject to average or where an individual loss limit applies within a sum insured.

The formula used is:

$$\frac{\text{policy sum insured}}{\text{total value at risk}} \times \text{loss}$$

Example 8.3

Policy A sum insured:	£10,000
Policy B sum insured:	£20,000

Both policies are subject to average.

Total value at risk:	£50,000
Loss incurred:	£15,000

Whenever the total value at risk exceeds the total sum insured by all policies, each policy pays:

$$\frac{\text{policy sum insured}}{\text{total value at risk}} \times \text{loss}$$

Policy A pays:

$$\frac{10,000}{50,000} \times 15,000 = £3,000 \ (\tfrac{1}{5} \text{ of loss})$$

Policy B pays:

$$\frac{20,000}{50,000} \times 15,000 = £6,000 \ (\tfrac{2}{5} \text{ of loss})$$

The total payment, in this example, made by the two insurers is therefore £9,000. The balance of the loss (£6,000) must be borne by the insured as they have not fully insured the total value at risk.

B2 Modifications to the principle

There are some situations in which the principle of contribution is modified.

B2A Non-contribution clauses

Certain policies have what is known as a ***non-contribution clause***. This may be worded as follows:

> This policy shall not apply in respect of any claim where the insured is entitled to indemnity under any other insurance.

This means that the policy would not contribute if there was another insurance policy in force. The courts do not favour such clauses, and in situations where a similar clause applies to both (or all) policies, they are treated as cancelling each other out. This means that each insurer would contribute its rateable proportion.

B2B More specific insurance clauses

Certain policies include a clause which restricts cover in situations where a more specific insurance has been arranged. The most common example of cover being restricted in this way is in a household policy. It does this because many householders arrange specific insurance for jewellery and other items, and it is not the intention for both policies to contribute.

B2C Market agreements

There are many market agreements which operate to smooth the path of contribution settlements. For example, insurers are party to an agreement in relation to overlapping cover, caused when a driver has a 'driving other cars' extension and drives another person's car which they are also insured to drive as a named driver under the owner's policy. Insurers agree that the owner's policy will pay.

There is also an Association of British Insurers (ABI) agreement that applies when there is an overlap between travel, all risks, household and the personal effects section of a motor policy – the **Personal Effects Contribution Agreement (PECA)**. The agreement states that

insurers will not insist that the insured claims a proportion from each insurer where the sum involved is modest, regardless of what the policy conditions actually say.

Consider this…
What do you think are the advantages for insurers who are party to market agreements?

For the insured, there may be a reduction in premiums where such claims agreements are in force. This is because the insurers have saved money, both through cheaper administration and the avoidance of expensive and arguably disproportionate litigation.

C Subrogation

Subrogation is a common law right. Any means of reducing the size of the loss by exercising recovery rights are for the insurer's benefit, up to the amount that the insurer has paid out. The insured cannot claim an indemnity payment from an insurer and then also acquire a further payment from a negligent third party. This would result in a profit to the insured and would breach the principle of indemnity.

However, the requirement that the insurer must already have indemnified the insured before pursuing subrogation rights, gives rise to some problems. This is because the insurers would not have had complete control of proceedings from the date of the loss. Its eventual position could be severely prejudiced by delay or by some other action taken by the insured.

In order to gain this control, insurers invariably include a condition in the policy which gives them the power to pursue subrogation rights before the claim is paid. The only limitation is that the insurer cannot recover from a third party before it has actually settled its own insured's claim.

Consider this…
While your car is parked, another motorist collides with it, causing damage. You claim under your own comprehensive motor insurance policy and also contact the other motorist's insurance company to claim damages.
You receive two cheques in settlement; one from each of the insurers.

Are you entitled to keep both cheques?

You would clearly make a profit from this situation if you kept both cheques, which is in breach of the principle of indemnity. Therefore, the settlement from the third party insurers should by right of subrogation, go to your motor insurer to help compensate its loss. However, you are only obliged to reimburse your own insurer the amount that they had actually paid. You can keep the balance which may include an excess or other uninsured losses.

You will remember that the concept of indemnity is to place the insured in the financial position they were in immediately before the loss. In this case, your own motor insurer has already fulfilled this obligation; your insurer is, therefore, entitled to any money received from third parties in respect of the loss that it has already paid.

C1 Definition of subrogation

Subrogation can be defined as the right of an insurer, following payment of a claim, to take over the insured's rights to recover payment from a third party responsible for the loss. It is limited to the amount paid out under the policy.

Let us look at the leading case concerning indemnity and subrogation, namely ***Castellain v. Preston*** **(1883)**.

Preston was in the course of selling his house to Rayner when it was damaged by fire. Preston recovered the money for the damage from his insurers, but did not carry out any repairs. Subsequently, Preston received the full purchase price for the house, even though the building had not been repaired.

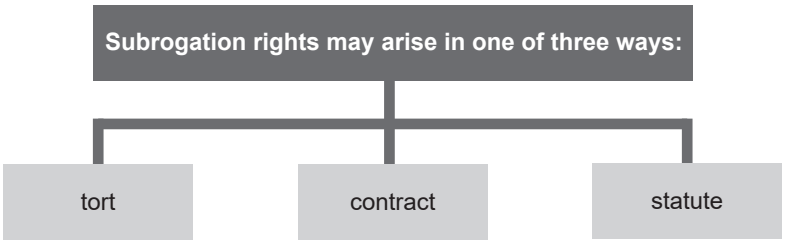
An action was brought on behalf of the insurers to recover the payment they had made to Preston. The action was successful because of the principle of indemnity and the doctrine of subrogation. The insured had received more than a full indemnity. He received both compensation from his insurers and the full purchase price for the house. However, it is more usual for insurers to recover all or part of their losses from the third party.

Consider this…
Why does the principle of subrogation not apply to life or personal accident policies?

D Insurers' subrogation rights

In keeping with the principle of indemnity, insurers are also not entitled to recover more than they have paid out. This is seen in the case of ***Yorkshire Insurance Co. v. Nisbet Shipping Co. Ltd* (1961)**. In this case, the insurers made a settlement of £72,000. However, there was a long period of time between the payment of the claim and the recovery from the third party and there had been changes in the rates of exchange. Consequently, the insured actually recovered £127,000. It was held that the insurers were only entitled to £72,000. The insured was entitled to the balance.

The position has become slightly blurred, following decisions by the Court of Appeal (***Coles v. Hetherton* (2013)**) and the Competition and Market Authority (2014) that insurers seeking vehicle repair costs at the market rate, when the work was carried out by their own repair network at a discounted rate, was lawful.



D1 Tort

Under common law, everyone has a duty to act in a reasonable way towards others. A breach of this duty is called a ***tort***. The person who has suffered damage or injury is entitled to compensation.

A breach of this duty may arise in a number of ways, for example:

- a lorry driver negligently loses control of their vehicle and crashes through your kitchen wall;
- your neighbour, practising their golf shots, hits a ball into your garden and it smashes your greenhouse; or
- a workman knocks over a road sign, causing your car to hit a roadroller.

In each of these examples, an individual has wronged you or your property. It is possible to arrange a policy to cater for each of these events. As well as the indemnity which insurers provide, the insured has a right (in tort) to financial compensation from the individuals involved in the wrongdoing. The insurers assume the rights of the insured and attempt to recover their outlay from the wrongdoer.

Consider this…
Your car is damaged by the negligent act of another motorist. As well as the repairs involved, you claim for the cost of hiring another car in order to carry on working. Your insurer pays only for the repairs to your car and sues in your name for recovery of the paid claim.
As a person can only be sued once for one event, how can you recover your costs for hiring the car (an uninsured loss)?

As an insurer must sue in an insured's name, the insured can include in the legal action a claim for the additional loss suffered through the hire of another car. In practice, the insurers would recover the full amount and would pass on the amount of the uninsured loss to the insured.

D2 Contract

Under certain contracts a breach entitles the aggrieved party to compensation, regardless of fault. Insurers can assume the benefits of these rights.

Example 8.4
Tony takes up a tenancy in rented accommodation. Part of the contract between Tony and the landlord makes Tony responsible for damage to the property. The property is damaged and a claim is made on the landlord's insurer. This insurer then exercises its subrogation rights and recovers its losses in respect of the damage from Tony, regardless of fault or the existence of alternative insurance to cover the loss.

Many building projects are entered into under particular forms of contract that specify the legal, and insuring, responsibilities of the parties; principal, contractor and subcontractors.

D3 Statute

Most insurers require that claims for riot, civil commotion and malicious damage must be notified within seven days of the event. This is because under the terms of the **Riot Compensation Act 2016 (RCA)** insurers may have rights of recovery against the police for riot damage, but have only 42 days from the date of the riot to do so.

E Insurers' rights arising from the subject-matter

If the insurer regards the property that is the subject-matter of insurance as being beyond economic repair, they may offer a total loss settlement. This often happens in motor insurance and under many motor policies the insurer states in advance what will constitute 'economic repair'. Market practice tends towards repairs exceeding 60% of market value as being uneconomic. Of course, when this happens there may be some residual value in the thing insured. This is termed ***salvage***. If the insurer meets the loss in full it is the insurer that is entitled to the benefit of the salvage value.

As it is a financial benefit, a question arises as to who has rights to the salvage itself. The **Financial Ombudsman Service (FOS)** has made it clear that the insured should always be given the opportunity to retain the salvage, provided a suitable deduction is made from the claim payment to take its value into account. The amount needs to be agreed between the insurer and the insured. This principle would govern the recovery of property. For example, if an insurer pays out a sum as a total loss for an item of jewellery that has been stolen and it is subsequently recovered, the insured must be offered the jewellery provided that the full claim payment is repaid to the insurer.

In an important respect rights arising from the salvage differ from subrogation rights. When the insurer retains the salvage, the insurer becomes the owner of it. If, when it is sold, a greater sum is achieved than the insurer originally assumed, there is no obligation to pass profit on to the insured.

Example 8.5
A painting by a little-known artist is damaged. It is regarded as a total loss and the insurer pays the claim accordingly and retains the damaged painting. The insurer gets an expert to repair the painting and offers it for sale. The artist in the meantime has become very popular and the sale value is well beyond the original claim payment. The profit made is to the benefit of the insurer.

Question 8.2

An insurer pays £10,000 and allows the insured to retain the salvage, valued at £1,000, in settlement of a claim for damage caused by a negligent third party. How much can the insurer claim from that third party when exercising its subrogation rights?

a. £1,000. ☐

b. £9,000. ☐

c. £10,000. ☐

d. £11,000. ☐

F Market agreements

There are many situations in which, by virtue of the operation of subrogation, insurers would be corresponding about money that they would need to claim back from each other. A limited number of market agreements exist to reduce the correspondence and administrative costs involved in pursuing frequent subrogation procedures.

F1 The ABI Memorandum of Understanding – Subrogated Motor Claims

This does not seek to avoid apportioning blame nor does it have an agreed formula for sharing losses. Instead it sets out principles for subrogated motor claims that are based on 'honesty and transparency'. It is not a legally binding agreement. In order to avoid disputes about quantifying subrogated claims, reduce costs and ensure prompt settlement, four key elements are incorporated:

- Consistency of practice in the control of own damage claims regardless of any subrogation rights.
- Subrogated claims are to represent the net cost to the insurer after all discounts, and certain items such as emergency treatment fees, are excluded.
- All material supporting documentary evidence should be volunteered, together with salvage value and the basis of calculation for vehicles written off.
- Legal costs should be avoided wherever possible.

On this basis insurers communicate with one another to decide the basis on which they will share losses. Often this will simply be by agreement on the telephone, or through a number of third party 'subrogation portals' that have developed in the last few years. Agreements will take into account contributory negligence where necessary.

G Precluded subrogation rights

We have seen that there are situations where a market agreement exists that relates to predetermined apportionment for subrogated claims. There are also some situations in which insurers are barred from exercising subrogation rights, or where they agree not to exercise them.

G1 Insured has no rights

The insurer's right to subrogate relies on the fact that the insured has rights against a negligent third party. In circumstances where an insured has waived those rights the insurer cannot re-acquire them. This could happen if an insured signs an agreement with a 'hold harmless' clause, which prevents the insured from pursuing recovery rights.

G2 Benefit policies

As we have established, certain policies, such as personal accident policies, are benefit policies. This means that they are not subject to the rules that flow from the principle of indemnity. It follows that even if a person negligently causes an accident in which the insured is injured, the personal accident insurer will have no right of recovery. This is true even if the insured successfully sues the negligent third party and receives financial compensation for the injuries. The insured is entitled to keep both the personal accident benefits and the court award.

G3 Subrogation waiver

There are circumstances in which insurers agree to waive their rights of subrogation. They do this through subrogation waiver clauses, which are common in commercial insurances. These clauses are usually designed to prevent the insurer from pursuing any subrogation rights it may have against a parent or subsidiary company of the insured.

G4 Negligent fellow employees

Insurers took the decision not to pursue their recovery rights against negligent fellow workers as a result of the court case, ***Lister v. Romford Ice and Cold Storage Ltd*** **(1957)**. The details of this case are that a son injured his father in the course of his employment (they were fellow workers). The insurers paid out for the father's injuries under the employer's liability policy. They then successfully recovered their outlay from the son (because his father's injuries were the result of a lack of reasonable care on his part). There was criticism of the insurance industry and a general feeling that this was harsh. Therefore, insurers have generally agreed (except in extreme circumstances) not to pursue recovery rights against negligent fellow workers.

Key points

The main ideas covered by this chapter can be summarised as follows:

Contribution

- Contribution is the right of an insurer to recover part of a claim payment where two or more polices cover the same interest, the same risk and are in force when the loss occurs.
- Although contribution always exists where there is more than one insurance covering the same loss, many policies include a contribution condition, which compels the insured to make a claim under each valid policy for the sum for which each insurer is liable.
- For contribution to apply the insurable interest, peril and subject-matter must be common to all the policies.
- Each insurer pays their rateable proportion of any claim, which is calculated either by the sum insured method or by the independent liability method.
- Contribution can be modified by non-contribution clauses, more specific insurance clauses and by market agreement.

Subrogation

- Subrogation can be defined as the right of an insurer, following payment of a claim, to take over the insured's rights to recover payment from a third party responsible for the loss. It is limited to the amount paid out under the policy.
- Subrogation rights may arise out of tort, contract or statute.
- In certain situations insurers cannot or will not exercise subrogation rights. They cannot where the insured has no right against a negligent third party or the policy is a benefit one.

Question answers

8.1 a. £20,000.

8.2 c. £10,000.

Self-test questions

1. Which principle of insurance seeks to share the burden of loss fairly among all insurers who cover the loss?

   a. Subrogation. ☐

   b. Contribution. ☐

   c. Average condition. ☐

   d. Proximate cause. ☐

2. Gareth has two policies covering his camera. The sum insured with policy A is £500. The sum insured with policy B is £250. What is the rateable proportion payable by insurer A?

   a. 1/4. ☐

   b. 1/3. ☐

   c. 2/3. ☐

   d. 1/2. ☐

3. Romesh has two insurance policies covering the same loss, both subject to average. Policy A's sum insured is £20,000. Policy B's sum insured is £30,000. The total value at risk is £60,000. If the claim is for a loss of £30,000, what contribution would policy A pay?

   a. £15,000. ☐

   b. £20,000. ☐

   c. £30,000. ☐

   d. £10,000. ☐

4. An insurer has paid a claim of £150,000 but, under their subrogation rights, has recovered £160,000. Who is entitled to the balance of £10,000 over and above the claim value?

   a. The insured. ☐

   b. The insurer. ☐

   c. The third party. ☐

   d. The insured and the insurer in equal shares. ☐

5. In common law, a breach of duty to act in a reasonable way towards others is known as:

   a. A tort. ☐

   b. Subrogation. ☐

   c. A breach of contract. ☐

   d. Liability. ☐

6. A car is badly damaged in an accident and is found to be beyond economic repair. If the insurer meets the loss in full and the car is then sold for scrap, who is entitled to the salvage value?

   a. The policyholder. ☐

   b. The garage. ☐

   c. The insurer. ☐

   d. The insurer and the policyholder in equal shares. ☐

7. Julie's bicycle is badly damaged by a negligent third party. Her insurer pays £1,500 and allows her to keep the camera as salvage, valued at £500. What is the value of the insurer's subrogation rights in respect of the negligent third party?

   a. £500. ☐

   b. £1,500. ☐

   c. £1,000. ☐

   d. £2,000. ☐

8. A 'hold harmless' clause in respect of a recent accident means that the insurer:

   a. Can acquire Tony's subrogation rights. ☐

   b. Can only claim if the third party is insured. ☐

   c. Must pay the full amount of the claim. ☐

   d. Has no subrogation rights. ☐

9. What type of insurance policy has no subrogation rights?

   a. A benefit policy. ☐

   b. An indemnity policy. ☐

   c. Motor insurance. ☐

   d. Household insurance. ☐

10. An insurer is **least** likely to waive their subrogation rights if the claim is against a:

    a. Parent company of the insured. ☐

    b. Subsidiary company of the insured. ☐

    c. Negligent third party of the insured. ☐

    d. Negligent fellow employee of the insured. ☐

You will find the answers at the back of the book

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9

Compulsory insurance and the rights of third parties

Contents	Syllabus learning outcomes
Introduction	
A Compulsory insurance	*11.1*
B Legislation concerning third parties	*11.3*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- outline the main types of compulsory insurance in the UK; and
- describe the effect on insurance contracts of the Contracts (Rights of Third Parties) Act 1999 and the Third Parties (Rights Against Insurers) Act 2010.

Introduction

In this chapter, we focus on the areas where the Government has legislated to make certain forms of insurance compulsory, and look at how the law has developed to ensure third party rights are protected when a liable party with insurance becomes insolvent.

Key terms

This chapter features explanations of the following terms and concepts:

Compulsory insurance	Employers' liability insurance	Privity of contract	Professional indemnity insurance
Public liability insurance			

A Compulsory insurance

In the UK, the Government acts as an insurer in its own right by providing certain benefits for individuals. These are important and include welfare benefits, unemployment benefits and retirement benefits. However, this will not be true in every country. Many countries, for example, have a form of worker's compensation cover (giving fixed benefits), which is provided by the private sector rather than by the state. Internationally, there is considerable variation as to whether health insurance is provided by the state or the private sector and in how these two sources are balanced.

The UK Government has tended to make the insuring of certain risks, relating to legal liability or negligence, compulsory through legislation. The aim is to make sure that funds are available to compensate the innocent victims of many types of accident (though not all).

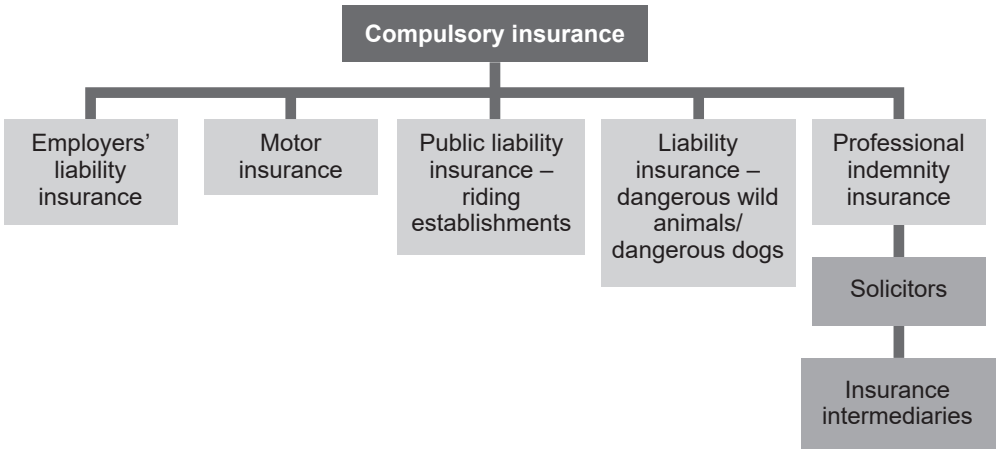
Those made compulsory by law may be summarised as follows:

- **Private individuals**. Motor insurance and public liability insurance in respect of the ownership of dangerous wild animals and/or dangerous dogs are compulsory for private individuals.
- **Professions and businesses**. Motor insurance is compulsory for every business which uses motor vehicles on a road and employers' liability (EL) insurance is compulsory for companies with employees. Public liability (PL) insurance is also compulsory for specific trades and professions, including riding establishments. Solicitors and other professionals, including insurance intermediaries, must have professional indemnity (PI) insurance. Marine pollution liability insurance is compulsory, as is liability insurance for operators of nuclear reactors.

The following are the main reasons why certain forms of insurance are compulsory in particular cases:

- **To provide funds for compensation**. The main objective of compulsory insurance is to provide means by which persons injured, or suffering loss, through the fault of others may receive compensation. There would be little point in awarding damages to someone if there were no funds to meet the award. Compulsory insurance ensures, as far as possible, that funds are available when damages are awarded by a court, even though the person who caused the injuries may lack the necessary financial resources.
- **In response to national concerns**. The areas where insurance has been made compulsory represent areas of greatest national concern.

Figure 9.1: Compulsory insurance in the UK



A1 Employers' liability insurance

The **Employers' Liability (Compulsory Insurance) Act 1969** made it compulsory for employers in Great Britain to effect employers' liability insurance. This insures them against their liability to pay compensation to employees who sustain bodily injury or disease, arising out of and in the course of their employment. There is a list of exemptions from this requirement, mainly relating to family members and government agencies. In practical terms, however, most employers have to insure this risk. The minimum required limit of indemnity has been increased and now stands at £5m, though the insurance market provides £10m as standard. Although there had been a requirement for employers to retain the certificates, this was changed by the **Employers' Liability (Compulsory Insurance) (Amendment) Regulations 2008**. There is no longer any specific requirement to keep certificates for a specified period. The previous legal requirement to display certificates at each place of work is satisfied if employees have reasonable access to the certificate in an electronic format.

A2 Motor insurance

The **Road Traffic Act 1988** (as amended) stipulates that it is illegal to cause or permit the use of a vehicle on a public road (extended now to include 'any other public place') unless an insurance policy is in force, covering third-party property damage and third-party bodily injury or death.

Although compulsory third-party personal injury cover featured as part of UK law well before the first EU motor insurance directive (in 1972), many subsequent changes to UK law have been prompted by EU directives. Compulsory third-party property damage cover and the requirement to be able to trace the insurer of a vehicle from its registration plate are two examples. Five EU motor insurance directives were brought into UK law between 1973 and 2007, which were consolidated by the **Codified Motor Directive** introduced in 2009.

The certificate of motor insurance has always been used as evidence of valid Road Traffic Act 1988 insurance cover. Section 9 of the **Deregulation Act 2015**, however, amended the Road Traffic Act and there were some consequential changes to the requirements:

- Insurance certificates must still be delivered to policyholders, but delivery is no longer required for the policy to be effective.
- Where a policy is cancelled mid-term the policyholder is no longer required to return the certificate or make a statutory declaration or any statement acknowledging the policy has ceased to have effect (and not doing so ceases to be an offence).
- Insurers are relieved of the burden of requesting policyholders to surrender certificates for cancelled policies as a prerequisite of avoiding contractual liability.

The Motor Insurers' Bureau has a key role to play in handling motor insurance claims for compulsory motor insurance.

Refer to
Motor Insurers' Bureau covered in *Motor Insurers' Bureau (MIB)* on page 2/30

A3 Public liability insurance: riding establishments

One of the provisions of the **Riding Establishments Act 1970** is that all proprietors of riding establishments must have public liability insurance.

The insurance must indemnify the insured against claims arising from the use of the insured's horses. This would include injuries sustained by both persons riding the horses and members of the public. The insurance must also indemnify the horse riders themselves against any liability they may incur for injury to members of the public, arising out of the hire or use of the proprietors' horses. The terms and limitations of the insurance are not specified in the Act.

A4 Liability insurance: dangerous wild animals and/or dangerous dogs

Apart from motor insurance, the other forms of liability insurance which are compulsory for private individuals are in respect of the ownership of dangerous wild animals or dangerous dogs.

The nature and scope of such insurance is not defined in the **Dangerous Wild Animals Act 1976** or the **Dangerous Dogs Act 1991**. However, the local authority, which issues the appropriate licence, must be satisfied as to the adequacy of the insurance.

In general, insurers are not willing to issue a policy that would only cover the liability arising out of the ownership of the dangerous wild animal or dangerous dog. To do so would amount to selection against the insurer. Instead the insurer would probably only be prepared to insure the risk as an extension to another insurance policy held by the insured/owner. Such a policy could be the household policy, where it would be covered within the public liability section.

Example 9.1

Keith has bought a pit bull terrier, mistakenly believing it was a different breed. Having decided to keep the dog, he has managed to obtain an exemption from the courts on the basis that the dog does not pose a threat to the public. The local authority has issued him with a license.

He has spoken to numerous mainstream insurers, but has found it very difficult to obtain liability insurance cover specifically for the pit bull terrier. Speaking to his current home insurer, he has been advised that he can potentially extend his cover to include this by paying an additional premium. Alternatively, he can seek cover for this specific risk from a specialist insurer, most likely via a broker.

A5 Professional indemnity (PI) insurance

PI insurance is compulsory for certain professions. These include solicitors and others such as accountants and insurance intermediaries who are authorised by the ***Financial Conduct Authority (FCA)***.

A5A Solicitors

The **Solicitors (Amendment) Act 1974** states that solicitors must hold PI insurance. This insurance must indemnify the solicitor against claims for financial loss suffered by clients as a result of the solicitor's professional negligence.

There are many different situations that provide scope for negligence on the part of solicitors which might result in financial loss to a client, such as:

- negligence in the making of all the necessary enquiries in relation to the purchase of a property; and
- errors or omissions in the preparation of legal documents resulting, possibly, in the completion of defective contracts and consequent financial loss to the client.

A5B Insurance intermediaries

Insurance intermediaries authorised by the FCA must have PI insurance. Appointed representatives and introducer appointed representatives are not required to have this form of insurance, since everything they do is undertaken for an insurer or an intermediary that is

responsible for their actions. The FCA rules require insurance intermediaries to hold liability insurance in respect of financial loss suffered by a third party caused by their professional negligence up to substantial limits and stipulate the minimum level of cover they must purchase.

The minimum level is currently €1,300,380 for a single claim, and for aggregate losses, the higher of €1,924,560 or 10% of annual income (up to £30m). The limits were raised in August 2021, with the minimum requirements originating from the **Insurance Distribution Directive (IDD)** in 2018. Regardless of the minimum levels, all firms should consider their potential liabilities and purchase sufficient insurance to cover these.

Consider this…
PI policy premiums have increased dramatically in recent years, as have the numbers of PI claims. What do you think are the reasons for this?

A6 Possible conclusion

The UK is arguably becoming a more litigious society (following in the footsteps of the USA) so the need for PI cover has grown.

Reasons for this include:

- the rising cost of legal services;
- retrospective legislation which may 'move the goalposts' to the detriment of insurers; and
- adverse judicial decisions.

Question 9.1

An employer has 50 employees making overalls in a factory. What insurance must they have by law?

a. Business interruption. ☐

b. Employers' liability. ☐

c. Products liability. ☐

d. Public liability. ☐

In many areas where there is a risk that innocent victims can suffer death, injury or loss, liability insurance has been made compulsory. However, we can see that this is not true of all areas. For example, there is no compulsory requirement for manufacturers of defective or dangerous products to insure their liability to the public. Similarly, there is no requirement to insure a more general liability to the public. Nevertheless, we can argue that in those areas where there are most likely to be innocent victims of accidents or poor advice, the existence of compulsory insurance means that they will be compensated.

We have considered the effect of legislation in the area of compulsory insurance. There is other legislation that has an impact on insurance that we need to be aware of. We will consider three significant examples of such legislation in the next four sections.

B Legislation concerning third parties

B1 Contracts (Rights of Third Parties) Act 1999

The concept of '***privity of contract***' means that a person can only enforce a contract if they are a party to it. Consequently, even if a contract is made with the purpose of benefiting someone who is not a party to it, that person (the 'third party') has no right to sue for breach of contract.

The **Contracts (Rights of Third Parties) Act 1999** reforms this rule and sets out the circumstances in which a third party will have a right to enforce a term of the contract. Broadly speaking, either the contract must make express provision for the enforcement or the third party must be expressly identified in the contract by name, class or description. The

remedies allowed are those usually permitted (damages, injunction or specific performance). If we were to take motor policies as an example, we would see that it is common for individuals other than the policyholder to be named (e.g. as drivers) and for classes of persons to be identified (e.g. in certificate wordings).

Insurers do not wish to extend their liability and, as it is permissible to contract out of the provisions of the Act, this is what insurers have tended to do in their liability and motor policies. There is now a standard general exclusion stating that the terms of this legislation do not apply to the insurance contract.

B2 Third Parties (Rights Against Insurers) Act 2010

The **Third Parties (Rights Against Insurers) Act 2010** sets out to protect insurance proceeds from the effects of insolvency. The **Third Parties (Rights Against Insurers) Act 1930** confers rights on third parties against insurers in the event of the insured becoming insolvent. Under the 1930 Act, however, the process is complex, requiring an application to be made to the court to restore a dissolved insured company to the Register of Companies in order to establish liability and bring a claim against it. This process can be costly and time consuming.

The 2010 Act permits a third party to bring a claim directly against the insurer, without having to restore the insolvent company to the register. This prevents circumstances in which insurance monies are paid to the insolvent insured and then on to the general creditors as part of insolvency proceedings, rather than being paid to the intended beneficiaries of an insurance policy. Prior to the new Act the protection offered by insurance contracts was often undermined. For example, although companies with employees are obliged by law to take out compulsory employers' liability insurance, if an employee was injured the claims monies would be paid to the insolvent insured and then to the general creditors and not the injured employee.

In order for the 2010 Act to apply, an insured must:

- incur a liability to a third party for which they have insurance; and
- be insolvent.

In addition, the 2010 Act gives claimants more rights to establish whether a company has insurance before issuing a claim. Both changes help save time and costs.

Example 9.2

Tom, who worked mainly for one employer for his entire working life as a construction worker, is diagnosed with an asbestos-related illness. After engaging a solicitor to support him with an employers' liability claim against the company, he discovers that it has recently become insolvent.

Under the 2010 Act, Tom is entitled to issue a claim directly against the insurers that provided cover to his employer during the period of his employment, rather than having to seek permission from the courts to do so.

Due to fast changing solvency legislation, the 2010 Act was defective and was not brought into force after Royal Assent. The **Insurance Act 2015 (IA 2015)** includes amendments to the Third Parties (Rights Against Insurers) Act 2010, aimed at rectifying the failure to include certain insolvency circumstances in the original 2010 Act. Other amendments deal with long-tail liabilities, such as mesothelioma (a cancer associated especially with exposure to asbestos), which may have a latency period of up to 50 years. The long-awaited Act was finally brought into effect on 1 August 2016.

Any insured that became insolvent in the past under previous insolvency legislation is included within the scope of the 2010 Act, but only where the insured incurs a liability after commencement of the Act. Where liability was incurred prior to the 2010 Act, the 1930 Act still applies.

Key points

The main ideas covered by this chapter can be summarised as follows:

Compulsory insurance

- The Employers' Liability (Compulsory Insurance) Act 1969 made it compulsory for employers in Great Britain to effect employers' liability insurance.
- The Road Traffic Act 1988 (as amended) makes it illegal to drive a motor vehicle on a public road or any other public place without insurance covering third-party property damage, injury or death.
- Other compulsory insurances are public liability insurance for riding establishments and for private individuals owning dangerous wild animals or dogs.
- Professional indemnity insurance is compulsory for certain professions, e.g. solicitors and insurance intermediaries.

Legislation concerning third parties

- The Contracts (Rights of Third Parties) Act 1999 sets out the circumstances in which a third party will have a right to enforce a term of the contract.
- The Third Parties (Rights Against Insurers) Act 2010 protects insurance proceeds from the effects of insolvency.

Question answers

9.1 b. Employers' liability.

Self-test questions

1. Which of the following is **not** a type of compulsory insurance in the UK?
   a. Public liability insurance for riding establishments. ☐
   b. Employers' liability insurance. ☐
   c. Travel insurance. ☐
   d. Motor insurance. ☐

2. What type of insurance are insurance intermediaries required to hold?
   a. Professional liability insurance. ☐
   b. Public liability insurance. ☐
   c. Public indemnity insurance. ☐
   d. Professional indemnity insurance. ☐

3. Which concept is reformed by the Contracts (Right of Third Parties) Act 1999?
   a. Estoppel. ☐
   b. Privity of contract. ☐
   c. Proximate cause. ☐
   d. Subrogation ☐

You will find the answers at the back of the book

10
Statutory regulation

Contents	Syllabus learning outcomes
Introduction	
A UK regulatory framework	*11.5*, *11.6*
B Prudential Regulation Authority (PRA)	*11.5*, *11.6*
C Financial Conduct Authority (FCA)	*11.5*, *11.6*
D Application of PRA and FCA rules	*11.5*, *11.6*
E Discipline and enforcement	*11.7*
F Authorisation and regulation of insurers	*11.4*, *11.10*
G Authorisation and regulation of intermediaries	*11.4*, *11.8*
H Insurance: Conduct of Business Sourcebook (ICOBS)	*11.8*, *11.9*
I Insurance Distribution Directive (IDD)	*11.8*
J Money laundering	*12.2*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- explain the role of the financial services regulators in the authorisation, supervision and regulation of insurers and intermediaries;
- explain the basic powers of the Financial Conduct Authority (FCA) for the authorisation, supervision and regulation of intermediaries;
- explain the concept of the regulators' principles for businesses and Senior Managers & Certification (SM&CR) regime;
- state the consequences of non-compliance with PRA/FCA rules;
- describe the reporting requirements for FCA-regulated firms; describe the reporting requirements for FCA-regulated firms;
- explain the capital adequacy requirements of the PRA;
- describe the scope of the Insurance: Conduct of Business (ICOBS) rules; and
- define money laundering and discuss the relevant legislation in place to combat it.

Introduction

The effectiveness of any form of regulation depends on the general willingness of society to obey the law and respect the sanctions which the regulatory body enforces. Statutory regulation takes the form of statutes (i.e. laws) governing aspects of the transaction of insurance. In this section, we look at the regulatory structures in place in the UK governing insurance companies, and some of the key pieces of legislation which are applicable to intermediaries and insurers.

Key terms

This chapter features explanations of the following terms and concepts:

Approved persons	Authorisation	Capital adequacy	Conduct risk
Controlled functions	Fair treatment of customers	Financial Conduct Authority (FCA)	Insurance: Conduct of Business Sourcebook (ICOBS)
Money laundering	National Crime Agency (NCA)	Principles for Businesses (PRIN)	Prudential Regulation Authority (PRA)
Retail Mediation Activities Return (RMAR)	Solvency II	Solvency margin	

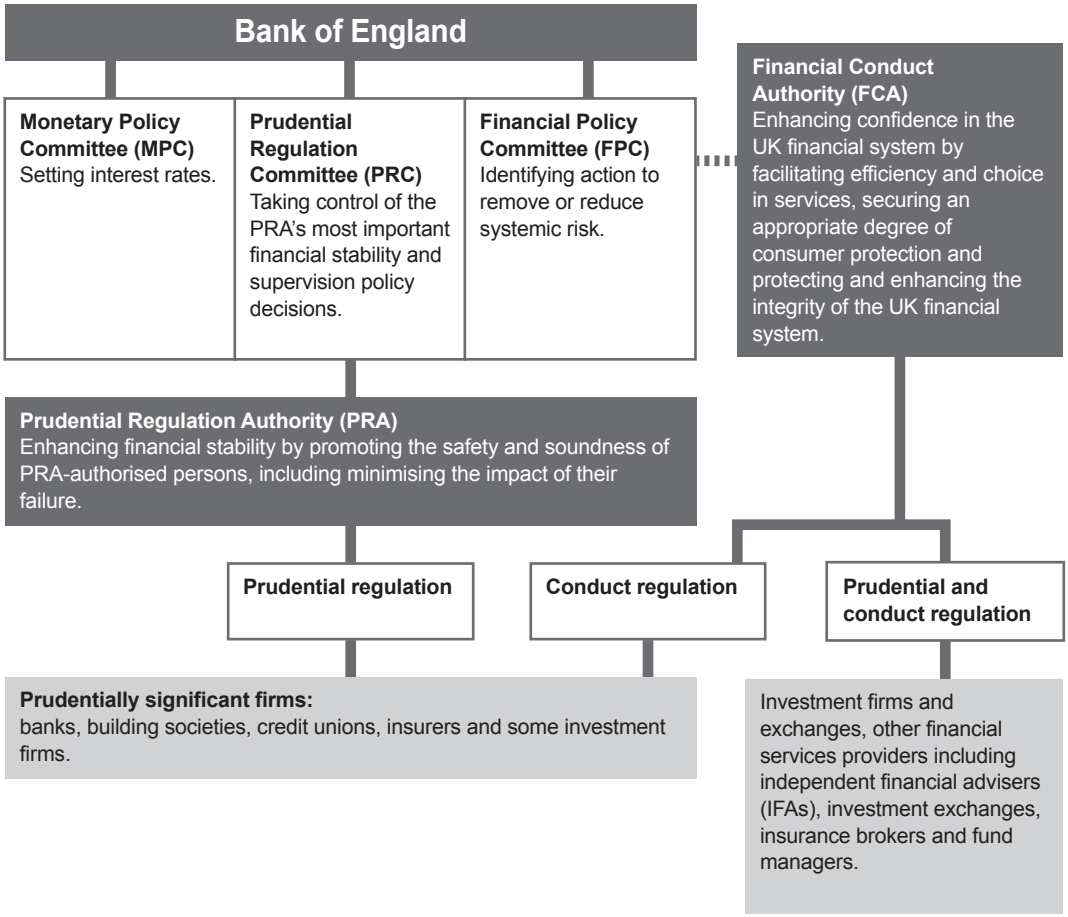
A UK regulatory framework

Since 1 April 2013, financial services regulation has been the responsibility of the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA).

- The ***Prudential Regulation Authority (PRA)*** is part of the Bank of England and is responsible for the stability and resolvability of systemically important financial institutions such as banks, building societies and insurers. It will not seek to prevent all firm failures but seeks to ensure that firms can fail without bringing down the entire financial system. The PRA also places emphasis on a 'judgment-based' approach to supervision focusing on the external environment, business risk, management and governance, risk management and controls, and capital and adequacy.
- The ***Financial Conduct Authority (FCA)*** is responsible for conduct of business and market issues for all firms including insurers, and prudential regulation of small firms (e.g. insurance brokers and financial advisory firms). The FCA is focused on taking action early in order to protect consumers. It will use thematic reviews and market-wide analysis to identify potential problems in areas like financial incentives. The FCA will also review the full product life cycle from design to distribution with the power to ban products where necessary.

A third body, the **Financial Policy Committee (FPC)** within the Bank of England, is responsible for monitoring emerging risks to the UK financial system as a whole and providing overall strategic direction for the entire regulatory regime.

The **Bank of England and Financial Services Act 2016** put the Bank of England at the heart of UK financial stability by strengthening the Bank's governance and ability to operate more effectively as 'One Bank'. The PRA became part of the Bank, ending its status as a subsidiary, and a new **Prudential Regulation Committee (PRC)** has been established. The PRC operates alongside the other two Bank committees, namely the FPC and the Monetary Policy Committee (MPC).



B Prudential Regulation Authority (PRA)

The PRA is responsible for the prudential regulation of all 'systemically important firms', defined as those firms that pose a risk to the financial system if they were to fail. It is responsible for the regulation of all institutions that accept deposits or which accept insurance contracts. This means that the PRA authorises and supervises all banks, building societies, credit unions, general insurers and life insurers.

B1 PRA objectives

The PRA has two primary objectives:

- To promote the safety and soundness of the firms it regulates.
- Specific to insurance firms, to contribute to ensuring that policyholders are appropriately protected.

It also has one secondary objective:

- To facilitate effective competition in the markets for services provided by PRA-authorised firms.

B2 Threshold Conditions

The Threshold Conditions are the minimum requirements that firms must meet in order to be permitted to carry on regulated activities. The PRA is responsible for those Threshold Conditions designed to promote safety and soundness. At a high level, they require:

- a firm's head office, and in particular its mind and management, to be in the UK;
- a firm's business to be conducted in a prudent manner and that the firm maintains appropriate financial and non-financial resources;
- the firm itself to be fit and proper and appropriately staffed; and
- the firm and its group to be capable of being effectively supervised.

Firms must ensure that they meet the Threshold Conditions at all times. The PRA will assess firms against them on a continuous basis.

B3 Judgment-led regulation

The PRA's judgment-led approach to supervision is characterised by a move away from rules and a focus on forward-looking analysis, including an assessment of how a firm would be resolved if it were to fail, the impact this would have on the system as a whole and the use of new public funds. The aim is therefore to 'pre-empt risks before they crystallise'. Central to the approach is a risk assessment framework.

B4 Risk assessment framework

The framework operates in a way that reflects the PRA's additional objective to protect policyholders as well as the financial system. The framework captures three elements:

- The **potential impact** on policyholders and the financial system of a firm coming under stress of failing.
- How the **macroeconomic and business risk** context in which a firm operates might affect the viability of its business model.
- **Mitigating factors**, including risk management, governance and financial position (e.g. solvency position and resolvability).

B4A The intensity of supervision

The intensity with which firms are supervised depends on their level of riskiness related to these three areas.

A small firm, for example, will not pose a great threat to the wider financial market should they fail from an isolated risk. However, all firms face at least a '**baseline level of monitoring**'. This will involve:

- ensuring compliance with prudential standards for capital;
- liquidity, asset valuation, provisioning and reserving;
- at least an annual review of the risks posed by firms or sectors to the PRA's objectives;
- examining individual firms when a risk crystallises; and
- assessing a firm's planned recovery actions and how it might exit the market.

B5 Proactive Intervention Framework (PIF)

The PRA's judgment about proximity to failure will be captured in the firm's position within the Proactive Intervention Framework (PIF). Judgments about a firm's proximity to failure are derived from those elements of the supervisory assessment framework that reflects the risks faced by a firm and its ability to manage them – namely, external context, business risk, management and governance, risk management and controls, capital and liquidity.

There are five clearly demarcated PIF stages, each denoting a different proximity to failure, and every firm will sit in a particular stage at each point in time. As a firm moves to a higher PIF stage – i.e. as the PRA determines that the firm's viability has deteriorated – supervisors will review their supervisory actions accordingly. Senior management of firms are expected to ensure they take appropriate remedial action to reduce the likelihood of failure and the authorities will ensure appropriate preparedness for resolution.

B6 Firms' culture and prudential supervision

The PRA expects insurers to have a culture that supports their prudent management. Good prudential management must be pursued by all individuals working in an insurance company not just senior staff. However, the PRA has 'no right culture in mind' when making judgments about firms. The PRA focuses instead on 'whether boards and management clearly understand the circumstances in which the insurer's solvency and viability come into question, whether accepted orthodoxies are challenged, and whether action is taken to address the risks on a timely basis'.

The PRA's supervisory approach suggests that firms will face increased scrutiny the more their organisational culture fails to demonstrate a strong, joined up model to managing the prudential risks related to their business. Supervisors will assess risks using expertise and judgment rather than box-ticking. It is, therefore, up to firms to show how their organisation is managing prudential risks appropriately – no one approach to risk management will be right for everyone. If firms fail to do this they could find themselves facing greater intervention as they move up the PIF.

B7 Regulation of Lloyd's

The PRA is the lead regulator for Lloyd's as a whole although the FCA takes responsibility for certain conduct of business issues. Legislation confirms that the Society of Lloyd's and Lloyd's managing agents are dual-regulated firms (i.e. regulated by the PRA for prudential risks, and the FCA for conduct risks) and that Lloyd's members' agents and Lloyd's brokers are FCA-regulated firms.

C Financial Conduct Authority (FCA)

C1 FCA objectives

The FCA's overarching strategic objective is to **make sure the relevant markets function well**.

It has three operational objectives:

- **Consumer protection**: securing an appropriate degree of protection for consumers.
- **Integrity**: protecting and enhancing the integrity of the UK financial system.
- **Competition**: promoting effective competition in the interests of consumers.

C2 Approach to regulation

C2A Product intervention and governance

The FCA is more proactive than the FSA and intervenes at an earlier stage to pre-empt and prevent widespread harm to consumers. Powers include temporary intervention rules and product pre-approval.

C2B Super-complaints

The FCA is able to review and react to detailed submissions by consumer groups. Previously only the Office of Fair Trading (OFT) could receive these super-complaints highlighting systematic problems in particular markets. Previous submissions have led to enquiries from the Competition Commission into payment protection insurance (PPI) and extended warranties.

The **Competition and Markets Authority (CMA)** obtained its full powers on 1 April 2014. Its aim is to promote fair competition for the benefit of consumers both within and outside the UK. It supersedes and brings together the functions of the Competition Commission and the consumer functions of the OFT.

C2C Competition powers

The FCA's competition objective – to promote effective competition in the interests of consumers – will mean:

- firms must compete for business by offering better services, better value and types of products that customers want and need;
- prices offered are in line with costs; and
- firms will innovate and develop new products over time: the FCA will draw a distinction between 'good' innovation that meets consumers' genuine needs and other types that exploit consumers.

C3 Approach to supervision

C3A General principles

Refer to

Refer to *Fair treatment of customers* on page 10/9 for more on the fair treatment of customers

The FCA requires all firms to meet its high-level Principles for Businesses (PRIN), including the **fair treatment of customers**, as well as comply with more detailed rules in specific areas. More information on PRIN and other aspects of the FCA Handbook can be found in *Application of PRA and FCA rules* on page 10/8. Guidance has also been issued which is

available on the FCA website. The FCA aims to act more quickly and decisively, and attempts to address issues before they cause harm.

C3B Supervisor organisation

This approach requires a flexible focus on bigger issues as they emerge, either in individual firms or across sectors. This means that some firms might be supervised with a dedicated supervision team whilst others will be supervised as part of a portfolio. As of 2020, the FCA supervised over 59,000 firms.

C3C Supervisory work

There are eight core principles which guide the FCA's supervisory work:

- Forward-looking.
- A focus on firm strategy and business models.
- A focus on culture and governance.
- A focus on individual as well as firm accountability.
- Proportionate and risk-based
- Two-way communication.
- Coordinated.
- Putting right systematic harm that has occurred and stop it happening again.

C3D Supervision model

The supervision model is based on three types of work and applies to all firms:

- **Proactive** – pre-emptive identification of harm through review and assessment of firms and portfolios: this includes business model analysis and reviewing the drivers of culture.
- **Reactive** - dealing with issues that are emerging or have happened to prevent harm growing.
- **Thematic** – wider diagnostic or remedy work where there is actual or potential harm across a number of firms.

C3E The FCA's approach to supervising small firms

Small firms receive will generally receive less contact from the FCA in comparison to larger, higher risk firms.

To support the small firms, the FCA makes increasing use of roadshows and workshops and any visits are usually as a result of thematic reviews, whistle-blowing or other information which may have come to light.

While the supervision of small firms is relatively light-touch by comparison to larger firms, the degree of intrusiveness from the regulator depends on the ability of small firms to evidence best practice in the interests of customers. Similar to large firms then, small firms must consider the appropriateness of employees' training and competence, the governance of incentive schemes, and the kinds of systems and controls necessary to resolve potential conflicts of interest if they want to successfully navigate the current regulatory regime.

On the Web
www.fca.org.uk/publication/corporate/our-approach-supervision.pdf

C4 Intervention

The FCA has powers to intervene to prevent detriment occurring. The Financial Services Act 2012 confirmed a number of regulatory initiatives to shift the balance from tackling the symptoms of consumer detriment to the 'root causes'.

Here are some examples:

- Where the FCA identifies a serious problem with a product or service feature, it is able to take timely and necessary steps to ban it. Legislation enables the FCA to make temporary product intervention rules in the retail sector without prior cost-benefit analysis or consultation valid up to twelve months.
- The FCA is able to take action in relation to misleading financial promotions.
- The FCA is able to vary the permissions granted to firms.
- The FCA is also able to disclose the fact that enforcement against a firm or individual has commenced.

The FCA is required to alert a firm of its proposed course of action and to allow for, and consider representations by, firms before publishing any details of its action. The FCA is only allowed to use its product intervention powers in relation to retail customers.

C5 Publication of enforcement action

The FCA takes a very proactive approach to enforcement by pressing for tough penalties for offenders and being willing to pursue cases against individuals, including senior management. The FCA is allowed to publish the fact that a warning notice had been issued about a firm as well as making a summary of the notice publicly available. This power is also available to the PRA.

In making a decision about whether or not to disclose the warning notice, the regulator must consider a number of factors, including whether publication of the information would be unfair to the person to whom the warning notice relates.

C6 Market intelligence gathering and research

The FCA's Policy, Risk and Research Division combines research into what is happening in the market and to consumers with better analysis of the types of risks where they appear. It is intended to be the 'radar' of the organisation. It is designed to identify and assess risks to consumers, create a common view to inform the FCA's supervision, enforcement and ***authorisation*** functions. While relying on existing sources for evidence, including consumer groups, the media and ongoing market monitoring and analysis, the FCA also makes use of the consumer action line.

C7 Authorisation and approvals

The FCA's authorisation function focuses on the proposed business model, governance and culture, as well as the systems and controls the firm intends to put in place, especially over:

- product governance;
- end-to-end sales processes; and
- prevention of financial crime.

The FCA also works closely with the PRA in considering applications to approve individuals to roles which have a material impact on the conduct of a firm's regulated activities. The FCA assesses whether applicants have a good understanding of how to ensure good outcomes through corporate culture, conduct risk management and product design.

C8 Accountability

The FCA is required to report annually to Government and Parliament. The FCA's work is overseen by a board appointed by government with a majority of non-executive directors.

The Financial Services Act 2012 contains a provision for independent reviews on the efficiency and effectiveness of the FCA's use of resources. There is also a requirement for the FCA to make a report to the Treasury in the event of a regulatory failure and where this failure was due to the FCA's actions.

C9 Engagement with consumers

The FCA seeks to build a better understanding of consumer behaviour, needs and experiences to shape how it designs its interventions. The FCA also engages more with consumers directly through social media, consumer bodies, road shows, focus groups and face-to-face contact. The FCA collects and analyses consumer information from other sources such as complaints, including those investigated by the FOS, and external, academic and public interest research.

C10 Transparency and disclosure

The FCA is required to have in place four statutory panels representing the views of consumers, regulated firms, smaller regulated firms and market practitioners. The FCA has continued to build on the FSA's approach to consultation as part of the rule-making process and is seeking to develop more effective ways of getting feedback on proposals, including those from consumers and their representatives. The FCA publishes more information about its views on markets (key trends, products and services) and the comparative performance of a firm.

D Application of PRA and FCA rules

The FCA Handbook and PRA Rulebook contain the high-level principles which apply both to insurers and intermediaries. We will see that there are some rules that are specific to each category when we come to consider the more detailed rules. In the following sections we will summarise the main high-level rules that are relevant to all general insurance organisations. Each of these is a rulebook in its own right.

D1 Principles for Businesses (PRIN)

There are eleven principles of good business practice that must be met. They are as follows:

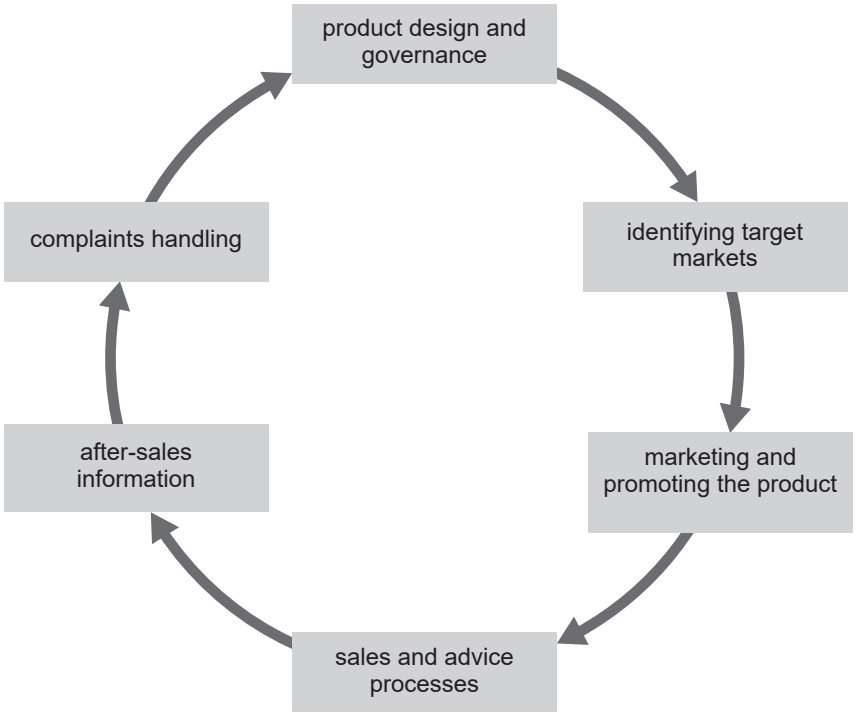
Principles for Businesses (PRIN)	
Principle	**Detail**
1. Integrity	A firm must conduct its business with integrity.
2. Skill, care and diligence	A firm must conduct its business with due skill, care and diligence.
3. Management and control	A firm must take reasonable care to organise and control its affairs responsibly and effectively, with adequate risk management systems.
4. Financial prudence	A firm must maintain adequate financial resources.
5. Market conduct	A firm must observe proper standards of market conduct.
6. Customers' interests	A firm must pay due regard to the interests of its customers and treat them fairly.
7. Communications with clients	A firm must pay due regard to the information needs of its clients, and communicate information to them in a way which is clear, fair and not misleading.
8. Conflicts of interest	A firm must manage conflicts of interest fairly, both between itself and its customers and between a customer and another client.
9. Customers: relationships of trust	A firm must take reasonable care to ensure the suitability of its advice and discretionary decisions for any customer who is entitled to rely upon its judgment.
10. Clients' assets	A firm must arrange adequate protection for clients' assets when it is responsible for them.
11. Relations with regulators	A firm must deal with its regulators in an open and cooperative way, and must disclose to the FCA appropriately anything relating to the firm of which that regulator would reasonably expect notice.

Note: The PRA applies Principles 1 to 4, 8 and 11 only. © Financial Conduct Authority

Separate sections in the FCA Handbook and PRA Rulebook develop each of these themes more fully. Some principles are expected to be embedded in a firm's operations and procedures, e.g. the fair treatment of customers.

D2 Fair treatment of customers

The FCA expects authorised firms to embed the fair treatment of customers principle in their corporate strategy and build it into their firm's culture and day-to-day operations. This means addressing the fair treatment of customers throughout the product life cycle, as illustrated in the following diagram.



There are six positive consumer outcomes that firms should strive to deliver to ensure the fair treatment of customers:

- **Outcome 1**: Consumers can be confident they are dealing with firms where the fair treatment of customers is central to the corporate culture.
- **Outcome 2**: Products and services marketed and sold in the retail market are designed to meet the needs of identified consumer groups and are targeted accordingly.
- **Outcome 3**: Consumers are provided with clear information and are kept appropriately informed before, during and after the point of sale.
- **Outcome 4**: Where consumers receive advice, the advice is suitable and takes account of their circumstances.
- **Outcome 5**: Consumers are provided with products that perform as firms have led them to expect, and the associated service is of an acceptable standard and as they have been led to expect.
- **Outcome 6**: Consumers do not face unreasonable post-sale barriers imposed by firms to change product, switch provider, submit a claim or make a complaint.

It is the role of firms to ensure that they implement procedures to achieve these outcomes.

In essence, the initiative is simple – firms must focus on delivering the six outcomes and recording evidence that they are doing so. In practice, this means firms should:

- look at their business and identify all of the outcomes that are relevant to them; and
- ensure they have appropriate systems in place – using management information or other sources – to measure whether they are delivering all the identified outcomes. Firms may find it helpful to consider where there are specific risks when they are assembling their evidence, look at what the evidence is telling them – and act on it.

Evidence could come in a variety of forms, for example, conventional management information, results of compliance checks, senior management assessments of call-centre

traffic or press coverage. In fact, anything that provides sound and reliable information on whether a firm is treating its customers fairly could, in principle, be used as evidence. The evidence does not necessarily have to be structured around the customer outcomes, but firms must be able to demonstrate through their evidence that they are delivering those outcomes.

The FCA introduced new rules (PROD 4) in October 2018 covering the development, distribution and life cycle of new products as a result of the Insurance Distribution Directive, which we look at in *Insurance Distribution Directive (IDD)* on page 10/27.

Consider this…
You are looking at developing and selling personal possessions cover for people in residential care homes. What would you need to consider to ensure you deliver fair outcomes for customers?

D2A Ethical behaviour and delivering positive customer outcomes

The principles set by the FCA reflect the professional and ethical standards that should guide everyone in the financial services industry. However, it's vitally important that customers have confidence that they are dealing with people who are putting their interests first; not because they have to, but because they believe it's the right thing to do.

Vulnerable customers
Financial services firms also have a duty to protect vulnerable customers for which the FCA has issued finalised guidance, available at

www.fca.org.uk/publication/finalised-guidance/fg21-1.pdf.

The **Financial Vulnerability Taskforce** is a newly-created independent professional body covering the insurance and wider financial sectors. Its objective is to promote greater understanding, encourage appropriate behaviours and establish good outcomes in respect of customer vulnerability.

Its resources can be found at *www.fvtaskforce.com/resource-library*.

The CII Code of Ethics (see *The CII Code of Ethics: an overview* on page 11/8) provides members of the insurance profession with a framework in which to apply their role-specific technical knowledge in delivering positive consumer outcomes. Under the fifth 'Core duty' within the Code, members are required to: 'treat people fairly regardless of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation'.

Delivering a positive customer outcome is not just about treating the customer fairly or giving special thought to those who may be vulnerable for whatever reason. It is about thinking about the customer's whole situation when discussing a product or providing advice, to ensure that the end result is positive.

Question 10.1

At which stage of a policy's lifecycle does the Financial Conduct Authority expect an insurer to treat the customer fairly?

a. At the proposal stage. ☐

b. At inception of the policy. ☐

c. At the time of a claim. ☐

d. During the whole lifecycle. ☐

D3 Senior management arrangements, systems and controls (SYSC)

In the next few sections, we will focus on a few key areas of the **senior management arrangements, systems and controls (SYSC)** section of the FCA Handbook, including:

- the **Senior Managers and Certification Regime (SM&CR)**, which has replaced the Approved Persons Regime (APER); and
- requirements around whistle-blowing, in line with the **Public Interest Disclosure Act 1998 (PIDA)**.

D4 Threshold Conditions

Refer to
Refer back to *Threshold Conditions* on page 10/3 for the PRA's Threshold Conditions

These rules relate to conditions that must be met when becoming authorised and subsequently maintained. They are concerned with:

- the legal status of the organisation;
- the location of its offices;
- close links (concerned with the nature of controlling interests by persons or organisations);
- the adequacy of resources; and
- issues that relate to suitability of the person or firm to be, and remain, authorised.

D5 Senior Managers and Certification Regime (SM&CR)

The **Senior Managers and Certification Regime (SM&CR)** started on 7 March 2016, came into force for insurers on 10 December 2018, and all remaining FSMA authorised firms were brought into scope for this regime from 10 December 2019. This new regime is the result of changes required by ***Solvency II*** and the regulators' intention to bring insurance into line with new banking supervision rules.

The SM&CR introduced a new regulatory framework for individual accountability to replace the Approved Persons Regime (APER). It focuses on the most senior individuals in firms who hold key roles or have overall responsibility for whole areas of relevant firms. Firms are required to:

- ensure each senior manager has a **Statement of Responsibilities**, setting out the areas for which they are personally accountable;
- produce a 'Responsibilities Map' that knits these together; and
- ensure that all senior managers are pre-approved by the regulators before carrying out their roles.

The Government also introduced a 'duty of responsibility', which means senior managers are required to take the steps that it is reasonable for a person in that position to take, to prevent a regulatory breach from occurring. This formed part of the **Bank of England and Financial Services Act 2016**. The SM&CR is likely to result in greater disciplinary action on individuals should governance controls be lacking in the business area for which they are responsible.

Firms are split into three categories, to ensure that the regime is flexible and proportionate.

- '**Core**': applies to the majority of firms.
- '**Enhanced**': carries increased obligations, and applies to larger and more complex organisations.
- '**Limited scope**': more light-touch, with fewer obligations than core and enhanced.

SM&CR is formed of **three key pillars**:

- Senior Managers Regime.
- Certification Regime.
- Conduct Rules.

D5A Senior Managers Regime (SMR)

The Senior Managers Regime (SMR) applies to persons performing the most senior roles in a firm – 'senior managers'. These roles, known as **senior management functions** (**SMFs**), have been specified in rules made by the PRA and FCA. Any firms planning a new senior manager appointment, or a material change in role for currently approved individuals, must prepare and submit an application to the regulators for approval.

The SMR has a broader scope than the previous Approved Persons Regime (APER), with new roles including:

- **Head of key business area** – this relates to individuals managing a business area so large (relative to the size of the firm) that it could jeopardise the safety and soundness of the firm, and so substantial in absolute terms that it would warrant a separate SMF – even though the individual performing it may report to the CEO or another SMF.
- **Group entity senior manager** – individuals employed in another group entity or parent company who can exercise significant influence over the firm's affairs.
- **Significant responsibility function** – senior executives responsible for certain functions or business areas where key risks exist, but not currently categorised under a significant management function.

The SMFs are prescribed by the PRA and the FCA, and for each regulatory body are split into Executive and Non-executive – these are listed in the table below.

PRA	FCA
Executive	
• Chief executive function. • Chief finance function. • Chief risk function. • Head of internal audit. • Head of key business area. • Group entity senior manager.	• Executive director. • Significant responsibility senior manager. • Money laundering reporting officer or nominated officer. • Compliance oversight.
Non-executive	
• Chairman. • Chair of the risk committee. • Chair of the audit committee. • Chair of the remuneration committee. • Senior independent director.	• Non-executive director. • Chairman of the nominations committee.

A **Statement of Responsibilities (SoR)** should be prepared for each senior manager, setting out their responsibilities in managing the firm's affairs – this should include the appropriate **Prescribed Responsibilities** as set out by the FCA. It should be complemented by the individual's CV, personal development plan, job description, organisation chart showing reporting lines and the firm's responsibilities map.

A responsibilities map sets out the firm's management and governance arrangements, including reporting lines and responsibilities. Extending the principle of proportionality, the FCA distinguishes between large and small firms, and acknowledges that in the latter the map will be a simple document.

D5B Certification Regime

The Certification Regime (CR) applies to individuals who are not carrying out SMFs, but whose roles have been deemed capable of causing significant harm to the firm or its customers by the regulators. The CR requires firms to assess the fitness and propriety of persons performing other key roles, and to formally certify this at least annually. These 'significant harm function' roles are also specified by the regulators in rules but the appointments are not subject to prior regulatory approval.

Within a firm, a senior manager must be allocated the responsibility for the Certification Regime, and will be personally accountable for how it is managed.

Unlike the SMR, which applies to roles overseas with an impact on a firm's UK strategy, the CR generally only applies to UK-based employees (with the exception of those categorised as 'material risk takers' or those dealing with UK clients).

D5C Conduct Rules

Under SM&CR, the regulators have the power to make Conduct Rules, which will apply to senior managers, certified persons and other employees. For senior managers (and other approved persons), these rules replace the Statements of Principle made under APER.

There are two tiers of Conduct Rules:

1. **Individual Conduct Rules** – rules which apply to most employees within a firm.
2. **Senior Manager Conduct Rules** – rules which only apply to SMs.

D6 The Fit and Proper test (FIT) for employees and senior personnel

An individual in senior management or a certified position under SM&CR must be (and remain) **'fit and proper'** for their function. This means that they must be tested with regard to their:

- honesty, integrity and reputation;
- competence and capability; and
- financial soundness.

This reflects the position under the previous regime, although the onus is now on the firm to determine whether an individual is fit and proper for the role. To ensure that individuals meet the appropriate standards, authorised firms will carry out such measures as credit enquiries, bankruptcy and County Court judgment checks, and references from all previous employers in the last six years, while the regulator also carries out its own monitoring in these areas.

There is a requirement for firms to assess relevant employees at the point where their application is prepared for submission, and for there an annual re-certification process in place.

D7 Public Interest Disclosure Act 1998 (PIDA)

The **Public Interest Disclosure Act 1998 (PIDA)** concerns ‘whistle-blowing’, which is the public allegation of a firm’s concealed misconduct, usually from within the same organisation. It lists a wide range of possible illegal or criminal activities known as ‘protected disclosures’. Guidance on its application to regulated firms’ relationships with the regulator (but not guidance on all the terms of the Act) is provided in SYSC, which applies to all regulated firms.

The Act was born out of a desire to encourage a culture of openness within an organisation on the basis that prevention is better than cure. PIDA states that individuals who make qualifying disclosures of information in the public interest have the right not to suffer detriment by any act or omission of their employer because of the disclosure.

A qualifying disclosure is one which, in the reasonable belief of the worker, tends to show that one or more of the following has been, is being, or is likely to be committed:

- A criminal offence.
- A failure to comply with any legal obligation.
- A miscarriage of justice.
- The putting of the health and safety of any individual in danger.
- Damage to the environment.
- Deliberate concealment relating to any of the above.

PIDA protects those who make such a disclosure to their employer, provided it is made in good faith. Firms are encouraged by the FCA to adopt appropriate internal procedures encouraging workers to blow the whistle internally when they are concerned about compliance-related matters. However, a wise employer would not restrict this solely to regulatory issues.

For a larger firm, such appropriate internal procedures may include a statement of intent that the firm takes failures seriously and which indicates what it regards as a failure. Written

procedures should show respect for the confidentiality of workers who raise concerns and describe how such concerns may be raised (outside the usual management structure and, if necessary, outside the firm). The firm should consider offering access to an external body, such as an independent charity, for advice. The procedures should also describe the penalties for making false and malicious allegations and ensure that once a worker has made a protected disclosure they are not victimised. In addition, they should make whistle-blowing procedures accessible to staff of key contractors.

A less wide-ranging set of procedures may be appropriate for smaller firms.

E Discipline and enforcement

The PRA and FCA have a range of measures and sanctions available in their enforcement and disciplining of individuals and firms. A number of new powers were invested in the regulators under the Financial Services Act 2012 as outlined in *Proactive Intervention Framework (PIF)* on page 10/4 and *Intervention* on page 10/6.

We will consider the actions the PRA could take against an insurer that fails to meet minimum ***capital adequacy*** requirements in *Intervention* on page 10/19 and *Winding-up* on page 10/19. Here we will look at the disciplinary measures available in general terms. These measures include financial penalties, public censure and public statements. In addition, there are civil remedies and, even, criminal prosecution. These are valuable measures because they show that regulatory standards are taken seriously and are being upheld, thus helping to maintain market confidence. They may also act as a deterrent against financial crime.

E1 Public censure

Where the FCA considers that the firm has failed to meet a requirement imposed on it under the Financial Services Act 2012, it may issue a public statement of misconduct on an approved person. The FCA may indicate its intention by first giving a warning notice to that person. It may use this approach where it considers a financial penalty to be inappropriate or, possibly, in addition to a financial penalty.

Consider this…
Why would public censure be an effective punishment?

Public censure would draw the public's attention to the firm's or approved person's misconduct, damaging their reputation. This could hinder the future success of the firm or individual.

E2 Financial penalties

The FCA may impose financial penalties on a firm itself where the firm has contravened a requirement of the Financial Services Act 2012 or on an approved person guilty of misconduct. The seriousness of the offence and the extent to which misconduct may have been deliberate or reckless will influence the regulator in determining the penalty. In its calculations it will also take into account the:

- resource level of the person in contravention; and
- amount of profit accrued or loss avoided as a result of the contravention.

Other circumstances will also be considered, such as:

- the conduct of the firm or person following the contravention;
- their disciplinary record; and
- their compliance history or other relevant history in relation to their dealings with the regulator.

Example 10.1
Recent examples in the insurance sector include a fine of £29.1m against The Carphone Warehouse (March 2019) for mis-selling mobile phone insurance, and a fine of just under £5.3m against Liberty Mutual Insurance Europe SE for issues relating to complaints handling, culture and governance, and the unfair treatment of customers (October 2018).

E3 Prosecution for criminal offences

The FCA also has the power to bring criminal prosecution proceedings against individuals for a wide range of offences in England, Wales and Northern Ireland. These include:

- carrying on a regulated activity without authorisation;
- failing to cooperate with, or giving false information to, the regulator's appointed investigators;
- failing to comply with provisions about control over authorised persons;
- providing false or misleading information to an auditor; and
- misleading the regulator.

There are guidelines in place for cases of mutual interest to the FCA and other agencies such as the Serious Fraud Office, Crown Prosecution Service and Association of Chief Police Officers in Scotland. These guidelines exist to assign the correct investigative agency, enable cooperation between agencies, prevent undue duplication of work and avoid subjects of proceedings being treated unfairly for unwarranted involvement of more than one agency.

E4 Civil and less formal remedies

The FCA may take civil or regulatory action, such as:

- injunctions;
- restitution;
- withdrawal or variance of approval;
- cancellation of permission;
- withdrawal of authorisation; and/or
- prohibition of individuals from carrying out functions in connection with regulated activities.

It is possible that the FCA may issue a formal caution rather than prosecute an offender. If so a record of the caution is kept by the FCA, but it is not published.

The FCA may consider that disciplinary action is inappropriate. However, because of an inability to meet minimum standards or doubts about the fitness or propriety of an approved person, it may feel that some remedial action is necessary. In these circumstances it may decide to:

- vary or cancel the permission of a firm;
- withdraw its terms of authorisation;
- withdraw an individual's status as an approved person; or
- on a more limited basis, withdraw approval for the performance of a specified function.

In the case of minor transgressions the regulator may issue a private warning. In this case nothing would be made public but it is possible that the FCA may take such issues into account when deciding upon any action for future breaches.

Be aware
In rare circumstances the FCA may even ask a firm to **voluntarily** apply for a requirement to be imposed (see *www.fca.org.uk/publication/requirement-notices/wonga-vreq.pdf*).

F Authorisation and regulation of insurers

Any UK-domiciled company wishing to transact insurance in the EU must be authorised to do so by the PRA. To gain this authorisation, the PRA must be satisfied that the company complies with its requirements. The objective is that only companies operated by 'fit and proper' persons should be authorised to transact business. In brief, the PRA has the power to authorise a company to transact general business, and can also restrict authorisation to specific classes of general insurance, such as accident, damage to property or general liability.

When a UK-based insurance company decides that it wishes to transact insurance, it has to complete and submit detailed forms to the PRA. The information given on these forms is

used by the PRA to satisfy itself that the company is financially sound, that its markets, administration and premium structure are sound and that its key personnel are 'fit and proper' persons. The Insurance: Conduct of Business Sourcebook (ICOBS) rules apply to insurers.

Brexit

The UK voted to leave the European Union (EU) on 23 June 2016 and left on 31 January 2020. A transition period applied until 31 December 2020, during which the UK continued to follow all the EU's rules.

At 11pm on 31 December 2020, UK insurers lost their passporting rights to write insurance business in the European Economic Area (EEA). To continue servicing their EEA clients, many UK insurers decided to operate through their subsidiaries in the EEA, while the UK agreed to EEA companies continuing their activities in the UK as branches. Some European insurance regulators have recently challenged such arrangements, particularly where the new European operation was set up by the UK insurer purely to deal with EU insurance business post Brexit and it has no, or only a limited number of, employees physically present in the relevant EU Member State.

Regarding the run-off period for existing contracts, the UK has allowed EEA insurers a 15-year period to continue servicing such contracts with UK insureds. The matter is more complex for UK insurers' contracts with EEA insureds, as every EU State has implemented different rules which apply to UK insurers in its jurisdiction.

Negotiations about an equivalence regime between UK and EU insurance regulation started in March 2021 with the aim of establishing a Memorandum of Understanding (MoU). Both sides agree to the content of the MoU, but it has not been officially approved by the EU. The UK Government remains hopeful that the MoU will be signed off but two stumbling blocks remain – matters relating to the Northern Ireland Protocol and an internal EU debate about whether the MoU constitutes a discussion framework or a more formal arrangement for regulatory cooperation. If it is the latter, then EU institutions will want to play a role in determining the nature of that cooperation.

The matter is also uncertain because the EU has not confirmed its readiness to grant an equivalence regime. The main reason is the suggested, possible divergence by the UK from EU rules in the future.

Please note: This is the position at the time of publication. Any relevant changes that may affect CII syllabuses or assessments will be announced as they arise on the qualification update page for the unit.

Refer to

Refer to *Insurance: Conduct of Business Sourcebook (ICOBS)* on page 10/22 for the ICOBS rules

F1 Capital adequacy

Capital acts as a buffer to absorb unexpected losses. Having enough capital of sufficiently high quality therefore reduces the risk of a firm becoming unable to meet the claims of its creditors. Since capital is intended to provide the capacity to meet unforeseen losses, it is also crucial for maintaining the confidence of those creditors.

A ***solvency margin*** is the amount by which assets must exceed liabilities. Each company must maintain a minimum balance between its assets and how much it knows it has to pay or would be likely to pay in liabilities.

This is a dynamic area of change as a result of the **Solvency II** initiative set in motion in 2007, and finally implemented in January 2016. Solvency II replaced **Solvency I** (introduced in the early 1970s), which required a general insurer to calculate its solvency on two different bases. The greater of the two sums produced as a result was then used as the minimum solvency margin. One of these methods was to apply a scale of percentages to premiums and the other to apply a different scale to claims. Each was adjusted for reinsurance. The detail of these calculations is beyond the scope of the IF1 syllabus.

The design of Solvency I lacked risk sensitivity and did not capture key risks, including market, credit and operational risk. Enhancing the Solvency I requirements, the FSA introduced a risk-based approach to insurers' capital requirements, described as an enhanced capital requirement (ECR). The ECR was calculated by a non-life insurer by adding together:

- an **asset-related** requirement: a prescribed percentage determined by each type of admissible asset an insurer has, such as loans and shares; and
- an **insurance-related** requirement: a prescribed percentage determined by each class of business and calculated separately for net written premiums (total debited premiums less reinsurance costs) and technical reserves (these include elements such as current outstanding claims and unearned premium reserves).

From this total a deduction was allowed for any equalisation provision (these are amounts set aside by the insurer designed to smooth fluctuations in loss ratios for future years). Specific rules apply in determining its calculation.

Refer to
Refer to *Intervention* on page 10/19 for the regulator's powers of intervention

The ECR was designed to minimise the risk of an insurance company having insufficient funds to meet present and future claims. Where the minimum capital requirements (MCRs) prescribed are not maintained by a company, the regulator has powers of intervention.

Solvency II sets out a new, stronger EU-wide requirement on capital adequacy and risk management for insurers with the aim of increasing protection for policyholders. The strengthened regime should reduce the possibility of consumer loss or market disruption in insurance. Solvency II has the following three pillars:

- Pillar 1 – capital adequacy.
- Pillar 2 – systems of governance.
- Pillar 3 – supervisory reporting.

Be aware
Following the UK's departure from the European Union, there has been a review of the ongoing suitability of Solvency II for the UK insurance market.

On 20 July 2021, the PRA launched its Quantitative Impact Study, a data collection exercise which is seeking responses from insurance firms within three months. The responses will be used by the PRA to consider and understand the potential impact of reforms on different insurance sectors as well as the industry as a whole. Until this time, Solvency II regulation remains in place for UK PRA-regulated firms.

F1A Pillar 1 – capital adequacy

Pillar 1 covers the financial requirements that Solvency II imposes and defines the resources a company needs to be considered solvent, ensuring that a firm is adequately capitalised to deliver policyholder protection.

The Solvency II capital requirements include the following:

- **Solvency capital requirement** (**SCR**): the level of capital required to give 99.5% confidence that assets will be sufficient to cover liabilities over the following twelve months.
- **Minimum capital requirement** (**MCR**): the level of capital required to give the national supervisor 85% confidence that assets will be sufficient to cover liabilities over the following twelve months.

Firms that fall below their SCR will trigger the 'ladder of intervention', which consists of common European intervention tools aimed at recovering firms' solvency position within a set period of time. Firms which fall below the MCR will have a shorter period of time to recover their position, with the ultimate supervisory action being closure if the solvency position is not recovered.

Firms can calculate their capital requirements using one of the following:

Standard formula	Designed to capture the standard risks a firm may face and calculate the capital requirements to these risks. The standard formula categorises risks into risk modules for capital purposes. The risk modules are market risk, credit risk, underwriting risk (life and non-life) and operational risk.
Undertaking specific parameters	In some cases a firm may change the parameters on the standard formula to ones more appropriate to their business. This can only be applied to certain risks and needs to follow a set calculation process, with ultimate approval from the regulator.
Internal models	For complex firms, a full or partial internal model allows a more bespoke assessment of a particular business and its risk profile.

Any firm wishing to use an internal model or a partial model has to obtain prior approval of their model from the PRA. Lloyd's managing agents have to seek approval of their models from Lloyd's of London, who in turn get approval from the PRA.

F1B Pillar 2 – systems of governance

The **Own Risk and Solvency Assessment** (**ORSA**) is a set of processes and procedures that are used to identify, assess, monitor, manage and report the short- and long-term risks a (re)insurance company faces or may face. The ORSA also enables companies to determine the level of funds which would be necessary to ensure that their solvency needs are met. This new risk management process is a key part of pillar 2. It aims to assess, in a continuous and prospective way, the overall solvency needs related to the specific risk profile of the insurance company capturing non-quantifiable risk where capital is not necessarily the best measure.

ORSA information is reported to the supervisory authorities and will help inform their view of capital adequacy as part of the supervisory review process. The matching of own funds to the risk profile is meant to help promote a strong culture of risk management in a business.

F1C Pillar 3 – supervisory reporting

Solvency II introduces new public and regulatory (private) reporting. Pillar 3 has a key role to play in the Solvency II regime by ensuring greater transparency to encourage market discipline and is achieved by giving information to the regulator and the market in the form of public and private reports:

- **Solvency and Financial Condition Report (SFCR)** – this is public.
- **Regulator Supervisory Report (RSR)** – this is a private report between a firm and its national supervisor.

The disclosures contained in these reports will be both qualitative and quantitative. The RSR will provide an additional level of detail and granularity for private disclosure to the regulator over and above that required for public disclosure in the SFCR. For example, the results of the ORSA will be kept private in the RSR, in order to allow firms to conduct a fully transparent ORSA. However, how the process is undertaken and integrated into management in the decision-making of the company must be publicly disclosed in the SFCR.

Similarly, the RSR will include details and findings of audits performed, as well as the description of how the internal audit function operates and maintains its independence, which is required in the SFCR.

F2 Monitoring

The PRA needs to ensure that its standards, including capital requirements, are being maintained. Regular monitoring is, therefore, an important supervisory aspect of its work. Each financial year, every authorised insurance company must prepare and submit information, as part of the monitoring process, to the PRA.

Refer to
Refer back to *Pillar 3 – supervisory reporting* on page 10/18 for the required reports

However, with the implementation of Solvency II, insurers are obliged to provide a number of new reports. The SFCR and the RSR contain both **qualitative** and **quantitative** reports. The following table details the quantitative and qualitative reports required.

Sections covered in the quantitative reports	Sections covered in the qualitative reports
• Balance sheet. • Premium claims and expenses. • Own funds. • Variation analysis. • SCR and MCR. • Assets. • Technical provisions. • Reinsurance. • Group reporting.	• Business and performance. • System of governance. • Risk profile. • Valuation for solvency purposes. • Capital management.

Although qualitative reports are required annually, some quantitative reports are required quarterly. The PRA will also require additional ad hoc reporting as it has always done.

The PRA also expects firms with an approved internal model to report the model's outputs so they can supervise internal models on an ongoing basis. In order to do this, the PRA has developed templates that allow firms to capture outputs from different internal model structures. These templates recognise the differences in internal model structure and the main risk drivers between life and non-life insurance activities.

As Lloyd's is approved to use an internal model to calculate its SCR, the PRA expects it to report the internal model outputs produced by the managing agents for each syndicate it manages.

F3 Intervention

The idea of monitoring a company's performance is only of value if the PRA is also able to intervene if the monitoring process identifies problems. The PRA can and would intervene, for example, if a company failed to comply with the PRA's requirements – such as failing to maintain adequate solvency margins.

In addition, the PRA can intervene where, for example, the company has departed significantly from its original business plan. The PRA will take into account how close a firm is to failing when considering actions. Its judgment about a firm's proximity to failure will be captured in that firm's position within the PIF. In these and other cases, the PRA has various powers of intervention.

For example, the PRA can:

- restrict the company's premium income;
- require the company to submit accounts more frequently than yearly;
- require the company to provide further information;
- prevent the insurer from accepting new business;
- require a company to restore its capital position;
- impose requirements on the company's investment policy; and/or
- as a final sanction, withdraw authorisation.

The PRA does not rely entirely upon returns submitted by insurers; it also adopts a process of risk-based assessments.

F4 Winding-up

Ultimately, if an insurance company fails to meet its requirements, the PRA can intervene and the company can be wound-up (i.e. formally cease to operate).

G Authorisation and regulation of intermediaries

Despite this section's focus on intermediaries, many of the areas covered also apply to the sales and administration activities of insurers.

Any intermediary looking to undertake insurance mediation activities must become authorised or exempt. Certain types of insurance sale may be exempt from FCA regulation, such as extended warranty. Certain persons are also exempted under the FCA by virtue of their profession, e.g. solicitors.

The only exemption currently allowed is that of becoming an appointed representative.

Insurance mediation can be defined as the activities of introducing, proposing or carrying out other work preparatory to the conclusion of contracts of insurance, or of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim.

An **appointed representative (AR)** is a person or firm that is exempt from regulation because another authorised firm (the ***principal***) takes responsibility for them under a written contract. This contract must set out how the principal will control and monitor their activities and supervise them. The principal accepts complete responsibility for the actions of the AR, so the FCA does not authorise the AR directly. The principal must advise the FCA of the appointment, which will then add it to a register and approve its directors. If they are not added to the register they cannot undertake any activities for the principal.

The principal accepts responsibility for the monitoring of any insurance mediation activities, including the quality of any advice as well as the systems and controls operated by the AR. It also accepts responsibility for their training and competence. In practice, this means that the principal must physically audit files in order to establish that proper procedures are being followed.

The ICOBS rules apply to intermediaries.

G1 Record-keeping and reporting

The FCA requires the reporting of certain information so it can monitor a firm's regulatory position. The focus of this monitoring relies upon the completion by firms of a **Retail Mediation Activities Return (RMAR)** submitted via an online system named GABRIEL. The purpose of the RMAR is to provide a framework for the collection of information required by the FCA as a basis for its supervision activities. It also helps the FCA to monitor capital adequacy and financial soundness. In addition, firms are required to complete and submit a complaints return via an online form within 30 days of their accounting reference date and half year accounting reference date.

G2 Retail Mediation Activities Return (RMAR)

For small retail firms a set of detailed guidance notes has been produced by the FCA.

G2A Accounting information

The frequency of reporting for this section varies according to the type of firm and the amount of regulated income. Larger firms with higher incomes may be required to report more frequently (quarterly). The firm must supply details of its profit and loss and balance sheet and its assets and liabilities.

If the firm has ARs, it must include their income in with its own, as well as any complaints. ARs do not complete any returns to the FCA (they are completed by the principal firm).

The form also asks for details of client money – how it is held, the type of bank account and amounts involved.

G2B Regulatory capital

Whether or not the firm comes under the client money rules determines the percentage of its income it must hold as regulatory capital as a buffer against difficult trading conditions.

G2C Professional indemnity (PI) insurance

The firm has to supply details of its professional indemnity insurance, including details of the insurer, policy number and excess.

Be aware

As we discussed in *Insurance intermediaries* on page 9/4, the FCA requires an intermediary to have hold PI cover up to substantial limits of at least €1,300,380 for a single claim, and the higher of €1,924,560 or an amount equivalent to 10% of annual income (up to €30m).

G2D Threshold Conditions

The FCA requires confirmation that a firm continues to meet the Threshold Conditions. These are a pre-requisite to continuing authorisation. Questions in this section of the return relate to whether there have been any changes to a firm's Close Links and Controllers.

G2E Training and competence

The return requires a statement as to the number of individuals that give advice, the number of supervisors, those that have left and the number currently assessed as competent.

G2F Conduct of business data

In this section of the return the FCA is seeking data in relation to:

- whether regulated activities are its core business or it is a secondary intermediary (where insurance activities are secondary to the firm's core business, for example a motor dealer or estate agent);
- the number of ARs; and
- the monitoring of ARs.

The FCA uses the data collected in this section to establish the extent and nature of the business, and to assess the potential risks posed by the business activities.

G2G Product sales data

Data on the different types of product sold is collected on this part of the return. The FCA gathers certain information from product providers and uses this data in conjunction with product sales data to identify market trends. It therefore assists the FCA in carrying out its thematic supervision work (topic-based research within the market). The combined data may be used for supervisory purposes. Specific information is required relating to critical illness insurances.

This section of the return is concerned with:

- the types of policies sold:
- the volume of policies;
- areas where a firm is part of a chain of supply; and
- where a particular product type formed a significant part of the firm's business.

G2H Calculation of fees

The return requires firms to provide details of their income from regulated activities. This information is used to calculate a firm's fees to the FCA.

G3 Complaints monitoring

We will deal with the FCA's requirements regarding complaints handling in *Complaints procedures* on page 11/13. The reporting of complaints is one of the means by which the FCA monitors the performance of authorised firms. We will therefore deal with that aspect here.

Firms must provide details of the type of product they have received complaints about and the nature of the complaint, for example, whether the complaint relates to:

- advising, selling and arranging;
- information, sums/charges or product performance;
- general admin/customer service;
- arrears; or
- another consideration.

Firms must also provide details of how long it has taken them to handle their complaints. They must stipulate how many complaints were closed within three days, within eight weeks or took longer than eight weeks to close.

Details of the amount of redress paid must also be provided, along with the number of complaints that were upheld versus the number of complaints received.

Firms with high volumes of complaints have to publish details on their website and the FCA also publish information to enable customers see how insurers and intermediaries are performing, and compare results.

Consider this…
Why do you think the FCA is interested in complaints?

G4 FCA monitoring

The FCA has developed an approach to supervision and a risk framework. The FCA is primarily concerned with a firm's business model and culture to see whether the business is run on a foundation of the fair treatment of customers. It then looks at how this translates through to product design and the services it provides to customers and whether the processes in place support appropriate outcomes for customers.

H Insurance: Conduct of Business Sourcebook (ICOBS)

ICOBS is a rulebook that applies specifically to the sales and administration process for general insurance. Importantly, because of particular issues that arose with payment protection indemnity policies, when firms advise on or sell these, and certain pure protection (life) policies, there are more stringent requirements than those that apply generally. The FCA has also recently introduced stricter rules governing the sale of guaranteed asset protection (GAP) policies.

Some of the rules in the FCA Handbook we have already looked at are more specifically addressed by ICOBS. Generally, therefore, in order to be authorised a firm has to meet the requirements of the FCA's principles and standards set out in the Handbook and also comply with the more specific rules of ICOBS.

Be aware
The introduction of the **Insurance Distribution Directive (IDD)** in October 2018 has meant a number of changes to ICOBS. See *Insurance Distribution Directive (IDD)* on page 10/27 for more details on the IDD and the main changes from the Insurance Mediation Directive (IMD).

There are eight chapters in ICOBS. In the following sections we will give a brief summary of them.

H1 Application of the ICOBS rules

This section defines the range of activities to which the rules apply, and includes the fact that they apply to the activities of the firm's ARs in the UK. The particular activities are:

- insurance distribution activity;
- effecting and carrying out contracts of insurance (including claims management);
- managing the underwriting capacity of a Lloyd's syndicate as a managing agent at Lloyd's; and
- communicating or approving financial promotions.

Where there is a chain of intermediaries between the insurer and the customer, the rules apply to the intermediary who is in contact with the customer, not to others in the distribution chain. If an insurer is dealing directly with a customer the rules also apply to them. Some exemptions apply in relation to the application of the rules for reinsurance and 'large risks' (for which there is a definition).

H2 General matters

Different rules apply, depending on the category of customer. A **consumer** is one who is acting in their private capacity. Otherwise, customers will fall into the category of '**commercial customer**'. A customer whose capacity is unclear must be treated as a consumer. However, if the customer is acting in the capacity of both consumer and a commercial customer, they are to be treated as a commercial customer unless the customer is acting mainly for the purposes unrelated to their trade or profession in relation to a particular contract of insurance, in which case the customer is a consumer. On the whole, consumers receive more detailed protection.

H2A Financial promotions

A financial promotion is the phrase the FCA uses to describe advertising of any kind intended to encourage a person to buy insurance or make an investment. There are rules that relate to product brochures, advertising and websites. Firms must show that they have taken reasonable steps to ensure that promotions are clear, fair and not misleading. Firms are required to check and keep records to demonstrate that any promotion they undertake is compliant with the rules.

H2B Inducements

As a firm's first duty is to its customers it has to take care that payments it receives, including commission or hospitality from insurers, don't lead (induce) it to favour one insurer above another.

H2C Record-keeping

Records have to be kept to demonstrate compliance with the rules, particularly how sales were made, the reason for any advice given, and why it meets the customer's demands and needs.

H2D Exclusion of liability

It is not possible to contract out of regulatory requirements, however it is permissible to delegate tasks to a third party. In doing so, if there are absolute obligations placed on the firm itself these will be retained. For example, a regulated firm cannot opt out of its obligation to handle claims promptly because of the inefficiency of a third-party firm to which it has delegated certain claims functions.

The requirements refer to the general law, including the **Unfair Terms in Consumer Contracts Regulations 1999 (UTCCRs)** (for contracts entered into before 1 October 2015) and the **Consumer Rights Act 2015**, which also limits the scope for a firm to exclude or restrict any duty or liability to a consumer.

H3 Distance communications

The **Distance Marketing Directive** applies rules to protect consumers who have entered into an insurance contract through a distance sale (e.g. over the telephone or through a website). They give consumers a cooling-off period and for a sale over the telephone, with the customer's explicit permission, the firm can shorten the sale and send the rest of the information by post or email.

Generally, information in a prescribed form and in a 'durable medium' (i.e. paper not an email) must be supplied before the conclusion of the contract. There are special rules relating to payment of the premium and to cancellation rights.

H4 Information about the firm, its services and remuneration

Insurers and insurance intermediaries have obligations under the rules to consider the information needs of the customer. The firm should consider what a customer needs in order to understand the relevance of the information and at what point in the sales process the information will be most useful to the customer to enable them to make an informed decision.

The minimum information required to be disclosed is prescribed and additional information is needed to be provided by insurance intermediaries.

In order to inform its customers about the extent to which the firm has carried out the search in the market, the firm must state whether the advice given is on the basis of a 'fair analysis of the market'. To make this claim, a firm must, using professional criteria, have considered a sufficiently large number of insurer's products. If it does not claim a fair analysis, the firm must state whether there is a contractual restriction on the number of insurer's products on which it may provide advice. If this is the case, the customer is entitled to know which insurers the intermediary has approached and must be given this information if they ask for it.

If no recommendation is given to a customer, the firm must make the customer aware of the need for the customer to ensure that the policy meets their demands and needs.

It is not a requirement that commission should be disclosed unprompted. However, if a commercial customer does ask, it must be disclosed promptly and the amount must include the earnings of any associates in addition to the firm's earnings.

Although FCA rules do not oblige firms to disclose commission unless requested by a commercial customer, an intermediary also has fiduciary duties when acting as an agent for any customer, and under agency law is obliged to account for their earnings and not make a secret commission.

H5 Identifying client needs and advising

There are rules concerning the assessment of a customer's demands and needs and the suitability of a contract that is recommended. An intermediary must provide a statement of the customer's 'demands and needs' and give reasons for any advice given in relation to a policy.

Because of the nature of PPI products, especially those that are sold in conjunction with a loan or mortgage, limited information may be requested initially. The reason for this is because the provider relies upon eligibility criteria as one of the main means of underwriting and risk selection. One of the problems this creates is that those who may have been paying premiums for some time could find that for health or other reasons, they are ineligible to claim. They may only find this out at the point of claim notification. This has prompted a separate rule for such contracts, placing an onus on the advising firm to check eligibility when providing initial advice.

Refer to

See *Insured's duty of disclosure – non-consumer insurance* on page 5/3 for the impact of IA 2015

The FCA provides guidance on the need to explain the duty of disclosure of material circumstances, consequences of failure and the need to ask clear questions, in order to avoid problems of claims avoidance arising from non-disclosure.

H6 Product information

Certain rules deal with the information that must be given on the scope of the cover provided under policies. A firm must take reasonable steps to ensure a customer is given appropriate information about a policy. This information must be made in good time and be in a form that the customer can use to make an informed decision about the arrangements proposed.

Generally, the insurer is responsible for producing the information and for providing its content. Where there is an authorised intermediary, that firm is generally responsible for providing the information to the customer.

The type of information provided to customers and its timing are specified in the rules and include:

- price disclosure, separating the premium from the prices for any other goods or services;
- the law applicable to the contract;
- complaints handling procedures, including reference to the FOS;
- the EEA State of the insurer and the head office address;
- for pure protection (some life) policies or payment protection indemnity insurances there is a strengthening of disclosure requirements as an FCA rule (this is by way of a guidance note for other insurances) in relation to significant exclusions, the importance of reading the document and pricing information, together with the production of a policy summary; and
- cancellation provisions.

The summary itself must be provided under the rules for PPI or pure protection policies. Alternatively, it may be produced in response to the FCA guidance note, as a means of ensuring that a client can make an informed choice.

Be aware
The FCA has also updated its rules to ensure they are in line with the Insurance Distribution Directive (IDD), which requires that certain information for non-life policies is provided to the customer in the form of a standardised insurance product information document (IPID), such as details of the risk, how premiums are charged, and key exclusions. We look at the broader changes introduced by the IDD in *Insurance Distribution Directive (IDD)* on page 10/27.

H6A Guaranteed asset protection (GAP) insurance

Following a review on general insurance add-ons, the FCA voiced concerns about competition in the guaranteed asset protection (GAP) insurance market and consulted on changes to remedy this. As a result it published rules, which came into force on 1 September 2015 and were updated on 1 October 2018, aimed at empowering customers when making decisions about purchasing add-on GAP insurance, and limiting the point-of-sale advantage of add-on distributors.

Firms distributing add-on GAP insurance in connection with the sale of a motor vehicle are required to:

- provide customers with prescribed information to help them shop around and be more engaged when making decisions about purchasing the product; and
- introduce a deferral period, which means GAP insurance cannot be introduced and sold on the same day.

Except as specified in the rules, a GAP contract cannot be concluded by a firm until at least two clear days have passed since the firm provided the information prescribed for this type of insurance.

Before a GAP contract is concluded, a firm must give the customer the following information:

- the total premium of the GAP contract;
- significant features and benefits;
- significant and unusual exclusions or limitations, and cross references to the relevant policy document provisions;
- duration of the policy;
- whether the GAP contract is optional or compulsory;
- when the GAP contract can be concluded by the firm; and
- the date the above information is provided to the customer.

In addition, the firm must also comply with the rules described in *Product information* on page 10/24.

H7 Cancellation

The cancellation rules do not apply to short-term policies or events (of less than one month's duration). Neither do they apply where the terms of the contract have been met in full. Beyond these, this section of ICOBS does give a consumer, though not a commercial customer, the right to a cooling-off period of 14 days for most general insurance contracts. Strictly speaking this is not a 'cooling off' period since, in certain circumstances, the rules allow insurers to charge for the services that they have provided when a policy is cancelled.

There is no provision for insurers to make a charge for the time they have been on risk unless a claim has been made.

H8 Claims handling

The general principle adopted is that an insurer is responsible for the handling of claims whether personally undertaken, delegated or outsourced.

The firm must keep their client advised on the progress of their claim, and there are special rules for when an insurer wishes to decline to deal with a claim.

The rules themselves relate to the fair and prompt handling of claims and the reasonable guidance that must be given. Insurers must not unreasonably reject a claim and must settle promptly once the claim has been agreed. Intermediaries must act with skill, care and due diligence and not put their own interests above those of their client. Any conflict of interest must be resolved with the client's approval of the proposed arrangement.

We considered in chapter 5 the implications of non-disclosure and misrepresentation on the payment of claims. There is a further requirement imposed upon insurers in relation to warranties and the payment of claims. FCA rules state that an insurer will not refuse to pay a claim (from a consumer policyholder only) where a warranty has been breached, unless the circumstances of the claim are connected with the breach and the warranty is material to the risk and was drawn to the customer's attention before the conclusion of the contract.

Refer to
See *Insured's duty of disclosure – non-consumer insurance* on page 5/3 and *Consequences of a breach of the duty of fair presentation* on page 5/13 for the impact of IA 2015

The ICOBS rules now also reflect the protection given to consumers in relation to non-disclosure or misrepresentation in recent legislation.

Following the implementation of the Insurance Act 2015, effective from August 2016, insurers have more restrictions placed on them where there is a breach of warranty by a non-consumer customer.

The **Enterprise Act 2016** amended the Insurance Act 2015 by adding an implied term into every contract of insurance that insurers must pay any sums due to their insured within a 'reasonable time'. If a valid claim is not paid within a reasonable time, the insured will be entitled to enforce payment of the claim and pursue a claim for damages. The potential implications of this for insurers has already been explored earlier in this chapter.

Refer to
Enterprise Act 2016 covered in *Speed of indemnity – Enterprise Act 2016* on page 7/10

Motor claims that occur abroad have separate prescriptive rules to ensure compliance with the terms of EU motor insurance directives. These include the requirement for insurers to appoint claims representatives in each Member State of the EU as required by the **Fourth EU Motor Insurance Directive**.

I Insurance Distribution Directive (IDD)

Insurance Distribution Directive

The **Insurance Distribution Directive 2016/97/EC (IDD)** came into force in 2016 and each Member State, including the UK, had to transpose the Directive into their own legislation by 1 July 2018. The requirements have applied to firms since 1 October 2018. This means that although the UK has now left the EU, the IDD is still in force in the UK as it is part of UK law.

The IDD is a revision and replacement of the **Insurance Mediation Directive 2002/92/EC (IMD)**. The IDD's aim is to make it easier for firms to trade across borders, strengthen policyholder protection and provide a level playing field. It sets out consumer protection provisions in insurance and the scope of regulation is increased to include all firms that sell, advise on, or conclude insurance contracts and those who assist in administering and performing them, including those that shortlist as part of a selection process (such as aggregators), or introduce insurance. However, just providing general information about insurance products, insurers or brokers without collecting such information has been excluded, as is providing data on potential policyholders to insurers/brokers.

The key provisions of the Directive are:

- **Professionalism**. All firms engaged in any of the activities covered by the Directive must possess appropriate knowledge and ability to complete their tasks and perform their duties adequately, such as: the insurance market; applicable laws governing insurance distribution; claims handling; complaints handling; assessing customer needs and business ethics standards/conflict of interest management. Staff must complete at least 15 hours of professional training or development per year.
- **Commission disclosure**. Pre-contractual disclosure of the intermediary and the nature, not amount, of their remuneration (whether commission, fee or other type of arrangement). This would be waived for contracts involving large risks or for professional customers. The pre-contract disclosure regime will be extended to insurance undertakings. Firms must state what type of firm they are (intermediary or insurer) and whether they provide a personal recommendation. Firms that sell insurance on a non-advised basis must ensure that the products they are selling fulfil the customers most fundamental needs.
- **Harmonisation**. The IDD is a minimum harmonisation directive, allowing Member States to set stricter requirements ('gold plate') if they deem this necessary. This allows the UK to maintain its rules for retail investment advisers under the Retail Distribution Review (RDR), for example.
- **New product governance requirements**, which are largely in line with the FCA's product governance requirements.
- A new category of insurance settler called **Ancillary Insurance Intermediaries**. This includes connected travel insurance providers that don't sell or introduce insurance as their main business, but still do so and therefore are subject to selling rules.
- New duties applicable to insurance companies that are selling products through companies that are not authorised by the FCA.
- A requirement for all general insurance firms in the retail and small corporate market to provide customers with Insurance Product Information Documents. These are similar to the Key Features Documents, previously used by insurers. An IPID is a short, pre-contractual, non-personalised product summary document, the layout of which is fixed and must follow closely what is prescribed in the IDD. After 1 October 2018, an IPID must be issued to every retail customer purchasing a general insurance product, regardless of the channel being used, ahead of closing a sale or renewal. The purpose is to allow customers at the quotation stage to compare similar products offered by different insurers in an easy-to-follow consistent way so they can see at-a-glance the differences between products and make informed decisions. The requirement to provide an IPID only applies to consumer insurance contracts.

I1 The IDD general principles

The IDD introduces general principles that apply to all insurance distributors. These are overarching requirements, which apply in a similar way to the UK's Principles for Businesses. In summary, these are:

- Distributors must act honestly, fairly and professionally in the best interests of their customers.
- Distributors must communicate in a way which is clear, fair and not misleading, including ensuring that marketing materials are clearly identifiable as such.
- Remuneration of a distributor or its employees, and performance management of employees, must not conflict with the duty to act in the customer's best interests.

The IDD definition of 'remuneration' includes commission, fee, charge or other payment, including an economic benefit of any kind or any other financial advantage or incentive offered or given in respect of the insurance distribution activity.

Firms should note that these overarching general principles will apply to **all** firms carrying out insurance distribution activities, where they have a direct impact on the policyholder. This means that firms conducting insurance distribution activities as part of a distribution chain will be caught by the customer's best interests rule. This will include, for example, a wholesale intermediary who concludes a policy placed with it by a retail intermediary, or a comparison website which proposes a contract but directs a customer to another intermediary or insurer.

J Money laundering

Be aware
While general insurance does not come under the money laundering regulations that apply to other financial services, it does come under the **Proceeds of Crime Act 2002 (POCA)** which includes some aspects of money laundering.

Money laundering is the process by which criminals and terrorists convert money that has been obtained illegally into legitimate funds.

This does not apply only to large criminal organisations; it may also be carried out on a much smaller scale.

Money laundering has a particular relevance in the financial services sector. A criminal may choose to deposit their illegally obtained cash into an apparently legitimate arrangement, such as a pension, life policy, unit trust, building society account or into traveller's cheques. They may take out a general insurance policy and then cancel it shortly after so they can get the return premium. Criminals are happy to discount money if the result of the transaction is that it becomes 'clean' money.

There are three stages in the money laundering process:

Placement	This is the process of putting cash into the financial system and converting it into other financial assets, such as cheques or even property.
Layering	It may still be possible to trace the money back to its illegal origins so the criminal will want to get involved in layering. To conceal the origins of the money they will create a series of complex transactions (this is layering). This may include fund transfers overseas or trading in stocks or futures.
Integration	Integration is where the criminal finally gets access to the money. There are many ways of giving the impression of something legitimate. The replacement of stock and its sale to the public is one example. Often much more sophisticated methods are used. Buying property and leasing it or creating a company and drawing a salary are just two examples.

J1 Application of the law and regulation

In general terms there are three strands to the legal rules that apply to money laundering. These strands are:

- Specific laws that define what represents a criminal offence and the penalties that apply to such acts (which are of general application).
- Money laundering regulations that apply to a stated range of firms carrying on activities in the financial sector (but not specifically to general insurance or general insurance mediation).
- Regulatory rules and guidance apply in different ways to different categories of firms.

J2 Specific legislation

The most important legislation relating to money laundering is given in this section.

J2A Criminal Justice Act 1993

This extended the scope of the **Criminal Justice Act 1988** (which applied only to drug trafficking and terrorism) by making it a criminal offence to launder gains from other crimes. It not only requires individuals to not be actively involved in money laundering, collusion or concealment, but also that they report any knowledge or suspicion of money laundering. It also makes 'tipping off' a suspected person a criminal offence.

The Act provides for 'unlawful conduct' to include any conduct occurring in a country outside the UK that would be unlawful in that country or which would have been unlawful if committed in the UK.

The offences
There are three principal offences under the terms of the **Criminal Justice Act 1993**:

- Assistance to a criminal where you either know or suspect, or ought to have known or suspected, that money laundering was taking place (maximum 14 years' imprisonment). (This means that you help them retain the benefits of their criminal activities or you acquire, possess or use the benefits yourself, or you conceal or transfer the proceeds in order to avoid prosecution or confiscation of assets.)
- Failing to report either actual knowledge or suspicion of money laundering (maximum five years imprisonment). This is extended under POCA.
- Tipping off (maximum five years' imprisonment). Deliberately telling someone that you suspect them of being involved in money laundering or that there is a formal or police investigation under way.

Consider this…
Why do you think the law takes such a strong approach to money laundering?

J2B Proceeds of Crime Act 2002 (POCA)

The **Proceeds of Crime Act 2002 (POCA)** extends the range of offences for money laundering.

POCA set up an Assets Recovery Agency (ARA) with financial investigators whose purpose was to recover the proceeds of criminal activity. Criminal lifestyle is a key test and is defined in the Act. There are provisions for fines and confiscation or restraint orders.

Offences under POCA are:

- Concealing, disguising, converting or transferring criminal property or removing it from the UK.
- Acquiring, possessing or using criminal property.
- Failing to disclose that someone else is engaged in money laundering.

Like the Criminal Justice Act 1993, POCA applies across the board in the UK and therefore to all employees of regulated firms, whether or not the specific money laundering rules apply to those firms.

J2C Serious Crime Act 2007

The **Serious Crime Act 2007** extended a range of serious crime prevention orders that could be made by the High Court and amended POCA in a number of important respects. It abolished the ARA and transferred all its activities to the Serious Organised Crimes Agency (SOCA). SOCA's operations merged into a larger **National Crime Agency (NCA)** created through the **Crime and Courts Act 2013**, which commenced operations on 7 October 2013.

On the Web
NCA: *www.nationalcrimeagency.gov.uk*

J2D Serious Crime Act 2015

The **Serious Crime Act 2015** gave effect to a number of legislative proposals relating to serious and organised crime. It builds on current law to ensure the National Crime Agency, the police and other law enforcement agencies have the powers they need to effectively and relentlessly pursue, disrupt and bring to justice serious and organised criminals. The Act contains provisions amending the Proceeds of Crime Act 2002 to strengthen the asset recovery process including increased prison sentences for failure to pay confiscation orders.

J3 EU money laundering regulations

J3A The Money Laundering Regulations 1993

MLR 1993 is foundational to money laundering prevention in the financial sector. It requires the creation and maintenance of systems to prevent and control money laundering and effective training to be in place.

The provisions apply to defined organisations operating in the UK financial sector, but not general insurance activities, including mediation activities.

J3B The Money Laundering Regulations 2017

Further Regulations were brought into force in 2003, but these were supplemented by the Money Laundering Regulations 2007, effective from December 2007, and then the **Money Laundering Regulations 2017 (MLR 2017)**, effective from June 2017. MLR 2017 covers a wider range of businesses. These are defined as:

- credit and financial institutions (including life insurance companies and financial advisers); and
- auditors, accountants, tax advisers and insolvency practitioners, independent legal professionals, trust or company service providers, estate agents, high value dealers (dealing with goods with a transaction value greater than €15,000).

MLR 2017 covers the following areas:

- **Customer due diligence**. This involves verifying the identity of the customer (and the beneficial owner, if different) and obtaining information on the purpose and intended nature of the business relationship. If the customer is not present for the transaction further measures are required, such as the production of additional documents, confirmation of identity from an appropriate financial institution, or payment through a credit institution.
- **Policies and procedures**. These are to be risk-sensitive. The rules relate to due diligence measures, reporting, record-keeping, internal control, risk assessment and monitoring in order to prevent activities related to money laundering and terrorist financing.
- **Registration**. Organisations must register and there are detailed procedures for this as well as a list of reasons for the FCA to refuse registration.
- **Enforcement**. Enforcement powers include the right to enter and inspect premises and take copies of any relevant documents. Designated authorities may impose 'appropriate' civil penalties. 'Appropriate' is defined as being effective, proportionate and dissuasive. If partners or directors are personally responsible for failure to comply with regulations they may be fined (up to an amount not exceeding the statutory maximum) or imprisoned for up to two years, or both. In this case they would not also be liable to a civil penalty.

J4 Regulatory rules and guidance

The FCA has a responsibility to prevent and detect money laundering. Regulated persons should be aware of the risk that their business could be used in connection with the commission of financial crime. It also provides that they take appropriate measures (in relation to their administration and employment practices and the conduct of transactions by them) to prevent financial crime, facilitate its detection and monitor its incidence.

'Financial crime' is defined in the Act as fraud, dishonesty, misconduct in, or misuse of information relating to, a financial market or handling the proceeds of crime.

Firms must have in place systems and controls, which must include giving their employees suitable training, with regard to money laundering. The governing body and senior management must be in receipt of certain information and the money laundering reporting officer must make a report, at least annually, on how the systems and controls operate and on their effectiveness.

The firm also needs to document both its risk profile and risk management policies in relation to money laundering. On a day-to-day basis it must take the risk of money laundering into account when developing new products, taking on new customers and when changing its business profile.

Money laundering reporting officer (MLRO)
A director or senior manager must take overall responsibility for establishing and maintaining effective anti-money laundering systems and controls within the firm. This role is often undertaken by the **money laundering reporting officer (MLRO)**.

The MLRO is:

- expected to be based in the UK;
- required to have a certain level of authority and independence within the firm; and
- required to have sufficient resources and information to enable them to fulfil their responsibilities.

Anyone who suspects that money laundering is taking place must report this to the MLRO. The MLRO must then decide whether the suspicious transaction should be reported to the NCA.

J5 Protection measures

To aid the detection of money laundering it is important to protect the person who reports their suspicions. The NCA must know who they are as they may need to obtain further information from them in pursuing their investigations. Outside the investigation, however, their names will be concealed and they will not be called upon to give evidence.

J6 Client verification

Firms must take all practical measures to check the identity of new clients and that their addresses are genuine. Money laundering regulations are not specific as to the precise nature of appropriate means of identification. Guidelines issued by JMLSG state that client verification for individuals should be by means of a valid passport, valid photocard driving licence (full or provisional), National Identity card (non-UK nationals), firearms certificate or shotgun licence or an identity card issued by the Electoral Office for Northern Ireland.

A home visit to the client is suitable evidence, provided that it is clear that the house is genuinely the personal residence of the client and this is one of two means of identification.

A client's bank or another reputable financial institution can be asked to verify their identity where they are not being met face-to-face.

In the case of a company, it would be necessary to establish its full name, registered number, registered office in country of incorporation and business address and to check that it legally exists for normal business operations. This could be done by, for example, obtaining a copy of its Certification of Incorporation or searching the relevant company registry. Any complex ownership arrangements should be clarified.

Proof of identity should be obtained as soon as possible and transactions should not be completed until this has been provided. Although general insurance firms are not subject to the Money Laundering Regulations they must ensure that they are able to demonstrate to

the regulator that the extent of their customer due diligence measures is appropriate in view of the risks of money laundering and terrorist financing.

Any verification difficulties should usually be reported to the MLRO and, possibly, by the MLRO to the authorities. Records must be kept for five years.

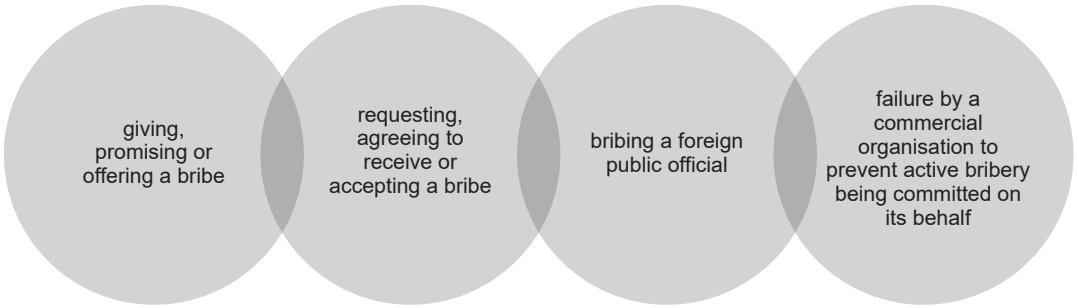
J7 Summary of money laundering rules

General insurers and intermediaries are subject to the high-level rules, and in particular SYSC, which contains specific requirements regarding anti-money laundering measures. Their employees are also individually subject to the terms of CJA and POCA. Therefore, although general insurers and intermediaries are not directly impacted by the Money Laundering Regulations, there are specific money laundering rules that apply to them. Firms must follow guidance issued by the JMLSG in relation to client identification and verification, and appropriate systems and controls.

J8 Bribery Act 2010

The **Bribery Act 2010** is one of the most far-reaching Acts relating to improper payments – the range of offences under the Act is extremely wide. The Act has been in force since 1 July 2011 and applies to all commercial organisations.

The Act created four new criminal offences:



It is the last of these that has been a main cause for concern because of the possibility of 'failing to prevent' bribery. Linked to this, even before its introduction, very heavy fines had been levied by the FSA (two in excess of £5 million) in relation to inadequate measures taken by firms to prevent financial crime.

The terms of this Act must be taken into account alongside the need for effective measures to combat money laundering and other areas of financial crime.

Key points

The main ideas covered by this chapter can be summarised as follows:

UK regulatory framework

- The FPC, PRA and FCA form the UK's financial services regulation framework.
- Under the Bank of England and Financial Services Act 2016, the PRA became part of the Bank of England and a new Prudential Regulation Committee (PRC) was established.

The Prudential Regulation Authority (PRA)

- The PRA is responsible for the prudential regulation of all 'systemically important firms' such as insurers.
- Its primary objectives are to contribute to ensuring that policyholders are appropriately protected.
- The PRA's risk assessment framework supports its additional objective to protect policyholders as well as the financial system.

The Financial Conduct Authority (FCA)

- The FCA is responsible for the conduct of business and market issues for all firms, and prudential regulation of small firms.
- The FCA's main objective is to ensure the relevant market functions well.
- The FCA has three operational objectives covering the areas of consumer protection, integrity and competition.

The FCA Handbook and PRA Rulebook

- There are eleven principles for businesses.
- The FCA expects authorised firms to embed the fair treatment of customers principle into their corporate strategy.
- The PIDA concerns public allegations of a firm's concealed misconduct, usually within the same organisation.
- Senior management functions should be carried out only by those who meet appropriate standards, i.e. those who are identified as 'senior managers' by firms and authorised as such by the FCA.

Discipline and enforcement

- There are a number of measures and sanctions available to the regulators in their enforcement and disciplining of firms and individuals.
- The PRA is able to take action against a firm that fails to meet minimum capital adequacy requirements.

Authorisation and regulation of insurers

- A UK-based company wishing to transact insurance in the UK must be authorised by the PRA.
- To be authorised a firm must be operated by fit and proper persons and meet capital adequacy requirements.
- Each authorised firm must make certain reports to the FCA on a prescribed basis.

Authorisation and regulation of intermediaries

- The only way to carry out insurance mediation activity in the UK is to be authorised by the FCA or exempt.
- An authorised intermediary must supply the FCA with an RMAR.

Key points

Insurance: Conduct of Business Sourcebook (ICOBS)

- Different rules apply depending on whether the customer is a private individual or a commercial client.
- There are more stringent rules relating to advice on PPI contracts and pure protection contracts as well as the sale of GAP products.
- ICOBS contains rules concerning financial promotions, identifying client needs, advising and selling standards and product disclosure.
- There are also rules on cancellation and claims handling.
- Specific rules apply for contracts sold at a distance (e.g. call centres) and for electronic means of communication.

Money laundering

- Money laundering is the process by which money that has been obtained illegally is converted into legitimate funds.
- There are serious penalties for aiding money laundering, failing to report money laundering and for tipping off those suspected of money laundering.
- All authorised persons by the FCA must appoint an MLRO.
- The Proceeds of Crime Act 2002 establishes a number of offences around the handling of criminal property and the reporting of money laundering.
- Firms must take all practical measures to check the identity of new clients.

Question answers

10.1 d. During the whole lifecycle.

Self-test questions

1. Which two bodies regulate the UK insurance market?
   a. The FCA and Lloyd's. ☐
   b. The FCA and FPC. ☐
   c. The PRA and FPC. ☐
   d. The PRA and FCA. ☐

2. Which of these is **not** a threshold condition that the PRA requires to be met when becoming authorised?
   a. Be appropriately staffed. ☐
   b. Have a head office in Europe. ☐
   c. Be capable of being effectively supervised. ☐
   d. Conduct business prudently. ☐

3. The Prudential Regulation Authority's Principles for Businesses states that a firm must maintain financial resources that are:
   a. Adequate. ☐
   b. Easy to liquidate. ☐
   c. Equal to its liabilities. ☐
   d. Less than its liabilities. ☐

4. A Polish insurer wants to set up an office in the City of London. In order for the insurer to be authorised to transact insurance business, approval **must** be obtained from the:
   a. Department for Business, Energy & Industrial Strategy. ☐
   b. Financial Conduct Authority. ☐
   c. Foreign & Commonwealth Office. ☐
   d. Home Office. ☐

5. Under its disciplinary procedures, when is the Prudential Regulation Authority **most likely** to take action against an approved person, instead of the firm?
   a. When the approved person has deliberately breached the regulations. ☐
   b. When the approved person has delegated correctly, but the fault was outside of their control. ☐
   c. When the approved person has performed an influence and a regulatory failure has occurred in the area for which they are responsible. ☐
   d. When the firm has breached the reasonable care rule in maintaining its systems and controls. ☐

6. The Insurance: Conduct of Business sourcebook (ICOBS) is issued and regulated by the:

   a. Association of British Insurers. ☐

   b. Chartered Insurance Institute. ☐

   c. Financial Ombudsman Service. ☐

   d. Financial Conduct Authority. ☐

7. What are the three stages in money laundering?

   a. Placement, layering and integration. ☐

   b. Placement, hiding and integration. ☐

   c. Finding, layering and integration. ☐

   d. Placement, layering and reusing. ☐

8. A transaction which is suspected of involving money laundering has been reported to and validated by a firm's money laundering reporting officer (MLRO). Which organisation should the MLRO report this matter to?

   a. HM Revenue & Customs. ☐

   b. The Department for Business, Energy & Industrial Strategy. ☐

   c. The Serious Fraud Office. ☐

   d. The National Crime Agency. ☐

9. What is the principal purpose of the Proceeds of Crime Act 2002?

   a. To enable retrieved goods which have been obtained by theft or deception to be returned to their rightful owners. ☐

   b. To empower authorities to confiscate funds where it is believed that such funds have been obtained unlawfully. ☐

   c. To evaluate the annual loss to the British economy from organised criminal activities. ☐

   d. To facilitate the conviction of persons suspected of money laundering activities. ☐

You will find the answers at the back of the book

11

Consumer protection and dispute resolution

Contents	Syllabus learning outcomes
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Learning objectives

After studying this chapter, you should be able to:

- describe the effects of data protection legislation;
- explain the scope and operation of the CII Code of Ethics;
- explain the Financial Conduct Authority (FCA) requirements for training and competence;
- describe the prescribed FCA complaints procedures and the services provided by the Financial Ombudsman Service (FOS); and
- explain the provisions of the Financial Services Compensation Scheme (FSCS).

Introduction

In this chapter we will consider the rules and regulations in place for the protection of data and also look at the ethical standards which firms must comply with. We will go on to explain why it is important to have effective complaints handling procedures in place and examine the roles of the Financial Ombudsman Service (FOS) and the Financial Services Compensation Scheme (FSCS).

Key terms

This chapter features explanations of the following terms and concepts:

Code of Ethics	Competence	Complaints handling	Data protection
Ethical standards	Financial Ombudsman Service (FOS)	Financial Services Compensation Scheme (FSCS)	Personal data
Special category data			

A Data protection law in the UK

A1 Data Protection Act 2018

The DPA 2018 came into effect in the UK in May 2018, to coincide with the implementation of the GDPR and the **Law Enforcement Directive (LED)**. It aims to modernise UK data protection laws to ensure they are effective in the years to come.

The main elements of the DPA 2018 include the following:

General data processing

- Implement GDPR standards across all general data processing.
- Provide clarity on the definitions used in the GDPR in the UK context.
- Ensure that sensitive health, social care and education data can continue to be processed to ensure continued confidentiality in health and safeguarding situations can be maintained.
- Provide appropriate restrictions to rights to access and delete data to allow certain processing currently undertaken to continue where there is a strong public policy justification, including for national security purposes.
- Set the age from which parental consent is not needed to process data online at age 13, supported by a new age-appropriate design code enforced by the Information Commissioner.

Regulation and enforcement

- Enact additional powers for the Information Commissioner who will continue to regulate and enforce data protection laws.
- Allow the Commissioner to levy higher administrative fines on data controllers and processors for the most serious data breaches; being up to £17.5m or 4% of annual global turnover.
- Empower the Commissioner to bring criminal proceedings for offences where a data controller or processor alters records with intent to prevent disclosure following a SAR.

Post-Brexit – 'UK GDPR'

The GDPR is retained in domestic law now the Brexit transition period has ended, but the UK has the independence to keep the framework under review. The 'UK GDPR' sits alongside an amended version of the DPA 2018, with the key principles, rights and obligations remaining the same. The UK GDPR applies to controllers and processors based outside the UK if their processing activities relate to offering goods or services to individuals in the UK; or monitoring the behaviour of individuals in the UK.

A2 General Data Protection Regulation (GDPR)

Who does the GDPR apply to?
The GDPR applies to controllers and processors in the EU. The definitions are broadly the same as previously – i.e. the controller says how and why personal data is processed and the processor acts on the controller's behalf. However, GDPR places new legal obligations on processors, for instance, firms are required to maintain records of personal data and processing activities, and a firm has significantly more legal liability if it is responsible for a breach.

Controllers are not relieved of their obligations where a processor is involved – the GDPR places further obligations on controllers to ensure their contracts with processors comply with the regulations.

What information does the GDPR apply to?
The GDPR applies to personal data. However, the GDPR's definition is more detailed than before, reflecting changes in technology and in the way in which information is collected. It makes it clear that information such as an online identifier – e.g. an IP address – can be personal data.

The GDPR applies to both automated personal data and to manual filing systems where personal data is accessible according to specific criteria. This is wider than the DPA 1998's definition and could include chronologically ordered sets of manual records containing personal data. Personal data that has been anonymised – e.g. key-coded – can fall within the scope of the GDPR depending on how difficult it is to attribute the pseudonym to a particular individual.

Sensitive personal data
The GDPR refers to sensitive personal data as 'special categories of personal data'. These categories include:

- race;
- ethnic origin;
- politics;
- religion;
- trade union membership;
- genetics;
- biometrics (where used for ID purposes);
- health;
- sex life; or
- sexual orientation.

Principles
Under the GDPR, the data protection principles set out the main responsibilities for organisations. They are similar to those in the DPA 1998 with added detail. The most significant addition is an emphasis on accountability. The GDPR requires firms to show how they comply with the principles – for example, by documenting the decisions they take about a processing activity.

Consider this…

Data Protection Principles under the GDPR
The following principles apply to all personal data:

1. Lawfulness, fairness and transparency – data should be processed lawfully; data should be handled in ways people would expect giving consideration to the effect of processing the data on the individuals concerned; and there should be full compliance with the obligations of the 'right to be informed'.
2. Purpose limitation – data should only be collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes.
3. Data minimisation – data should be adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed.
4. Accuracy – data should be accurate and, where necessary, kept up to date.
5. Storage limitation – kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data is processed.
6. Integrity and confidentiality – data should be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

Lawful processing
For processing to be lawful under the GDPR, firms need to identify a lawful basis before they can process personal data and document it. This is significant because this lawful basis has an effect on an individual's rights: where a firm relies on someone's consent, the individual generally has stronger rights, for example to have their data deleted.

Consent
Consent under the GDPR must be a freely given, specific, informed and unambiguous indication of the individual's wishes. There must be some form of positive opt-in – consent cannot be inferred from silence, pre-ticked boxes or inactivity, and firms need to make it simple for people to withdraw consent. Consent must also be separate from other terms and conditions and be verifiable.

Firms can rely on other lawful bases apart from consent – for example, where processing is necessary for the purposes of an organisation's or a third party's legitimate interests. They are not required to automatically refresh all existing DPA consents in preparation for the GDPR, but if a firm relies on individuals' consent to process their data, it must make sure it will meet the GDPR standard. If not, firms must either alter the consent mechanisms and seek fresh GDPR-compliant consent or find an alternative to consent.

Rights
The GDPR creates some new rights for individuals and strengthens some of those that existed under the DPA. These are:

- the right to be informed;
- the right of access;
- the right to rectification;
- the right to erasure;
- the right to restrict processing;
- the right to data portability;
- the right to object; and
- rights in relation to automated decision making and profiling.

Subject access request
Under GDPR, individuals have the right to find out if an organisation is using or storing their personal data. They can exercise this right by submitting a subject access request (SAR) to the organisation concerned. The SAR can be made verbally or in writing. The organisation generally has one month to respond to a SAR, although they can take an additional two months in certain circumstances. If the organisation fails to respond, the individual must complain to the organisation in the first instance. If they remain dissatisfied after that, they

can make a complaint to the Information Commissioner's Office. The first copy of an individual's personal data should be provided free, although charges are permitted for additional copies if the organisation feels such a request is unfounded or excessive. Where this is the case, they can ask for a reasonable fee to cover administrative costs.

Accountability and governance
Accountability and transparency are more significant under the GDPR. Firms are expected to put into place comprehensive but proportionate governance measures. Good practice tools such as privacy impact assessments and privacy by design are now legally required in certain circumstances. Practically, this is likely to mean more policies and procedures for organisations, although many will already have good governance measures in place.

Breach notification
The GDPR introduces a duty on all organisations to report certain types of data breach to the relevant supervisory authority, and in some cases to the individuals affected.

Transfers of personal data to third countries or international organisations
To ensure that the level of protection of individuals afforded by the GDPR is not undermined, restrictions have been imposed on the transfer of personal data outside the EU, to third countries or international organisations.

GDPR still applies directly to firms operating in the EEA post-Brexit, and to any organisations in Europe that send data to firms in the UK.

Example 11.1

Jerzy completes the application process with an insurer to receive a quote for a motor insurance policy. After receiving the quote, he decides not to proceed, but over the coming months receives emails from the insurer regarding the application and other insurance products they consider may be suitable for him.

While Jerzy has previously opted in to receive marketing emails (i.e. provided consent), he no longer wants the insurer to hold the personal information he provided in the application.

Jerzy therefore contacts the insurer by phone to request that they delete any personal data that they hold in relation to him. As the insurer did not provide Jerzy with an insurance policy, and is therefore not exposed to any claims from or against him, it is likely that the insurer would have to comply with the request. The insurer would then be expected to delete the data held about Jerzy across its systems, within the one-month time limit stipulated by the GDPR.

Consider this…

List some areas in which insurance companies and brokers etc. will be affected by the right to data portability.

Question 11.1

What is the key requirement in order to hold personal data under GDPR?

a. Using it regularly. ☐

b. Only using it once. ☐

c. Only storing it electronically. ☐

d. Permission from the person concerned. ☐

B Consumer Rights Act 2015 – unfair terms

Be aware
The **Unfair Terms in Consumer Contracts Regulations 1999 (UTCCRs)** applied, with certain exceptions, to unfair terms in contracts concluded between a consumer and a seller or supplier.

The **Consumer Rights Act 2015** consolidates and clarifies existing consumer legislation on unfair contract terms, removing conflicting overlaps between the **Unfair Contract Terms Act 1977** and the UTCCRs. The provisions cover both 'consumer contracts' and 'consumer notices' (which may be either written or oral). A consumer notice includes announcements and other communications intended to be read by a consumer, including renewal notices and customer promotions (e.g. financial promotions).

The Act consolidates and clarifies existing consumer legislation on unfair contract terms. It now ensures that terms used in contracts and notices will only be binding upon the consumer if they are fair. It defines 'unfair terms' as those that put the consumer at a disadvantage, by limiting the consumer's rights or disproportionately increasing their obligations as compared with the trader's rights and obligations.

It also sets out factors a court should take into account when determining whether a term is fair, notably that it should consider the specific circumstances existing when the term was agreed, other terms in the contract and the nature of the subject matter of the contract. This assessment is known as the 'fairness test'.

Example 11.2
A contract could contain a term allowing the insurer to cancel the cover at short notice. In deciding whether this is fair or not, the court would consider issues such as whether the insured can also cancel at short notice or obtain a refund if the insurer cancels the contract.

When developing proposals for the Act, the Government took into account the definitions and measures contained within the EU Directive on Consumer Rights and, as far as appropriate, has made the Act consistent with it to achieve overall a simple, coherent framework of consumer legislation.

The Act also clarifies the circumstances when the price or subject matter of the contract cannot be considered for fairness and, in particular, makes clear that to avoid being considered for fairness those terms must be 'transparent' and 'prominent'.

A term is **transparent** if it is expressed in plain and intelligible language and (in the case of a written term) is legible.

A term is **prominent** if it is brought to the consumer's attention in such a way that an average consumer would be aware of the term. The Act defines an 'average consumer' as a consumer who is reasonably well-informed, observant and circumspect.

B1 Grey list

The Act also clarifies the role of, and extends the indicative list of, terms that may be regarded as unfair (the so-called 'grey list').

A key term included in the grey list for insurance, which is regarded as unfair, is a term which has the object or effect of excluding or hindering the consumer's right to take legal action or exercise any other legal remedy, in particular by:

- requiring the consumer to take disputes exclusively to arbitration not covered by legal provisions;
- unduly restricting the evidence available to the consumer; or
- imposing on the consumer a burden of proof which, according to the applicable law, should lie with another party to the contract.

Another key term included in the grey list has the object or effect of enabling the trader to alter the terms of the contract unilaterally without a valid reason unless:

- the trader is required to inform the consumer of the alteration at the earliest opportunity; and
- the consumer is free to dissolve the contract immediately.

New additions to the grey list of terms presumed to be unfair include:

- disproportionately high charges where the consumer decides to cancel the contract;
- terms enabling the trader to determine the characteristics of the subject matter of the contract after the conclusion of the contract; and
- terms allowing the trader to determine the price after the consumer is bound by the agreement.

B2 Regulation

If an insurer has been found to use policies containing unfair terms or has been found to breach consumer law, the **Competition and Markets Authority (CMA)** or the FCA may require an undertaking to amend the term. They may also bring injunctive action to prevent further use of the terms. The Act introduces enhanced measures including redress measures such as compensatory payments to consumers who have suffered as a result of the use of unfair terms, enabling consumers to terminate a contract and, where a consumer cannot be identified, measures taken for the collective interest of consumers. The Act also extends the bodies that may act as private enforcers, specified as such by the Secretary of State. Private enforcers are expected to include consumer representative organisations. The FCA will issue its finalised guidance on variation terms in December 2019, following a period of consultation.

C Ethical standards

In its most general sense, the subject of ethics is tied up with issues of morality. ***Ethical standards*** are therefore concerned with the way in which a moral outcome can be achieved in given circumstances. They are concerned with behaviour and conduct. In the context of a profession, the hallmark of a professional is the ability to step back from issues of self-interest and provide competent independent advice in the best interests of a client. This will inspire public trust in their services. By contrast, any real or perceived lack of ethical standards is likely to lead to a serious undermining of trust, not merely in the individual giving advice, but possibly in the profession as a whole.

In considering ethical standards it is necessary to take account of best practice in other professions and the requirements of legislation and regulatory authorities.

All professional bodies produce a code, often described as a **code of conduct**, to which their members must adhere. Codes of conduct do not have the force of law and, although there may be penalties for failure to comply, a breach does not provide any automatic grounds for criminal prosecution.

Codes of conduct apply to individuals as a result of their membership of a professional body. Often there are more rigorous requirements for senior categories of membership. Professional bodies are linked to those whose job is in a particular sector. They set appropriate examinations and coursework assignments, often at different levels, to provide a path of progression towards their highest qualification – typically fellowship. Beyond qualification by examination there is a requirement to continue professional development, often in a prescriptive way.

In one sense we need to distinguish between examination success and membership of a professional body. This is because success in the former will affirm a level of technical ability or knowledge whereas the latter relates to behaviour and values. Where they meet is what we might call professional competence.

Trade bodies may have their own codes to which members subscribe on a voluntary basis. A breach of the provisions of such a code would not necessarily result in disciplinary action, although there would be regard to the contents of a code in any disciplinary proceedings. However, professional bodies can and do take disciplinary action against members who are in breach of their codes of conduct since such codes are designed to provide a framework of

appropriate behaviour. It follows that failure to follow the code may bring the individual or the profession into disrepute.

Consider this…
If you were to describe someone as being 'professional in their conduct' what would you be saying about them? Why would it be important for someone working in insurance to be seen in this way?

C1 The CII Code of Ethics: an overview

The Chartered Insurance Institute (CII)'s ***Code of Ethics*** represents a set of ethical principles for insurance and financial services professionals worldwide. As the Code is 'principles-based' it is sufficiently flexible to take account of the wide range of different roles undertaken within the sector.

It is described in the following way by the CII:

> This Code should not be seen as yet another regulatory burden but rather as a virtuous platform for improving the reputation of CII members as a whole and in distinguishing our membership in comparison with less qualified and regulated competitors. Beyond this, adoption of and adherence to the Code can help promote standards and public trust.

The Code itself should be considered as a whole. We can view it as a series of overlapping requirements, each of which emphasises a particular aspect of ethical behaviour as shown in figure 10.1.

Figure 11.1: Overlapping requirements of ethical behaviour

The Code has as its purpose the meeting of standards and maintaining the reputation of the CII. It is concerned with attitude and behaviour and, therefore, tends to have a wider application than the regulatory rules that will overlap many aspects of business life. Rather than setting a series of minimum requirements, the Code represents a positive statement of the core principles that must inform decision-making, business relationships and a member's more general behaviour.

To assist members in the way that the principles should be applied in different situations, there is a section entitled 'key questions to ask yourself'. This section tries to help people think about how the Code and the principles that underpin it affect them as an individual. The CII's aim is to make the Code more of a 'living' document that individuals will read and consult regularly. To this end, the CII has also produced two companions to the Code, covering **digital ethics** and **financially inclusive customer outcomes**.

Refer to
The Code appears in *CII Code of Ethics* on page 2/1.

Members are obliged to comply with the Code. If they do not, the CII may take disciplinary action against them. The central principles that underpin it are summarised in the next section.

C2 Central principles of the Code

There are five central principles in the Code of Ethics. The Code states that members must:

- comply with the code and all relevant laws and regulations;
- act with the highest ethical standards and integrity;
- act in the best interests of each client;
- provide a high standard of service; and
- treat people fairly, regardless of: age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion and belief, sex, and sexual orientation.

We will consider the scope of each in the following sections. In addition, we will identify scenarios that have the potential to produce both ethical and unethical behaviour in each area.

C2A Compliance with the Code, relevant laws and regulations

This section of the Code embraces the member's dealings with the CII and regulatory authorities, requiring an open, cooperative and courteous manner. Emphasising the ethical nature of the Code, members must abide by both the spirit and letter of the law. Individuals must be properly authorised and regulated and, as far as they are able, make sure that their organisations are suitably regulated and compliant. Breaches must be reported to the CII.

There are some key practical questions in this section implying a need to be up to date with regulatory and legislative developments and to be aware of specific regulations regarding advertising, data protection and competition. These are not exhaustive. So, for example, as the **Bribery Act 2010** was enacted in the UK its implications needed to be understood and acted upon to ensure the compliance regime within the firm, including the updating or developing of policies and approach where necessary.

From a legal perspective, the decisions of the **Financial Ombudsman Service (FOS)** are highlighted. These decisions are independent of the court system and demonstrate the FOS' expectations of the fair treatment of consumers.

Case study
You are an intermediary. Your internal compliance procedures state that the renewal process for a client should begin one month prior to renewal. You are aware that a particular client will be on holiday for a significant part of the period immediately prior to renewal and that there is likely to be a need to consider other insurers' terms because of the poor claims experience during the current policy period.

We are concerned here with the difference between the 'spirit' and the 'letter'. You would arguably be acting compliantly if you were to commence the renewal process one month before renewal. However, to act ethically, you would need to start the process earlier to be able to give your client advice in good time to make an informed decision.

C2B Highest ethical standards and integrity

Honesty, trustworthiness and reliability underpin this section of the Code. It deals with avoiding taking unfair advantage of a client, a colleague or a third party. It prohibits wrongly motivated inducements (whether given or received) or even those that have the appearance of implying an improper obligation. This section is not all prohibitory. Members must promote professional standards and encourage the use of ethical codes within their firms.

This section also covers membership of the CII and the use of CII designations. It includes a requirement to advise the CII of material changes in circumstances that affect either of

these. Operating professionally extends to being financially responsible, including the need to remain solvent.

Key questions include assessing the likely perception of others of ethical standards seen from our actions, whether we need to refer to someone more senior for advice and matters of trustworthiness. The difference between 'getting away with things' and positive ethical behaviour is highlighted.

Case study

You work for an insurance company. You have an expense account that permits you to entertain intermediaries that are likely to generate new business flows. There is a stated limit for any one meal/event. A particular intermediary shows encouraging signs of being willing to consider placing business with you having not been a supporter of yours in the past.

The issue here is the extent to which it is appropriate to entertain for legitimate reasons and the point at which this would be seen as providing a level of inducement that may appear to point towards an improper obligation. Continual entertaining patterns or expensive one-off events may fall in this category. From the intermediary's viewpoint, support for an insurer that is based upon personal entertainment levels for the intermediary's benefit, rather than any real benefit to the client is wrong and so is the provision of entertainment by the insurer that encourages such behaviour.

C2C The best interests of each client

The fair treatment of clients is a key theme of the FCA and of the Code. Members should encourage their firms to place the fair treatment of clients at the centre of the firm's corporate culture. Emphasis is placed on understanding and meeting client needs and providing comprehensive information so that an informed decision can be made by the client. Promises about product performance and after sales service must be true. Confidentiality and the need to avoid conflicts of interest are dealt with.

Key questions in this section focus upon honesty, truthfulness, and objectivity. They also cover the rewards culture within the firm and the need to take account of client requirements, emphasising the need for two-way communication with clients.

Case study

You are an intermediary that has arranged separate private motor insurances for two different clients. As part of your service you have agreed to attempt to recover for each client their uninsured losses (costs of car hire, out of pocket expenses etc.) following a non-fault motor accident. There is a car collision involving both your clients and each maintains that it is the fault of the other.

The issue that arises here is the way that you ensure that you treat each client fairly. It is insufficient simply to 'know' yourself that you will be fair and even handed with each. You clearly cannot avoid this conflict (since you have already agreed to act for each). An ethical approach is firstly to disclose the conflict to each client. Secondly, a course of action should be proposed acceptable to each party. An example would be the allocation of the handling of each separate claim to a different member of staff to represent each of their separate interests, or that the uninsured loss claims are managed by the insureds' chosen legal representatives. Such 'arm's length' arrangements may often be the only effective means of being fair and of being seen to be fair to each client.

C2D High standard of service

Communication with clients must be accurate and straightforward. Transparency (including fees and other costs) and suitability are the main elements of this section, which also emphasises the need for a member to recognise their personal limitations and to keep up to date, meeting any CPD requirements.

Key questions highlight the need for reliability in the fulfilment of promises and a positive attitude towards personal improvement. Approachability is a key quality, ensuring those supervised are properly motivated and trained. Lessons must be learned from complaints and customer satisfaction feedback.

Case study
You work for an insurance company. An analysis of recent customer complaints shows that the team you manage is receiving an increasing number of complaints that customers expected to be covered under their policies, but were excluded. The timing coincides with the introduction of a rewritten series of scripted answers for the provision of information about cover (provided at point of sale). Its introduction reduced the average time for each sale significantly.

Although the motivation for the introduction of the new scripted answers may have seemed sound financially, an appropriate ethical approach now prompts us to analyse whether the possible connection between providing less information and the increase in unexpected excluded claims is substantiated. If there is real connection, then the insurer (and the team) is failing in its promises and this needs to be addressed and corrected. As team leader this should be pursued. It is unethical to simply 'accept' the greater level of complaints as an unfortunate but necessary byproduct of the greater efficiencies.

C2E Treating people fairly (non-discrimination)

The focus of this section is the avoidance of unfair discrimination on grounds of age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion and beliefs, sex, and sexual orientation. It relates to the equality and diversity laws in the member's country. Rules require that each person is treated as an individual and emphasise openness, fairness, respect and opportunity.

The key questions emphasise the need to consider actions or treatment from the perspective of the other individual and to consider whether any requests present unnecessary barriers or difficulties.

Case study
You work for an insurance company that has a practice of offering travel insurance for those up to 70 years of age. You have been challenged about this practice by someone who is 74 years of age arguing that they are fitter than most 65 year-olds.

The question here revolves around legitimate (or otherwise) practice in discrimination on grounds of age. It would be inappropriate simply to state that it was 'company practice' and leave things there. There is no absolute answer but an ethical response would be to establish that differential treatment had been justified by data fairly reflecting the different risk profiles of different age groups. Acceptable evidence would be supported by actuarial, statistical, medical or other information relating to the person's age provided that it was relevant, accurate and from a source upon which it was reasonable to rely. Any response should be related to these facts.

Activity
Take a look at the CII Code of Ethics in appendix 2. Consider your everyday working life and measure your approach to your work and actions against the principles (and key questions posed) as far as they apply to your job role.

D Training and competence

While the FCA relies upon its high-level rules to provide the framework and principles for ***training*** and ***competence***, a separate sourcebook provides more detailed rules that relate to achieving and maintaining competence for specific categories of firm. For all firms, the FCA places great importance on the quality of performance and especially the quality of advice given to clients.

Refer to
Refer back to *Senior management arrangements, systems and controls (SYSC)* on page 10/11 for details of the SYSC requirements

High-level rules, applying to all authorised firms, are found in the senior management arrangements, systems and controls (SYSC) sourcebook. Firms should satisfy themselves of the suitability of those acting on their behalf and this includes honesty as well as competence. The principles are that a firm must:

- employ personnel with the skills, knowledge and expertise necessary for the discharge of the responsibilities allocated to them; and
- take into account the nature, scale and complexity of its business and the nature and range of financial services and activities undertaken in the course of that business.

For those providing advice in the general insurance sector, the extra requirements of the training and competence sourcebook apply only to firms whose employees advise on contracts with consumers. (A firm may choose to take account of the extra requirements in the training and competence sourcebook even if they are not subject to its terms.)

Competence means having the skills, knowledge and expertise needed to discharge the responsibilities of the employee's role. This includes achieving a good standard of ethical behaviour. The FCA states that there are three key areas of training and competence that all firms need to consider. These are:

- assessing competence;
- maintaining competence; and
- record-keeping.

It is necessary to supervise employees until such time as they demonstrate the necessary competence to carry on the activity. Subsequently, supervision is expected to be less intense. Assessing an employee as competent must follow clear criteria and procedures. These should be in place in every firm, so that it can demonstrate when and why a reduced level of supervision was considered appropriate.

Firms must have in place a detailed written manual that indicates how they deal both with the assessment of competence and its maintenance at every stage of an employee's development. This applies from the initial checking of information when a person first applies for a job, through to the point at which they are deemed to be competent. It then continues to apply to the maintaining of that competence level, through appropriate continuing professional development.

Consider this…

How would you go about assessing whether someone was competent to do the task set for them?

You should note that the FCA does insist on a range of approved qualifications for those who wish to provide financial advice in areas of life insurance, pensions and investments. However, they do not have such a range for general insurance, though firms may choose to use an approved qualification as part of their means of establishing competence.

Once competent, the maintenance of competence must take account of:

- technical knowledge and its application;
- skills and expertise; and
- changes in the market and to products, legislation and regulation.

For firms advising on insurance, the FCA requires that records of training and assessment of competence must be kept for at least three years from the time that the employee ceased to carry out that role.

Be aware
The **Insurance Distribution Directive (IDD)**, which came into effect in October 2018, imposes a requirement on those directly involved in the 'distribution' of insurance (broadly speaking those involved in activities that are regulated by the FCA) and those supervising them to do at least 15 hours of professional training or development per year. The staff knowledge and competence requirements will apply to insurers and intermediaries. The FCA proposes to apply them only to those employees directly involved in insurance distribution. This includes relevant people within the management structure with responsibility for insurance distribution (for example, product or sales managers). The requirements will not apply to employees in ancillary roles such as HR, facilities management and IT.

IDD examined in *Insurance Distribution Directive (IDD)* on page 10/27.

E Complaints procedures

In *Complaints monitoring* on page 10/21 we considered the procedures for reporting complaints that an authorised firm must follow. The FCA requires its detailed rules to be incorporated into each firm's procedures. We will consider the effect of the **Dispute Resolution: Complaints (DISP) sourcebook** and the way in which a compliant complaints system should operate.

Every authorised firm should order its recruitment methods, training programmes and systems in such a way that complaints should not arise. However, if they do arise there must be an effective system in place that complies with regulatory requirements and standards.

In some companies, complaints procedures are wider in scope than is strictly required by regulation. They consider it to be more straightforward to treat all those affected by their business activities equally when it comes to any grievance that they may have. More stringent regulatory rules apply to 'eligible complainants'.

Thorough complaints procedures also:

- limit the impact of customer dissatisfaction;
- avoid exposure to errors and omissions claims;
- enable an insurer to identify problems with its systems and rectify them; and
- enable an insurer to improve its standards.

A complaint may emanate from a number of sources. FCA regulation is concerned with two categories of complainant, 'eligible' and 'non-eligible' (defined later), though in practice handling procedures may embrace all types of complaint.

Prompt resolution of complaints, from whatever source, satisfactorily and fairly, will automatically discharge regulatory responsibilities. There are certain specific FCA rules that relate to eligible complainants, since they have an automatic right to pursue their complaint through the FOS. A firm must appoint a senior individual at a firm, or in the same group as the firm, to have responsibility for oversight of the firm's compliance with the FCA's complaints handling rules and for the overall **complaints handling** function in the firm.

Each stage in the handling of a complaint is important. The starting point is establishing whether the situation falls within the firm's definition of a complaint. If so, it must then be recorded, investigated and a decision made that is appropriate, timely and fair by someone independent of the original complaint. In order to operate the system fairly and impartially a firm may decide that every complaint must be referred to, say, the head of department. They will then determine whether it is to be treated as a complaint and who should handle it.

Be aware
The **Insurance Distribution Directive (IDD)** imposes requirements on both insurers and reinsurers in respect of dispute resolution. DISP already incorporates many of the requirements but there will be some minor changes needed to comply with the IDD.

E1 Definition of a complaint

A complaint is defined in DISP as:

> Any oral or written expression of dissatisfaction, whether justified or not, from, or on behalf of, a person about the provision of, or failure to provide, a financial service, which alleges that the complainant has suffered (or may suffer) financial loss, material distress or material inconvenience.

An 'eligible complainant' is defined as a:

- consumer;
- micro-enterprise;
- charity with an annual income of less than £6.5m;
- trustee of a trust with a net asset value of less than £5m;
- consumer buy-to-let (CBTL) consumer;
- small business at the time the complainant refers the complaint to the respondent; or
- guarantor.

All complaints from eligible complainants are subject to FCA complaints handling rules and complainants within these categories have a right of access to the ***Financial Ombudsman Service (FOS)***. The FOS will determine eligibility by reference to appropriate evidence, such as audited accounts or value added tax returns.

Be aware
The eligibility of 'small businesses' was introduced on 1 April 2019, as part of an extension of the FOS' jurisdiction, alongside increases to the upper limit for a charity's annual income and a trust's net asset value (both previously £1m).

For non-eligible complainants, firms must have in place, and operate, appropriate procedures for registering and responding to the expression of dissatisfaction.

E2 Recording complaints

All complaints files must be retained for at least three years from the date the complaint was received, and a record must be kept of measures taken for its resolution.

Most firms will have a complaints form that must be completed and kept on file or a master complaints log – this will be used to track the progress of the complaint.

A firm has to keep a register (or log) of eligible complainants in order to be able to fulfil its regulatory reporting responsibilities. Full details of the complaints which have been investigated are also required so that root cause analysis can be undertaken and any trends and issues identified. Firms should be able to demonstrate the steps they have taken to ensure that similar complaints do not occur in the future; for example, by changing processes or retraining.

The firm must update entries in the register (or log) at every material stage of development. The register is then kept as a permanent record.

E3 Time limitations and procedures

There are compulsory time limitations under FCA rules for dealing with complaints from eligible complainants. Every complaint must be acknowledged promptly and the progress of complaints should be monitored.

Where complaints are resolved early (within three business days) they may be handled less formally without sending out a final response letter. In this case, however, firms will still need to issue a Summary Resolution Communication to complainants, advising them that although the complaint appears to have been resolved; if that is not the case, the complainant has a right to refer the matter to the FOS.

Refer to
FOS covered in *Financial Ombudsman Service (FOS)* on page 11/15

Firms should aim to resolve complaints as quickly as possible, and must ensure the complainant is kept informed of the progress of the measures being taken to resolve the complaint.

Within eight weeks of receiving a complaint, a firm must provide either:

a '**final response**' – a written response from the respondent – which	• accepts the complaint and, where appropriate, offers redress or remedial action; or • offers redress or remedial action without accepting the complaint; or • rejects the complaint and gives reasons for doing so; and which • encloses a copy of the FOS standard explanatory leaflet; and • informs the complainant that if they remains dissatisfied with the respondent's response, they may now refer their complaint to the FOS and must do so within six months;
or	
a **written response** which	• explains why it is not in a position to make a final response and indicates when it expects to be able to provide one; • informs the complainant that they may now refer the complaint to the FOS; and • encloses a copy of the FOS standard explanatory leaflet.

The FCA expects that within a period of eight weeks of receipt almost all complaints will have been substantively addressed through a firm's final response or written response as described above.

If a complainant has already indicated acceptance of the response then provided the firm has properly advised the complainant of their rights to refer the matter to the FOS, the firm is relieved of further compliance with the rules.

Lloyd's also has a Personal Lines Claims and Complaints Handling Code. Eligible complainants who have a policy placed at Lloyd's usually have their complaint independently handled by Lloyd's if they remain dissatisfied with the final response they receive from the firm, although they still have a right to pursue their complaint through the FOS.

F Financial Ombudsman Service (FOS)

The **FOS** was introduced following the enactment of the **Financial Services and Markets Act 2000 (FSMA)**, assimilating the independent Ombudsmen that existed under previous regimes. The FOS is an independent body that has a memorandum of understanding with the FCA for cooperation and communication as they carry out their independent roles. Membership is compulsory for all authorised insurers and other authorised firms, including intermediaries.

The FOS is an independent mechanism for dealing with disputes from 'eligible complainants'. It is not concerned with commercial insurances for larger enterprises. The FOS aims to provide both impartial and independent resolution of disputes between either insurer and policyholder or intermediary and client. Although the vast majority of cases referred to the FOS involve claims, any cause for complaint is investigated.

A complainant needs a final response from the firm they have used before a complaint can be referred to the FOS. The complainant then has a period of six months or more (depending on the time period the firm has chosen) from the date of the final decision of the authorised person/firm to refer the matter to the FOS. The FOS ensures that all possible steps are taken by the insurance company or intermediary to try to resolve the dispute. However, if the dispute remains unresolved, the FOS then steps in to review the dispute and make a decision.

Be aware
The maximum award the FOS can require a firm to make to a complainant changed on 1 April 2019. It is now:

- **£355,000** for complaints about actions or omissions by firms that occurred on or after 1 April 2020.
- **£350,000** for complaints about actions or omissions by firms on or after 1 April 2019, and which were referred to the FOS between 1 April 2019 and 31 March 2020.
- **£160,000** for complaints about acts or omissions by firms before 1 April 2019, but which were referred to the FOS after that date.

The FOS may recommend a higher figure, if appropriate, but this will not be binding on the firm.

The complainant must then accept or reject the decision within the time limit specified by the FOS. If the complainant accepts the decision it is binding on the respondent. If the complainant rejects the decision it is not binding and they are free to pursue the matter in court. If the complainant does not respond to the FOS's decision letter it is treated as a rejection and the respondent is not bound by the decision.

On the Web
www.financial-ombudsman.org.uk

G Financial Services Compensation Scheme (FSCS)

The ***Financial Services Compensation Scheme (FSCS)*** is the UK's compensation fund of last resort for customers of deposit-taking companies and investment firms, as well as for those of authorised insurance companies and intermediaries.

The FSCS covers claims against firms where they are unable, or likely to be unable, to pay claims against them. Usually this is when a firm has become insolvent or has gone out of business. The scheme was set up mainly to assist private individuals, although small businesses (broadly speaking those with a turnover of less than £1 million) are also covered.

In the case of insurance, policyholders are protected if they are given advice by or have their policies arranged by an authorised intermediary or are insured by an authorised insurance company under contracts issued in the UK (or in some cases in the European Economic Area, Channel Islands or the Isle of Man). The scheme covers compulsory (e.g. third-party motor insurance), general and life insurance and is usually triggered if an insurance company goes out of business or into liquidation. The amount of compensation a policyholder can receive depends on the type of policy; whether it concerns compulsory insurance, non-compulsory insurance or long-term insurance.

The amount of protection a policyholder can receive depends on the type of policy:

100% protection	• compulsory insurance (third-party motor and employers' liability); • professional indemnity insurance; • long-term insurance (e.g. pensions and life insurance); and • certain claims for injury, sickness or infirmity of the policyholder.
90% protection (no upper limit)	• other types of policy, including general insurance advice and arranging.

The FSCS is funded by a levy on all authorised firms who receive an income from eligible claimants.

On the Web
www.fscs.org.uk

Key points

The main ideas covered by this chapter can be summarised as follows:

Data protection

- The Data Protection Act 2018 (DPA 2018) and General Data Protection Regulation (GDPR) set out data protection law in the UK.
- Personal data is information relating to a living individual who can be identified from that data.
- Data protection principles cover how personal data is processed.
- Data subjects have certain rights in respect of information held about them and these have been strengthened under the DPA 2018 and GDPR.
- Firms are now responsible for demonstrating their compliance with the regulations and ICO has increased supervisory powers with which to regulate. This includes the ability to impose much higher fines.

Consumer Rights Act 2015

- The Consumer Rights Act 2015 provides protection for consumers relating to unfair terms in contracts between a consumer and a trader, seller or supplier.

Ethical standards

- The CII's Code of Ethics is concerned with attitudes and behaviour.
- It has five central principles and 'key questions to ask yourself'.

Training and competence

- Firms must have a detailed written manual indicating how they deal with the assessment of competence and how it is maintained.

Complaints

- The FCA has specific rules as to how complaints from eligible complainants should be handled.

Financial Ombudsman Service (FOS)

- Eligible complainants can refer their complaint to the FOS if not satisfied with the authorised company's response. They must fulfil certain criteria first.
- The FOS is an independent, impartial mechanism for dealing with disputes between policyholders and insurers and between intermediaries and clients.

Financial Services Compensation Scheme (FSCS)

- The FSCS provides compensation to customers of deposit-taking companies, investment firms and authorised insurers and independent intermediaries where the firms are not longer able to meet claims against them.
- Who is eligible to be compensated, and how much they will receive, depends on whether the insurance is compulsory, non-compulsory or long-term.

Question answers

11.1 d. Permission from the person concerned.

Self-test questions

1. An insurer wishes to use a motor policyholder's personal data in connection with a proposed direct marketing campaign. Under the Data Protection Act 2018, it **cannot** proceed with the mailing unless it:

   a. Ensures that all data is held electronically. ☐

   b. Ensures that the policy is still valid. ☐

   c. Guarantees the policyholder's anonymity. ☐

   d. Gives the policyholder permission to opt in or out of the mailing. ☐

2. When considering an insurance contract, the Consumer Rights Act 2015 applies to individuals and:

   a. Brokers. ☐

   b. Insurers. ☐

   c. Reinsurers. ☐

   d. Trade bodies. ☐

3. What are the **main** elements covered in the Chartered Insurance Institute's Code of Ethics that relate to delivering a high standard of service?

   a. Accuracy, transparency and suitability. ☐

   b. Accuracy, price competitiveness and suitability. ☐

   c. Non-discrimination, price competitiveness and suitability. ☐

   d. Non-discrimination, transparency and suitability. ☐

4. What is the limit for an award made by the Financial Ombudsman Service for acts or omissions after 1 April 2020?

   a. £1,000,000. ☐

   b. £500,000. ☐

   c. Unlimited. ☐

   d. £355,000. ☐

5. Which organisation will become involved if an insurance company is unable to pay its claims?

   a. The FOS. ☐

   b. The PRA. ☐

   c. The FSCS. ☐

   d. The FCA. ☐

6. Under the Financial Services Compensation Scheme, for what total percentage of a compulsory third party motor insurance claim may compensation be provided?

a. 100%. ☐

b. 80%. ☐

c. 70%. ☐

d. 90%. ☐

You will find the answers at the back of the book

Appendix 1 Standard fire policy (material damage)

The Insurer agrees (subject to the terms, definition, exclusions, provisions and conditions of this policy) that if after payment of the first premium any of the Property Insured described in the Schedule be lost destroyed or damaged by

1 FIRE but excluding loss destruction or damage caused by
   (a) explosion resulting from fire
   (b) earthquake or subterranean fire
   (c) (i) its own spontaneous fermentation or heating, or
   (ii) its undergoing any heating process or any process involving the application of heat

2 LIGHTNING

3 EXPLOSION
   (a) of boilers
   (b) of gas

   used for domestic purposes only but excluding loss destruction or damage caused by earthquake or subterranean fire

during the period of insurance (or any subsequent period for which the Insurer accepts a renewal premium) the Insurer will pay to the Insured the value of the property at the time of its loss or destruction or the amount of the damage or at the Insurer's option reinstate or replace such property or any part of it

provided that the liability of the Insurer under this policy shall not exceed

(i) in the whole the total sum insured or in respect of any item its sum insured at the time of the loss destruction or damage
(ii) the sum insured remaining after deduction for any other loss destruction or damage occurring during the same period of insurance, unless the Insurer shall have agreed to reinstate any such sum insured.

This policy incorporates the Schedule, Specification and Endorsements which shall be read together as one contract. Words and expressions to which specific meaning is given in any part of this policy shall have the same meaning wherever they appear.

Signed on behalf of the Insurer

DEFINITION

The word "DAMAGE", in capital letters, shall mean loss or destruction of or damage to the Property Insured.

GENERAL EXCLUSIONS

This policy does not cover

1 DAMAGE occasioned by riot civil commotion war invasion act of foreign enemy hostilities (whether war be declared or not) civil war rebellion revolution insurrection or military or usurped power

2 loss or destruction of or damage to any property whatsoever or any loss or expense whatsoever resulting or arising therefrom or any consequential loss directly or indirectly caused by or contributed to by or arising from
   (a) ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel
   (b) the radioactive toxic explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof

3 DAMAGE in Northern Ireland occasioned by or happening through or in consequence of
   (a) civil commotion
   (b) any unlawful wanton or malicious act committed maliciously by a person or persons acting on behalf of or in connection with any unlawful association

For this purpose of this exclusion

"unlawful association" means any organisation which is engaged in terrorism and includes an organisation which at any relevant time is a proscribed organisation within the meaning of the Northern Ireland (Emergency Provisions) Act 1973

"terrorism" means the use of violence for political ends and includes any use of violence for the purpose of putting the public or any section of the public in fear

In any action suit or other proceedings where the Insurer alleges that by reason of the provisions of this exclusion any DAMAGE is not covered by this policy the burden of proving that such DAMAGE is covered shall be upon the Insured

4 loss or destruction or damage caused by pollution or contamination but this shall not exclude destruction of or damage to the Property Insured, not otherwise excluded, caused by
(a) pollution or contamination which itself results from a peril hereby insured against
(b) any peril hereby insured against which itself results from pollution or contamination

5 property which at the time of the happening of DAMAGE is insured by or would but for the existence of this policy be insured by any marine policy or policies except in respect of any excess beyond the amount which would have been payable under the marine policy or policies had this insurance not been effected

6 any property more specifically insured by or on behalf of the Insured

7 consequential loss or damage of any kind or description except loss of rent when such loss is included in the cover under this policy.

GENERAL PROVISIONS

Condition of Average (Underinsurance)
The sum insured by each item (under each column) of this policy (other than those applying solely to fees, rent, removal of debris or private dwelling houses) is declared to be separately subject to Average.

Whenever a sum insured is declared to be subject to Average, if such sum shall at the commencement of any DAMAGE be less than the value of the property covered within such sum insured, the amount payable by the Insurer in respect of such DAMAGE shall be proportionately reduced.

Contracting Purchaser's Interest
If at the time of DAMAGE the Insured shall have contracted to sell his interest in any building hereby insured and the purchase shall not have been but shall be thereafter completed, the purchaser on completion of the purchase (if and so far as the property is not otherwise insured against such DAMAGE by him or on his behalf) shall be entitled to benefit under this policy without prejudice to the rights and liabilities of the Insured or the Insurer until completion.

GENERAL CONDITIONS

1 **Policy Voidable**
This policy shall be voidable in the event of misrepresentation misdescription or non-disclosure in any material particular.

2 **Alteration**
This policy shall be avoided with respect to any of the Property Insured in regard to which there be any alteration after the commencement of this insurance
(a) by removal or
(b) whereby the risk of DAMAGE is increased or
(c) whereby the interest of the Insured ceases except by will or operation of law
unless admitted by the Insurer in writing.

3 **Warranties**
Every warranty to which this policy or any item thereof is or may be made subject shall from the time the warranty attaches apply and continue to be in force during the whole currency of this policy. Non-compliance with any such warranty in so far as it increases the risk of DAMAGE shall be a bar to any claim in respect of such DAMAGE provided that whenever this policy is renewed a claim in respect of DAMAGE occurring during the renewal period shall not be barred by reason of a warranty not having been complied with at any time before the commencement of such period.

4 **Reasonable Precautions**
The Insured shall take all reasonable precautions to prevent DAMAGE.

CLAIMS CONDITIONS

1 **Action by the Insured**

(a) In the event of DAMAGE the Insured shall

— notify the Insurer immediately

— notify the Police Authority immediately it becomes evident that any DAMAGE has been caused by Malicious Persons

— carry out and permit to be taken any action which may be reasonably practicable to prevent further DAMAGE

— deliver to the Insurer at the Insured's expense

(i) full information in writing of the property lost destroyed or damaged and of the amount of DAMAGE

(ii) details of any other insurances on any property hereby insured

within 30 days after such DAMAGE or such further time as the Insurer may allow

(iii) all such proofs and information relating to the claim as may reasonably be required

(iv) if demanded, a statutory declaration of the truth of the claim and of any matters connected with it.

(b) No claim under this policy shall be payable unless the terms of this condition have been complied with.

2 **Fraud**

If a claim is fraudulent in any respect or if fraudulent means are used by the Insured or by anyone acting on his behalf to obtain any benefit under this policy or if any DAMAGE is caused by the wilful act or with the connivance of the Insured all benefit under this policy shall be forfeited.

3 **Reinstatement**

If any property is to be reinstated or replaced by the Insurer the Insured shall at his own expense provide all such plans documents books and information as may reasonably be required. The Insurer shall not be bound to reinstate exactly but only as circumstances permit and in a reasonably sufficient manner and shall not in any case be bound to expend in respect of any one of the items insured more than its sum insured.

4 **Insurer's Rights following a Claim**

On the happening of DAMAGE in respect of which a claim is made the Insurer and any person authorised by the Insurer may without thereby incurring any liability or diminishing any of the Insurer's rights under this policy, enter take or keep possession of the premises where such DAMAGE has occurred and take possession of or require to be delivered to the Insurer any property insured and deal with such property for all reasonable purposes and in any reasonable manner. No claim under this policy shall be payable unless the terms of this condition have been complied with.

No property may be abandoned to the Insurer whether taken possession of by the Insurer or not.

5 **Contribution and Average**

If at the time of any DAMAGE there is any other insurance effected by or on behalf of the Insured covering any of the property lost destroyed or damaged the liability of the Insurer hereunder shall be limited to its rateable proportion of such DAMAGE.

If any such other insurance shall be subject to any average (underinsurance) condition this policy if not already subject to any such condition of average shall be subject to average in like manner.

If any such other insurance is subject to any provision whereby it is excluded from ranking concurrently with this policy either in whole or in part or from contributing rateably the liability of the Insurer under this policy shall be limited to that proportion of the DAMAGE which the sum insured under this policy bears to the value of the property.

6 **Subrogation**

Any claimant under this policy shall at the request and expense of the Insurer take and permit to be taken all necessary steps for enforcing rights against any other party in the name of the Insured before or after any payment is made by the Insurer.

7 **Arbitration**

If any difference arises as to the amount to be paid under this policy (liability being otherwise admitted) such difference shall be referred to an arbitrator to be appointed by the parties in accordance with statutory provisions. Where any difference is by this condition to be referred to arbitration the making of an award shall be a condition precedent to any right of action against the Insurer.

Appendix 2
CII Code of Ethics

Introduction

The Chartered Insurance Institute is committed to setting, maintaining and supporting high professional and ethical standards in insurance and financial planning.

In order to uphold these standards, the Chartered Insurance Institute requires all members to adhere to its Code of Ethics.

The Code sets down the principles which all Chartered Insurance Institute members must follow in the course of their professional duties.

As such you are required to:

1. Comply with the Code and all relevant laws and regulations.
2. Act with the highest ethical standards and integrity.
3. Act in the best interests of each client.
4. Provide a high standard of service.
5. Treat people fairly regardless of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Failure to comply with the Code may result in individual sanctions and adverse publicity for the member and the member's employer.

Note: the Chartered Insurance Institute's Code of Ethics is subject to regular review to ensure it remains relevant and appropriate. This published Code has been updated to improve clarity and to reflect recent changes introduced by the Equality Act. It came into force on 14th April 2014.

For further details visit **cii.co.uk/code**

1. You must comply with this Code and all relevant laws and regulations.

This includes, but is not limited to:

1.1 dealing with the Chartered Insurance Institute in an open, clear and co-operative manner;

1.2 dealing with regulators in an open, clear and co-operative manner;

1.3 ensuring regulators and the Chartered Insurance Institute are treated courteously and not in a vexatious or frivolous manner and that all queries are dealt with promptly;

1.4 meeting any Continuing Professional Development (CPD) requirements;

1.5 working not only within the law but also within the spirit of the law;

1.6 if within your control, making sure your organisation is suitably regulated and has effective compliance arrangements;

1.7 ensuring, where required, you are individually authorised or regulated; and

1.8 reporting any breaches of the Code to the Chartered Insurance Institute.

Where this core duty conflicts with another core duty this duty will have priority over the others.

By way of example, notwithstanding core duty 3, it is your duty to give confidential information to the relevant authorities where the information relates to a criminal act or fraud by your client.

Some key questions to ask yourself:

- Am I up-to-date with recent regulatory and legislative developments?
- Am I aware of general business regulatory requirements covering areas such as advertising, data protection and competition?
- Do I take full account of reports on individual cases from ombudsman services, as well as the wider regulatory and legal framework?
- Do I appreciate the general purpose of the rules I am following, for example, do I follow the letter of the regulation but fail to think about the outcome for my client?
- Am I aware of internal compliance arrangements?
- Do I consider the compliance arrangements within my organisation are effective and comply with all relevant regulations?
- Am I aware of how to update or correct compliance arrangements or whom to contact if they require change or update?

2. You must act with the highest ethical standards and integrity.

This includes, but is not limited to:

2.1 being honest and trustworthy;

2.2 being reliable, dependable and respectful;

2.3 not taking unfair advantage of a client, a colleague or a third party;

2.4 not bringing the financial services industry or the Chartered Insurance Institute into disrepute whether through your actions in work or outside work;

2.5 not offering or accepting gifts, hospitality or services which could, or might appear to, imply an improper obligation;

2.6 promoting professional standards within the industry;

2.7 encouraging your organisation to produce an ethical code;

2.8 making sure your Chartered Insurance Institute membership or chartered status is described correctly;

2.9 informing the Chartered Insurance Institute of any change in your work or circumstances which affect your membership or chartered status; and

2.10 operating both professionally and in a financially responsible manner including avoiding personal insolvency.

Key questions:

- What would an outsider think of what I am doing, and does this matter ethically?
- How would my actions look to the Chartered Insurance Institute?
- Should I discuss my proposed actions with my superior or another appropriate person or the Chartered Insurance Institute?
- Do I know if my organisation has an ethical code and do I fully understand it?
- Does my organisation reward good ethical behaviour?
- Does my organisation follow a whistle blowing policy?
- How can I promote trust in my organisation and the financial services industry?
- Do people trust me? If not, why not?
- Do I think it is OK if I don't get caught?
- Do I say "show me where it says I can't" or do I say "is this ethical"?
- Why am I being entertained or offered hospitality?

3. You must act in the best interests of each client.

This includes, but is not limited to:

3.1 encouraging your organisation to put fair treatment of clients at the centre of its corporate culture;

3.2 basing your decisions on a clear understanding of client needs, priorities, concerns and circumstances;

3.3 giving your client all the information, of which you are aware, which is needed for your client to make an informed decision provided that information is not confidential to another client;

3.4 making sure the promises you make to clients about a product's performance and the after sale service are true;

3.5 respecting confidential information of clients, former clients and potential clients;

3.6 ensuring you do not use information from work improperly and/or to your personal or business advantage;

3.7 turning down work where a conflict of interest exists between you or your employer and the client; and

3.8 refusing to act where a conflict of interest exists, save where acting in these circumstances is expressly permitted by a regulator.

A conflict of interest is a situation in which someone has competing professional or personal interests. Depending on the circumstances, there may be a perceived rather than an actual conflict of interest. Both perceived and actual conflicts must be dealt with appropriately.

Conflicts of interest can arise where:

- You owe, or your firm or employer owes, separate duties to two or more clients in relation to the same or related matters and those duties conflict or there is a significant risk they may conflict; or
- Your duty to act in the best interests of any client conflicts, or there is a significant risk it may conflict, with your own interests.

Key questions:

- Am I acting fairly towards this client or my employer or my colleagues?
- Are my opinions and statements objective?
- Am I being honest and truthful?
- How can I better help my client to make capable and confident decisions?
- Would I like to be treated in this way if I were a client?
- Is this in the best interests of my client or my bonus?
- Do I try to cover up my mistakes?
- Does my organisation reward arrangements that deliver fair treatment to customers as well as offer incentives to help employees grow the business?
- Are employees rewarded in ways which encourage them to put their client's best interests first?
- If the client is vulnerable, what extra steps can I take to make sure I act in my client's best interest?
- How can I help my clients to understand financial services?
- Do I provide clear information pre and post sale?
- Do I listen to my clients or just hear them?
- Will acting for this client compromise my position?
- If I act for this client will it harm them or be to the detriment of another client?

4. You must provide a high standard of service.

This includes, but is not limited to:

4.1 communicating with each client in a way that is accurate and straightforward and expressed in a way that the individual client can understand;

4.2 being transparent about fees and other costs;

4.3 making sure reasonable steps are taken to ensure all advice is accurate and suitable for the individual client;

4.4 obtaining and providing clear information before, during and after the point of sale;

4.5 ensuring adequate and correct records are kept;

4.6 acting with skill, care and diligence;

4.7 acting only within your ability and authorisation and seeking help where necessary;

4.8 ensuring your knowledge and expertise is kept up-to-date and relevant for your work;

4.9 ensuring those who work for you have appropriate training and supervision and contributing to their learning and development; and

4.10 if it is within your control, making sure your firm has a clear written complaints procedure which is followed.

Key questions:

- Do I do what I say I will do and do it when I say I will?
- How can I improve the service I give my clients?
- Am I approachable?
- Do I give and receive constructive feedback to/from colleagues?
- Does my organisation seek feedback from clients?
- Does my organisation have a swift and effective mechanism for resolving complaints?
- Do I learn from complaints?
- Do I take complaints seriously?
- Can I improve my knowledge by additional training?
- Do I encourage subordinates to increase their knowledge?
- Do I ask for help when I need it?
- Does my organisation have systems for managing paperwork and data which work?
- Does my organisation assess customer satisfaction and provide feedback to employees?

5. You must treat people fairly regardless of:

Age

Disability

Gender reassignment

Marriage and civil partnership

Pregnancy and maternity

Race

Religion and belief

Sex

Sexual orientation

This includes, but is not limited to:

5.1 treating each person as an individual;

5.2 challenging and reporting unlawful or otherwise unfair discriminatory behaviour and practice;

5.3 always acting openly and fairly and treating employers, employees, colleagues, clients, potential clients and suppliers with equal respect and opportunity;

5.4 making reasonable adjustments to assist people with disabilities or particular needs you may deal with at work;

5.5 encouraging your organisation to produce and promote an equality and diversity policy setting out how the business plans to promote equality, diversity and inclusion, prevent discrimination and deal with any instances of discrimination which might happen; and

5.6 if it is within your control, making sure processes and procedures do not discriminate.

You must treat people fairly regardless of continued:

You should be aware:

- Disability is defined as a physical or mental impairment which lasts, or will last, for over a year and which adversely affects the individual's capacity to undertake day to day activities. It includes conditions as diverse as dyslexia and cancer;
- Race includes ethnic or national origin, colour and nationality;
- Religion and belief includes non religious beliefs (including no-religion) and philosophical beliefs which impact upon the way in which an individual chooses to live their life.

Key questions:

- If I belonged to any of these protected characteristics, would I feel unfairly disadvantaged?
- Is what we are asking for more difficult for this person to achieve? And, if so, is the thing we want really necessary or can we make an adjustment to make it easier for the person to achieve?
- What can I do to promote a workforce that is representative of the people we serve?
- Does my organisation have effective equality and diversity training arrangements?
- Does my organisation systematically audit its own policies and practice to ensure that these comply?
- Does my organisation create unnecessary hurdles for this person?

Chapter 1 self-test answers

1 c. Financial, pure and particular.
2 d. Similar risks which help determine a pattern.
3 b. Speculative risk.
4 b. Risk identification, risk analysis and risk control.
5 a. Physical control measure.
6 a. Costs of operating the pool and an element of profit.
7 d. The construction company has a direct contractual relationship with each of the insurers.
8 c. Self-insurance.
9 b. Employers' liability insurance.
10 b. Fixed benefits in the event of an accident, illness or loss of job.

Chapter 2 self-test answers

1 b. Market reform contract.
2 d. Commission based on the premiums charged.
3 a. He can act for Kent Regal Ltd in bringing them into legal relationships with others.
4 b. Actions on behalf of the insurer.
5 a. Insurance brokers.
6 d. The true cost may be higher once fuller details are submitted.
7 b. smooth peaks and troughs in the trading results.
8 c. Some general insurance premiums.
9 a. Compliance officer.

Chapter 3 self-test answers

1 d. Consideration.
2 a. A counter offer.
3 c. May's counter offer acts as a rejection of the original offer.
4 b. A letter of acceptance is posted.
5 d. Premium paid by the insured.
6 a. Travel insurance with a term of less than a month.
7 c. Not be liable for claims resulting from this, but will be liable for losses occurring after a breach has been remedied.
8 d. Agent for the insurer.
9 a. The agent has implied authority.
10 b. Define and allocate the responsibilities and rights of each party.

Chapter 4 self-test answers

1 c. Subject-matter, legal relationship and financial value.
2 b. Subject-matter.
3 d. Subject matter of the contract.
4 a. Still enforceable because insurable interest existed at inception.
5 b. He had no financial interest in the car at the time of the claim.
6 d. General insurance.
7 b. Ownership, contract and legislation.
8 a. Bailee.
9 c. They may be liable for the cost of repairs.
10 c. Agent for the other party.

Chapter 5 self-test answers

1 a. The duty of disclosure ends at inception of the policy.

2 b. Her epilepsy is relevant information and she has a duty to disclose this to her insurer.

3 a. To ensure changes to business activity are notified.

4 d. The insurer is deemed to have waived its rights regarding the missing information.

5 c. Met in full as Sakon's insurer had not sought further details.

6 c. Influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms.

7 d. Details of the proposer's circumstances that relate to the insurance being applied for.

8 a. Refuse the claim, set the whole contract aside, and retain the premium.

9 b. Compulsory motor insurance.

10 d. For third party injury and property made compulsory by statute.

Chapter 6 self-test answers

1 b. There is always a direct link between proximate cause and resulting loss.
2 a. Storm.
3 d. Fight.
4 c. More than a single cause.
5 a. The storm.
6 d. An excluded peril.
7 b. Not mentioned in the policy.
8 c. Uninsured peril.
9 b. The proximate cause was an insured peril.
10 d. Named in the policy as specifically not covered.

Chapter 7 self-test answers

1 a. Legally entitled to financial compensation.
2 b. Restores the subject matter to the same condition it was in before the loss.
3 b. A value can be placed on the subject matter insured.
4 a. A reinstatement memorandum clause.
5 d. Labour and costs in respect of work in progress and finished stock.
6 b. Farming stock.
7 c. First loss policy.
8 c. There is a single item limit.
9 d. £1,500.
10 a. Underinsurance.

Chapter 8 self-test answers

1 b. Contribution.
2 c. 2/3.
3 d. £10,000.
4 a. The insured.
5 a. A tort.
6 c. The insurer.
7 b. £1,500.
8 d. Has no subrogation rights.
9 a. A benefit policy.
10 c. Negligent third party of the insured.

Chapter 9 self-test answers

1 c. Travel insurance.
2 d. Professional indemnity insurance.
3 b. Privity of contract.

Chapter 10 self-test answers

1 d. The PRA and FCA.
2 b. Have a head office in Europe.
3 a. Adequate.
4 b. Financial Conduct Authority.
5 a. When the approved person has deliberately breached the regulations.
6 d. Financial Conduct Authority.
7 a. Placement, layering and integration.
8 d. The National Crime Agency.
9 b. To empower authorities to confiscate funds where it is believed that such funds have been obtained unlawfully.

Chapter 11 self-test answers

1 d. Gives the policyholder permission to opt in or out of the mailing.
2 b. Insurers.
3 a. Accuracy, transparency and suitability.
4 d. £355,000.
5 c. The FSCS.
6 a. 100%.

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