Asian Institute of Insurance
(Formerly known as Malaysian Insurance Institute)

PRE-CONTRACT EXAMINATION FOR INSURANCE AGENTS (PCEIA)

10th edition

Aii Certificate Series

Pre Contract Examination for Insurance Agents

10th Edition

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APPRECIATION

Asian Institute of Insurance would like to thank Life Insurance Association of Malaysia (LIAM) and General Insurance Association of Malaysia (PIAM) for their invaluable contribution, support and assistance rendered in making the publication of this new edition possible.

Pre Contract Examination for Insurance Agents

10th Edition

BRIEF CONTENTS

ASIAN INSTITUTE OF INSURANCE

Asian Institute of Insurance (Aii) is the foremost professional organisation for insurance professionals in Malaysia, dedicated to upholding the highest standards of professionalism, ethical conduct, and expertise within the insurance industry.

We are committed to fostering your personal and career development through Aii's membership offerings and the multitude of advantages they bring. Our focus is on enhancing your knowledge and expertise through our comprehensive insurance qualifications while equipping you with the essential skills required to thrive in a competitive industry.

Whether you aspire to attain a prestigious designation in insurance, expand your professional network, or advance your career within the insurance sector, Aii empowers you to excel by providing the guidance and resources necessary to pave your way to success

THE DEVELOPMENT TEAM

Asian Institute of Insurance would like to thank the following people for their invaluable contribution, support, and assistance rendered in making the publication of this new edition possible.

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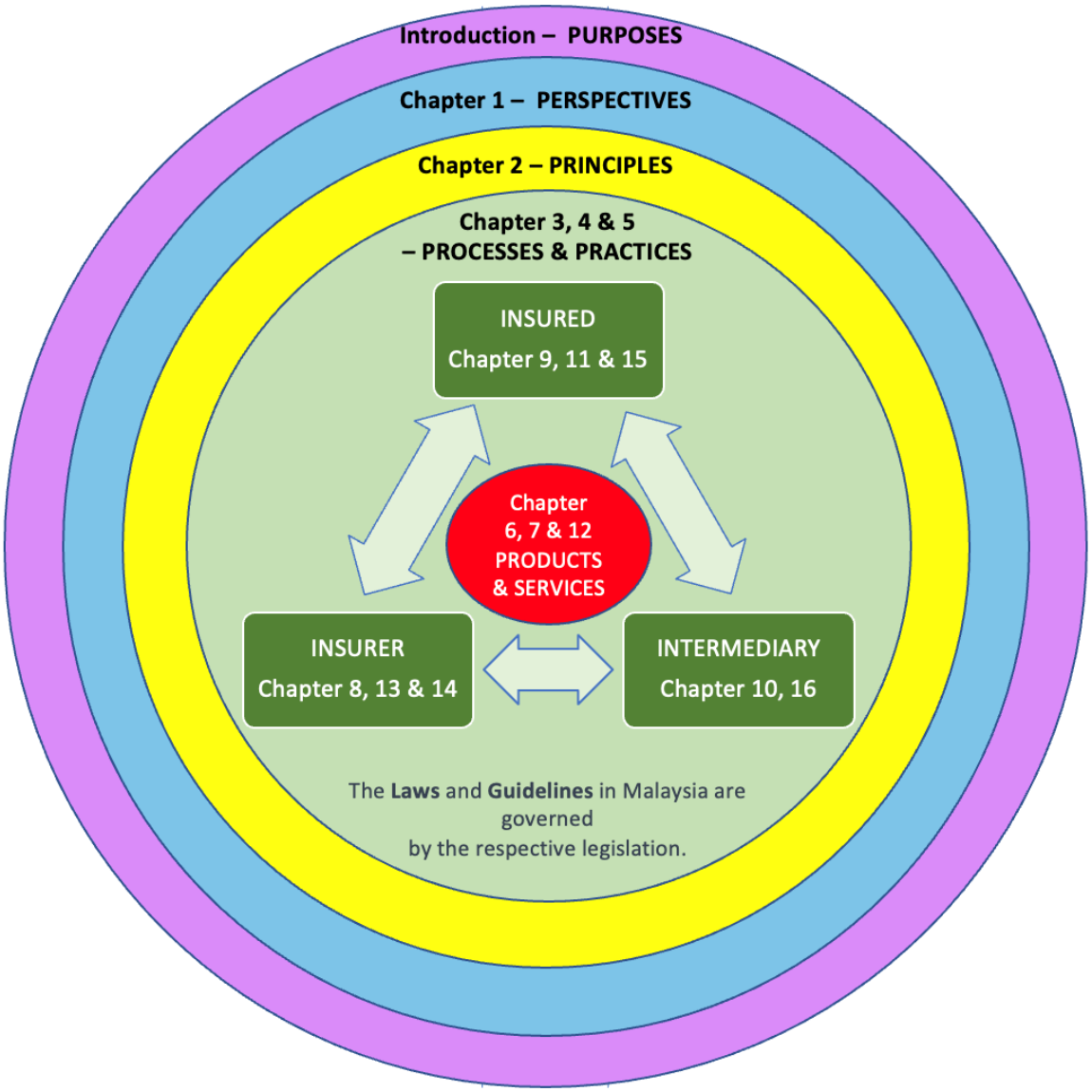
PREFACE

WELCOME TO YOUR PRE CONTRACT EXAMINATION FOR INSURANCE AGENTS STUDY TEXT



THE ABSTRACT OF PCEIA

Let us prepare ourselves for the **PCEIA** by reviewing a few 'Key Words' that will facilitate a quick grasp of the entire content. They are the **6 'P'** and the 3 'I'. We will expand on each topic at their respective chapter accordingly.

Introduction: The **Purposes**[1] & Benefit of Insurance

Life insurance serves a noble purpose by offering financial security and protection. It safeguards dependents, aids in estate planning, and ensures business continuity in the face of death, disability, or illness.

General insurance's noble purposes revolve around mitigating financial losses and providing protection against risks. It offers financial security, aids in risk management, and contributes to social and economic stability.

Chapter 1: **Perspectives**[3] on Insurance & Risk Management

Gain a solid foundation in insurance and risk management as you embark on your licensing journey. Explore risk classification, concepts of peril, hazard, and loss. Understand risk management methods. Delve into insurable risks, insurance market dynamics, and industry trends. Learn from historical perspectives and prepare for future challenges. This chapter offers comprehensive insights into Malaysia's insurance landscape.

Chapter 2: Basic **Principles**[3] of Insurance

The Principles of Insurance serve as fundamental concepts and guidelines that underpin the insurance industry. These principles include principles of utmost good faith, insurable interest, indemnity, subrogation, contribution, and proximate cause. Compliance with these principles ensures fairness, integrity, and transparency in insurance transactions.

Chapter 3, 4 & 5: Overview of the Contract Act and Financial Services Act in Malaysia

These chapters highlight the Contract Act and Financial Services Act (FSA) in Malaysia, which are key legislative frameworks governing the life and general insurance industries. They establish the policies and guidelines that regulate all processes and practices within these sectors.

The Contract Act ensures that insurance contracts are legally binding, transparent, and fair, while the FSA provides a robust framework for the regulation and supervision of insurance companies. Together, these laws support the integrity, stability, and transparency of the insurance industry in Malaysia. Adherence to these guidelines fosters trust and confidence among policyholders and contributes to the overall health of the financial system.

Important Note: **Chapters 3, 4 & 5** provide the context for and dictate the content of all the following chapters.

Chapter 8, 13 & 14: **Processes**[4] & **Practices**[5] surrounding the Insurer[1]
Chapter 9, 11 & 15: **Processes**[4] & **Practices**[5] surrounding the Insured[2]
Chapter 10, & 16: **Processes**[4] & **Practices**[5] surrounding the Intermediary[3]

Processes[4] that connect the Insured, Insurer and the Intermediary in the Insurance Industry are governed and guided by:

- **The Law of the Country**
  The law of the country remains the highest authority and provides the legal foundation for all activities, including insurance. It encompasses statutes, acts, and regulations that govern insurance operations and practices.

- **Guidelines of Various Regulatory Agencies**
  Regulatory agencies, such as insurance regulatory bodies, issue guidelines and regulations to interpret and implement the law and Principles of Insurance. These guidelines provide more specific instructions on insurance operations, market conduct, and consumer protection.

- **The Insurance Contract**
  The Insurance Contract represents the contractual agreement between the insurer and the policyholder. It outlines the terms, conditions, and coverage provided by the insurance policy. Compliance with the terms of the contract is essential for both the insurer and the policyholder to ensure the proper functioning of the insurance relationship.

The **Practices**[5] with the Insurance Industry are operationalized through the application of:

- **The Rules of Various Processes or Procedures**
  Within the insurance industry, there are established rules and procedures that govern various aspects of insurance operations. These rules cover areas such as underwriting, claims handling, policy issuance, premium calculation, and policy servicing. They provide detailed instructions and standards to ensure consistency and efficiency in insurance processes.

- **The Practice of All the Above by Common People**
  The ultimate test of compliance and effectiveness lies in the actual practice and behavior of individuals, including insurance companies, intermediaries, and policyholders. It is their responsibility to understand and comply with the law, principles, guidelines, and contractual obligations. Adhering to these principles and implementing the prescribed processes ensures fair and ethical conduct in the insurance industry.

Chapter 6, 7 & 12: The **Products**[6] & Services

- **Types of Insurance Products and Services**
  These chapters describe the various insurance products that are designed to serve diverse needs. Understanding their features, benefits and limitations is essential before recommending them to clients.

In summary, the order of importance in the context of regulatory compliance and governance starts with the law of the country as the highest authority, followed by the guidelines issued by regulatory agencies, the rules governing specific processes or procedures, and ultimately the practice and adherence to these by individuals and organizations. Each level builds upon the other to create a comprehensive framework that promotes legal and ethical conduct while ensuring the smooth functioning of industries and sectors within the country.

By incorporating the Principles of Insurance and the Life Insurance Contract into this hierarchy, we enhance the framework to account for the specific principles and contractual obligations unique to the insurance industry. This expanded framework further promotes legal compliance, ethical behavior, and the proper functioning of insurance transactions within the broader regulatory context.

INTRODUCTION: THE PURPOSES & BENEFITS OF INSURANCE

Welcome to Pre-Contract Examination for Insurance Agents (PCEIA).

Whether You are:

- Contemplating Building a Professional Career in The Lucrative Insurance Business,
- Desiring to Build an Alternative or Additional Income Source,
- Purposed in Your Heart to Protect Family Members & Friends from Financial Uncertainty,
- A Student of Psychology, Finance, Economics, Law, Marketing, Digitization, or
- Seeking an Avenue to Hone Your Business Acumen before Embarking on Your True Passion.

The life insurance and general insurance communities warmly welcome You. Our businesses revolve around providing individuals and businesses with financial protection, peace of mind, and stability in the face of various risks and uncertainties.

In essence, your role as an insurance intermediary is to stand alongside Your clients and help ensure that every family member will always have:

- Food on their tables,
- Clothes on their backs,
- Roofs over their heads,
- Books in their hands, and
- Pride and dignity when they retire.

By undertaking the PCEIA, you are taking a significant step toward becoming a trusted advisor who can guide individuals and businesses in securing their financial future. We are excited to have You join our industry and contribute to the well-being of individuals, families, and communities through the invaluable services You will provide as an insurance intermediary.

1. The Purpose of Life Insurance

Life insurance serves the noble purpose of providing financial security and protection to individuals and their families. It ensures that loved ones are financially supported in the event of the insured's death, disability, or illness. The essence of life insurance lies in:

1.1 Income Protection
2.1 Education and Retirement Planning
3.1 Estate Planning
4.1 Business Continuity

1.1 Income Protection

Life insurance allows individuals to provide for themselves and their dependents, ensuring their financial needs, such as mortgage payments, education, and living expenses, are met even after the insured's death. Here are some examples or scenarios that illustrate how life insurance can specifically address the financial needs of dependents and to an individual:

1.1.1 Ongoing Living Expenses

Imagine a family where the primary breadwinner suddenly passes away. The life insurance policy ensures that the surviving spouse and children can continue to meet their daily living expenses, such as mortgage or rent payments, utility bills, groceries, and other essential needs. It provides a source of income replacement, allowing the family to maintain their standard of living even in the absence of the primary earner.

1.1.2 Final Expenses and Debt Cancellation

Final Expenses and Debt Cancellation are crucial aspects of life insurance that address the immediate financial obligations following the death of the insured. These expenses include:

a. Outstanding Income Tax
   Ensuring that any remaining tax liabilities are settled to prevent legal complications for surviving family members.

b. Mortgage
   Paying off the remaining balance on a home loan to provide security and stability for the deceased's family.

c. Car Loan
   Settling auto loans to avoid repossession and financial strain on loved ones.

d. Personal Loan or Overdraft
   Clearing any personal loans or overdrafts to protect the financial well-being of the surviving family members.

e. Hospital Bills
   Covering any medical expenses incurred during the insured's final illness or injury.

f. Funeral Expenses
   Handling the costs associated with the funeral, burial, or cremation, which can be substantial.

g. Overseas Inheritance Tax/Estate Duty
   Addressing any inheritance taxes or estate duties that may be due on overseas assets to ensure smooth transfer of the estate.

By addressing these financial obligations, life insurance alleviates the burden on the surviving family, allowing them to focus on grieving and recovery without the added stress of managing significant debts and expenses. This support ensures that the deceased's financial responsibilities are met, preserving the family's financial stability and peace of mind

1.1.3 Education Costs

Life insurance can also help secure the future education of dependents. In the event of the insured's death, the policy's death benefit can be used to cover educational expenses, including school tuition fees, college or university costs, and other related expenses. This ensures that the insured's children can pursue their educational goals without financial burden or compromise.

1.1.4 Healthcare Needs

Serious illnesses or disabilities can have a significant impact on a family's financial stability. Life insurance policies with additional benefits or riders, such as hospital and surgical coverage or disability benefits, can provide financial support in such situations. The policy's proceeds can be used to cover medical expenses, rehabilitation costs, and ongoing healthcare needs, ensuring that the family has access to quality healthcare without depleting their savings.

1.1.5 Critical Illness Coverage

Critical illness coverage is a rider that provides a lump sum payment if the insured is diagnosed with a specified critical illness, such as cancer, heart attack, stroke, or kidney failure. This benefit helps alleviate the financial burden associated with expensive medical treatments, ongoing care, or lifestyle adjustments that may be necessary following a critical illness diagnosis.

1.1.6 Disability Benefits

Disability benefits rider provides financial protection in case of a disability that prevents the insured from working and earning income. If the insured becomes disabled and meets the policy's disability criteria, this rider provides regular income payments or a lump sum benefit to replace lost earnings and assist with living expenses during the disability period.

1.1.7 Accidental Death and Dismemberment (AD&D) Coverage

AD&D coverage is a rider that offers an additional death benefit if the insured's death occurs as a result of an accident. It may also provide benefits in case of severe injuries or dismemberment caused by an accident, such as the loss of a limb or eyesight. AD&D coverage can provide additional financial support to the insured's family in case of accidental death or help cover medical expenses and rehabilitation costs in case of severe injuries.

1.2 Education and Retirement Planning

Life insurance products encourage thrift, disciplined saving, and compelled long-term investment. By committing to regular premium payments, individuals are essentially forced into a disciplined savings regimen. This disciplined approach ensures that funds are consistently set aside for significant future needs, such as children's education or retirement. The long-term nature of life insurance policies compels policyholders to maintain their contributions over time, fostering a habit of saving and investing. This enforced saving mechanism not only provides financial protection but also helps in accumulating a substantial corpus for future goals, securing both the policyholder's and their family's financial stability.

1.3 Estate Planning

Life insurance can be used as a tool for estate planning, helping individuals pass on their wealth and assets to beneficiaries and mitigate potential estate taxes. Life insurance plays a significant role as a tool for estate planning by providing financial support and liquidity to fulfill the objectives outlined in an individual's will, trust, or foundation. Here is an overview of how life insurance can be used in conjunction with these estate planning tools:

1.3.1 Will supported with Life Insurance

A will is a legal document that outlines how a person's assets and property should be distributed after their death. Life insurance can be used to financially support the execution of the deceased's will in various ways:

a. Covering Estate Taxes
Life insurance proceeds can be used to pay any estate taxes that may be due upon the individual's death. This ensures that the beneficiaries receive their intended inheritance without the burden of tax liabilities (this would apply for assets held overseas that have inheritance tax).

b. Equalizing Inheritances
If an individual wishes to distribute their assets unequally among their beneficiaries, life insurance can be utilized to provide an equalizing mechanism. The policy proceeds can be designated to the beneficiaries who will receive a smaller share of the estate, thus balancing out the inheritances.

1.3.2 Trust supported with Life Insurance

A trust is a legal entity that holds assets for the benefit of designated beneficiaries. Life insurance can be utilized within a trust structure to achieve specific estate planning goals:

a. **Providing for Dependents**
Life insurance proceeds can be directed to a trust to provide financial support for dependents, such as minor children or disabled family members. The trust can manage and distribute the insurance proceeds according to the stipulations outlined in the trust document.

b. **Preserving Family Wealth**
Life insurance can be used to replenish assets placed in an irrevocable trust that may be depleted due to taxes or distributions. This ensures the long-term preservation of family wealth and provides a financial safety net.

1.3.3 Foundation supported with Life Insurance

Establishing a foundation allows individuals to leave a lasting legacy by supporting charitable causes. Life insurance can be utilized to create a charitable foundation or endowment in the individual's name:

a. **Funding Charitable Contributions**
By naming a foundation as the beneficiary of a life insurance policy, the proceeds can be directed to support the charitable goals outlined by the individual during their lifetime. This provides a sustainable source of funding for philanthropic endeavours.

It is important to note that the utilization of life insurance in estate planning should be carefully considered in consultation with legal and financial professionals. The specific structure and strategies for incorporating life insurance will depend on the individual's goals, financial situation, and applicable laws and regulations.

1.4 Business Continuity

Life insurance can safeguard businesses by providing funds for succession planning, covering business debts, compensating for the loss of a key employee, or facilitating business buyouts. Life insurance can also play a vital role in safeguarding businesses and ensuring their continuity in various ways.

1.4.1 Succession Planning

Life insurance can provide funds for business succession planning. If a business owner passes away, the policy's death benefit can be used to facilitate the smooth transition of ownership to a designated successor. The proceeds can help cover estate taxes, buy out the deceased owner's shares, or provide financial stability during the transition period.

1.4.2 Coverage for Business Debts

Businesses often have debts, such as loans or mortgages. If a key person responsible for those debts passes away, life insurance can provide the necessary funds to repay those obligations. This prevents the burden of debt from falling on the business or the deceased person's estate.

1.4.3 Key Person Protection

Key employees play a crucial role in the success and continuity of a business. If a key employee, such as a founder, owner, or a highly skilled professional, unexpectedly dies, it can have significant financial implications for the business. Life insurance can compensate for the loss of that key person by providing funds to hire and train a replacement, cover lost profits, or sustain operations during the transition period.

1.4.4 Business Buyouts

In the case of business partnerships, life insurance can facilitate a smooth buyout process. By having each partner hold life insurance policies on one another, the death benefit can be used by the surviving partner(s) to purchase the deceased partner's share of the business. This ensures that the deceased partner's family is fairly compensated while allowing the business to continue without disruption.

1.4.5 Key Employee Retention

Life insurance can be used as a key employee benefit to attract and retain top talent. A business can offer life insurance policies to key employees, with the company as the beneficiary. In the event of the employee's death, the business receives the death benefit, which can be used for recruitment, training, or other business needs.

By utilizing life insurance in these ways, businesses can mitigate the financial risks associated with the loss of key individuals, ensure a smooth transition of ownership, cover debts, and protect the long-term viability of the company. It is important for businesses to carefully evaluate their needs and consult with insurance professionals to determine the most suitable life insurance solutions for their specific circumstances.

2. The Purpose of General Insurance

The noble purposes of general insurance are centered around mitigating financial losses and providing protection against various risks that individuals, businesses, and properties may face. The essence of general insurance lies in:

2.1 Financial Protection
2.2 Risk Management
2.3 Social and Economic Stability

2.1 Financial Protection

General insurance policies, such as property insurance, motor insurance, or liability insurance, protect individuals and businesses from potential financial losses arising from events like accidents, theft, natural disasters, or legal liabilities.

2.1.1 Property Insurance

a. Property Damage
General insurance policies cover damage to buildings, homes, or other structures caused by events like fire, natural disasters, vandalism, or accidents.

b. Loss or Theft of Belongings
Policies provide coverage for the loss or theft of personal belongings, such as furniture, electronics, jewellery, or other valuable items, whether at home or while traveling. Example: If a fire damages a home, property insurance will cover the cost of repairs or reconstruction, helping the homeowner recover and restore their property.

2.1.2 Motor Insurance

a. Vehicle Damage and Theft
Motor insurance provides coverage for damage to vehicles caused by accidents, natural disasters, or theft.

b. Third-party Liability
It covers legal liabilities arising from bodily injury or property damage caused to third parties due to a motor vehicle accident. Example: If a car is involved in an accident and sustains significant damage, motor insurance will cover the cost of repairs or, if necessary, the replacement of the vehicle.

2.2 Risk Management

General insurance allows individuals and businesses to manage and transfer risks to insurance companies. This enables them to focus on their core activities without the constant fear of unexpected losses jeopardizing their financial stability.

2.2.1 Liability Insurance (Liability for accidents or injuries)

General insurance policies include liability coverage, protecting individuals or businesses from legal claims arising from accidents, injuries, or property damage caused by their actions or negligence.

Example
If a customer slips and falls in a store, liability insurance will cover the medical expenses and legal costs associated with the resulting lawsuit, ensuring that the business is protected from financial liability.

2.2.2 Professional Indemnity Insurance (Professional liability)

This insurance is essential for professionals such as doctors, lawyers, architects, and consultants. It protects against claims arising from errors, omissions, or negligence in the performance of professional services.

Example
If a client suffers financial losses due to incorrect advice provided by a financial consultant, professional indemnity insurance will cover the costs of legal defence and any resulting settlements or judgments.

2.3 Social and Economic Stability

General insurance provides a safety net for individuals and businesses, helping them recover from unforeseen events and financial losses. Whether it is property damage from a fire, liability claims arising from accidents, vehicle damage or theft, or professional liability, general insurance offers the necessary financial protection to restore stability and ensure peace of mind. By providing insurance coverage, general insurance plays a crucial role in promoting social and economic stability. It helps individuals and businesses recover from unforeseen events and continue their operations, contributing to the overall resilience of the society and economy.

3. Overall Benefits of Insurance

Life and general insurance serve as essential tools in safeguarding individuals, families, businesses, and society as a whole from financial hardships caused by unexpected events, providing them with security and stability. Insurance has a broader impact on promoting social and economic stability in the following ways:

- **Stability in Communities**
  Insurance helps individuals and families maintain stability during challenging times. It provides financial protection against unforeseen events, ensuring they can recover from losses and maintain their quality of life. Insurance coverage for homes, property, and belongings safeguards communities from the devastating effects of natural disasters, accidents, or theft, promoting resilience and enabling faster recovery.

- **Economic Growth and Investment**
  Insurance mitigates risks for businesses, providing a safety net that allows them to operate with reduced uncertainty. This encourages economic growth by enabling businesses to focus on innovation, investment, and expansion. Insurers manage and diversify risks, facilitating investment and entrepreneurship. Insurance protection supports businesses in pursuing new ventures, accessing financing, and attracting investments.

- **Resilience at Individual and Business Levels**
  Insurance enables individuals and businesses to recover and rebuild after a loss. It provides financial compensation for losses, helping maintain living standards, replace damaged assets, and meet financial obligations. For businesses, insurance coverage minimizes disruptions caused by unforeseen events, ensuring they can repair or replace assets, compensate for business interruption, and meet liability claims. Insurance promotes overall economic stability by preventing financial hardships and facilitating faster recovery.

- **Risk Pooling and Social Solidarity**
  Insurance operates on the principle of risk pooling, where premiums from individuals and businesses contribute to a collective fund used to compensate those who suffer losses. This fosters social solidarity by spreading the financial burden across a broader community, ensuring support for those facing severe risks and losses beyond their individual means.

To put in simply, the direct and indirect benefits of insurance are as follows:

3.1 Peace of Mind

The knowledge that insurance exists to meet the financial consequences of certain risks provides a form of peace of mind. This is important for private individuals when they insure their car, house, possessions and so on, but it is also of vital importance in industry and commerce.

This peace of mind or security has become an important aspect of business activity in many sectors where some forms of insurance are compulsory by law (motor insurance) and others are required to be in force under the terms of contracts (construction insurance) to have the security of knowing that the people they are doing business with are protected by insurance.

3.2 Cost Stabilisation

Insurance acts as a stimulus for the activity of business which is already in existence. This is done through the release of funds for investment in the productive side of the enterprise, which would otherwise be required to be held in easily accessible reserves to cover any future loss.

Insurance, therefore, provides a means of stabilizing the costs involved in managing risks by the payment of fixed and predetermined amount of premiums for the required insurance coverage.

3.3 Loss Control

Insurers have a common 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 from losses. Traditionally, the expertise of surveyors was concentrated on pre-loss control (minimising the chance that something will happen) or post-loss control (after an event has occurred) of risks for which commercial insurance was available. Increasingly, the services include identification and control of all risks faced by organizations, as part of a wider risk and enterprise management service.

3.4 Social Benefits

Insurance provides business owners with the funds available to recover from a loss to continue employment of the workforce and the production of goods and services to ensure that there are no unnecessary economic hardships to the community at large and at the same time contribute to the national economy.

3.5 Compelled Savings

With insurance, individuals are committed to compelled long term saving by putting aside funds for retirement or old age. For example, life endowment plans provide for the payment of the sum assured with bonus (for participating policies) upon maturity as well as protection against loss of income in the event of premature death or disability.

3.6 Capital for Investment

Insurance companies have large amounts of money at their disposal since there is a time gap between the receipt of a premium and the payment of a claim. The investment of funds constitutes a wide range of different forms, such as long, medium, and short-term investments. These investments provide a source of capital for industry and commerce, and help the government access borrowing, which in turn contributes towards the overall national economic development.

3.7 Creation of Employment

The insurance industry provides employment to professionals as well as others in insurance companies, insurance broking firms, loss adjusting, financial advisory services; and life and general insurance agents.

In conclusion, insurance plays a vital role in maintaining social and economic stability. It enables individuals, businesses, and communities to recover from losses, supports economic growth, encourages investment and entrepreneurship, fosters resilience, and promotes social solidarity. Life insurance and general insurance intermediaries provide valuable products and services, offering financial protection and peace of mind, thus creating a more secure and sustainable environment for individuals, businesses, and society as a whole.

4. Outlook of Insurance Market in Malaysia

4.1 Insurance Industry Performance

4.1.1 General Insurance Sector

The General Insurance sector registered an increase of 10% in 2022, with total gross direct premiums amounting to RM19.43 billion. Motor remained the largest class with a market share of 46.2% followed by Fire at 19.7% and Personal Accident at 7.4%. Motor insurance recorded gross direct premiums of RM8.98 billion, registering an increase of 9.1% as compared to 2021. [1]

[1] *Source: ISM Statistical Bulletin Market Share by Line of Business General Insurance and General Takaful Jan to Dec 2022 issued on 28 Feb 2023 and ISM Statistical Bulletin Market Share by Line of Business General Insurance and General Takaful Jan to Dec 2021 issued on 28 Feb 2022*

4.1.2 Life Insurance Sector

The Malaysian insurance industry remained resilient, recorded fairly positive trend in few key indicators even during the Covid-19 pandemic period, adapting to new market conditions and continuing to meet the needs of customers.

Reference to Table 1 below, the total in-forced premium shown an upward trend from RM34.4 billion in 2018 to RM44.1 billion in 2022 with gross 28.2% growth over the 5 years period. Total sum-assured in-forced and policy-in-forced also registered an upward trend for similar 5 years period.

The life insurance industry recorded a slight decline of 6.3% in new business total premiums from RM12.8 billion in 2021 to RM12 billion in 2022 but still fairly higher than RM10.3 billion recorded in 2018. The decline in the overall new business premiums was possibly attributed to the economic slowdown due to the COVID-19 pandemic .

However, the overall new business sums assured increased by 8.4% from RM461.1 billion in 2021 to RM497.7 billion in 2022 reflected a greater awareness on the needs for higher protection sum-assured.

Here are 2 tables summarizing the key indicators for the Malaysian insurance industry.

Table 0-1 ***Key indicators for life insurance industry 2018 - 2022***

Key Figures	2018	2019	2020	2021	2022
Sum assured in forced	RM 1.51trillion	RM 1.6 trillion	RM 1.7 trillion	RM 1.8 trillion	RM 1.9 trillion
Total in forced premium	RM 34.4 billion	RM 41.2 billion	RM 43.4 billion	RM 42.7 billion	RM 44.1 billion
Policies in forced	12.67 million units	12.7 million units	12.8 million units	13.37 million units	13.38 million units
New business sum assured	RM 452.1 billion	RM 471.3 billion	RM 437.2 billion	RM 461.1 billion	RM 497.7 billion
New business total premium	RM 10.3 billion	RM 11.8 billion	RM 11.4 billion	RM 12.8 billion	RM 12 billion
New policies issued	1.24 million units	1.31 million units	1.2 million units	1.9 million units	1.8 million units
Claims pay-out	RM 10.8 billion	RM 11.9 billion	RM 11.6 billion	RM 11.9 billion	RM 13.4 billion

(Source: Life Insurance Association of Malaysia (LIAM) Annual Report 2018 - 2022)

Table 0-2 ***Key indicators illustrate the consolidation of the insurance industry since 2000***

As at end of December	2000	2015	2017	2019	2021	2023
Direct Insurers	53	33	33	36	36	33
Life	7	10	10	14	14	14
General	36	19	19	22	22	19
Composite	10	4	4	0	0	0
Professional Reinsurers	11	7	7	8	7	6
Insurance Brokers	36	29	29	28	26	25
Adjusters	41	41	45	50	51	54
Financial Advisers	N/A	21	26	33	37	44
Life Agents	87,375	85,376	78,716	75,999	88,068	81,655
General Agents	41,233	39,220	39,380	38,390	39,877	40,856
Registered Insurance Agents	128,608	124,596	118,096	114,389	127,945	122,511

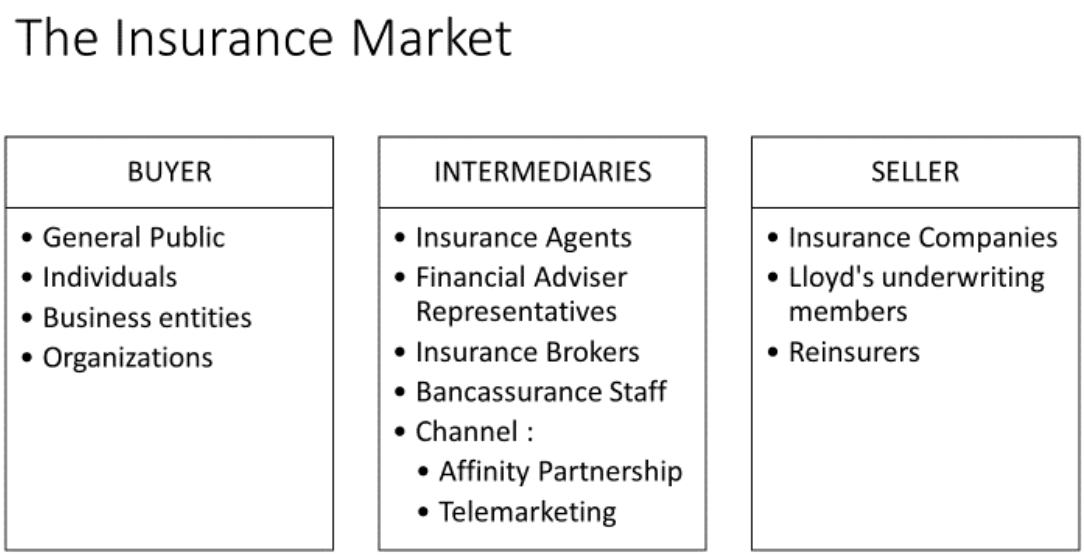
4.1.3 The Insurance Market

The provisions of the Financial Services Act 2013 (which came into force on June 30, 2013) regulate both Life and General insurance business in Malaysia. Licensed insurers may conduct Life or General insurance business, Composite insurance is no longer permitted in Malaysia. Only a professional reinsurer shall carry on both life and general insurance business.

The insurance market conventionally comprises buyers, sellers, and intermediaries. Insurance intermediaries assist in the placement and purchase of insurance, as well as provide services to insurance companies and customers that complement an insurance transaction through various distribution channels.

The distribution of insurance products has been mainly dominated by the agency force channel i.e. insurance agents. However, with the convergence in the financial services market, increasing customers' sophistication and advent of the internet, the channels through which customers can buy products and services have evolved, from conventional channels such as the agency force and insurance brokers to alternative distribution channels such as financial adviser, bancassurance, affinity partnerships and telemarketing.

FIGURE 0-1 ***The Insurance Market***



The current common intermediaries in the Malaysian insurance market are as follows:

- Insurance/Takaful Agents

  Insurance agents are, in general, licensed to conduct business on behalf of an insurance company. Agents represent the insurance company and operate under the terms of an agency agreement with the insurer.

- Insurance Brokers

  Insurance brokers are full-time professional intermediaries who act on behalf of potential policyholders. They represent their clients who want to buy insurance coverage and provide advice on the best insurance cover to meet their clients' insurance needs and negotiate for the best possible terms for their clients with insurance companies.

- Financial Advisers (FAs)

  Financial Adviser are licensed under BNM to carry on financial advisory business which include any of the followings:

  a. analyzing the financial planning needs of a person relating to an insurance product;
  b. recommending an appropriate insurance product to a person;
  c. sourcing an insurance product from a licensed insurer for a person;
  d. arranging of a contract in respect of an insurance product for a person; or
  e. such other business, service, or activity in relation to a financial service.

  FAs distribute insurance products and services from multiple insurance services providers.

  Financial Adviser Representatives (FARs) are licensed individuals who perform for the financial advisers any services relating to financial advisory business.

- Bancassurance Staff

  These are sales staff who are employed by banks and are licensed to sell insurance products on behalf of the bank to bank customers.

Table 0-3 ***Difference between an Insurance Agent and a Financial Adviser***

Represents	Insurance Agent Insurance Company	Financial Adviser Financial Consumer	Insurance Broker Financial Consumer
Approved/Registered by:	PIAM - General Insurance Agent LIAM - Life Insurance Agent	Bank Negara Malaysia	Malaysian Insurance & Takaful Brokers Association (MITBA)
Remuneration:	Commission	Fees and Commission	Commission

4.2 Future Opportunities Shaped by Past Events

4.2.1 Following the global impact of the COVID -19 pandemic, the two years (from the beginning of 2020 to 2021) saw a rapid acceleration of the adoption of digital channels as an enabler for intermediaries to enhance selling and servicing, as well as an alternate channel to traditional face-to-face marketing of insurance products such as the agency force and bancassurance.

4.2.2 Technological advancements and a tech-savvy population bodes well for the development of marketing strategies using digital distribution channels. While the mode of acquiring new customers and retaining existing ones, through the agency or bancassurance channels will continue to evolve, more products will be distributed via digital channels as insurers begin to view digital transformation as the way forward to increase efficiency and productivity to gain a competitive edge.

4.2.3 The Malaysian insurance industry is still undergoing regulatory reform. In particular, 'deregulation of tariffs' for the motor class has been underway since Bank Negara Malaysia started phased liberalization in 2016. Continued progress towards liberalization could put pressure on premium growth and profitability in the motor class in the short term. However, these developments are expected to benefit the industry in the long run as consumers can enjoy lower rates if they maintain good driving behaviour with lower accident rates, and insurers can attract more low-risk drivers by applying risk-based pricing.

4.2.4 The industry laid out a five-year roadmap and strategic plan to achieve the desired targets set under the Financial Sector Blueprint (FSBP) 2022-2026 launched by Bank Negara Malaysia (BNM) in January 2022. Overall, the industry remained committed to easing financial pressures on consumers, implementing various strategies and innovative plans, and contributing to a more dynamic, innovative, and sustainable financial sector in Malaysia.

The blueprint will be driven by five strategic thrusts aimed at:

- Funding Malaysia's economic transformation
- Elevating the financial well-being of households and businesses
- Advancing digitization of the financial sector
- Positioning the financial system to facilitate an orderly transition to greener economy
- Advancing value-based finances through Islamic finance leadership

In conclusion, the life insurance and general insurance communities warmly welcome individuals with diverse backgrounds and aspirations. These communities are dedicated to offering financial protection, peace of mind, and stability to individuals and businesses in the midst of different risks and uncertainties.

1

CHAPTER 1 PERSPECTIVES ON INSURANCE & RISK MANAGEMENT

INTRODUCTION

Welcome to the first chapter of our comprehensive guide to the history and fundamentals of insurance, a critical step in your journey towards becoming licensed in the field of insurance in Malaysia. This chapter will serve as a foundation, exploring the intricate facets of risk and insurance at a granular level. Our journey begins with understanding the very essence of risk – what it means, how it is classified, and the relationship it shares with key concepts such as peril, hazard, and loss.

From here, we delve deeper into the realm of risk management, and the various methods employed in handling risk. We then transition into the realm of insurance and takaful, helping you differentiate between these two risk management techniques that are deeply entrenched in Malaysian society. By learning about their functions and benefits, you will gain a more robust understanding of their value and how they contribute to financial stability and economic development.

We then move on to the nature of insurable risks and the parameters that define what can and cannot be insured. The concept of the insurance market, its structure, dynamics, key players, and its bifurcation into life and general insurance will be discussed in detail. A special segment dedicated to the state of the insurance industry will give you a historical perspective and a context for understanding the market trends.

1.1 HISTORY OF INSURANCE

The history of insurance dates back to the ancient world, and it has evolved significantly over time to the sophisticated system we know today. Let us take a brief journey through the history of insurance:

1.1.1 ANCIENT BEGINNINGS

The earliest form of insurance was practiced in ancient China and Babylon. In China, merchants distributing goods along dangerous river routes would redistribute their goods across many vessels to limit the loss due to any single vessel's capsizing. In Babylon, around 1750 BC, traders used loans that could be repaid if the goods were successfully delivered. This practice was recorded in the famous Code of Hammurabi.

1.1.2 MARINE INSURANCE IN THE MIDDLE AGES

Marine insurance is considered one of the earliest forms of modern insurance. It began in the Italian city-states of Genoa and Venice in the 14th century. Under these contracts, lenders would agree to pardon loans to sea captains if their shipment was lost at sea. This system spread throughout Europe and was brought to the Americas with the colonists.

1.1.3 INSURANCE IN THE 17TH CENTURY

The Great Fire of London in 1666 emphasized the importance of insurance and led to the growth of fire insurance. In the aftermath of the fire, Nicholas Barbon and eleven associates established the first fire insurance company, "The Fire Office," to insure brick and frame homes.

1.1.4 DEVELOPMENT OF LIFE INSURANCE AND HEALTH INSURANCE

The concept of life insurance has been around since the ancient Romans, but modern life insurance began in the 17th century. The first recorded life insurance policy was issued in 1583 to a man named Richard Martin. However, it was not until the 18th century that life insurance started to gain traction.

Health insurance, on the other hand, did not start until the 19th and 20th centuries. Germany passed laws in 1883 and 1884 requiring certain workers to have health insurance. This served as a model for other countries, and compulsory health insurance laws began appearing across Europe.

1.1.5 MODERN INSURANCE

In the 19th century, with the Industrial Revolution and the associated increase in the complexity of society and industry, the types of insurance on offer expanded significantly. This included insurance against injuries and accidents, liability insurance, and even some types of insurance against credit risks.

In the 20th century, the welfare state was introduced in many countries, leading to the state taking over many insurance functions. However, private insurance continues to be important, and the industry has grown significantly in the past few decades.

Today, the insurance industry is a complex and critical component of economies worldwide, helping individuals, businesses, and societies manage risk and protect against unforeseen events. From its humble beginnings, insurance has grown into an industry of enormous size and influence.

1.1.6 HISTORY OF INSURANCE IN MALAYSIA

Malaysia has its own specific history and development regarding insurance.

Insurance in Malaysia has roots in British law, given the country's colonial past. The British introduced the concept of insurance to Malaysia in the late 19th century, and the first insurance company was established in 1908. Since then, the industry has grown and developed extensively.

Post-independence in 1957, the Malaysian insurance industry underwent significant transformation and growth. The government introduced various regulations to supervise and control the insurance sector. The Insurance Act 1963, Insurance Act 1996 and Financial Services Act 2013 are significant milestones in shaping the industry.

In 1984, takaful, which is based on Islamic principles, was introduced to cater to the Muslim population's needs. It operates on the basis of shared responsibility, cooperation, and mutual indemnification of losses among participants.

By the turn of the 21st century, the insurance industry in Malaysia was well-established with various domestic and international insurance companies operating in our country. The industry also provides a wide range of insurance products such as life insurance, general insurance, health insurance, and motor insurance.

The Bank Negara Malaysia (BNM), the nation's central bank, plays a critical role in supervising and regulating insurance and takaful businesses in Malaysia today. It has undertaken several reforms to strengthen the insurance sector and improve accessibility, efficiency, and transparency of insurance in the country.

To summarize, while the broader history of insurance applies globally, the development and growth of insurance in Malaysia have unique aspects influenced by the nation's cultural, social, and economic context.

1.1.7 INTRODUCTION TO TAKAFUL IN MALAYSIA

Takaful is an Islamic insurance concept grounded on the principles of mutual assistance and shared risk. Its participants contribute to a pool that is used to indemnify the losses of any member who suffers a mishap. The term "**Takaful**" indeed stems from the Arabic language, signifying mutual guarantee and protection. The operation is managed by a **takaful operator**, which acts as a trustee, manager, and entrepreneur.

Takaful is designed to avoid elements forbidden in Islamic law (**Shariah**), such as **Riba** (interest), **Gharar** (uncertainty), and **Maiser** (gambling). Instead, it operates on the principles of **Mudharabah** (profit and loss sharing) and **Tabarru'** (donation), among others, that are in line with Shariah.

Regarding the Shariah Advisory Council (SAC) of Bank Negara Malaysia (BNM), it is indeed a prominent authority that oversees the compliance of islamic finance, including takaful, with the principles of Shariah. Comprising distinguished scholars and experts in the field of banking, finance, law, and islamic economics, the SAC ensures that all products and services within the islamic financial sector in Malaysia are in harmony with islamic law.

The Central Bank of Malaysia Act 2009 further cemented the SAC's role and functions, declaring it the exclusive authoritative entity on Shariah matters relating to islamic banking, takaful, and islamic finance. The rulings of the SAC not only take precedence over any conflicting ruling issued by a Shariah body or committee in Malaysia but are also binding and need to be referred to by courts and arbitrators during any proceedings related to islamic financial business.'

Takaful is a specialized field within the insurance industry, requiring a distinct knowledge set and approach. Therefore, in Malaysia, individuals wishing to practice in the takaful industry require a separate license and must pass specific examinations.

The Islamic Banking & Finance Institute Malaysia (IBFIM) provides a range of qualifications for those interested in a career in the takaful industry. These include the 'Takaful Basic Examination (TBE)', which provides a solid grounding in the principles and practices of takaful. The examination covers the fundamental elements of takaful, including the principles of islamic insurance, the operation of takaful businesses, and the legal and regulatory framework for takaful in Malaysia.

It is important to note that, in order to provide takaful advice or sell takaful products in Malaysia, individuals need to have passed the relevant examinations and hold the necessary licenses. This ensures that practitioners are well-equipped with the knowledge and understanding necessary to provide effective and compliant services in this specialized field.

1.2 RISK MANAGEMENT

1.2.1 UNDERSTANDING RISK

Risk can mean hazard, danger, and chance of loss or injury, the degree of probability of loss, a person, thing, or factor likely to cause loss or danger. Risk is also used as a verb. For example, 'to risk crossing a busy street' is to risk being exposed to hazards or to incur the chance of unfortunate consequences by doing something.

Uncertainty regarding loss is often termed as risk. With many similar loss exposures, an insurance company can predict an expected loss; however, there is an element of *uncertainty* as the *actual loss* may not be the same as the *expected loss*.

Hence, risk can also be defined as the variation in outcomes in each situation and can be referred to as:

(a) Possibility of Loss

- This is one of the most common ways to understand risk. It refers to the potential for financial loss or harm that could occur. For example, if you own a house, there is a risk that it could be damaged by fire, leading to a financial loss. Insurance is used to protect against this kind of risk, by transferring the financial responsibility from the insured to the insurer.

(b) Exposure to Danger

- In the context of insurance, danger is often considered synonymous with risk, highlighting the possible perils that an individual, property, or business might face. For example, a worker in a high-risk occupation (like construction or mining) has a higher exposure to danger, and thus, a higher risk of injury or accident. Insurance policies like workers' compensation or personal accident insurance can mitigate these risks.

(c) Subject Matter of Insurance

- The "subject matter" of insurance refers to the object or person that is insured. This could be a physical object, such as a car or a house (in the case of auto or homeowners' insurance), or it could be a person (as in life or health insurance). The subject matter of insurance is always at risk of loss or damage - this is the risk that insurance is designed to cover.

1.2.2 CLASSIFICATION OF RISK

There are four main types of risk:

1) Pure risks are traditionally the basis of insurance cover.
2) Speculative risks provide the possibility of a financial gain or profit.
3) Fundamental risks may affect a large section of the population and therefore, it is difficult to measure the extent of a loss in financial terms.
4) Particular risks affect an individual at any particular time as opposed to affecting an entire community or society.

Table 1-1 *Classification of Risk*

Risk	Outcome	Example
Pure Risk	May result in financial loss or no loss.	Factory fire or risk of injury from a road accident.
Speculative Risk	May result in a loss, profit, or break even.	Investments in the share market or in business.
Fundamental Risk	May affect a large number of people or an entire community at one time.	Pandemic, natural disaster, war, terrorism, inflation, or recession.
Particular Risk	May affect only an individual, a family or a group travelling together.	Death, illness, or accident.

1.2.3 PERIL, HAZARD, AND LOSS

a. Peril

Peril is the **prime cause** of a loss. In insurance terms, a peril refers to a specific event that might cause a loss. It is the cause of the potential loss. Common perils include events like fire, theft, flood, earthquake, and accidents. When you buy an insurance policy, it typically covers specific perils, and if a loss occurs due to one of these perils, you are eligible to make a claim.

b. Hazard

A hazard, on the other hand, is a condition that **increases** the likelihood or severity of a loss. Hazards can be physical (like a broken stair, which increases the chance of someone falling and getting injured), moral (like dishonesty, which could increase the likelihood of fraud), or moral (such as a person's reckless driving habits increasing the likelihood of a car accident). By identifying and managing hazards, individuals and businesses can significantly decrease the likelihood of a peril leading to a loss.

c. Loss

In insurance, a loss refers to the financial harm or damage suffered when a peril occurs. For example, if your house catches on fire (the peril), the destruction of your property would be the loss. An insurance policy is essentially a contract in which the insurer agrees to compensate the insured for the financial loss caused by certain perils.

These three elements work together in insurance. Hazards increase the chances of a peril occurring, and when a peril does occur, it leads to a loss. Therefore, a key part of managing risk (and in turn, reducing insurance premiums) involves identifying potential hazards and taking steps to mitigate them, thereby reducing the likelihood of a peril causing a loss.

FIGURE 1-1 ***Peril, Hazard, and Loss***

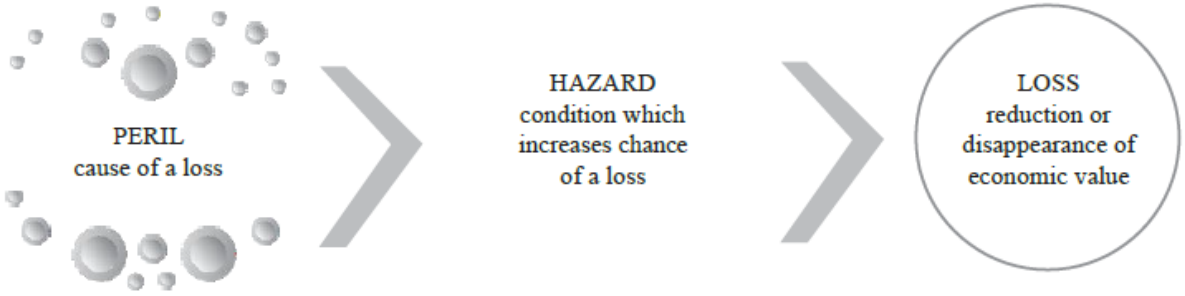


Table 1-2 ***Peril, Hazard, and Loss***

Peril	Hazard	Example
Fire	Physical hazard	Building constructed from highly flammable material such a wood or thatch
Theft	Physical hazard	Lack of security cameras
Flood	Physical hazard	Building in a flood-prone area
Earthquake	Physical hazard	Building on an earthquake fault line
Accident	Moral hazard	Engaging in high-risk activities
Illness / Injury	Moral hazard	Not taking precautions to avoid illness/injury
Road Accident Liability	Legal hazard	Lawsuits arising from accidents

Note: *This table is not exhaustive and there may be other hazards and perils associated with each example. The examples provided are meant to illustrate the concept of peril and hazard, and how they may be relevant in various insurance contexts.*

Table 1-3 ***Type of Hazards***

Type of Hazards	Life Insurance Examples	General Insurance Examples
Physical Hazards	A person's physical condition or health issues, such as obesity or a pre-existing medical condition like heart disease.	A physical condition such as a slippery floor that increases the chance of someone slipping and falling.
Moral Hazards	Someone lying about their medical history or smoking habits on their insurance application.	Someone intentionally damages their own property to claim insurance money.

Morale Hazards	A person with life insurance engaging in risky behavior, like extreme sports, under the assumption that they are fully covered by their policy.	A homeowner neglecting home maintenance, increasing the chance of property damage, because they assume any damage will be covered by their insurance.
Legal Hazards	Changes in legislation or regulation that could impact the terms of an insurance policy or the claims process.	Changes in legislation or regulation that could impact the terms of an insurance policy or the claims process.

Risk Management Steps

Risk management is about "identification, analysis and economic control of those risks which can threaten the assets or earning capacity of an enterprise''.

The risk management process involves three basic steps:

1. Risk Identification

   This is the first step of risk management and involves the process of identifying and describing the risks that could potentially affect the business. This can include risks related to operations, financial transactions, legal compliance, and more. Risk identification can involve a range of strategies, such as brainstorming sessions, historical data analysis, risk registers, and risk workshops, among others.

2. Risk Analysis

   Once risks have been identified, they must be analyzed to understand their potential impact and likelihood of occurrence. This is typically done through qualitative and quantitative risk analysis methods. Qualitative methods may involve rating risks on their perceived threat level, while quantitative methods may involve more detailed statistical models and numerical analysis. The result of this analysis should be a clear understanding of the potential implications of each risk.

3. Risk Control

   After the risks have been identified and analyzed, the next step is to decide on how to manage them. There are several strategies that can be used, depending on the nature and severity of the risk. These might include:

   i. *Risk avoidance* (not engaging in the activity that presents the risk),

   ii. *Risk prevention/mitigation* (taking steps to reduce the likelihood or impact of the risk),

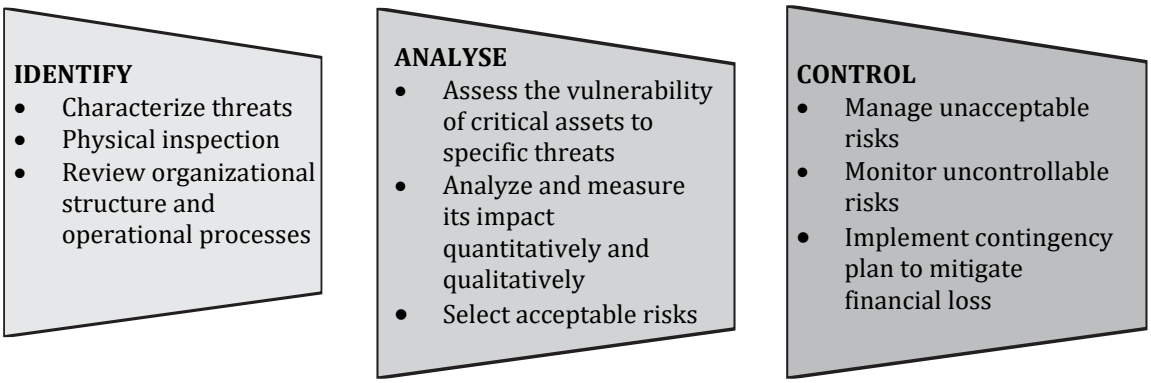
   iii. *Risk control* (discussing ways to lessen the potential impact of the risk or the likelihood of its occurrence),

   iv. *Risk transfer* (such as buying insurance to shift the risk to another party), and

   v. *Risk acceptance* (accepting the potential impact of the risk and budgeting for potential losses).

These three steps form the foundation of the risk management process, but it is important to note that risk management is not a one-time activity. It is an ongoing process that should be regularly updated and reviewed as conditions change.

FIGURE 1-2 ***Risk Management Steps***



1.2.4 RISK HANDLING METHODS

There are various methods of handling risks, but the following are the main ones:

a. Avoidance

Risk is avoided by the non-participation in an activity that poses a risk.

Example

Risk Handling Method - Avoid

In the manufacturing sector, to avoid the risk of being sued for loss or injury from defective products, the manufacturer will cease production and recall products from the shelves if defects in the products sold or supplied have been identified.

b. Prevention

Risk can be prevented with the implementation of prudent risk management practices to reduce the likelihood of a loss occurrence.

Example

Risk Handling Method - Prevent

To prevent water from a nearby river overflowing into the premises, the owner can build a wall around his property.

c. Mitigation and Control

Risk of severe losses can be mitigated with adequate disaster recovery and business continuity plans to ensure business as usual within the shortest time possible.

Example

Risk Handling Method - Control

The use of fire-resistant materials and automatic sprinkler systems in building construction help to reduce the likelihood and severity of fire losses.

d. Retention

Minor losses can be retained or self-borne within a person's financial capacity.

Example

Risk Handling Method - Retain

The part of an insurance claim to be paid by the insured, known as an excess or deductible, is agreed between the insured and the insurer, whereby the insured becomes his own insurer for the amount.

e. Transfer

Insurance is a risk transfer mechanism by an insured to an insurance company. Similarly, reinsurance is risk transferred from an insurer to a reinsurance company in return for peace of mind, cost stabilization and other benefits of insurance.

Example

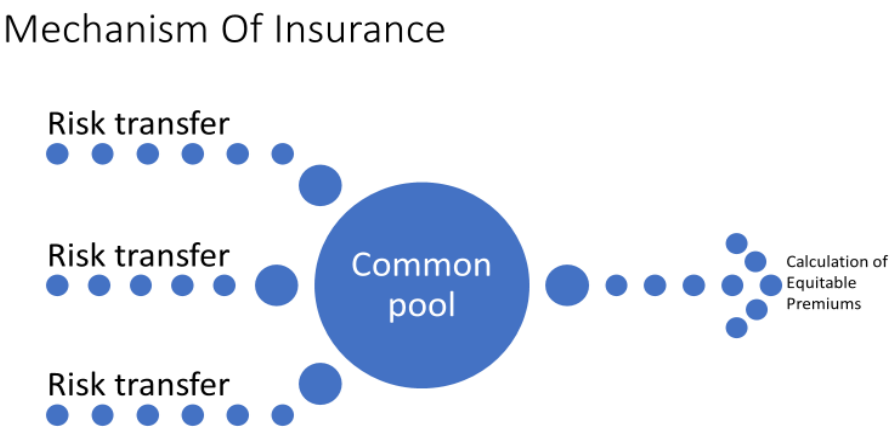
Risk Handling Method - Transfer

A business might purchase insurance to transfer the financial risk of property damage or liability claims to an insurance company.

1.3 THE MECHANISM OF INSURANCE

Insurance serves three primary functions, all of which are interconnected: risk transfer, creation of a common pool, and calculation of equitable premiums.

FIGURE 1-3 ***Mechanism of Insurance***



1.3.1 RISK TRANSFER

This transaction effectively transfers the responsibility of carrying the risk of potential loss or damage from the insured to the insurer. Consequently, once the risk is accepted, the insurer essentially stands in the shoes of the insured, bearing the uncertainties associated with the risk.

In the context of general insurance, consider car insurance. The policyholder pays premiums to the insurance company, and in return, the company agrees to cover the costs associated with potential damage to the policyholder's vehicle. Thus, the financial risk of potential car damage is transferred from the policyholder to the insurer.

In life insurance, risk transfer involves the policyholder paying premiums to the life insurance company. In exchange, the company commits to pay a death benefit to the policyholder's beneficiaries upon the policyholder's death. The financial risk associated with the policyholder's premature death is thereby transferred to the insurance company.

1.3.2 CREATION OF THE COMMON POOL

The common pool concept traces its roots back to the early days of marine insurance. During this time, merchants would contribute to a communal fund that would cover the losses of anyone who suffered a loss during a voyage. Modern insurers also adopt a similar pool system, known as a class or portfolio (e.g., fire insurance). All premiums collected for a specific class of business are placed into this pool. In the event of a loss suffered by any contributor to this pool, the necessary amount will be paid out from the pool to cover the loss.

In both general and life insurance, insurance companies create a common pool with the premiums collected from policyholders.

For instance, in general insurance, the premiums collected from policyholders of home insurance policies form a common pool. If a house catches fire and incurs damage, the insurer uses funds from this pool to pay for the losses.

Similarly, in life insurance, the insurer manages and invests the premiums collected, creating a pool of funds. If a policyholder passes away, the insurer uses the funds in this pool to pay the death benefit to the policyholder's beneficiaries.

1.3.3 CALCULATION OF EQUITABLE PREMIUMS

In insurance, each insured's premium must reflect the level of risk they introduce to the pool. While the class of insurance may be the same, each insured will pay a premium that justifies the risk they bring. When calculating premiums for insurance policies, insurers assess the risk each policyholder brings to the pool. These risk assessments depend on various factors.

In general insurance, such as home insurance, factors like the location of the house, its construction type, and safety features installed can influence the premium. For example, a wooden house in a wildfire-prone area would attract higher premiums than a concrete house in a location with minimal fire risks.

For life insurance, factors such as age, gender, medical history, lifestyle habits (like smoking or alcohol consumption), and occupational risks come into play. A young, non-smoking female with no serious health issues will typically pay lower life insurance premiums than a middle-aged male smoker with a history of heart disease. This is because the latter presents a higher risk to the insurance pool.

1.4 NATURE OF INSURABLE RISKS

The possibility of an event becoming a claim under an insurance policy depends on whether the risk meets certain criteria. The following are the key features of insurable risks:

1.4.1 FORTUITOUS (UNPREDICTABILITY)

The insured event must be uncertain and unintentional. While the occurrence of some events, like death, is certain, it is the unpredictability of when it will happen that makes it insurable. Intentional acts or inevitable occurrences, such as wear and tear or depreciation, are not insurable.

1.4.2 FINANCIAL VALUE (QUANTIFIABLE LOSS)

The risk that is to be insured must have a financial impact that can be measured. This could be the cost to repair or replace damaged property or a liability amount determined by a court. For life insurance, the financial compensation is agreed upon at the start of the policy.

1.4.3 INSURABLE INTEREST

The policyholder must have a legal stake in the preservation of the insured item or person, and would suffer a financial loss if a claim event occurred. This 'insurable interest' distinguishes insurance from gambling and is a prerequisite for a valid insurance contract.

1.4.4 HOMOGENEOUS EXPOSURES (SIMILAR RISK EXPOSURE)

Insurance companies prefer to insure groups of similar or 'homogeneous' risks to leverage the 'law of large numbers', which facilitates more accurate prediction of potential losses. Without a substantial number of similar risks, premium calculation becomes challenging, turning into more of an educated estimate than a precise calculation.

The law of large numbers suggests that as the number of identical exposure units increases, the predicted loss becomes increasingly close to the actual loss. However, two conditions must be met for this principle to work efficiently:

(a) The loss exposures must be independent of each other, and
(b) The occurrence of a loss must be by chance or random.

Despite the law of large numbers being a cornerstone of insurable risks, there are exceptions. For instance, space satellites are unique risks as they are relatively rare and lack a substantial statistical history for insurers to utilize. As a result, their associated risk is uncertain and significantly high, leading to substantially higher premium rates.

1.4.5 PURE RISKS

Insurance primarily deals with 'pure risks' – situations where there is **a chance of loss but no chance of gain**. This differentiates it from 'speculative risks', which can result in a loss or a gain, such as launching a new product line in clothing. The risk that the new line will sell or not is clearly a speculative one but the risk of fire damaging the factory in which the garments are made is a pure risk.

1.4.6 PARTICULAR RISK (SPECIFIC RISKS)

Insurable risks are usually 'particular risks' that impact specific individuals or entities, as opposed to 'fundamental risks' that are widespread and indiscriminate, like war or inflation. However, insurance may still be available for fundamental risks arising from natural disasters, depending on the risk's frequency, severity, and location.

1.4.7 CONSIDERATION OF PUBLIC POLICY

An insurance policy should not support illegal activities or behaviors that society deems unacceptable. Therefore, risks associated with illegal activities or penalties imposed by law are not insurable as this would contradict public interest.

In conclusion, through this chapter, the reader will gain a deeper understanding of risk management and insurance. By exploring various methods of handling risk the reader will comprehend their functions, benefits, and their contribution to financial stability and economic development. Additionally, the historical perspective and insights into current trends will set the tone for future challenges and offer a comprehensive insight into the world of insurance in Malaysia.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*What is the correct definition of a pure risk?*
A	a. A risk where there is only the possibility of a loss or break-even outcome. b. A risk that only affects individuals as opposed to society as a whole. c. A risk that cannot be measured in financial terms. d. A risk where there is a possibility of financial gain.

2	**Review Question**
Q	*Which of the following is NOT a characteristic of an insurable risk?*
A	a. It should not be against public policy. b. It must be fortuitous or accidental in nature. c. It must be a speculative risk. d. Homogenous exposures with the same expectation of loss.

3	**Review Question**
Q	*Which of the following statements is true?* *i. The earliest form of insurance was practiced in ancient China and Babylon.* *ii. Marine insurance is considered one of the earliest forms of modern insurance. It began in the Italian city-states of Genoa and Venice in the 14th century.* *iii. The Great Fire of London in 1666 emphasized the importance of insurance and led to the growth of fire insurance.* *iv. The first recorded life insurance policy was issued in 1583.*
A	a. I & II only. b. I, II & III. c. I, III & IV. d. All of the above.

4	**Review Question**
Q	*Which of the following is the least effective approach to handling risks?*
A	a. Avoiding the risk. b. Transferring the risk. c. Retaining the risk. d. Ignoring the risk.

5	**Review Question**
Q	*For insurance purposes, fire damage is classified as*
A	a. A speculative risk. b. A fundamental risk. c. A pure risk. d. A physical hazard.

6	**Review Question**
Q	*Which of the following descriptions is incorrect?*
A	a. Peril is the prime cause of a loss. b. Hazard will increase the chance of a loss. c. Uncertainty regarding loss is often termed as risk. d. Moral hazard is identified by the physical characteristics of the risk.

7	**Review Question**
Q	*Which of the following is NOT a risk covered by insurance?*
A	a. Death due to sickness or illness. b. Liability to consumers arising from the sale of products. c. Financial loss due to a drop in the share price. d. Damage to vehicle as a result of a chain collision.

8	**Review Question**
Q	*What is the difference between life and general insurance?*
A	a. Both provide financial protection. b. Life insurance is long term whereas general is yearly renewable. c. Life insurance offers financial security after retirement and in old age. d. General insurance covers risks other than life insurance.

9	**Review Question**
Q	*What are some strategies that can be used to manage risks?* *i. Risk taking (bravely facing and addressing risks or challenges directly).* *ii. Risk prevention/mitigation (taking steps to reduce the likelihood or impact of the risk).* *iii. Risk transfer (such as buying insurance to shift the risk to another party).* *iv. Risk acceptance (accepting the potential impact of the risk and budgeting for potential* *v. losses).*
A	a. I & II. b. I, II & III. c. II, III & IV. d. All of the above.

10	**Review Question**
Q	*Which of the following is not a characteristic of an insurable risk?*
A	a. The risk is fortuitous and unpredictable. b. The risk can result in both a gain and a loss. c. The policyholder has an insurable interest. d. The risk has a quantifiable financial value.

11	**Review Question**
Q	*The principle of 'Homogeneous Exposures' in insurance mainly refers to:*
A	a. The occurrence of a loss being by chance or random. b. The policyholder having a legal stake in the preservation of the insured item. c. Insurance companies preferring to insure groups of similar risks to leverage the 'law of large numbers'. d. An insurance policy supporting illegal activities.

12	**Review Question**
Q	*Why is insurable interest a prerequisite for a valid insurance contract?*
A	a. It prevents insurance from being a form of gambling. b. It allows for accurate prediction of potential losses. c. It supports the principle of homogeneous exposures. d. It guarantees the financial value of the insured risk.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

2

CHAPTER 2 FUNDAMENTAL PRINCIPLES OF INSURANCE

2.1 WHAT ARE THE SIX BASIC PRINCIPLES OF INSURANCE?

The fundamental principles of insurance form the basis for understanding and navigating the world of insurance, encompassing **both life insurance and general insurance**. These principles establish the core concepts and guidelines that govern the insurance industry, providing a framework for fair and transparent transactions between insurers and policyholders. By understanding these fundamental principles, individuals can make informed decisions about their insurance needs and ensure they receive the necessary protection in times of uncertainty.

These principles serve as guiding standards within the insurance industry, ensuring ethical practices and providing a solid foundation for insurance policies. While each type of insurance may have unique factors in determining coverage and cost, there are **six universal principles** that underpin all insurance policies. Familiarity with these principles is essential for insurers to effectively operate their businesses and for customers to make well-informed decisions when purchasing insurance. The **six basic principles** of insurance are as follows:

1) Utmost Good Faith

   Insurance contracts are built on a foundation of trust and honesty between the insured and the insurer. Both parties are expected to act in utmost good faith, providing accurate and complete information during the application and underwriting process. This principle ensures transparency and fairness throughout the insurance relationship.

2) Insurable Interest

   To have a valid insurance contract, the insured must demonstrate an insurable interest in the subject matter of the insurance. This means they must have a financial or legal relationship to the person or property being insured. Insurable interest ensures that insurance is obtained for legitimate reasons and prevents speculative or fraudulent practices.

3) Indemnity

   The principle of indemnity seeks to restore the insured to the same financial position they were in before a loss or damage occurred. Insurance policies are designed to compensate for actual financial losses suffered, rather than provide an opportunity for profit. Indemnity ensures that policyholders are appropriately reimbursed without undue advantage.

4) Subrogation

   Subrogation grants insurers the right to step into the shoes of the insured and seek recovery from third parties who may be responsible for the loss or damage. By subrogating the claim, the insurer can recoup the amount paid to the insured, preventing the insured from receiving a double recovery. Subrogation helps maintain fairness and holds responsible parties accountable. The purpose of including a subrogation clause in an insurance policy is to allow the insurer to initiate recovery proceedings before compensating the insured for their loss.

5) Contribution

   Contribution applies when the insured has obtained multiple insurance policies covering the same risk. In such cases, each insurer shares the responsibility for covering the loss proportionally based on the sum insured under their respective policies. Contribution prevents overcompensation and ensures a fair distribution of liability among insurers.

6) Proximate Cause

   Proximate cause refers to the primary/dominant cause of loss or damage that sets in motion a chain of events leading to the insured event. Insurance coverage is typically triggered by the proximate cause, allowing insurers to determine liability and provide appropriate compensation. Identifying the proximate cause helps establish a clear connection between the insured event and the policy coverage.

Understanding these six principles is crucial for insurance agents to conduct their business ethically and for customers to make informed decisions when purchasing insurance. By adhering to these principles, insurers maintain integrity, while policyholders can trust in the protection and benefits provided by their insurance policies.

2.2 FUNDAMENTAL PRINCIPLES APPLICABLE TO LIFE INSURANCE

The fundamentals of life insurance involve the principles and concepts that govern this type of insurance, which is designed to provide financial protection to individuals and their beneficiaries in the event of the insured's death. Here are the fundamental principles of life insurance:

2.2.1 UTMOST GOOD FAITH (UBERRIMAE FIDEI)

The Importance of utmost good faith in life Insurance:

Both the policyholder and the insurer are **legally obligated** to act in utmost good faith throughout the application and underwriting process of a life insurance policy. This fundamental principle requires both parties to provide accurate and complete information about the insured's health, lifestyle, and any other factors that may impact the risk being insured.

This principle of utmost good faith ensures that both the policyholder and the insurer have access to all relevant information needed to assess the risk accurately. By disclosing existing health conditions or other pertinent details, the policyholder enables the insurer to make an informed decision about coverage, premiums, and policy terms.

Unlike typical commercial contracts where buyers are responsible for evaluating goods and determining their value, insurance contracts operate under a different standard. In insurance contracts, the insurer relies on the insured to provide necessary information. The principle of "**caveat emptor**" (let the buyer beware) does not apply in the same way to insurance contracts. Instead, there is an expectation of full disclosure from the insured, allowing the insurer to accurately assess the risk and offer suitable coverage.

By adhering to the principle of utmost good faith, both parties contribute to a fair and balanced insurance relationship, where **trust and transparency** are paramount. This principle fosters a sense of mutual responsibility and ensures that the policyholder receives appropriate coverage while the insurer can effectively manage and mitigate risks."

(a) Duties of the policyholder, insurer, and the obligation to take reasonable care

(i) Duty of Policyholder

The duty of utmost good faith requires both the policyholder and the insurer to act honestly and transparently throughout the insurance contract process. During the pre-contractual stage, the policyholder has a duty of disclosure, which involves providing accurate and complete information that may affect the insurer's decision to accept the risk and determine the rates and terms.

- Pre-contractual Duty of Disclosure for Insurance Contracts Other Than Consumer Insurance Contracts (Financial Services Act 2013 Schedule 9 Section 129 Para 4)

  The policyholder must disclose relevant information that they know or that a reasonable person in the given circumstances would consider relevant. This duty of disclosure includes disclosing matters that impact the insurer's decision and those that a reasonable person would expect to be relevant. There are exceptions to this duty, such as matters that reduce the risk, are commonly known, or are already known to the insurer. If the policyholder fails to answer, provides incomplete or irrelevant answers, or the insurer does not pursue the matter further, it is deemed that the insurer has waived the duty of disclosure for that matter. The insurer must clearly inform the policyholder in writing about the duty of disclosure, which continues until the contract is finalized, varied, or renewed.

Example of Exceptions to the Duty of Disclosure

1. *Matters that Reduce the Risk*

Example:
A policyholder has recently started taking health supplements, exercising regularly, and following a healthy diet. These lifestyle changes contribute to better overall health and reduce the risk of developing chronic diseases.

Why It is an Exception:
While these positive lifestyle changes do reduce health risks, they are generally not required to be disclosed to the insurer. Such personal health practices are considered routine and do not typically need to be reported unless specifically asked during the application process.

2. *Matters that are Commonly Known*

Example:
Common, self-limiting illnesses such as a normal flu or sore throat that are fully recovered and do not occur frequently or lead to other symptoms of chronic illness.

Why It is an Exception:
Such conditions are commonly known and understood to be minor and temporary. If these illnesses are not frequent and do not contribute to more serious health issues, they generally do not need to be disclosed to the insurer.

3. *Matters Already Known to the Insurer*

Example:
The insurer has access to a medical database that already indicates the policyholder's previous treatments for a common condition like seasonal allergies. The insurer is aware of this condition from previous claims or shared medical records.

Why It is an Exception:
Since the insurer already possesses this information, the policyholder is not required to disclose it again during the application process.

Advice:
However, to ensure complete transparency and avoid any potential issues, it is advisable for policyholders to disclose all relevant health information, even if they believe the insurer already knows it. This practice helps to maintain utmost good faith and can prevent any disputes over non-disclosure.

Additional Example of Insurer Waiving the Duty of Disclosure

Example:
During the application process, a policyholder mentions having had "some past issues with hypertension." If the insurer does not follow up for more specific details or clarification and issues the policy based on the provided information, the insurer has effectively waived the duty of disclosure for those specifics.

Why It is an Exception:
By not requesting additional information, the insurer is considered to have accepted the disclosed information as sufficient, relieving the policyholder of the obligation to provide more details unless specifically asked.

- Pre-contractual Duty of Disclosure for Consumer Insurance Contracts (Financial Services Act 2013 Schedule 9 Section 129 Para 5)

  Consumer insurance contracts have specific requirements for disclosure. The insurer may ask the consumer specific questions relevant to their decision to accept the risk and determine rates and terms. Consumers must take reasonable care to avoid misrepresenting information when answering these questions or confirming/amending any matter. The insurer may request the consumer to answer specific questions or provide information about any changes in previously disclosed matters during contract renewal. Consumers must take reasonable care not to make misrepresentations when answering these questions or confirming/amending information. If the insurer does not make a request, the duty of disclosure is considered waived. The insurer must inform the consumer in writing about their duty of disclosure, which continues until the contract is entered into, varied, or renewed.

Example

Illustrating the Importance of Utmost Good Faith in Life Insurance Contracts

Alex applies for a life insurance policy and fails to disclose a pre-existing heart condition during the application process. When Alex passes away due to a heart-related illness, the insurer discovers the non-disclosure. This may lead to complications during the claims process or potential denial of the claim due to a breach of the duty of disclosure.

(ii) Duty of Insurer (*Financial Services Act 2013 Schedule 9 Section 129 Para 11*)

Insurers also have duties when it comes to the pre-contractual stage of insurance contracts. They are required to provide accurate and truthful information to the policyholder, explain the duty of disclosure, and avoid misleading or fraudulent actions. If an insurer violates their pre-contractual duty of disclosure, the policyholder may have the right to rescind or cancel the contract.

Example

Illustrating a Violation of the Duty of Disclosure by the Insurer

Sarah meets with an insurance agent who knowingly provides false information about coverage benefits and misrepresents the terms and conditions. Sarah relies on this misleading information and purchases the policy. Upon discovering the deception, Sarah may have the right to rescind or cancel the policy due to the insurer's breach of the duty of disclosure.

(iii) Duty to Take Reasonable Care (*Financial Services Act 2013 Schedule 9 Section 129 Para 6*)

Both the policyholder and the insurer have an obligation to take reasonable care during the insurance contract process. Insurers must design comprehensive proposal forms that include specific questions to elicit relevant information from applicants. Applicants, in turn, must disclose all material facts and exceptional circumstances that could influence the insurer's decision.

Example

Illustrating Mutual Responsibility in Insurance Applications

Albert diligently fills out a life insurance application form, providing accurate information to the best of his knowledge. The insurer asks clear and specific questions, enabling Albert to make informed decisions and disclose any material facts related to his health or lifestyle. If there are certain factors the insurer should have been aware of, they must take those into consideration when assessing Albert's duty of care.

(iv) Material Matter or Material Fact (*Financial Services Act 2013 Schedule 9 Section 129 Para 13*)

Material facts refer to information that, if known by the insurer, would have influenced their decision to accept the risk or impose different terms. Material facts significantly impact the insurer's risk assessment and the terms and conditions of the policy. Failure to disclose material facts can lead to complications during the claims process or potential denial of claims.

Example

Illustrating Material Facts and Non-disclosure

Alfred applies for a life insurance policy but fails to disclose his pre-existing heart condition, which is a material fact. If the insurer discovers this non-disclosure after John's passing, it may affect the validity of the policy or the insurer's obligation to pay the claim.

(v) The Proposal Form and its Role in Disclosure

The proposal form is a crucial tool for fulfilling the duty of disclosure. It is a questionnaire that applicants fill out when applying for insurance. Insurers must design proposal forms that include specific questions to elicit relevant information, allowing applicants to disclose all material facts. Applicants are obligated to complete the proposal form accurately and disclose any exceptional circumstances that are not covered by the specific questions.

Example

The Importance of Accurate Disclosure on the Proposal Form

John is applying for a health insurance policy. The proposal form asks specific questions about his medical history, including any past surgeries, chronic illnesses, and current medications. John carefully reviews the questions and provides accurate information about his recent knee surgery and ongoing treatment for high blood pressure. However, the form does not ask about occasional, minor ailments such as seasonal allergies.

Description:

By accurately disclosing his significant health conditions and treatments, John fulfills his duty of disclosure. Even though the form does not specifically ask about minor ailments like seasonal allergies, John does not need to disclose them as they are not material facts that significantly impact the insurer's decision. However, if John had a serious allergy requiring frequent medical intervention, it would be his responsibility to disclose this exceptional circumstance even if not directly asked.

(b) Breach of good faith

A breach of good faith can occur through misrepresentation or non-disclosure by the insured. Misrepresentation involves providing false information, while non-disclosure refers to the failure to disclose pertinent information. Both can result in complications, policy cancellation, denial of claims, or legal action.

(i) Remedies for Breach of Good Faith by the Insured (Financial Services Act 2013 Schedule 9 Section 129 Para 7)

Insurers have different remedies for innocent breaches and fraudulent breaches of good faith. In innocent breaches, insurers may have the right to avoid the policy as a whole but cannot keep the premium. In fraudulent breaches, insurers may have the right to avoid the policy and retain the premium.

Case Study: Differentiating Fraudulent, Careless, and Innocent Breaches

- A **fraudulent** breach occurs when an insured intentionally provides false information or deliberately omits important details to deceive the insurer.
    - **Example**: If a policyholder knowingly hides a recent cancer diagnosis when applying for life insurance, this constitutes fraud. Insurers may void the policy and retain the premium in such cases, as the breach was deliberate and deceitful.

- A **careless** breach happens due to negligence or oversight without malicious intent.
    - **Example**: An applicant forgets to mention a minor benign cyst surgery from several years ago during the application process. The omission was not intended to deceive but occurred because the applicant genuinely forgot. When discovered, insurers might adjust the policy terms to exclude related conditions or impose a loading fee, reflecting the carelessness of the omission but not outright fraud.

- An **innocent** breach involves errors made despite the insured's best efforts to be honest and transparent.
    - **Example**: If a policyholder fails to disclose an allergy because they were unaware it was relevant or forgot due to its minor impact on their life, this is seen as an innocent mistake. In such cases, the insurer may still adjust the policy, but the breach is considered understandable, and the policyholder is not penalized as severely as in fraudulent or careless breaches.

Overall, fraudulent breaches lead to severe consequences, including policy voidance and retained premiums. Careless breaches may result in policy adjustments and loading fees, while innocent breaches are treated more leniently, with potential policy adjustments reflecting the inadvertent nature of the error.

FIGURE 2-1 ***Innocent Breaches and Deliberate Breaches***

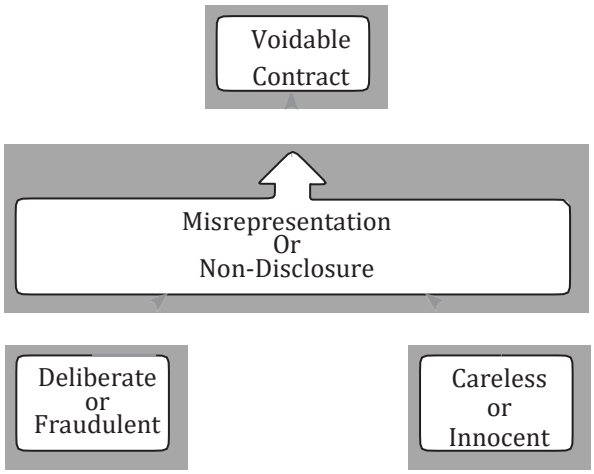


Table 2-1 ***Summary for Remedies for Breach of Good Faith by the Insured***

Insurer	Innocent Breach	Fraudulent Breach
1. Right to avoid the policy as a whole?	Yes	Yes
2. Right to keep the premium as well?	No	Yes
3. Right to ignore the breach and allow the policy to stand?	Yes	Yes
4. Right to refuse a particular claim but allow the policy to stand?	No	No

SAMPLE CASE STUDY: DIFFERENTIATING INNOCENT AND FRAUDULENT BREACHES

Case Study: John and Jane's Insurance Applications

John's Innocent Breach:

John applies for a life insurance policy. During the application process, he accurately discloses his medical history but forgets to mention a minor outpatient procedure from five years ago to remove a benign cyst. This omission is not intentional; John genuinely believes the procedure was too minor to be relevant.

Outcome:

The insurer discovers the omission during a claim assessment. Since John's omission was an innocent breach, the insurer has the right to avoid the policy as a whole but cannot keep the premium.

Alternatively, the insurer might decide to ignore the breach and allow the policy to stand, considering the minor nature of the omitted information.

Jane's Fraudulent Breach:

Jane applies for a health insurance policy. To obtain a lower premium, she intentionally omits disclosing a recent diagnosis of diabetes. This omission is deliberate, as Jane knows that her premium would be higher if the insurer knew about her condition.

Outcome:

The insurer discovers the deliberate omission during a claim assessment. Since Jane's omission is a fraudulent breach, the insurer has the right to avoid the policy as a whole and keep the premium.

The insurer also has the right to refuse any claims made under the policy and can take legal action against Jane for fraud.

How To Draw the Line:

- Intentionality:

  The key factor in differentiating between innocent and fraudulent breaches is the intent behind the omission or misrepresentation. Innocent breaches occur without intent to deceive, often due to forgetfulness or misunderstanding. Fraudulent breaches involve a deliberate attempt to mislead the insurer.

- Materiality:

  The significance of the omitted or misrepresented information also matters. Minor omissions that do not significantly impact the insurer's risk assessment may be treated more leniently, whereas material misrepresentations that alter the risk profile are taken seriously.

- Response:

  Insurers have specific remedies depending on the nature of the breach. Innocent breaches might lead to policy adjustments or cancellations without retaining premiums, while fraudulent breaches result in more severe consequences, including policy voidance and retention of premiums.

Conclusion

By examining the intent and materiality of omissions or misrepresentations, insurers can differentiate between innocent and fraudulent breaches. This differentiation guides the appropriate remedies and ensures fair treatment of policyholders while protecting the insurer's interests.

(c) Consumer insurance contracts

(i) Consumer Insurance Contracts (Financial Services Act 2013 Schedule 9 Section 129 Para 5)

"**Consumer Insurance Contract**" means a contract of insurance entered into, varied or renewed by an individual wholly for purposes unrelated to the individual's trade, business or profession. *(Financial Services Act 2013 Schedule 9 Section 129 Para 1)*

"**Wholly for purposes unrelated to the individual's trade**" means the insurance coverage provided by the contract is solely for **personal reasons** and not related to any commercial or professional activities conducted by the individual.

In simpler terms, a consumer insurance contract refers to an insurance agreement that is undertaken by an individual for personal reasons, not connected to their trade, business, or profession. It typically includes insurance policies such as personal auto insurance, home insurance, personal health insurance, personal liability insurance, and other forms of coverage aimed at protecting an individual's personal interests and assets.

Table 2-2 *Duty of Disclosure*

Duty of Disclosure	Description
Pre-contractual Stage	The licensed insurer may ask specific questions to the consumer proposer that are relevant to their decision on accepting the risk and determining rates and terms. It is the duty of the consumer to take reasonable care not to make any misrepresentation when answering these questions.
Renewal of Contracts	The licensed insurer may request the consumer to answer specific questions or provide information about any changes in previously disclosed matters. The consumer must take reasonable care not to make any misrepresentation when answering these questions or confirming/amending information.
During the Currency of Contract	The consumer has a duty to take reasonable care in disclosing any matter (other than those covered in the pre-contractual stage and renewal) that they know to be relevant to the insurer's decision on accepting the risk and determining rates and terms.

During the Claims Process	The duty of utmost good faith applies to both the consumer and the licensed insurer in their dealings with each other, including the making and payment of claims. Fraudulent claims or acting in bad faith is not permitted.
Exceptions to the Duty of Disclosure	If the insurer does not make a request for information, compliance with the consumer's duty of disclosure is deemed waived by the insurer. If the consumer fails to answer or provides incomplete or irrelevant information, and the insurer does not pursue the matter further, the insurer is deemed to have waived the duty of disclosure.

(ii) Disclosure duties: pre-contractual, renewal, and ongoing obligations

Insurance Contracts Other than Consumer Insurance Contracts (Financial Services Act 2013 Schedule 9 Section 129 Para 4):

These types of insurance contracts cater to specific sectors, professions, or industries, offering coverage for risks beyond the scope of personal consumer needs.

Brief definition of each type of insurance contract as mentioned above:

- Commercial Insurance Contracts

  These contracts provide coverage for businesses and organizations, protecting them against various risks and liabilities specific to their operations and industry.

- Professional Liability Insurance Contracts

  Also known as errors and omissions (E&O) insurance, these contracts offer coverage to professionals such as doctors, lawyers, architects, and consultants, protecting them from claims and lawsuits arising from errors or negligence in their professional services.

- Directors and Officers (D&O) Liability Insurance Contracts

  These contracts provide coverage for directors and officers of companies, safeguarding them against legal liabilities they may face while performing their duties and responsibilities.

- Reinsurance Contracts

  Reinsurance contracts are agreements between insurance companies (primary insurers) and other insurers (reinsurers). Primary insurers transfer a portion of their insurance risks and liabilities to reinsurers in exchange for premium payments, helping them manage their exposure to large losses.

- Marine Insurance Contracts

  Marine insurance contracts provide coverage for risks related to marine activities, including cargo transportation, hull damage, liability, and marine

adventure risks. These contracts are tailored for shipowners, cargo owners, and others involved in marine operations.

- Specialty Insurance Contracts

  Specialty insurance contracts are designed to address unique risks or industries. They include policies such as aviation insurance (covering aircraft and aviation-related risks), cyber insurance (covering data breaches and cyber threats), environmental liability insurance (covering pollution-related risks), terrorism insurance, product liability insurance (covering liabilities related to products), and event cancellation insurance.

Table 2-3 *Duty of Disclosure*

Duty of Disclosure	Description
Pre-contractual Stage	The proposer (applicant) must disclose to the licensed insurer *any relevant information* that they know or that a reasonable person in the circumstances could be expected to know, which may impact the insurer's decision on accepting the risk and determining rates and terms.
Renewal of Contracts	The insured must inform the insurer of any material changes in the risk being insured, as the *renewal of the contract is considered a new contract*. This enables the insurer to assess the risk appropriately and adjust the premium accordingly.
During the Currency of Contract	The insured has a continuous duty to *disclose new material facts that arise during the contract* and may affect the risk being insured. This includes changes in the contract or an increase in risk.
During the Claims Process	The insured must act in good faith when making a claim and *provide accurate information* regarding the loss or damage incurred. Making fraudulent claims or providing false information is not permitted.
Exceptions to the Duty of Disclosure	The duty of disclosure does not require the disclosure of matters that diminish the risk to the insurer, are of common knowledge, are known by the insurer, or have been waived by the insurer. If the proposer fails to answer or provides incomplete or irrelevant answers to questions in the proposal form, and the insurer does not pursue the matter further, the insurer is deemed to have waived the duty of disclosure.

(iii) Exceptions to the Duty of Disclosure

Non-consumer insurance contracts require the proposer to disclose all relevant material facts, even if specific questions are not asked. However, certain exceptions exist, such as matters that reduce the risk, are commonly known, already known to the insurer, or waived by the insurer. Consumer insurance contracts are considered compliant if the applicant fully and faithfully answers the questions on the proposal form. In the absence of specific questions or an express request for information, insurers cannot repudiate a claim based on non-disclosure.

(d) Non-contestability for life insurance contracts

(i) Non-contestability for life insurance contracts (Financial Services Act 2013 Schedule 9 Section 129 Para 13)

Paragraph 13 of Schedule 9 of the Financial Services Act 2013 discusses the non-contestability clause associated with life insurance contracts. These rules apply to all

life insurance contracts, irrespective of whether they are consumer insurance contracts or not.

- If a life insurance contract has been in effect for *more than two years* during the lifetime of the insured, the insurance provider cannot invalidate the contract based on a claim that a statement in the insurance proposal or in a doctor's report or any other document leading to the issuance of the life policy was inaccurate, false, or misleading.

- The *only exception* to this rule is when the insurer can prove that the misleading or omitted statement was about a crucial matter or concealed an important fact, and that it was intentionally made or omitted by the policy owner or the insured.

The provision of non-contestability applies to life insurance contracts, regardless of whether they are consumer insurance contracts or not. It states that if a life insurance policy has been active for more than two years while the insured person is alive, the insurance company cannot cancel the policy or deny a claim based on any inaccurate, false, or misleading statements made by the policy owner or insured person in the insurance application, medical reports, or related documents.

However, there are some conditions to this provision. The insurance company can only challenge the statements if they are related to important information that, if known by the insurer, would have resulted in the refusal to issue the policy, or would have led to less favorable terms for the policy owner. Additionally, the insurer must prove that the statements were intentionally fraudulent.

In simple terms, the non-contestability provision protects the policy owner after the life insurance policy has been active for more than two years. The insurance company cannot cancel the policy or deny a claim based on minor inaccuracies or omissions in the application unless the statements were intentionally fraudulent and related to important information that would have affected the issuance of the policy.

Example

Protection Under the Non-Contestability Clause

Let us consider Rose, who applied for a life insurance policy and provided all the necessary information honestly and accurately. However, due to a misunderstanding, she inadvertently failed to disclose a minor pre-existing medical condition, such as a mild allergy, on her application form. The insurer issued the policy, and Rose faithfully paid her premiums for over two years.

Unfortunately, Rose passes away unexpectedly, and her beneficiaries submit a claim to the insurance company. During the claims investigation, the insurer discovers the undisclosed pre-existing condition, which was a mild allergy that did not significantly impact Rose's overall health or mortality risk. However, since the policy has been active for more than two years, the insurer cannot contest the claim or cancel the policy based on the non-disclosure of the minor medical condition. The non-contestability provision protects Rose's beneficiaries and ensures they receive the life insurance benefits as intended.

This example demonstrates how the non-contestability provision safeguards policyholders and their beneficiaries after a certain period of time. It prevents the insurance company from using minor inaccuracies or omissions in the application to deny claims or terminate the policy, thereby providing peace of mind and financial protection to policyholders and their loved ones.

2.2.2 INSURABLE INTEREST (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 SECTION 128 PARA 3)

Insurable interest is a fundamental concept in life insurance that ensures there is a valid financial interest between the policyholder (or the person on whose life the policy is based) and the insured individual. It is a requirement for the policyholder to have a close relationship or financial dependency on the insured person in order to establish insurable interest.

(i) Who has Insurable Interest?

Under Schedule 8 of the Financial Services Act 2013 in Malaysia, there are provisions regarding insurable interest:

1. A life policy insuring the life of anyone other than the person effecting the insurance or a person mentioned in subparagraph (3) shall be void unless the person effecting the insurance has an insurable interest in that life at the time the insurance is effected.

2. A group life policy shall not be void by reason only that the group policy owner did not have, at the time when the insurance was effected, an insurable interest in the lives of the persons insured under the policy.

3. A person shall be deemed to have an insurable interest in the life of another person if that other person is—
   (a) his spouse or child;
   (b) his ward under the age of majority at the time the insurance is effected;
   (c) his employee; or
   (d) a person on whom he is wholly or partly dependent for maintenance or education at the time the insurance is effected.

4. In this paragraph, insuring the life of a person means insuring the payment of moneys on a person's death or on the happening of any contingency dependent on his death or survival and includes granting an annuity to commence on his death or at a time referred to in the annuity.

Under Schedule 8 of the Financial Services Act 2013, specific provisions outline insurable interest:

- A life insurance policy insuring the life of anyone other than the person effecting the insurance or a person mentioned in subparagraph (3) shall be void unless the person effecting the insurance has an insurable interest in that life at the time the insurance is effected.

- *A group life policy* shall not be void solely because the group policy owner did not have an insurable interest in the lives of the persons insured under the policy at the time the insurance was effected.

Insurable interest is deemed to exist in the following relationships:

- Spouse, Child, or Ward

  A person has insurable interest in their spouse, child, or ward who is under the age of majority. For example, a parent can take out a life insurance policy on their child, as they have a financial interest in their well-being and future.

- Employee

  A person has an insurable interest in their employee. This allows a company to take out a life insurance policy on a key employee to protect against financial loss in the event of their death.

- Dependent for Maintenance or Education

  A person has insurable interest in someone they are wholly or partly dependent on for maintenance or education. For instance, an individual can take out a life insurance policy on their primary caregiver, as they rely on them for financial support and care.

(ii) When should Insurable Interest Exist?

Insurable interest must exist at the time the insurance is effected for the policy to be considered valid. This requirement ensures that the policyholder has a genuine financial interest in the insured person's life.

Table 2-4 *Life Insurance Example*

Relationship	Description	Life Insurance Example
Spouse, Child, or Ward	A person has insurable interest in their spouse, child, or ward who is under the age of majority.	A parent takes out a life insurance policy on their child.
Employee	A person has an insurable interest in their employee.	A company takes out a life insurance policy on a key employee.
Dependent for Maintenance or Education	A person has insurable interest in someone they are wholly or partly dependent on for maintenance or education.	An individual takes out a life insurance policy on their primary caregiver.

Understanding the concept of insurable interest is important when considering life insurance policies. It ensures that the policyholder has a legitimate reason to want the insured person to remain alive and well, and prevents individuals from taking out insurance policies solely for the purpose of profiting from someone's death or disability.

Insurable interest must exist at the inception of the policy for it to be valid. It ensures that the person purchasing the policy has a legitimate reason to want the insured to remain alive and well.

2.2.3 INSURABLE INTEREST IN CREDITOR AND DEBTOR RELATIONSHIPS

The Financial Services Act 2013 Schedule 8 Section 128 in Malaysia does not explicitly mention the creditor and debtor relationship in its provisions on insurable interest. The Act outlines specific relationships where insurable interest is presumed, such as between spouses, children, wards, employees, and dependents.

However, in practice, the concept of insurable interest is often extended to include creditor-debtor relationships. Legal precedents and industry practices recognize that creditors have an insurable interest in the lives of their debtors to the extent of the debt. This recognition is based on the financial loss a creditor would suffer if the debtor were to die before repaying the debt.

INDUSTRY PRACTICES AND LEGAL PRECEDENTS

Common Law Principles:

In many jurisdictions, including Malaysia, courts have recognized that creditors have an insurable interest in the lives of their debtors to the extent of the debt owed. This recognition is based on the financial loss the creditor would suffer if the debtor were to die before repaying the debt.

Atkin's Court Forms Malaysia:

Authoritative sources such as Atkin's Court Forms Malaysia also support the broader interpretation of insurable interest to include financial relationships. This legal resource provides comprehensive guidance on civil litigation forms and procedures, including interpretations of insurable interest that extend to creditor-debtor relationships.

Example

Creditor and Debtor Relationship

Scenario:
Tom, a small business owner, lends a significant sum of money to Jerry, a trusted friend and entrepreneur, to help start a new business. To protect his financial interest, Tom takes out a life insurance policy on Jerry's life for the amount of the loan. This ensures that if Jerry were to pass away before repaying the loan, Tom would receive the insurance payout to cover the debt.

In this case, Tom, as the creditor, has an insurable interest in Jerry's life to the extent of the debt at the time the insurance is effected. This arrangement is permissible under common industry practices, as it protects Tom's financial interest in the event of Jerry's untimely death.

2.2.4 INDEMNITY

LIFE INSURANCE

Life insurance is not construed as a contract of indemnity. The agreed-upon sum assured, also referred to as the death benefit, is predetermined and does not function as an indemnity for tangible financial losses.

As a principle, it is not commonly applied in the context of life insurance. Unlike general insurance, where indemnity aims to restore the insured to their pre-loss financial position, life insurance operates on a different basis. In life insurance, the purpose is to provide a predetermined sum of money, known as the death benefit, to the beneficiary upon the insured's death. The death benefit is not typically tied to the actual financial loss suffered by the beneficiary but rather serves as a form of financial protection or support.

CRITICAL ILLNESS RIDER

This rider operates similarly to life insurance, in that it does not provide indemnity. The payout is a predetermined lump sum that does not correlate with the actual cost of treating the illness.

ACCIDENT RIDER

The accident rider, analogous to life insurance and the critical illness rider, does not adhere to the principle of indemnity. The payout, a predetermined sum, does not compensate for the financial loss resulting from the accident. In some cases, there may be provisions for reimbursement of medical expenses related to the accident, which could align with the principle of indemnity.

MEDICAL CARD/HEALTH INSURANCE

In contrast, health insurance, epitomized by the medical card, conforms to the principle of indemnity. The policy intends to compensate for the actual medical expenses incurred, subject to policy limits.

2.2.5 SUBROGATION CLAUSE IN MEDICAL INSURANCE

The subrogation clause in a medical insurance policy states:

"If the Company becomes liable for any payment under this Annexure, the Company shall be subrogated to the extent of such payment to all the rights and remedies of the Life Assured against any party and shall be entitled at its own expense to sue in the name of the Life Assured. The Life Assured shall give or cause to be given to the Company all such assistance in his/her power as the Company shall require to secure the rights and remedies, and at the Company's request shall execute or cause to be executed all documents necessary to enable the Company to effectively bring suit in the name of the Life Assured."

Explanation

Subrogation allows the insurance company to step into the shoes of the insured (Life Assured) and seek recovery from the third party responsible for the insured's injury or illness. This ensures that the party at fault bears the financial responsibility for the damages rather than the insurance company, which has already compensated the insured for their loss.

Example

Subrogation

Scenario:
Jane is covered under a medical insurance policy. One day, while driving her car, she is hit by another driver, John, who ran a red light. As a result, Jane suffers serious injuries and incurs medical expenses amounting to RM100,000. Jane files a claim with her medical insurance company, and the company pays for her medical expenses.

Subrogation Process:

1. **Payment:**
   The insurance company pays RM100,000 to cover Jane's medical expenses.

2. **Right to Sue:**
   By making this payment, the insurance company gains the right to seek reimbursement from John, the negligent driver.

3. **Legal Action:**
   The insurance company decides to pursue John for the RM100,000. At its own expense, the company sues John in Jane's name.

4. **Assistance Required:**
   Jane is required to cooperate with the insurance company by providing necessary information, documents, and any other assistance needed to build the case against John.

5. **Recovery:**
   If the insurance company wins the lawsuit, John or his auto insurance company will pay the RM100,000, which will reimburse Jane's medical insurance company.

Benefits of Subrogation

- **For the Insured:**

  Jane receives prompt medical care and reimbursement for her expenses without having to wait for a legal settlement with John.

- **For the Insurer:**

  The insurance company can recover the costs it incurred by pursuing the responsible party, thereby reducing its overall expenses and helping to keep insurance premiums stable.

Conclusion

Subrogation is a crucial mechanism in insurance that ensures the responsible party pays for the damages while allowing the insured to receive timely compensation. By including subrogation clauses in policies, insurers can manage costs and uphold the principle that liability should rest with the party at fault.

2.2.6 CONTRIBUTION

LIFE INSURANCE, CRITICAL ILLNESS RIDER, ACCIDENT RIDER

The principle of subrogation typically does not apply to these insurance provisions, and insurers generally do not pursue recovery of claim costs from third parties.

MEDICAL CARD/HEALTH INSURANCE

In health insurance, subrogation applies if a third party is responsible for the insured's illness or injury, allowing the insurer to recover claim costs from that party or their insurer.

2.2.7 PROXIMATE CAUSE

LIFE INSURANCE, CRITICAL ILLNESS RIDER, ACCIDENT RIDER

These insurance products abide by the principle of proximate cause. The triggering event for the policy or rider benefit must be an event covered under the policy.

MEDICAL CARD/HEALTH INSURANCE

Health insurance also adheres to the principle of proximate cause. It covers treatment costs for ailments or injuries specified in the policy. Should the cause not be covered, the insurer reserves the right to deny the claim.

It is important to note that life insurance operates under its own set of principles and practices, distinct from those of general insurance. The focus in life insurance is primarily on providing financial protection to beneficiaries upon the insured's death, rather than the specific principles of subrogation and contribution seen in general insurance.

In summary, these fundamental principles form the basis of life insurance contracts and help ensure fairness and transparency in the coverage provided. It is crucial to thoroughly understand the terms, conditions, and benefits of a life insurance policy before purchasing it to meet your specific financial and protection needs.

2.3 FUNDAMENTAL PRINCIPLES APPLICABLE TO GENERAL INSURANCE

The fundamentals of general insurance, also known as non-life, which include but are not limited to property and casualty insurance, involve the principles and concepts that govern this type of insurance. General insurance provides coverage for a wide range of risks other than life insurance.

Here are the fundamental principles of general insurance:

2.3.1 UTMOST GOOD FAITH (UBERRIMAE FIDEI)

Both the insured and the insurer are required to act in utmost good faith, meaning they must disclose all *material facts* related to the insurance policy. It is the duty of the insured to provide accurate and

complete information, and it is the duty of the insurer to provide clear and transparent policy terms and conditions.

In general insurance, *material facts* refer to information that is significant and can influence the insurer's decision-making process regarding the acceptance of the risk and the terms and conditions of the insurance policy. These facts are considered essential because they have the potential to impact the underwriting process and the determination of premiums.

Material facts are those that *a reasonable person would recognize as important* and relevant in assessing the risk being insured. They are facts that, if known by the insurer, would likely affect their decision to issue the policy or result in the imposition of different terms.

Example 1

Property Insurance Policy

In a property insurance policy, a material fact could be the absence of a security system in the insured premises. If the insured fails to disclose this information, it may affect the insurer's assessment of the risk. The absence of a security system could potentially increase the risk of theft or damage, leading to higher premiums and/or deductible. Non-disclosure of this material fact could impact the validity of the insurance contract and the insured's ability to make a successful claim in case of a loss.

Example 2

Motor Insurance

In motor insurance, material facts could include details such as the insured's driving history, previous accidents or claims, modifications made to the vehicle, or any relevant convictions. Failure to disclose these facts could affect the insurer's decision to accept the risk or could result in a higher premium being charged.

(a) Disclosure Requirements (Financial Services Act 2013 Schedule 9 Section 129 Para 4&5)

Under this Schedule 9, FSA 2013, there is a duty of disclosure for both insurance contracts other than consumer insurance contracts and consumer insurance contracts. Proposers are required to disclose relevant information to the insurer before entering into or renewing a contract.

(i) Pre-contractual Stage

Before entering into a contract of insurance, at the commencement of negotiations, both parties (applicant and insurer) have a duty to disclose accurate and relevant information in a clear, concise and timely manner to enable the consumer to make an informed decision and the insurer to decide on suitable terms of acceptance of the risk.

Example

Pre-contractual Stage

During the pre-contractual stage of a general insurance policy, let us consider a scenario involving property insurance. An individual, John, is looking to insure his residential property against fire and natural disasters. John approaches an insurance company to obtain a quote and initiate the insurance process.

At this stage, both John (the applicant) and the insurer have certain duties regarding disclosure:

1. Duty of John (Applicant)

    - Accurate Information
      John must provide accurate details about the property, including its location, construction type, occupancy, and any other relevant factors that could impact the risk assessment.

    - Relevant Information
      John should disclose any previous claims made for similar insurance coverage, previous damage to the property, or any other information that could influence the insurer's decision.

    - Timeliness
      John should provide all the necessary information in a clear, concise, and timely manner, ensuring that he does not withhold any material facts that could affect the insurer's decision or the terms of the policy.

2. Duty of the Insurer

    - Clear Communication
      The insurer must clearly outline the coverage options, policy terms, exclusions, and any other relevant details to John during the negotiation process. This includes explaining deductibles, coverage limits, and any additional conditions or requirements.

    - Risk Assessment
      Based on the information provided by John, the insurer assesses the risk associated with insuring the property. They may consider factors such as the property's location, previous claims history, and any unique characteristics that could impact the likelihood of a claim.

    - Suitable Terms
      The insurer uses the disclosed information to determine suitable terms for accepting the risk. This includes calculating the premium amount, setting coverage limits, and specifying any additional conditions or endorsements.

By both parties fulfilling their duty of disclosure, John can make an informed decision about the insurance coverage that best suits his needs, while the insurer can accurately assess the risk and offer appropriate terms for insuring the property against fire and natural disasters.

(ii) Renewal of General Insurance Contracts

At renewal, the duty of utmost good faith must be similarly observed by both parties (insured and insurer) but the onus is on the insured to inform the insurer of any material changes in the risk to be insured (as renewal becomes a new contract) to allow the insurer to carry out an appropriate assessment of the risk so that a premium commensurate with the risk accepted can be charged.

Example

Renewal of General Insurance Contracts

Continuing from the above scenario involving John and his property insurance, let us explore the renewal stage and the duty of utmost good faith:

Several years have passed since John initially obtained the property insurance policy, and now it is time for policy renewal. John received a renewal notice from the insurance company, indicating the upcoming expiration of his current policy.

During the renewal process, both John (the insured) and the insurer have specific responsibilities:

1. Duty of John (Insured)

    - Material Changes
      John must inform the insurer about any material changes that have occurred since the inception of the policy. For example, if John has made significant renovations to the property, installed additional security measures, or experienced any previous claims during the policy period, he should disclose this information to the insurer.

    - Timely Disclosure
      John needs to provide the updated information to the insurer within the specified time frame mentioned in the renewal notice. This ensures that the insurer has sufficient time to assess the changes and determine suitable terms and premium adjustments for the renewed policy.

    - Accurate Information
      John should provide accurate and complete details regarding the changes to the property or any other relevant factors that may impact the risk assessment. This allows the insurer to evaluate the renewed risk accurately.

2. Duty of the Insurer

    - Assessment of Changes
      Upon receiving the information about the material changes from John, the insurer evaluates the impact of these changes on the risk profile of the insured property. They consider factors such as the nature of renovations, improved security measures, or any previous claims history.

    - Premium Adjustment
      Based on the updated risk assessment, the insurer determines if any premium adjustments are necessary. If the changes increase the risk associated with the property, the insurer may adjust the premium accordingly to reflect the new level of risk.

    - Policy Terms and Conditions
      The insurer communicates any modifications to the policy terms and conditions resulting from the material changes. This may include updates to coverage limits, exclusions, or any additional requirements.

By fulfilling their respective duties during the renewal process, both John and the insurer ensure that the renewed policy accurately reflects the current risk profile of the property. John's disclosure of material changes allows the insurer to assess the risk accurately and charge a premium that corresponds to the level of risk accepted by the insurer.

(iii) During the Currency of the Contract

There is a continuing duty (imposed on the insured) to disclose new material facts affecting the risk under the following circumstances:

- Changes in the contract
  For example, when the insured changes his car or wishes to add new drivers; or
- Increase in the risk
  For example, the insurer must be notified of any alteration in the property insured, which increases the risk of damage as the cover will cease unless the alteration is admitted. Insurers often incorporate a clause in the policy to that effect.

Example

The continuing duty of disclosure during the currency of a general insurance contract

Let us say Sarah has a comprehensive auto insurance policy for her car. A few months into the policy period, Sarah decides to sell her current car and purchase a new one. As per the terms of her insurance contract, Sarah has a duty to disclose this change to her insurer.

Sarah contacts her insurance company and informs them about the change in her vehicle. She provides the necessary details about the new car, such as the make, model, year, and vehicle registration number. By disclosing this material change, Sarah allows the insurer to assess the risk associated with the new vehicle accurately.

Upon receiving the information, the insurer evaluates the updated risk profile of Sarah's new car. They consider factors such as the car's value, safety features, and the associated risks, such as theft or accident statistics for that particular model. Based on this assessment, the insurer may adjust the policy terms, coverage limits, or premium to reflect the change in the insured vehicle.

Additionally, if Sarah decides to add new drivers to her policy, such as family members or friends who will be using her car, she has a duty to disclose this information to the insurer. Sarah provides the necessary details about the additional drivers, including their names, ages, driving history, and relationship to her. The insurer assesses the increased risk associated with adding new drivers and may adjust the policy terms and premium accordingly.

It is important for Sarah to fulfill her duty of disclosure by promptly notifying the insurer of these changes. Failure to disclose such material facts can lead to potential issues during claims settlement or even the possibility of the policy being deemed void if the insurer determines that the non-disclosure of relevant information was intentional or fraudulent.

By maintaining a continuing duty of disclosure, Sarah ensures that her insurance policy remains up-to-date and accurately reflects the risk factors associated with her vehicle and any changes she makes during the policy period.

(iv) During the Claims Process

The general duty of good faith exists when the insured makes a claim. For example, claiming for a loss that one knows has not occurred, or for property that has not been lost is clearly fraud.

Example

The general duty of good faith during the claims process

Let us say John has a homeowner's insurance policy that covers his property against various risks, including theft and fire. One day, John's house catches fire due to an electrical malfunction, resulting in significant damage to his property.

John promptly contacts his insurance company to file a claim for the fire damage. He provides all the necessary documentation, such as photographs of the damaged property, a detailed list of the items affected, and an estimate for the cost of repairs.

However, in an attempt to receive a larger claim payout, John includes items in his list that were not actually damaged by the fire. He knowingly includes these items in the claim, even though they were not lost or affected in any way.

By doing so, John is engaging in fraudulent behavior. He is claiming for losses that he knows have not occurred, and he is attempting to receive compensation for property that has not been lost or damaged in the fire. This action goes against the general duty of good faith that exists when making an insurance claim.

Insurance companies rely on the honesty and integrity of their policyholders during the claims process. Claiming for losses that have not occurred or exaggerating the extent of the damage is considered fraudulent and can lead to serious consequences. If the insurer discovers John's fraudulent claim, they may deny the claim entirely, cancel his policy, and potentially pursue legal action against him for insurance fraud.

It is essential for policyholders to act in good faith when making an insurance claim. This means providing accurate and truthful information, substantiating the loss or damage with proper documentation, and not attempting to deceive or defraud the insurer in any way.

2.3.2 INSURABLE INTEREST

There must be a valid insurable interest between the insured and the subject matter of insurance. In general insurance, the insured must have a financial interest in the property or the subject matter being insured. Without insurable interest, the insurance contract would be considered invalid.

(a) How to Establish Insurable Interest in General Insurance?

There is a direct relationship between insurable interest and the subject matter of insurance in general insurance. Insurable interest refers to a legal or financial interest that the insured party must have in the subject matter being insured. It is a fundamental principle in insurance that ensures the validity and enforceability of the insurance contract.

Example

Insurable Interest

Let us say Sarah owns a commercial property that she rents out to tenants. She has a financial interest in the property because she relies on the rental income for her livelihood. In this case, Sarah has a valid insurable interest in the property.

Sarah decides to purchase a general insurance policy to protect her commercial property against various risks, such as fire, theft, and natural disasters. By insuring the property, Sarah seeks to safeguard her financial investment and mitigate potential losses that could occur due to unforeseen events.

The insurance policy provides coverage for the property's structure, contents, and liability. In the event of a covered loss, such as a fire that damages the building or theft of valuable equipment, Sarah can file a claim with the insurance company to receive compensation for the financial loss she incurs as a result.

In this example, Sarah's financial interest in the commercial property establishes her insurable interest. Without such an interest, Sarah would not be able to obtain a valid general insurance policy for the property. Insurable interest ensures that insurance contracts are based on legitimate financial relationships and that individuals cannot insure properties or assets in which they have no genuine stake.

Having insurable interest is a fundamental requirement in general insurance to prevent individuals from taking out insurance policies on assets or properties for which they have no legitimate financial attachment. It helps maintain the integrity and purpose of insurance contracts by ensuring that only those with a genuine interest in the subject matter of insurance can obtain coverage.

(b) What is the Subject Matter of Insurance?

In general insurance, the subject matter of insurance can be life, limb, property, or even potential legal liability and may vary with the type of insurance available. Some examples of the subject matter of insurance which are insured by various types of insurance policies are as follows:

Table 2-5 *Types of Insurance Policies*

Types of Insurance	Subject Matter
Motor	Motor vehicle and third-party liability
Marine	Cargo or hull
Life and Personal Accident	Life and limb
Aviation	Aircraft and passenger liability
Fire	Building and contents

Example

Insurable Interest

John owns a commercial property that he rents out to tenants. He has taken out a general insurance policy to protect the property against potential damages and losses. In this case, John has a clear insurable interest in the property because he owns it and stands to suffer financial loss if any damage or loss occurs.

Now, consider a scenario where Sarah, who is not related to John or the property, attempts to purchase an insurance policy for the same commercial property. Since Sarah does not have any financial interest in the property, she lacks insurable interest. As a result, the insurance contract would be considered void because there is no valid insurable interest between Sarah and the subject matter of insurance.

This example demonstrates the importance of establishing insurable interest in general insurance contracts. It ensures that the parties involved have a legitimate financial stake in the subject matter being insured, providing a basis for the contract's validity, and protecting against potential misuse or fraud.

For the insurance contract to be valid, the insured must have a valid and legal insurable interest in the subject matter being insured. This means that the insured must have a financial or legal stake in the subject matter such that they would suffer a financial loss or be legally liable in case of damage or loss to the insured property or liability.

(c) What is Subject Matter of the Insurance Contract?

The subject matter of the insurance contract is the financial interest of the insured.

Example

Subject Matter of the Insurance Contract

Consider a bank who has granted a loan on a property for an amount of RM 300,000. While the subject matter of insurance in a fire policy is the building, the financial interest of the bank is limited to the amount of the loan which is RM 300,000.

Table 2-6 *Insurance Contracts*

Insurance Contracts	Subject Matter of Insurance Contract
Fire Policy	Financial interest of the bank: Loan amount
Car Insurance	Financial interest of the owner: Market value of the car
Home Insurance	Financial interest of the homeowner: Replacement value of the property
Business Liability Insurance	Financial interest of the business: Total assets or potential liability

(d) When should Insurable Interest Exist?

In respect of general insurance, insurable interest must exist at:

1. the beginning; and
2. at the time of loss; otherwise, the insurance contract is void.

Example

When should insurable interest exist?

John purchases a comprehensive car insurance policy for his vehicle, establishing a valid insurable interest as the owner with a financial stake in its well-being.

Several months later, without notifying the insurance company, John sells the car to his friend Peter. Peter, recognizing the importance of insurance coverage, promptly purchases a third-party car insurance policy for the vehicle before driving it on the road.

Unfortunately, an accident occurs where the car sustains significant damage, but there are no injuries to third parties. Peter files a claim under John's insurance policy. During the investigation, it becomes evident that John no longer has an insurable interest in the car since he has already sold it. Furthermore, since Peter had obtained a separate third-party car insurance policy, that policy became the primary coverage for the accident, specifically for third-party injuries. Consequently, John's insurance contract is rendered void due to the absence of insurable interest at the time of the loss.

In this scenario, it is important to note that John inadvertently neglects to cancel his policy and fails to request a refund for the remaining coverage period.

Therefore, it is crucial for insurable interest to exist both at the beginning of the insurance contract and at the time of the loss for the contract to be valid and enforceable.

(e) Insurable Interest on Marine insurance is an Exception

The concept of insurable interest in marine insurance differs from other types of insurance such as motor insurance. In marine insurance, the ownership of goods or cargoes *often changes hands during the voyage or transit*. This creates a unique situation where the insured party may not have ownership of the goods at the time of insuring them. This is the reason why insurable interest for marine insurance is determined *at the time of loss*.

Example

Insurable interest in marine insurance

Consider a scenario where an importer plans to purchase goods from an exporter on Cost and Freight (C&F) terms. The importer has not yet acquired ownership of the goods, but they anticipate acquiring ownership upon the arrival of the goods at the destination. In this case, the importer can validly arrange marine insurance for the goods even before payment is made, as they have an insurable interest based on their expectation of acquiring ownership.

This exception exists in marine insurance because the nature of the shipping industry often involves multiple parties with varying degrees of ownership and financial interest in the goods being transported. Insuring goods based on anticipated ownership allows for the effective protection of financial interests throughout the voyage or transit.

On the other hand, in motor insurance or other types of insurance where the ownership remains fixed, prospective buyers cannot arrange insurance for a vehicle they anticipate owning in the future. In these cases, insurable interest is typically established when the ownership is transferred and the buyer becomes the legal owner of the property.

Overall, the exception in marine insurance allows for the unique circumstances of changing ownership during transit, while other types of insurance, like motor insurance, require the ownership to be established before arranging coverage.

(f) Insurable Interest on Property Insurance & Liability Insurance

In property insurance, the concept of insurable interest pertains to the financial or legal interest that an individual or entity has in the property being insured. The following parties typically have insurable interest in property insurance:

1. Owner

   The legal owner of the property has a direct financial interest in protecting the property against potential risks or damages. They have insurable interest because they stand to suffer a financial loss if the property is damaged or destroyed.

2. Trustee

   If the property is held in trust, the trustee, who manages the property on behalf of the beneficiaries, has an insurable interest. They are responsible for safeguarding the property for the benefit of the beneficiaries, and any loss or damage to the property would impact their ability to fulfill their duties.

3. Agent

   An agent, such as a person acting on behalf of the owner, also has an insurable interest in the property. They have a financial stake in ensuring that the property is protected, as any damage or loss may affect their ability to carry out their responsibilities effectively.

4. Mortgagee

   If the property is mortgaged, the mortgagee (lender) has an insurable interest. They have a financial stake in the property as the mortgage is secured by it. Protecting the property with insurance ensures that their financial interest is safeguarded in the event of damage or loss.

5. Hirer

   If the property is leased or hired, the hirer (tenant) may have insurable interest. Although they may not have ownership of the property, they have a financial interest in protecting their liability and the contents they may have within the leased space.

In liability insurance, insurable interest is established when a person or entity has a potential legal liability to third parties. For example, a business owner may have insurable interest in liability insurance because they can potentially be held legally responsible for injuries or damages caused to others in the course of their business operations. By obtaining liability insurance, they protect their financial interest by ensuring coverage for potential legal costs and expenses associated with such liability.

Overall, insurable interest is established when an individual or entity has a financial or legal interest in the property or potential liability that is being insured. It is this interest that forms the basis for obtaining insurance coverage to protect against potential losses or liabilities.

Table 2-7 *Examples of Insurable Interest*

Party	Financial Interest	Type of Insurance
Owner	Protection of property value and investment	Property insurance
Trustee	Preservation of trust property for beneficiaries	Property insurance
Agent	Protection of property under their care	Property insurance
Mortgagee	Preservation of property securing the mortgage	Property insurance
Hirer	Protection of liability and leased contents	Liability insurance
Business Owner	Protection against potential legal liabilities	Liability insurance

(g) Assignment of General Insurance Policy

In general insurance, an assignment refers to the transfer of rights and liabilities from one person (assignor) to another person (assignee). This means that the assignee takes over the rights and obligations of the original insured under the insurance policy.

When an insurance policy is assigned, the assignee essentially steps into the shoes of the assignor and assumes all the rights and responsibilities associated with the policy. This means that the assignee has the same rights to claim benefits from the insurer as the assignor had. However, it is important to note that the insurer can use the same grounds to deny liability against the assignee as they could have used against the assignor. This means that if the insurer had valid reasons to reject a claim from the original insured, those reasons would still apply to the assignee.

Example

Assignment of General Insurance Policy

John has a property insurance policy covering his house. He decides to sell the house to Sarah and assigns the insurance policy to her as part of the sale agreement. In this case, John is the assignor, and Sarah is the assignee.

After the assignment, Sarah becomes the new insured under the policy, and she has the right to make claims and receive benefits in case of a covered loss or damage to the property. However, if there was any misrepresentation or non-disclosure of relevant information by John during the application process that would have given the insurer valid grounds to deny a claim, the same grounds can be used by the insurer to reject a claim from Sarah as well.

Overall, an assignment of an insurance policy allows for the transfer of rights and liabilities from one person to another. The assignee assumes the rights and responsibilities of the original insured, but the insurer can use the same grounds to deny liability against the assignee as they could have used against the assignor.

(i) Prior Consent of the Insurer

In general insurance contracts, when there is a transfer of interest in the insured property, such as when a motor vehicle or house is sold, it is important to obtain prior consent from the insurer for the assignment to be valid. The consent of the insurer ensures that they are aware of the change in ownership and can assess any potential impact on the insurance coverage.

Obtaining the prior consent of the insurer involves informing them in writing about the transfer of interest in the policy and providing them with the necessary particulars regarding the new owner. This allows the insurer to update their records and adjust the policy accordingly.

Without the prior consent of the insurer, the assignment may not be considered valid, and the new owner may not be properly covered under the insurance policy. It is crucial to follow the necessary procedures and obtain the insurer's consent to ensure a smooth and seamless transition of the insurance coverage to the new owner.

By obtaining prior consent, both the previous owner and the new owner can have peace of mind knowing that the insurance coverage remains intact and that any claims or losses will be appropriately handled by the insurer. It is a vital step in protecting the interests of all parties involved in the assignment of the insurance policy.

(ii) Exceptions to the Rule

Exceptions to the general rule of obtaining prior consent for assignment exist in specific cases.

- Marine Cargo Insurance

  According to the Marine Insurance Act of 1906, marine cargo policies are freely assignable. This provision facilitates international trade by allowing the transfer of the policy to parties involved in the shipment process. The certificate of marine insurance plays a significant role in this regard, serving as a form of financial security for bankers to issue letters of credit on behalf of the buyer to the seller. However, it is important to note that marine hull policies typically include a clause that restricts the assignment of the policy without the prior written consent of the insurer.

- Will & Operation Law

  Another exception occurs when a policyholder transfers their interest in the insured property through a will or by operation of law. For example, in the case of fire insurance, the policy may provide for the automatic transfer of interest in the subject matter of insurance upon the death of the insured to their legal personal representatives or estate. This ensures that the coverage remains intact and is transferred to the appropriate individuals as determined by law.

These exceptions recognize specific circumstances where the assignment of an insurance policy may be allowed without obtaining prior consent from the insurer. However, it is important to review the terms and conditions of the policy to understand any specific requirements or restrictions related to assignment.

2.3.3 INDEMNITY

The principle of indemnity states that the insured should be compensated for the actual financial loss suffered due to an insured event, up to the maximum limit specified in the policy. The purpose of insurance is to restore the insured to the same financial position they were in before the loss occurred, without allowing them to make a profit from the insurance claim.

Insurance contracts promise "to make good the insured loss or damage". This promise is subject to the principle of indemnity. The principle of indemnity requires the insurer to restore the insured to the same financial position as he had been enjoying immediately before the loss. The object of the principle is to ensure that the insured, after being indemnified, shall not be better off than before the loss. The effect of the principle of indemnity is to ensure that the insured does not receive more than the loss, although he may receive less than the loss as a result of policy conditions, such as application of average (due to inadequate sum insured), policy excess or limits.

General insurance Contracts are Contracts of Indemnity because the subject matter of insurance can be measured in terms of monetary value or replacement value. However, Life and Personal Accident insurance are not contracts based on the principle of indemnity, but rather on 'Benefit Policies' or 'Benefit Based Insurance', as the lost value of a person's life and limb cannot be measured in monetary terms, as they are irreplaceable. The compensation paid out under these policies is usually a pre-agreed lump sum amount or a multiple of the insured's income, rather than being based on the actual financial loss suffered.

Note that however, Life and Personal Accident insurance are not a contract that based on the principle of indemnity, rather it based on 'Benefit Policies' or 'Benefit Based Insurance, 'since the lost value of person's life and limb cannot be measured in monetary terms, as they are irreplaceable.

MEASUREMENT OF INDEMNITY

Table 2-8 *Measurement of Indemnity*

Types of Insurance	Basis of Indemnity
Property	Cost of repair, replacement, or reinstatement to make good property lost or damaged. Market value is the basis of the sum insured for property other than buildings where deduction will be made for wear, tear and depreciation.
Liability	Potential court award for special and general damages including costs and legal expenses incurred in defence of the insured.
Pecuniary	Financial loss suffered by the insured, for example under fidelity guarantee insurance, the policy indemnifies the employer for the financial loss caused by dishonest employees.
Marine	Identifiable insured value which is agreed at the start, and this is unaffected by subsequent market price variation. The 'agreed value' is the amount paid to settle a total loss claim.

Example

Continue with the example of Sarah and her commercial property above

Sarah's commercial property is insured under a general insurance policy. Unfortunately, a severe storm causes significant damage to the building, resulting in repair costs and loss of rental income while the property remains unusable.

Upon filing a claim with her insurance company, the principle of indemnity comes into play. The insurance policy specifies a maximum limit of coverage, let us say RM500,000 for building repairs and RM50,000 for loss of rental income.

After assessing the damage and reviewing the claim, the insurance company determines that the repair costs amount to RM300,000 and the loss of rental income is estimated at RM30,000. As per the principle of indemnity, the insurance company will reimburse Sarah for her actual financial loss suffered due to the storm, up to the policy's specified limits.

Sarah will receive RM300,000 for the building repairs, covering the actual cost incurred to restore the property to its pre-loss condition. Additionally, she will receive RM30,000 as compensation for the loss of rental income during the time the property was uninhabitable.

It is important to note that the principle of indemnity aims to restore the insured to the same financial position they were in before the loss occurred. Therefore, Sarah will not receive more than the actual financial loss she incurred. The purpose of insurance is not to provide a profit or windfall for the insured but rather to compensate for the genuine financial loss experienced due to the insured event.

In this example, the principle of indemnity ensures that Sarah is appropriately compensated for her actual financial loss resulting from the storm damage, helping her recover and restore the commercial property without making a profit from the insurance claim.

2.3.4 SUBROGATION

Subrogation is the right of the insurer to step into the shoes of the insured after paying a claim and take legal action against any third party responsible for the loss or damage. It allows the insurer to recover the amount paid to the insured from the party at fault.

Example

Subrogation

Example: Let us say John owns a commercial vehicle insured under a general insurance policy. While driving, another driver, Mike, runs a red light and collides with John's vehicle, causing significant damage. John promptly reports the accident to his insurance company and files a claim.

John's insurance company pays for the repairs to his vehicle, which amounts to RM50,000. After settling the claim, the insurance company decides to exercise their right of subrogation. They step into John's shoes and pursue legal action against Mike, the at-fault driver, to recover the amount they paid for the repairs.

Through the subrogation process, John's insurance company aims to hold Mike accountable for his negligent driving and recover the RM50,000 they paid to repair John's vehicle. They argue that Mike's failure to adhere to traffic laws and causing the accident resulted in the financial loss incurred by the insurer.

If the insurance company is successful in proving Mike's fault and negligence, they may be able to recover the RM50,000 from him. This helps the insurer minimize their financial loss and transfers the responsibility to the at-fault party.

In this example, John's insurance company exercises subrogation rights to recover the RM50,000 they paid for the repairs from Mike, the at-fault driver. This process allows the insurer to seek compensation and minimize their losses in cases where another party is legally responsible for the damage.

Subrogation is an important principle in general insurance as it allows insurers to seek reimbursement from parties responsible for causing the insured loss. By pursuing subrogation, the insurance company can ensure that they are not solely responsible for bearing the financial burden caused by someone else's actions.

HOW SUBROGATION MAY ARISE?

(i) Subrogation Rights Exist at Common Law

Subrogation rights refer to the rights held by an insurer to step into the shoes of the insured and pursue recovery from a third party who is responsible for causing the loss or damage. These rights exist under common law and do not necessarily need to be explicitly stated in the insurance policy.

The purpose of including a subrogation clause in an insurance policy is to allow the insurer to initiate recovery proceedings before compensating the insured for their loss. By doing so, the insurer gains more control over the process and increases the chances of successfully recovering the amount paid out for the claim.

Example

Subrogation Rights

An insured person suffers a loss due to the negligence of another party, they have the option to either claim compensation from their own insurer or file a lawsuit against the negligent party for damages. If the insured decides to seek reimbursement from their insurer, the insurer can exercise their subrogation rights and take legal action against the negligent party on behalf of the insured, even before fully indemnifying the insured for their loss.

It is important to note that the principle of subrogation typically applies to property and liability insurance policies, which are considered policies of indemnity. These policies aim to compensate the insured for their actual financial loss suffered.

On the other hand, personal accident and life insurance policies are not policies of indemnity. Therefore, subrogation rights do not typically apply to these types of insurance. In personal accident or life insurance, the insured can make a claim under their policy for benefits, and they also have the right to seek compensation from the negligent party responsible for their injuries or loss.

(ii) Subrogation Rights May Arise Under Contract

One way in which subrogation rights can arise is through a contractual agreement. Insurance policies often contain provisions that grant the insurer the right to pursue subrogation against third parties. These contractual provisions allow the insurer to seek reimbursement for the amount it has paid out to the insured.

Example 1

Subrogation Rights Under Contract

Let us say an individual's property is damaged due to the negligence of a contractor. The individual's insurance company pays for the repairs and then exercises its subrogation rights by pursuing a claim against the contractor to recover the amount it has paid. The contractual agreement between the insured and the insurer establishes the insurer's subrogation rights in this situation.

Example 2

Subrogation Rights Under Contract

A business owner engages a security firm to escort his money while in transit to and from the bank. He also takes up a money insurance policy in the event of any loss caused by an untoward event. If the money is lost the business owner has two resources: to make a claim against his insurance company or to recover the loss from the security firm. If an insurance claim is made, the insurer will be entitled to subrogation rights to recover the same loss from the security firm under contract with the business owner.

It is important to note that subrogation rights are not automatic and may be subject to certain conditions and limitations specified in the insurance policy. The right to subrogation may also vary depending on the jurisdiction and the specific terms of the contract.

Overall, subrogation rights that arise under contract allow insurance companies to seek reimbursement or recover damages from third parties to mitigate their losses and prevent unjust enrichment. These rights enable insurers to maintain a balance of financial responsibility and promote fairness in the insurance industry.

(iii) Salvage

Salvage refers to the process of recovering or obtaining possession of property or assets that have been damaged or deemed a total loss. In the context of insurance, salvage is often associated with situations where the insured property has suffered severe damage and the insurer has paid out the full value of the loss.

When an insurance claim is settled for a total loss, the insurer becomes entitled to exercise subrogation rights. This means that the insurer can take over the ownership rights of the

insured property, including the salvage or wreckage, in order to recover some of the amount paid out for the total loss.

By taking possession of the salvage, the insurer aims to mitigate their own financial loss by selling or disposing of the damaged property and recovering any residual value. The salvage value is typically determined based on the remaining worth of the damaged property after the loss event.

The insurer's right to salvage is based on the principle of subrogation, which allows them to step into the shoes of the insured and pursue recovery from any potential sources. This process helps the insurer to offset some of their losses by recovering funds from salvage operations, salvage sales, or other means.

It is important to note that the specific terms and conditions regarding salvage rights may vary depending on the insurance policy and the applicable laws and regulations. The insurer may have specific procedures and requirements that need to be followed for the transfer of ownership and handling of the salvage.

2.3.5 CONTRIBUTION

Contribution applies when the insured has obtained multiple insurance policies covering the same risk. In such cases, each insurer contributes proportionately to the loss based on the sum insured under their policy. The insured cannot claim more than the actual loss from multiple insurers.

General insurance contracts, being contracts of indemnity, are subject to the principle of contribution except for personal accident policies.

ESSENTIALS OF CONTRIBUTION

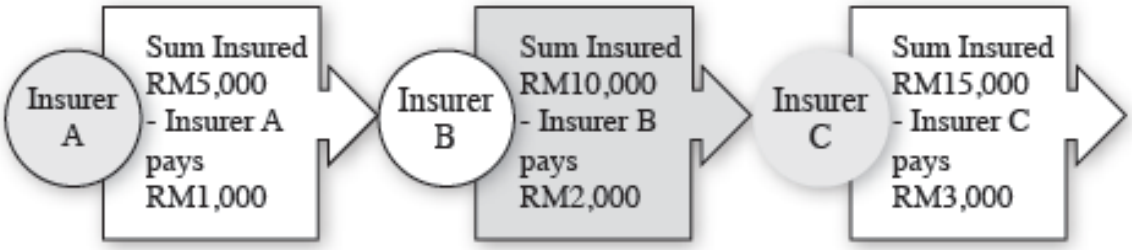
For contribution to apply, the following conditions must be fulfilled:

- the policies must be in force at the time of loss;
- the policies must cover a common interest;
- the policies must cover a common peril which gives rise to the loss;
- the loss must involve the same subject matter covered by all the policies;
- the policies must be legally enforceable.

The principle of contribution arises under common law and its application resulted in difficulties for the insurers. To avoid this, most property insurance policies now contain a contribution condition to state that whenever contribution applies, the insured is obliged to claim against all the insurers, each of whom will have to pay a rateable proportion of the loss in accordance with their respective sum insured.

Formula		
The amount that each insurer must pay follows the formula below:		
Sum Insured - Each Insurer *Total Sum Insured - All Insurers (RM 30,000)*	*X*	*Total Amount of the Loss (RM 6,000)* *= Amount Payable*

FIGURE 2-2 Amount Each Insurer Must Pay



Formula

The amount that each insurer must pay follows the formula below:

John owns a property that is insured by two different insurance companies, Company A and Company B.

Both policies are in force at the time of loss, and they cover the same property against the risk of fire. Unfortunately, a fire occurs and causes significant damage to the property. The total loss suffered by the insured is RM100,000.

- *Company A has insured the property for RM60,000, and*
- *Company B has insured it for RM40,000.*

Since both policies cover a common interest (the insured property) and a common peril (fire), contribution comes into play. The insured is entitled to claim compensation from both insurers for the loss suffered.

To determine the contribution amount, the insured will submit a claim to both Company A and Company B.

Based on the principle of contribution, the insurers will share the loss proportionally according to the sum insured under each policy.

In this case, the contribution ratio can be calculated as follows:

- *Contribution Ratio for Company A = Sum Insured by Company A / Total Sum Insured*
- *Contribution Ratio for Company A = RM60,000 / (RM60,000 + RM40,000) = 0.6 or 60%*
- *Contribution Ratio for Company B = Sum Insured by Company B / Total Sum Insured*
- *Contribution Ratio for Company B = RM40,000 / (RM60,000 + RM40,000) = 0.4 or 40%*

Based on the contribution ratios, Company A would be responsible for contributing 60% of the loss (RM60,000) and Company B would contribute 40% of the loss (RM40,000).

Therefore, Company A would pay RM60,000 x 0.6 = RM36,000 towards the loss, and Company B would pay RM40,000 x 0.4 = RM16,000 towards the loss.

The insured would receive a total compensation of RM52,000 (RM36,000 from Company A and RM16,000 from Company B), which represents the combined contribution from both insurers.

This example demonstrates how contribution works in cases where multiple insurance policies cover the same subject matter and peril. Each insurer contributes a proportionate share based on their sum insured, ensuring a fair distribution of the loss between the insurers involved.

2.3.6 PROXIMATE CAUSE

Proximate cause refers to the primary cause of loss or damage that sets in motion a chain of events resulting in the insured event. It is essential to determine the cause of loss to establish liability under the insurance policy.

Example 1

Proximate Cause

A car accident occurs when a driver fails to stop at a red light and collides with another vehicle at an intersection. As a result of the collision, both cars sustain significant damage, and the drivers and passengers suffer injuries.

In this case, the proximate cause of the damage and injuries is negligent driving and failure to stop at the red light. The actions of the driver directly set in motion the chain of events that led to the accident and the resulting harm. The injured parties would file claims with their respective automobile insurance companies, which would investigate the accident, determine liability, and provide coverage based on the proximate cause of the loss.

Example 2

Non-Proximate Cause

A homeowner's property is damaged by a severe thunderstorm. While inspecting the damage, it was discovered that the roof had pre-existing structural issues, including weak supports and worn-out materials. As a result, the roof partially collapses during the storm, causing water damage to the interior of the house.

In this scenario, the proximate cause of the damage would not be the thunderstorm itself, but rather the pre-existing structural issues of the roof. The weakened roof was not able to withstand the storm, leading to the collapse and subsequent water damage. In this case, the homeowner's insurance may not provide coverage for the damage, as it is determined to be a result of the non-proximate cause (the pre-existing roof issues) rather than the insured event (the thunderstorm).

It is important to note that the determination of proximate cause may vary depending on the specific circumstances and the terms of the insurance policy. Insurance providers assess each claim individually to determine the relationship between the insured event and the resulting loss or damage.

The doctrine of proximate cause plays a crucial role in determining liability and coverage in insurance claims. It seeks to identify the dominant or effective cause that sets in motion a chain of events leading to a specific result, without the intervention of any new independent force.

In the case of Pawsey v. Scottish Union & National Insurance Co. (1907), the court provided a classic definition of proximate cause. It refers to the active and efficient cause that initiates a series of events directly contributing to the outcome, without any additional force or factor introduced from an unrelated source.

To apply the doctrine of proximate cause, the focus is on identifying the primary cause that directly leads to the loss or damage. It involves *analyzing the sequence of events* and determining the *underlying cause* that is most closely connected to the result. This determination is crucial in establishing liability under an insurance policy and assessing the extent of coverage provided.

By understanding the doctrine of proximate cause, insurers and insured parties can better navigate insurance claims and determine the causative factors behind a loss or damage. It helps ensure that the appropriate party is held accountable based on the true cause of the incident, rather than secondary or remote factors.

OPERATION OF A SINGLE CAUSE

If a loss is brought about by a single event, the question of liability can be easily ascertained by distinguishing between the *'proximate cause*' and the *'remote cause*'. The concept of proximate cause is used to determine the primary or dominant cause that sets in motion a chain of events leading to the loss or damage. On the other hand, the remote cause refers to any cause that is not directly connected to the loss.

By identifying the proximate cause, insurers can determine whether the loss falls within the scope of coverage provided by the insurance policy. If the proximate cause is an insured peril, the insurer is likely to accept liability and provide coverage for the claim. However, if the proximate cause is an uninsured or excluded peril, the insurer may deny the claim as it falls outside the coverage provided.

It is important to note that the concept of proximate cause considers the direct and immediate cause of the loss rather than remote or indirect causes. This helps in determining the liability of the insurer and ensuring that the policy terms and conditions are applied appropriately.

(i) Insured Peril

An insured peril refers to a specific event or cause of loss that is covered under an insurance policy. In the example of a fire insurance policy, a fire due to an electrical short circuit is considered an insured peril. The policy provides coverage for damage caused by fire, and the insurer is liable for the resulting loss to the insured building.

In the given scenario, when the fire occurred due to an electrical short circuit, it damaged the insured building. While the fire brigade was extinguishing the fire, water was used which caused damage to the surrounding building and its contents. In this case, the water damage is considered a consequential result of the fire, and it is deemed to be proximate caused by the insured peril (the fire). As a result, the insurer is responsible for covering not only the damage caused by the fire to the insured building but also the water damage to the property in the immediate vicinity.

(ii) Uninsured Peril

An uninsured peril refers to an event or cause of loss that is not covered under an insurance policy. In the example provided, the explosion of gas used for commercial purposes, such as acetylene gas in a motor repair shop, is considered an uninsured peril under a standard fire insurance policy.

Example

Insured Peril and Uninsured Peril

If an explosion occurs in the motor repair shop due to the gas tank, causing a fire that results in severe damage to the building and its contents, the fire insurance policy will not cover this loss unless the peril of explosion is specifically included in the policy with the payment of an additional premium. In this case, since the explosion is not covered under the standard fire insurance policy, the insurer will not be liable for the damage caused by the explosion.

However, there is an exception to this rule. If the explosion happens following a fire that could have been started by an insured peril, such as an electrical short circuit, the insurer will be liable for the damage caused by the fire and the subsequent explosion if the loss was inseparable. This means that if the fire and explosion are interconnected and the explosion is a direct consequence of the fire, the insurer may consider the damage as a single loss event and provide coverage for both the fire damage and the resulting explosion.

(iii) Excluded Peril

An excluded peril refers to an event or cause of loss that is explicitly stated in the insurance policy as not being covered. Unlike an uninsured peril, an excluded peril cannot be covered even with the payment of an additional premium, as it is more appropriately covered by a different type of insurance policy.

Example

Excluded Peril

in a personal accident policy, illness may be listed as an excluded peril. If an insured individual suffers accidental injuries and is taken to a hospital for treatment, but later succumbs to an infectious disease contracted during the hospital stay, the court may determine that the proximate cause of death was the disease and not the original accident. In this case, since the cause of death falls under the excluded peril of illness, the claim would not be payable under the personal accident policy.

The purpose of excluding certain perils from coverage is to ensure that each type of insurance policy focuses on its specific area of coverage. Excluding perils that are more appropriately covered by other insurance policies helps maintain clarity and prevents overlap in coverage.

OPERATION OF CONCURRENT CAUSES

When multiple perils operate concurrently to cause a loss, it raises the question of how liability should be determined. In such cases, the *doctrine of concurrent causation* comes into play. The doctrine recognizes that multiple causes can contribute to a loss and seeks to establish which peril should be considered the proximate or dominant cause.

Using the example of a building being damaged by a fire and a storm simultaneously, the insurer will assess the circumstances to determine the proximate cause of the loss. If it is determined that the fire was the dominant or proximate cause, the insurer will be liable for covering the damage caused by the fire. Conversely, if the storm is deemed to be the dominant cause and if the policy excludes damage caused by storms, the insurer would exclude liability for the damage caused by the storm.

The application of the concurrent causation doctrine depends on various factors, including the specific terms and conditions outlined in the insurance policy, any exclusions or endorsements that may apply, and the legal interpretation of the proximate cause of the loss. Insurance policies may

include provisions or clauses that address concurrent causation scenarios, helping to guide the determination of liability in such situations.

(i) No Excluded Peril

Where there are concurrent causes and no excluded perils, the liability would be determined based on the proximate cause of the loss. If one of the causes is an insured peril, while the other causes are not relevant or are considered secondary, the insurer would be liable for the loss.

Example

No Excluded Peril

A man with heart disease sustains an accident which, coupled with his weak heart, leads to death. The proximate cause of death is considered to be the accident itself. Even though the man had a pre-existing heart condition, it is determined that a person with a normal heart would have recovered from the accident. Therefore, the accident is considered the dominant or proximate cause of the loss, and the insurer would be liable to cover the loss under the applicable insurance policy.

(ii) Excluded Peril

In cases where there are concurrent causes and one of the causes is an excluded peril, the insurer would not be liable for claims arising from the excluded peril. The presence of an excluded peril overrides any coverage provided by the insurance policy.

Example

Excluded Peril

If property is stolen during a riot, the loss or damage would not be covered under a burglary policy if the policy specifically excludes losses due to riot, strike, and civil commotion. In this case, the excluded peril of riot overrides the coverage for burglary. Therefore, the insurer would not be liable for the stolen property as it falls within the scope of the excluded peril.

(iii) Separated Peril

When losses occur concurrently from both an insured peril and an uninsured peril, if it is possible to separate and distinguish the damages caused by each peril, the insurer will only be liable for the loss caused by the insured peril.

Example

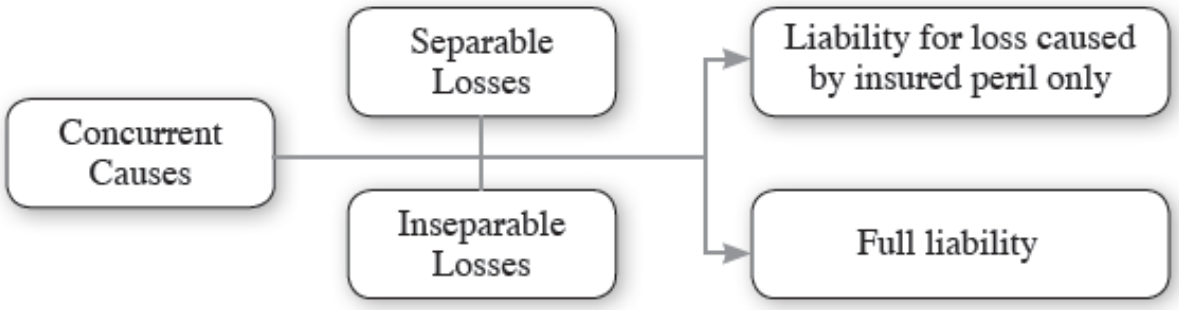
Separated Peril

A fire breaks out during a storm, but the fire is not caused by the storm itself. As a result, there is both burning damage caused by the fire and wind damage caused by the storm. In this situation, the insurer would only cover the damage caused by the fire, which is the insured peril. The wind damage, being an uninsured peril in this scenario, would not be covered under the insurance policy.

(iv) Unseparated Peril

In cases where losses arising from an insured peril and an uninsured peril cannot be separated or distinguished, the insurer would be liable for the full amount of the loss, as long as the loss was not caused by an excluded peril.

FIGURE 2-3 ***Example of Unseparated Peril***



SUCCESSIVE CAUSES

In cases where several causes operate one after the other, and the original cause is an insured peril, there may be apparent liability under the policy. However, if a subsequent loss occurs that is specifically excluded under the policy, such as theft during or after a fire, there would be no coverage for that particular loss. The exclusion modifies the doctrine of proximate cause, meaning that even though the proximate cause of the loss was the fire, which is an insured peril, the subsequent loss caused by theft is excluded from coverage.

If the direct chain of events leading to the loss can be traced back to an excluded peril, there will be no liability under the policy. For example, if a motor repair shop and its contents are insured under a fire policy and the damage is caused by the explosion of acetylene gas used for welding, which is an excluded peril, the insurer would not be liable for the loss if the explosion occurred before the fire. However, if the explosion happened after the fire, the insurer would be liable for the loss caused by the fire.

If the chain of events leading to the loss is broken by the intervention of a new and independent cause, whether the insurer is liable will depend on whether the new cause is an insured peril or an excluded peril as defined in the policy.

2.3.7 LOSS MINIMIZATION

The insured has a duty to take reasonable steps to minimize the loss or damage after an insured event occurs. Failing to take necessary measures to mitigate the loss may affect the claim settlement process.

Example

Loss Minimization

John owns a commercial property that is insured against fire damage. One day, a fire breaks out due to an electrical malfunction in the building. John immediately notices the fire and calls the fire department to report the incident. He then takes quick action to evacuate the premises, ensuring the safety of his employees and customers.

While waiting for the fire department to arrive, John tries to control the fire by using nearby fire extinguishers and activates the building's fire suppression system. Although the fire causes some damage to a portion of the property, John's prompt response helps prevent the fire from spreading further and minimizes the extent of the damage.

In this example, John demonstrates the principle of loss minimization by taking immediate and appropriate steps to mitigate the loss. His quick action in reporting the fire, evacuating the premises, and attempting to control the fire not only ensures the safety of individuals but also helps minimize the overall damage to the property.

By fulfilling his duty to minimize the loss, John has acted responsibly and fulfilled an important obligation under his general insurance policy. His actions may positively impact the claim settlement process, as the insurer will recognize his efforts to mitigate the loss and may accordingly process the claim in a more favorable manner.

These fundamental principles provide the framework for general insurance contracts and help establish the rights and obligations of both the insured and the insurer. It is important to carefully review and understand the terms and conditions of a general insurance policy before entering into a contract.

In conclusion,

- As agents (*Intermediaries*) gain an understanding of the fundamental principles of insurance, they are instrumental in navigating the insurance industry. These principles establish guidelines for fair and transparent transactions, ensuring ethical practices and providing a solid foundation for insurance policies.

- By understanding these principles, customers (*Insured*) can make well-informed decisions when purchasing insurance that aligns with their financial needs. This understanding empowers them to ensure they receive the appropriate protection during uncertain times and effectively manage risks.

- The universal principles underlying all insurance policies create a framework that insurance companies (*Insurers*) can follow to effectively operate their businesses.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*The proximate cause of a loss is always*
A	a. the dominant cause. b. the cause nearest the loss in time. c. the cause nearest the loss in distance. d. an insured peril.

2	**Review Question**
Q	*Why do insurers insert a subrogation condition in their policies?*
A	a. To give them the right to pursue a recovery action against a responsible party. b. To allow them to commence a recovery action before they pay a claim. c. To allow them to pursue a recovery action in their own name. d. To prevent the insured from claiming twice for the same loss.

3	**Review Question**
Q	*Which principle is a corollary of indemnity and gives the insurer the right to call on other insurers similarly liable to pay part of a claim?*
A	a. Proximate cause. b. Subrogation. c. Contribution. d. Insurable interest.

4	**Review Question**
Q	*How is indemnity measured under property insurance policies?*
A	a. According to a formula. b. On agreed value basis. c. On a reinstatement basis. d. On a first loss basis.

5	**Review Question**
Q	*For a life insurance policy to be valid, when must insurable interest exists?*
A	a. At the inception of the policy only. b. At the time of a claim. c. At the inception of the policy and at the time of a claim. d. At the inception of the policy or at the time of a claim.

6	**Review Question**
Q	*What is meant by a 'consumer insurance contract' as defined under Schedule 9 of the Financial Services Act 2013?*
A	a. A contract entered into by a consumer of life and general insurance. b. A contract entered into by an individual not related to his trade, business or profession. c. An insurance contract entered into by a homeowner. d. Insurance policies bought by consumers in general.

7	**Review Question**
Q	*What distinguishes an uninsured peril from an excluded peril?*
A	a. An excluded peril is uninsurable. b. An uninsured peril can be covered with additional premium but an excluded peril is more appropriately covered by some other policy. c. An uninsured peril can be included by removing the exclusion clause. d. An uninsured peril is lower risk compared to an excluded peril.

8	**Review Question**
Q	*When does the right of an insurer to repudiate liability arise in the event that a prospective policy owner failed to disclose relevant information that would affect the decision to accept or reject the risk?*
A	a. At pre-contractual stage. b. During the currency of the policy. c. At the time of a claim. d. At renewal stage.

9	**Review Question**
Q	*Which remedy is NOT available to the insurer if there was fraudulent breach of good faith by the insured?*
A	a. Avoid the policy as a whole. b. Avoid the policy and keep the premium. c. Ignore the breach and allow the policy to stand. d. Refuse a particular claim but allow the policy to stand.

10	**Review Question**
Q	*Which one of the following has no insurable interest in the life of another?*
A	a. Child dependent on a parent. b. Employer on an employee's life. c. Principal on an agent's life. d. Legal guardian on a minor's life.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

3

CHAPTER 3 LEGISLATION AND CONSUMER PROTECTION

3.1 INSURANCE LEGISLATION

The development of legislation and consumer protection in the insurance industry in Malaysia has progressed over time to establish a comprehensive legal framework that safeguards the rights and interests of insurance consumers.

3.1.1 HISTORICAL DEVELOPMENT

The historical milestones in this development can be summarized as follows:

- Insurance Act 1963

  The insurance industry in Malaysia was initially governed by the Insurance Act 1963, which provided the regulatory foundation for insurance operations in the country. This act outlined the basic requirements for insurance companies and established provisions related to licensing, solvency, and consumer protection.

- Insurance Act 1996

  The Insurance Act 1996 replaced the Insurance Act 1963, bringing significant changes to the regulatory landscape of the insurance industry in Malaysia. The act introduced updated provisions to enhance consumer protection, address market conduct issues, and establish guidelines for insurance operations.

- The Financial Services Act 2013 (FSA) and the Islamic Financial Services Act 2013 (IFSA)

  Repealed the Insurance Act 1996 and the Takaful Act 1984 (*save for transitional provisions in respect of specific provisions of the repealed Acts for the insurance and takaful sectors respectively*).

  The FSA and the IFSA came into force on 30 June 2013.

  These new laws were enacted to provide a broader regulatory framework that encompasses various financial services, including insurance. Both the laws consolidated and replaced several previous laws, and expanded the scope of regulatory oversight to ensure consumer protection, licensing, risk management, and governance in the financial services sector.

  They consolidate several separate laws in respect of financial services in Malaysia i.e., conventional banking and insurance as well as Islamic banking and takaful. Thus, the regulation and supervision of financial institutions (banks and insurance companies), payment systems and other relevant entities and the oversight of the money market and foreign exchange market is now under a *single legislative framework*.

Table 3-1 *FSA and IFSA*

FSA Repeals Four Existing Acts	IFSA Repeals Two Existing Acts
1. Banking and Financial Institutions Act 1989 (BAFIA)	1. Islamic Banking Act 1983 (IBA)
2. Exchange Control Act 1953 (ECA)	2. Takaful Act 1984
3. Insurance Act 1996	
4. Payment Systems Act 2003 (PSA)	

Source : Financial Services Act 2013 Part XVII S.271

3.1.2 PURPOSE OF THE NEW LEGISLATION

The primary objectives of the Financial Services Act 2013 (FSA) and the Islamic Financial Services Act 2013 (IFSA) legislation are as follows:

- Clarity, Transparency, and Effective Administration

  Both the FSA and IFSA aim to provide greater clarity and transparency in the administration and regulation of the financial services sector by the Central Bank of Malaysia (Bank Negara Malaysia). These acts establish clear frameworks, rules, and guidelines for the governance and operation of financial institutions.

- Shariah Compliance and Governance

  The IFSA specifically focuses on promoting Shariah compliance and governance in the Islamic financial sector. It sets standards and requirements to ensure that Islamic financial institutions operate in accordance with Shariah principles, fostering trust and confidence in Islamic finance.

- Differentiated Regulatory Requirements

  The acts recognize that different financial intermediation activities pose varying risks to the overall financial system. They provide provisions for differentiated regulatory requirements, tailoring regulations to the specific nature and risks of different types of financial intermediation activities.

- Regulation of Financial Holding Companies and Non-Regulated Entities

  The acts include provisions to regulate financial holding companies and non-regulated entities to ensure effective oversight of the entire financial services ecosystem. This allows for comprehensive supervision and regulation of entities that may have a significant impact on the stability and integrity of the financial system.

- Business Conduct and Consumer Protection

  Both acts strengthen business conduct and consumer protection requirements to promote consumer confidence in using financial services and products. They establish standards for fair treatment, disclosure of information, and resolution of consumer complaints, aiming to protect the interests and rights of consumers in their interactions with financial institutions.

- Effective Enforcement and Supervisory Intervention

  The acts incorporate provisions for effective and early enforcement and supervisory intervention. This allows regulatory authorities to take timely actions to address potential risks, misconduct, or non-compliance within the financial services sector, ensuring the stability and integrity of the financial system.

Overall, the FSA and IFSA provide a comprehensive regulatory framework with a focus on clarity, transparency, Shariah compliance, differentiated regulation, consumer protection, and effective supervision. These objectives aim to foster a stable, transparent, and consumer-centric financial services sector in Malaysia.

3.1.3 CHANGES IN EQUITY (FINANCIAL SERVICES ACT 2013 SCHEDULE 16)

The Insurance Act 1996 required a Malaysian incorporated licensee to maintain a minimum paid-up capital as prescribed by Bank Negara Malaysia. Licensed foreign-incorporated insurers are required to maintain a corresponding surplus of assets over liabilities in Malaysia.

Minimum paid-up capital or surplus of assets over liabilities prescribed by the Act

(a) RM100 million for local/foreign direct insurers and local professional general reinsurers;
(b) RM50 million for local professional life reinsurers;
(c) RM20 million for foreign professional life and general reinsurers;
(d) Insurance brokers and adjusters are required to maintain a paid-up capital (unimpaired by losses) of RM 500,000 and RM 150,000, respectively.

3.1.4 ROLE OF THE CENTRAL BANK OF MALAYSIA (BANK NEGARA MALAYSIA)

Bank Negara Malaysia, as the Central Bank of Malaysia, plays a crucial role in the regulation and oversight of the insurance sector. With the enactment of the Financial Services Act 2013 and the Central Bank of Malaysia Act 2009, Bank Negara Malaysia has been empowered to fulfill its key regulatory objectives and responsibilities in relation to the insurance industry. These objectives include:

- Promoting Fair and Professional Business Conduct

  Bank Negara Malaysia aims to foster fair, responsible, and professional business conduct among financial institutions, including insurance companies. By setting and enforcing regulatory standards and guidelines, it ensures that insurers operate ethically and maintain high standards of professionalism.

- Protecting the Rights and Interests of Financial Consumers

  Consumer protection is a priority for Bank Negara Malaysia. It strives to safeguard the rights and interests of financial consumers by establishing regulations and measures that promote transparency, fairness, and adequate disclosure of information in insurance transactions. This helps ensure that consumers make informed decisions and are treated fairly by insurance providers.

- Monitoring Solvency and Market Conduct

  Bank Negara Malaysia closely monitors the solvency and market conduct of insurance companies to maintain the stability and integrity of the insurance industry. By regularly assessing insurers' financial strength, risk management practices, and compliance with regulatory requirements, it aims to enhance professional standards and foster consumer confidence in the insurance sector.

- Promoting Monetary and Financial Stability

  Bank Negara Malaysia's role extends beyond the insurance sector to include the promotion of overall monetary and financial stability in Malaysia. By implementing effective macroeconomic policies, monitoring financial market developments, and managing systemic risks, it creates a conducive environment for sustainable economic growth, which indirectly supports the stability and growth of the insurance industry.

Through its regulatory powers and supervision, Bank Negara Malaysia ensures that the insurance sector operates in a safe and sound manner, upholding high standards of professionalism and protecting the interests of financial consumers. Its proactive approach in promoting fair business conduct, consumer protection, solvency monitoring, and overall financial stability contributes to the well-regulated and trusted insurance industry in Malaysia.

3.1.5 RISK-BASED CAPITAL FRAMEWORK

In line with the objective to keep a close watch on solvency and market conduct to enhance professional standards and consumer confidence in the insurance industry, Bank Negara Malaysia introduced the Risk-Based Capital (RBC) Framework which came into force on 1 January 2009 (Revised on 17 Dec 2018) to determine the Capital Adequacy Ratio (CAR) of insurance companies in Malaysia.

Reference to the latest Risk-Based Capital (RBC) Framework the requirements detailed in this Framework aim to ensure that each licensed insurer (life insurance company, general insurance company and reinsurer) maintains a capital adequacy level that is commensurate with its risk profile at all times. This Framework has been developed based on the following principles:

(i) Allowing greater flexibility for a licensed insurer to operate at different risk levels in line with its business strategies, so long as it holds commensurate capital and observes the prudential safeguards set by the Bank Negara Malaysia;

(ii) Explicit quantification of the prudential buffer with the aim of improving transparency;

(iii) Providing incentives for licensed insurers to put in place appropriate risk management infrastructure and adopt prudent practices;

(iv) Promoting convergence with international practices so as to enhance comparability across jurisdictions and reduce opportunities for regulatory arbitrage within the financial sector; and

(v) Providing an early warning signal on the deterioration in the capital adequacy level of a licensed insurer, hence allowing prompt and pre-emptive supervisory actions to be taken.

The Capital Adequacy Ratio (CAR) measures the adequacy of capital available in the insurance and shareholders' funds of a licensed insurer to support the Total Capital Required (TCR). A licensed insurer shall compute the CAR as follows:-

Example

The formula:

$$\text{Capital Adequacy Ratio (CAR)} = \frac{\text{Total Capital Available (TCA)}}{\text{Total Capital Required (TCR)}} \times 100\%$$

Note: *BNM has set a Supervisory Target Capital Level of 130 per cent. Each insurer must set its own Individual Target Capital Level to reflect its own risk profile. The Individual Target Capital Level must be higher than the Supervisory Target Capital Level.*

Source : Risk-Based Capital Framework for Insurers , BNM/RH/PD 032-12, Issued on: 17 December 2018

3.1.6 MAIN PROVISIONS OF THE FINANCIAL SERVICES ACT 2013 RELATED TO INSURANCE BUSINESS

Table 3-2 *Main Provisions Related to Insurance Business*

Section	The Law	Provision
126	Financial Ombudsman Scheme	Ensures fair, accessible, and effective way of handling complaints and resolution of disputes in connection with financial services or products
124(1)	List Of Prohibited Business Conduct	Schedule 7 sets out the List Of Prohibited Business Conduct
128	Provisions Relating to Policies	Schedule 8 sets out the provisions relating to life insurance policies
129	Pre-Contractual Duty of Disclosure and Representations & Remedies for Misrepresentation	Schedule 9 (Part 2) sets out the duty of disclosure for insurance contracts other than consumer insurance contracts. Part 3 sets out on the non-contestability and remedies for misrepresentations
130	Payment of Policy Moneys under Life and Personal Accident Policy	Schedule 10 sets out the provisions relating to payment of policy monies upon death of a policy owner under a life policy including a life policy under section 23 of the Civil Law Act 1956 and a personal accident policy effected by him upon his own life

3.2 PERBADANAN INSURANS DEPOSIT MALAYSIA (PIDM)

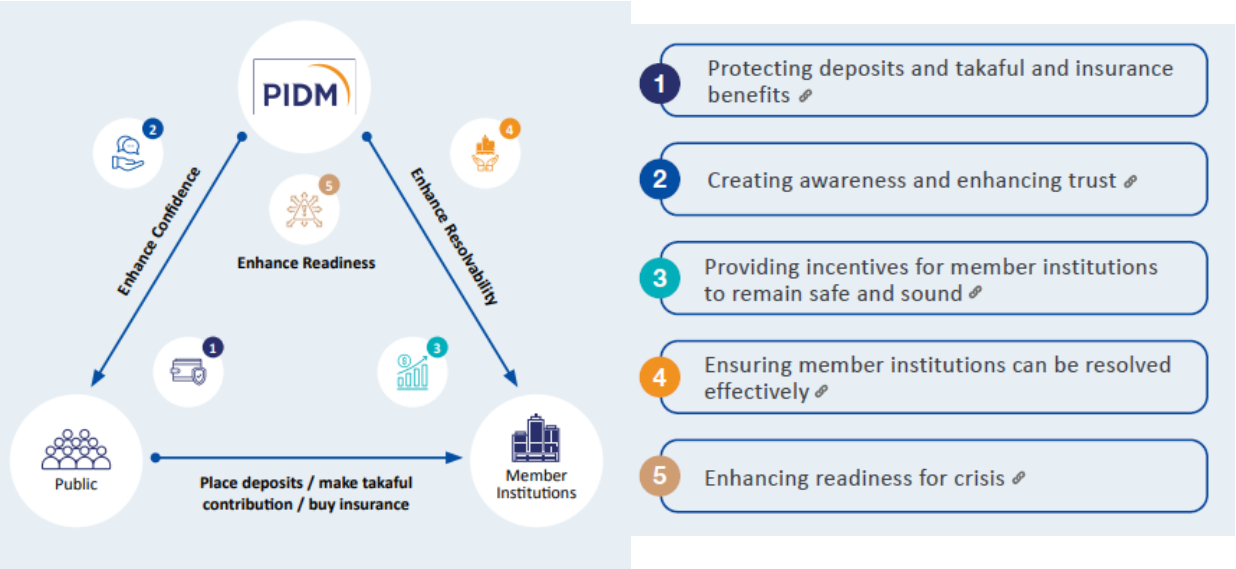
Perbadanan Insurans Deposit Malaysia (PIDM) is a statutory body established in 2005 under the Malaysia Deposit Insurance Corporation Act (PIDM Act). Membership of PIDM is compulsory for all commercial and Islamic banks, as well as insurance companies and takaful operators licensed under the Financial Services Act and Islamic Financial Services Act (known as member institutions). The full list of PIDM's member institutions is available on PIDM's website (www.pidm.gov.my).

PIDM, together with other financial safety net players including Bank Negara Malaysia and the Ministry of Finance, ensure smooth functioning and confidence in the financial system.

ROLE OF PIDM

PIDM administers the Deposit Insurance System and Takaful and Insurance Benefits Protection System ("TIPS") in the event of a member institution failure. PIDM is also the resolution authority for its member institutions. In fulfilling its mandate, PIDM protects financial consumers in Malaysia by:

FIGURE 3-1 ***Financial Consumers Protection By PIDM***



TAKAFUL AND INSURANCE BENEFITS PROTECTION SYSTEM OR TIPS

TIPS came into effect on 31 December 2010 under the PIDM Act. It is a system established by the Government to protect owners of takaful certificates and insurance policies, in one of the two ways, in the event a PIDM's insurer member (namely, insurance companies and takaful operators licensed under the Financial Services Act and Islamic Financial Services Act) fails:

1. PIDM, as a resolution authority, can ensure continuity coverage on takaful or insurance benefits, for example, by transferring the business of the failed insurer member to another insurer member or bridge institution under PIDM; or
2. PIDM can file for liquidation of the failed insurer member and pay takaful or insurance benefits to owners of takaful certificates and insurance policies, up to the limits. Generally, most types of benefits under eligible takaful certificates and insurance policies are protected by PIDM up to limits, for example death, disability, healthcare, property damage and third party related losses. The protection by PIDM is automatic and no application is required. Please refer to PIDM's website for more details on TIPS protection.

ROLE AS AGENT: DISCLOSURE OF TIPS PROTECTION

It is important that the customers know about PIDM and how PIDM protects their takaful or insurance benefits in promoting public confidence.

In this regard, insurer members and their agents are to inform customers on:

(a) insurer member's membership in PIDM; and

(b) TIPS protection provided by PIDM, including if takaful or insurance benefits under the takaful or insurance products are protected by PIDM or not.

The aim of these disclosures is to ensure that customers receive accurate, relevant, consistent, and timely information regarding TIPS protection to empower informed and sound decision-making before they buy takaful or insurance products.

Please check with insurer members or refer to PIDM's website https://www.pidm.gov.my/pidm2022/media/downloads/2022/Guidelines/Guidelines-on-Provision-of-Information-on-Takaful-and-Insurance-Benefits-Protection.pdf?ext=.pdf for more information on the disclosure requirements for TIPS protection.

3.3 FINANCIAL CONSUMER LITERACY AND EDUCATION

The Consumer Education Programme (CEP) is a programme initiated by Bank Negara Malaysia and the insurance and takaful industry. The programme is designed as a long-term programme to provide educational information to enhance financial literacy and awareness, its key objectives are:

- To enable consumers to make well-informed decisions when purchasing insurance or takaful products;
- To assist consumers to be in a better position to select insurance or takaful products that best meet their needs; and
- To understand their rights and responsibilities as consumers of insurance or takaful products and services.

3.4 FINANCIAL CONSUMER COMPLAINTS AND DISPUTES

There are various avenues for consumers to lodge a complaint in order to resolve a dispute with a Financial Service Provider (an insurance company or takaful operator) before taking the case to court. Complaint mechanisms stated in 3.4.1, 3.4.2 and 3.4.3 were implemented to provide consumers with easy access, speedy response, and fair and independent avenue to seek redress.

The following are the essential steps which a consumer must take in making a complaint:

FIGURE 3-2 ***Financial Consumers Protection By PIDM***

3.4.1 COMPLAINT UNIT OF FINANCIAL INSTITUTIONS

The Complaint Unit of the Financial Service Provider (FSP) must be easily accessible (via telephone, email or website) by customers and be able to address complaints effectively and promptly. The FSP must provide a written acknowledgement within two working days, and the final decision or request for more information (if the case is complicated) within two weeks of receiving the complaint.

If the complainant fails to respond within two weeks, with the required information, the FSP must allow an extension of another two weeks for the complainant to respond and if there is still no response, the complaint can be treated as "No Further Action" and the complainant will be advised accordingly.

In all cases, the FSP will advise the complainant to submit the complaint either to the Ombudsman for Financial Services (OFS) or Bank Negara Malaysia (BNM) if the complainant is not satisfied with the outcome of the complaint resolution by attaching a copy of the decision letter of the insurance company or takaful operator.

3.4.2 OMBUDSMAN FOR FINANCIAL SERVICES (OFS)

OFS
OMBUDSMAN FOR FINANCIAL SERVICES
OMBUDSMAN PERKHIDMATAN KEWANGAN

Ombudsman for Financial Services (OFS), (formerly known as the Financial Mediation Bureau) was incorporated on 30 August 2004 and commenced its operations on 20 January 2005. OFS is the operator of the Financial Ombudsman Scheme (FOS) approved by Bank Negara Malaysia (BNM) pursuant to the Financial Services Act 2013 and the Islamic Financial Services Act 2013.

The FOS was launched on 1 October 2016. OFS is a non-profit organisation and functions as an Alternative Dispute Resolution (ADR) channel to resolve disputes between Members who are Financial Service Providers (FSPs) i.e., Licensed Commercial Banks, Islamic Banks, Takaful operators & Insurance companies and Financial Consumers who are individuals and Small & Medium Enterprises (SMEs).

WHAT IS AN OMBUDSMAN?

An Ombudsman is an independent person or body who addresses and resolves disputes fairly and speedily away from the courts or any other legal means.

OFS aims to resolve disputes amicably through negotiation, mediation, and conciliation by providing a platform for objective and timely resolution of disputes, claims and complaints arising from financial services or products. This service is offered free to financial consumers.

Table 3-3 *OFS Scope and Jurisdiction*

Claims, Complaints or Disputes Involving	Monetary Limits
Banking and Payment Systems	RM 250, 000
Insurance and Takaful Claims	RM 250,000
Motor Third Party Property Damage Claims	RM 10,000
Unauthorised transactions using designated payment instruments or channels such as internet banking, mobile banking, or Automated Teller Machine (ATM) or unauthorised use of a cheque.	RM 25,000

OFS will not consider any claims, complaints or disputes related to the following:

- Exceeding the monetary limits stipulated;
- General pricing, product features, credit or underwriting decisions or applications to restructure or reschedule a loan;
- Referred to court or arbitration exceeding six months from the date of final decision issued by the financial service provider;
- Time barred under the Limitation Act 1953 involving third party bodily injury or death involving payment of policy moneys under life and personal accident insurance (as per schedule 10 of the FSA 2013).

DISPUTE RESOLUTION APPROACH

OFS adopts a two-stage dispute resolution process, namely the Case Management stage and Adjudication stage.

1. At the Case Management stage, the Case Manager will try to resolve the dispute through mediation and, if no settlement is reached, the Case Manager will issue a recommendation. If either party disagrees with the recommendation, they may refer the matter to the Ombudsman for Adjudication.
2. The Ombudsman will review the dispute independent of the Case Manager's findings and issue a Decision. If the complainant accepts the final Decision, the Decision is binding on the complainant and the financial service provider. If the complainant does not accept the Decision, they are free to pursue their claim through any other legal means, such as the court of law.

Each dispute is viewed independently and with impartiality. All facts and evidence provided by the financial service provider and the complainant are weighed carefully before a fair and reasonable resolution is proposed.

3.4.3 BNMTELELINK/ELINK

BNMLINK represents one of Bank Negara Malaysia's important points of contact with the general public. It acts as a centralised point of contact to facilitate a rapid and effective response for members of the public and small and medium enterprises (SMEs) in matters related to the financial sector. Through its exhibitions, self-service kiosks, and booklets, BNMtelelink/eLink also provides consumer financial education as well as awareness of the role of Bank Negara Malaysia in nation building to the public.

Types of complaints not handled by BNM:

- Complaints that have been referred to OFS
- Complaints that have been referred to and decided by OFS
- Cases that have been referred to solicitors or legal actions have been instituted
- Cases pertaining to institutions not under BNM's supervision, such as repair workshops and managed care organisations
- Complaints made by agents against their principals or on employer/employee relationships or other matters not related to insurance or takaful.

3.5 PERSONAL DATA PROTECTION ACT (PDPA) 2010

The Personal Data Protection Act 2010 (PDPA) came into force in November 2013 to regulate the processing of personal data in a commercial transaction.

PDPA applies to:

- Any person who processes or authorizes the processing of any personal data in respect of commercial transactions
- Personal data processed in Malaysia
- Uses of equipment in Malaysia for processing personal data

The purpose of the PDPA is to protect personal data belonging to the public from being :

- Misused through commercial transactions
- Protect sensitive data from being misused
- Facilitate international trade
- Protect consumer rights

Personal Data

- Is any personal information in respect of commercial transactions
- Relates directly or indirectly to a data subject

- Includes sensitive personal data e.g., physical, or mental health, political opinions, religious beliefs, offences, or any other data as the Minister may determine
- Includes expressions of opinion about the data subject

3.5.1 SEVEN PRINCIPLES OF THE PERSONAL DATA PROTECTION ACT 2010 (PDPA)

1. General

   Personal data shall be processed if:

   - the data subject has given consent
   - the processing is necessary for or directly related to that purpose
   - it is adequate and not excessive in relation to that purpose

   Sensitive data shall be processed if:

   - the data subject has given explicit consent
   - processing is necessary for employment, vital interest, medical, legal, administration of justice and others where the Minister thinks fit
   - information has been made public by the data subject

2. Notice and Choice

   Data subjects should be informed by written notice:

   - that their personal data is being processed and
   - a description of the personal data is provided
   - of the purpose of the collection
   - of the source of the personal data
   - of their rights to:
     - request access to and correct the data
     - contact the data user for enquiries and complaint
     - be informed of the third parties to whom the data user discloses or may disclose the personal data
     - limit the choices and means of processing personal data

Whether it is obligatory or voluntary for the data subject to supply the personal data.

Notice shall be given at the soonest:

- At the time the data subject is first asked by the data user to provide his personal data
- At the time the data user first collects the personal data
- Before data user uses the personal data or discloses to a 3rd party
- **Notice** shall be given in the national and the English language

3. Disclosure

No **Personal Data** shall be disclosed without the consent of the data subject:

- for any other purpose(s) other than the purpose(s) it was collected, or a purpose directly related to the purpose the data was collected
- to any other party

4. Security

   A DATA USER needs to take practical steps to protect the personal data from any:

   - Loss
   - Misuse
   - Modification
   - Unauthorised or accidental disclosure
   - Alteration or destruction

   Need to consider the following:

   - The nature of personal data
   - The harm that would result from such misconduct
   - The place or location where the personal data is stored
   - The security measures to ensure reliability and integrity
   - Measures taken to ensure the security transfer of the personal data

5. Retention
   - The personal data processed shall not be kept longer than necessary for the fulfilment of the purpose

   - The data user must take all reasonable steps to ensure that all personal data is destroyed or permanently deleted if it is no longer required for the purpose for which it was processed

6. Data Integrity

   Data user shall take reasonable steps to ensure that the personal data is:

   - Accurate
   - Complete
   - Not misleading
   - Kept up to date by having regard to the purpose of the data

7. Access

   A data subject shall be given their rights and access to:

   - their personal data, and
   - the ability to correct that personal data if it is:
     - Inaccurate
     - Incomplete

- Misleading
- Not up to date

3.6 ANTI-MONEY LAUNDERING, ANTI-TERRORISM FINANCING AND PROCEEDS OF UNLAWFUL ACTIVITIES ACT 2001 (AMLA)

The Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001 (AMLA) is the primary statute governing money laundering and terrorism financing activities in Malaysia. The Act was gazetted as law on 5 July 2001 and came into force on 15 January 2002. The latest amendment which came to operation on 5 February 2024 included additional measures on counter proliferation financing and targeted financial sanctions for financial institutions.

3.6.1 ANTI-MONEY LAUNDERING, COUNTERING FINANCING OF TERRORISM, COUNTERING PROLIFERATION FINANCING AND TARGETED FINANCIAL SANCTIONS FOR FINANCIAL INSTITUTIONS (AML/CFT/CPF/TFS FOR FIS)

In response to the evolving money laundering and terrorism financing threats, and to upkeep with international standards, Malaysia has established a comprehensive *Anti-Money Laundering & Counter Financing of Terrorism (AML/CFT/CPF/TFS)* regime, which covers the Legal & Regulatory Framework, Preventive Measures for Reporting Institutions, Financial Intelligence & Law Enforcement Agencies; and Domestic & International Cooperation.

WHAT IS MONEY LAUNDERING?

Money laundering is a process of converting cash or property derived from criminal activities to give it a legitimate appearance. It is a process to clean 'dirty' money to disguise its criminal origin.

WHAT IS TERRORISM FINANCING?

Terrorism financing is the act of providing financial support, funded from either legitimate or illegitimate sources, to terrorists or terrorist organisations to enable them to carry out terrorist acts or used to benefit any terrorist or terrorist organisation.

While most of the funds originate from criminal activities, they may also be derived from legitimate sources, for example, through salaries, revenues generated from legitimate business or the use of non-profit organisations to raise funds through donations.

Impact of money laundering and terrorism financing on the nation:

- Increase in the overall rate of crime that could threaten national security.
- Inhibit the growth and competitiveness of the economy.
- Taint the integrity and reputation of the business and financial sector.
- Increase cost of doing business and operations of various sectors of the economy.

3.6.2 CRIMES POSING HIGH MONEY LAUNDERING THREAT

The National Risk Assessment 2020 (NRA 2020) has identified top five crimes posing high Money Laundering (ML) threat to the country and these are:

- Fraud, which includes cheating and illegal investment scheme;
- Illicit drugs trafficking;
- Corruption and bribery;
- Smuggling offences, including evasion of customs and excise duties; and
- Organised crimes.

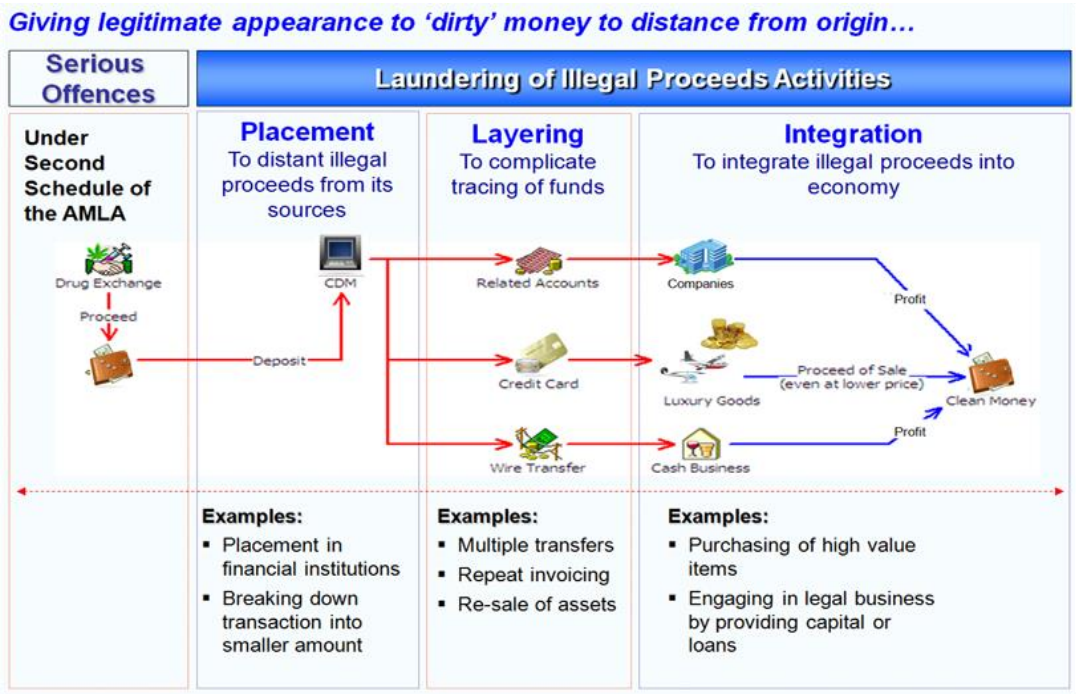
3.6.3 THREE COMMON STAGES OF MONEY LAUNDERING PROCESS

1. *Placement* is one of the ways where illicit funds are separated from their illegal source and are placed into the financial system.

2. *Layering* is the second stage of the money laundering process where it involves the process of creating multiple layers of transactions to further distance the illegal funds from their illegal sources. The purpose of layering is to obscure or to make it difficult to trace the origin of the funds.

3. *Integration* is the final stage that completes the money laundering process where laundered proceeds are successfully integrated into the economy as legitimate funds.

FIGURE 3-3 *Money Laundering Process*



The table below describes the three common methods of money laundering within the insurance context:

1. Placement

Description

Illicit funds are separated from their illegal source and placed into the financial system.

Insurance Context Example

An illicit organization, engaged in unlawful acts such as drug trafficking, fraud, kidnapping, corruption, cybercrime, or illicit online gambling, may accumulate vast sums of money. To launder this illegally acquired capital, they might procure a life insurance policy with a substantial face value.

These entities then proceed to pay the policy premiums using cash or cash equivalents, effectively injecting their unlawful proceeds into the financial system. This method serves to conceal the source of the funds and enables their integration into the legitimate economy, thereby complicating the efforts of regulatory bodies and law enforcement agencies in tracing these transactions and their origins.

2. Layering

Description

Multiple layers of transactions are created to distance the illegal funds from their illegal sources, obscuring the origin of the funds.

Insurance Context Example

Money laundering schemes often involve the misuse of insurance products to obfuscate the trail of illegal funds. A money launderer may purchase an insurance policy with illicit funds and then manipulate the policy's beneficiaries frequently. By adding or removing individuals or legal entities such as trusts or corporations, they create a convoluted network of transactions that veil the funds' origin, making it challenging for authorities to trace their source.

Two types of insurance products are particularly vulnerable to such abuse:

1. **Single Premium Policies:**
   These policies enable a launderer to dispose of substantial amounts of illicit money in one transaction. The premium is paid upfront, and the policy is fully funded, providing an immediate avenue to move significant sums into the financial system.

2. **Annuity Policies:**
   These policies can be used to generate a legitimate income stream after paying the premiums with illegally obtained funds. The launderer makes a lump-sum payment or a series of payments and then receives regular disbursements over a predetermined period, further distancing the illicit funds from their original source.

These methods illustrate the complexity of money laundering through insurance products and underscore the importance of rigorous due diligence and compliance processes within insurance companies to combat such fraudulent activities.

3. Integration

Description

Final stage where the laundered proceeds are successfully integrated into the economy appearing as legitimate funds.

Insurance Context Example

Money launderers often utilize sophisticated methods to camouflage illicit funds, one of which involves exploiting insurance policies. A launderer might purchase a life insurance policy using illegally acquired money and subsequently surrender the policy for its cash value. The insurance company, in response, issues a check reflecting the policy's surrender value, which the launderer deposits into a bank account. These funds, seemingly legitimate proceeds from an insurance policy, become challenging for authorities to flag as criminal proceeds.

Alternatively, the launderer might choose to wait until an insured event transpires, such as death or disability, and then receive a seemingly legitimate insurance payout. Once received, these funds can be seamlessly integrated into the economy, further obscuring their illicit origins.

Payments made by insurance companies can also be exploited for money laundering purposes. These include:

1. **Claims / Maturity**
   Payments made by insurance companies in response to a claim or at the maturity of a policy can serve as a method for integrating illegal funds into the legitimate financial system.

2. **Policy Loans**
   Loans taken against the value of an insurance policy can provide a launderer with an ostensibly legitimate source of funds.

3. **Refunds Due to Overpayment of Premiums or Free-look**
   Refunds issued by insurers due to overpayment of premiums or during the free-look period can be used to give an appearance of legitimacy to illicit funds.

4. **Surrenders / Withdrawals**
   Surrendering a policy or withdrawing funds from it can also provide a seemingly legitimate source of funds.

5. **Third Party Payments & Policy Assignments**
   Assigning a policy to a third party or making payments to a third party on behalf of the policyholder can complicate the trail of money and obscure its origin.

These manipulations highlight the importance of stringent compliance measures within insurance companies to detect and prevent money laundering activities.

Source: Bank Negara Malaysia

3.6.4 WHAT IS PROLIFERATION FINANCING (PF)

Proliferation Financing is an act of raising, moving or making available funds, other assets or economic resources, in whole or in part, to persons or entities for purposes of weapons of mass destruction ("WMD") proliferation, including the proliferation of their means of delivery or related materials (including both dual-use technologies and dual-use goods for non-legitimate purposes).

In other words, **proliferation financing** is an act of financing the parties that engages in proliferating, among any other, the production & transportation of WMDs (nuclear, chemical and biological weapons).

Potential indicators of proliferation financing:

- Higher risk jurisdictions that are known to proliferate WMDs & PFs
- Involves containers whose numbers have been changed or ships that have been renamed
- Inconsistencies in the information provided in trade documents and financial flows

3.6.5 WHAT ARE TARGETED FINANCIAL SANCTIONS (TFS)

Sanctions are restrictions or prohibitions that a country or a coalition of countries impose on another country, jurisdiction, region, specific individuals, entities or vessels, with the primary purpose of provoking a change in behaviour or policy.

It can also be served as an official order, can restrict trade, financial transactions, diplomatic relations, and movement. They can be specific or general in their implementation and enforcement

Obligations of Financial Institutions:

- Immediately freeze funds
- Do not enter into financial transactions
- Inform regulator of the information relating to the funds

Source: Bank Negara Malaysia Policy Document on Anti-Money Laundering, Countering Financing of Terrorism, Countering Proliferation Financing and Targeted Financial Sanctions for Financial Institutions (Updated 05/02/2024)

3.6.6 PREVENTIVE MEASURES FOR REPORTING INSTITUTIONS

All reporting institutions are required by law to undertake preventive measures to prevent their institutions from being used as a conduit for money laundering or terrorism financing activities including:

- Carrying out risk assessments;
- Conducting customer due diligence;
- Submitting suspicious transaction report and cash threshold report (where relevant);
- Maintaining and retaining records of transactions; and
- Implementing anti-money laundering and countering financing of terrorism (AML/CFT/CPF/TFS) compliance programme that is reflective of the reporting institution's money laundering and terrorism financing risk exposure and its size, nature, and complexity.

Below describes the AML/CFT/CPF/TFS preventive measures for Reporting Institutions in the insurance industry:

1. Risk Assessment and Management

Description

To assess the potential ML/TF/PF risks customers may pose to the insurer before accepting them, expanding or continuing business relations with them.

Insurance Industry Example

An insurer identifies and assess the potential ML/TF/PF risk that may arise with respect to:

(a) New products and services, new business practices, including new delivery mechanisms; and
(b) New or developing technologies for both new and existing products.

2. Know Your Customers

The core of AML/CFT/CPF is to know your customers. Purposes are for insurers to have a good understanding of the customer's profile, understand the reason for the proposed transaction and to evaluate whether or not the proposed transaction is consistent with the customer's profile.

There are two measures to be conducted, briefly as follows:

i. Customer Due Diligence (CDD)
A process of collecting customer's information & validating customer's identity using independent, reliable sources or documents to ensure the accuracy and legitimacy of that information.

ii. Enhanced Customer Due Diligence (ECDD)
An enhanced CDD process which is to be performed when a customer is identified as presenting a higher risk ("HRC") for ML/TF/PF. Example of High Risk Customers ("HRCs") are political exposed persons (PEPs), persons with high risk occupation (eg. money changer), persons from high risk countries, cash-incentive business (eg. casino), charities and private non-profit organisations and relatives and close associates of HRCs.

Insurance Industry Example

An insurance company is obliged to verify the identity of a customer when they are purchasing a life insurance policy, and to assess their risk profile. This identity verification process involves the inspection of a valid Identification Document (ID), which must clearly specify the customer's full name (along with any alias, if applicable), a unique ID number, date of birth, nationality, and a clear photograph of the customer.

Additionally, if the customer's residential address isn't specified in the ID, documentary evidence such as a bank statement, telephone bill, or correspondence from a government agency should be obtained to verify the residential address.

Expired IDs, such as old passports or employment passes, cannot be used to verify a customer's identity due to the potential outdatedness of the information. Representatives are tasked to cross-verify the photograph on the ID with the customer to ensure consistency.

This meticulous identity verification process not only helps to prevent fraudulent activities but also ensures compliance with regulatory requirements in the process of policy purchase.

3. Record-Keeping

Description

Insurance companies are mandated to maintain records of customer identification documents, transaction records, and other pertinent information. This requirement includes keeping these records for a duration of not less than six years from the date an account has been closed, or a transaction has been completed or terminated.

Furthermore, in instances relating to matters under investigation or those subject to suspicious transaction reporting, a longer retention period may be necessary. The exact duration can be stipulated by the relevant authorities or other law enforcement agencies.

Such comprehensive record-keeping facilitates the inspection, detection, and prevention of money laundering or terrorist financing activities. It also enables insurance companies to cooperate effectively with regulatory authorities during inspections, inquiries, or investigations, thereby ensuring full compliance with anti-money laundering, counter-terrorist financing, counter proliferation financing and targeted financial sanctioned (AML/CFT/CPF/TFS) regulations.

Insurance Industry Example

An insurer keeps records of customer identification documents and transaction details for all policyholders.

Example:

Detailed Record-Keeping in an Insurance Company

Scenario:

Life Insurance Policy Application and Claims Process

1. Policy Application:

- Customer Identification:
  When Tan Ah Kow applies for a life insurance policy with ABC Insurance Company, he is required to provide various identification documents, including his national ID and income verification documents (e.g., recent payslips or tax returns).

- Record Creation:
  ABC Insurance Company creates an electronic file for Tan Ah Kow, scanning and saving all provided documents into their secure document management system. These documents are tagged with metadata for easy retrieval.

- Transaction Records:
  Details of the initial premium payment, including payment method (bank transfer) and transaction ID, are recorded and linked to Tan Ah Kow's policy file.

2. **Ongoing Transactions:**

   - Premium Payments:
     Throughout the life of the policy, records of all subsequent premium payments are maintained. Each payment record includes the date, amount, payment method, and transaction reference number.

   - Policy Updates:
     If Tan Ah Kow updates his beneficiary information or changes his contact details, these changes are documented and saved in his policy file.

3. **Claims Process:**

   - Claim Submission:
     Upon Tan Ah Kow's passing, his beneficiary, Yong Ah Moy, submits a death claim to ABC Insurance Company. Yong Ah Moy provides necessary documents, including the death certificate and a completed claim form.

   - Document Verification:
     The insurer verifies the claim documents and records the verification process details, including date, time, and personnel involved.

   - Claim Settlement:
     Once the claim is approved, ABC Insurance Company records the payment transaction details, including the amount paid, payment method, and date of settlement. This record is linked to both Tan Ah Kow's policy file and Yong Ah Moy's beneficiary file.

4. **Record Retention:**

   - Retention Period:
     All records related to Tan Ah Kow's policy are retained for at least six years after the policy is closed or the last transaction is completed. This includes all identification documents, transaction records, and claim settlement details.

   - Extended Retention:
     If Tan Ah Kow's policy or claim was subject to any suspicious activity reporting or investigation, ABC Insurance Company might be required to retain these records for a longer period as specified by regulatory authorities.

Purpose and Benefits:

   - Compliance:
     This detailed record-keeping ensures ABC Insurance Company complies with AML/CFT/CPF/TFS regulations, aiding in the detection and prevention of money laundering and terrorist financing activities.

   - Regulatory Cooperation:
     The comprehensive records allow ABC Insurance to efficiently cooperate with regulatory bodies during audits, inquiries, or investigations.

- Operational Efficiency:
  Detailed and organized records improve the insurer's operational efficiency, ensuring quick access to important documents and transaction histories.

4. AML/CFT/CPF/TFS Compliance Program

Description

Insurance companies are required to establish and maintain a comprehensive anti-money laundering and counter-terrorist financing (AML/CFT/CPF/TFS) compliance program. This program encompasses a range of components including risk assessment, policies, procedures, robust internal controls, and independent audits.

In particular, it is vital that appropriate steps are taken to ensure regular and comprehensive training for employees, officers, and tied intermediaries. This training should cover a wide scope, such as:

(a) Understanding of the relevant AML/CFT/CPF/TFS laws and regulations, particularly in relation to customer due diligence measures and the detection and reporting of suspicious transactions.
(b) Familiarity with the prevailing techniques, methods, and trends in money laundering and terrorist financing (ML/TF).
(c) (c) Comprehensive knowledge about the company's own policy, standards, procedures, controls and the specific roles and responsibilities of the employees, officers, and tied intermediaries in combating ML/TF risk exposure.

Such a well-rounded compliance program ensures a thorough understanding of the regulatory requirements among all parties involved, and thus promotes the prevention of illicit financial activities.

Insurance Industry Example

A Takaful operator institutes a robust compliance program, ensuring that its employees and tied intermediaries are adequately trained in AML/CFT/CPF/TFS policies and procedures. This compliance program is not a one-time training but rather an ongoing process that includes new appointments and refresher training sessions.

Specialized training is provided for those officers, employees, and tied intermediaries who require deeper knowledge in specific areas, such as:

(a) Understanding the requirements and procedures for customer due diligence;
(b) Knowing how to conduct customer screening, understanding its purpose, dealing with the screening results, and following the respective procedures;
(c) Identifying suspicious transactions or customer behavior and knowing how to report them properly; and
(d) Keeping abreast of significant changes to AML/CFT/CPF/TFS regulations that may impact the company's AML controls and business processes.

This training regime ensures that all relevant parties within the organization are continuously updated and educated about their roles and responsibilities in the fight against money laundering and terrorist financing.

5. Suspicious Transaction Reporting

Description

Filing of STR occurs when there are reasonable grounds for suspicion that the customer's transaction is suspicious or it does not commensurate with his/her profile.

Insurance Industry Example

An insurance provider must stay vigilant for any suspicious transactions or behaviors that could indicate money laundering or terrorist financing. This includes activities that may not make economic sense, such as:

i. Surrendering a policy with a significant loss, suggesting that the policyholder may be more interested in cleaning illicit funds than preserving their investment.
ii. Premium payments that are not in line with the declared income of the policyholder, raising questions about the source of the funds.
iii. Payment of premiums via large or unusual amounts of cash, which can be a way of introducing illicit cash into the financial system.
iv. Frequent inflows and outflows, such as multiple loans and repayments or frequent policy surrenders and purchases, which could suggest an attempt to obscure the origin of funds.
v. Policy assignment to unrelated third parties for no plausible reason, which may indicate an attempt to obscure the true beneficiary of a policy.
vi. Payments made by unrelated third parties for no plausible reason, which could suggest the involvement of other parties in money laundering activities.

Suspicious behavior can also serve as a red flag for potential money laundering or terrorist financing, such as:

i. A client's reluctance to provide identification documents or documentary evidence for wealth corroboration, which can suggest an attempt to hide their identity or the true source of their wealth.
ii. Unusual curiosity about the insurer's compliance procedures or reporting requirements or monitoring thresholds, which may indicate an attempt to avoid triggering any controls or alarms.
iii. A lack of concern regarding the costs of purchasing the policy but an unusual interest in early termination features (such as the free-look period or surrender/withdrawal value), which could suggest a primary interest in moving money rather than obtaining coverage.

If such suspicious transactions or behaviors are identified, the insurance provider is obligated to report them to the relevant authorities to ensure compliance with Anti-Money Laundering, Counter-Financing of Terrorism, counter proliferation financing and targeted financial (AML/CFT/CPF/TFS) regulations.

3.6.7 CUSTOMER DUE DILIGENCE (CDD)

For any business transactions secured through agents, reporting institutions shall ensure their agents perform Customer Due Diligence (CDD). When referring to "establishing a business relationship" in the context of Customer Due Diligence (CDD), it typically means at the time of initiating the business relationship between the customer and the insurance company. This is the point at which the customer expresses an interest in purchasing an insurance product or enters into a contract with the insurance provider.

Table 3-4 *Summary of the Key CDD Measures for Insurance Companies*

CDD Measure	Description
1. Identifying Customers	Collect and verify customer identification documents, such as passports, driver's licenses, or national ID cards.
2. Understanding the nature of the relationship	Obtain information on the purpose and intended nature of the business relationship, including types of insurance products and reasons for purchasing them.
3. Identifying beneficial owners	Identifying and verifying the beneficial owner(s) of an insurance policy is a crucial part of AML/CFT/CPF/TFS procedures. A beneficial owner (BO) refers to the individual or entity who ultimately owns or controls the policy or on whose behalf a transaction is being conducted. **Example: Individual Context** Ravi Kumar provides funds to his son, Arjun Kumar, to purchase a life insurance policy. Although the policy is in Arjun's name, Ravi stipulates that all future transactions related to the policy must be approved by him. In this case, Ravi Kumar is considered the beneficial owner because he maintains control over the policy and its related transactions, despite the policy being in Arjun's name. **Example: Corporate Context** Wong Enterprises purchases a key person insurance policy on its CEO, Li Wei. The beneficial owner in this context would be the individual who ultimately has control over the company, typically a major shareholder. Suppose Chen Hui holds a 30% share in Wong Enterprises and has significant control over its operations. In this scenario, Chen Hui is identified as the beneficial owner. His identity must be verified as part of the AML/CFT/CPF/TFS procedures to ensure transparency and prevent potential money laundering or terrorist financing activities. In both of these scenarios, it's essential for the insurance provider to accurately identify and verify the beneficial owner(s) to prevent and detect potential money laundering or terrorist financing activities.
4. Risk Assessment	Assess the customer's risk profile based on factors such as occupation, source of funds, and type of insurance product, and determine the appropriate level of due diligence required.

5. Ongoing Monitoring	Continuous monitoring of customer relationships and transactions is an essential aspect of AML/CFT measures. It is vital to understand that a customer's risk profile may evolve over time, and therefore, regular reassessments are necessary. Such monitoring includes both financial and non-financial transactions, aiming to identify any unusual or suspicious activities that may indicate a change in risk or potential illicit activities. Financial Transactions include but are not limited to: • Payment of premiums, considering the amount and frequency. • Benefit payouts. • Claims payouts. Non-Financial Transactions could encompass: • Assignments, where the policyholder transfers the rights and benefits of the policy to another party. • Nominations, where the policyholder nominates a beneficiary. • Updates to personal information, such as changes in address, nationality, or occupation.
6. Enhanced Customer Due Diligence (ECDD)	For customers deemed high-risk, additional due diligence measures are necessary. This enhanced due diligence involves obtaining comprehensive information about the customer's financial background and understanding the purpose behind purchasing the insurance policy. Source of Wealth (SOW) • This pertains to the origin of the customer's total net worth. Understanding the SOW can provide insights into how a customer has accumulated their wealth. It could be through various channels such as employment income, returns from investments, inheritance, lottery winnings, etc. Source of Funds (SOF) • This refers to the origin of the funds used to purchase the insurance policy. Identifying the SOF helps to ensure that the funds used to pay for the policy premium are from legitimate sources, and the insurance provider is not facilitating any money laundering activities. The SOF could be the customer's employment income, payments made by a third-party, funds obtained through premium financing, etc. In addition to identifying the SOW and SOF, Enhanced Due Diligence (EDD) could also include more frequent ongoing monitoring and obtaining detailed information about the intended beneficiaries of the policy. By taking these steps, an insurer can better manage its risk and protect against potential involvement in illicit activities.

7. Agent CDD compliance	Ensure that agents acting on behalf of the insurance company perform CDD measures and provide appropriate training, guidance, and oversight to ensure compliance with the company's AML/CFT/CPF/TFS policies.

THE ROLE OF AGENTS IN FIGHTING AGAINST AML/CFT/CPF/TFS

Agents play a crucial role in the detection and prevention of money laundering and terrorist financing. Their direct interaction with clients positions them well to notice any unusual behavior or suspicious activities. Here's what agents should do if they suspect a client could be involved in laundering money:

1. Know the Red Flags:
   - Agents should be aware of common indicators of money laundering, such as reluctance to provide personal information, irregular or large transactions, and inconsistent information.

2. Report Suspicious Activities:
   - If an agent suspects a client is involved in money laundering, they should report their suspicions to the company's compliance officer or the designated AML/CFT/CPF/TFS officer immediately.
   - Agents should provide detailed information about the suspicious activity, including the nature of the transaction, the parties involved, and the reasons for suspicion.

3. Follow Internal Procedures:
   - Adhere to the internal reporting procedures set by the insurance company. This often involves completing a suspicious activity report (SAR) and submitting it to the relevant department within the organization.

4. Maintain Confidentiality:
   - It is crucial that agents maintain the confidentiality of the report and the suspected individual. They should not disclose their suspicions to the client or any third parties to avoid tipping off the suspected individual.

5. Continuous Training:
   - Agents should participate in regular AML/CFT/CPF/TFS training sessions to stay updated on the latest regulations, trends, and red flags associated with money laundering and terrorist financing.

Example

Reporting Suspicious Activity

Ahmad, an insurance agent, notices that his client, Mr. Lee, has made several large and irregular premium payments in cash over a short period. Additionally, Mr. Lee is hesitant to provide detailed information about the source of the funds. Ahmad follows the company's internal procedures and reports his observations to the compliance officer, providing all relevant details. The compliance officer then evaluates the report and decides on further actions, which may include filing a report with the relevant authorities.

IMPORTANCE OF AGENT INVOLVEMENT

Agents are the first line of defence in identifying and reporting suspicious activities. Their vigilance and proactive approach can significantly contribute to the effectiveness of AML/CFT/CPF/TFS measures, protecting the integrity of the financial system and ensuring compliance with regulatory requirements

3.7 FAIR TREATMENT OF FINANCIAL CONSUMERS (FTCF)

Effective Date and Historical Context

This Guideline comes into effect on 27 March 2024, with specific requirements related to the treatment of vulnerable consumers and corporate culture becoming effective on 1 April 2025.

Importance of Fair Treatment

Financial Service Providers (FSPs) must be responsive and trustworthy to ensure a resilient and progressive financial system. The Fair Treatment of Financial Consumers (FTFC) leads to higher customer satisfaction, retention, and long-term business performance. FSPs must be fair, responsible, and professional when dealing with financial consumers. Poor treatment can result in conduct and reputational risks, as well as significant costs.

Conduct Risk Management

Conduct risk management should be an integral part of the overall risk management framework of FSPs. This includes:

- Risk Assessment:
  Identifying potential risks in areas such as business models, product development, governance, sales, marketing, and staff remuneration.
- Management and Monitoring:
  Implementing processes for managing and monitoring these risks.
- Reporting:
  Regular reporting on conduct risk to ensure transparency and accountability.

Objectives of the FTFC Guideline

This Guideline aims to:

1. Foster High Standards of Conduct:
   Upholding high standards of responsible and professional conduct in all interactions with financial consumers.

2. Integrate Consumer Interests:
   Embedding the interests of financial consumers into business strategies and operations.

3. Manage Conduct Risk Effectively:
   Setting expectations for effective conduct risk management through comprehensive risk assessment, management, monitoring, and reporting.

4. Ensure Consumer Confidence:
   Providing financial consumers with the assurance that FSPs will act with due care, skill, and diligence, ensuring fair dealings.

5. Consider Vulnerable Consumers:
   Promoting a culture where the interests and needs of vulnerable consumers are appropriately considered and addressed in business operations.

6. Provide Clear Guidance and Support:
   Setting requirements and providing clear guidance for FSPs to support vulnerable consumers, ensuring fair treatment and positive outcomes.

Vulnerable Consumers

Consumers may become vulnerable due to various life changes, making it essential for FSPs to recognize and address their specific needs. Neglecting the needs of vulnerable consumers can lead to unfair treatment, financial hardship, or exclusion from essential services. FSPs that understand and meet the needs of vulnerable consumers can enhance customer satisfaction and loyalty, whereas neglecting these needs can result in a loss of competitiveness.

Specific Requirements and Guidance

1. Policies and Procedures:
   Implementing appropriate policies and procedures to meet the needs of vulnerable consumers and ensure fair treatment.

2. Training and Empowerment:
   Training staff, representatives, and agents to recognize, assess, and respond to the needs of vulnerable consumers.

3. Monitoring and Evaluation:
   Regularly monitoring and evaluating the effectiveness of policies and procedures in delivering fair outcomes.

4. Prohibition of Predatory Practices:
   Avoiding predatory practices that exploit vulnerable consumers and ensuring fair and transparent communications and agreements.

By adhering to these guidelines, FSPs can foster trust and satisfaction among financial consumers, achieving sustained long-term success in the financial industry.

3.8 MALAYSIAN FINANCIAL PLANNING COUNCIL

Malaysian Financial Planning Council (MFPC) is an independent body set up with the noble objective of promoting nationwide development and enhancement of the financial planning profession. MFPC provides an evolving set of Best Practice Standards and Code of Ethics that must be adhered to by Registered Financial Planner (RFP) and Shariah RFP designees.

Life Insurance Association of Malaysia (LIAM) has accorded greater significance of the RFP course for the CPD hours. Please refer to *Chapter 16.5.2 RFP Requirement* - In recognizing the importance of the Registered Financial Planner (RFP) designation to upgrade professionalism of life insurance intermediaries as well as to promote the development of the financial planning industry.

3.9 LIFE INSURANCE ASSOCIATION OF MALAYSIA (LIAM)

Formed in 1974, the Life Insurance Association of Malaysia (LIAM) is a trade association registered under the Societies Act 1966. LIAM has a total of 16 members, of which 14 are life insurance companies and 2 life reinsurance companies.

LIAM's Objectives

- to promote a progressive life insurance industry;
- to enhance public understanding and appreciation for life insurance;
- to upgrade the image and professionalism of the life insurance industry and;
- to support the regulatory authorities in developing a strong industry.

LIAM Mission & Vision

- To promote and establish a sound structure in Malaysia
- To promote public understanding and appreciation for life insurance
- To enhance the professionalism of staff and agents through continuous training and education
- To formulate rules and guidelines to instill good business practices
- To give support to regulatory authorities in developing a strong and healthy industry
- To improve the image of the life insurance industry through self-regulation

3.10 PERSATUAN INSURANS AM MALAYSIA (PIAM)

The history of Persatuan Insurans Am Malaysia (PIAM), i.e. the General Insurance Association of Malaysia, originated from the establishment of various insurance and tariff associations set up in 1885 that played a role as a collective voice of the insurance industry in Malaya and Singapore, shortly after the independence of Malaya in 1957. In June 1961, the Insurance Association of Malaya was formed to maintain tariff discipline, respond to new insurance legislations and promote sound insurance practices. For the first time, an Association was established in Kuala Lumpur to safeguard the country's general insurance interest.

Subsequently, PIAM was incorporated in 22 February 1982 as a statutory trade association recognised by the Government of Malaysia for all registered insurers who transact general insurance business. Currently, PIAM has 23 member companies comprising 19 direct general insurance and 4 reinsurance companies operating in Malaysia.

PIAM Mission Statement

To be a Dynamic Trade Association serving the interests of our members by creating a favourable business environment and working closely with all stakeholders to support the initiatives under our National Agenda.

In summary, Chapter 3 highlights the significant strides made in Malaysia to establish a robust and comprehensive legal framework that safeguards the rights and interests of insurance consumers. This framework serves as a solid foundation for ensuring transparency, fairness, and accountability within the insurance industry. By setting clear guidelines and regulations, it aims to protect consumers from unfair practices, misrepresentations, and fraudulent activities.

The development of this legal framework reflects the commitment of regulatory bodies and policymakers to prioritize consumer protection and enhance the overall trust and confidence in the insurance sector. It encompasses various laws, acts, and regulations that govern different aspects of insurance, including policy provisions, claims handling, disclosure requirements, and dispute resolution mechanisms.

Through this framework, insurance consumers can have peace of mind, knowing that their rights are protected and that they have recourse in case of any grievances or disputes. It empowers them to make informed decisions when purchasing insurance products, ensuring that their financial interests are aligned with their coverage needs.

Furthermore, this legal framework promotes a fair and competitive marketplace, encouraging insurers to uphold high ethical standards and provide quality services to consumers. It also emphasizes the importance of transparency in communication, ensuring that policyholders have access to clear and accurate information about their insurance coverage, terms, and conditions.

By establishing a comprehensive legal framework, Malaysia has demonstrated its commitment to creating an environment where insurance consumers can have confidence in the industry. It is an ongoing process that requires continuous monitoring and adaptation to keep pace with evolving market dynamics and emerging consumer needs. Overall, this framework plays a vital role in fostering a sustainable and trustworthy insurance landscape that benefits both consumers and the industry as a whole.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*Which of the following is NOT a function of Bank Negara Malaysia?*
A	a. Enhance professional standards and business conduct of the agency force. b. Foster fair, responsible and professional business conduct of insurance companies. c. Strive to protect the rights and interests of financial consumers. d. Keep a close watch on solvency and market conduct of the insurance industry.

2	**Review Question**
Q	*Which new legislation replaced the Insurance Act of 1996?*
A	a. Islamic Financial Services Act 2013. b. Financial Services Act 2013. c. Insurance Act 2013. d. Financial Services Authority 2013.

3	**Review Question**
Q	*The Consumer Education Programme (CEP) is a programme initiated by Bank Negara Malaysia and the insurance and takaful industry. The programme is designed as a long-term programme to provide educational information to enhance financial literacy and awareness. Which are the key objectives?* *i. to enable consumers to make well-informed decisions when purchasing insurance or takaful products.* *ii. to assist consumers to be in a better position to select insurance or takaful products that best meet their needs.* *iii. to understand their rights and responsibilities as consumers of insurance or takaful products and services.* *iv. to maximise profit and returns from buying insurance products.*
A	a. i & ii b. i & iii c. i, ii & iii d. ii, iii & iv

4	**Review Question**
Q	*Which of these is an Alternative Dispute Resolution channel for financial consumers?*
A	a. Ombudsman for Financial Services (OFS) b. Complaints Unit of an insurance company c. Malaysia Competition Commission (MyCC) d. Companies Commission of Malaysia (CCM)

5	**Review Question**
Q	*On whom is Customer Due Diligence to be conducted as required by the Anti-Money Laundering, Counter Financing of Terrorism, Counter Proliferation Financing & Targeted Financial Sanctions (AML/CFT/CPF/TFS) guidelines?*
A	a. Insurance intermediary or agent b. Financial Adviser c. Customer or Beneficial Owner d. Financial Service Provider

6	**Review Question**
Q	*Which of the following is NOT considered 'personal data' by the Personal Data Protection Act 2010?*
A	a. Any personal information in respect of commercial transactions. b. Personal information posted on social media. c. Sensitive personal data e.g., physical, or mental health, political opinions, religious beliefs, offences, or any other data as the Minister may determine. d. Expression of opinion about the data subject.

7	**Review Question**
Q	*Which type of complaint is handled by an Ombudsman for Financial Services (OFS)?*
A	a. General pricing, product features or underwriting decisions. b. Cases involving third party bodily injury or death. c. Insurance and Takaful Claims below RM 250,000. d. Cases referred to the court or arbitration.

8	**Review Question**
Q	*Who administers the Takaful and Insurance Benefits Protection System (TIPS)?*
A	a. Financial Institutions b. Bank Negara Malaysia (BNM) c. Insurance Companies and Takaful Operators d. Perbadanan Insurans Deposit Malaysia (PIDM)

9	**Review Question**
Q	*Under the Financial Services Act 2013 'authorized business' licensed by the Minister include the following EXCEPT*
A	a. Insurance business b. Insurance broking c. Insurance loss adjuster d. Financial advisory services

10	**Review Question**
Q	*Which law requires an insurance company to be incorporated as a public company and a broker, financial adviser, and loss adjuster to be incorporated as a private company?*
A	a. Companies Act 1965 b. Financial Services Act 2013 c. Insurance Act 1996 d. Competition Act 2010

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

4

CHAPTER 4 THE INSURANCE CONTRACT

INTRODUCTION

A contract is a legally binding agreement, i.e., one which the courts will recognise and enforce. An insurance contract, therefore, is a legally binding agreement to insure. It is the binding nature of an insurance contract which provides a solid foundation for the business of insurance and enables people to buy policies with confidence.

The cornerstone of the insurance industry is the insurance contract. It forms the basis of the insurer-insured relationship, outlining the rights and responsibilities of each party, while also serving as a legally binding agreement that provides coverage against potential risks or losses.

4.1 THE LAW OF CONTRACT

In Malaysia, most types of contracts, including those for insurance, sale of goods or land, employment, hire, etc., are governed by the rules of the law of contract prescribed by the Contracts Act 1950 (Revised 1974). This Act sets out the general principles relating to the formation, validity, and enforceability of contracts.

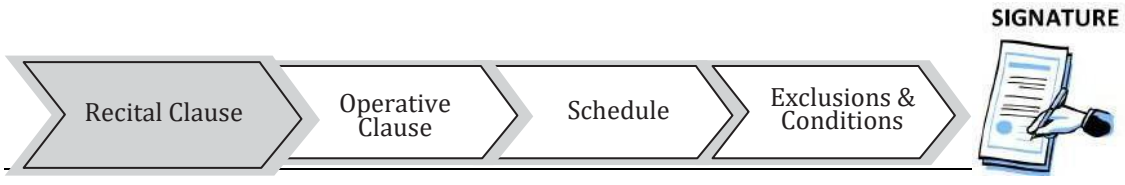
However, it is important to note that many specific types of contracts, such as insurance, have their own specialized statutes that provide more detailed regulations. In particular, insurance contracts may be subject to the Financial Services Act 2013. According to Paragraph 1(2) of Schedule 9 of the Financial Services Act 2013, where there is a conflict or inconsistency between a provision of this Schedule and the Contracts Act 1950, the provision of this Schedule shall prevail.

In this section, we delve into the critical components that constitute an insurance contract, from its basic structure to the fundamental principles governing its implementation. Understanding these key elements is essential for anyone operating in the insurance industry, as they form the basis of interaction between the insurer and insured.

4.1.1 THE BASIC STRUCTURE OF AN INSURANCE CONTRACT

Every insurance policy, regardless of the type, consists of several key elements that collectively make up the contract. Each of these components plays a critical role in defining the terms and scope of the coverage:

FIGURE 4-1 ***Insurance Contract Basic Structure***



1. The Recital Clause

   The recital clause describes the parties to the insurance contract. The head of the policy form will contain the registered name and address of the insurance company and refer to the other party as the insured described in the schedule. The preamble states that the insured had applied for insurance by a proposal and declaration which shall be the basis of the contract and has paid or

agreed to pay the premium in consideration of the cover afforded by the policy subject to the terms, conditions, endorsements, clauses, or warranties forming part of the policy.

2. The Operative Clause

   The operative clause will state under what circumstances the policy will operate and specifies the events upon which the policy becomes operative to trigger a claim. In life insurance, for example, the sum assured becomes payable on the death of the life assured, whereas with general insurance, the peril insured such as 'fire material damage' and the basis of settlement which is, 'to indemnify the insured' is described in the operative clause.

3. The Schedule

   The policy schedule contains the insured's particulars and details of the risk and subject matter insured. The information contained in the schedule includes the following and is not exhaustive as it varies with the type of policy:

   - Name of Insured
   - Commencement date or period of insurance
   - Date of proposal and declaration which forms the basis of the contract
   - Description of interest insured
   - Sum insured
   - Situation of risk
   - Date of birth or age (for life insurance)
   - Amount of premium, service tax (if any) and stamp duty

4. Exclusions

   It is normal for an insurance policy to exclude fundamental risks such as war, terrorism, and nuclear risks due to the catastrophic nature of such losses. At the same time, there are certain risks which are more appropriately covered by a separate policy, for example theft of property is excluded by a fire policy and should be covered by a commercial theft policy. Exclusions are also excluded perils which may be extended on payment of additional premium by endorsement to the policy.

5. Conditions

   Policy terms and conditions exist so that parties to the contract understand their respective duties, rights, and obligations. For example, a condition precedent to liability is that the insured must give immediate notice in the event of a claim. Conditions can also restrict the scope of cover, for example committing suicide within the first 12 months of a life insurance policy will not be covered. There are conditions which provide special privileges such as the 15-day 'cooling-off' or 'free-look' period as well as fundamental conditions which go to the root of the contract such as the requirement to pay premium before assumption of risk by insurers.

6. Attestation (Signature)

   An attestation is a declaration by a witness that an instrument in this case, an insurance policy, has been executed according to the formalities required by law. By signing one's name to it, the authorized person affirms that it is genuine.

4.1.2 PRINCIPLES OF AN INSURANCE CONTRACT

Insurance contracts operate under several fundamental principles that govern the relationship between the insurer and insured:

- Utmost Good Faith

  Utmost good faith, also known as uberrimae fidei, is a cornerstone principle in insurance contracts. It requires both the insurer and insured to act honestly, disclose all material facts, and provide complete and accurate information during the contract formation. This principle ensures transparency, trust, and fair dealing between the parties. For example, when applying for life insurance, the insured must disclose their medical history and any pre-existing conditions to the insurer in utmost good faith.

- Insurable Interest

  Insurable interest is the legal or financial interest that an insured party must have in the subject matter of the insurance contract. It ensures that insurance is based on a valid economic relationship and helps prevent speculative insurance contracts. The insured must demonstrate that they would suffer a financial loss or have a legal interest in protecting the subject matter insured. For instance, a person can only purchase property insurance for a property they own or have a legal interest in.

- Indemnity

  The principle of indemnity states that insurance contracts aim to restore the insured to the same financial position they were in before the occurrence of the insured event. Insurance is not meant to be a source of profit but a means of compensation for actual losses suffered. For example, if a car is damaged in an accident, the insurer will compensate the insured for the repair costs but not provide additional payment beyond the actual expenses incurred.

- Subrogation

  Subrogation allows the insurer, after settling a claim, to step into the insured's shoes and pursue any rights or remedies the insured may have against third parties responsible for the loss. It helps prevent double recovery by the insured and allows the insurer to recover its costs from the party at fault. For instance, if an insured's property is damaged due to another party's negligence, the insurer can subrogate and legally pursue the negligent party to recover the claim amount.

- Proximate Cause

  The principle of proximate cause determines the cause-and-effect relationship between an insured event and the resulting loss. It helps identify the most immediate or direct cause of the loss and assess whether it falls within the scope of coverage. Insurance policies typically specify the covered perils or causes of loss. For example, if a fire breaks out and damages a building, the proximate cause of the loss would be the fire itself, rather than any subsequent damage caused by water used to extinguish the fire.

- Contribution

  Contribution applies when multiple insurance policies cover the same subject matter and risk. If an insured has multiple policies providing overlapping coverage, the principle of contribution allows the insured to claim from any of the policies but not exceed the total loss amount. The insurers will then share the liability based on their proportionate coverage. This principle prevents the insured from profiting from multiple claims on the same loss.

The principles of an insurance contract have been extensively discussed in Chapter 2, which focuses on the basic principles of insurance. Therefore, this section will not delve into them further.

4.2 THE LEGAL FRAMEWORK OF INSURANCE CONTRACTS

This section provides an in-depth look into the legal landscape that governs insurance contracts. The focus is on the legal principles that guide their formation, enforcement, and interpretation, thus providing an insurance advisor with the knowledge to advise clients effectively and professionally.

4.2.1 THE LAW OF CONTRACT IN INSURANCE

Contract law forms the bedrock of insurance contracts, so it is crucial for an insurance advisor to understand its tenets. The contract law in insurance pertains to how contracts are formed, interpreted, executed, and potentially breached.

FORMATION OF INSURANCE CONTRACTS

In line with general contract law, insurance contracts come into existence when the following elements are met:

(i) Offer and Acceptance

- The process of forming an insurance contract begins with the prospective insured making an offer by submitting an application to the insurer. The insurer accepts the offer by issuing a policy or delivering a binder.

- For instance, an individual seeking insurance initiates the contract process by presenting a fully filled and signed proposal form. This can be sent directly to the insurance company or via an insurance agent, representing an offer to the insurer. The insurance company then has the option to either accept the proposed risk, decline it altogether, or propose a modified agreement with specific conditions. This modified agreement represents a counter-offer from the insurer, which the individual seeking insurance can choose to accept or reject.

(ii) Intention to Create a Legal Relationship

- It is a basic requirement to the formation of any contract, be it oral or written, that there must be a mutual assent or a “meeting of the minds” of the parties on all proposed terms and essential elements of the contract. It has been held by the courts that there can be no contract unless all the parties involved intended to enter one. This intent is determined by the outward actions or actual words of the parties and not just their secret intentions or desires.

In the context of an insurance contract, this intention is demonstrated by:

- The Proposer

  By submitting a proposal for insurance (often through a completed and signed application form), the proposer expresses an intention to enter an insurance contract. This is the initial step towards the creation of an insurance contract and can be done directly to the insurer or through an insurance agent.

- The Insurer

  The insurer displays intention by assessing the proposal, indicating acceptance of the offer (often by issuing the policy), or making a counter-offer (perhaps with certain terms and conditions). It is essential to note that the insurer has the right to reject the proposal based on the risk assessment.

In both cases, the intention to create a legal relationship is demonstrated through concrete actions and words, establishing a mutual agreement or "meeting of the minds" on all proposed terms and essential elements of the contract.

(iii) Consideration

- Consideration can be defined 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".

- The consideration, in the context of an insurance contract, typically involves the exchange of premium payments from the policyholder for the promise of coverage or compensation from the insurer.

- While a valid contract of insurance will come into force once an offer has been accepted, the risk may not attach immediately. Equally, it is important to understand that under English law, a valid insurance contract may exist before the insured has actually paid the premium, provided they have agreed to pay. A promise to pay is as good consideration as payment itself. However, insurers may stipulate that the risk will not run until the premium is paid.

- In Malaysia, the 'cash-before-cover' ruling applies to motor insurance, individual travel, and personal accident insurance. The ruling requires actual payment of the premium to complete the contract and assumption of risk by the insurer. In marine insurance, however, insurers often agree in advance to extend the policy to cover some risks excluded from the original contract if the need arises, with the additional premium to be fixed afterwards.

(iv) Legal/Contractual Capacity

- Both parties involved must have the capacity to enter into a contract. This typically means that both parties must be of legal age, sound mind, and not under duress or undue influence.

- In the context of insurance, a minor is a person below the age of 18 and is not competent to enter into a contract. However, this position is altered by statute i.e., the Financial Services Act 2013 s.128 schedule 8(4), which provides for a minor to insure on his own life or upon the life of another as more specifically described below:

    - A minor who has attained the age of 10 but not attained the age of 16 with the consent in writing of his parent or guardian may affect a life policy on his own life or upon another life in which he has an insurable interest; and may assign the life policy on his own life or take an assignment of a life policy.

    - A minor who has attained the age of 16 may affect a life policy on his own life or upon another life in which he has an insurable interest; and may assign the life policy on his own life (with the consent in writing of his parent or guardian) or take an assignment of a life policy.

Table 4-1 ***Type of Insurance for Age Groups***

Type of Insurance	Age Group	Life Insurance Actions Allowed
Life	10-15 years	Take out a life insurance policy on one's own life or on someone else's life with insurable interest.
Life	16 years or above	Take out a life insurance policy on one's own life or on someone else's life with insurable interest.
ILP	18 years or above	Take out a life insurance policy on one's own life or on someone else's life with insurable interest.

- The Contractual Capacity of Insurers

  In Malaysia, insurance companies are corporations formed and registered under the Companies Act 2016 as public companies. Corporations in general have the same legal rights and duties as a private individual of full age and capacity and may therefore make contracts. However, a corporation has an existence which is independent of its members and can be wound up or liquidated if it is unable to pay its debts. Legislation has been enacted specifically to regulate the activities of insurers to reduce the risk of an insurer becoming insolvent to protect its policyholders as discussed in Chapter 3.

(v) Legal Form

- In some cases, the law requires a contract to be in a particular form and this will always involve some type of written documentation. Writing obviously makes for greater certainty as to what has been agreed and may warn people against entering into a contract too lightly. In Malaysia, all insurance contracts must be in writing but under English law, there is no general requirement for an insurance contract to be recorded in written documentation. Insurance cover may be given orally (often by telephone) and, although a written policy is eventually issued in almost every case; a claim may well happen before the policy is prepared. Only a marine insurance contract must be in writing under the Marine Insurance Act 1906 (s 22).

- In Malaysia, section 91 of the Road Transport Act 1987 requires a 'policy' of insurance to be in force and para (4) states that a policy shall be of no effect unless and until a

certificate of insurance is issued in the prescribed form and delivered to the policyholder.

- Life insurance contracts are also subject to some formal rules as required by the Financial Services Act 2013. Schedule 8 (2) provides for '*objection to life policy*' by the insured within 15 days after the delivery of the life policy. The insured is entitled to cancel the policy by returning the policy document within the "*cooling-off*" or "*free-look*" period and the insurer must allow a full refund of the premium immediately.

Example 1

Legal Form

Kim submits a completed and signed application form for life insurance to ABC Insurance Company. ABC Insurance Company accepts the proposal and issues a policy to Kim, indicating their acceptance of the offer. This demonstrates the process of offer and acceptance in forming an insurance contract.

Example 2

Legal Form

Irene applies for property insurance with XYZ Insurance Company. However, XYZ Insurance Company rejects Irene's application due to the high-risk nature of the property. In this case, the rejection of the proposal represents the non-formation of an insurance contract.

INTERPRETATION OF INSURANCE CONTRACTS

Interpretation of contract terms is crucial in resolving disputes regarding the scope of coverage. In general, any ambiguity in an insurance contract is typically interpreted in favor of the insured, given that the insurer usually drafts the contract (principle of contra proferentem).

Example 1

Interpretation of Contract

If there is an ambiguous clause about what types of damages are covered in an insurance policy, under the principle of contra proferentem, the court would likely interpret the clause in a way that favors coverage for the policyholder. This is because the insurer wrote the policy and therefore had the opportunity to specify the terms more clearly.

Example 2

Interpretation of Contract

In an automobile insurance policy, there may be a clause regarding coverage for "collision." If the policyholder is involved in an accident where their car collides with another vehicle, the interpretation of the term "collision" will determine if the damages are covered under the policy. If there is an ambiguity in the contract, the court will likely interpret the term in favor of the insured, providing coverage for the damages.

RIGHTS AND RESPONSIBILITIES OF THE PARTIES

Each party in an insurance contract has certain rights and responsibilities. The insured, for example, has the duty to pay premiums, report claims promptly, and cooperate with the insurer in the event of a claim. The insurer, on the other hand, has the duty to offer the agreed-upon coverage, investigate and pay valid claims, and provide the insured with timely and accurate information regarding their policy and claims.

BREACH OF INSURANCE CONTRACTS

If either party fails to uphold their part of the contract, it may be considered a breach. Remedies for a breach of an insurance contract by the insurer could include damages equivalent to the benefits the insured would have received if the contract was appropriately honored. Breach by the insured, such as non-payment of premiums, could result in the insurer cancelling the policy.

By thoroughly understanding these aspects of contract law, an insurance advisor can better navigate the formation, execution, and potential disputes of insurance contracts, thereby providing effective and knowledgeable service to their clients.

4.2.2 UNDERSTANDING VOID, VOIDABLE, AND UNENFORCEABLE INSURANCE CONTRACTS

Insurance contracts, like any other legal contracts, can be classified as void, voidable, or unenforceable under certain circumstances. Understanding the differences between these terms is crucial for grasping the implications of each type of contract.

Let us delve into each concept and provide specific examples or scenarios to illustrate them.

VOID CONTRACTS

A contract is considered void if it lacks any of the essential elements that make a contract valid, such as offer, acceptance, and consideration, or if it's illegal or contrary to public policy. A void contract is not enforceable by law.

A void contract has no binding effect on either party. Because void contract is no contract at all, the expression is used to describe agreements which neither party can fully enforce.

Example 1

No Insurable Interest

In the context of life insurance, an insurance policy insuring the life of anyone other than the person effecting the insurance or a person mentioned in Schedule 8 of the Financial Services Act 2013 shall be void unless the person effecting the insurance has an insurable interest in that life at the time the insurance is effected. If someone takes out a life insurance policy on the life of a stranger without any insurable interest, the contract would be void because it lacks the essential requirement of insurable interest.

Example 2

Lack of Mutual Assent

If there is a fundamental mistake or disagreement from the start, the contract may be void. For instance, if the insured and the insurer have completely different understandings of the coverage being provided and there is no agreement or "meeting of the minds" on the terms of the contract, the contract would be void.

Example 3

Non-fulfillment of Policy Condition Precedent

Certain conditions must be fulfilled before an insurance policy becomes effective. For example, in life insurance, the policy may require the payment of the premium before the coverage starts. If the insured fails to fulfill this condition precedent, the contract may be void.

VOIDABLE CONTRACTS

Voidable contracts, unlike void contracts, are valid contracts that may be *declared invalid* at the option of one of the parties. A contract is voidable if one of the parties was under duress, undue influence, mistake, or misrepresentation at the time of contract formation. The aggrieved party has the right to either enforce or reject the contract.

A voidable contract is a contract where *breaches exist* that can render the contract invalid. If it is believed that a contract was not made in good faith, it is up to the *aggrieved party to decide* if it is good and valid and, therefore, enforceable. A voidable contract will remain valid unto the point that it is declared void once a breach has been determined.

Insurance contracts are contracts of utmost good faith and deliberate withholding of material facts by the policyholder would affect the validity of an insurance policy at the time of claim and make it voidable.

The insurer has equal responsibility in complying with the pre-contractual duty of disclosure; as per Para 11(1) of Schedule 9 of the Financial Services Act 2013, which states;

"No licensed insurer, insurance agent, approved insurance broker, approved financial adviser or financial adviser's representative in order to induce a person to enter into, vary or renew, or offer to enter into, vary or renew, a contract of insurance, whether or not a consumer insurance contract, with it or through him: -

- ✓ *shall make a statement which is misleading, false or deceptive, whether fraudulently or otherwise;*
- ✓ *shall fraudulently conceal a material fact; or*
- ✓ *in the case of an insurance agent, use any sales brochure or sales illustration not authorized by the licensed insurer."*

If a person is induced to enter into, vary or renew a contract of insurance in a manner described above, the contract of insurance shall be voidable and the person shall be entitled to rescind it. In this regard, section 19 of the Contracts Act 1950 provides: when consent to a contract is induced by coercion, the contract is voidable at the option of the party who was coerced

> *In the context of insurance, if an insured was misled about the terms of the policy or if there was a mutual mistake about the subject of insurance, the insured might have the right to make the contract voidable. If the contract is voided, it is as if the contract never existed, but if it's affirmed, the contract continues as valid.*

Example 1

Misrepresentation of Material Facts

Suppose an insured knowingly provides false information on their application for life insurance, such as concealing a pre-existing medical condition or misrepresenting their age, with the intention to secure a policy they would not otherwise qualify for or to receive a lower premium. In such cases, the insurer may have the right to declare the contract voidable and reject any claims made by the insured.

Example 2

Mutual Mistake

If both parties to the contract are mistaken about a fundamental aspect of the contract, it may be considered voidable. For instance, if the insured and the insurer mistakenly believe that a particular risk is covered under the policy, but it is later discovered that the policy specifically excludes that risk, either party may have the right to void the contract.

UNENFORCEABLE CONTRACTS

Unenforceable contracts are those that may have all the elements of a valid contract but fail to meet certain other legal requirements, rendering them unenforceable by law. These issues might include problems with the way the contract is written, lack of capacity, or a statute of limitations.

For example, an insurance policy that offers coverage for damages incurred by a policyholder during an illegal activity would not be enforceable as it violates the law. The policyholder cannot legally enforce the payment of benefits and the insurer is not legally entitled to the premium payments.

Example

Violation of Legal Requirement

An insurance policy that offers coverage for damages incurred by a policyholder during an illegal activity would be unenforceable as it violates the law. The policyholder cannot legally enforce the payment of benefits, and the insurer is not legally obligated

4.2.3 UNILATERAL NATURE AND FRAUD IN INSURANCE CONTRACTS

UNILATERAL NATURE OF INSURANCE CONTRACTS

Insurance contracts, especially life insurance contracts, are characterized as unilateral agreements. In such contracts, only one party, which is the insurance company, makes legally enforceable promises. When the insured party pays the premium, the insurer is obligated to provide the coverage defined in the policy terms and conditions. The insured, after paying the premium, does not have additional obligations. This unilateral nature distinguishes insurance contracts from many other types of agreements, which are typically bilateral, where obligations are imposed on both parties.

FRAUD IN INSURANCE CONTRACTS

Unlike most contracts, insurance contracts follow a unique set of rules when it comes to handling fraud. In general contract law, fraud can lead to the cancellation of the agreement. However, insurance contracts, due to their specialized nature, handle instances of fraud differently.

Fraud in the context of insurance contracts occurs when a party knowingly *misrepresents material facts*, which influences the issuance, pricing, or terms of the policy. For instance, in life insurance, this could occur if an individual knowingly provides false information on their application to secure a policy they would not otherwise qualify for or to receive a lower premium.

Upon discovery of such fraud, the insurance company can take various actions, depending on the circumstances and applicable law. These actions may include retroactively increasing the premium, cancelling the policy, refusing to pay a claim, or even taking legal action against the fraudulent party. The specific course of action will depend on the terms and conditions of the policy and the jurisdiction's laws.

Example 1

Instances of fraud in insurance contracts

Jane applies for health insurance and intentionally fails to disclose her pre-existing medical condition in the application. By concealing this material fact, Jane misrepresents her health status to the insurer, aiming to secure coverage without the insurer knowing the actual risk. This is an example of fraud in an insurance contract.

Example 2

Instances of fraud in insurance contracts

Mark purchases a life insurance policy and decides to fake his death to claim the death benefit for his beneficiaries. This deliberate act of deceit and misrepresentation constitutes insurance fraud and can have severe legal consequences.

4.3 PRACTICAL TIPS FOR CONTRACT FORMATION

TIP: COMPLETING PROPOSAL FORMS ACCURATELY

To ensure a smooth contract formation process, it is crucial for policyholders to complete proposal forms accurately and truthfully.

Take the following steps:

1. Provide comprehensive information

   Include all relevant details about your personal circumstances, medical history, and any other factors that may affect the insurability or risk assessment.

2. Seek professional assistance if needed

   If you are unsure about certain questions or terms in the proposal form, seek guidance from an insurance agent or advisor to ensure you understand the implications of your responses.

3. Review before submission

   Before submitting the proposal form, carefully review all the information provided to ensure its accuracy and completeness. Correct any errors or omissions to avoid potential issues in the future.

4.4 DISPUTE RESOLUTION MECHANISMS

In the event of a dispute arising from an insurance contract, various mechanisms are available to resolve the disagreement. One widely recognized and effective alternative dispute resolution process is mediation. Mediation involves a neutral third party, the mediator, who assists the parties in reaching a mutually acceptable resolution. This approach offers several benefits in the context of insurance contract disputes:

- Confidentiality

  Mediation proceedings in Malaysia are typically confidential, ensuring that discussions and negotiations remain private. This confidentiality allows the parties to freely express their concerns and explore potential solutions without fear of the information being disclosed to others.

- Cost-effectiveness

  Mediation is generally a more cost-effective option compared to litigation or arbitration. It typically involves fewer formalities and legal procedures, reducing the associated expenses. Parties also have the option to choose the mediator and mutually agree on the allocation of mediation costs.

- Flexibility

  Mediation provides flexibility in resolving disputes. Parties have the opportunity to actively participate in the process, share their perspectives, and jointly explore creative and tailored solutions. The mediator facilitates communication and negotiation, assisting the parties in finding common ground and reaching a resolution that meets their specific needs.

- Preservation of relationships

  Mediation focuses on fostering open communication and collaboration between the insured and the insurer. By preserving relationships, it helps maintain a positive long-term engagement, which can be beneficial for both parties. This is particularly valuable in insurance contracts where the ongoing relationship between the parties may continue beyond the resolution of the immediate dispute.

4.5 EMERGING TRENDS AND ISSUES: THE IMPACT OF DIGITALIZATION ON INSURANCE CONTRACTS

In today's digital age, the insurance industry is experiencing significant transformations driven by digitalization. The adoption of digital platforms, blockchain technology, and smart contracts is revolutionizing the way insurance contracts are created, stored, and executed. To provide a more comprehensive understanding of this topic, let us delve into the potential benefits, challenges, and considerations associated with the impact of digitalization on insurance contracts.

4.5.1 BENEFITS OF DIGITALIZATION IN INSURANCE CONTRACTS

1. Streamlined Processes

   Digital platforms facilitate faster and more efficient contract formation, eliminating the need for manual paperwork and reducing administrative burdens. Policyholders can complete application forms online, reducing the time and effort required to initiate coverage. Additionally, digitalization enables insurers to automate underwriting processes, leading to quicker policy issuance.

2. Enhanced Transparency

   Blockchain technology provides a decentralized and transparent ledger system, ensuring the integrity of contract terms and promoting trust between parties. The immutable nature of blockchain records enhances transparency, allowing both insurers and policyholders to have access to the same information, minimizing disputes and misunderstandings.

3. Automated Claims Processing

   Smart contracts, powered by blockchain technology, can automate claims settlement processes. These contracts are self-executing and self-enforcing, with predefined conditions triggering automatic claim payments. By removing the need for manual claims assessment, smart contracts enable faster and more accurate payouts, enhancing customer satisfaction.

4.5.2 CHALLENGES AND CONSIDERATIONS IN DIGITALIZED INSURANCE CONTRACTS

1. Data Security

   With the increased reliance on digital platforms, the security of sensitive customer data becomes paramount. Insurers must implement robust cybersecurity measures to protect customer information from unauthorized access, data breaches, and cyberattacks. Ensuring compliance with data protection regulations, such as the General Data Protection Regulation (GDPR), is essential to maintain customer trust and meet legal obligations.

2. Privacy Concerns

   Digitalization brings forth concerns regarding the privacy of customer data. Insurers must adopt privacy policies and practices that align with applicable data protection regulations. It is crucial to obtain informed consent from policyholders regarding the collection, storage, and usage of their personal information. Clear communication and transparency regarding data handling practices can help alleviate privacy concerns.

3. Legal Validity

   The legal validity of digital contracts is a significant consideration. While digital platforms offer convenience and efficiency, it is essential to ensure that digital insurance contracts comply with the legal requirements of electronic contracts and electronic signatures. Jurisdictions may have specific regulations governing electronic transactions, and insurers must adhere to these regulations to ensure the enforceability of digital contracts.

4. Customer Education

   As digitalization reshapes the insurance landscape, insurers should prioritize customer education and awareness regarding digital insurance contracts. Policyholders need to understand the implications of conducting insurance transactions online, including the rights, responsibilities, and potential risks associated with digital contracts. Clear communication, user-friendly interfaces, and accessible support channels can facilitate customer understanding and confidence in digital insurance processes.

4.5.3 EXAMPLES OF DIGITALIZATION IN INSURANCE CONTRACTS

1. Online Policy Purchase

   Customers can visit insurers' websites or mobile applications to explore various insurance products, compare prices, and purchase policies entirely online. The entire process, from obtaining quotes to policy issuance, can be completed digitally, offering convenience and accessibility to customers.

2. Smart Contract-enabled Claims

   Using smart contracts, insurers can automate claims processing and settlement. For example, in the event of a predefined triggering event, such as a flight delay, a smart contract can automatically initiate a claim payment to the policyholder without the need for manual intervention.

3. Blockchain-based Policy Management

   Blockchain technology allows for secure and transparent policy management. Policy details, endorsements, and claims history can be stored on a blockchain, ensuring the accuracy and integrity of the information. Policyholders and insurers can access and

In conclusion, the importance of the concept of a legally binding insurance contract cannot be overstated. It is the cornerstone of the insurance industry, providing a solid foundation for conducting business and instilling confidence in policyholders. By establishing a clear framework for the insurer-insured relationship, the insurance contract outlines the rights and responsibilities of each party involved. Moreover, as a legally enforceable agreement, it offers individuals and businesses the assurance that they will be protected against potential risks and losses. The insurance contract not only ensures the smooth functioning of the insurance industry but also provides individuals with the necessary coverage and peace of mind.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*What are the essentials for the formation of a valid contract?* *i. There must be an agreement by offer and acceptance.* *ii. There must be an intention to create legal relationships.* *iii. The parties must have capacity to contract.* *iv. The agreement must be in the form required by law.* *v. There must be consideration.*
A	a. I, II III and IV. b. II, III, IV and V. c. I and III. d. I, II, III, IV and V.

2	**Review Question**
Q	*What is the operative clause of an insurance policy?*
A	a. The clause that describes what the insured must do in the event of a claim. b. The clause that describes or refers to the cover provided by the insurers. c. The clause that describes the risks excluded from the policy cover. d. The operating clause that refers to the proposal, the parties and the premium.

3	**Review Question**
Q	*Which of the following does NOT make an insurance contract void?*
A	a. No insurable interest at the time of effecting the policy. b. No consensus or a fundamental mistake or disagreement from the start. c. Fraudulent misrepresentation or concealment at the pre-contractual stage. d. Innocent misrepresentation at the time of filling up the proposal form.

4	**Review Question**
Q	*A key characteristic for a contract to be considered legally binding is:*
A	a. Freedom to contract by all parties. b. Intention to create a legal relationship. c. Mutual agreement arising out of goodwill. d. Seal and stamp on the written document.

5	**Review Question**
Q	*The 'Operative Clause' of an insurance policy describes the:*
A	a. Insured's particulars. b. Scope of cover. c. Excluded perils. d. Policy conditions.

6	**Review Question**
Q	*What is a voidable contract?*
A	a. A breach of contract by one or both parties. b. A fundamental mistake rendering the contract void. c. A contract which is binding but either party has the right to set it aside. d. One party's legal incapacity to enter a contract.

7	**Review Question**
Q	*Which of the following is NOT normally found in the Schedule of a policy?*
A	a. Name and address of the insured. b. Period of insurance. c. Amount of premium. d. Exclusions.

8	**Review Question**
Q	*Which of the following best describes an unenforceable contract?*
A	a. Legally binding even if one party refuses to keep to the agreement. b. A valid contract but cannot be enforced in a court. c. A valid contract which is not illegal. d. A legal contract which is not binding.

9	**Review Question**
Q	*What is meant by "consideration" in relation to an insurance contract?*
A	a. Cover note in return for proposal for insurance. b. Premium payable in return for cover provided. c. Payment of claim in return for premium paid. d. A promise to pay the sum assured.

10	**Review Question**
Q	*Which rule of law governs contracts in Malaysia?*
A	a. Sale of Goods Act 1965. b. Financial Services Act 2013. c. Contracts Act 1950. d. Insurance Act 1996.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

5

CHAPTER 5 LAW OF AGENCY

In Malaysia's insurance market, there are several types of intermediaries that act as a link between insurance services providers and the customers.

The distribution of insurance products, in Malaysia, has been mainly dominated by *insurance agents*. Even though, with the advent of the internet, the channels through which customers can buy products and services have evolved, from conventional channels such as the agency force, brokers, and corporates, to *alternative distribution* channels such as bancassurance, affinity partnerships and telemarketing.

In this chapter 5, the legal relationship between the Insurer (insurance company) and the Agent (the intermediary).

5.1 LAW OF AGENCY

An agent is a person who has the authority or power to act on behalf of another person known as the 'principal'. Usually, the task of the agent is to bring about a contract between their principal and a third person who in insurance is referred to as a 'financial consumer'.

An insurance agent is defined by the Financial Services Act 2013 as a person who does all or any of the following:

1. "solicits or obtains a proposal for insurance on behalf of an insurer;
2. offers or assumes to act on behalf of an insurer in negotiating a policy; or
3. does any other act on behalf of an insurer in relation to the issuance, renewal or continuance of a policy".

According to the excerpt from FSA 2013 Schedule [Section 129] Para 12, the following can be understood regarding the knowledge and statements made by insurance agents:

- Agency Relationship

  When an insurance agent, authorized by a licensed insurer, solicits, or negotiates a contract of insurance, they are considered the agent of the insurer for the purpose of forming or varying the insurance contract. This means that the actions and knowledge of the insurance agent are attributed to the insurer.

- Imputed Knowledge

  "The knowledge of that insurance agent shall be deemed to be the knowledge of the insurer". This means the knowledge possessed by the insurance agent is considered the knowledge of the insurer. This implies that any information or awareness the agent has regarding the insurance contract is imputed to the insurer, and the insurer is deemed to have that knowledge.

- Statements and Acts

  Any statements made or acts performed by the insurance agent are treated as if they were made or done by the licensed insurer. This applies to the formation or variation of the insurance contract, regardless of any contravention by the insurance agent of any provisions of the Act.

- Exceptions

  There are two exceptions to the application of this section. It does not apply in cases where there is collusion or connivance between the insurance agent and the proposer in the formation or variation of the insurance contract. Additionally, if an individual ceases to be an insurance agent for a licensed insurer and the insurer has taken all reasonable steps to inform or make policy owners aware of this fact, this section does not apply.

The relationship between the principal and the agent may come about in three main ways:

1. Agency by Agreement (or Consent)

   An agency by agreement is a legal contract creating a fiduciary relationship whereby the first party ("the principal") agrees that the actions of a second party ("the agent") binds the principal to later agreements made by the agent as if the principal had himself personally made the later agreements. The power of the agent to bind the principal is usually legally referred to as authority. Agency created via an agreement may be a form of implied authority, such as when a person gives their credit card to a close relative, the cardholder may be required to pay for purchases made by the relative with their credit card.

2. Agency by Ratification

   An agency relationship is created retrospectively by ratification where the agent does not have actual authority. For example, confirmation by an insurance company of the acts of its agent, regardless of whether these acts were committed within the limit of authority granted the agent by the company. By so ratifying the agent's acts, the company becomes responsible for consequences arising from these acts.

3. Agency by Necessity

   Agency by necessity refers to a situation where an agent by necessity makes a critical decision on behalf of another party who is not in a condition to do so. For example, if Person A was severely injured in a car accident and was in a coma, Person B could make the decision to allow medical staff to operate on Person A. Under normal circumstances, Person A would have to give consent, but if he or she was unable to do so, an agent can make the decision instead.

In Malaysia, insurance agencies are created only through appointment by express agreement i.e., by execution of a written contract. The agency agreement will normally be embodied in a written contract and the agent must act in accordance with its terms. The terms of the agency including the authority and powers of the agent, the duties to be performed, the period of the agreement and the commission and other remuneration payable will be set out in detail.

Individuals interested in becoming insurance agents are typically required to undergo training and pass the relevant licensing examinations conducted by the Asian Institute of Insurance (Aii). These examinations assess the knowledge and competence of prospective agents in areas such as insurance principles, products, regulations, ethics, and sales practices.

The licensing examinations for insurance agents in Malaysia include the core Pre-Contract Examination for Insurance Agents (PCEIA) and Certificate Examination in Investment-Linked Life Insurance (CEILLI) for insurance agents to be licensed to sell Investment-Linked Insurance products. These examinations are designed to ensure that agents possess the necessary knowledge and understanding of the insurance industry to perform their roles effectively and ethically.

The PCEIA covers fundamental concepts of insurance, ethics, legal and regulatory frameworks, and agent responsibilities.

Passing these licensing examinations is a requirement for individuals who wish to become licensed insurance agents in Malaysia. The examinations aim to ensure that agents have a good understanding of insurance principles, regulations, and best practices to provide appropriate advice and services to customers.

It is important to keep in mind that the specific requirements and regulations for becoming an insurance agent and/or maintenance of contract (M.O.C.) in Malaysia may have evolved or been updated over time. It is the Agent's responsibility to be updated with the most accurate and up-to-date information. Agents are recommended to consult their respective Principals or relevant authorities or industry organizations involved in insurance agent licensing in Malaysia, such as the Asian Institute of Insurance (Aii) or the regulatory body Bank Negara Malaysia (BNM).

5.2 DUTIES OF AN INSURANCE AGENT TO THE PRINCIPAL

1. To obey the principal's instructions

   An agent must carry out all lawful instructions. Where an insurance intermediary has no instructions on a particular point, he may follow market usage where such practice is clear.

2. To exercise proper care and skill

   An agent owes a duty to his principal to exercise reasonable care and skill and may on occasion be found to have assumed a duty to third parties.

3. To perform duties personally

   An agent may not delegate duties to a 'sub-agent' and must perform his duties in person except for the delegation of routine clerical and administrative tasks to employees.

4. To act in good faith towards the principal

   An agent must act in good faith when dealing with the principal. He must not conceal any relevant information, must maintain confidentiality, not accept secret commissions, and always act in the principal's best interest and not for his own.

5. To pay sums received for the principal

   An agent is bound to render proper accounts to his principal on demand and to pay to his principal all sums received on his account.

   Several remedies are available to the principal if an agent fails in his duties. The principal may:

   (a) Sue the agent for damages for breach of contract.

   (b) Sue the agent in tort (for example, where the agent has refused to return the principal's property).

   (c) Dismiss the agent without Notice or Compensation (in the case of a serious breach)

(d) Rescind any contract made through the agent and refuse commissions (if the breach is fraudulent).

5.3 DUTIES OF THE PRINCIPAL TO AN INSURANCE AGENT

1. To pay the agreed remuneration

   The principal is responsible for paying the agreed remuneration or commission to the insurance agent for their services. The specific commission structure and rates for different lines of business are typically outlined in the agency agreement between the principal and the agent. The agent usually covers the expenses related to running the insurance agency using the commission received.

2. To indemnify the agent

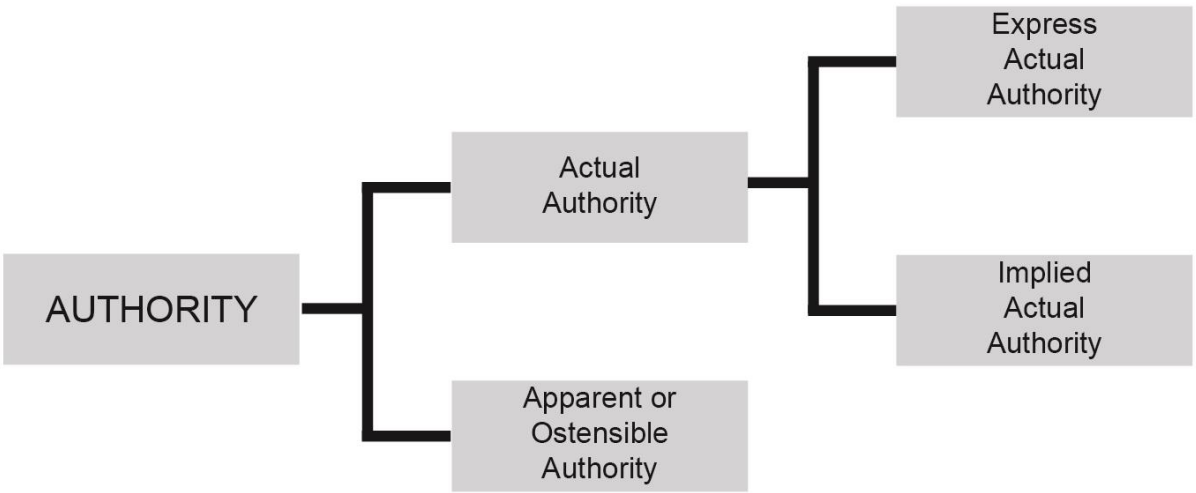
   The principal has a duty to indemnify the agent against any consequences arising from lawful acts performed by the agent within their authority on behalf of the principal. This means that if the agent acts within the scope of their authority and in accordance with the principal's instructions, the principal is obligated to protect the agent from any legal or financial repercussions that may arise as a result of those actions.

By fulfilling these duties, the principal ensures that the agent is compensated for their work and is protected from liabilities that may arise during the course of their authorized activities on behalf of the principal. This helps to maintain a mutually beneficial relationship between the principal and the insurance agent.

5.4 AUTHORITY OF AGENTS

There are two types of authority: actual authority and apparent authority, illustrated below:

FIGURE 5-1 ***Authority of Agents***



5.4.1 ACTUAL AUTHORITY

Actual authority is real in the sense that the agents have been given the right or power to act on behalf of the principal either expressly or by implication. There are two types of actual authority: express actual authority and implied actual authority.

- *Express actual authority* arises from the instructions which have been given to the agent, stating what is required and what is allowed. These instructions form part of the agency agreement and may be oral or in writing. If the instructions are ambiguous, the agent should seek clarification from the principal.

- *Implied actual authority* is an authority inferred from the express actual authority which is incidental to, or necessary for the carrying out of the express instructions given to the agents. An agent may also have implied authority to perform those acts which are usually performed by persons in the agent's position or usual in a particular trade or profession that is in line with the express actual authority. This is also known as usual authority (or customary authority).

5.4.2 APPARENT (OR OSTENSIBLE) AUTHORITY

This arises where the agent has no real authority to do the act in question. However, it appears in the eyes of the third party that they have such authority and, therefore, can bind their principal.

A principal is bound not only by acts which are within the actual authority of the agent but also by acts which are within the authority they appear to have. The principal can be held liable on the grounds of apparent/ostensible authority even if the agent acted fraudulently and for his own benefit.

Apparent/ostensible authority arises only when the principal gives the agent the appearance of authority. The principal must make some representation, by word or conduct, to the third party that the 'agent' is entitled to act on their behalf and the third party must rely upon the representation.

Apparent authority can arise in cases where:

- the principal has restricted the authority of a validly appointed agent which was unknown to the third party;

- the apparent agent has never been appointed at all but appear to be the principal's agent in the eyes of the third party; and

- unknown to the third party, the authority of the agent has been terminated.

Table 5-1 *Type of Authority*

Type of Authority	Description	Life Insurance Industry Example
Actual Authority	Authority explicitly granted to an agent by the principal, either in writing or verbally.	An insurance company provides a written agreement to an agent, including all written instructions issued from time to time by the insurance company, outlining their responsibilities and authority to sell life insurance policies.
Express Actual Authority	Actual authority specifically and explicitly stated by the principal.	An insurance company sends an email to an agent granting them permission to offer promotional discounts on life insurance policies for a limited time.
Implied Actual Authority	Authority that is not explicitly stated but is usually implied from the express actual authority given to the agent and considered necessary for the agent to carry out their express actual authority.	An agent is authorized to sell life insurance policies and, by implication, can also provide potential clients with quotes and policy information.
Apparent (or Ostensible) Authority	Authority that occurs when the principal's actions lead to a third party to reasonably believe that the agent has authority, even if the agent lacks actual authority.	An insurance company's promotional materials feature an agent who no longer has actual authority. A client purchases a policy, reasonably believing the agent represents the company. The company may be held responsible for honouring the policy due to the agent's apparent authority.

5.5 INSURANCE CONTRACTS FORMED THROUGH AN AGENT

When agents are appointed to facilitate contracts with third parties, the outcome of their actions is influenced by whether the principal's identity is revealed or undisclosed. For instance, if a person is authorized by a licensed insurer to act as its insurance agent and engages in activities such as soliciting or negotiating an insurance contract on behalf of the insurer, they are considered to be the insurer's agent. In this case, any information or knowledge possessed by the insurance agent is considered to be equivalent to the insurer's knowledge. This understanding is significant when it comes to establishing or modifying the terms of the insurance contract.

5.6 TERMINATION OF AGENCY

The principal and agent relationship may be terminated by act of the parties or by operation of law as follows:

- by notice of revocation given by the principal to the agent;
- by notice of renunciation given to the principal by the agent;
- by the completion of the transaction where the authority was given for that transaction only;
- by expiration of the period stipulated in the contract of agency;
- by mutual agreement;

- generally, by death, lunacy or bankruptcy of the principal or the agent; or
- by operation of any law which renders the contract of an agent illegal.

5.7 LIST OF PROHIBITED BUSINESS CONDUCT

Schedule 7 of the Financial Services Act 2013 comprising the list of prohibited business conduct would apply equally to insurers and insurance intermediaries including agents as follows:

1. Engaging in conduct that is misleading or deceptive, or is likely to mislead or deceive in relation to the nature, features, terms or price of any financial service or product.

2. Inducing or attempting to induce a financial consumer to do an act or omit to do an act in relation to any financial service or product by:

    - making a statement, illustration, promise, forecast or comparison which is misleading, false, or deceptive;
    - dishonestly concealing, omitting, or providing material facts in a manner which is ambiguous; or
    - recklessly making any statement, illustration, promise, forecast or comparison which is misleading, false, or deceptive.

3. Exerting undue pressure, influence or using or threatening to use harassment, coercion, or physical force in relation to the provision of any financial service or product to a financial consumer, or the payment for any financial service or product by a financial consumer.

4. Demanding payments from a financial consumer in any manner for unsolicited financial services or products including threatening to bring legal proceedings unless the financial consumer has communicated his acceptance of the offer for such financial services or products either orally or in writing.

5. Exerting undue pressure on, or coercing a financial consumer to acquire any financial service or product as a condition for acquiring another financial service or product.

6. Colluding with any other person to fix or control the features or terms of any financial service or product to the detriment of any financial consumer except for any tariff or premium rates or policy terms which have been approved by the Bank.

In conclusion, the purpose of this chapter is to establish clear guidelines and standards for businesses operating in the financial sector, ensuring that they conduct their operations in an ethical and responsible manner. By explicitly outlining prohibited behaviors, the chapter seeks to protect consumers from misleading, deceptive, or coercive practices that could harm their financial well-being.

The regulations outlined in this chapter serve multiple purposes:

- Protecting Consumers

  The primary aim is to safeguard the interests of financial consumers by preventing businesses from engaging in conduct that misleads, deceives, or exerts undue pressure on individuals. These regulations help ensure that consumers have access to accurate and transparent information about financial services and products.

- Promoting Fairness

  By prohibiting collusive practices and controlling the terms and features of financial services or products to the detriment of consumers, these regulations strive to maintain a level playing field in the industry. This promotes healthy competition and prevents unfair advantages for specific market participants.

- Fostering Trust

  Establishing a framework of prohibited business conduct fosters trust between financial service providers and consumers. When consumers feel protected and confident in their financial dealings, it enhances the overall integrity of the financial system.

- Regulatory Compliance

  The chapter provides a clear reference point for businesses to ensure they are compliant with the regulations governing their operations. By adhering to the prescribed standards, businesses can mitigate legal risks and maintain their reputation as responsible financial service providers.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*Which of the following is NOT true about the role of an insurance agent?*
A	a. Responsible for the sales of insurance products and services. b. Considered to be the agent of the insurer and bound to the insurer he represents. c. Represents many insurers and shops for an insured. d. Assists the insured in submitting covered claims for payment.

2	**Review Question**
Q	*Under which circumstances can the agency be terminated?* *i. By the completion of the transaction where the authority was given for that transaction only.* *ii. By expiration of the period stipulated in the contract of agency.* *iii. By mutual agreement.* *iv. By death, lunacy or bankruptcy of the principal or the agent.* *v. By operation of any law which renders the contract of an agent illegal.*
A	a. I, II and III. b. II, IV and V. c. II, III and IV. d. All the above.

3	**Review Question**
Q	*Under what circumstances, if any, can an agent delegate a task to someone else?*
A	a. Under no circumstances. An agent must always perform his duties and tasks personally. b. Where the agent has the status of a del credere agent. c. Where the work delegated is purely clerical. d. Where the sub-agent has himself acted as an agent for the principal in a previous transaction.

4	**Review Question**
Q	*How is the relationship between an insurer and an agent created in Malaysia?* *i. By agreement or consent* *ii. By ratification* *iii. By necessity*
A	a. I only. b. I and II. c. II and III . d. All of the above.

5	**Review Question**
Q	*Which of the following statements describes an agent's right to indemnity?*
A	a. If an agent does what is asked of him under the agreement, he has the right to be paid for his services. b. If an agent arranges an insurance contract on behalf of his principal, both agent and prin- cipal are entitled to indemnity under the contract. c. If an agent expends money in the course of his duties, he is entitled to be reimbursed by his principal. d. If an agent commits the principal to expenditure under the contract, the agent is liable if the principal fails to pay.

6	**Review Question**
Q	*Which of the following are prohibited business conducts?* *i. Engaging in conduct that is misleading or deceptive.* *ii. Exert undue pressure or coerce a financial consumer to buy a product.* *iii. Disclose confidential information obtained in the course of his duties as an agent to parties other than his principal.* *iv. Demand payments from a financial consumer in any manner for unsolicited financial services or products.*
A	a. I and II. b. I, II and IV. c. III and IV. d. All of the above.

7	**Review Question**
Q	*In which of the situations stated below is the agent working for the insurer and NOT the customer?*
A	a. Agent seeks a quotation for an insurance policy. b. Agent relays the price quoted by underwriters to the customer. c. Agent confirms to the underwriter that the quotation has been accepted. d. Agent collects the premium from the customer and passes it on to the insurer.

8	**Review Question**
Q	*Which of the following statements is NOT true about actual authority?*
A	a. Actual authority may be express or implied. b. Express actual authority may be oral or in writing. c. Authority that may appear to be apparent. d. Implied actual authority is also termed usual authority or customary authority.

9	**Review Question**
Q	*An insurance agent is a person who does any of the following EXCEPT*
A	a. act on behalf of an insurer in the issuance, renewal, or continuance of a policy. b. arrange an insurance contract on behalf of his principal. c. delegate his duties to a sub-agent. d. act on behalf of an insurer in negotiating policy terms.

10	**Review Question**
Q	*Which of the following is NOT a valid remedy for a principal if the agent fails in his duties?*
A	a. Sue the agent for damages for breach of contract. b. Terminate the insurance policies sold by the agent. c. Dismiss the agent without notice or compensation for a serious breach. d. Rescind any contract made through the agent and refuse commissions if the breach is fraudulent.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

6

CHAPTER 6 MEDICAL AND HEALTH INSURANCE / TAKAFUL PRODUCTS (MHIT)

6.1 INTRODUCTION

Medical and Health Insurance/Takaful (MHIT) is an important financial tool that provides protection against medical expenses. In Malaysia, the MHIT industry has grown significantly over the years due to increasing demand for quality healthcare services and awareness of MHIT cover as a risk mitigation tool.

Since 2006, the MHIT business has grown five-fold based on the total premiums and takaful contributions of MHIT policies/certificates underwritten by licensed insurers and takaful operators (licensed ITOs). During the same period, a number of significant developments have also influenced the MHIT business such as the rise in non-communicable diseases, growth of private healthcare services and escalating medical inflation. These have contributed towards an increase in the utilisation of medical services and magnitude of claims, where the MHIT claims had grown by 11.6% on average annually between 2006-2021.

There has also been increased expectations for MHIT business to provide more comprehensive and inclusive coverage, as well as account for latest development in medical technologies and supporting preventive care. These developments have placed increased focus on licensed ITOs to continuously innovate to meet evolving consumers' needs while balancing the need to ensure that the MHIT business remains sustainable in the long term. This is important to promote continued access to healthcare services while ensuring that financial support is available via MHIT products when it is needed

6.1.1 CHALLENGES AND INNOVATIONS IN THE MALAYSIAN MEDICAL AND HEALTH INSURANCE/TAKAFUL INDUSTRY

However, the MHIT industry faces several challenges, including rising non-communicable diseases, growth of private healthcare services, and escalating medical inflation, which have contributed to an increase in the utilization of medical services and magnitude of claims. To address these challenges, licensed insurers and takaful operators (licensed ITOs) must continuously innovate to meet evolving consumer needs while ensuring that the MHIT business remains sustainable in the long term.

The MHIT industry in Malaysia is regulated by the Bank Negara Malaysia and the Ministry of Health. Licensed ITOs are required to adhere to guidelines and regulations, to protect the interests of policy owners/takaful participants.

The term "MHIT policy/takaful certificate" refers to a type of insurance or takaful policy that provides coverage for medical, surgical, or hospital expenses resulting from illness, diseases, or infirmity. This coverage may take the form of reimbursement for medical expenses, a lump sum payment of the sum insured/participated, or regular allowances or income streams for a specified period while the policy owner/takaful participant is incapacitated and/or hospitalized.

6.1.2 ENHANCING MEDICAL AND HEALTH INSURANCE (MHI) IN MALAYSIA: GUIDELINES AND CONSUMER BENEFITS

The development of Medical and Health Insurance (MHI) in Malaysia has been guided by specific guidelines that were first issued in 24 December 1998. These guidelines underwent a revision process, and the revised guidelines came into effect on January 1, 2006. The purpose of these guidelines is to establish minimum standards for insurers operating in the MHI business, ensuring that policyholders are provided with improved benefits and adequate protection.

One significant aspect of the development of MHI in Malaysia is the requirement for insurers to revise their existing MHI products to align with the revised guidelines. This revision process aimed to enhance the terms of issue, premium setting, limitations on core benefits, and disclosures to policyholders. Insurers were given a deadline until the end of 2005 to make the necessary adjustments, promoting consistency and fairness in the industry.

The revised guidelines introduced several key improvements to benefit consumers. These improvements include reduced additional waiting periods from 12 months to 120 days before policyholders can claim benefits, allowing them to access necessary medical services more quickly. Additionally, a minimum 15-day "free-look" period was introduced, enabling consumers to evaluate the suitability of newly purchased policies and make informed decisions.

To enhance clarity and comparability, the revised guidelines standardized important policy terms and conditions through the adoption of more consistent definitions. This reduced ambiguity and facilitated easier comparisons between different MHI products. The guidelines also imposed limitations on the co-payment terms, ensuring that policyholders are not burdened excessively with medical claim expenses.

Clear and plain disclosures on key policy features became a requirement at the point of sale. This development aimed to ensure that consumers have a comprehensive understanding of the coverage provided by their chosen MHI policies.

Furthermore, the revised guidelines emphasized the importance of fair treatment for higher risk individuals. Insurers were required to moderate any premium increases or surcharges imposed on such individuals based on portfolio experience. This measure aimed to provide added protection and affordability for individuals with higher health risks.

Importantly, the revised guidelines prohibited insurers from refusing to renew an MHI policy solely based on previous claims made by policyholders. This safeguarded the rights of policyholders while allowing insurers to consider other relevant underwriting factors in their decision-making process.

Overall, the development of MHI in Malaysia has focused on improving consumer protection, enhancing benefits, and promoting fair practices within the industry. The guidelines serve as a framework to ensure that insurers adhere to minimum standards, providing policyholders with reliable and comprehensive medical and health coverage.

The Bank's Financial Sector Blueprint 2022-2026 issued on 24 January 2022, to promote the following: (https://www.bnm.gov.my/publications/fsb3)

a. Ensure that consumers can access a wider choice of MHIT products that cater to different healthcare needs and within respective consumers' reasonable means;

b. Facilitate consumers' decision-making process when purchasing MHIT products and promote enhanced understanding of MHIT products;

c. Protect policy owners'/takaful participants' interests;

d. Preserve the continuity and sustainability of the MHIT business through sound underwriting and pricing policies; and

e. Facilitate greater data sharing to support better cost control management and pave way towards greater transparency

In summary, MHIT remains an important component of health financing in Malaysia, providing consumers with financial protection against medical expenses. However, to ensure the sustainability of the MHIT industry, licensed ITOs must continuously innovate to meet evolving consumer needs while balancing the need for sound underwriting and pricing policies.

6.2 TYPES OF MEDICAL AND HEALTH INSURANCE/TAKAFUL BUSINESS (MHIT) PRODUCTS

(Source extracted from BNM/RH/ED 029-29 Medical and Health Insurance/Takaful Business Exposure Drafts Issued on: 30 December 2022)

MHIT policy/takaful certificate is a type of insurance/takaful policy that provides coverage for medical expenses, surgeries, hospitalizations, or illness-related expenses incurred by the policy owner/takaful participant due to sickness, infirmity, or diseases. The benefits may be in the form of reimbursement of medical expenses, lump sum payment of the sum insured/participated, or a regular allowance or income stream for a specific period during which the policy owner/takaful participant is incapacitated or hospitalized.

MHIT products refer to insurance or takaful products falling within the definition of MHIT policy/takaful certificate, including, but not limited to the following:

Table 6-1 ***MHIT Products***

	MHIT Product	Definition
1.	Medical reimbursement insurance/takaful product	Provides coverage for medical expenses incurred due to illness or injury. This coverage can include hospitalization expenses, surgical expenses, diagnostic tests, and medication expenses.
2.	Critical illness or dread disease insurance/takaful product	Provides a lump sum payment upon diagnosis of a critical illness or dread disease, such as cancer, heart attack, or stroke. This payment can be used to cover medical expenses, lost income, or other financial needs.
3.	Long-term care insurance/takaful product	Provides coverage for long-term care expenses, such as nursing home care or home health care, for individuals who are unable to perform basic daily activities due to a chronic illness or disability.
4.	Hospital income insurance/takaful product	Provides a daily cash benefit for each day that the policyholder is hospitalized due to an illness or injury. This benefit is paid in addition to any other insurance or takaful benefits received.
5.	Dental insurance/takaful product	Provides coverage for dental care expenses, such as routine cleanings, fillings, and extractions. Coverage can also include more extensive procedures, such as root canals or orthodontics.

Source: Guidelines on Medical and Health Insurance Business (Revised) issued on 26 August 2005 & description as per BNM MHIT Exposure Draft dated 30 December 2022

Each MHIT product offered by different ITOs will have different coverage, benefits, exclusions, and limitations. It is important for the buyers to read and understand the terms and conditions of the product before purchasing, to ensure that the product meets their healthcare needs

6.2.1 MEDICAL REIMBURSEMENT INSURANCE/TAKAFUL PRODUCT

Features and terminologies that are commonly seen under a medical reimbursement insurance/takaful product:

a. Coverage

(i) Basic Coverage

- Hospital accommodation & nursing expenses
- Intensive Care Unit (ICU)
- Hospital Supplies & Services
- Surgical Fees (Surgeon's fees & cost associated with surgery)
- Operating Theatre
- Anaesthetist Fees
- In-Hospital Physician Visit
- In-patient tests
- Pre-Hospital Diagnostic Tests
- Pre-Hospital Specialist Consultation, Treatment, and Prescribed Medicines
- Post-Hospitalisation Treatment

(ii) Other Possible Benefits

- Organ Transplant
- Ambulance Fees
- Day Surgery
- Post-Hospitalisation Home Nursing Care
- Outpatient Cancer Treatment
- Outpatient Kidney Dialysis Treatment
- Outpatient Treatment for Specific Diseases (e.g., Dengue Fever and Zika Virus)
- Emergency Accidental Outpatient Treatment
- Outpatient Imaging (MRI/PET)

(iii) Sometimes Covers

- Overseas cover
- Accidental death benefit

b. Annual Limit

As medical costs continue to rise, insurance companies in Malaysia have adapted their offerings to provide higher annual limits for medical card policies. Nowadays, it is common to see annual limit of RM1,000,000 or even higher, depending on the plan and the ITOs. These higher limits aim to provide better coverage and financial protection for policy owners / takaful participants in case of serious illnesses or accidents that require extensive medical treatment.

c. Lifetime Limit

In recent years, many insurance companies in Malaysia have started offering medical cards with no lifetime limit. This change is in response to the increasing medical costs and the demand for more comprehensive coverage.

With no lifetime limit, policy owners / takaful participants can have peace of mind knowing their insurance coverage will not run out, no matter how much they have claimed over their lifetime. This feature is especially valuable for those with chronic conditions or who require long-term medical care.

d. Exclusion

Some commonly seen exclusions:

- Maternity
- Congenital abnormalities
- Accidental Injuries or illnesses arising from racing
- Cosmetic or Plastic Surgery
- Dental work or treatment including oral surgery
- Pre-existing conditions – Conditions and illnesses experienced by you prior to applying for the policy. These conditions and illnesses would be excluded from coverage by your insurance company.

In addition to the exclusions listed above, each product may have some other exclusion clauses that are added in view of the added benefits within the product.

e. Reimbursement Features

It is important to provide a comprehensive comparison of various reimbursement methods in medical insurance. Understanding the differences between these methods, such as full reimbursement, co-payment/co-insurance, and deductible, can help clients make informed decisions when selecting a medical card that suits their needs. The following table presents an overview of each reimbursement method, including their pros and cons, along with examples to illustrate their application.

(i) Full Reimbursement

With full reimbursement, the insurance provider covers the entire cost of eligible medical expenses. This means that the policyholder does not have to pay anything out of pocket for the covered services. It provides comprehensive coverage and offers financial peace of mind, but the premium for such coverage is typically higher.

(ii) Co-payment/Co-insurance

Co-payment (commonly referred to as "co-pay") or co-insurance requires the policyholder to share a portion of the medical expenses with the insurance provider. It involves paying a fixed amount or a percentage of the cost for each visit or service, while the insurance covers the remaining portion. Co-payment or co-insurance plans often have lower premiums but require individuals to pay a predictable portion of the expenses.

(iii) Deductible

A deductible is an amount that the policyholder must pay out of pocket before the insurance coverage kicks in. Once the deductible is met, the insurance company begins to cover the eligible expenses. Typically, higher deductibles are associated with lower premiums. Deductibles are commonly used in policies such as auto insurance and health insurance.

Table 6-2 ***Examples of Deductibles***

	MHIT Product	Definition
1.	Full Reimbursement	Medical expenses: RM5,000 Insurance covers: RM5,000 Out-of-pocket cost: RM0
2.	Co-payment / Co-insurance	Medical expenses: RM5,000 Co-payment (20%): RM1,000 Insurance covers: RM4,000 Out-of-pocket cost: RM1,000
3.	Deductible	Medical expenses: RM5,000 Deductible: RM2,000 Insurance covers: RM3,000 Out-of-pocket cost: RM2,000

f. Waiting Period

The imposition of Waiting Period clause in an insurance policy serves several purposes:

- Protection against adverse selection

  It helps insurance companies manage the risk of covering individuals who may knowingly apply for insurance coverage while already suffering from a pre-existing condition. By imposing the Specified Illnesses clause, the insurer reduces the likelihood of paying out claims for these conditions immediately after the policy is purchased.

- Encouragement of early insurance purchase

  The Specified Illnesses clause incentivizes individuals to buy insurance coverage early on, when they are still healthy, rather than waiting until they develop a medical condition that might require immediate attention.

- Cost management

  Insurance companies need to balance the premiums they collect against the claims they pay out. By limiting coverage for specified illnesses during the initial first 120 days, insurers can better manage their costs and offer more affordable premiums to all policyholders.

- Maintaining sustainability

  Imposing waiting periods for specified illnesses helps insurance companies maintain the long-term sustainability of their products. This ensures that they can continue to offer coverage to existing policyholders and attract new customers.

(i) General Waiting Period

A waiting period in the context of a MHIT policy refers to a specific period during which the policy owners / takaful participants are not eligible for certain benefits or coverage after obtaining the policy. This waiting period for medical reimbursement insurance is typically *30 days*.

After this 30-day period, the insurance company will pay for eligible medical expenses subject to certain conditions. Specifically, the life assured must be receiving medically necessary services or treatments due to illness or injury, which was diagnosed after the waiting period or occurred after the risk effective date.

However, the insurance company will not pay for medical expenses related to a condition that existed or was diagnosed during the waiting period, or for any sign or symptom that would prompt a reasonable person to seek medical care or attention before or during the waiting period.

It is essential to clarify that the waiting period does not apply to injuries resulting from accidents.

(ii) Additional waiting period: Specified Illnesses Clause during the first 120 days

Specified Illnesses refer to certain medical conditions and their related complications that are not covered by an insurance policy during the first 120 days from the Risk Effective Date. If there is a break in coverage prior to the expiry of the 120 days, a fresh period of 120 days will apply again from the date of reinstatement.

The conditions considered as "Specified Illnesses" include:

- Hypertension, diabetes mellitus, and cardiovascular disease;
- All tumors, cancers, cysts, nodules, polyps;
- Stones of the urinary system and biliary system;
- All ear, nose (including sinuses), and throat conditions;
- Hernias, haemorrhoids, fistulae, hydrocele, varicocele;
- Diseases of the reproductive system, including endometriosis;
- Vertebro-spinal disorders (including disc) and knee conditions.

g. Pre-existing Illness

Pre-existing illness refers to any disabilities or medical conditions which have existed prior to the effective date of the policy, that the policy owner / takaful participants are reasonably aware of.

A policy owner/takaful participant may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:-

- the policy owner/takaful participant had received or is receiving treatment;
- medical advice, diagnosis, care, or treatment has been recommended;
- clear and distinct symptoms are or were evident; or
- its existence would have been apparent to a reasonable person in the circumstances

h. Reasonable and Customary Charges

The amount that a health plan deems reasonable for medical services or procedures. This term considers the cost of medical care in a particular geographic area, as well as other factors such as the complexity of the procedure and the experience of the provider.

This is to ensure that insurance companies do not overpay for services or procedures while ensuring that the healthcare provider receives fair compensation. The charges should be in accordance with accepted medical standards and practices that could not have been omitted without adversely affecting the Life Assured's medical condition.

i. Cost Containment Measures

These measures aim to manage claims costs, prevent abuse and fraud, and ensure the sustainability of the insurance industry. Some examples of cost containment measures:

- Inner Limit

  Insurance policies often have an inner limit and schedule of surgical procedures. These terms define the maximum amount payable for certain surgical procedures or categories of surgeries. The inner limit may vary based on the complexity and nature of the surgery.

  The inner limit refers to the predetermined amount set by the insurance provider for a particular surgery. It acts as a cap on the coverage provided for that specific procedure. If the actual charges for the surgery exceed the inner limit, the policy owner/takaful participant may be responsible for paying the difference.

- Schedule of Surgical Procedure

  On the other hand, the schedule of surgical procedures outlines a list of surgeries and their corresponding coverage limits. It provides clarity on the maximum coverage available for each procedure. The inner limits and schedules help manage costs and provide clarity on the extent of coverage for different surgeries.

- Maximum Period of Compensation

  Policies may impose a maximum period during which compensation is provided for certain benefits. This limitation helps contain costs and ensures that coverage is provided for a reasonable duration.

- Time Frame

  Policies may set time frames within which certain benefits are eligible for reimbursement. This allows for better management of claims costs and prevents excessive or unnecessary claims.

j. Continuity of Coverage

(i) Yearly Renewable MHIT Policy/Takaful Certificate

Refers to a MHIT policy/takaful certificate whereby renewability upon policy/takaful certificate expiry is at the option of a licensed ITO.

MHIT Policy owners/takaful participants have the option to renew their coverage upon the expiry of the current term subject to renewal notification:

- If there are modified terms and conditions for renewal, the licensed ITO will inform the policy owner/takaful participant about these changes and provide reasons for the modifications.
- If the licensed ITO decides not to renew the coverage or chooses to defer or terminate the renewal, they will notify the policy owner/takaful participant in writing, including the appropriate reasons for the decision.

(ii) Guaranteed Yearly Renewable MHIT Policy/Takaful Certificate

Refers to a MHIT policy/takaful certificate whereby the renewability of the policy/takaful certificate on its anniversary is at the option of the policy owner/takaful participant and is non-cancellable by the licensed ITO, subject to below conditions.

The licensed ITO cannot terminate or refuse renewal of a Guaranteed Renewable MHIT Policy/Takaful Certificate unless specific renewal conditions are met. These conditions for renewal include:

- The policy owner/takaful participant commits fraud or misrepresents material facts during the application process.
- Any premium/takaful contribution remains unpaid beyond the stipulated grace period.
- The MHIT Policy/Takaful Certificate expires, lapses, is cancelled, surrendered, or converted to an extended-term insurance/takaful product.
- Total claims under the MHIT Policy/Takaful Certificate reach the specified lifetime limit and/or in the event of the policy owner/takaful participant's death.
- The policy owner/takaful participant no longer qualifies as a dependent based on the policy/certificate's definition or exceeds the specified coverage age limit.

k. Cashless Admission Facility

Cashless admission facility in Malaysia refers to a convenient service provided by some health insurance providers or health maintenance organizations (HMOs) that allows policy owners/takaful participants to receive medical treatment at participating hospitals or clinics without having to pay upfront.

With cashless admission, policy owners/takaful participants can present their health insurance or HMO card at the network hospital or clinic, and the medical expenses will be directly settled between the insurance provider and the healthcare facility. This eliminates the need for Policy owners/takaful participants to pay out-of-pocket and then seek reimbursement from the insurance company.

Cashless admission offers several benefits, including:

- Convenience

  Policy owners/takaful participants can access medical services without the need for immediate payment, making the process smoother and less financially burdensome.

- Financial Flexibility

  By eliminating upfront payments, policy owners/takaful participants can better manage their cash flow and avoid unexpected out-of-pocket expenses.

- Streamlined Processes

  Cashless admission reduces paperwork and administrative procedures, simplifying the billing and reimbursement process for both the policy owners/takaful participants and the healthcare provider.

IMPORTANT NOTE:

Cashless admission is typically available only at network hospitals or clinics that have an agreement with the insurance provider or HMO. Policy owners/takaful participants should familiarize themselves with the list of participating healthcare providers to ensure they receive cashless benefits.

l. Re-pricing and risk pooling practices

Re-pricing and risk pooling practices play a vital role in the management of Medical and Health Insurance/Takaful (MHIT) products in Malaysia, regulated by Bank Negara Malaysia (BNM). While the new MHIT guideline is in the form of an Exposure Draft and yet to be in effect, BNM has communicated important specifications on MHIT repricing and risk pooling through letters to the industry. Although these letters may not be considered official guidelines, they provide valuable guidance from the regulatory authority.

Insurers and Takaful Operators (ITOs) are required to develop internal policies and procedures for the re-pricing of medical reimbursement insurance/takaful products. The primary objective of the re-pricing exercise is to strike a balance between ensuring equity among different groups of policyholders/takaful participants and leveraging the benefits of risk pooling. The process must be consistent with sound actuarial principles and comply with regulatory requirements.

ITOs are also responsible for effectively communicating any price adjustments to policyholders or takaful participants, ensuring transparency and providing them with options to manage the impact of price increases, such as switching to other plans. This helps to maintain customer satisfaction and ensure fair treatment.

The need for re-pricing in the MHIT market is driven by various factors, including rising medical costs, an increasing incidence of chronic diseases, an ageing population, and advancements in medical treatments. These factors necessitate periodic evaluation and adjustment of premiums to ensure the sustainability of the insurance/takaful portfolio.

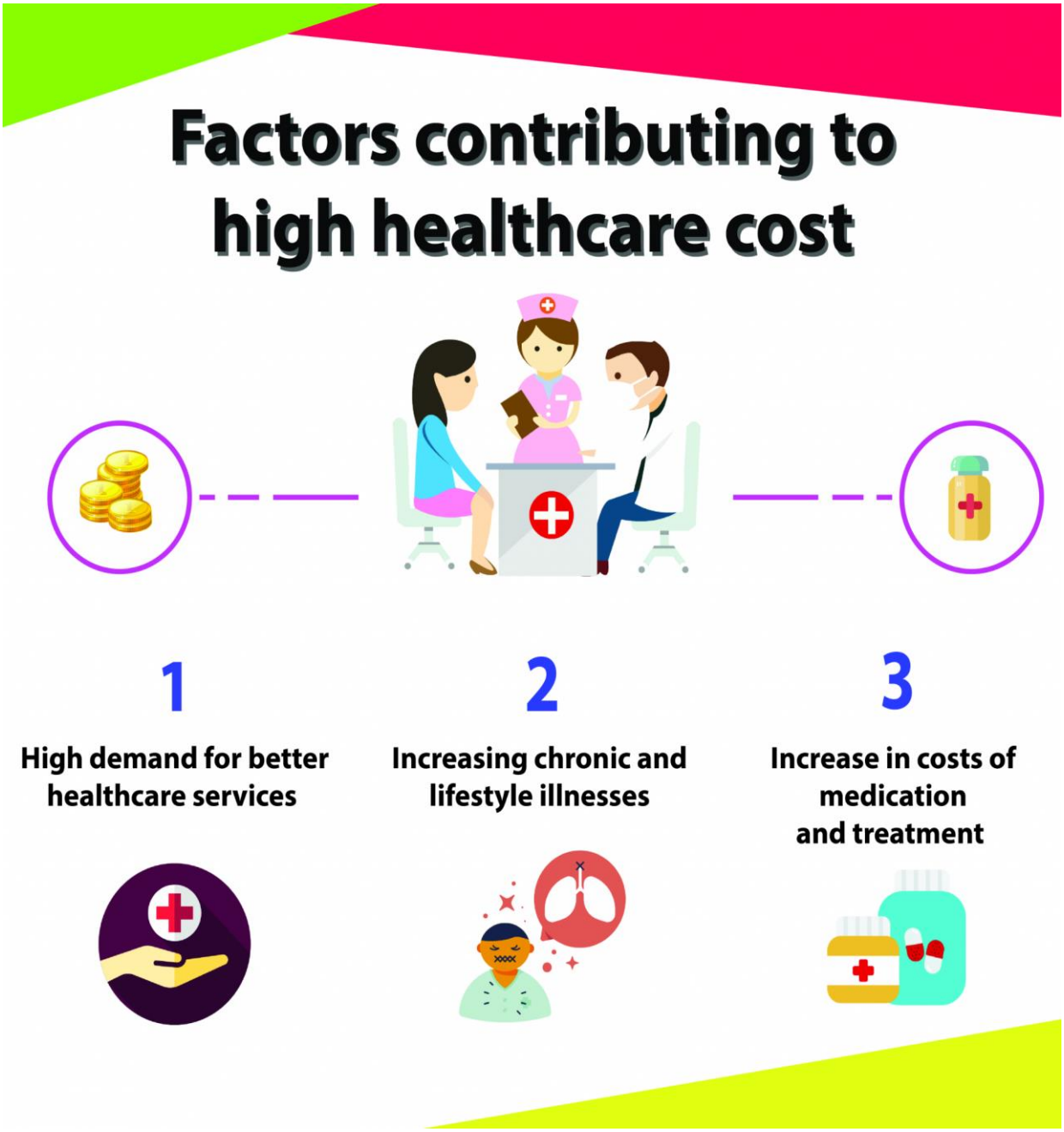
In addition to re-pricing, risk pooling is a crucial aspect of MHIT management. It involves pooling the risks and claims experience of a group of policyholders/takaful participants, allowing for more efficient risk management and fair distribution of costs. Risk pooling helps to mitigate the financial impact of high claims for individuals and promotes stability in the MHIT market.

Overall, the implementation of sound re-pricing and risk pooling practices in the MHIT sector aligns with BNM's objectives of promoting fair and sustainable insurance/takaful practices.

m. Medical Inflation

Medical Inflation refers to the year-on-year increase in the average treatment cost as billed by the hospitals for surgical treatments and/or non-surgical treatments covered under the insured's/covered person's medical reimbursement insurance/takaful product figure.

FIGURE 6-1 ***Medical Inflation***


Factors contributing to high healthcare cost
1
High demand for better healthcare services
2
Increasing chronic and lifestyle illnesses
3
Increase in costs of medication and treatment

What can policy/certificate holders do to help reduce medical inflation cost?

#01

Compare expected costs between hospitals for non-emergency admissions or elective surgeries.

#02

Understand the necessity of all recommended procedures and tests; and avoid paying for any tests or treatments that are deemed unnecessary.

#03

Insist on getting an itemised bill when you are discharged from the hospital. Verify the bill and ask questions if you feel some of the charges seem high.

#04

Ask your doctor if the recommended procedure can be done as an outpatient or day surgery which would reduce your bill.

#05

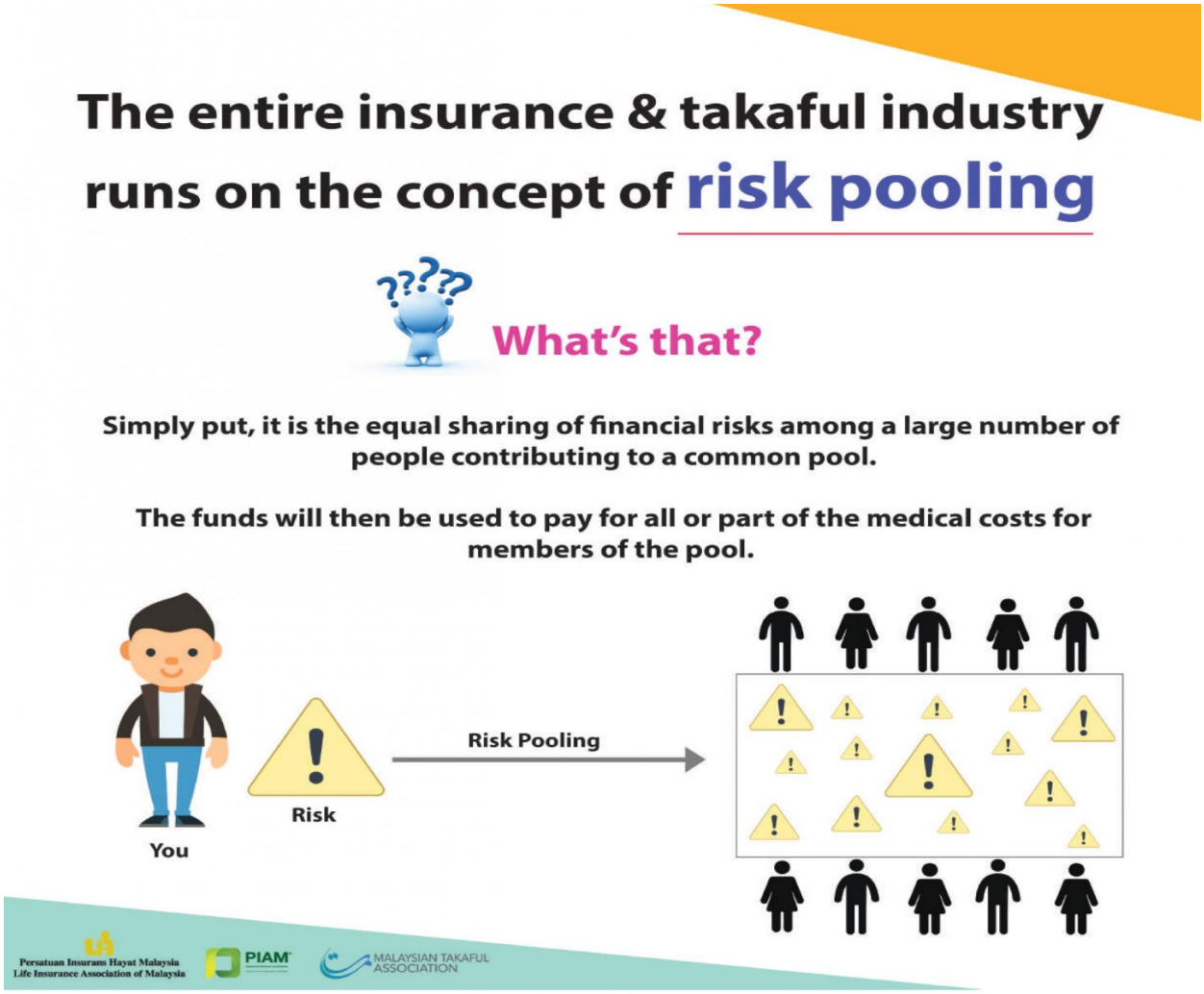
Stay within your purchased Plan Room & Board entitlement to avoid any co-insurance/co-takaful imposed on staying above the entitlement.

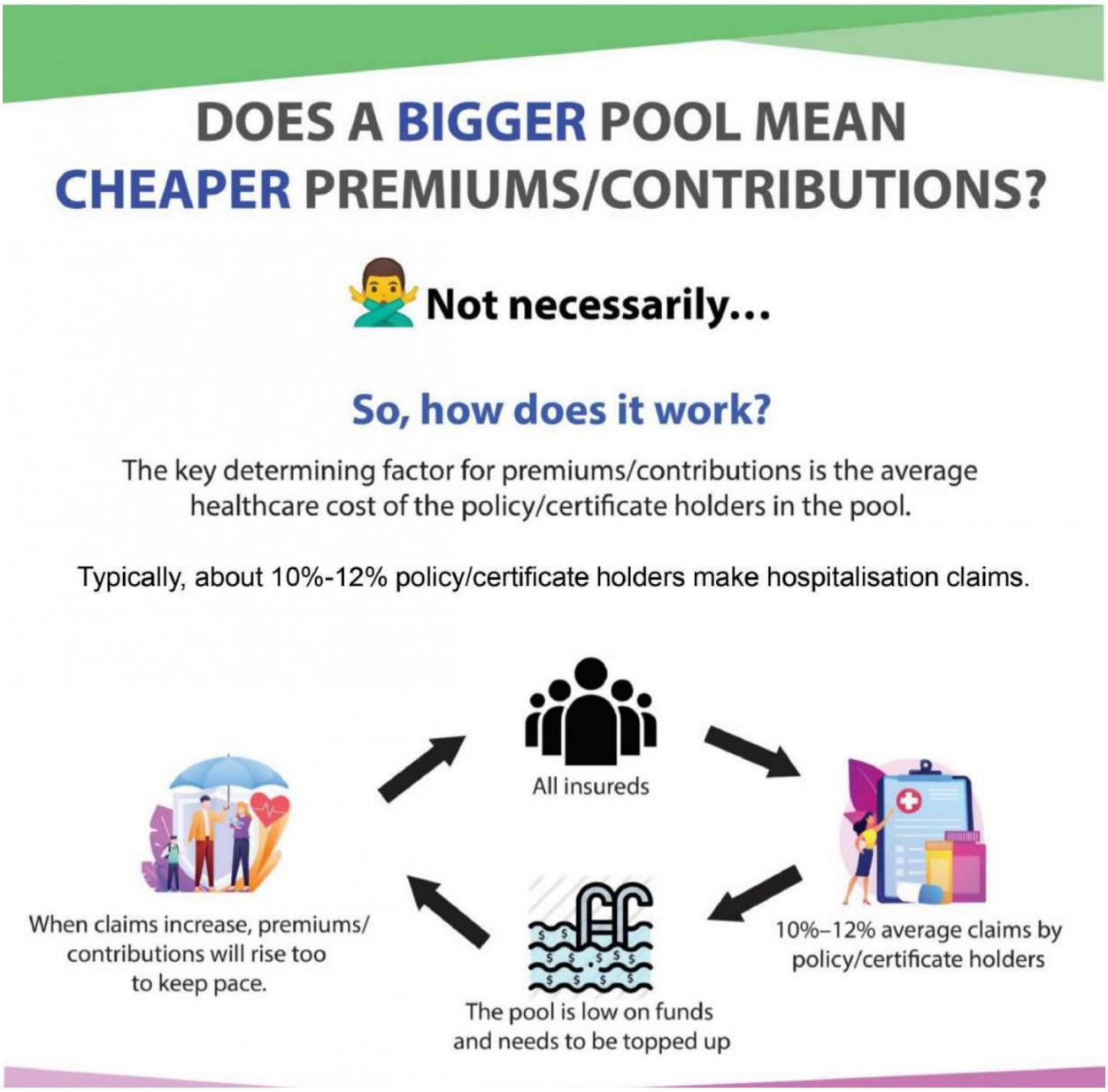
What policy/certificate holders can expect when they do their part in keeping medical inflation low

Longer repricing cycle

Lower premium/ contribution increment

Preservation of annual/lifetime limit


The entire insurance & takaful industry runs on the concept of risk pooling
What's that?
Simply put, it is the equal sharing of financial risks among a large number of people contributing to a common pool.
The funds will then be used to pay for all or part of the medical costs for members of the pool.
You
Risk
Risk Pooling
Persatuan Insurans Hayat Malaysia
Life Insurance Association of Malaysia
PIAM
MALAYSIAN TAKAFUL ASSOCIATION



6.2.2 CRITICAL ILLNESS OR DREAD DISEASE PRODUCT

Critical illness insurance is a type of insurance policy that provides coverage for life-threatening illnesses, as specified in the policy. Upon diagnosis of a critical illness, the policy pays out a lump sum amount to help cover the costs of medical care, lost income, and other expenses associated with the illness.

In Malaysia, most critical illness policies cover a standard set of critical illnesses, including cancer, heart attack, stroke, and coronary artery bypass surgery. Some policies may also cover other illnesses, such as kidney failure, major organ transplant, Parkinson's disease, and Alzheimer's disease. The specific critical illnesses covered will depend on the insurer and the policy's terms and conditions. Some policies may cover a larger number of critical illnesses, while others may only cover the most common types.

Critical illness policies may be purchased as *standalone* products or as a *rider* attached to a life insurance policy. Premiums for the policy will depend on the policy owners/takaful participants' age, health status, and other factors. The lump sum payment can be used to cover medical expenses, living expenses, and other costs associated with the illness.

(a) List of Most Common Types of Covered Critical Illnesses (*Source: LIAM Website*)

1. Alzheimer's Disease / Severe Dementia
2. Angioplasty and other invasive treatments for coronary artery disease
3. Bacterial Meningitis
4. Benign Brain Tumor
5. Blindness – Permanent and Irreversible
6. Brain Surgery
7. Cancer
8. Cardiomyopathy– of specified severity
9. Chronic Aplastic Anaemia
10. Coma
11. Coronary Artery By-Pass Surgery
12. Deafness – Permanent and Irreversible
13. Encephalitis -resulting in permanent inability to perform Activities of Daily Living
14. End-Stage Liver Failure
15. End-Stage Lung Disease
16. Full-blown AIDS
17. Fulminant Viral Hepatitis
18. Heart Attack
19. Heart Valve Surgery
20. HIV Infection due to Blood Transfusion
21. Kidney Failure
22. Loss of Independent Existence
23. Loss of Speech
24. Major Head Trauma
25. Major Organ / Bone Marrow Transplant
26. Medullary Cystic Disease
27. Motor Neuron Disease
28. Multiple Sclerosis
29. Muscular Dystrophy
30. Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection
31. Paralysis of Limbs
32. Parkinson's Disease– resulting in permanent inability to perform Activities of Daily Living
33. Primary Pulmonary Arterial Hypertension – of specified severity
34. Serious Coronary Artery Disease
35. Stroke
36. Surgery to Aorta
37. Systemic Lupus Erythematosus with severe kidney complications
38. Terminal Illness
39. Third Degree Burns

(b) Single and Multiple Claim of CI Policy

Critical Illness (CI) policies provide a lump-sum benefit payment if the policyholder is diagnosed with one or more of the specific illnesses covered by the policy.

(i) Single Claim CI Policy

A single claim critical illness policy pays out once, upon the diagnosis of any of the covered critical illnesses. After a claim has been paid, the policy usually terminates, and no further claims can be made, even if the policyholder is diagnosed with a different covered illness in the future. In essence, the policyholder is only insured for the first occurrence of a covered critical illness.

(ii) Multiple Claim CI Policy

On the other hand, a multiple claim critical illness policy allows the policyholder to make more than one claim during the policy term. After a claim has been made for one illness, the coverage continues, and future claims can be made if the policyholder is diagnosed with a different covered illness. Some policies may also allow repeated claims for the same illness after a certain waiting period.

The structure of a multiple claim CI policy can vary. Some policies may offer full reset of the sum insured after a certain period post a claim, others may cover minor and major categories of illnesses separately, allowing for multiple claims across these categories.

- Multiple claims for different CI

  Some multiple claim CI policies may also offer a reset benefit feature. With a reset benefit, the policy owners/takaful participants' benefit amount is reset to the full coverage amount after a claim has been made for a specific critical illness.

Example 1

Multiple claims for different CI

Consider a scenario where an insured individual makes a claim following a cancer diagnosis and receives a benefit payment. In this case, with certain types of multiple claim critical illness policies, the coverage amount for other specific illnesses, such as heart attack or stroke, is not diminished. The individual remains eligible to make a claim for the full benefit amount for these other illnesses, in case of a subsequent diagnosis.

- Multiple claims for same CI

  Some critical illness insurance policies may allow for multiple claims for the same illness, provided there is a waiting period in between claims. This waiting period is usually defined in the policy terms and can range from a few months to a few years.

Example 2

Multiple claims for same CI

Consider a critical illness insurance policy that covers specific illnesses, including cancer, and allows for multiple claims for the same illness, subject to a waiting period of 2 years between claims. In a scenario where an insured individual is diagnosed with cancer and subsequently receives a benefit payment, they must adhere to the stipulated waiting period before making another claim for cancer.

Should the individual be diagnosed with cancer again after the waiting period has elapsed, they are eligible to make another claim and receive an additional benefit payment.

(c) Critical Illness Policy that Covers Early & Intermediate Stage of Critical Illness

Some policies may offer coverage for early or intermediate stages of critical illnesses, as an acceleration of the policy benefit instead of paying only upon advanced stages of critical illness.

Table 6-3 ***Examples of Coverage for Early and Intermediate Stage Critical Illness***

Critical Illness	Coverage Criteria	Benefit Payment
Cancer	Early Stage: Diagnosed of early-stage breast cancer but not yet spread to other parts of the body	25% of the total benefit amount
	Intermediate Stage: Mastectomy for CIS Breast cancer has not spread to nearby tissues or lymph nodes but need to remove the breast	50% of the total benefit amount
	Advanced Stage: Breast Cancer has spread to distant organs or tissues	The full lump sum benefit amount
Stroke	Early Stage: Carotid Angioplasty and Stent Placement	25% of the total benefit amount
	Intermediate Stage: Carotid Artery Surgery resulting in some permanent neurological deficit	50% of the total benefit amount
	Advanced Stage: Severe stroke resulting in total permanent disability	The full lump sum benefit amount
Heart Attack	Early Stage: Cardiac Pacemaker Insertion	25% of the total benefit amount
	Intermediate Stage: Cardiac Defibrillator Insertion resulting in damage to the heart muscle	50% of the total benefit amount
	Advanced Stage: Severe heart attack resulting in heart failure or other serious complications	The full lump sum benefit amount

(d) Female Critical Illness Policy

Female critical illness policy is a type of critical illness insurance that covers female-specific health conditions.

Female illness coverage typically covers a range of conditions including cervical cancer, breast cancer, ovarian cancer, and complications related to pregnancy and childbirth. Depending on the policy, it may also cover other conditions such as endometriosis, uterine fibroids, or hysterectomy.

The coverage amounts and terms and conditions of female illness coverage may vary depending on the insurer and policy selected. Some policies may offer a lump sum payment upon diagnosis of a covered condition, while others may provide ongoing payments to cover medical expenses related to the illness.

(e) Juvenile Critical Illness Policy

Juvenile critical illness policy is a type of critical illness insurance that covers specific health conditions on children and young adults, such as congenital heart disease, leukemia, and childhood cancers

The coverage amounts and terms and conditions of the policy may vary depending on the insurer and policy selected.

Some juvenile critical illness policies may also offer add-on benefits, such as coverage for hospitalization or outpatient treatment related to a covered illness, or coverage for additional conditions that are not covered under the standard policy.

(f) Waiting Period

The specifics of the waiting period in critical illness policy is generally 30 days from the policy commencement date before claims can be made for certain events.

An exception applies to a subset of serious and life-threatening illnesses. For these specified conditions, the waiting period extends to 60 days. The conditions falling under this category include:

- Heart Attack
- Coronary Artery By-Pass Surgery
- Cancer
- Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease
- Other Serious Coronary Artery Disease

When policy owners/takaful participants acquire a critical illness policy, they need to be aware that there could be waiting periods implemented prior to eligibility for making a claim pertaining to certain illnesses or events.

(g) Survival Period

The Survival Period in a Critical Illness (CI) policy is a predetermined length of time that the policyholder must survive, typically 30 days, following the diagnosis of a covered critical illness, before the policy's benefits are payable. The purpose of this period is to ensure that the policy provides a payout for serious, long-term conditions, rather than illnesses from which the policyholder might pass away immediately.

Example 1

Survival Period

if an insurer specifies a Survival Period of 30 days, this means that if the policyholder is diagnosed with a covered critical illness, such as a heart attack or stroke, they must live for at least 30 days following the date of diagnosis. If the policyholder survives this 30-day period, they will be eligible to receive the critical illness benefit payout.

The length of the Survival Period can vary between different insurers and different policies, but 30 days is a common duration. It is crucial for policyholders to be aware of the Survival Period in their policy, as it is a key determinant of whether or not they will be able to claim their critical illness benefit.

It is important to note that if the policyholder does not survive the Survival Period, the benefit from the CI policy would not be payable. In such cases, death benefits from a separate life insurance policy may apply.

(h) Exclusions for CI

Some exclusions that are commonly seen in critical illness policies:

- Specified Illnesses within 120 days from the Commencement Date or Reinstatement Date whichever is the later;
- Any Disability (except for Injury) and its signs or symptoms that appear within 30 days from the Date of Commencement or Date of Reinstatement whichever is the later;
- Self-inflicted injuries or suicide or attempted suicide, while sane or insane;
- Injuries or Hospitalisation as a result of drug abuse, addictive disorders from substance misuse or while under the influence of alcohol;
- War or any act of war, declared or undeclared, criminal, or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection;
- Ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste;
- Sickness or injury arising from racing of any kind (except foot racing) hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sports and illegal activities; or
- Participation in any form of aviation (except as a fare-paying passenger or crew member on a regular route operated by a licensed commercial airline), or aerial sports such as (but not limited to) skydiving, parachuting, bungee jumping, hang gliding or ballooning.
- Pre-existing conditions.

(i) Accelerated and Non-Accelerated CI

Accelerated and non-accelerated critical illness (CI) plans are two types of CI insurance that differ in the way the policy benefits are paid out.:

Accelerated CI plans offer an early pay-out of the full or partial sum assured upon diagnosis of a critical illness. The pay-out of the critical illness benefit is deducted from the overall sum assured, which reduces the death benefit payable upon the policyholder's death.

On the other hand, non-accelerated CI plans provide an additional lump sum payment upon diagnosis of a critical illness, without affecting the overall sum assured of the policy.

The choice between these two types of CI plans depends on the policyholder's needs and preferences.

(j) Pre-Existing Conditions

A pre-existing illness, refers to any medical condition or related health issue that the policy owner/takaful contributor already has or had at the time of purchasing the insurance policy. This includes any condition that the policy owner/takaful contributor was diagnosed with or received treatment for prior to the start of the policy.

How pre-existing conditions are handled can vary among ITO and individual policies, but here are some general principles:

- Exclusion of pre-existing conditions

  Many CI policies exclude pre-existing conditions. This means the policy will not provide a payout if the policyholder makes a claim related to a pre-existing condition. For example, if a policy owner/takaful contributor has a history of heart disease before buying the policy, and later suffers a heart attack (a covered critical illness), the ITO would likely not pay the claim.

- Certain waiting period

  Some ITOs may cover pre-existing conditions after a certain waiting period, which is a stipulated time after the policy begins. If the policy owner/takaful contributor remains symptom-free and does not require treatment for the pre-existing condition during this period, future claims related to this condition may be covered.

- Loading of premiums

  In some cases, ITOs may agree to cover pre-existing conditions, but this is usually reflected in higher premiums. This practice, known as premium loading, compensates for the increased risk the ITO is taking on by covering the pre-existing condition.

- Full medical underwriting

  During the application process, the insurer will typically ask a series of health questions and may request medical reports. This process, known as medical underwriting, helps the insurer assess the risk profile of the applicant. Any pre-existing conditions disclosed during this process may influence the terms of coverage and the premium.

6.2.3 LONG-TERM CARE PRODUCT

Long-term care insurance is designed to provide coverage for the costs associated with long-term care services.

These services are typically needed when an individual is unable to perform daily activities independently due to illness, disability, or cognitive impairment. Here are some examples of what long-term care insurance may cover:

- Nursing home care

  This includes coverage for the cost of staying in a nursing home facility, where individuals receive 24-hour skilled nursing care.

- Assisted living facilities

  Long-term care insurance may cover the expenses of residing in an assisted living facility, which aids with activities of daily living (ADLs) such as bathing, dressing, and medication management.
- Home care services

  It may cover the cost of receiving care in the comfort of one's own home, including services provided by home health aides, skilled nursing care, physical therapy, and occupational therapy.

- Adult day-care

  Coverage may be provided for attending adult day-care centres, where individuals receive supervision, social activities, and assistance with daily living activities during the day.

- Respite care

  This coverage can offer temporary relief to family caregivers by covering the cost of professional caregivers who take over caregiving responsibilities for a short period, allowing the primary caregiver to take a break.

6.2.4 HOSPITAL INCOME PRODUCT

Hospital Income is a type of insurance policy that pays a fixed or pre-agreed amount of cash to the policyholder for each day they are hospitalized due to a covered illness or injury. This cash benefit can be used by the policyholder to cover any expenses that may arise during their hospitalization, such as transportation costs, childcare, or lost income.

For example, if a policyholder has a hospital income policy that pays RM200 per day, and they are hospitalized for 5 days due to a covered illness or injury, they will receive RM1,000 in cash benefits from the insurance company.

Waiting period & Specified Illness & Pre-existing illness, Exclusion clause are applicable per those stated under *6.2.1 d "Medical Reimbursement Insurance".*

6.2.5 DENTAL PRODUCT

Dental insurance in Malaysia is a type of insurance coverage specifically designed to help individuals manage the costs of dental care and treatments. It provides financial protection and assistance for various dental services, including preventive care, routine check-ups, cleanings, fillings, extractions, root canals, crowns, and sometimes orthodontic treatments.

Dental insurance plans typically work on a reimbursement basis, where the policyholder pays for dental services upfront and then submits a claim to the insurance company for reimbursement of eligible expenses based on the coverage and limits outlined in the policy. The insurance company

will reimburse a portion or percentage of the dental treatment costs, up to the policy's coverage limits.

It is important to note that dental insurance plans may have certain exclusions, waiting periods, and limitations. Pre-existing dental conditions may not be covered, and some plans may have waiting periods before certain services or treatments are covered.

When considering dental insurance in Malaysia, it is essential to review and understand the specific coverage, limits, exclusions, waiting periods, and terms and conditions of the insurance policy to determine if it meets your dental care needs.

Dental insurance plans can be offered under both group and individual policies in Malaysia. Group dental insurance is typically provided through an employer or an organization for a group of individuals, such as employees of a company or members of an association. The coverage and benefits may be negotiated by the employer or organization, and the premiums may be shared between the employer and employees or members.

On the other hand, individual dental insurance is purchased by individuals directly from an insurance provider. Individual dental insurance allows individuals to customize their coverage and select a plan that best suits their specific dental care needs. The premiums for individual dental insurance are paid solely by the individual policyholder.

Both group and individual dental insurance plans can offer similar coverage for dental treatments and services, but the specific details, costs, and terms of the plans can vary.

6.3 STANDALONE VS RIDER

MHIT products may be offered on a standalone *basic* or as a *rider*.

Rider refers to a supplementary or extension of cover attached to a basic life policy/family takaful certificate that provides additional benefits;

The main difference between a standalone MHIT policy or an MHIT rider is that, standalone MHIT policy very specifically provides only MHIT insurance cover within the policy itself; while MHIT rider is a supplementary add-on to a basic plan that may provide some other insurance coverage.

For example, a person can purchase a standalone critical illness or dread disease insurance/takaful policy to provide coverage for a lump sum payment upon diagnosis of a critical illness or dread disease. Alternatively, a person can attach a critical illness or dread disease insurance/takaful rider to an existing life insurance/takaful policy to provide additional coverage for critical illnesses or dread diseases.

6.4 GROUP MEDICAL & MEDICAL INSURANCE

6.4.1 PROVISIONS FOR GROUP MEDICAL AND HEALTH INSURANCE POLICIES WITHOUT INSURABLE INTEREST

(Guidelines on Medical and Health Insurance Business (Revised) issued on 26 August 2005)

These provisions appear to focus on group Medical and Health Insurance (MHI) policies where the arranger does not have an insurable interest in the lives of the people insured under the policy.

Under these guidelines, the insurer is required to issue individual certificates of insurance to each insured person under the policy, in addition to the master policy contract issued to the group policy owner. These certificates must outline all the relevant information regarding the policy, including the policy terms and conditions, benefits and limitations, exclusions, terms of renewal, and any obligations the individual insured person has under the policy.

Furthermore, the insurer must prominently display on the proposal form that the insured individual should:

(a) Receive an individual certificate of insurance as proof of their coverage, and

(b) Follow up with the group policy owner or the insurer to confirm their coverage under the group policy if they do not receive their certificate within a reasonable period.

Finally, the guidelines prohibit insurers from:

(a) Entering into any arrangement with a group policy owner to tie the purchase of an MHI product with any other product or service offered by the group policy owner, and

(b) Knowingly issuing group MHI policies to parties involved in direct selling and/or multi-level marketing distribution.

These provisions help protect the individual insured persons, ensuring they receive appropriate documentation and that their MHI coverage is not unfairly linked to other products, services, or distribution models.

6.4.2 NO INDIVIDUAL RISK EVALUATION OR SELECTION

Group Medical & Health Insurance is often included in employer benefit packages as a means of attracting or retaining quality employees, with premiums partially covered by the employer but often also deducted from employee paychecks.

The healthcare benefits provided by employers may be arranged on:

- reimbursement basis or
- paying directly to the hospital through the use of medical cards.

The premium is lower for an individual in a group policy than it would be if they had an individual Medical & Health Insurance policy because of two reasons:

- the volume of business results in a greater spread of risk; and
- the administration cost is lower as only one invoice is issued to the employer.

Experience Rating is where the premiums are calculated according to the group's claims experience over the previous twelve-month period, or longer, rather than a collection of individual tabular ratings.

The group premium quoted will be based on general factors, such as:

- who will be covered
- the age profile of the group
- scale(s) of cover selected

- the group's past claims experience
- the method of payment
- any additional risk factors apparent due to the occupation of the members.

An insurer must estimate future claims accurately to maintain their ongoing profitability of the group or account.

6.4.3 CONTRIBUTORY OR NON-CONTRIBUTORY INSURANCE

A group medical and health insurance may be on a contributory or non-contributory basis. A non-contributory plan covers all eligible employees or members where the premium is paid by the group policy owner or employer. A contributory plan requires the participation of at least seventy-five percent (75%) of eligible group members, where the premium may be partly subsidised or contributed in full by the member or employee.

In conclusion, the Malaysian Medical and Health Insurance/Takaful (MHIT) industry plays a crucial role in providing financial protection against medical expenses. As the industry continues to grow, it faces significant challenges such as the rise of non-communicable diseases, the expansion of private healthcare services, and the increasing medical inflation, which impact the utilization of medical services and the magnitude of claims.

To overcome these challenges, licensed insurers and takaful operators must embrace innovation to meet the changing needs of consumers while ensuring the long-term sustainability of the MHIT business. This requires continuous adaptation and development of new solutions to effectively address the evolving healthcare landscape.

Regulated by the Bank Negara Malaysia and the Ministry of Health, the MHIT industry operates within a framework of guidelines and regulations. This regulatory oversight aims to safeguard the interests of policy owners and takaful participants, ensuring transparency, fairness, and accountability.

By navigating the challenges and fostering innovation, the MHIT industry in Malaysia can effectively provide individuals and families with the necessary financial protection and peace of mind in the face of escalating healthcare costs. Through ongoing collaboration between stakeholders, the industry can strive towards enhanced accessibility, affordability, and sustainability, ultimately improving the overall healthcare ecosystem in Malaysia.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*Which of the following events does NOT automatically terminate a medical and health insurance policy?*
A	a. Exhaustion of the annual limit or lifetime limit stipulated in the policy. b. The anniversary date following the insured's maximum eligibility age. c. Breach of a policy condition. d. The death of an insured person.

2	**Review Question**
Q	*What are the various methods used by insurers to contain medical claims cost and inflated claims?* *i. Inner limits.* *ii. Schedule of surgical procedures.* *iii. Maximum period of compensation.* *iv. Time frame.* *v. Deductible or Cost – Sharing option.*
A	a. I and II. b. II, III and IV. c. I, II, III and IV. d. I, II, III, IV and V.

3	**Review Question**
Q	*What benefits are payable under a hospital income insurance policy?*
A	a. Income stream to replace a portion of the pre-disability income if insured is not able to work due to illness. b. Fixed allowance on daily due to hospitalisation caused by illness or injury. c. Reimbursement of medical expenses due to hospitalisation caused by illness or injury. d. Lump sum payment of sum insured upon diagnosis of any Advanced Stage Dread diseases.

4	**Review Question**
Q	*What is the main purpose of the revised Guidelines on Medical and Health Insurance Business?*
A	a. To increase premium rates on higher-risk individuals. b. To reduce escalating claim costs. c. To prescribe minimum standards to be observed by life and general insurers. d. To introduce new limitations on core benefits.

5	**Review Question**
Q	*Under which type of MHIT policy/takaful certificate is the renewability at the option of the licensed ITO?*
A	a. Yearly Renewable MHIT Policy/Takaful Certificate. b. Guaranteed Yearly Renewable MHIT Policy/Takaful Certificate. c. Non-renewable MHIT Policy/Takaful Certificate. d. Fixed-term MHIT Policy/Takaful Certificate.

6	**Review Question**
Q	*What factors are considered when determining the group premium for Medical & Health Insurance?*
A	a. Who will be covered, age profile, scale of cover, method of payment. b. The group's claims experience, method of payment, occupation of the members. c. Who will be covered, scale of cover, group's past claims experience. d. Age profile, group's past claims experience, method of payment.

7	**Review Question**
Q	*One of the requirements of the revised guidelines is for insurers to provide clear and plain disclosures on key policy features:*
A	a. After the policy is purchased. b. Only upon request from the policyholder. c. At the point of sale. d. Only if the policyholder has made a previous claim.

8	**Review Question**
Q	*What is the definition of "Pre-existing Illness" in the insurance policy?*
A	a. Disabilities that occur after the Risk Effective Date. b. Disabilities that are not covered by the insurance policy. c. Disabilities that the Life Assured is aware of before the Risk Effective Date. d. Disabilities that require immediate medical attention.

9	**Review Question**
Q	*What does "Reasonable and Customary Charges" refer to in medical insurance?*
A	a. The charges for medical care that are considered reasonable by the insurance company. b. The charges for medical care that are customary in the industry. c. The charges that are considered usual and customary in a specific geographic area. d. The charges that exceed the general level of charges in the healthcare industry.

10	**Review Question**
Q	*What is the purpose of a deductible in a medical insurance policy?*
A	a. To limit the coverage for certain medical services or treatments. b. To share the cost of medical expenses between the policyholder and the insurance company. c. To provide full reimbursement for all medical expenses. d. To encourage early insurance purchase.

11	**Review Question**
Q	*What is the main difference between co-payment and co-insurance in medical insurance?*
A	a. Co-payment is a fixed amount, while co-insurance is a percentage of the medical expenses. b. Co-payment is paid by the insurance company, while co-insurance is paid by the policyholder. c. Co-payment applies to hospitalization, while co-insurance applies to outpatient treatments. d. Co-payment is mandatory, while co-insurance is optional.

12	**Review Question**
Q	*What is the primary purpose of a medical reimbursement insurance/takaful product?*
A	a. Provides coverage for long-term care expenses. b. Provides a lump sum payment upon diagnosis of a critical illness. c. Provides coverage for medical expenses incurred due to illness or injury. d. Provides a daily cash benefit for hospitalization expenses.

13	**Review Question**
Q	*Which insurance/takaful product offers coverage for dental care expenses?*
A	a. Medical reimbursement insurance/takaful product. b. Critical illness or dread disease insurance/takaful product. c. Long-term care insurance/takaful product. d. Dental insurance/takaful product.

14	**Review Question**
Q	*What type of benefit does a hospital income insurance/takaful product provide?*
A	a. Reimbursement of medical expenses. b. Lump sum payment upon diagnosis of a critical illness. c. Daily cash benefit for hospitalization. d. Coverage for long-term care expenses.

15	**Review Question**
Q	*Critical illness insurance provides coverage for:*
A	a. Minor illnesses. b. Routine medical check-ups. c. Life-threatening illnesses. d. Pre-existing conditions.

16	**Review Question**
Q	*How are pre-existing conditions typically handled in critical illness policies?* *i. They are automatically covered without any waiting period.* *ii. They are excluded from coverage.* *iii. They are covered after a certain waiting period.* *iv. They are covered at a higher premium rate.*
A	a. I, II. b. II, III. c. II, III, IV. d. All of the above.

17	**Review Question**
Q	*Multiple claim critical illness policies allow policyholders to:* *i. Make multiple claims for the same illness without any waiting period.* *ii. Make multiple claims for different illnesses without any waiting period.* *iii. Make multiple claims for the same illness after a waiting period.* *iv. Make multiple claims for different illnesses after a waiting period.*
A	a. I &II. b. II & III. c. III & IV. d. All of above.

18	**Review Question**
Q	*Under a Yearly Renewable MHIT Policy/Takaful Certificate, the renewability of the policy/takaful certificate upon expiry is at the option of the:*
A	a. Policy owner/takaful participant. b. Licensed ITO. c. Insurance company. d. Regulating authority.

19	**Review Question**
Q	*If there are modified terms and conditions for renewal under a Yearly Renewable MHIT Policy/Takaful Certificate, the licensed ITO is required to:*
A	a. Renew the coverage without any changes. b. Inform the policy owner/takaful participant about the modifications and provide reasons for the changes. c. Terminate the policy without any notice. d. Increase the premium/takaful contribution without informing the policy owner/takaful participant.

20	**Review Question**
Q	*Under a Guaranteed Yearly Renewable MHIT Policy/Takaful Certificate, the renewability of the policy/takaful certificate on its anniversary is:*
A	a. At the option of the licensed ITO. b. Non-cancellable by the licensed ITO. c. Subject to modification by the policy owner/takaful participant. d. Determined by the regulating authority.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

7

CHAPTER 7 GENERAL INSURANCE BUSINESS

7.1 INTRODUCTION

All insurance businesses other than life insurance is termed General Insurance. In Malaysia, an insurance company must be authorised under the Financial Services Act 2013 (FSA) to carry out general insurance business. General insurance mainly comprises annual or short-term contracts with variable premiums based on the nature of the risk to be insured, the overall experience of a particular class of business (motor or non-motor), or a portfolio of risks within the same class (motor third party liability risks). General insurance is specifically designed for the indemnification of financial loss and to restore a policy owner to the same financial position he occupied immediately before the loss. General insurance or non-life insurance is broadly segregated into motor and non-motor.

7.2 MOTOR INSURANCE

Road Transport Act 1987 (RTA) regulates motor vehicles and traffic on roads in Malaysia and enforces compulsory insurance. Section 90 (1) of the RTA states that: '*it shall not be lawful for any person to use or to cause or permit any other person to use, a motor vehicle unless there is in force a policy of insurance or such other security in respect of third-party risks*'.

Why is motor insurance made compulsory by law?

- To make available funds needed to compensate victims of road accidents.
- To ensure funds are readily available when damages are awarded by the courts.
- To ease the Government' s financial burden and to protect national interest.

What is the penalty for contravention of the law?

Section 90(2) of the RTA states that a person who contravenes this section of the law shall be guilty of an offence and liable to *a fine not exceeding RM1,000 or 3 months imprisonment and if the court deems fit, the offender will be disqualified from holding a driving licence for 12 months* from the date of conviction.

What is the minimum cover required by law?

Section 91(b) of the RTA states that a policy of insurance must be issued by an 'authorized insurer' to cover **liability for death or bodily injury to any person** caused by or arising out of the use of the vehicle or land implement drawn on a road.

What is the definition of a 'road' under the law?

The RTA defines 'road' to mean *any public road and any other road to which the public has access (i.e., including private roads)*. 'Road' also includes bridges, tunnels, lay-bys, ferry facilities, interchanges, roundabouts, traffic islands, road dividers, all traffic lanes, acceleration lanes, deceleration lanes, side-tables, median strips, overpasses, underpasses, approaches, entrance and exit ramps, toll plazas, service areas, and other structures and fixtures to fully effect its use, and a road under construction.

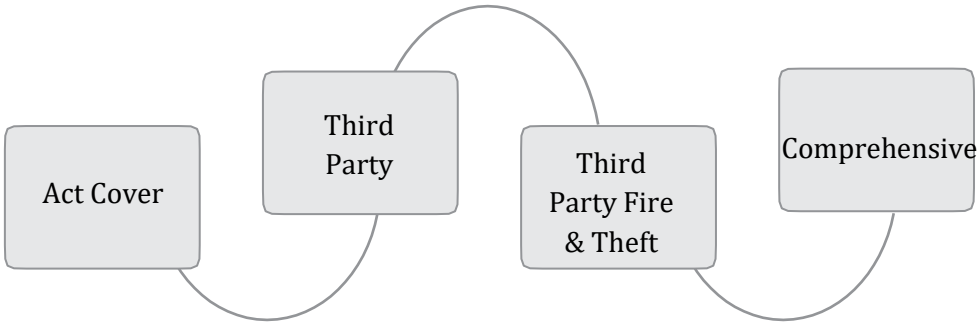
7.2.1 CLASSIFICATION OF MOTOR VEHICLES

Table 7-1 *Classification of Motor Vehicles*

Private Car	Commercial	Motor Cycles
Used for solely domestic and pleasure purpose and insured's own business only. Excludes use for hire and reward, racing, reliability trials, speed testing, tuition, carriage of goods other than samples, carriage of passengers for hire and reward, etc.	Used for the carriage of goods: private goods carrier ('C' permit) or public goods carrier ('A' permit). Public hire taxis Private hire: self-drive or chauffeur-driven Private and public buses and coaches Special types such as ambulance or hearse	Private motor cycles used for social, domestic and pleasure purpose and insured's own business only. Commercial motorcycles with or without side- cars used for business or trade including carriage of goods but excluding carriage of passengers.

7.2.2 TYPES OF MOTOR INSURANCE COVERAGE

FIGURE 7-1 *Types of Motor Insurance Coverage*



1. **Act Cover** is the minimum statutory insurance prescribed by the Road Transport Act 1987 (RTA). The term 'Act' implies that the insurance policy is issued in accordance with the requirements of the RTA, which is to cover **liability for death or bodily injury to any person** arising from the use of a motor vehicle on a road. In Malaysia, 'Act Cover' is not sold as a policy but is provided together with third party insurance which includes liability for property damage. A main reason for this is the low premiums and the high risk of providing unlimited third-party liability for bodily injury claims.

2. **A Third-Party** policy insures **liability for property damage** in addition to liability for death or bodily injury to any person arising from the use of a motor vehicle on a road. While third party insurance premiums are higher than those for Act Cover, they are very much lower than those for comprehensive policies. Because of its low premiums, third party cover is sought after mainly by owners of older vehicles (since their value is low anyway) while insurers become more selective in providing third party insurance because the premiums do not commensurate with long-tailed liability risks. Cost of claims invariably escalates as claim reserves, eroded by inflation, have to increase with time and in line with the trend of large court awards for personal injury claims.

3. **Third Party, Fire and Theft** insurance covers **loss of or damage to the insured vehicle as a result of fire or theft** in addition to third party insurance described above. The premium rate for the coverage is 75 percent of the premium charged for comprehensive insurance and is favoured by consumers who wish to save on premiums and still enjoy wider coverage than third party insurance.

4. **Comprehensive** insurance is the widest form of cover available and caters for newer vehicles, those under hire purchase or finance. As the term 'comprehensive' suggests, the scope of cover is for **any loss of or damage caused by specified perils** which includes accidental collision or overturning including collision or overturning *consequent upon wear and tear or mechanical breakdown*.

   The policy comprises two sections:

   - covers loss of or damage to the insured vehicle.
   - covers third party liability arising from the use of the vehicle.

7.2.3 PRIVATE CAR COMPREHENSIVE INSURANCE

Scope of Cover

Table 7-2 *Scope of Cover*

Section A- Loss or Damage to the Vehicle caused by:

a. accidental collision or overturning;
b. collision or overturning caused by mechanical breakdown or wear and tear;
c. impact damage caused by falling objects provided no flood, typhoon, storm, volcanic eruption, earthquake, landslide, subsidence, or other convulsion of nature is involved;
d. fire, explosion, or lightning;
e. burglary, housebreaking, or theft;
f. malicious act;
g. when in transit (including its loading or unloading) by:
   i. road, rail, or inland waterway
   ii. direct sea route across the straits between the island of Penang and the mainland

Section B- Liability to Third Parties Causing:

a. death or bodily injury to any person for unlimited liability
b. damage to property as a result of an accident limited to RM3 million any one claim

Main Exclusions

- Death or bodily injury to any passenger being carried for hire or reward or to any person where such death or injury arises out of or in the course of employment by the insured or his authorised driver.

- Loss, damage, or liability arising from flood, typhoon, hurricane, storm, tempest, volcanic eruption, earthquake, landslide, landslip, subsidence or sinking of the soil/earth or other convulsion of nature is involved.

- Loss, damage, or liability if the vehicle is used for any motor sport or competition (other than treasure hunts), reliability trials, hill climbing tests and rallies.

- Claims, legal costs and expenses outside Malaysia, Singapore, or Brunei.

Extra Benefits

These are 'buy-back' options in respect of certain exclusions on payment of additional premiums. The table below summarises the extra benefits and their respective premium rates (based on motor tariff).

NOTE:

- Premium rates may differ from one insurer to another in non-tariff product.
- Premiums for Extra Benefits / Extensions below are applied to Tariff Policy only.
- For Non-Tariff Policy, premium charged for certain Extra Benefits / Extensions may differ between members.

Table 7-3 *Extra Benefits*

Extra Benefits	Additional Premiums
1. flood, windstorm, rainstorm, typhoon, hurricane, volcanic eruption, earthquake, landslide, etc.	0.5% of the sum insured or minimum RM15
2. breakage of glass in windscreen or windows	15% of the value of glass or minimum RM30
3. strike, riot and civil commotion	0.3% of the sum insured or minimum RM5
4. car accessories	15% of value of accessories
5. tuition and testing purposes for privately owned cars, not owned and operated by a driving institute/school	50% of the scheduled premium (without no-claim discount)
6. additional named driver	RM10 each additional driver
7. all drivers (private cars issued to a company or business organization)	RM50 per vehicle
8. liability to passengers	25% of third-party premium (additional RM10 for every seat exceeding 5 including driver)
9. liability of passengers for acts of negligence	RM7.50 per vehicle

Policy Excess

An excess is the first amount that must be borne by the insured in the event of a claim. Imposing a policy excess will avoid small (petty or frivolous) claims which are expensive to administer. An excess also acts as a deterrent to ensure the insured acts as if he was uninsured to prevent a loss since he will have to bear the first portion of the claim.

Compulsory Excess

In addition to the policy excess, an additional excess of RM 400 will apply in the event of any claim (other than fire, or theft) arising under Section A of the private car comprehensive policy if the vehicle is being driven by any person who is:

- under the age of 21 years

- the holder of a provisional or probationary driving licence
- not a named driver in the policy
- the named driver, under the age of 21 years and/or holder of a provisional or probationary driving licence

7.2.4 COMMERCIAL VEHICLE INSURANCE

The scope of coverage is like private car insurance described earlier except for two additional exclusions, namely:

1. Damage caused by overloading or strain; and
2. Damage caused by explosion of any boiler forming part of or attached to or on the insured vehicle.

7.2.5 LIABILITY TO PASSENGERS LIABILITY TO PASSENGERS IS NOT COMPULSORY IN MALAYSIA EXCEPT FOR :

i. passengers carried for hire or reward (affects public or private buses, coaches, or taxis); or

ii. passengers carried by reason of or in the pursuance of a contract of employment with the insured (e.g. employees carried in their employer's vehicle)

In this regard, commercial vehicles, particularly buses and taxis which carry passengers for hire or reward must have compulsory insurance to cover **liability to passengers for death or injuries sustained while travelling including entering or alighting from the vehicle**.

Unlike private car policies, a commercial vehicle policy does **not** include the following policy exclusion: *'death or bodily injury to any passenger, being carried for hire or reward' under the third-party liability section*.

However, the commercial vehicle policy **excludes** liability to any person in the following circumstances:

i. Death or bodily injury to any person where such death or injury arises out of and in the course of the employment of such person by the insured or his authorized driver. For example, bus drivers, conductors or lorry attendants are more appropriately covered by workmen's compensation or employer's liability insurance instead of motor insurance; and

ii. Death or bodily injury to any person being carried in or upon or entering or getting on to or alighting from the vehicle **unless** the person is required to be carried in or on the vehicle by reason of or in pursuance of his contract of employment with the insured, his authorized driver and/or the person's employer. For example, an employee of the insured being carried as a passenger in the employer's vehicle.

7.2.6 MOTOR TRADE

A motor trade insurance policy is also referred to as '*road risk*' insurance. It is taken out by motor traders who are engaged in the business of manufacture, repair, and dealership of motor vehicles. A

motor trade policy provides indemnity only while the motor vehicle is on the road or is temporarily garaged during a journey anywhere within the geographical boundaries and while on the business premises of the insured.

For example, a 'motor trade licence' or motor trade plate is required for each motor vehicle traded or a general licence may be taken out for all motor vehicles in the trader's custody as compulsory insurance for road risk is required if the vehicle is used on a public road.

7.2.7 E-HAILING INSURANCE

E-hailing regulations in Malaysia came into effect on 12 July 2018 with the passing of the 2017 amendments to the Land Public Transport Act 2010. The current law regulates both E-hailing operators and drivers.

To operate an E-hailing service, the operator is required to have an intermediation business licence which allows the licensing board to regulate the operator by attaching conditions, such as ensuring standards and safety measures.

For drivers, their E-hailing vehicles are now classified as Public Service Vehicles ("PSV") which has been defined as "*a motor vehicle having a seating capacity of four persons and not more than eleven persons (including the driver) used for the carriage of persons on any journey in consideration of a single or separate fares for each of them, in which the arrangement, booking or transaction, and the fare for such journey are facilitated through an electronic mobile application provided by an intermediation business*".

Regulations require E-hailing vehicles to be covered by vehicle, passenger, and third-party insurance. However, the fundamental issue with providing insurance for E-hailing, is the classification of a private car, which is specified as, '*solely for domestic and pleasure purpose' and excludes 'use for hire or reward*'.

As E-hailing services involves ferrying passengers for hire or reward using the operator's or driver's private motor vehicle, E-hailing insurance is offered by insurers as an add on or extension to a private car insurance policy, which could either be a 'Third Party', 'Third Party Fire & Theft' or 'Comprehensive' insurance.

A comprehensive private car insurance comprises two sections namely:

1. **Section A**
   Loss or Damage to the vehicle, as a result of an accident, fire or theft of the vehicle.

2. **Section B**
   Liability to Third Parties causing property damage, and/or bodily injury or death arising from the use of the vehicle.

Additional features may include the following benefits depending on the insurer:

1. Accidental injury to or death of the e-hailing driver.
2. Legal liability to and of passengers in the insured vehicle.
3. Compensation for faulty repair or replacement parts.
4. Alternative travel assistance.

7.3 PROPERTY INSURANCE

Property insurance covers tangible property such as buildings, machinery, plant, etc. against loss or damage caused by fire, flood, and other extraneous perils. Although the term 'property' includes such things as motor vehicles, ships and aircraft, insurance for such property is dealt with separately by specialised types of insurance such as motor, marine and aviation.

Table 7-4 *Property Insurance*

Policy	Property Insured
Fire and Special Perils	Buildings, machinery, stock, etc.
All Risks	Articles of value
Business Interruption	Gross Profit or Revenue
Houseowners	Dwelling House or Flat
Householders	Household contents and personal effects
Theft	Moveable property

7.3.1 FIRE AND SPECIAL PERILS

The basic fire insurance policy provides cover for physical loss of or damage to the property insured, as a result of:

- fire,
- lightning or
- domestic explosion.

Main Exclusions under a Basic Fire Insurance Policy

- Earthquake, volcanic eruption, or other convulsion of nature
- Typhoon, hurricane, tornado, and the like
- Burning of property by order of any public authority
- Subterranean fire
- Explosion other than explosion of gas used for illuminating and domestic purposes
- Burning of forest, bush, lallang, prairie, pampas or jungle and the clearing of land by fire
- Goods held in trust or on commission
- Bullion or unset precious stones
- Manuscripts, plans, drawing or designs, patterns, models, or moulds
- Securities, obligations or documents of any kind, stamps, coins or currency notes, cheques, books of account or other business books or computer systems records
- Explosives
- Loss by theft during or after occurrence of fire
- Loss or damage to property resulting from its own fermentation, natural heating, or spontaneous combustion

In addition to the basic fire, lightning and explosion cover, the fire insurance policy can be extended to include various extraneous or special perils upon payment of additional premiums.

Special Perils

- Aircraft damage
- Earthquake and volcanic eruption
- Storm tempest
- Flood damage
- Explosion
- Impact Damage
- Bursting or overflowing of water tanks, apparatus, or pipes
- Riot, Strike and Malicious Damage
- Electrical Installation Clause B
- Bush or Lallang Fire
- Subsidence and Landslip
- Spontaneous Combustion
- Damage by falling trees or branches and objects therefrom
- Sprinkler leakage
- Smoke damage

7.3.2 ALL RISKS

All Risks insurance is wider in scope compared to fire and special perils insurance because it covers against any '**accidental damage**' as well as '**theft**'. All Risks policies are issued on 'named perils' basis, for example fire, water damage, theft, and accidental damage while others provide cover for 'any physical loss of or damage by a misfortune not specifically excluded'.

All Risks policy insures specific property especially articles of value such as jewellery, watches, cameras, artworks, antiques, or collectibles, etc. The sum insured is usually on an 'agreed value' basis because indemnification on market value or replacement value may be difficult for such items.

Main Exclusions

- loss or damage consequent upon riot, strike, civil commotion, earthquake, or volcanic eruption.

- loss or damage arising from wear and tear, depreciation, gradual deterioration, moth, vermin or from any process of cleaning or restoring any article.

- scratching and breakage of lenses, glass, or other brittle substances, mechanical or electrical breakdown or derangement of any mechanical or electrical equipment;

- loss or damage arising from confiscation or detention by customs or other official authorities.

- theft by deception.

7.3.3 BUSINESS INTERRUPTION

Business interruption (BI) policies endeavour to relieve the hardship associated with consequential loss following an event such as a fire. The BI policy covers the loss of 'profits' while the premises are rebuilt or repaired. It is intended to replace the loss of income as a result of cessation of production

during the restoration period. The method of providing indemnity normally used to settle a claim under a BI insurance policy is by cash payment based on a formula.

The formula used takes into account the loss of gross profit due to the reduction (shortage) in turnover (sales) and the additional (increased) cost of working expended to minimize the loss of gross profit.

Example

Definitions

Gross Profit = (Turnover + closing stock + work in progress) – (Opening stock + work in progress + uninsured working expenses)

Uninsured Working Expenses = purchases, cost of transport, advertisement, water, and electricity, etc.

Indemnity Period = beginning from the date of the material damage and ending no later than the number of months specified as the Maximum Indemnity Period

Sum Insured (SI) = the multiple of the Gross Profit (GP) corresponding to the Indemnity Period (IP). Example: IP = 18 months; SI = Annual GP x 18/12

The business interruption policy covers consequential losses that arise following material damage which directly results in a necessary interruption of operations. It is quite possible for a small amount of material damage to cause a serious business interruption. For example, lightning or fire may cause minor damage to some equipment but may shut down a production line until the damaged machinery is restored to its working condition. The loss can be aggravated if the spares are unavailable locally and the necessary overseas express freight charges will add cost to minimize the waiting period.

Business interruption insurance EXCLUDES the following types of losses: -

- Loss of production that results from industrial action or sabotage
- Cost of recovering lost reputation
- Loss of customers or business
- Loss of key personnel or skilled manpower
- Loss due to bankruptcy or closure of business
- Loss of goodwill, copyright, trademarks, and economic losses

7.3.4 HOUSEOWNERS INSURANCE

The houseowners policy is designed to cover buildings occupied as private dwelling houses, flats and apartments used solely for residential purposes, including fixtures and fittings, garages, out-buildings, walls, gates and fences against loss or damage caused by specified or named perils.

Specified perils under houseowners insurance

1. Fire, Lightning, Thunderbolt and Subterranean Fire.

2. Bursting or Overflowing of Domestic Water Tanks, Apparatus and/or Pipes.

3. Theft by actual, forcible, and violent means.

4. Explosion.
5. Earthquake and Volcanic eruption.
6. Aircraft and other aerial devices and/or articles dropped therefrom.
7. Impact with any of the buildings by any road vehicles or animals not belonging to or under the control of the Insured or any member of his family.
8. Hurricane, Cyclone, Typhoon, Windstorm.
9. Flood but excluding loss or damage caused by subsidence or landslip.
10. Rent (up to 10% of total sum insured) if building is rendered uninhabitable by an insured peril.
11. Public Liability up to RM 50,000 including legal expenses with insurer's consent.

Main Exclusions under houseowners insurance policy

- loss or damage caused by hurricane, cyclone, typhoon, or windstorm to any building under construction, reconstruction, or repair; metal smoke stacks, awnings, blinds, signs and other outdoor fixtures and fittings including gates and fences
- loss or damage caused by subsidence and landslip except where it is occasioned by earthquake or volcanic eruption

7.3.5 HOUSEHOLDERS INSURANCE

The householders insurance policy covers household goods and Insurance personal effects kept in the private dwelling home or residence. The total value of jewellery, gold, and silver articles, etc. is normally restricted to one-third of the total sum insured on contents. The scope of cover is the same as the specified perils from items 1 to 11 of the houseowners insurance policy mentioned above and includes:

1. Property temporarily removed but remaining in Malaysia, up to 15% of the total sum insured on contents.
2. Property in transit or on the person but excluding loss or damage by earthquake, volcanic eruption, hurricane, cyclone, typhoon, windstorm, and flood, cover up to 15% of the total sum insured on contents.
3. Breakage of Mirrors excluding hand mirrors.
4. Fatal injury causing death (within 3 months) up to RM 10,000 or one half of total sum insured on contents whichever is lower.
5. Loss or damage caused by any of the insured perils to servants' clothing and personal effects.

Main Exclusions under Householders Insurance

- subsidence or landslip except if occasioned by earthquake or volcanic eruption;
- loss or damage to contents resulting from its own fermentation, natural heating and spontaneous combustion

Table 7-5 *Optional extensions available under houseowners and householders insurance*

Applicable to houseowners insurance	Applicable to householders insurance (contents policy only)	Applicable to both
• Plate glass exceeding RM500 per piece • Alterations, repairs, and additions	• Un-occupancy in excess of 90 days • Full theft cover (*i.e., theft without being accompanied by actual, forcible, and violent means)*	• Riot, Strike and Malicious Damage • Subsidence and Landslip • Increased Limits to Public Liability

7.3.6 BURGLARY INSURANCE

Theft of property usually arising out of violent entry into or exit from the premises is covered by burglary insurance. The policy provides cover against loss of or damage to insured property usually on a business premises (for example, stocks and materials- in-trade, furniture, office equipment, plants and machinery, and personal effects of employees). Damage to the business premises (either to the building or property insured) following a burglary or housebreaking is covered even if no items were stolen as a result.

Burglary insurance can be insured on full value or on first loss basis:

1. **Full Value** is the actual total value of the property to be insured. Such basis is normally adopted for high value goods that are easily disposable and which can be carted away by thieves in one attempt.

2. **First Loss** sum insured represents the maximum probable loss estimated by the insured considering that the property is heavy or bulky and may be difficult for thieves to remove the entire lot in one attempt. The first loss sum insured represents a percentage of the actual value or 'full value' of the property at the business premises. A lower percentage, for example 20% of the actual total value will attract a higher premium than a higher percentage of, say 50% as the level of exposure is reduced.

Main Exclusions under Burglary Insurance

- depreciation, consequential loss, loss of market and losses discovered at stock-taking;
- loss or damage occasioned by fire or explosion;
- loss or damage brought about by or in collusion with the insured, members of his household, employees, servants, or any person lawfully on the premises;
- loss or damage when the premises are left vacant or abandoned

7.4 MARINE INSURANCE

Marine insurance is one of the earliest forms of insurance and had its humble beginnings in *Edward Lloyd's Coffee House* which became the meeting place for parties in the shipping industry wishing to insure cargoes and ships, and those willing to underwrite such ventures. These informal undertakings eventually led to the establishment of the insurance market called *Lloyd's of London* and several related shipping and insurance businesses. Marine insurers provide cover for known quantifiable risks, mainly hull and machinery insurance for shipowners, and cargo insurance for cargo owners.

The subject matter of marine insurance and their potential exposure to risks are summarized below:

Table 7-6 *Marine Insurance and potential exposure to risks*

Hull and Machinery	Sinking, stranding, grounding, or capsizing Collision liability
Cargo and Freight	Loss or damage caused by perils of the sea, fire, theft, and pilferage including while loading, unloading and temporary storage
Ship Builders' Risks	Loss or damage to vessel in the course of construction.

7.4.1 MARINE HULL INSURANCE

Marine hull insurance covers loss or damage to the vessel and machinery arising from maritime perils as well as salvage costs and limited property damage liability. The terms and conditions of the coverage are spelt out in the Institute Time Clauses – Hulls. Ship Builders' risk policies, on the other hand, protect these same vessels during construction until they are ready for operation

3/4th Collision Liability

Marine hull insurance covers damage caused by **collisions with other ships** for only ¾ of the liability for such damage (a quarter of such damage is paid by Protection & Indemnity Clubs). The maximum recovery under hull policies, including damage to the insured ship and liability for the damage it had caused is the insured value of the ship.

Protection & Indemnity (P&I)

P&I Clubs provide insurance cover for broader, indeterminate risks, such as third party liabilities that marine insurers usually do not cover. Third party risks include a carrier's liability to a cargo-owner for damage to cargo, a shipowner's liability after a collision, environmental pollution and P&I **war risk insurance**, that is to say legal liability arising out of acts of war affecting the ship.

For example, assume that both vessels in a collision are insured for ¾ collision liability with their hull underwriters and for ¼ with their P&I Clubs. Vessel A is 75% to blame for the collision and vessel B is 25% to blame. Vessel A suffers damage costing $100,000 and vessel B suffers damage costing $200,000.

The payments by each underwriter are illustrated below.

Table 7-7 *Types of Payments by Underwriters*

	Vessel A	Vessel B
Per cent to blame	75%	25%
Own damage	$100,000	$200,000
Liability to other vessel	$150,000 (75%x$200,000)	$25,000 (25%x$100,000)
Net settlement	$125,000 paid to B	
Underwriter's pay	$112,500 (3/4 x $150,000)	$18,750 (3/4 x $25,000)
P&I pays	$ 37,500 (1/4 x $150.000)	$ 6,250 (1/4 x $25,000)

Each collision liability underwriter reimburses its share of each vessel's gross liability to the other vessel. In most maritime jurisdictions, the question of responsibility for collisions is determined with reference to the International Regulations for the Prevention of Collisions at Sea, which codify how vessels should conduct themselves to avoid collisions. The apportionment of liability between the vessels is normally based on the causative importance of any breaches of these Regulations.

7.4.2 MARINE CARGO INSURANCE

Marine cargo may take the following forms of insurance when using sea or inland waterway transportation:

1. **Free on Board (FOB)**
   Risk passed on to the buyer including payment of all transportation and insurance cost once delivered on board the ship by the seller.

2. **Cost and Freight (CFR)**
   Title, risk, and insurance cost passed on to the buyer when delivered on board the ship by the seller who pays the transportation cost to the destination port.

3. **Cost, Insurance and Freight (CIF)**
   Title and risk passed on to the buyer when delivered on board the ship by the seller who pays the cost of transportation and insurance to the destination port.

There are three main types of marine cargo policies which would incorporate any one of the following clauses:

1. Institute Cargo Clause A - All Risks
2. Institute Cargo Clause B - Specific Risks
3. Institute Cargo Clause C - Specific Risks

The perils insured by the respective Institute Cargo Clauses are described below:

Table 7-8 *Types of Perils by Institute Cargo Clauses*

Named Perils	Institute Cargo Clauses		
	A	B	C
Sinking, stranding, grounding, capsizing	√	√	√
Fire, explosion	√	√	√
Collision	√	√	√
Overturning, derailment of land conveyance	√	√	√

Earthquake, volcanic eruption, lightning	√	√	X
General Average Sacrifice	√	√	√
Jettison	√	√	√
Discharge of cargo at port of distress	√	√	√
General average and salvage charge	√	√	√
Washing overboard	√	√	X
Entry of sea, lake, river water into vessel	√	√	X
Total loss of package during loading or discharge	√	√	X
Pirates and thieves	√	X	X
Deliberate damage or destruction	√	X	X
Wilful misconduct of the insured	X	X	X
Ordinary leakage, loss in weight or volume, wear and tear	X	X	X
Insufficiency or unsuitability of packing	X	X	X
Inherent vice or nature of the subject matter	X	X	X
Unseaworthiness and unfitness of vessel (i.e. when the insured is privy to it)	X	X	X
Insolvency or financial default of carrier	X	X	X
War, strikes, riots and civil commotions	X	X	X
Atomic and nuclear weapons	X	X	X

Marine Cargo Extensions

The following extensions are provided on payment of additional premiums as prescribed by the Institute of London Underwriters (ILU):

- Institute War Clause
- Institute Strike Clause

Marine Cargo Exclusions

- Wilful misconduct of the Assured
- Ordinary leakage, loss in weight or volume, wear, and tear
- Improper packing
- Inherent vice
- Delay
- Insolvency or financial default of carrier

7.4.3 AVIATION INSURANCE

Most aviation insurance policies are issued on an "all risks" basis covering damage to the hull, liability to passengers and public liability.

Generally, for mid-range aircrafts, there are two main types of policies:

- Hull, spares, and third-party liability (usually in combined single limit), and
- War and allied perils

In addition, aviation insurance policies may include cover for the following:

- Freight liability to cover aircraft owner's liability to cargo owners
- Personal accident for crew

- Loss of licence of pilot, flight engineers

Aviation insurance buyers mainly comprise large commercial airliners who may arrange "Fleet Policies" to cover all aircrafts owned or operated by them.

Other buyers may include:

- Corporate/business aircraft owners
- Private owners; and
- Flying clubs

Malaysian risks and Malaysian interests abroad are written collectively by the Malaysian Aviation Pool comprising eight local insurers and four reinsurers with an underwriting capacity of RM393 million. No single insurer has the resources to retain a risk the size of a major airliner, or even a substantial proportion of such a risk. The catastrophic nature of aviation risks can be measured in the number of losses that have cost insurers hundreds of millions of dollars.

The Montreal Convention (formally, the Convention for the Unification of Certain Rules for International Carriage by Air) was adopted by a diplomatic meeting of International Civil Aviation Organization (ICAO) member states in 1999. The multilateral treaty came into force in 2003 and standardizes the rights of passengers on international flights.

7.4.4 GOODS IN TRANSIT INSURANCE

Goods in transit insurance covers conveyances of goods as a direct result of domestic sales or purchases. The insurance is normally taken out by the owner of the goods or by a professional carrier or logistics company, who are equally responsible for the goods in their custody. The goods in transit policy usually offer 'All Risks' type of coverage on an annual basis or on each transit basis.

Scope of Cover

- indemnity for physical loss of or damage to goods by fire, accident, theft, or pilferage while being conveyed on land by road, rail and inland waterway (e.g., by ferry from the mainland to Penang Island); and

- while loading and unloading from the vehicle or trailers and during temporary storage in the ordinary course of transit within the geographical boundaries (e.g., Malaysia and Singapore).

Main Exclusions under Goods in Transit Insurance

- wear, tear, and depreciation;
- delay, loss of market, consequential loss of any kind;
- theft or pilferage by the insured's employees;
- earthquake and subterranean fire;
- moth, vermin, insects, damp, mildew, or rust;
- deterioration and changes by natural causes;
- goods accompanying commercial travellers;
- cargo such as explosives, hazardous chemicals and acids, cash, bank and currency notes, securities, jewellery, and business books.

7.5 LIABILITY INSURANCE

Liability insurance provides indemnity against claims made by third parties for bodily injury or property damage and, in the case of professional indemnity and directors' and officers' liability insurance, for economic or pure financial loss for which the insured may be held legally liable.

7.5.1 MAIN TYPES OF LIABILITY POLICIES AND SCOPE OF COVERAGE

Table 7-9 *Main Types of Liability Policies and Scope of Coverage*

Public Liability	• Covers legal liability of a business enterprise for bodily injury to any member of the public and/or loss of or damage to their property arising from the operation of their business. • Environmental risks are included but only for sudden and accidental pollution liability.
Product Liability	• Covers legal liability of a manufacturer towards third parties who have sustained bodily injury or property damage caused by a defective product. • Indemnity is for losses occurring after the delivery of goods produced.
Professional Indemnity	• Covers legal liability of a professional for financial loss sustained by a third party, particularly his customers, for breach of professional duty of care. • Policy is normally issued on claims-made basis.
Directors' and Officers' Liability	• Indemnity for directors and officers of a company, trust, organization, etc., against their personal liability for financial loss suffered by third parties • as a result of their wrongful acts e.g., imprudent investments.

7.6 EMPLOYER'S LIABILITY AND WORKMEN'S COMPENSATION INSURANCE

Employer's Liability insurance provides indemnity to an employer for damages and defence costs in respect of liability of the employer to employees, who sustain injury or illness in the course of their employment. The cover includes legal costs and expenses including costs incurred in defending or representing the employer at any hearing for breach of statutory duty, under the Occupational Safety and Health Act 1994 (OSHA).

Who is eligible to be covered?

An employee who is not insured under any Workmen's Compensation Insurance or who is not eligible to contribute to the Social Security Organization (SOCSO).

Common Law Liability

An employer is liable to employees for injury or occupational disease sustained in the course of their employment. To claim compensation under common law, an employee has to prove negligence on the part of the employer in the following circumstances, for example:

- The employer failed to provide:
    - safe place of work;
    - safe plant & machinery;
    - safe procedures and systems or
    - safe people to work with.

In the event an employee takes legal action against his employer under common law, the employer can defend himself, by demonstrating that he had taken reasonable care or that there was an element of contributory negligence on the part of the employee, for example; where an accident occurs due to the employee's failure to abide by safety procedures imposed by the employer.

Whilst the Employer's Liability policy includes common law liability, Workmen's Compensation insurance must be extended to include liability under common law. Insurers usually provide cover up to a limit of RM1,000,000 for any one accident and/or in the aggregate for any one period of insurance, subject to Malaysian law and jurisdiction.

Policy Exclusions

The Employer's Liability policy does not cover:

- Employees of insured's contractors
- Liability assumed by agreement (contractual liability)
- Any injury by accident or disease sustained outside Malaysia
- Liability by virtue of Workmen's Compensation laws
- War and Terrorism
- Cyber Liability
- Asbestosis

7.6.1 WORKMEN'S COMPENSATION INSURANCE

Workmen's Compensation insurance provides payment of compensation in accordance to the scale of compensation under the Workmen's Compensation Act 1952. Section 4 of the Act stipulates that; if in any employment, personal injury by accident arising out of and in the course of the employment is caused to a workman, his employer shall be liable to pay compensation and any expenses incurred in the treatment and rehabilitation of such workman.

Section 26 of the Act stipulates compulsory insurance by the employer, particularly for employees who are not eligible to contribute to the Social Security Organization (SOCSO).

Table 7-10 *Difference between Workmen's Compensation and Employers' Liability Insurance*

Workmen's Compensation	Employer's Liability
A 'no-fault' system where the employee is not required to prove negligence.	Employee must prove negligence to receive 'full' compensation under common law.
Provides reasonable redress for economic or financial loss for work-related injury.	Contributory negligence (by the employee) will be considered by the court.
Uses fixed scales of compensation for medical care, cost of rehabilitation, lost earnings, and benefits for surviving dependents.	Common law liability includes general damages such as pain and suffering, loss of amenity and loss of faculty.

7.6.2 SOCIAL SECURITY ORGANIZATION (SOCSO)

Employees' Social Security Act 1969 (ESSA) enforces compulsory contributions to the Social Security Organization (SOCSO) by both the employer and the employee. An employee whether temporary or part time, under a contract of service in connection with the work of an industry to which the ESSA applies is required to be registered with SOCSO.

Who is eligible to contribute to SOCSO?

All Malaysian workers earning monthly wages of not more than RM3,000 must contribute to SOCSO. This is because Malaysian workers are no longer subject to the Workmen's Compensation Act 1952, after 1 July 1992.

Section 42 of the ESSA prohibits an employee who receives compensation from SOCSO to receive 'any other benefit under any other written laws'; This means that an employee is prohibited from taking his employer to court for additional compensation (more than that provided by SOCSO) even if he can prove negligence of the employer.

7.6.3 SOCSO'S EMPLOYMENT INJURY (EI) SCHEME FOR FOREIGN WORKERS

New foreign workers (excluding domestic servants) entering Malaysia on or after 1 January 2019 have to register with SOCSO once they are validated by the Immigration Department of Malaysia at any gazetted port of entry. For existing foreign workers who have valid Foreign Workers Compensation Scheme (FWCS), they have to be registered with SOCSO by their employers by 1 January 2020.

Under the EI scheme, foreign workers are not required to make any contribution to SOCSO, however the employer is required to contribute on a monthly basis, 1.25% of the worker's monthly wages (subject to the insured wage ceiling of RM 4,000 per month).

7.7 MISCELLANEOUS ACCIDENT INSURANCE

The types of insurance which may be found in the miscellaneous accident department include personal accident insurance and other policies termed 'pecuniary' (exacted in money or monetary payments) such as money insurance, fidelity guarantee, bonds, etc. which are not specifically covered under motor, property, marine, aviation, liability, or engineering insurance.

7.7.1 PERSONAL ACCIDENT

Personal accident insurance provides protection against the economic consequences of accidents, usually in the form of loss of earnings. Unlike worker's compensation which is obligatory, the cover provided under personal accident insurance applies not only to accidents at work but worldwide for accidents of any kind whether at home, while travelling, during leisure time, during sports activities, and in road traffic, and is known as '24-hour cover'.

Personal accident insurance is offered to individuals or to a group of employees in one policy to cover bodily injury caused solely and directly by violent accidental external and visible means which directly and independently of any other cause results in death or disablement.

Table 7-11 *Personal Accident Extent of Cover and Benefits*

Extent of Cover	Benefit
Death	Lump sum payment of the sum insured in the event of accident death.
Permanent Disablement	Lump Sum Payment of the Sum Insured or a Percentage of it for Permanent and Total Disablement (for the rest of one's life) or Partial Disablement referenced to a dismemberment schedule.
Temporary Disablement	Weekly Rate of a Fixed Allowance in the Event of Temporary Disablement from Attending to Usual or Main Occupation, Limited to a Maximum Compensation Period of 104 Weeks.
Daily Hospital Cash Allowance	Daily Rate of a Fixed Allowance in the Event of Hospitalisation due to an Accidental Injury.
Medical Expenses	Reimbursement of Actual Medical Expenses Incurred due to an Accident.

Personal accident insurance does not cover death or disablement caused by:

- Suicide, Insanity or under the influence of drugs or intoxicating drinks
- AIDS, Sexually Transmitted Diseases and any illness
- Unlawful Acts
- Flying or navigating an aircraft or crew member
- Armed police or military duty
- Professional sports and hazardous sports
- Pregnancy, childbirth, miscarriage, abortion
- Pre-existing physical or mental defect

7.7.2 MONEY INSURANCE

The term "money" includes cash, bank and currency notes, cheques, postal orders, currency, postage and revenue stamps belonging to the insured or for which he is legally responsible. Money insurance is usually issued on 'All Risks' basis covering loss of money in the following circumstances:

- in transit between the insured's premises and the bank by the insured's authorized employees or representatives;
- on the insured's premises during business hours;
- in a locked safe or strong room on the insured's premises after business hours;
- in the private residence of any principal or director of the insured; or
- other specified situations

In addition to loss of money, the money insurance policy provides

- indemnity for the following losses up to a specified limit:
- cost of repair or replacement of the safe or strong room as a result of damage consequent upon forcible and violent entry or as a result of armed robbery

- compensation to carriers for injuries sustained during transit of money as a result of robbery or hold-up
- infidelity of the carrier who may abscond with the money

The money policy does not pay any claims arising from:

- fraud or dishonesty of employees (other than limited cover of the carrier)
- shortage due to errors or omissions
- loss occurring outside the territorial limit
- loss from any safe or strong room following the use of the key (left in the same room)
- depreciation in value of currency
- loss of money from an unattended vehicle (escorted by security guards)
- confiscation, nationalization, requisition, or wilful destruction by any government authorities

7.7.3 FIDELITY GUARANTEE

The object of fidelity guarantee insurance is to provide cover against loss by reason of the dishonesty of persons holding positions of trust. Employees who are responsible for handling money or stocks belonging to their employer may commit acts of misappropriation, embezzlement or fraudulent conversion of property belonging to the employer for personal gain.

Table 7-12 *Types of Policies and Guarantees*

Types of Policies	Types of Guarantees
Individual -named employee or a specified position	per employee/person
Collective -selected number of named or unnamed employees by position	per person and event per year
Blanket -all employees of the organization	per person and event in the annual aggregate/per policy

There are two issues pertaining to what triggers a claim under a fidelity guarantee policy:

1. the act of misappropriation has to be committed during the period of insurance and during the employee's uninterrupted service or employment;
2. the discovery of the loss has to be within a specified period (i.e., usually six to twelve months) after the resignation, death, dismissal, retirement of the guilty party/employee or after the termination of the policy, whichever happens first.

The fidelity guarantee policy does not pay any claims for:

- Indirect financial losses e.g., loss of interest, losses due to business interruption

- Negligence, stocktaking, or inventory losses
- Bankers' blanket bonds

7.7.4 BONDS

Bonds are a form of surety insurance. Surety exists when one party guarantees performance by another party of an undertaking or obligation. A surety bond is a written agreement, whereby the surety, who issues the bond, obligates itself to a beneficiary or employer to pay a stipulated amount in the event of breach or default of a contractor.

Under a performance or construction bond, the insurance company stands as surety to the principal or employer that if the construction company is unable to complete the contract works, then the insurance company will provide the financial means to do so (usually limited to 5 percent of the total contract value). Other types of bonds include tender bonds, advanced payment bonds, maintenance bonds and supply bonds.

Bonds are written in conjunction with engineering works for which construction insurance and workmen's compensation insurance are taken by the principal and the main contractor appointed to execute the works. The insurer provides for the payment of the amount guaranteed should the contractor fail to fulfil his obligations under the contract.

7.8 ENGINEERING INSURANCE

Engineering insurance comprises specialised classes of insurance business and policies may be classified as:

1. Renewable
2. Non-Renewable policies

7.8.1 RENEWABLE ENGINEERING POLICIES

The table below lists three of the most common types of renewable policies issued in the engineering department and briefly describes the coverage and main exclusions of each of the policies:

1. Boiler and Pressure Vessels
    - Damage (other than by fire) to boiler or pressure vessel (driven by steam or hot water) due to explosion or collapse
    - Legal liability for third party (surrounding) property damage
    - Legal liability for third party injury or death
2. Machinery Breakdown and Loss of Profits
    - Sudden and unforeseen damage (other than by fire) to machinery and plant at work or being dismantled for the purpose of cleaning, inspection, overhauling, subject to
        - a) Annual maintenance agreement; and
        - b) Regular inspection warranty

- Loss of profits policy covers loss of operating profits and standing charges consequent to machinery breakdown

3. Electronic Equipment

- 'All Risks' basis of cover for any physical loss of or damage to electronic data processing systems and its peripherals.
- Section 1 Material Damage to computer hardware
- Section 2 External Data Media and cost of reprocessing lost data
- Section 3 Increased Cost of Working

Main Exclusions:

1. Boiler and Pressure Vessels

- wear and tear but explosion or collapse arising from wear and tear is covered
- failure of expendable parts (that is, parts requiring routine maintenance) unless such defects result in explosion or collapse
- damage caused by fire to property belonging to the insured
- damage or liability caused by wilful act or neglect by the insured
- loss sustained by stoppage of work
- loss or damage caused by typhoon, hurricane, volcanic eruption, earthquake, and the like

2. Machinery Breakdown and Loss of Profits

- normal wear and tear
- loss or damage arising from fire and explosion
- inundation, subsidence, earthquake, and the like

3. Electronic Equipment

- earthquake, volcanic eruption, hurricane, cyclone, or typhoon
- faults or defects existing at the commencement of policy within the knowledge of the insured
- failure or interruption of any gas, water, or electricity supply
- atmospheric conditions
- maintenance costs

- loss or damage for which the supplier or manufacturer is responsible by law or contract
- loss or damage to hired equipment for which the owner is responsible by law or contract consequential loss or liability

7.8.2 NON-RENEWABLE ENGINEERING POLICIES

These types of policies are mainly issued in conjunction with civil or mechanical engineering project works which are associated with high insured values and long duration of cover which may last several years in some cases.

Contractors' All Risks

Contractors' all risks (CAR) insurance is designed for the purpose of complying with a contractor's obligations under a civil engineering contract which includes construction of buildings, bridges, and roads, etc. on an 'all-risks' basis. Material damage to the works and third party liability arising from the works occurring during the period of construction and during the 'maintenance' or 'defects liability' period will be covered.

Section 1 - Material Damage

Covers physical loss of or damage to:

a. Contract works and all materials incorporated and on site

b. Contractor's plant, machinery and equipment used in the construction

c. Existing or surrounding properties of the principal or employer

Section 2 - Third Party Liability

Covers insured's legal liability for:

a. Accidental property damage and/or

b. Bodily injury to a third party arising from the execution of the contract work

The purpose of contractors' all risks insurance is to provide immediate funds following an accident to mitigate the risk of delay or non-completion. The risk becomes more acute nearing completion due to the high insured value which in turn would increase the severity of a loss or damage compared to the beginning stage of the construction.

Erection All Risks

Erection all risks (EAR) insurance is similar to contractors' all risks insurance in that the coverage is on an '*all-risks*' basis covering material damage to the works and third party liability arising from the works. The distinction is that EAR involves *mechanical engineering* projects and covers the erection of a plant or installation of specialised machinery, whereas CAR covers mainly civil engineering works as explained above.

The policy has two sections:

1. **Material Damage** section covers damage to the plant or machinery including materials on site. The limit of indemnity represents the total contract value including all materials on site.
2. **Third Party Liability** section covers property damage and/or bodily injury that result from the execution of the work insured. The limit of indemnity should take into account the existing and surrounding properties and inhabitants exposed to such peril.

The period of insurance begins from the time of installation, and continues during *testing* and *commissioning* until handed over to the principal.

EAR may cover a single large machinery, its apparatus and assembly lines or a turnkey project involving a power producing plant and its facilities. Both types of work may include the following items:

- Incidental and related civil engineering works
- Contractor's plant, machinery or equipment used in execution of the work
- Existing property on site, belonging to or held in the care and custody of the insured
- Expenses incurred for the clearance of debris after a loss
- Additional expenses incurred for overtime, express freight, etc.

Main Exclusions under CAR and EAR

- faulty design, defective materials or workmanship
- wear and tear, corrosion, and deterioration
- mechanical and/or electrical breakdown of construction plant
- and machinery
- motor vehicles licensed for public road use or waterborne
- vessels or aircraft
- documents, files, drawings, accounts, bills, currency, notes,
- securities and cheques
- stock taking or inventory
- excess or deductibles
- consequential loss
- wilful acts of any director, manager, or employee

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*Which of these types of damage would be covered automatically under a commercial fire policy?*
A	a. Damage caused by an explosion that results from a fire b. Damage caused by the fire brigade in putting out a fire c. Damage caused by spontaneous combustion d. Damage caused as a result of a subterranean fire

2	**Review Question**
Q	*What is business interruption insurance primarily designed to cover?*
A	a. The loss of production that results from industrial action b. Consequential losses that arise following material damage c. The cost of recovering lost reputation following a product liability claim d. The loss of profits that results from a key customer going out of business

3	**Review Question**
Q	*When is liability to passengers compulsory in Malaysia?*
A	a. Passengers while travelling in a motor vehicle including entering or alighting from it b. Passengers carried for hire or reward or being carried in the employer's vehicle in pursuance of their employment c. Employees travelling as passengers in a vehicle belonging to the employer d. Any person who has a contract of employment with the insured or his authorised driver.

4	**Review Question**
Q	*A windstorm damages property and claims were received under a houseowners policy for roof repairs, repairs to garden fence and repainting of the ceiling as a result of water damage. What will be covered by the policy?*
A	a. Roof repairs only b. Roof repairs and damage to the ceiling only c. Roof repairs and repairs to garden fence only d. Roof repairs, repairs to garden fence and repainting of the ceiling

5	**Review Question**
Q	*Which of these claims will be covered under a comprehensive private motor car policy?*
A	a. Car's front tyres were damaged under severe braking to avoid a collision b. Reduction in value of the car following after an accident repair c. Cost of hiring a temporary replacement after the car was impounded by the police d. Fire damage to the interior of the car which resulted from an electrical short circuit under the dashboard

6	**Review Question**
Q	*The basis of cover for machinery and plant under an engineering policy is in respect of fire and explosion damage.*
A	a. explosion or mechanical breakdown b. sudden and unforeseen damage *c.* explosion and consequential loss

7	**Review Question**
Q	*Commercial theft insurance normally covers loss of the insured property caused by any means of theft including deception.*
A	a. theft involving entry into or exit from the premises by forcible and violent means. b. any means of theft except misappropriation of funds due to the dishonesty of an employee. *c.* any means of theft except shoplifting.

8	**Review Question**
Q	*A contractors' all risks insurance policy insures the contract works against*
A	a. mechanical or electrical breakdown. b. losses that arise due to defective design or workmanship only. c. fire and limited explosion only. d. 'all-risks' of loss or damage, subject to specific exclusions.

9	**Review Question**
Q	*A professional indemnity policy EXCLUDES liability arising from the insured's*
A	a. dishonesty. b. breach of duty. c. negligent acts. d. errors or omissions.

10	**Review Question**
Q	*Motor insurance is made compulsory under the Road Transport Act 1987 for the following reasons EXCEPT*
A	a. to make available funds needed to compensate victims of road accidents. b. to ensure funds are readily available when damages are awarded by the courts. c. to compensate victims of untraceable (hit and run) drivers. d. to ease the Government's financial burden and to protect national interest.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

8

CHAPTER 8 GENERAL INSURANCE UNDERWRITING

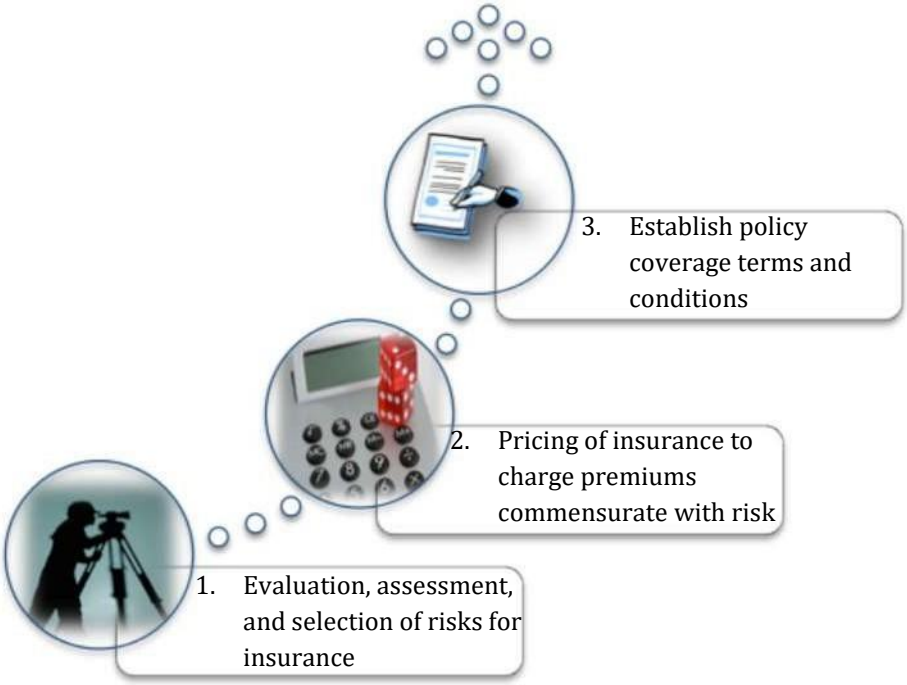
8.1 INTRODUCTION

Underwriting is the process of selecting risks for insurance and classifying them according to their degrees of insurability so that the appropriate rates may be assigned. The process also includes rejection of those risks that do not qualify.

An underwriter would normally refer to an 'Underwriting Guide' to decide which risks are acceptable and which to decline according to the underwriting practices of the insurance company. Underwriting also involves the pricing of insurance coverage. It is important to ensure that insurers charge the right amount for the coverage they provide. This is because if an insurer charges too little, it will suffer underwriting losses; if loss experience deteriorates and if it charges too much, it may lose business to its competitors. The underwriter's job requires a certain level of skill to balance between premium growth and profitability.

8.2 THE UNDERWRITING PROCESS

FIGURE 8-1 ***Underwriting Process***



8.3 UNDERWRITING GUIDELINES

1. Each insurance company has its own list of '**preferred risks**'. For example, with regards to motor insurance, older and experienced drivers, usually married males above the age of 30 years have shown good claims record and will be regarded as 'good risks'.

2. On the other hand, '**referred risks**' are those considered hazardous due to certain characteristics attaching to the risk. For example, in writing fire insurance, furniture and wood working risks will be re-evaluated after a **survey is conducted by a risk engineer** or surveyor to assess the structures, processes and overall housekeeping. The underwriter would require such information to decide whether to accept the risk or decline it and if

acceptable will determine the appropriate rates, policy terms and may even recommend risk improvement measures.

3. Risks are **declined** by insurers because of the '**high risk exposures**'. For example, motor vehicles such as taxis, tour coaches, and express buses which carry passengers for hire or reward may cause accumulation of losses in the event of an accident involving damage to the vehicle, third party property damage and liability to passengers. This is like aviation risks which can cause a catastrophic loss as a result of an air crash. In Malaysia, insurance for such risks is arranged by pooling as in the case of the Malaysian Motor Insurance Pool and the Malaysian Aviation Pool.

8.4 PRICING OF GENERAL INSURANCE PREMIUMS

The calculation of insurance premiums has to take into account the minimum and maximum rates and the extent to which premiums are adjustable in the light of its volume and loss amounts in respect of a particular class of business.

Generally, the gross premium comprises the following factors:

a. risk premium
b. expenses, commission, or brokerage
c. contingency or security (for variation in losses)
d. margin for profit

8.5 PHASED LIBERALISATION OF THE MOTOR AND FIRE TARIFFS

Premium rates for motor and fire insurance are regulated or tariffed in Malaysia. Discussions on the detariffication of motor and fire insurance started in the early 2010s, and in March 2016, the Central Bank (Bank Negara Malaysia) announced the phased liberalisation of motor and fire insurance.

The detariffication allowed for the removal of the tariff structure or fixed premiums so that insurers could charge premiums that corresponded with the risk profile of their consumers.

Detariffication also gave birth to the inevitable need for insurance companies to digitise their internal processes and build their own operating systems. With the ability to charge premiums based on the risk they can take, insurers looked at creating better products at cheaper rates by digitising their products as well as making the back-end processes smoother to create a better customer experience.

The Malaysian Motor Insurance Tariff (introduced in 1978) prescribes the types of motor insurance cover, basis of premium rating, standard policy wording, exclusions, extensions, extra benefits and their respective premiums and level of no-claim discounts applicable for the various types of motor vehicles used in peninsular and east Malaysia.

The Revised Fire Tariff 2.0 (RFT 2.0- effective Oct 2022 on 97 trade codes) regulates fire insurance business in Malaysia and prescribes the basis of premium rating, discounts for fire extinguishing appliances (FEA), construction and town classifications, scope of cover of the standard fire insurance policy, warranties, clauses, and endorsements applicable to the various types of trade and its processes.

8.6 MOTOR PREMIUM COMPUTATION

The following is an example of how motor insurance premium is calculated using the tariff rates.

Example

Motor Premium Computation

Risk Details:

Owner	: ABC COMPANY Limited
No-Claim-Discount	: NIL (history of 2 previous claims)
Vehicle	: BMW 5281 SALOON
Cubic Capacity	: 2,793
Year of Manufacture	: 2008
Sum Insured	: RM 300,000

Extra Benefits:

- Windscreen for RM 3,000
- Strike, Riot, Civil Commotion
- Flood and Windstorm
- Liability to Passengers

Table 8-1 *Motor Tariff Rates*

Cubic Capacity Not Exceeding	Electric Motor Capacity Watt Not Exceeding	Comprehensive		Third Party (Endorsement No. 3 (p) must be used)	Act
Cu Cms			RM	RM	RM
1400	68,628	273.80	Plus RM26 for each RM1,000 or part thereof on value exceeding RM1,000	120.60	109.35
1650	80,883	305.50		135.00	121.50
2200	107,844	339.10		151.20	137.70
3050	149,551	372.60		167.40	153.90
4100	200,982	404.30		181.80	166.05
4250	208,335	436.00		196.20	178.20
4400	215,688	469.60		212.40	194.40
Over 4400	Over 215,688	501.30		226.80	206.55

Example

Motor Premium Computation for ABC Company Limited

Basic Premium (RM 304.20 + 26.00 x 299)	: RM 8,078.20
Less No-Claim-Discount (if any)	: NIL
Strike, riot, and civil commotion - 0.30% of sum insured	: 900.00
Breakage of glass in windscreen or windows - 15% of windscreen sum insured	: 450.00
Flood, windstorm, rainstorm, typhoon, hurricane, volcanic eruption, earthquake, landslide - 0.50% of sum insured	: 1,500.00
Liability to Passengers - 25% of third-party premium	: 24.75
All drivers (private cars issued to a company or business organization)	: 50.00
Total Premium	: 11,002.95
Add: 6% Service Tax	: 660.18
Add: Stamp Duty	: 10.00
Total Amount Payable	**: 11,673.13**

8.7 FIRE PREMIUM COMPUTATION

The following is an example of how fire insurance premium is calculated using the tariff rates.

Example

Fire Premium Computation

Risk Details:

Insured	: XYZ Company Limited
Situation of risk	: Ground floor, shop lot on Jalan Ampang, Kuala Lumpur
Construction	: Brick walls and concrete roofing
Trade	: Printers and book publishers

Interest	**Sum Insured**
Building	: RM 500,000
Plant and Machinery	: RM 100,000
Stock	: RM 200,000
Office Equipment	: RM 20,000

Special Perils:

- Bursting or Overflowing of Water Tanks, Apparatus, Pipes
- Electrical Installation Clause (B)
- Riot, Strike and Malicious Damage
- Flood

Table 8-2 *Fire Tariff Rates*

Code	Trade/Occupation Classification	Construction Classification				Warranties Applicable
		1A	1B	2	3	
2100	Paper and Printing					
2104	Printers					
2124	Magazine/periodicals/book printers	0.190	0.254	0.411	0.644	

Example

Fire premium computation for XYZ Company Limited

Basic fire, lightning, and domestic explosion cover:

Trade Code: 2124	Sum Insured	Premium
Basic Rate: 0.190%	RM 820,000	RM 1,558.00

Additional Perils:

Riot, Strike & Malicious Damage:	0.014 % of sum insured	114.80
Bursting or Overflowing of Water Tanks	0.005% of sum insured	41.00
Electrical Installation Clause (B)	0.056% on electrical machinery	56.00
Flood	0.086% of sum insured	705.20
Add Service Tax	6 % of Gross Premium	148.50
Stamp Duty		10.00
Premium Payable		**RM 2,633.50**

8.8 UNDERWRITING CONSIDERATIONS AND RATING FACTORS

In this section we will examine the underwriting considerations and rating factors of the following classes of insurance.

Table 8-3 *Underwriting Considerations and Rating Factors*

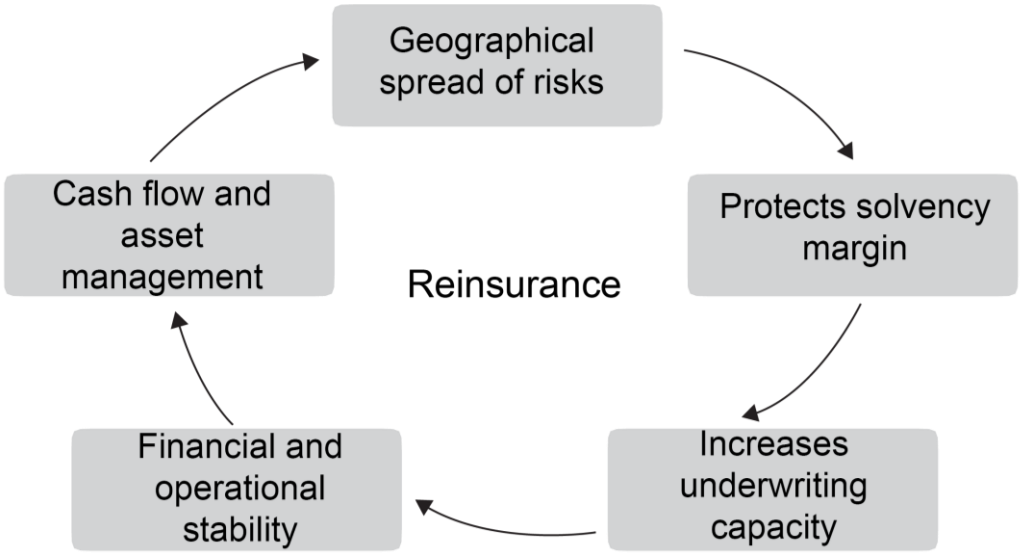
Types of Insurance	Underwriting Considerations	Rating Factors
Motor (may differ from one insurer to another in non-tariff product)	• Vehicle type (private car, motorcycle or commercial) • Use of vehicle (passenger or goods carrying) • Age and condition of vehicle • Modification to the vehicle, if any • Occupation of the vehicle owner	• Cubic capacity or tonnage • Market value of the vehicle • Year of manufacture • Claims history • Driving experience
Fire	• Hazardous process (spray painting) or storage (explosives) • Basis of indemnity (market value or agreed value • Location and terrain (hill slope or low lying and flood prone) • Adequacy of sum insured (on reinstatement as new basis)	• Trade or occupation • Construction class • Extraneous perils such as subsidence or landslip • Fire extinguishing appliances installed • Duration of cover (short term or annual)

Burglary	• Type of goods (high value, precious or heavy and bulky) • Location of risk (busy commercial lot or out of town and remote) • Structure of building (entry and exit points) • Security and burglar alarms installed	• Type of goods and business retail general store, warehouse, showroom, or factory • Sum insured (first loss or full value)
Personal Accident	• Age of person to be insured • Health and physical condition • Hazardous sports or activities	• Occupation • Benefits (lump sum payments, weekly disablement, or reimbursement of medical expenses)
Contractors' All Risks	• Exposure to technological changes such as new materials, new methods of construction, prototype design, new dimensions, and higher operational temperatures • Exposure to natural hazards such as flood	• Insured values for material damage and third-party liability • Duration of cover including maintenance period • Background and experience of contractors in carrying out similar projects

8.9 REINSURANCE

Reinsurance is the **transfer of risks** by an insurer to a reinsurer, in other words, it is "**insuring insurers**". A reinsurance contract is formed between the **reinsured and the reinsurer**.

Reinsurance has many uses and benefits:



Two key functions of reinsurance are:

1. To cushion the impact of **a catastrophic loss** such as earthquake, tsunami, and flood where a single event can stretch the financial resources of an insurer to breaking point.

2. To protect against the **accumulation of losses** arising from a single catastrophic event such as an air crash or terrorist attacks at the World Trade Center on 9/11 which could cause the accumulation of individual losses under various types of insurances such as property, liability, and casualty.

8.10 GENERAL INSURANCE DOCUMENTS

8.10.1 THE PROPOSAL FORM

Proposal forms are documents drafted by the insurer in the form of questionnaires for each class of insurance to gather relevant information required to assess the risks appropriately. The use of the proposal form enables an underwriter to exercise prudent judgement based on the answers given and if the need arises, further information or clarification may be sought from the proposer before a final decision is made.

Before entering into a contract of insurance, both parties (applicant and insurer) have a duty to disclose accurate and relevant information in a clear, concise and timely manner to enable the consumer to make an informed decision and the insurer to decide on suitable terms of acceptance of the risk.

Proposal forms are not used in marine cargo insurance because shipping documents such as invoice, purchase order and shipper's receipt provide underwriters with the necessary information and documentary evidence to decide quickly before the shipment takes off.

8.10.2 THE COVER NOTE

A cover note is a temporary document to confirm insurance cover while waiting for the policy form to be issued. The cover note is documentary evidence of a valid insurance contract entered into by the insured with the insurer and is subject to the standard policy terms, conditions, and exclusions for the class of insurance.

Most insurance contracts must be in writing as in the case of marine insurance (Marine Insurance Act 1906 s.22). In Malaysia, an insurance contract where written documentation is required is motor insurance, currently governed by the Road Transport Act 1987. **Section 91** requires a 'policy' of insurance to be in force and, para (4) states that a policy shall be of no effect unless and until a "**certificate of insurance**" is issued in the prescribed form and delivered to the policyholder.

8.10.3 MOTOR E-COVER NOTE

The electronic motor cover note system replaced the physical motor cover note in the year 2005 as part of the e-Government initiative. A policy of insurance (which includes a cover note) is required for registration and licensing of motor vehicles. Insurers transmit the cover note to the Road Transport Department (JPJ) electronically for confirmation (unsettled summonses, etc. may prohibit confirmation) for renewal of road tax or registration of new vehicles.

8.10.4 CERTIFICATE OF INSURANCE

a. A motor certificate of insurance is documentary proof of motor insurance coverage and must be issued and delivered in the form prescribed by the Road Transport Act 1987. If the policy is cancelled during the period of insurance by either party, the policy owner must within seven (7) days of the cancellation, surrender the certificate to the insurer or, if it has been

lost or destroyed, make a statutory declaration to that effect, and if he fails to do so, shall be guilty of an offence.

b. Certificates are also used in marine insurance transactions in the case of a marine open cover covering marine cargo shipments under a floating policy. A certificate of marine insurance is documentary evidence of a valid contract of insurance.

8.10.5 THE POLICY FORM

An insurance policy is a document drafted by insurers and an **evidence in writing** of a contract of insurance and is not the contract itself. A policy must be stamped in accordance with the provisions of the Stamp Act; otherwise, it cannot be used as evidence in court. Where the class of business is governed by a tariff which prescribes policy wordings, it becomes obligatory for insurers to use the standard policy wording provided by the tariff in the case of fire and motor insurance.

8.10.6 THE RENEWAL NOTICE

Most general insurance contracts are issued on an annual basis and are renewable except for contractors' and erection all risks and marine cargo insurance. There is no legal obligation on the part of the insurer to advise the insured that his policy is due to expire on a particular date; however, insurers usually invite renewal to retain good business which may otherwise be lost to competitors.

At renewal, the duty of utmost good faith must be observed by both parties (insured and insurer) but the onus is on the **insured to inform** the insurer of any **material changes** in the risk to be insured (as renewal becomes a new contract) to allow the insurer to carry out a re-assessment of the risk so that the renewal premium is commensurate with the risk covered.

The renewal notice incorporates relevant particulars of the policy including the insured's name, policy number, expiry date of policy, existing sum insured and premium. Renewal is the time to review the adequacy of the sum insured particularly in the case of property and motor insurance. The insured will be requested to revise the sum insured in line with the current market value or reinstatement value for insurance on buildings; otherwise, the condition of 'average' will apply for underinsurance at the time of a claim.

8.10.7 THE RENEWAL CERTIFICATE

Whenever a general insurance policy is renewed for a furtherperiod, a new contract is formed. If the renewal is on similar terms as the original contract, insurers frequently confirm the renewal by issuing a renewal certificate. On the other hand, if the renewal is on different terms, a fresh policy form is usually issued. A renewal certificate contains information like that found in the Schedule of a policy and will highlight any amendments made to the original policy terms and conditions.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*Which of the following is NOT part of the underwriting process?*
A	a. Establishing policy coverage terms and conditions b. Pricing of insurance to charge premiums commensurate with risk c. Investigating and assessing of loss d. Evaluating, assessing, and selecting risks for insurance

2	**Review Question**
Q	*Why is it important for insurers to establish underwriting guidelines?* *I. To set standards of acceptance in line with insurer's risk appetite* *II. To distinguish hazardous from non-hazardous risks* *III. To segregate high risk exposures into separate underwriting pools* *IV. To rank according to preferred, referred or risks to be declined*
A	a. I, III and IV b. II, III and IV c. I and IV d. I. II, III and IV

3	**Review Question**
Q	*Kevin sells his car and therefore wishes to cancel his motor policy during the period of insurance. He has a hard copy of the policy document and certificate of insurance. What is the correct position?*
A	a. Only the insurer has the right to cancel the policy during its term. b. The insured must return the certificate within 7 days of cancellation. c. The insured must return the policy document within 14 days of cancellation. d. The insured must destroy the certificate within 21 days of cancellation.

4	**Review Question**
Q	*For which type of insurance is the premium fixed by the tariff?*
A	a. Employer's Liability b. Private Motor c. Personal Accident d. Burglary

5	**Review Question**
Q	*Which of the following is NOT a direct benefit of reinsurance?*
A	a. Geographical spread of risks b. Protects solvency margin of the insurer c. Increases underwriting profitability d. Increases underwriting capacity

6	**Review Question**
Q	*Under which section of the Road Transport Act 1987 does it state that a certificate of insurance must be issued in the prescribed form and delivered to the policyholder?*
A	a. Section 91(4) b. Section 94(1) c. Section 90(1) d. Section 90(4)

7	**Review Question**
Q	*The following are important factors in considering whether to accept a proposal for burglary insurance EXCEPT*
A	a. type of goods (high value, precious or heavy and bulky). b. location of risk (busy commercial lot or out of town and remote). c. number of employees handling cash. d. security and burglar alarm installed.

8	**Review Question**
Q	*Which of the following is NOT a peril that can be extended with payment of additional premium under a commercial fire insurance policy?*
A	a. Bursting or overflowing of water tanks, apparatus, pipes b. Theft of property following a fire c. Riot, strike, and malicious damage d. Floods

9	**Review Question**
Q	*How do insurers normally incentivise policyholders to improve their physical risks to a standard beyond the accepted or required minimum?*
A	a. By offering increased sums insured b. By offering premium discounts c. By imposing lower excesses d. By increasing the scope of cover

10	**Review Question**
Q	*For which of these proposers might a first loss insurance arrangement be suitable?*
A	a. Paul has recently bought a vintage sports car that he wants to insure against loss or damage. b. Raju has been told he must insure his liability for injury to his employees. c. Mr. Lim owns a large warehouse and wants to insure the contents against theft. d. Farida wants to insure her new office building against a terrorist attack.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

9

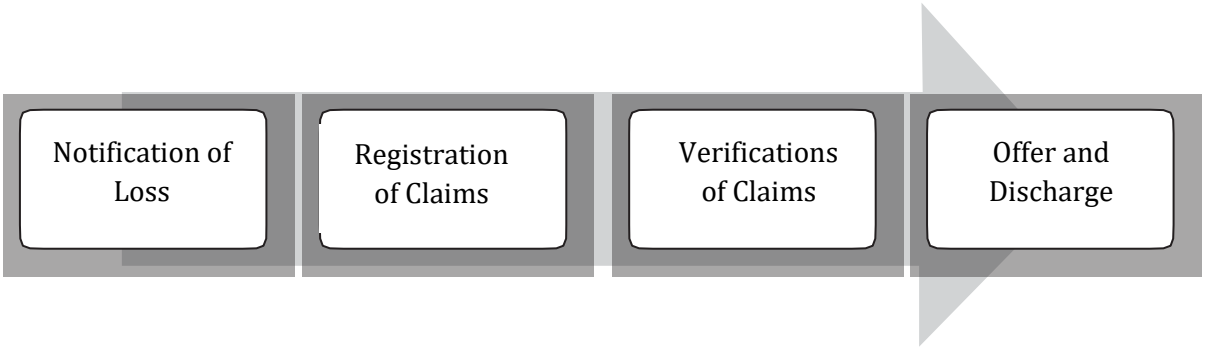
CHAPTER 9 GENERAL INSURANCE CLAIMS

9.1 INTRODUCTION

The insurer has a legal and moral duty to pay claims promptly and fairly and the hallmark of an insurance company in fulfilling its contractual obligations is in the efficient handling and settlement of claims. A satisfied customer will inevitably, by word of mouth, advertise the products and services of the insurance company, which in turn will facilitate sales and marketing of insurance products by agents and intermediaries.

Regulators have established guidelines on the minimum standards and timelines for the settlement of claims; however, the challenge for insurers is in ensuring that only valid claims are paid and preventing fraudulent or exaggerated claims which would otherwise increase the cost of claims and eventually the cost of insurance.

9.2 STEPS IN THE CLAIMS PROCESS



9.2.1 NOTIFICATION OF LOSS BY THE INSURED

It is a condition precedent to liability that when a loss occurs, immediate notification of the loss is given to the insurer. Depending on the wording of the notification condition, notice may be verbal or written and it may require the insured to furnish full particulars together with the claim form with details of the loss, identity of the claimants, etc. with supporting documents as proof within 14 to 30 days as stipulated in the policy.

In this regard, motor insurance policy provides clear timelines for claim notifications, which reads as follows:

"We must be notified in writing or by phone in either case with particulars of the vehicles involved, date of accident and, if possible, a brief description of the circumstances of the accident within the specific time frame as follows after an event which may become the subject of a claim under this Policy: -

a. *Within 7 days if you are not physically disabled or hospitalised following the event.*
b. *Within 30 days or as soon as practicable if you are physically disabled and hospitalised as a result of the event.*
c. *Other than (a) and (b), a longer notification period may be allowed subject to specific proof by the insured."*

It is also a condition precedent to liability that the insured acts in *good faith* to take immediate remedial action to minimize further loss in the event of a claim. For example, a clause in the comprehensive motor policy provides that the insured shall take reasonable steps to safeguard the motor car from loss or damage, and in the event of an accident or breakdown, the motor vehicle

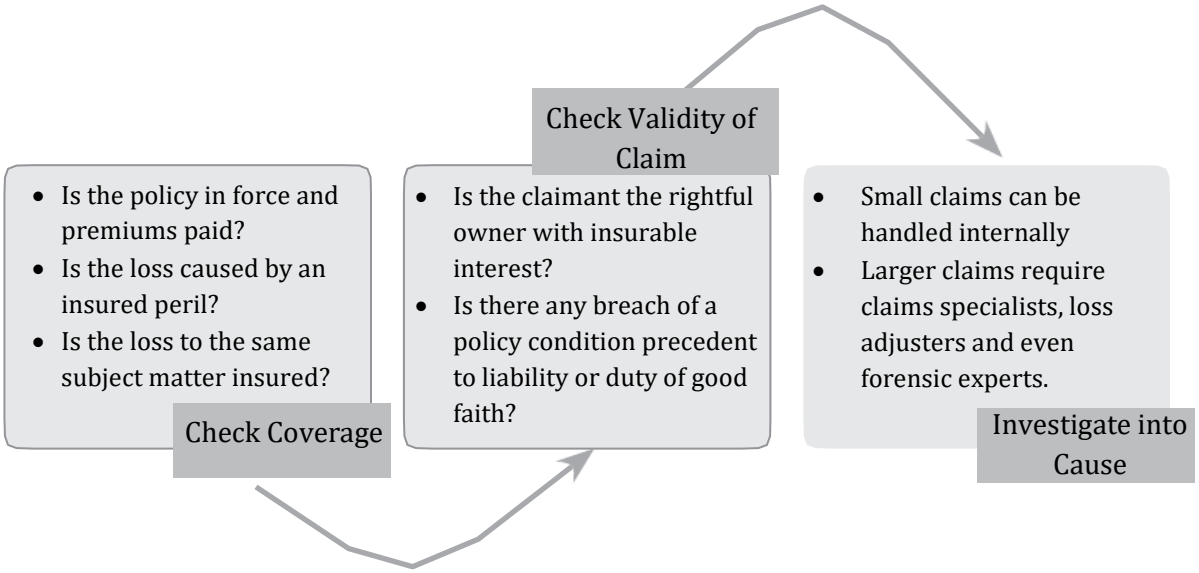
should **not** be left unattended. In liability insurance, the insured is required to submit all writs, summons or other legal documents to the insurer and should not admit any liability, reply to any letters, and acknowledge summonses, without the prior written consent of the insurer.

9.2.2 REGISTRATION OF CLAIMS

Every insurer is required to maintain an up-to-date register of all insurance claims immediately upon becoming aware of any claim intimated or notified. This is to ensure proper and accurate provisions are maintained and these claim reserves cannot be removed from the claims register if the claim is still outstanding or unsettled.

The claims register serves as an **official record** of claims notified to the insurer and may be in any form, either stored electronically in a computer database or in manual form or both. Upon registration of a claim, an acknowledgement letter will be issued to the claimant within seven (7) days, in compliance with the guidelines on claims settlement.

9.2.3 VERIFICATION OF CLAIMS



9.2.4 INVESTIGATION

Upon verification of the claim, the next step is to proceed with investigation into the cause of loss and to ascertain the amount of loss. Depending on the estimated size and complexity of the claim, an expert trained in the field of claims investigation and loss adjustment will be appointed by the insurer.

Insurance loss adjusters must be registered to conduct adjusting business in Malaysia. They are independent professionals appointed by insurance companies to investigate the cause and circumstances of a loss and ascertain the quantum of the loss in relation to an insurance claim.

The loss adjuster plays an important role and his responsibilities include and are not limited to the following:

- Negotiate and act as a settlement agent to bring about a swift resolution for the benefit of the claimant.
- Preserve the interest of the insured and to provide immediate assistance to prevent aggravated damage and reduce further loss.

- Advise the insurer on possible risk improvement measures to prevent recurrence of a similar loss.

- Assist the insured to furnish full particulars of the loss and to track down witnesses if required to attend court.

- Ascertain subrogation rights to make recoveries from negligent third parties.

- Establish proportion of contribution from and to other insurers.

9.3 CLAIM DOCUMENTS

The initial claim form serves to elicit basic information of the claim. However, to support the statements made in the claim form, the claimant will be required to produce supporting evidence to substantiate the claim. The documents may vary depending on the nature of the claim and class of insurance, as summarised below:

Table 9-1 ***Claim and Class of Insurance***

Fire Insurance
Photographs
Technician's report (where applicable)
Purchase invoices, repair bills, sales record, and other related documents
Police report (where damage is extensive)
Fire brigade report (where damage is extensive)
Burglary Insurance
police report
purchase invoices, repair bills, sales record, and other related documents
Personal Accident Death Claim
post-mortem report
death certificate
burial certificate
police report
letter of employment
Motor Own Damage Claim
police report
certified copy of vehicle registration card and road tax
certified copy of driving licence and identity card of driver

9.4 CLAIM SETTLEMENT

All general insurance contracts are contracts of indemnity. **Except** for personal accident (which pay a fixed amount of compensation), all other insurance contracts state that the insurer will **indemnify** the insured for any loss or damage sustained as a result of an insured peril or contingency.

The method of settlement may vary with the type of insurance but overall, the principle of indemnity is to put back the insured in the **same financial position** he was in before the loss, after the loss. The option to pay cash, repair, replace or reinstate lies with the insurer concerned, based on the nature and severity of the loss.

With liability insurance, the insured is indemnified for his potential legal liability to a third party. Such claims may take a long time to settle if they get caught up in a long drawn legal process. Insurance companies will have to keep adequate reserves to pay future claims as they adjust for inflation to their outstanding claim liabilities. For example, the court may award non-financial losses such as 'pain and suffering', and loss of amenities or faculties in addition to liquidated damages in personal injury claims.

It is important to note that not all claims intimated to the insurer will result in a settlement. Insurers may repudiate liability on a technical breach or for breach of good faith. In any event, justifiable reasons for repudiation together with advisory service on alternate avenues for appeal and information about the Ombudsman Financial Services (OFS) must be given to policy owners.

Insurers may repudiate liability on the following grounds:

1. The loss or damage was not caused by an insured peril.
2. The loss was not included by the scope of cover.
3. The policy has been rendered void as a result of a breach of a fundamental condition.
4. There is non- disclosure of a material fact which the insured is not aware of.

9.5 CLAIM RECOVERIES

The claim settlement process will also involve making appropriate recoveries from **co-insurers** and/or **reinsurers**, third parties under **subrogation rights** and other insurers under **contribution rights**, if such rights exist.

Subrogation arises when an insurer compensates the insured for a loss caused by a third party is subrogated to the rights of the insured to be compensated by that third party. Salvage is the equitable right of the insurer to the residual value of the property for which the insurer has paid a total loss to the insured. Ceding insurers commonly share subrogation and salvage recoveries with the reinsurers who contributed to the loss payments.

Reinsurance contracts commonly contain clauses which specifically allocate subrogation and salvage recoveries or net them off in determining the "ultimate net loss" payable by the reinsurer. The reinsurer, by payment of its portion of the loss, has an equitable right to an appropriate portion of the subrogation or salvage recovery.

9.6 APPLICATION OF AVERAGE IN CLAIMS

The term 'subject to average' means that if the sum insured at the time of a loss is less than the insurable value of the insured property, the amount claimed under the policy will be reduced in proportion to the under-insurance. Average applies when property is underinsured and there is a partial loss claim settlement. Most property insurance policies incorporate a pro-rata condition of average except in the case of "agreed value" policies.

The formula generally used to adjust the claim is as follows:

$$\text{Claims payable} = \frac{\text{Sum Insured}}{\text{Value at Risk}} \text{ X Loss}$$

Disputes can arise when policy owners are unaware that a deduction will be made when there is a claim for a partial loss, if the sum insured is below the actual value at risk. To avoid disappointments, a proposer for insurance is advised to ensure that the sum insured is adequate and that it represents the current market value or reinstatement value of the property insured. It is the insured' s duty to review the sum insured is in line with the cost-of-living index and/ or inflation at the time of renewal and during the period of insurance if new additions or improvements are made which inevitably would increase the value of the property insured.

9.7 THE MOTOR INSURERS' BUREAU

The Motor Insurers' Bureau (MIB) was based on a Principal Agreement on 15 January 1968, with the Minister of Transport and 'authorised general insurers' to secure compensation to third party victims of road accidents in cases where such victims are denied compensation by the absence of insurance or of effective insurance as required under section 90 of the Road Transport Act 1987.

Under the said agreement, when a judgment obtained in a court (in West Malaysia) is not satisfied within 28 days, MIB will become liable to pay the full judgment sum against an uninsured person for death or injury to a third party. As MIB is a company limited by guarantee, it does not hold any assets to cover its potential liabilities, but its members who are general insurance companies guarantee the payment of liabilities as and when the need arises.

However, after 1 January 1992, the principal agreement was rescinded and replaced by a Substituted Principal Agreement to include Sabah and Sarawak. The substituted agreement provides for **compassionate payments** or allowances upon application by victims of motor accidents caused by uninsured drivers, without having to obtain a court judgment.

Uninsured drivers are persons who have no valid insurance or where the insurance policy is ineffective (expired). Although there is no specific provision for victims of untraceable drivers or hit and run cases, MIB will make **compassionate payments** at its sole discretion, to such victims or to their dependents for injury or death caused by the use of motor vehicles on a public road.

9.8 KNOCK-FOR-KNOCK AGREEMENT

The Knock-for-Knock (KFK) is a **market agreement** signed in 1987 incorporated in the Malaysian Motor Tariff, for enforcement by licensed general insurers who are members of the General Insurance Association of Malaysia to speed up the settlement of claims and reduce legal and administrative expenses of handling third party claims.

Under the agreement, each insurer will handle the claim from their own insured provided the parties involved in the accident have private *car comprehensive insurance* regardless of who was to blame for the accident. KFK works on the principle of swings and balances with each motor insurer agreeing **not to exercise subrogation rights** against each other. If this is arranged on a long-term basis, no one insurer will gain or lose from participating in such an arrangement.

The main provisions of the agreement are:

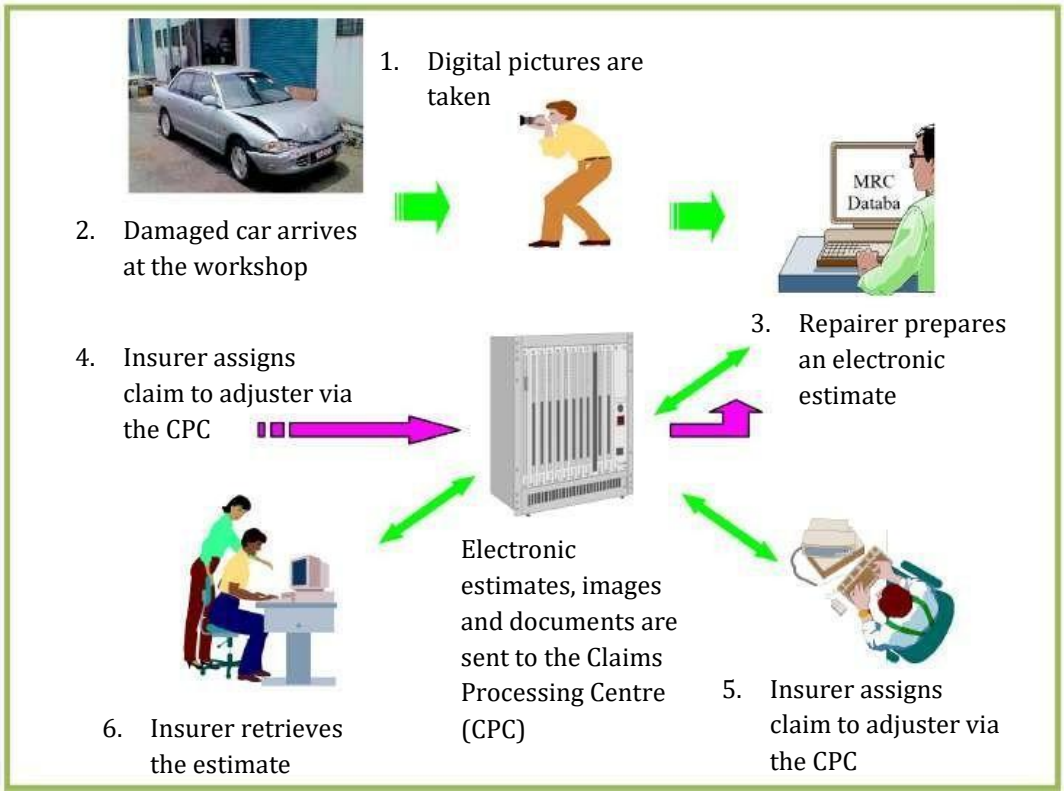
- Application of excess (if any)
- Exclusion of any vehicle used for the carriage of passengers for hire or reward such as taxis, buses, etc.
- Exclusion of any vehicle used for hire and drive either self-drive or chauffeur-driven
- Exclusion of loss or damage by fire only

KFK was revised in June 2001 (Supplemental Agreement - **Revised Knock-For-Knock Agreement)**. In 2018, an Addendum 2 was issued to include e-hailing vehicles. This provides that in the event of an accident involving the insured and a third party vehicle, the insured, under a comprehensive insurance policy, has an option to make a claim for damage to his vehicle against his own insurer (if the insured or his authorized driver is not at fault) instead of making a third party claim against the insurer of the third party who was to blame for the accident. Under such cases, the insured's No-Claim- Discount entitlement will not be forfeited.

9.9 CENTRALISED DATABASE FOR MOTOR REPAIRS ESTIMATION

In 2001, the Centralised Database for Motor Repairs Estimation (developed by the **Motordata Research Consortium Sdn Bhd**) was implemented with the purpose of minimising subjectivity in motor repairs estimation. With improved transparency in the estimation of accident damage claims, incidences of fraud and leakage as a result of collusion between the vehicle owner and repairer would be reduced.

The diagram below illustrates the process workflow from the time the damaged vehicle arrives at a panel workshop for assessment and estimation of the repair cost by an authorised repairer which in turn may have to be verified by a loss adjuster (if the loss is substantial) before insurers approve the repairs.



1. Repairer assesses the damage and takes pictures of the damaged vehicle.

2. Repairer creates the estimate electronically, itemizing every part to be repaired or replaced and the labour time needed to complete the job.

3. The estimates and the images of the damaged vehicle and supporting documents are scanned to be sent to the insurer, through the Claims Processing Centre (CPC).

4. Insurers will access the claim electronically and assign it to an adjuster, if necessary, before approving the claims electronically.

5. A loss adjuster would be appointed if the loss amount is large and requires further verification.

6. All claim transactions are therefore electronically recorded and duplicate claims will be checked to prevent fraud.

7. If the same claim (identified through the vehicle registration number) appears more than once in the CPC, the Motordata Research Consortium Sdn Bhd will alert the insurers concerned of the possibility of a fraud.

9.10 CLAIM DISPUTES

Disputes between claimants and insurers may involve one of two issues:

1. the question of liability, (whether the insurer is liable or not); and

2. if the insurer is liable, the amount or quantum of claim settlement.

Other disputes may arise due to:

- delay in claim settlement
- material fact not disclosed
- proposal form not duly signed
- no insurable interest
- inferior repairs
- poor customer service
- panel workshop has not started repairs
- no parts available

When a claim dispute arises, it may be resolved through any one of the following channels:

1. **Negotiation**
   Amicable settlement reached through discussions between the two parties.

2. **Arbitration**
   Settlement of disputes relating to the quantum of claim (usually incorporated as a policy condition) heard in a less formal setting than a court of law and adjudicated by an arbitrator instead of a judge.

3. **Mediation**
   An alternative dispute resolution channel through the Ombudsman Financial Services (OFS) set up as an independent body to adjudicate claim disputes. The decision of the OFS is binding on the insurance company but not on the insured or claimant.

4. **Litigation**
   If negotiation and arbitration fail to achieve an amicable settlement, the insured has the right to take legal action through the court process. However, this is not only a costly affair but may take a long time and would be considered.

9.11 POST-SETTLEMENT ACTION

After a claim is paid, the insurer may take one of the following actions:

1. **Terminate the policy** if the claim involves '**total loss**' of the subject matter insured and when the sum insured becomes payable. Examples are accidental death under a personal accident policy or theft under a comprehensive motor insurance policy or at the time of a claim under a fidelity guarantee insurance which involves investigation into the amount of loss and employees insured by the policy.

2. **Reduce the sum insured** by the amount of loss under property insurance. In the event of a 'partial loss', the sum insured will be reduced by the amount of the loss paid. The standard fire insurance policy incorporates a '**reinstatement of loss clause**' which provides for the automatic reinstatement of the sum insured to its original amount until expiry of the period

of cover, subject to the payment of pro rata additional premium. This protects the insured from being underinsured should another loss occur within the same period of insurance.

9.12 GUIDELINES ON CLAIMS SETTLEMENT PRACTICES

In February 1995, the BNM Guidelines on Claims Settlement Practices (Consolidated) - BNM/RH/GL/003-09 prescribing minimum standards for handling general insurance claims were issued. Part I of the Guidelines refers to claims other than motor and Part II refers to motor insurance claims. The Guidelines also provide for the proper maintenance and registration of all claims and for the review and updating of the information in records in a timely and on regular basis. The regulations also require insurance companies to set up an internal workflow and organizational structure for the various classes of claims and to establish authority limits for each claims handler to ensure claims are processed and approved accordingly.

The following are the prescribed timelines for insurers under the Guidelines:

Table 9-2 ***Timelines for Insurers***

Claims Process	Timelines
1. Acknowledgement of claim notification received	7 days upon registration
2. Assignment of adjusters	7 days (major towns) 14 days (other locations)
3. Adjusters to submit report	7 days
4. Approval by insurer	7 days
5. Payment to claimant	7 days (reimbursable claims) 14 days (below RM 1mil) 21 days (above RM 1mil)
6. Repudiation	14 days

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*What is the purpose of the Centralised Database for Motor Repairs Estimation?*
A	a. To implement an approved panel of motor repairers to prevent fraud and claim leakages b. To improve transparency in the estimation of accident damage claims to reduce fraud as a result of collusion between the insured and repairer c. To increase expediency of motor claims settlement for minor accident claims d. To estimate the cost of accident repairs

2	**Review Question**
Q	*Which condition in a home contents insurance policy gives the insurer the right to call on other insurers similarly liable to pay part of a claim?*
A	a. Arbitration condition b. Contribution condition c. Reasonable precautions condition d. Subrogation condition

3	**Review Question**
Q	*What is the timeline for a claimant to notify the insurer of an accident involving the insured's motor vehicle if he was not physically disabled?*
A	a. Immediately b. Within 7 days c. Within 30 days d. As soon as reasonably possible

4	**Review Question**
Q	*Who is responsible for investigating the cause and circumstances of a loss and for ascertaining the quantum of the loss in relation to an insurance claim?*
A	a. The loss assessor b. The insured c. The risk engineer d. The loss adjuster

5	**Review Question**
Q	*Fire causes $10,000 worth of damage to the contents of Mr. Wong's shop. The loss adjuster reports that the value of contents at risk is $100,000 and yet the policy sum insured for these items is only $60,000. If the policy is subject to pro-rata condition of average, what claim settlement can Mr. Wong expect to receive?*
A	a. Nothing b. $4,000 c. $6,000 d. $8,000

6	**Review Question**
Q	*Which of the following claims will NOT automatically terminate the insurance policy?*
A	a. A death claim under a personal accident policy b. A theft claim under a comprehensive motor insurance policy c. A fire claim for damage to a unit in a block of flats d. A fidelity guarantee claim involving investigation into the amount of loss

7	**Review Question**
Q	*What is the role of the Motor Insurers' Bureau (MIB)?*
A	a. To compensate victims of road accidents caused by uninsured or untraceable drivers b. To prosecute uninsured drivers in court to pay compensation to victims of road accidents c. To track down untraceable drivers in hit and run cases in order to prosecute them d. To consider complaints from victims of road accidents to improve traffic laws

8	**Review Question**
Q	*The amount paid to settle a total loss claim under a marine insurance policy is normally based upon which of the following?*
A	a. The market value of the property at the time of the loss b. The insured value of the property c. The replacement value of the property at the time of the loss d. The replacement value of the property at the time of loss less deduction for betterment

9	**Review Question**
Q	*When a claim dispute arises, which of the following is NOT a claim resolution channel?*
A	a. Litigation b. Repudiation c. Arbitration d. Mediation

10	**Review Question**
Q	*Under the revised knock-for-knock agreement, which option would best serve the insured if his vehicle was involved in an accident with a third party vehicle and he is not at fault?*
A	a. Make a claim against the third party insurer for insured and uninsured losses b. Sue the owner of the third party vehicle who was to blame for the accident c. Make a claim against his own insurer as well as the third party insurer d. Make an 'own damage' claim against his own insurer without having to lose his no-claim-discount

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

10

CHAPTER 10 REGISTRATION AND REGULATION OF GENERAL INSURANCE AGENTS

10.1 INTRODUCTION

The Inter-Company Agreement on General Insurance Business (ICAGIB) was signed on 24 April 1992 between members of Persatuan Insurans Am Malaysia (PIAM) comprising licensed general and composite insurance companies in Malaysia with the following objectives:

1. to regulate and control the conduct and activities of every person transacting general insurance business in Malaysia.

2. to monitor tariffs, commissions, and remuneration applicable to such general insurance business.

10.2 GENERAL INSURANCE AGENTS REGISTRATION AND REGULATIONS (GIARR)

Pursuant to the ICAGIB, all intermediaries appointed by member companies to procure general insurance business on their behalf will be subject to the General Insurance Agents Registration and Regulations (GIARR).

Under the GIARR, a registered general insurance agent is an individual person or persons whether corporate or unincorporated authorized to sell, solicit or negotiate any general insurance (other than life insurance) for and on behalf of an insurer.

A corporate agency means a body corporate formed or incorporated in Malaysia and includes:

- a company incorporated under the Companies Act 1965

- a sole-proprietor or a partnership

- a society, club or organisation whether registered under the Societies Act 1966 or any society registered under any written law relating to co-operative societies

- a public authority or agency of the federal or state government of Malaysia

10.3 FUNCTIONS OF A GENERAL INSURANCE AGENT

A registered general insurance agent shall solicit and procure new general insurance business in accordance with the terms of his appointment and shall endeavour to conserve the business already secured. In procuring new general insurance business, an agent shall:

- take into consideration the needs of the proposer for general insurance and their capacity to pay premiums.

- make all reasonable enquiries in regard to the risks and to bring to the notice of his Principal any circumstances which may adversely affect the risk to be underwritten.

- take all reasonable steps to ensure that the necessary proposal forms are fully and accurately completed by the proposer for insurance.

10.4 REGISTRATION OF GENERAL INSURANCE AGENTS

An application for registration can be submitted either manually in a requisite form or through the online agency registration system. The application must be approved and countersigned by a member of PIAM, which the applicant desires or purports to represent as his 'Principal'. A registered general insurance agent may at any time represent not more than two (2) general insurance companies as Principal.

A provisional registration may be granted for a period not exceeding three (3) months from the date of the application, where the agent is presently operating for one Principal, and a **second Principal** is appointing the agent or where there is a **change of Principal**. A Principal is, therefore, permitted to immediately transact business with the agent once a declaration to that effect has been duly executed by the Chief Executive Officer.

Persons exempted from the process of registration:

i. Licensed Commercial Banks and Finance Companies;

ii. Bank Pertanian Malaysia, Bank Simpanan Nasional and Bank Perusahaan Kecil & Sederhana Malaysia Berhad (SME Bank);

iii. Motor Vehicle Franchise Holders defined as a person (corporate or unincorporated) who has been granted the sole rights to the importation, promotion, sale, distribution and/or manufacture of a particular brand of motor vehicle inclusive of after-sales service in Malaysia by the franchisor.

10.5 MINIMUM ENTRY QUALIFICATION (EFFECTIVE 1 APRIL 2003)

An applicant wishing to register as an agent must have the minimum qualification of SPM/GCE 'O' Level or its equivalent. However, a person may be granted exemption in appropriate cases either unconditionally or on such conditions as the Board deems fit. In addition, the applicant must have passed the **Pre Contract Examination for Insurance Agents (PCEIA)** set by Asian Institute of Insurance (Aii), unless the applicant already holds one or more of the qualifications stated in the Appendix attached to the GIARR.

10.6 CERTIFICATE OF REGISTRATION

A person shall not engage in any agency operations or transactions until he has been issued with a Certificate of Registration which indicates the company or companies which he represents as his Principal. The agent can represent only the company or companies named in the Certificate of Registration and no other. In the event the agent ceases to represent any company, he must immediately notify the PIAM Board and apply for the issuance of a new certificate (for new Principal).

The Certificate of Registration is valid (unless earlier cancelled) for a period of **two years**. The commencement date of the two- year term is determined by the Board. An agent who wants to be retained in the Register after the expiry date of the Certificate of Registration, should apply to be retained no later than sixty (60) days before the expiry date. The application and the payment of the prescribed fee shall be made pursuant to such procedures as established by the Board from time to time.

10.7 BIENNIAL CERTIFICATES

A Biennial Certificate authorizing the agent to be recognized as a registered general insurance agent during the ensuing two years will be issued upon application and payment of the prescribed fees provided the registered agent has a continuing agency with his principal and in compliance with the requirements of renewal.

A registered agent who has failed to apply for a biennial certificate in the manner and within the period laid down in the Regulations may, on making an application in such form and on payment of such additional fee as may be prescribed be granted a Biennial Certificate for the remaining period of the two-year term if the application is made at any time during the two years ensuing the expiry of the last certificate issued.

The name of any general insurance agent who was previously in the Register and who fails to obtain a Biennial Certificate for the relevant period will be removed from the Register. All undertakings given by the registered agent at the time of his application to register as a registered agent however will continue to apply so long as the registered agent remains registered in the Register.

10.8 PLACE OF BUSINESS

A registered agent shall at all times ensure that his place of business has:-

a. A proper office premises to transact general insurance business;

b. A valid licence obtained from the local authorities or municipality to operate such business;

c. A proper signboard on display indicating the name of the registered agent and the insurance company or companies that it represents; each letter in the name of the agency appearing on the signboard is to be at least twice the size (both in length and breadth) of each letter of the name of the insurance company or companies it represents; in addition, the words “agent for” is to precede the name of the insurance company or companies which the agent represents;

d. At least one (1) qualified staff who is a holder of a certificate of proficiency in general insurance (called the designated person-in-charge) stationed at the branch office to attend to the daily transactions of general insurance business at the branch office provided that where the designated person-in- charge leaves the employment and/or services of the agent, the agent shall obtain another designated person-in-charge within 30 days from the resignation date of the designated person-in- charge from the agency.

e. The Certificate of Registration (issued to each branch office) to be displayed at his place of business; if he has more than one place of business, each place of business must be registered as a ‘branch office’ including the principal place of business which is to be stated as such in the requisite form.

10.9 NOTIFICATION OF CHANGES BY AN AGENT

An agent shall notify the Registrar in writing whenever there has been any change in his name or address or when he commences or ceases to represent any general insurance company. Such notification shall be made within one (1) month of such change and the notification may be made through his Principal. Notwithstanding the foregoing provision a member shall notify the Registrar

in writing within fourteen (14) days of any change in the name or address of its agent or when its agent ceases to represent it.

The Registrar shall from time to time amend, insert or remove from the Register any relevant particulars which come to his knowledge regarding the name and address of any person registered as an Agent therein or concerning the general insurance company such Agent represents. The Board may direct the Registrar to remove from the Register the name of an agent who is deceased; or has his address in Malaysia where he cannot be traced. The Board may cause to be published in any manner as it reasonably deems fit any correction, alteration or deletion to the Register.

10.10 CONFLICTS OF INTEREST

a. An applicant for registration as an agent or a registered agent having any other business interests shall declare in writing all such other business interests and the Board shall have the absolute power to determine whether or not such other business interest(s) may be continued and if so the condition (if any) on which and the period for which they may be continued.

b. An agent shall not be an employee or a director of or a shareholder or debenture holder in or have any interest in any other company or firm which is engaged in insurance business including insurance broking and loss adjusting without the prior written approval of the Board, provided that the prohibition shall not apply where the shares are listed on the Kuala Lumpur Stock Exchange.

c. A corporate agency shall not employ or engage any person who is an employee, director, shareholder or debenture holder in **another corporate agency** without the prior written approval of the Board, provided that the prohibition in employing or engaging a shareholder or debenture holder or holder of any interest shall not apply where the shares are listed on the Kuala Lumpur Stock Exchange.

d. An employee, director, shareholder, debenture holder of a corporate agency shall not be a director, shareholder, or a debenture holder of **another corporate agency**; or have any interest in any other company or firm engaged in transacting insurance business including insurance broking and loss adjusting unless the shares of that other corporate agency are listed on the Kuala Lumpur Stock Exchange.

e. A corporate agency shall not employ or engage any person who is an employee, director, shareholder, or debenture holder who has an interest in another company engaged in transacting insurance business including insurance broking and loss adjusting, provided the shares of that other company are listed on the Kuala Lumpur Stock Exchange.

f. An employee, director, shareholder or debenture holder of a corporate agency or any other person having an interest in a corporate agency shall not have any interest in any other company or firm which is formed for the purpose of carrying on business as a Call Centre and rendering its Call Centre services to a general insurance company.

10.11 REFUSAL TO REGISTER OR CANCELLATION OF REGISTRATION

The entry of a person's name on the Register shall be prima facie evidence that the person described is registered and authorized to engage in general insurance agency business. However, an

application for registration as agent may be refused or the Certificate of Registration cancelled, if the person:

a. is found to be of unsound mind;

b. has been convicted of criminal misappropriation, criminal breach of trust, cheating or abscondment or forgery or abetment of or attempt to commit any such offence; has been convicted of fraud, dishonesty, or misrepresentation against any member or against any person having official dealings with any member;

c. has been declared a bankrupt or insolvent;

d. has outstanding premium debts or other financial obligations with another insurer with whom he previously had an agency agreement;

e. has had his registration terminated.

In addition, a Certificate of Registration may be cancelled and removed from the Register if it comes to the knowledge of the Board that:

a. the person has obtained registration by a fraudulent or incorrect statement; or

b. there is no subsisting agency agreement with any general insurance company or companies he purports to represent

In any event a notice to cancel the Certificate of Registration of any person and to remove his name from the Register will be by giving fourteen (14) days' prior notice to the person concerned to appear before the Board or to give any evidence or explanation. The Board may order suspension of the Certificate of Registration of an agent whose conduct is under investigation by the Board.

10.12 MINIMUM MAINTENANCE REQUIREMENT

With a view to instilling a higher level of professionalism and commitment amongst agents, every registered general insurance agent shall ensure that he procures sufficient general insurance business (be it new general insurance business or renewals of existing policies) which results in the actual receipt of gross premiums totalling at least RM20K in the first & 2nd year and RM50,000 in the 3rd year and onwards.

The minimum maintenance requirement shall be achieved during either the first or second year of the two (2) year period of validity of the Certificate of Registration. An agent who fails to meet the minimum maintenance requirements shall not be entitled to renew his Certificate of Registration or apply for registration as an agent for a period of twelve (12) months.

10.13 CODE OF PRACTICE

The General Insurance Business Code of Practice for All Intermediaries Other than Registered Insurance Brokers (Code) acts as a guide for agents to conduct general insurance business (as defined by the Financial Services Act 2013) with utmost good faith and integrity and to that effect a declaration of observance of the Code must be signed by the registered general insurance agent.

The Code includes the manner in which agents handle complaints from policyholders and requires them to co-operate with the insurance company in establishing the facts as well as to give proper

advice of the policyholder's rights and avenues for redress with the insurance company concerned. Insurers also undertake to enforce the Code and to use their best endeavours in ensuring that their marketing representatives observe the provisions therein.

A. Selling General Insurance

What the agent should do:

a. make a prior appointment to call on his prospective client and to ensure unsolicited or unarranged calls are made at a time suitable to the client;

b. identify himself and the insurance company he represents and inform the client outright that his intention is to discuss matters relating to his insurance needs;

c. ensure as far as possible that the policy proposed is suitable to the needs and resources of the prospective policyholder;

d. give advice only on insurance matters in which he is knowledgeable and seek or recommend other specialist advice if necessary; and

e. treat all information supplied by the prospective policyholder in confidence for the sole purpose of issuing an insurance policy.

What the agent should not do:

f. inform the prospective policyholder that his name has been given by another person, unless he is prepared to disclose that person's name if requested to do so by the prospective policyholder and has that person's consent to make that disclosure;

g. make, issue, or cause any written or oral statement misrepresenting or making misleading, unfair or biased comparison regarding the terms conditions or benefits in any policy; or

h. prevent the prospective policyholder from stating material facts to the insurance company or induce the person not to state them; or

i. induce the person effecting insurance in making false statements misrepresenting material facts or prevent the person effecting the insurance from disclosing material facts or induce the person to hide any material facts in relation to the proposal for insurance;

j. engage any person to solicit general insurance on his behalf and pay to such person any commission or any other compensation in lieu of the business procured; however, a corporate agency may engage full-time employees for the purpose of soliciting general insurance on its behalf.

B. Providing Insurance Coverage

The role of the agent is to explain the main provisions of the insurance contract by drawing the client's attention to policy restrictions and exclusions applicable and if necessary, to obtain specialist advice (from underwriters) to explain the scope of coverage, terms and conditions of the policy (as recommended by the agent) to ensure that the customer is treated fairly and that he understands the product purchased. This includes any extra charge imposed in addition to the basic premium by disclosing the amount and purpose of such charge.

C. Disclosure of Underwriting Information

The agent shall:

a. take all reasonable steps to ensure that the necessary proposal forms are fully and accurately completed by each prospective policyholder;

b. avoid influencing the prospective policyholder and make it clear that all the answers or statements are the latter's own responsibility;

c. ensure that the consequences of non-disclosure and inaccuracies are pointed out to the prospective policyholder by drawing his attention to the relevant statement in the proposal form; and

d. make all reasonable enquiries in regard to the risks and to bring to the notice of his Principal any circumstances which may adversely affect the risk to be underwritten.

D. Accounts and Financial Aspects

The agent shall, if authorised to collect monies in accordance with the terms of his agency appointment:

a. keep a proper account of all financial transactions with a prospective policyholder which involves the transmission of money in respect of insurance (including any monies due to the policyholder on endorsements or discounts allowed by the insurance company on the policy);

b. acknowledge receipt (which, unless the intermediary has been otherwise authorised by the insurance company, shall be on his own behalf) of all money received in connection with an insurance policy and shall distinguish the premium from any - other payment included in the money; and

c. remit any such monies so collected in strict conformity with his agency appointment.

E. Documentation

The agent shall not withhold from the policyholder any written evidence or documentation relating to the contract of insurance (including any endorsements or discounts or monies due to the policyholder thereon that are allowed by the insurance company).

F. Existing Policyholders

The agent shall abide by the principles set out in the Code to the extent that they are relevant to his dealings with existing policyholders, with a view to conserving the business already secured, endeavour to maintain contact with all persons who have become policyholders through him and shall render all reasonable assistance to the claimants in filing claims forms and generally in complying with the requirement laid down in relation to settlement of claims.

G. Claims

a. If the policyholder advises the intermediary of an incident which might give rise to a claim, the intermediary shall inform the insurance company without delay, and in any event within **three (3) working days**, and thereafter give prompt advice to the policyholder of the insurance company's requirements concerning the claim, including the provision as soon as possible of information required to establish the nature and extent of the loss. Information received from the policyholder shall be passed to the insurance company without delay.

b. Nothing contained in this Code, however, shall be deemed to confer any authority on an intermediary to perform functions pertaining to loss survey or loss adjustment or settling or approving of any insurance claims.

10.14 PREMIUMS OR MONIES COLLECTED ON BEHALF OF PRINCIPAL

An agent shall remit direct to his Principal or remit/deposit into a bank account designated by the Principal in the name of the Principal all premiums and/or monies collected on behalf of his Principal.

a. "Cash-Before-Cover" for motor policies:

Premiums must be collected in full before the commencement of the assumption of risk and remitted to the Principal within (7) working days from the date of collection or inception of the policy, whichever is earlier;

b. "Cash-Before-Cover" for individual personal accident and individual travel insurance:

All premiums must be collected in full before the commencement of the assumption of risk and remitted to his Principal within fifteen (15) calendar days from the date of receipt of the premium or inception of the policy, whichever is earlier;

c. **"Premium Warranty"** applies for other classes of business except for Marine Cargo, Marine Hull, Bonds, Contractors' All Risks and Erection All Risks policies. An agent may offer credit to his client for a maximum period of **sixty (60) days from the date of inception** of the policy and on such terms as are approved by his Principal in writing. All premiums collected by the agent must be remitted to the Principal **within fifteen (15) calendar days** from the date of collection.

10.15 COMPLIANCE WITH CASH-BEFORE- COVER (CBC) REQUIREMENTS FOR MOTOR INSURANCE POLICIES

As a Principal, a general insurance company is required to monitor its agents' compliance with CBC requirements for motor policies on a quarterly basis called "**Reporting Quarters**" for every two (2) calendar year period. The first of the two (2) calendar year period starts from 1 July 2005 and expires on 31 December 2006 and thereafter starts afresh for the next two calendar years.

Non-compliance with CBC requirements by an agent or agents will be reported to the Board of Persatuan Insurans Am Malaysia (PIAM), every reporting quarter. This is followed by a **Notification of Suspension Event** issued to the respective agent(s) in writing not later than fourteen (14) days after the expiry of the Reporting Quarter when the suspension event took place.

An agent will be suspended from conducting any CBC business for a period of six (6) months commencing fourteen (14) days from the date of notification of the suspension. All computer system access linked to the Principal's motor insurance business will be simultaneously shut down to prevent any unauthorised transactions by the suspended agent.

Events leading to a suspension event:

a. Non-compliance with CBC requirements: an agent regardless of whether he is registered with one or two Principals fails to remit motor insurance premiums to his Principal **within (7) working days** from the date of collection or inception of the policy, whichever is earlier.

b. Non-compliance with CBC requirements committed by an agent during any **three (3) reporting quarters**, whether consecutive reporting quarters or otherwise but within the two (2) year period, with one or both Principals.

c. Non-compliance with CBC requirements with **any one Principal** entitles the other Principal to similarly suspend the agent within fourteen (14) days from the date of receipt of such notification of a suspension event and the suspended agent would not be allowed to appoint a new Principal and/or change Principals during the period of suspension.

d. Upon expiry of the six (6) month suspension period, if the agent is again in breach of the CBC requirements for subsequent Reporting Quarter within the two-year period, the Board will cancel the Certificate of Registration and the agent will be barred from conducting any general insurance business for a period of twelve (12) months.

10.16 CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

The objective of Continuing Professional Development (CPD) is to raise the standard of competency and professionalism of the general insurance agency force in Malaysia. A registered general insurance agent is required to complete 20 CPD training hours in a year to comply with the **Minimum CPD Training Hours** effective January 1, 2005.

Credit points and accreditation can be earned either by attending training programmes or through assessment conducted by a trainer (such as assignments, evaluation tests, examination, etc.). The training should generally be based on skills and knowledge, regardless if they are structured or ad hoc.

As a guide, the breakdown between technical and non-technical training hours is as follows:

- Technical Training - minimum of 60% (12 hours)
- Non-Technical Training - maximum of 40% (8 hours)

10.17 CORPORATE NOMINEE

A corporate agency shall be represented by a Corporate Nominee subject to the approval of the Board and fulfilling the following qualifying criteria:

a. is the principal officer of the corporate agency or such other officer as may be approved by the Board in writing;

b. is engaged full time in the principal office of the corporate agency; and

c. is a person of good character and high business integrity.

Where a Corporate Nominee leaves the employment of the agency, the agency is required to replace the Corporate Nominee within 30 days from the date of resignation of the Corporate Nominee from the agency.

10.18 CONTRAVENTION OF GENERAL INSURANCE AGENTS' REGISTRATION REGULATIONS (GIARR)

Where the Board has reason to believe that an Agent has acted in contravention of these Regulations, the Board may issue orders to the Agent concerned for any or all the following:

a. the presentation of the written statements, illustrations or other materials used by him in the course of soliciting for general insurance business;

b. the submission of a statement or report under oath concerning the matter(s) alleged against him;

c. allowing access during normal working hours to a duly authorized inspector/s appointed by the Board to inspect the agent's books, documents, and other materials and to make any extracts necessary from those records.

An agent who fails to comply with an order of the Board within fourteen (14) days after receipt of a written notice from the Board shall be deemed to have committed an offence.

10.19 INQUIRIES INTO COMPLAINTS

Any written complaint against an insurance agent for alleged misconduct or unprofessional conduct will result in an inquiry into the said complaint or allegation and if the Board is satisfied that a case has been established the Board may order suspension of the current Certificate of Registration or if the agent is exempted from registration, require the agent to suspend all or such part of the agent's general insurance business as determined by the Board.

If after due inquiry the Board finds a registered general insurance agent or any person applying for registration guilty of the alleged offence or misconduct the Board shall cancel the Certificate of Registration of the person concerned or refuse to register him, as the case may be, provided that if the Board feels the conduct was not such as to warrant deregistration it may suspend the Certificate of Registration or impose a fine or both and/or reprimand in areas deserving censure.

Appeals:

Any person who has been found guilty in accordance with the Regulations above or whose registration has been cancelled or whose application for registration has been rejected by the Board in the circumstances cited by the Regulations is entitled to appeal to the Management Committee.

i. The person submitting an appeal shall do so in his own name.

ii. The appeal shall be in writing addressed to the Management Committee and shall not contain any disrespectful or improper language and shall be complete in itself.

iii. The appeal shall be submitted through the Board.

iv. No appeal under this Regulation shall be entertained unless it is submitted within a period of three (3) months from the date on which the intending appellant receives a copy of the order appealed against. Provided, the Management Committee decides to entertain the appeal after the expiry of the said period if it is satisfied that the intending appellant had sufficient cause for not submitting the appeal within the timeline.

v. The Board shall within a period of three (3) months from the date of receipt of appeal transmit to the Management Committee the appeal together with its comments and all relevant records.

Consideration of Appeal:

i. Where an appeal has been received, the Management Committee shall consider all circumstances of the case and make such order(s) deemed fit after the appellant has been given a reasonable opportunity to represent his case either in person or by written submissions.

ii. All appeals shall be disposed of as expeditiously as possible, and in any event not later than six (6) months from the date of receipt of the appeal by the Management Committee.

(Disclaimer: effective 15/6/2021 following amendment of PIAM constitution, the Association's objects and powers to make an enforce rules, regulations and by-laws have been removed. Starting from 8/7/2021 PIAM have ceased from issuing suspension termination and cancellation of agent's registrations for non-compliance with MMC, CBC &CPD.)

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*What are the objectives of the Inter-Company Agreement on General Insurance Business (ICAGIB)?* *I. To regulate and control the conduct and activities of every person transacting general insurance business in Malaysia* *II. To regulate the conduct of general insurance companies in Malaysia* *III. To monitor tariffs, commissions, and remuneration applicable to such general insurance business* *IV. To supervise the conduct of general insurance intermediaries with the public*
A	a. I, II, and III b. II and III c. I and III d. I, II, III and IV

2	**Review Question**
Q	*How does the General Insurance Agents' Registration Regulations (GIARR) define a 'registered general insurance Agent'?*
A	a. A body corporate authorized to sell general insurance products for any insurance company or companies b. An individual person or persons whether corporate or unincorporated authorized to sell, solicit or negotiate any general insurance (other than life insurance) for and on behalf of an insurer c. An individual authorized by a principal insurance company to sell their general insurance products d. Any person registered with Persatuan Insurans Am Malaysia as an agent to sell general insurance in Malaysia

3	**Review Question**
Q	*Which is the qualifying examination that an agent should pass before registration as an agent with the General Insurance Association of Malaysia?*
A	a. Sijil Pelajaran Malaysia (SPM) b. Certificate of Asian Institute of Insurance (CAii) c. Pre-Contract Examination for Insurance Agents (PCEIA) d. Basic Agency Management Course (BAMC)

4	**Review Question**
Q	*What is the penalty imposed by the principal if an agent contravenes the Cash-Before- Cover (CBC) regulations for motor insurance?*
A	a. The agent will be suspended from doing any general insurance business for a period of six (6) months. b. The agent will be suspended from conducting any CBC business for a period of six (6) months. c. The agent's computer access will be immediately shut down without notice. d. The agent will have to pay a fine of RM 500,000

5	**Review Question**
Q	*What is the purpose of the General Insurance Business Code of Practice for All Intermediaries Other than Registered Insurance Brokers?* *I. Act as a guide for agents to conduct general insurance business with utmost good faith and integrity* *II. Prescribe the manner in which agents handle complaints from policyholders* *III. Require agents to co-operate with the insurance company in establishing the facts of any complaint or dispute* *IV. Require agents to give proper advice of the policyholder's rights and avenues for redress with the insurance company*
A	a. I, II, and III b. I, III and IV c. III and IV d. I, II, III and IV

6	**Review Question**
Q	*What is the Minimum CPD Training Hours for a registered general insurance agent effective January 1, 2005?*
A	a. 30 hours a year b. 20 hours a year c. 20 hours in two years d. 25 hours in two years

7	**Review Question**
Q	*A general insurance agent can represent insurance companies named in the Certificate of Registration which is valid for years.*
A	a. two /two b. three/ two c. two/three d. three /three

8	**Review Question**
Q	*What do you understand by 'Cash-Before-Cover' regulations for motor policies?*
A	a. Part of the premium must be collected before the commencement of risk. b. Premium must be collected in full before the commencement of risk. c. Full premium must be collected within 7 working days of the commencement of risk. d. Premiums must be paid within 7 working days of the commencement of risk.

9	**Review Question**
Q	*What event could lead to the suspension of an agent from transacting motor insurance for six months?*
A	a. Non-compliance with CBC requirements during 3 reporting quarters within a 2-year period, with one or both Principals b. Non-compliance with CBC requirements during 2 reporting quarters within a 2-year period, with any one Principal c. Non-compliance with CBC requirements during 2 reporting quarters within a 3-year period, with any one Principal d. Non-compliance with CBC requirements during 3 reporting quarters within a 3-year period, with one or both Principals

10	**Review Question**
Q	*Which of the following is NOT true with regards to the role of an agent in handling an insurance claim?*
A	a. Inform the insurance company within 3 working days of receiving advice of an incident which might give rise to a claim. b. Give prompt advice to the policyholder of the insurance company's requirements concerning claim documents. c. Assist the policyholder to gather information required to establish the nature and extent of the loss and pass the information to the insurer without delay. d. Conduct a loss survey or loss adjustment so that the insurance claim can be settled promptly.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

11

CHAPTER 11 LEGAL PROVISIONS RELATING TO LIFE INSURANCE POLICIES

11.1 INTRODUCTION

Schedule 8 of the Financial Services Act 2013 (FSA) on *'Provisions Relating to Policies'* serves as a comprehensive framework that establishes the legal aspects of life insurance in Malaysia. It sets the benchmark and provides guidelines for the regulation and operation of life insurance policies within the country.

This schedule outlines the key provisions and requirements that govern the formation, content, and execution of life insurance policies. It covers various aspects, including policy application procedures, disclosure of information, policy document requirements, policy conditions, and rights and obligations of both the insurer and the policyholder.

The provisions specified in Schedule 8 of the FSA aim to ensure transparency, fairness, and consumer protection in the life insurance industry. It defines the minimum standards that insurance companies must adhere to when offering life insurance products and services to the public. By establishing these legal requirements, the schedule promotes accountability and consistency across the industry, enhancing the confidence and trust of policyholders.

Furthermore, Schedule 8 of the FSA provides a framework for the resolution of disputes or grievances related to life insurance policies. It may outline the procedures for lodging complaints, seeking redress, or resolving conflicts between insurers and policyholders. (refer to Chapter 3)

Overall, Schedule 8 of the Financial Services Act 2013 plays a crucial role in safeguarding the interests of policyholders and maintaining the integrity of the life insurance sector in Malaysia. It serves as a benchmark for the legal framework governing life insurance policies, ensuring compliance with industry standards and promoting a fair and transparent insurance market.

11.2 MISSTATEMENT OF AGE

Misstatement of age refers to the inaccurate declaration of an individual's age during the application process for a life insurance policy. It can occur when the insured intentionally provides false information about their age or unintentionally provides incorrect information. Misstatement of age can have significant implications for the policy, including the potential adjustment of premiums, coverage limitations, or even policy cancellation.

- A life insurer shall not void a life policy or refuse a claim by reason only of a misstatement of age of the life insured.

- The insurer can request proof of age at any time. Adjusting a policy based on this proof does not imply that the policy is in dispute.

However, the insurer may take the following course of action:

FIGURE 11-1 ***Misstatement of Age***

Life insurers cannot avoid a policy or refuse a claim solely because of age misstatement.

True age > initial

- **Vary** the sum insured and bonuses **proportionate** to the premium paid for the true age

True age < initial

- **Vary** the sum insured and bonuses **proportionate** to the premium that would have been paid for the real age, or
- **Reduce the premium** to the sum insured that would have been payable for the real age and refund the excess

Coverage Period Based on Age

- Age, **adjust** it to reflect the coverage period based on the true age

The insurer can ask for proof of age at any time and adjusting a policy according to these rules does not mean the policy is in dispute

True age as shown by the proof is **greater**:

- vary the sum assured and the bonuses in **proportion to** the amount of premiums paid and on the true age.

True age as shown by the proof is **less**:

- either vary the sum assured and the bonuses
- **or** reduce the premiums and **refund** as over-payments to the policy owner.

Period of coverage is calculated by reference to the age of the life insured:

- vary the policy by changing its **period of coverage** to the period that would have been based on the true age.

11.3 OBJECTION TO LIFE POLICY (FREE LOOK PERIOD/COOLING OFF PERIOD) (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 2)

Objection to a life insurance policy refers to the right of an insurance company or policyholder to challenge the validity or enforceability of the policy. This could arise due to reasons such as misrepresentation of information, non-disclosure of material facts, or fraud during the application process. If an objection is successful, the policy may be rendered void or subject to modification.

- **Policy Return & Premium Refund During Free Look Period/Cooling Off Period**
  A policy owner can return a life policy within 15 days (or longer if specified by the BNM) after delivery. The life insurer must immediately refund any paid premium, minus any medical

examination expenses. The policy is deemed cancelled upon refund, and the insurer's liability ceases.

- **Investment-Linked Policies**
  For investment-linked life policies, the insurer should refund unallocated premium, the value of allocated units at next valuation date, and any deducted insurance charges and fees, less any medical examination expenses.

- **Policy Delivery & Return**
  A policy is considered delivered on the date the policy owner receives it if personally delivered. For other delivery methods, insurers should take reasonable steps to ensure delivery. A policy is deemed returned to an insurer on the date received, or the date of posting if registered post, or the date of transmission if electronically transmitted.

- **Group Life Policy**
  A person insured under a group policy can notify the group policy owner to cancel their cover within 15 days (or longer if specified by BNM) after delivery of their certificate of insurance. The insurer must immediately refund any premium paid by that person, minus any medical examination expenses, directly to him. Upon refund, the insurer's liability for that person's cover ceases.

- **Investment-Linked Group Policies**
  For investment-linked group policies, the insurer should refund unallocated premium, the value of allocated units at the next valuation date, and any deducted insurance charges and fees, less any medical examination expenses.

Importance of Acknowledging Receipt of E-Policy Contracts

- E-policy contracts are becoming increasingly common in the insurance industry, and it is important for insured individuals to acknowledge receipt of these contracts in a timely manner.

- As an agent, you play a crucial role in ensuring that insured individuals are aware of the e-policy contract and the need to acknowledge receipt of it.

- You should inform the insured individual that they will receive the e-policy contract via the company's website and request them to log in to acknowledge the receipt of the e-policy contract.

- It is important to emphasize that failure to acknowledge receipt of the e-policy contract can result in the free-look period expiring before the insured individual has had a chance to review the contract.

- The free-look period is a period when the insured individual can review the e-policy contract and, if necessary, cancel the policy without penalty or cost. This free-look period varies from 30 to 75 days from the date the e-policy contract is made available on the website, depending on the company’s practices.

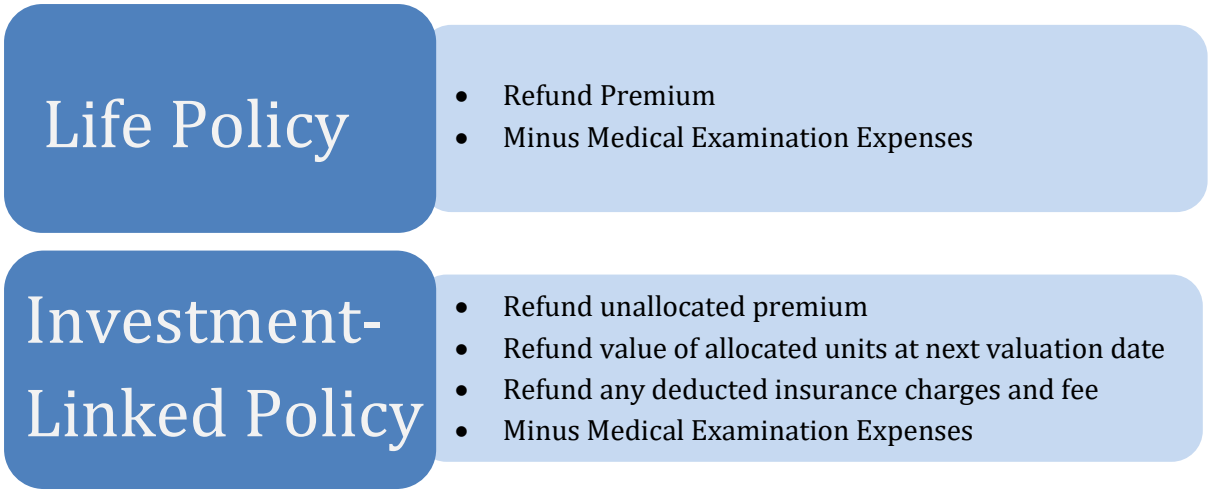
- If the free-look period expires before the insured individual has acknowledged receipt of the e-policy contract, they may lose the opportunity to review the contract and cancel the policy if necessary. Hence, it is crucial to remind insured individuals of the importance of

acknowledging receipt of the e-policy contract and to follow up with them to ensure that they have done so.

It is also important to remind policy owners that they will receive their e-policy contract via the insurance company's website and must log in to acknowledge receipt of the contract. If the policy owner fails to acknowledge the receipt of the e-policy contract, the free-look period will expire. This means that the policy owner will lose the opportunity to review the policy terms and conditions and request a cancellation with a full refund.

FIGURE 11-2 ***Objection to Life Policy***

A policy owner can return a life policy within 15 days (Free Look Period) after delivery.



Source : Financial Services Act 2013 Schedule 8 Para 2
Applicable to both individual or group policies

11.4 INSURABLE INTEREST (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 3)

Insurable interest refers to the financial or pecuniary interest that an individual or entity must have in the life of **another** in order to obtain a life insurance policy. It ensures that the policyholder has a legitimate reason to insure the life of the insured, typically based on a familial or financial relationship. Insurable interest serves as a key requirement in life insurance contracts to prevent speculative or unethical practices.

Insurable interest is a fundamental concept in insurance, especially life insurance. It refers to the financial interest a person or entity has on the insured person's life, such that the death or disability of the insured would result in a financial loss to the policyholder. The purpose of insurable interest is to prevent individuals from taking out insurance policies on the lives of others for the sole purpose of profiting from their death or disability.

Insurable interest must exist at the inception of the policy for it to be valid. It ensures that the person purchasing the policy has a legitimate reason to want the insured to remain alive and well.

- **Essentiality of Insurable Interest**
  A life insurance policy covering someone other than the person affecting the insurance or individuals specified[2] will be rendered void if the policyholder does not hold an insurable interest in the life of the insured at the inception of the policy.

- **Exemption for Group Life Policies**
  The lack of insurable interest at the policy's inception does not invalidate a group life policy.

- **Interpretation of Life Insuring**
  Insuring an individual's life refers to the agreement to pay a certain amount upon the person's death or upon the occurrence of any event linked to their death or survival, including the commencement of an annuity upon their death or at a predetermined time stipulated in the annuity.

- **Group Life Policy**
  A group life policy will not be void just because the group policy owner didn't have an insurable interest in the lives of the persons insured under the policy when it was created.

Table 11-1 Insurable Interest

Relationship (Individual Life)	Description	Example
Spouse, Child, or Ward	A person has insurable interest in their spouse, child, or ward who is under the age of majority	A parent takes out a life insurance policy on their child
Employee	A person has an insurable interest in their employee	A company takes out a life insurance policy on a key employee
Dependent for Maintenance or Education	A person has insurable interest in someone they are wholly or partly dependent on for maintenance or education	An individual takes out a life insurance policy on their primary caregiver, who provides essential daily care and support

Exemption for Group Life Policies: The lack of insurable interest at the policy's inception does not invalidate a group life policy.
Source : Financial Services Act 2013 Schedule 8 Para 3

While the principle of insurable interest is crucial to understanding the operation of life insurance policies, we will not delve into a detailed discussion of this topic in this chapter. Please refer to Chapter 2.2.2 <Insurable Interest>, where we have comprehensively discussed the concept of insurable interest, its implications, and its applications in various scenarios

11.5 CAPACITY OF MINOR TO INSURE (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 4)

The capacity of a minor to insure refers to the ability of an individual who has not reached the legal age of majority to enter into a life insurance contract. In many jurisdictions, minors are generally not

[2] Spouse, child, ward who is a minor, employee, or an individual on whom they rely partially or wholly for maintenance or education

allowed to enter into contracts without the consent of a legal guardian. However, some jurisdictions may allow minors to purchase life insurance policies with certain limitations or requirements.

- The regulations, in Malaysia, mentioned allow minors to participate in life insurance policies under specific conditions.

- Parents or guardians can purchase Investment-Linked Policies (ILPs) on behalf of their minor children. In this arrangement, the minor child becomes the life assured, while the parent or guardian acts as the policy owner.

- The policy owner pays the premiums and has control over the policy, including the right to make withdrawals, switch funds, or assign the policy. Once the child reaches the age of majority (typically 18 years in Malaysia), they might have the option to take over the policy ownership from their parent or guardian (practices may vary among companies)

Table 11-2 Capacity of Minor to Insure

Type of Insurance	Age Group	Life Insurance Actions Allowed	Additional Requirements
Life	10- 15 years	• Take out a life insurance policy one's own life or on someone else's life with insurable interest. • Assign or take assignment of a life policy.	Written consent from parent or guardian is required.
Life	16 years or above	• Take out a life insurance policy on their own life or on someone else's life if there is an insurable interest. • Assign or take assignment of a life policy.	For assigning a policy on their own life, written consent from parent or guardian is required.
ILP	18 years or above	• Take out a life insurance policy on one's own life or on someone else's life with insurable interest. • Assign or take assignment of a life policy.	For assigning a policy on their own life, written consent from parent or guardian is required.

These regulations aim to protect the interests of minors and ensure they are not exploited or involved in unethical practices related to life insurance policies. It is crucial for parents, guardians, and minors to understand these rules and follow them when dealing with life insurance policies.

Note: For an extensive discussion on this subject, please refer to *Chapter 4.2.1 titled "The Law of Contract in Insurance"*. In that chapter, we explored the concept thoroughly, outlining its various implications and applications in insurance.

11.6 LIFE POLICY MONIES TO BE PAID WITHOUT DEDUCTION (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 5)

This section of the Act emphasizes the importance of transparency and consent in the process of disbursing policy moneys. The insurer must not make any deductions from policy moneys without the policyholder's consent, protecting the policyholder's rights and interests.

- **Principle of Non-deduction**[3]
  Policy moneys under a life policy or those payable on surrendering the policy must be paid without any deduction for **moneys not due** under the policy or its assignment, unless the policyholder consents.

    - For instance, if Mr. A decides to surrender his policy with Insurer B, the insurer must pay the surrender value of the policy without making any deductions for charges or fees not specified in the policy terms, unless Mr. A explicitly consents to such deductions.

- **Void Provisions**[4]
  Any provision in a life policy or an agreement that allows the licensed insurer to make deductions without the consent of the entitled person is void.

    - To illustrate, suppose there is a clause in Mr. A's policy that says Insurer B can deduct an administrative fee from the policy moneys payable upon surrender. However, if Mr. A has not consented to this deduction, this clause is void, and the insurer cannot make this deduction.

- **Restrictions on Set-offs/Counter-claims**
  In proceedings for the recovery of policy moneys, no set-off or counter-claim can be made except for moneys due under the life policy or under an agreement charging the moneys on the life policy.

    - For example, imagine Mr. A wants to surrender his policy, but he also owes Insurer B some other unrelated debt. In this case, Insurer B cannot offset Mr. A's debt against the policy moneys due to him surrendering his policy. The insurer can only make deductions for money due under the life policy or under an agreement charging the moneys on the life policy.

When a life insurance policy is due for a payout (whether because of the death of the insured, the policy has reached maturity, or the policyholder decides to surrender the policy), the insurance company should pay the full amount of money due under the policy. They should not make deductions for other unrelated amounts that the policyholder might owe them.

For example, if the policyholder has taken a car loan or a home loan from the same insurance company, the insurer cannot deduct the outstanding loan amount from the life insurance payout. That is because these amounts are "not due under the life policy" – they are separate from the obligations outlined in the life insurance policy agreement.

[3] These rules apply to Malaysian life policies but not to policies issued before January 21, 1963.
[4] These rules apply to Malaysian life policies but not to policies issued before January 21, 1963.

However, there are exceptions to this rule. If the policyholder has outstanding dues that are part of the life insurance policy agreement (such as policy loans, unpaid premiums, policy fees and charges), these amounts can be deducted from the payout. This is because these amounts are considered "moneys due under the life policy".

11.7 SURRENDER OF LIFE POLICY (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 6)

This clause provides safeguards to policyholders who choose to surrender their life policies, ensuring that they receive a fair surrender value and that this value is determined and disclosed in a transparent and fair manner.

- **Surrender of Life Policy**
  A policy owner can surrender their life policy at any time after inception if the policy provides for a surrender value. The surrender value should be determined based on accepted actuarial principles, in a way that ensures fair treatment of policy owners, and in compliance with standards set by the BNM.

- **Disclosure of Surrender Value**
  A life insurer must disclose to a potential policyholder at the time of sale the surrender value payable under the policy and any applicable surrender charges. If no surrender value is payable, the insurer must provide a written statement to that effect.

- **Policies Issued on or Before 31 December 2008**
  The surrender value of policies issued on or before this date will be determined based on the terms set out in the policy.

- **BNM's Intervention**
  If the Bank thinks a life insurer has not properly determined the surrender value of a policy as required above,it can require the insurer to determine the surrender value on an approved basis and may require this basis to be applied retrospectively to already issued policies.

- **Policy Remains in Force**
  A life policy will remain in force until the insurer has paid the surrender value of the policy.

11.8 NON-PAYMENT OF LIFE POLICY PREMIUMS (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 7)

This provision ensures that policyholders who fail to pay premiums do not lose all their policy benefits but face proportionate reductions or adjustments. It is a form of consumer protection which also allows insurers to manage their risk exposure.

- **Non-Lapse Provision**
  In a situation where a life policy offers a surrender value, the non-payment of premiums should not cause the policy to lapse or be forfeited. A lapse in a life policy would typically occur when a policyholder fails to pay the premium within the grace period and the policy does not have enough cash value to cover the costs. However, this clause asserts that policies with surrender values should not be cancelled or lose all benefits due to unpaid premiums.

- **Policy Modification**
  The clause states that if the premiums are not paid, the policy will continue but with some modifications. These modifications can affect the duration of the policy, the benefits receivable, or both. For example, the insurer may reduce the death benefit, adjust the policy term, or alter other policy features in response to the non-payment of premiums.

- **Established Policies of Insurer**
  The modifications should align with the established policies of the insurer, specific to the life policy in question. This indicates that the insurer must handle such situations in a manner consistent with its established guidelines. These guidelines should be transparent, fair, and applicable to all policyholders in similar circumstances.

- **Policy Continuation**
  Despite the non-payment of premiums, the life policy remains in force, but with changes as per the insurer's guidelines. This condition ensures a level of protection for the policyholder, ensuring they do not lose all benefits due to non-payment, while also enabling the insurer to manage its risks.

11.9 ELECTION FOR PAID UP POLICY (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 8)

This clause allows policy owners to convert their life policies into paid-up policies while ensuring that the conversion is done in a fair and just manner, consistent with good business conduct and the policy owner's best interests.

- **Election for Paid-Up Policy**
  If a life insurance policy provides a surrender value, the policy owner may choose to convert this life policy into a paid-up policy. A paid-up policy is one where the policy remains active, but no further premium payments are required. The policy owner needs to notify the insurer in writing of this choice.

- **Determining the Sum Insured**
  The insured sum for the paid-up policy is calculated based on:

  - Generally accepted actuarial principles, which are guidelines and methodologies used by actuaries to estimate the risk and potential costs for an insurer.

  - Ensuring fair treatment of policy owners, which includes equitable consideration of the policy owner's interests and rights.

  - Consistency with the surrender value payable as mentioned in Paragraph 6, which outlines how to determine the surrender value of a life policy.

  - Compliance with standards on business conduct or fair treatment of policy owners as specified by BNM.

- **BNM Intervention**
  If BNM believes that the insurer has not accurately calculated the paid-up value as per the above criteria, it may require the insurer to recalculate the value on a basis approved by BNM. BNM can also mandate that this new or different basis be retrospectively applied to life policies already issued.

- **Continuation of Original Policy**
  After the policy owner elects for the policy to become paid-up, the original life policy is considered in force until the date when the next premium is due.

- **Date of Force**
  A new life policy issued in place of an earlier life policy is considered to have taken effect on the same date as the earlier policy. This means that the start date of the original policy is retained for the new paid-up policy.

11.10 ADDITIONAL RIGHTS CONFERRED BY PARAGRAPHS 6, 7 AND 8 (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 9)

This clause indicates that the rights established by paragraphs 6, 7, and 8 (which pertain to surrendering the policy, non-payment of premiums, and conversion to a paid-up policy, respectively) are provided as supplementary to any other rights that the policy owner may have under the terms of the life policy or through other means. They are not meant to override or diminish those other rights.

In simpler terms, it means that these specific provisions (regarding surrender value, non-payment, and conversion to paid-up policy) add to the rights of the policy owner, and do not take away or lessen any other rights that they may have under their life insurance policy or under law.

11.11 DISCLOSURE REQUIREMENTS (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 10)

The intention behind this clause is to ensure transparency and protect the interests of potential policyholders by providing them with all the necessary information to make an informed decision.

- Individual Life
  - No person can invite someone else to enter into an insurance contract without disclosing:

    a. The name of the licensed insurer: The individual making the invitation must reveal the name of the insurance company that is licensed to issue the policy.

    b. His relationship with the licensed insurer: The individual must disclose their relationship with the insurer. This could be whether they are an employee of the insurance company, an independent agent, a broker, or any other relevant role.

    c. The premium charged by the licensed insurer: The individual must inform the potential policyholder of the cost of the insurance, i.e., the premium that the insurer will charge.

- Group policies
  - where the person arranging the policy **does not have an insurable interest** in the individuals to be insured under the group policy. This person must disclose:

    a. The name of the licensed insurer

    b. His relationship with the licensed insurer

- The relationship between the person arranging the policy and the insurer must be disclosed

c. The conditions of the group policy, including the remuneration payable to him:
   - The person arranging the group policy must inform the potential policyholders about the terms and conditions of the policy.
   - This includes any fees or commissions the arranger is receiving for setting up the policy.

d. The premium charged by the licensed insurer
   - The cost of the policy, as charged by the insurer, must be disclosed to potential policyholders.

11.12 REQUIREMENTS RELATING TO GROUP POLICIES (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 12)

This clause stipulates the responsibilities and obligations of licensed insurers, group policy owners, and individuals insured under a group policy, particularly in situations where the group policy owner has no insurable interest in the life of an insured person.

This clause is designed to ensure that individuals insured under a group policy are not disadvantaged due to the actions (or inaction) of a group policy owner, and they have rights to recover monies due under the policy.

- Even if the insurer has not received the premium from the group policy owner, the insurer is still liable to an insured person who has paid the premium to the group policy owner.

- Any monies due under the policy to a person insured (when the group policy owner has no insurable interest in their life) must be paid directly to the insured person or any person who holds a right through them.

- If an insured person under a group policy pays the premium, they (or a person entitled through them) can recover monies due under the policy from the insurer. They can either proceed in their own names or add the group policy owner as a party to the recovery action.

  a. If the group policy owner is added as a party to the recovery action, the insured person (or any person entitled through them) must cover all legal costs and expenses related to the recovery action.

  b. The group policy owner may inform the insurer about any debt owed to them by the insured person upon receipt of the notice from the insured person.

  c. If the insurer agrees or is required to pay the monies due under the policy, it can deduct any debt owed by the insured person to the group policy owner and pay the balance directly to the insured person (or a person entitled through them).

  d. For the purposes of this clause, any person entitled through the insured person can include a trustee, assignee, nominee, or lawful executor or administrator.

11.13 REFUND OF PREMIUM (FINANCIAL SERVICES ACT 2013 SCHEDULE 8 PARA 12)

This clause refers to the requirements for refunding insurance premiums in certain situations. The intention behind this clause is to ensure that policy owners receive any refunds they are entitled to directly. It prevents potential misconduct or misappropriation of funds by insurance agents or intermediaries. This policy promotes transparency and helps to protect the financial interests of policy owners.

A licensed **general insurer** is required to pay any refund of premium directly to the policy owner. These refunds can become due for various reasons, such as the cancellation of the policy or changes in its terms and conditions. The clause is very explicit that under no circumstances should such a refund be paid or credited to an insurance agent.

In summary, Schedule 8 of the Financial Services Act 2013 (FSA) plays a vital role in the life insurance sector, and it holds significant importance for Life Insurance Agents. It serves as a fundamental framework that ensures the integrity of the industry and safeguards the interests of policyholders. By providing clear provisions and guidelines for the formation, execution, and operation of life insurance policies, Schedule 8 establishes industry standards that agents must adhere to.

Furthermore, Schedule 8 of the FSA is instrumental in fostering a fair and transparent insurance market in Malaysia. It sets the benchmark for professionalism and ethical conduct, guiding agents in their interactions with policyholders. Agents who understand and comply with the provisions outlined in Schedule 8 demonstrate their commitment to maintaining industry standards and prioritizing the best interests of policyholders.

Therefore, for Life Insurance Agents, a thorough understanding of Schedule 8 of the FSA is crucial. It not only helps them navigate the legal and regulatory landscape but also ensures they operate with integrity and provide the highest level of service to their clients.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*When does a life insurance policy acquire a surrender value?*
A	a. Any time after policy inception b. After three years of premium payment c. On the third anniversary of premium due date d. Two years after policy inception

2	**Review Question**
Q	*When does a minor possess the capacity to insure?* *I. A minor who has attained the age of ten years on his own life* *II. A minor who has attained the age of ten years on the life of another in which he has insurable interest with the consent of his parent or guardian* *III. A minor who has attained the age of sixteen years on his own life* *IV. A minor who has attained the age of sixteen years on the life of another in which he has insurable interest*
A	a. II, III and IV b. I, II, III and IV c. II and IV d. I and II

3	**Review Question**
Q	*Which of the following statements is NOT true about insurable interest in life insurance?*
A	a. A person has insurable interest in his own life to an unlimited extent. b. A life policy shall be void unless the person has insurable interest in that life insured. c. Insurable interest must exist at the inception of the life policy. d. Insurable interest means payment of moneys on the person's death or survival.

4	**Review Question**
Q	*When an agent invites any person or individual to make an offer or proposal to enter into a contract of insurance, the agent should disclose* *I. the name of the licensed insurer.* *II. his relationship with the insurer.* *III. the premium charged by the licensed insurer.* *IV. the benefit of taking up the offer with him.*
A	a. I, II, III and IV b. I, II and III c. II and IV d. I and II

5	**Review Question**
Q	*A person is said to have insurable interest in relation to another person who is* *I. his spouse.* *II. his child or ward being under the age of majority at the time the insurance is effected.* *III. his employee.* *IV. a person on whom he is wholly or partly dependent for maintenance or education at the time the insurance is effected.* *V. his debtor to the amount of outstanding debt.*
A	a. I, II and III b. I, II, III, IV and V c. I and II d. I, II, III and IV

6	**Review Question**
Q	*What is the meaning of 'non-contestability' in a life insurance contract?*
A	a. A life insurer is not allowed to contest the validity of the contract on the grounds of fraud. b. A life insurer is not allowed to contest the validity of the contract for misrepresentation after the policy has been in force for more than 2 years. c. A life insured is not allowed to contest the decision of the life insurer not to accept his proposal. d. A life insurer is not allowed to void the contract when false statements were made by the insured.

7	**Review Question**
Q	*What remedy is available for a policy owner who is not agreeable to the policy terms after taking delivery of the policy?*
A	a. Return the policy to the insurer within 30 days and request cancellation of the policy b. Return the policy to the insurer within the grace period and demand cancellation c. Return the policy within the 15 days and refund any expenses incurred by the insurer for issuing the policy d. Return the policy to the insurer within 15 days and expect a full refund minus expenses incurred for medical examination

8	**Review Question**
Q	*If a group insurance is arranged for persons in relation to whom the group policy owner has no insurable interest, the agent should disclose to each of the insured person?*
A	a. the name of the licensed insurer b. his relationship with the insurer c. the conditions of the group policy, including the remuneration payable to him and the premium charged by the licensed insurer d. All the above

9	**Review Question**
Q	*Matter which, if known by the insurer, would have led to its refusal to issue a life policy or would have led it to impose terms less favourable to the policy owner than those imposed in the life policy is termed ….*
A	a. key term. b. material fact. c. exclusion. d. condition of the contract.

10	**Review Question**
Q	*Which of the following statements is true?*
A	a. A life insurer may avoid a life policy or refuse a claim under a life policy by reason only of a misstatement of age of the life insured. b. Where the true age as shown by the proof is greater than that on which a life policy is based, the life insurer may avoid the life policy or refuse the claim. c. Where the true age as shown by the proof is less than that on which a life policy is based, the life insurer may avoid the life policy or refuse the claim. d. A life insurer may vary the policy by changing its period of coverage to the period that would have been based on the true age in the case of a misstatement of age.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

12

CHAPTER 12 LIFE INSURANCE PRODUCTS

12.1 INTRODUCTION

Life insurance is a contract between a policy owner and the insurer, where the insurer agrees to pay a specific amount of money **(sum assured)** to the policy owner or directly to the beneficiaries on death, disability, or diagnosis of a critical illness. The policy owner in return will pay a fixed amount of money, at regular intervals or in a lump sum (**premium**) into a fund managed by the insurance company.

The term '**assurance'** means coverage of an event that is certain to happen. Assurance is similar to 'insurance' (and sometimes the terms are interchangeable) except that insurance protects policyholders from events that are **uncertain** or might happen.

In addition to securing **financial protection** for dependents and covering the family's daily expenses, life insurance helps beneficiaries in the following ways:

- Maintain their standard of living
- Pay off any household debt
- Secure children's education
- Supplement retirement savings

Depending on one's needs, there are several types of life insurance policies available. Each type of policy offers a different balance of investment, risk, coverage, and cash value growth, so understanding these variations is crucial in selecting the best fit for your individual circumstances.

12.2 INDIVIDUAL LIFE & GROUP LIFE INSURANCE

Individual life insurance and group life insurance are two distinct types of life insurance policies that serve different needs.

a. Individual Life Insurance

Individual life insurance represents an agreement between a single policyholder and an insurance company. The policyholder commits to making routine premium payments, and in return, the insurance company vows to deliver a specified sum, referred to as the coverage amount or sum assured, to the named beneficiaries upon the policyholder's demise. Notably, individual life insurance does not only offer protection against mortality but also encompasses other contingencies such as Total Permanent Disability (TPD) and Critical Illness (CI).

Advantages:

- Flexibility
  Policies can often be tailored to meet specific needs of the individual.

- Duration
  Coverage is often for the life of the insured or for a specified term.

- Cash value
  Some types of individual life insurance build cash value over time that the policyholder can borrow against.

b. Group Life Insurance:

Group life insurance is a form of life insurance where a single policy encompasses a collective of individuals. It is frequently incorporated into an employment compensation package, but it is not exclusive to this context. Other entities, like professional associations, labor unions, financial institutions, social organizations, and educational institutions, may also offer such policies to their constituents.

Within the context of an employment setting, group life insurance is typically a mandatory scheme, forming part of the basic benefits offered to all company employees. However, beyond this fundamental protection, there can be additional benefits or optional schemes available. These can be seen as 'add-ons', providing employees the opportunity to enhance their coverage in line with their personal needs and circumstances. These add-ons could be opted into at the employee's discretion, allowing for greater customization of the benefits package.

When a member or employee exits the group or organization, the coverage generally concludes. Some policies may offer the possibility of converting the group coverage to an individual policy. It's essential to bear in mind that group life insurance primarily provides a baseline level of coverage, and it may be necessary to seek additional individual policies for more comprehensive protection.

Advantages:

- Cost-effectiveness
  Group life insurance is usually more economical than individual life insurance, making it a more affordable option for many members.

- Inclusivity
  This type of coverage is typically extended to all eligible members irrespective of their health condition. This means that members might not need to pass a medical examination to qualify for coverage.

- Ease
  Premiums are often conveniently deducted automatically, such as from a member's bank account/salary, relieving members of the need to manually make payments.

It is crucial to note that every form of life insurance comes with its own set of advantages and drawbacks. The best fit will invariably depend on the unique needs and circumstances of the individual or group in question.

12.3 VARIOUS LIFE INSURANCE POLICIES

a. Traditional Life Insurance:

Traditional life insurance policies can be subdivided into Participating (Par) and Non-Participating (Non-Par) types. The primary difference lies in the distribution of profits or "surplus" generated by the insurance company. Par policies share the profits with policyholders in the form of bonuses or dividends, while Non-Par policies do not.

i. Term Life Insurance:
This policy offers coverage for a predetermined term such as 10, 20, or 30 years. Should the policyholder pass away within this term, the beneficiaries receive the death benefit. Term life insurance is often the most economical form of life insurance.

ii. Whole Life Insurance
True to its name, whole life insurance provides lifelong coverage, as long as premiums are regularly paid. It often accumulates cash value over time, which can be borrowed against if required by the policyholder.

iii. Endowment Policies
Essentially savings plans, endowment policies involve regular premium payments by the policyholder. A lump sum is paid out after a specified term (at its 'maturity') or upon death, whichever occurs first.

iv. Life-Annuity Plan
Annuities are financial products offering a regular income stream for a designated period. Commonly incorporated into retirement planning, life annuity plans continue to make payouts for the remainder of the policyholder's life.
Note: As of now, Malaysia does not have life annuity plans available. It is important to clarify that such products are not offered in the Malaysian market at the moment.

b. Investment-Linked Policies (ILPs)

An investment-linked product has unique features, whereby premiums/takaful contributions paid by a policy owner/takaful participant are invested in investment-linked fund(s) offered by the licensed person, and this investment is used to fund the coverage of the policy owner's/takaful participant's insurance/takaful protection and other fees and charges related to such investment-linked policy/takaful certificate.

c. Universal Life

A universal life policy has the feature of providing for premiums to be paid by a policy owner into a non-unitised account to build up the account value of the policy. The policy account is invested at the discretion of the licensed insurer and the returns to the policy account are quoted based on annual crediting interest rates applied at the discretion of the licensed insurer. The account value of a universal life policy is used to fund the insurance protection for the policy owner and other fees and charges related to the policy.

It is crucial to remember that not every life insurance policy will be accessible to everyone, often depending on an individual's specific circumstances such as their health, age, and financial situation. Insurance companies may offer different variations of these policies. Therefore, thorough research and professional consultation are recommended before selecting an insurance policy.

12.3.1 TERM ASSURANCE

Term assurance, also known as term life insurance, is a type of life insurance policy that provides coverage for a specified term or period. This is the earliest and simplest form of life insurance. It offers pure life insurance protection without any cash value or investment component.

i. The key features

- Fixed term
  Term assurance policies provide coverage for a predetermined period, such as 10, 20, or 30 years. If the policyholder dies during this term, the death benefit will be paid to the beneficiaries. If the life assured survives the term, no benefits are payable.

- No cash or surrender value
  Term assurance policies do not accumulate cash value or have a surrender value. If the policy owner decides to terminate or cancel the policy before the end of the term, they will not receive any financial compensation.

- Lower premiums
  Term assurance typically offers lower premiums compared to permanent life insurance policies, such as whole life or endowment. This is because it provides pure life insurance protection without any additional features or investment components.

ii. Variations of term assurance

- There are several variations of term assurance policies to cater to the specific needs of consumers. Some examples include:

  a. Guaranteed renewable option: This option allows policyholders to renew their term assurance policy without submitting a new application or health declaration, ensuring continued coverage even if their health has changed.

  b. Guaranteed convertibility option: This option allows policyholders to convert their term assurance policy to a permanent life insurance policy without a health declaration. However, the premium rates will be subject to review upon conversion.

  c. Decreasing term assurance: In this type of policy, the level of protection decreases over time, while the premium remains the same. This is suitable for mortgage protection, as the sum assured reduces as the loan is repaid.

  d. Level Term Assurance: In a level term assurance policy, the death benefit stays consistent throughout the term of the policy. It is most suitable for individuals seeking a fixed amount of coverage for a specific period, providing a guaranteed sum to beneficiaries in case of the policyholder's death within the policy term.

Term assurance can be an attractive option for those seeking affordable life insurance coverage for a specific period. However, it is essential to understand its limitations and consider other options if lifelong coverage or cash value accumulation is desired.

iii. Advantages and Disadvantages

Table 12-1 ***Advantages and Disadvantages***

Advantages	Disadvantages
Lower premiums	No cash value or surrender value
Temporary coverage for specific needs	Coverage expires at the end of the term
Easy to understand	No benefits paid if the life assured survives the term

Customizable with riders and options	May become more expensive if renewed at an older age
Suitable for short-term financial obligations	May not provide lifetime coverage or meet long-term financial goals

iv. Function

Term assurance is commonly used to provide financial protection for specific needs and obligations during a fixed period. Some common usages for term assurance include:

- Income replacement
  Term assurance can help provide financial support to the policyholder's dependents in the event of the policyholder's death, helping them maintain their standard of living and cover daily expenses.

- Mortgage protection
  Term assurance is often used to cover mortgage payments, ensuring that the policyholder's family can continue to live in their home without the burden of mortgage debt if the policyholder passes away during the term of the policy.

- Debt repayment
  Term assurance can be used to cover outstanding debts, such as personal loans, car loans, or credit card debts, relieving the policyholder's family from these financial obligations in case of the policyholder's death.

- Education expenses
  Parents may purchase term assurance policies to ensure their children's education expenses are covered in the event of their death during the policy term.

- Business purposes
  Business owners may use term assurance to fund buy-sell agreements, cover key person risks, or provide financial protection for business loans in the event of the death of a business partner or key employee.

- Estate planning
  Term assurance can help cover expenses associated with the settlement of an estate, ensuring that the policyholder's heirs receive the intended assets without the burden of additional financial obligations.

Overall, term assurance is commonly used to provide temporary financial protection for specific financial obligations and responsibilities during a set period. It offers an affordable way to secure financial stability for loved ones or business partners in the event of the policyholder's death within the term.

12.3.2 WHOLE LIFE ASSURANCE

Whole life assurance, also known as whole life insurance, is a type of permanent life insurance that provides coverage for the insured person's entire life as long as the premiums are paid on time.

i. The key features

- Lifetime coverage
  Whole life assurance offers extended coverage that lasts until the end of the insured person's life, contrasting with term life insurance which provides coverage for a predetermined period. In general terms, a policy that ensures coverage until the age of 80 is often classified as a whole life plan. Therefore, whole life assurance does not necessarily have to last for the entire lifespan of the insured, but it does provide a significantly longer coverage period compared to term insurance.

- Premium Payments
  The premium payment structure for whole life assurance policies typically requires contributions over a specified duration or until a specific event, such as the death of the policyholder. Depending on the particular plan, it could either be a full-pay or limited-pay scheme.

  Under a full-pay plan, premium payments continue throughout the policyholder's lifetime or until their death. In contrast, a limited-pay plan necessitates premium payments only for a predetermined number of years or until the policyholder reaches a certain age. This diversity in payment structures enables policyholders to select a plan that aligns with their financial circumstances.

  While whole life assurance offers extended coverage, it is important to note that these policies primarily cover the event of death. Additional coverages, such as for critical illness or total permanent disability, may be available but are not always automatically included in whole life plans. Consequently, premiums may be higher than those for term insurance. Always review the specifics of any insurance policy to understand its coverage thoroughly.

- Cash value accumulation
  Whole life assurance policies come with a savings component, building up cash value as time passes. This cash value offers a degree of financial flexibility and can be employed in various ways. It can be surrendered for immediate needs, or used as collateral for securing a loan against the policy. Additionally, the accumulated cash value can be utilized to convert the policy into a fully paid-up plan or an extended term assurance, thereby adjusting the coverage or premium payments based on the individual's evolving needs and circumstances. This cash value feature makes whole life assurance policies a useful tool for long-term financial planning.

ii. Advantages and disadvantages

Table 12-2 ***Advantages and Disadvantages of Whole Life Insurance***

Advantages	Disadvantages
Provides lifetime coverage	Higher premiums compared to term life insurance
Cash value accumulation	

iii. Function
Whole life insurance plans can provide valuable financial protection in several ways:

- Lifetime Protection
  Whole life insurance plans offer ongoing coverage for the insured individual's entire lifespan, ensuring lifelong protection. As long as the premiums are duly paid, the

policy remains active. This enduring coverage guarantees that the insured individuals and their beneficiaries are safeguarded, irrespective of how their circumstances might evolve over time.

- Legacy Planning
  Whole life insurance is a powerful tool for legacy planning. The guaranteed death benefit can help secure the financial future of your loved ones, providing them with funds to manage expenses after your passing. This can ensure continuity of lifestyle, fund future educational needs, or serve as an inheritance.

- Financial Flexibility
  Whole life insurance policies accrue cash value over time, forming a tax-deferred savings element. This cash value can be accessed by policyholders through policy loans or withdrawals to cater to a variety of financial needs. This feature enhances the policy's usefulness, acting as a potential financial buffer for unexpected emergencies, supplementing retirement income, or contributing towards significant life events like education or property purchases.

- Estate Planning
  Whole life insurance can play a significant role in estate planning. It can help mitigate estate taxes, provide liquidity to cover estate settlement costs, and ensure the preservation and transfer of wealth to future generations.

In summary, whole life insurance plans are versatile financial tools that offer lifelong protection, facilitate legacy and estate planning, and provide financial flexibility. These policies not only safeguard the financial future of your loved ones, but they also accumulate cash value that can be used for various purposes, acting as a financial cushion in times of need. Therefore, a whole life insurance plan can be a key component of comprehensive financial planning, securing peace of mind and long-term stability.

12.3.3 ENDOWMENT INSURANCE

Endowment insurance is a type of life insurance that combines elements of protection and savings. It guarantees the payment of the sum assured if the policyholder survives to the end of the policy term, also known as the 'maturity date'. The sum assured is also paid to the beneficiaries in the event of the policyholder's premature death.

i. Key features:

- Protection and savings
  Endowment insurance provides both life insurance protection and a savings element, making it a suitable choice for those looking to accumulate wealth while ensuring financial security for their loved ones.

- Maturity benefits
  If the policyholder survives the policy term, they will receive the sum assured upon the policy's maturity. This payout can be used to fund children's education, retirement, or other financial goals.

- Cash value accumulation
  Endowment insurance policies feature a cash value element that accumulates over time, which can be leveraged in several practical ways. Firstly, this cash value can be

accessed directly through policy loans or withdrawals, providing a ready source of funds for immediate needs or opportunities. This could include making significant purchases, financing education, or even supplementing retirement income.

Additionally, the accumulated cash value in an endowment insurance policy can serve as a collateral for personal loans, potentially facilitating better loan terms or interest rates. Furthermore, if necessary, policyholders can surrender their policy and withdraw the cash value, although this may have implications for the coverage and potential penalties might apply.

In the longer term, the cash value from an endowment insurance policy can form a part of wealth accumulation and legacy planning strategies, contributing to the financial security of future generations. Thus, the cash value component of endowment policies provides both financial flexibility and a means for growth, supporting a variety of financial objectives.

ii. Advantages and disadvantages

Table 12-3 ***Advantages and Disadvantages of an Endowment Plan***

Advantages	Disadvantages
Provides both insurance coverage and savings elements	Higher premiums compared to term life insurance
May offer a guaranteed maturity benefit payable at the end of the policy term	May not offer as much coverage as pure life insurance policies
Can serve as a long-term savings plan with disciplined savings habits	May not be suitable for individuals seeking purely protection-oriented insurance
Offers a fixed policy term, encouraging goal-based savings and financial planning	
Provides a lump sum payout at maturity, helping meet specific financial goals	

iii. Function

Endowment life insurance combines elements of protection and savings, making it a versatile option for various financial goals. Some common usages of endowment life insurance include:

- Saving for specific goals
  Endowment insurance can be used to save for specific financial goals, such as funding children's education, buying a home, or starting a business. The maturity benefit provides a lump sum payment at the end of the policy term, which can be used to achieve these goals.

- Retirement planning
  Endowment policies can serve as a supplementary source of retirement income, providing the policyholder with a lump sum payment upon maturity. This payment can be used to cover living expenses or invest in other financial products for generating retirement income.

- Wealth accumulation
  The savings component of endowment insurance allows policyholders to accumulate wealth over time, with the potential for investment returns, depending on the type of endowment policy.

- Life insurance protection
  Endowment policies provide a death benefit to the policyholder's beneficiaries in the event of the policyholder's premature death, offering financial security and support during a difficult time.

- Emergency fund
  The cash value of an endowment policy can be accessed through policy loans or withdrawals in case of financial emergencies, providing policyholders with additional financial flexibility.

- Estate planning
  While Malaysia does not have estate taxes, endowment insurance can still be used as a tool for distributing assets and creating a financial legacy for heirs, ensuring that loved ones are financially taken care of after the policyholder's death.

- Debt repayment
  The maturity benefit from endowment insurance can be used to pay off outstanding debts, such as personal loans, mortgages, or credit card debts, helping policyholders achieve financial freedom.

Endowment is an insurance contract which guarantees the payment of the sum assured if the policyholder survives to the end of the policy term or on 'maturity date'. The sum assured is paid to the beneficiaries in the event of premature death. Endowment insurance therefore provides both protection and savings which enable the policyholder to fund children's education or save for retirement.

12.3.4 LIFE-ANNUITY PLAN

Life-annuity plans are uniquely structured to deliver a consistent income stream, primarily intended to provide financial support for the annuitant during their retirement years, while they are alive. This strategy stands in contrast to traditional life insurance policies, which generally aim to provide a lump sum payment to beneficiaries upon the occurrence of certain events, such as the death of the insured.

Though primarily designed with retirement in mind, life-annuity plans can also be customized to address other financial goals depending on individual circumstances. Thus, they offer a flexible solution to ensure ongoing financial stability during the annuitant's lifetime.

i. Types of annuities:

- Immediate Annuity
  With an immediate annuity, payments begin right after the purchase of the annuity contract. The annuitant will receive periodic payments for the rest of their lifetime. This type of annuity is suitable for individuals who have already reached retirement age and require a regular income immediately.

- Deferred Annuity
  A deferred annuity allows the annuitant to start receiving payments at a later date, typically after twelve months or upon reaching a specified age. The premiums for purchasing the annuity can be paid as a lump sum or through periodic payments for a defined period (e.g., 10 years). If the annuitant passes away during the deferral period, the premiums paid may be returned to the beneficiaries with or without interest, depending on the specific annuity terms.

ii. Life-Annuity Plan in Malaysia

Some key features:

- Life Insurance Coverage
  A Life-Annuity Plan includes life insurance coverage that pays out a death benefit to the beneficiaries upon the policyholder's death. The death benefit provides financial protection to the insured person's loved ones.

- Annuity Component
  The annuity component of a Life-Annuity Plan offers a guaranteed income stream during retirement. It allows the policyholder to receive regular payments over a specified period or for their lifetime, depending on the chosen annuity option.

- Retirement Income
  The annuity portion of the plan is designed to provide a stable income during retirement. The amount of the annuity payments depends on factors such as the accumulated savings, the chosen annuity option (fixed term or lifetime), and prevailing interest rates.

- Flexibility
  Life-Annuity Plans in Malaysia often offer flexibility in premium payments, allowing policyholders to contribute regularly or in lump sums. Some plans may also provide the option to make additional contributions to increase the annuity payouts or the death benefit.

- Tax Considerations
  The tax treatment of Life-Annuity Plans in Malaysia can vary depending on the specific policy and prevailing tax laws. It is advisable to consult with tax professionals or financial advisors to understand the tax implications of the plan.

  Life-Annuity Plans in Malaysia aim to provide individuals with a comprehensive financial solution that combines life insurance protection with retirement income. By offering a guaranteed income stream during retirement, these plans help policyholders meet their financial needs and maintain their standard of living in their later years.

Historical Example

Great Retirement Plan by G Company

While life annuity plans are not currently available, it is worth noting the historical example of the Great Retirement Plan by G Company, which included:

- Guaranteed Income: A stream of guaranteed yearly income for 10 years, starting at age 60 or the end of the premium payment term.
- Annuity Tax Relief: Up to RM3,000 yearly tax relief for premiums paid during 2012-2021.
- Payout for Unfortunate Events: Financial security in case of emergencies.
- Hassle-free Application: A straightforward application process.

iii. Function

Life-annuity plans are commonly used for:

- Retirement planning
  Life-annuity plans provide a reliable source of income during retirement, helping individuals maintain their standard of living and cover essential living expenses.

- Financial security
  Life-annuity plans offer a guaranteed income stream for the annuitant's lifetime, ensuring financial stability even in uncertain economic conditions.

- Longevity protection
  As life expectancies continue to rise, life-annuity plans can help protect individuals from outliving their retirement savings.

- Estate planning
  Depending on the type of annuity purchased, the remaining balance or premiums paid may be passed on to the annuitant's beneficiaries upon their death, providing financial support for loved ones.

iv. Advantages and Disadvantages

Table 12-4 *Advantages and Disadvantages of Life Annuities*

Advantages	Disadvantages
Provides lifetime income stream	Lack of liquidity
Ensures financial security during retirement	
May have favourable tax treatment	

12.3.5 INVESTMENT-LINKED LIFE INSURANCE, ILP

According to FSA Interpretation, "investment-linked policy" means a contract of insurance on human life or an annuity where the benefits are, wholly or partly, to be determined by reference to units, the value of which is related to:

a. the income from property of any description; or
b. the market value of such property;

ILPs have gained popularity in Malaysia due to their flexibility and potential for investment growth. They offer individuals the opportunity to tailor their investment strategy by choosing from a range

of investment funds, including equity funds, bond funds, and money market funds. The performance of these funds directly impacts the policy's cash value.

While ILPs offer investment flexibility and potential returns. These can include policy administration fees, non allocation portion, fund management fees, and mortality charges for the life insurance coverage. It's important for individuals considering an ILP to carefully review the terms and conditions, as well as the associated costs.
Overall, investment-linked policies are commonly used to provide life insurance protection, long-term wealth accumulation, and financial flexibility. Their versatility makes them a suitable option for addressing various financial needs and objectives, depending on the policyholder's risk appetite and financial goals.

This chapter will not delve deeply into the specifics of Investment-Linked Policies (ILPs), as the comprehensive CEILI textbook is dedicated to this particular product. To sell ILPs, individuals are required to pass the CEILI examination, which provides a detailed understanding of these policies.

12.3.6 UNIVERSAL LIFE[5]

A universal life policy has the feature of providing for premiums to be paid by a policy owner into a non-unitised account to build up the account value of the policy. The policy account is invested at the discretion of the licensed insurer and the returns to the policy account are quoted based on annual crediting interest rates applied at the discretion of the licensed insurer. The account value of a universal life policy is used to fund the insurance protection for the policy owner and other fees and charges related to the policy.

i. Key features:

- Death Benefit:
  Like other life insurance policies, universal life insurance provides a death benefit that is paid out to the designated beneficiaries upon the insured person's death.

- Non-Unitised Account:
  Premiums are channeled into a non-unitised account, differing from a unit-linked insurance plan where the account value is partitioned into units. In this arrangement, however, it is crucial to note that the entirety of the premium may not always contribute directly to building the account value. This is because the premiums may be subject to an allocation rate, which determines the proportion of the premium that is actually utilised to increase the account value.

- Investment by Insurer:
  The policy's account value is invested at the insurer's discretion, and the returns are quoted based on annual crediting interest rates determined by the insurer.

- Account Value for Funding Insurance Protection:
  The account value built up in the policy is used to fund the insurance protection for the policy owner. It is also used to pay other fees and charges associated with the policy.

[5] *source: BNM/RH/PD 032-22Universal Life Business Issued on: 13 February 2023*

Universal Life policies are sometimes seen as a middle ground between Traditional Life insurance and Investment-Linked Policies (ILPs). In terms of certainty of benefits, they lean closer to Traditional Life policies, providing a more predictable scope of coverage.

When it comes to transparency, particularly regarding costs and charges, they tilt more towards ILPs, shedding light on the financial aspects of the policy.

While certain features can make Universal Life policies adaptable to the fluctuating needs of the policyholder, it is crucial to remember that the level of flexibility varies based on specific product design and may not be as extensive as commonly perceived.

Regardless, these policies necessitate that the policyholder proactively oversee and manage the policy to ensure it aligns with their evolving needs and expectations. As with any insurance product, Universal Life policies carry inherent risks and costs. Therefore, it is crucial to thoroughly comprehend these factors before committing to a policy.
ii. Advantages and Disadvantages

ii. Advantages and disadvantages

Table 12-5 ***Advantages and Disadvantages of Universal Life Insurance***

Advantages	Disadvantages
Cash value accumulation	Investment risk
Investment component	Higher cost compared to term life
Tax advantages	Various fees and charges
	Complexity

12.4 GROUP LIFE INSURANCE

Group life insurance plays a vital role in employee benefits, offering essential financial protection to a collective group of individuals under a single policy. Typically provided by employers or organizations, group life insurance brings several advantages, including convenience, cost-effectiveness, and broader coverage options. In this section, we will explore the features, benefits, and considerations of group life insurance, highlighting its significance in safeguarding the well-being of individuals within a group or organization.

Features

Group life insurance primarily serves as a means for employers to **extend employee benefits** through a master policy. This coverage can be offered on a contributory basis, where employees contribute towards the premiums, or on a non-contributory basis, where the employer covers the premiums entirely.

Group life insurance is arranged mainly by employers (who Insurance have **insurable interest** in the lives of their employees) to provide employee benefits under a master policy. The insurance may be either on a **contributory** (premium paid by the employee) and voluntary basis or **non-contributory** (premiums paid by the employer) basis.

Moreover, group insurance arrangements can also cater to members of **trade unions, associations, and other entities** who lack insurable interest in the lives of their members. To ensure transparency and disclosure, the Financial Services Act 2013 (FSA) stipulates that any person arranging a group

policy **without an insurable interest** must disclose crucial information to each participant, including:

- the insurer's name,
- their relationship with the insurer,
- the group policy's conditions,
- the remuneration payable to the arranger, and
- the premium charged by the insurer.

Under the FSA, if the group policy owner lacks an insurable interest in an individual's life, the insurer remains liable to the person insured. Even if the premium is paid to the group policy owner, the insurer is obligated to fulfill its responsibilities and pay the rightful benefits to the insured individual or their entitled beneficiary.

By delving into the realm of group life insurance, we will gain a comprehensive understanding of its mechanisms, advantages, and legal provisions. This knowledge will empower us to make informed decisions regarding our insurance needs within the context of group coverage.

Underwriting Guidelines

Designed to prevent anti-selection, minimum standards for the acceptance of risks for group insurance are established such as:

- Minimum number of employees in a group is usually ten (10) although special consideration may be given for non- contributory schemes, where the employer pays the premium and 100% of eligible employees are insured. In all other cases, at least 75% of eligible employees must join the plan.

- Eligibility is confined to only permanent employees between the ages of 16 and 60 although the age limit may be extended on demand. New employees will be automatically added while employees who resign, retire or who are terminated will be deleted from the date of their recruitment or termination as the case may be.

Some common underwriting guidelines for group insurance:

- Minimum number of members
  Generally, a minimum number of members is required for a group insurance policy, which could vary depending on the insurer and policy type.

- Eligibility criteria
  Eligibility criteria may include age, income, profession, and health status of members. The insurer may require medical underwriting for some group policies.

- Premiums
  The premiums for a group insurance policy are based on factors like the age, gender, occupation, and health status of the members covered.

- Coverage limits
  Group insurance policies typically have limits on the amount of coverage provided to each member. The limits may be based on factors such as age, income, and occupation.

- Pre-existing conditions
  Some group insurance policies may exclude coverage for pre-existing medical conditions of members.

- Contribution levels
  For contributory policies, employers and employees may need to contribute a certain amount towards the premium. The contribution levels may vary depending on the policy and the agreement between the employer and employees.

- Waiting periods
  Some group insurance policies may have waiting periods before the coverage takes effect.

Note that these are general guidelines and specific underwriting requirements may vary depending on the insurer and policy type.

12.5 SUPPLEMENTARY CONTRACTS

A supplementary contract in insurance is an agreement that is added to an existing insurance policy to provide additional coverage or benefits, or to limit or modify the terms of the policy. It may include any endorsements, riders, amendments, or waivers that modify the original policy. Supplementary contracts can add or exclude coverage, and can be used to adapt a standard insurance policy to better fit the insured's needs.

Types of Supplementary Contracts

The aim of a supplementary contract is to customize a policy to better meet the specific needs of the policyholder. The importance of supplementary contracts in insurance lies in their ability to provide flexibility and adaptability in insurance coverage. These contracts enable policyholders to enhance their coverage, providing financial protection against a wider array of risks that a standard policy may not cover.

There are various types of supplementary contracts, including but not limited to:

- Endorsements:
  These are changes to the original terms of the policy that are typically added after the policy has been issued. They might alter the amount of coverage, add, or remove persons or property from the coverage, or change the policy's provisions in other ways.

- Riders:
  These are extensions in benefits to an insurance policy that provide additional coverage. For instance, in life insurance, a disability income rider could provide regular income if the policyholder becomes disabled and not able to work.

It is important to carefully review any supplementary contracts before adding them to an insurance policy, to ensure they provide the desired coverage at a reasonable cost.

Supplementary Contracts in Life Insurance

Some common seen supplementary contracts are as below:

- Waiver of Premium Rider
  A waiver of premium rider safeguards the policyholder's insurance coverage by exempting them from paying premiums under specific circumstances, such as if the insured becomes totally disabled and incapable of working or is diagnosed with a critical illness. The specific conditions and definitions of disability or critical illness can differ among insurers, so it is essential to comprehend these specifics when considering this rider.

- Accidental Death Benefit Rider
  Often referred to as an accidental death benefit rider, this provision stipulates an additional death benefit above the policy's standard death benefit if the insured's death results from an accident. This extra disbursement can offer meaningful financial assistance to beneficiaries. However, it is crucial to understand what constitutes an "accident" according to the policy terms, as definitions can vary among insurance companies.

- Critical Illness Rider
  This rider enables the policyholder to receive a lump sum payment if diagnosed with a critical illness that is specifically covered by the policy. The payout can be used according to the policyholder's needs, whether that be to cover medical expenses, compensate for loss of income during recuperation, or for any other financial obligations. The specific conditions defined as "critical illnesses" will vary among policies, so it is essential to thoroughly understand these particulars when considering this rider.

- Term Conversion Rider
  A term conversion rider allows the policyholder to convert a term life insurance policy into a permanent life insurance policy, such as whole life or universal life, without having to undergo a medical examination. This can be beneficial if the policyholder's health has deteriorated since the original policy was issued.

Each of these riders provides additional coverage or benefits that can be valuable in certain circumstances. However, they also increase the cost of the policy, so it's important to carefully consider the potential benefits and costs before adding any rider to a life insurance policy.

Supplementary Contracts in MHIT Insurance

- Riders in Health Insurance

  - Specialized Treatment Coverage
    Regular health insurance policies might not include coverage for specific treatments or therapeutic procedures. A rider like the 'Specialized Treatment Coverage' can extend the policy's coverage to include these particular services. For instance, unconventional healthcare practices such as acupuncture, homeopathy, or chiropractic services, which are typically not included in standard health insurance policies, can be covered with the help of this rider.

  - Increased Coverage Limits
    Standard health insurance policies have a maximum limit they will pay for specific treatments or overall healthcare costs. This rider increases those limits, providing greater financial protection in case of serious health conditions.

The Process of Adding a Supplementary Contract

Supplementary contracts can be added both **at the time of application** and **after the policy is already in effect**. The critical point is that any changes or additions to the policy must be clearly documented and agreed upon by both the insurer and the policyholder.

- As part of the insurance application process, it is crucial to understand that policyholders might opt to include certain riders or endorsements based on their assessed coverage requirements. For instance, a policyholder might incorporate a waiver of premium rider into a life insurance policy.

- However, it is imperative to note that as policyholders' circumstances and needs change over time, they might find that they need additional coverage not encompassed in their initial policy. In such instances, they can consider adding supplementary contracts to their existing policy. As an insurance professional, one should be well-versed in these possibilities and be prepared to provide advice and assistance when necessary. This ensures that policyholders maintain comprehensive, relevant, and timely insurance coverage that adapts to their evolving needs.

Impact of Supplementary Contracts on Premiums

The addition of supplementary contracts to an insurance policy can influence premiums in various ways, typically depending on the nature of the additional contract and the benefit.

- Increased Premiums
  Most supplementary contracts, such as riders or endorsements that enhance coverage or provide additional benefits, will increase the policy's premium. This is because they increase the insurer's liability, meaning the insurance company is potentially taking on additional risk. The insurer offsets this risk by charging more for the policy.

- Evaluation of Costs
  As insurance agents, it is crucial for us to assist policyholders in evaluating the costs associated with supplementary contracts added to their insurance policies. This evaluation allows policyholders to make informed decisions based on their individual needs and financial circumstances. Here are some key points to consider when discussing the evaluation of costs with policyholders:

- Understand the Added Benefits
  When discussing the addition of a supplementary contract, take the time to explain the specific benefits or modifications it offers. Help policyholders understand how these additions align with their insurance needs and provide value in terms of coverage.

- Assess the Cost-Effectiveness
  Encourage policyholders to evaluate the cost of the supplementary contract in relation to the benefits it provides. Discuss whether the added benefits justify the increase in premium and if they align with the policyholder's budget and long-term financial goals.

- Document the Changes
  Emphasize the importance of documenting any changes made to the policy, including the addition of a supplementary contract. Documenting the agreed-upon terms and conditions provides clarity and prevents any misunderstandings between the policyholder and the insurer

12.6 PARTICIPATING AND NON-PARTICIPATING LIFE POLICY

Participating and non-participating contracts are two different types of life insurance policies with distinctive features:

Distinctive Features

i. Participating Life Policy
According to FSA 2013, "participating life policy" means a life policy conferring a right to the policy owner to participate in allocations, of which the amount or timing is at the discretion of the insurer, from the assets of an insurance fund.

In a participating (or 'with-profits') policy, policyholders not only pay for the insurance coverage but also **participate in the profits** of the insurance company. These profits, derived from the insurer's *investment, mortality, and expense experience*, are returned to the policyholders in the form of dividends or bonuses. The exact amount is **not guaranteed** and can vary from year to year.

Advantages
- Potential for higher returns
  If the insurer's investments perform well, policyholders can receive dividends or bonuses.

- Long-term savings and protection
  This policy provides both life insurance coverage and a long-term savings opportunity.

Disadvantages
- More expensive
  These policies can be more expensive compared to other life insurance products because of the saving element.

ii. Non-Participating Life Policy
In contrast, non-participating (or 'without-profits') policies do not share the profits of the insurance company with policyholders. The policyholders pay for the insurance coverage and receive a **guaranteed** benefit, which is stipulated in the contract at the outset. There are no dividends or bonuses in non-participating contracts. The premiums for these policies are often lower, and the benefits are defined and guaranteed.

Advantages
- Guaranteed Benefits
  With non-participating policies, policyholders know exactly what they will get. The benefits are set when policyholders buy the policy, and they do not change.

- Lower Cost
  Non-participating policies usually cost less than participating ones because they do not participate in the company' s profit. This means they can be more affordable.

- Clarity and Simplicity
  These policies are straightforward. The cost and benefit structure are clearly defined from the onset, without the complexity of dividends or bonuses. This makes them easy for policyholders to comprehend and anticipate.

Disadvantages

- Lack of Profit Sharing
  Non-participating policies do not allow policyholders to partake in the insurance company's profits. Hence, any earnings made by the company do not reflect the benefits of these policies.

- Fixed Benefit
  Non-participating policies provide a predetermined benefit, with no investment component. As such, the value of the policy remains static and does not grow over time.

- Limited Flexibility
  The terms of non-participating policies are fixed and non-negotiable, meaning they cannot be adjusted to align with changes in the policyholder's circumstances. As such, they might not provide the most suitable coverage should the policyholder's needs evolve over time.

How Participating Life Insurance Works

In a participating life insurance policy, all premiums paid by the policyholders are pooled into a common fund, known as the participating fund. The insurance company manages this fund, investing it in a diversified portfolio that may include equities, bonds, property, and other assets.

The objective of the participating fund is to generate profits, which, if achieved, are shared with the policyholders in the form of dividends or bonuses. However, it is crucial to note that these dividends or bonuses are not guaranteed and depend on several factors, including the investment performance of the participating fund, the company's overall profitability, and the claims experience.

One unique feature of participating policies is 'smoothing'. This is a process where insurers retain some of the profits in good years to pay out in years where the fund's performance is poorer. This approach aims to provide a more consistent return over the life of the policy, avoiding sharp fluctuations that might occur due to market volatility.

i. Different types of bonuses payable
   Bonuses are the part of the profits of the insurance company allotted to the participating policyholders.

   - Cash Bonus / Dividends
     This is a non-guaranteed bonus that is determined annually by the insurance company. If declared, it is made available to the policyholders each year. However, policyholders have the choice in how they manage these bonuses or dividends. They may opt to receive them as cash payments, which can serve as a source of supplemental income. Alternatively, policyholders can choose to leave these dividends with the company to accumulate, potentially earning additional interest over time. This flexibility allows policyholders to manage their bonuses in a way that aligns with their individual financial objectives and circumstances.

   - Reversionary Bonus
     This is a non-guaranteed bonus generally allocated on an annual basis to a participating policy. Once allocated, the bonus increases the guaranteed value of the policy, given that the policyholder continues to fulfill premium obligations as specified in the policy contract.

However, if a policyholder decides to surrender the policy prior to its maturity, they might not receive the full amount of the allocated bonuses. The surrender value of the bonuses could be significantly less than the value if the policy was maintained until maturity or until the insured's death. This underlines the importance of considering long-term financial commitments when purchasing participating policies.

There are 2 types of Reversionary Bonus

1. Simple Reversionary Bonus
   This bonus is declared as a percentage of the sum assured. This means it is calculated only based on the initial sum assured in the policy. The bonus is payable under the same conditions as the original sum assured - that is, at the time of policy maturity or upon the death of the insured.

2. Compound Reversionary Bonus
   In contrast to a simple reversionary bonus, a compound reversionary bonus is determined not only based on the sum assured but also includes the bonuses that have already been accrued under the policy. It is called "compound" because the bonus is calculated on an accumulating basis, considering both the initial sum assured and the total accumulated bonuses. Similar to a simple reversionary bonus, a compound reversionary bonus is also payable at the time of policy maturity or upon the death of the insured.

   The key difference between the two types of bonuses lies in the basis on which they are calculated: a simple reversionary bonus is based only on the sum assured, while a compound reversionary bonus takes into account both the sum assured and previously accrued bonuses.

- Terminal Bonus
  A terminal bonus, also referred to as a final or maturity bonus, is an additional discretionary distribution that may be awarded upon the occurrence of certain specified events under the terms of a participating insurance policy. Such events include the policy reaching its maturity date, the death of the insured individual, the surrender of the policy, or in cases where claims are made due to the insured's diagnosis with a critical illness (CI) or total and permanent disability (TPD).

  The terminal bonus functions as a mechanism to allocate a share of the remaining surplus generated by the participating fund to policyholders. This surplus signifies the policy's proportion of the profits that have been accumulated within the fund but are yet to be distributed. The decision to award a terminal bonus and its amount generally depend on various factors, including the length of time the policy has been in force, the performance of the underlying participating fund, and the aggregate amount of regular (reversionary) bonuses that have been previously allocated to the policy.

- Interim Bonus
  Interim bonus for a participating policy is an additional bonus or profit share that is given to the policyholders if they decide to surrender their policy or if the policy matures during the year, before the insurance company's bonus announcement.

  The purpose of an interim bonus is to ensure that policyholders who exit the policy mid-year are still able to receive some portion of the bonuses earned during that year. The interim bonus rate is usually decided by the insurer and it is generally aligned with the bonus rate of the previous year, subject to the performance of the participating fund.

- Guaranteed Benefit
  Participating policy
  - Benefit that is assured by the insurance company, regardless of the performance of the participating fund for example Survival Benefit. This benefit is stipulated in the policy contract at the time of policy issuance and does not fluctuate with market conditions.

  - There are two main types of benefits in a participating policy: guaranteed and non-guaranteed. The guaranteed benefits, which can include a guaranteed survival benefit, are the minimum benefits that the policyholder will receive. They are defined at the outset and the insurance company is obligated to provide these benefits.

  On the other hand, non-guaranteed benefits, which include dividends and additional bonuses, are dependent on the performance of the participating fund. They are not guaranteed and can vary from year to year.

  However, it is important to note that not all participating policies may offer a guaranteed bonus. The terms and features of the policy can vary among different insurance companies.

How are the bonuses determined?

The bonuses which are not guaranteed, are determined by the Company based on the participating life fund's actual operating and investment performance.

Example:

- if the investments have performed well over the past year, the Company may be able to pay a higher bonus.

- If the investments have performed poorly, the Company may pay a lower bonus, or it may not be able to pay a bonus at all.

The investment performance is not the only factor that will affect the bonuses that policyholders will receive. Other factors such as expenses incurred to meet the direct distribution cost, agency-related expenses, and the Company's expenses, as well as the actual level of death and disability claims on the fund, will also affect the bonuses that policyholders will receive.

In addition to actual operating performance, bonuses may also be adjusted if there is an expected persistent deterioration in the future investment environment or operating conditions to maintain the long-term sustainability of the fund.

The bonuses paid are 'smoothed'. This means that, in years where the Company has experienced good operating and investment results, they may hold back some of the profits and use them to top up bonuses in poorer years. This is a feature unique to participating policies. This means that a Company will try to even out the payout to policyholders when results have not been so favourable. However, smoothing does not provide complete protection against poor results. If poor results continue over several years, the Company may have to reduce bonuses to reflect the poor results."

Simplified example of how bonus smoothing might work in the form of a table:

Table 12-6 *Bonus Smoothing*

Year	Actual Fund Return	Bonus Declared
1	10%	6%
2	2%	4%
3	5%	4%
4	1%	3%

Through this approach, the company can provide a more stable and predictable bonus to policyholders. However, as demonstrated in Year 4, if poor results continue over several years, the smoothing reserve may be depleted, and the company may have to reduce bonuses to reflect the poor results.

Illustration of Non-Guaranteed Benefits based on Guideline Scenarios

In accordance with the Management of Participating Life Business guidelines (15 July 2015), an illustration of non-guaranteed benefits is required to demonstrate the impact of different investment scenarios on policyholders.

The benefit illustration will present two hypothetical scenarios based on prescribed return rates of 2% and 5%. These scenarios are designed to showcase the potential range of non-guaranteed benefits policyholders may expect under different investment performance conditions.

- Scenario 1: 2% Return Rate
  In this conservative investment environment, where the return rate is 2%, the non-guaranteed benefits, such as dividends or bonuses, will reflect the lower investment performance. The illustration will provide insights into how this lower return rate affects the potential benefits received by policyholders.

- Scenario 2: 5% Return Rate
  Contrastingly, in a more favorable investment environment with a return rate of 5%, policyholders can anticipate higher non-guaranteed benefits, reflecting the improved investment performance. The illustration will showcase the potential increase in dividends or bonuses that policyholders may receive under this higher return rate.

It is important to note that these scenarios are hypothetical and intended solely for illustrative purposes. The actual benefits in participating life insurance policies may vary depending on factors such as investment performance, expenses, claims experience, and policy-specific terms and conditions.

Policyholders should be aware that non-guaranteed benefits are subject to change and are not guaranteed. They depend on the financial performance of the participating life insurance fund and the overall management of the policy by the insurance company.

By understanding these guideline-based scenarios, agents can better assist clients in making informed decisions regarding participating life insurance policies. This knowledge will equip agents with the necessary information to explain the potential variability of non-guaranteed benefits and help clients understand the impact of different investment scenarios on their policy's benefits.
In conclusion, it is essential for insurance agents to have a thorough understanding of the features, advantages, and disadvantages of life insurance products. By comprehending the intricacies of different policy types, agents can provide informed recommendations and assist clients in selecting the most suitable coverage.

Life insurance serves as a contract that offers financial protection to policy owners and their beneficiaries, ensuring a specified sum of money is paid out upon death, disability, or critical illness. The distinction between "assurance" and "insurance" lies in the certainty of events covered, with assurance pertaining to certain events and insurance covering uncertain or potential events.

Beyond the basic purpose of providing financial security, life insurance plays a vital role in maintaining a standard of living, settling household debt, securing children's education, and supplementing retirement savings for beneficiaries. However, the suitability of each policy type varies in terms of investment, risk, coverage, and cash value growth.

By fully grasping the nuances of different life insurance policies, insurance agents can guide clients in making well-informed decisions tailored to their individual circumstances. This knowledge equips agents to recommend the most appropriate coverage that aligns with clients' needs and financial goals, ensuring that they receive optimal benefits from their life insurance policies.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*The major objective of buying life insurance is*
A	a. to supplement retirement income. b. to reduce the financial burden of the insured. c. to protect the dependents in the case of premature death of the breadwinner. d. to maximize savings.

2	**Review Question**
Q	*A retirement annuity is particularly attractive to someone who has*
A	a. a large family. b. a severe illness. c. low longevity risk. d. high longevity risk.

3	**Review Question**
Q	*Which of the following policies has no savings element in it?*
A	a. Whole life b. Endowment c. Term d. None of the above

4	**Review Question**
Q	*A whole life policy differs from a term policy in that*
A	a. premium on a whole life policy increases each year. b. no premiums are required when the insured turns 65. c. the rate on a whole life policy is always lower than that charged on a term policy. d. a whole life policy accumulates cash value, whereas a term policy does not.

5	**Review Question**
Q	*When the assets of the life insurance fund exceed the liabilities, there is/are*
A	a. a surplus. b. profits. c. cash dividends. d. a bonus.

6	**Review Question**
Q	*When must insurable interest exists for a life insurance contract?*
A	a. At the time of claim b. At the time of surrender c. At inception of insurance d. At the time of changing the beneficiary

7	**Review Question**
Q	*An option to convert a term to permanent insurance without proof of insurability but with premium adjustment is known as*
A	a. guaranteed suitability option. b. guaranteed insurability option. c. guaranteed convertibility option. d. guaranteed permanent option.

8	**Review Question**
Q	*Which of the following is NOT true with regards to a whole life policy?*
A	a. The sum assured of the policy will never be greater than the accumulated cash value. b. Towards the end of its period, more premium is allocated for cash value accumulation than the protection element. c. When the insured dies, the beneficiary will receive the sum assured and any accumulated cash value. d. A whole life policy may be thought of as a forced method of saving.

9	**Review Question**
Q	*What is the "waiver of premium" provision in a life insurance policy?*
A	a. It waives the suicide clause. b. It allows the person to purchase additional insurance at no extra cost. c. It pays future premiums in the event of a permanent disability. d. It allows an insurance agent to pay premiums for the policyholder.

10	**Review Question**
Q	*Life insurance policyholders have a right to share in the divisible surplus of the insurer's life insurance fund only if*
A	a. the company earns a specified amount of profit. b. the policy is issued by a takaful company. c. the policy is from specific life insurance companies. d. they own a participating policy.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

13

CHAPTER 13 LIFE INSURANCE PREMIUM RATING

A life insurance premium is the financial obligation a policyholder must fulfill to maintain their life insurance policy. This amount is calculated through a process known as life insurance premium rating.

The core purpose of premium rating is to align the cost of a policy with the risk an insurer undertakes by insuring an individual's life. This means that a higher risk typically results in a higher premium. The intention is to balance the costs in a manner that allows the insurer to cover potential claims, manage operational expenses, secure profits, maintain competitive market pricing, and importantly, set aside adequate capital reserves. These reserves are critical to the insurer's financial stability, providing the necessary funds to honor future claims and manage risks associated with unpredictable claim variations or catastrophic events."

13.1 FACTORS INFLUENCE LIFE INSURANCE PREMIUM RATINGS

Several factors influence life insurance premium ratings. These typically include:

- Mortality Risk

  This is the risk associated with the possibility of the policyholder's death during the policy's active period. To estimate this risk, insurers utilize mortality tables, which are statistical charts demonstrating the death probability at each age. These tables form the basis for mortality risk assumptions, which play a critical role in premium calculation and setting reserves.

- Interest Rate

  The time value of money plays a significant role in premium rating. Insurers invest the premiums they receive, expecting a certain rate of return (interest) to help cover future claims.

- Policyholder's Characteristics

  These include age, gender, smoking status, occupation, health history, and lifestyle choices. For instance, older individuals, smokers, or people with high-risk occupations generally pay higher premiums due to increased risk.

- Policy Features

  The type of policy (term, whole life, etc.), policy term, sum assured, and any additional riders also impact the premium.

- Expenses

  These include the costs of selling the policy (commissions, advertising, etc.), administrative expenses, and costs related to claim processing.

These factors come together in complex mathematical models, which actuaries use to calculate the premium. This process is vital to ensure that insurers remain financially capable of paying claims, continue operations, and stay competitive.

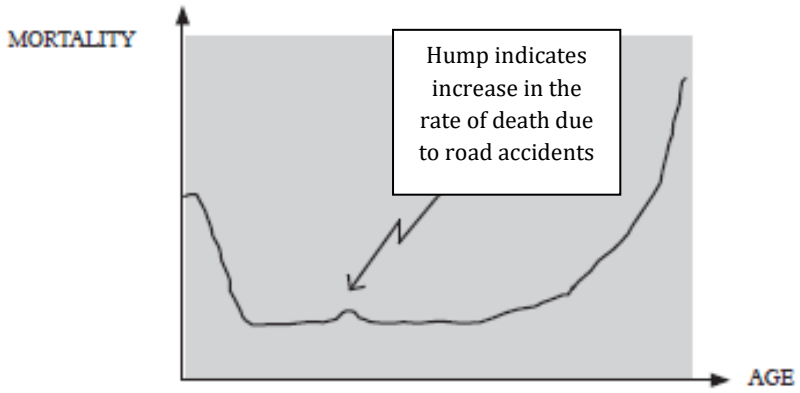
In the role of an insurance advisor, understanding the premium rating process is essential. It aids in explaining to potential policyholders why their premiums cost what they do and can help in customizing policies that balance coverage needs with affordability.

13.2 COSTING THE RISK

Costing the risk in life insurance involves understanding the likelihood of an insured event occurring - in this case, the death of the policyholder - and determining the potential financial impact of that event. This section elucidates the fundamental components of this risk assessment.

13.2.1 MORTALITY TABLES

FIGURE 13-1 ***Mortality Table***



Mortality tables, also known as life tables, are critical tools used by insurance companies in assessing the risk associated with life insurance policies. These tables provide data on the mortality rates of various age groups, typically segregated by gender. The data represent the likelihood of death for a person at each age, based on extensive analysis of a large population sample.

These tables are not static; they are derived from a vast array of historical data and are regularly updated to reflect evolving societal trends. Changes in lifestyle, advancements in healthcare, and other socio-economic factors that can influence life expectancy are accounted for during these updates.

Consider this example: A mortality table might suggest that a 30-year-old male has a 0.1% probability of dying within the next year, while a 60-year-old male might have a 1% chance. Insurance companies use such data to estimate the risk of death for a policyholder, and therefore, the likelihood of having to pay a death benefit.

Mortality tables used by insurers often standardize or modify to suit their needs for premium calculation purposes. These standard mortality tables draw from the collective mortality experiences of life insurers operating within a particular region, and different tables may be used for various types of policies.

Several factors influence the mortality rates represented in these tables:

- Age
  Mortality increases with age.
- Gender
  Generally, females have a lower mortality rate than males.
- Occupation
  Certain occupations carry more risk and hence higher mortality.
- Social Status
  Higher social status can correlate with lower mortality due to better access to healthcare and healthier lifestyles.
- Geographical Location
  Mortality can vary significantly between different regions due to differences in environment, healthcare access, and lifestyle.
- Marital Status
  Being married can correlate with lower mortality.
- Personal Habits
  Habits such as smoking, alcohol consumption, and drug use can significantly increase mortality.
- Avocation
  High-risk hobbies can increase mortality rates.
- Foreign Residence
  Living abroad, especially in regions with different health risks, can affect mortality.

OCCUPATIONAL CLASS AND RATING IN LIFE INSURANCE

When determining premiums for life insurance policies, insurance companies factor in a variety of risks associated with the policyholder. One of these risk factors is the policyholder's occupation, which is classified into different occupational classes. The nature of an individual's job can significantly impact their life expectancy and hence the risk to the insurer.

Occupational classes are typically categorized based on the perceived risk associated with different jobs. Higher-risk occupations tend to have higher premiums because the likelihood of death (and hence the insurer needing to pay a claim) is statistically higher. For instance, a construction worker or a professional diver might be deemed to have a higher-risk occupation than an office worker because their job involves more physical risk.

Each insurance company has its own way of defining occupational classes and determining the associated risk, but typically these can be grouped into four or five main categories. For example:

- Class 1 (Low Risk)
  People who work in a professional, managerial, or administrative capacity, usually in an office setting. Their work involves no manual labor and they are not exposed to any unusual health or safety risks in their work environment.

- Class 2 (Moderate Risk)
  Occupations that involve some level of manual work but are not generally considered high risk. This could include jobs like skilled tradespeople, shop workers, or people involved in light manufacturing.

- Class 3 (Moderate to High Risk)
  Jobs that involve a good deal of physical labor or working in hazardous conditions. This could include heavy manual laborers, builders, or mechanics.

- Class 4 (High Risk)
  These occupations have significant risks or hazards associated with them, such as miners, pilots, fishermen, and loggers.

Each occupational class is associated with a different premium rate, which is determined through statistical analysis of data related to morbidity and mortality for people in these occupations.

The occupational class and rating system is a way for insurers to manage the risks associated with insuring people in different occupations. As an insurance advisor, understanding these occupational classifications and their associated risks is vital in helping your clients choose the right insurance product for their needs.

By considering all these factors, insurers can construct detailed and precise mortality tables that help in predicting the likelihood of a policyholder's death and thus assist in the accurate pricing of life insurance premiums.

13.2.2 INTEREST, TIME VALUE OF MONEY, AND INVESTMENT RETURNS

The time value of money, related to **interest rates**, plays a pivotal role in determining the cost of risk. Insurance companies invest the premium payments they collect, aiming to generate returns over time, rather than merely storing these funds until they are needed for claims. This principle is underpinned by the concept of the time value of money, which states that a dollar today is worth more than a dollar in the future due to its potential to earn interest. Hence, the expected interest rate or investment return on premiums is a crucial component in the risk costing process.

This concept is particularly pertinent in life insurance, as claims may not materialize until many years or even decades after the policy issuance. Therefore, insurers need to calculate the future worth of the money received from premiums today when benefits will have to be disbursed.

The investment returns generated from these premiums significantly impact insurance premium calculations. After accounting for expenses, taxes, claims, and shareholder profits, the remaining premium balance is invested in income and capital-bearing assets. The return rate on these investments can substantially affect premium determination.

While current receipts from the premium balance can be invested at known return rates, future receipts must be invested at rates that will be in effect at the time. These future rates can be swayed by a myriad of unpredictable factors such as economic, political, and social conditions.

Therefore, insurers must make prudent estimates of likely future investment return rates over the medium to long term when calculating premiums. This estimation is often referred to as the interest rate assumption.

If potential investment returns are not factored into premium calculations, the result could be inflated rates. Thus, the interest rate assumption is a vital part of the premium calculation process. It enables the determination of premiums that not only accurately represent the cost of risk but also maintain fairness and affordability for policyholders.

13.2.3 OPERATIONAL EXPENSES

These expenses are categorized into initial, renewal, and termination expenses.

- Initial expenses include costs related to underwriting, policy issuance, and marketing.
- Renewal expenses are those incurred in the administration of policies, such as managing policy renewals and handling claims.
- Termination expenses occur when a policy is surrendered or terminated, including costs related to refunding premiums during the 'cooling off' period, paying out cash value and bonuses upon policy surrender, and additional administrative expenses like claims handling and potential litigation.

By understanding and accurately costing these three factors – mortality rates, the time value of money, and operating costs – insurance companies can effectively price the risk associated with insuring a person's life. This forms the foundation of how life insurance premiums are determined.

13.3 LEVEL PREMIUMS

Level premiums are a fundamental feature of many life insurance policies, designed to provide financial predictability and stability to policyholders. Unlike certain insurance types where the premium varies annually, a level premium remains the same throughout the entire policy term or even for the policyholder's life, depending on the contract specifics. The premium is calculated at the outset of the policy and remains unaltered, irrespective of changes in the policyholder's age, health status, or other risk factors.

13.3.1 CONCEPT AND CALCULATION OF LEVEL PREMIUMS

The concept of level premiums is based on the fact that while the pure risk premium varies with age, mortality increases as the policyholder gets older. The level premium, which remains constant throughout the policy duration, is designed to balance this increase in mortality risk over time.

In the calculation of level premiums, actuaries utilize mortality tables, interest rates, and expenses to ascertain the total cost of the policy over its lifespan. This cost is then divided by the number of payment periods (monthly or annually) over the policy term to establish the level premium amount.

In the initial years of the policy, when the risk of the policyholder dying is relatively low, the level premium exceeds the risk premium due to lower mortality. The surplus premium is invested by the insurer, creating a reserve. Over time, this reserve builds into a cash value that subsidizes the premium in the later years when mortality risk and, therefore, the cost of pure insurance, is higher. This process allows the premium to remain level over the duration of the policy, thereby keeping the policy affordable as the policyholder ages.

13.3.2 ADVANTAGES OF LEVEL PREMIUMS

The primary advantage of level premiums lies in their predictability. The constant premium facilitates more manageable budgeting and reduces uncertainty, which is particularly beneficial for personal financial planning. It alleviates the risk of unexpected premium increases that could strain the policyholder's budget in the future.

Over the long term, level premiums could result in significant savings for policyholders. While the initial premium might be higher than annually renewable term insurance, the unchanged premium could lead to lower total costs over the policy's life, particularly if the policyholder maintains the policy into older age when mortality rates and, therefore, premiums are usually higher.

Level premiums, therefore, are integral to life insurance policies. They provide policyholders with a predictable and constant payment plan that not only simplifies financial planning but also potentially offers long-term savings. This balancing act makes life insurance accessible and affordable for individuals across various age groups.

13.4 GROSS AND NET PREMIUMS

Premium rating tables for life insurance policies are structured based on the policyholder's age and the term of insurance. At the core of these calculations is the mortality rate, or the 'pure risk' factor. This is then adjusted for the time value of money, forming what is known as the 'net premium.'

The net premium reflects the inherent risk associated with insuring the life of the policyholder, accounting for their age, mortality rates, and the term of insurance. It is the cost necessary to cover the expected claims and provide the promised benefits, with adjustments for the interest rate assumption.

However, this net premium does not include the costs associated with managing the insurance policy. To cover these costs, a loading factor encompassing management expenses, contingencies, and a margin for profit is added to the net premium. The result of this addition is the 'gross premium.'

The gross premium, therefore, is the total cost to the policyholder. It includes the risk-based net premium, as well as additional amounts to cover the insurer's operational expenses, contingencies, and desired profit margin. The distinction between these two types of premiums provides insights into how life insurance pricing works, and how insurers manage the financial dynamics of providing coverage.

- ✓ Net Premium = pure risk premium plus interest
- ✓ Gross Premium = net premium + management expenses and contingencies + profit

13.5 LOADING FOR CONTINGENCIES

Loading for contingencies is a crucial part of life insurance premium calculation. It serves as a buffer for the insurer against unexpected events or changes that may occur in the future, which could potentially impact the financial viability of the insurance policy.

Several types of contingencies exist in the context of life insurance, and each requires its specific kind of loading:

- Endowment Policies

  These policies provide a sum assured if the policyholder survives to the end of the policy period or on earlier death. To cover the survival benefit, an extra premium or loading is charged. This is why premiums for endowment insurance are typically higher than for whole life and term insurance.

- Yearly Renewable Contracts

  These contracts may be renewed annually at the discretion of the insured and the insurer. If there is an adverse change in the insured's occupation or other contingencies like deteriorated health, a higher premium might be charged on renewal. In cases where there is no 'guaranteed insurability' option, the insurer may refuse renewal altogether.

- Participating Policies

  Policyholders with participating policies share in the company's divisible surplus. An extra premium or loading is charged for this privilege, allowing the policyholder to partake in the profits of the company.

- Periodic Premium Payments

  Policyholders who choose to pay their premiums on a periodic basis (monthly, quarterly, or semi-annually) will be charged a premium loading. This accounts for administrative costs and compensates for premiums that will not be collected after the date of death.

Each loading for contingencies is an additional charge atop the net premium, included in the gross premium, and is designed to ensure that the insurer remains financially secure even when faced with unexpected circumstances or changes.

13.6 GROUP INSURANCE PREMIUM

Group insurance premium calculations have distinct nuances that differ from individual life insurance. The most significant difference is that group insurance is typically 'experience rated.' This means premiums are calculated based on the average mortality rate of the entire group rather than individual risk factors.

- Experience Rating

  The 'experience' of the group, including past claims experience, is used to estimate the group's future claims. Groups with a higher-than-average claim rate in the past are usually deemed higher risk and may be charged higher premiums, while groups with lower-than-average claim rates may enjoy lower premiums.

- Mortality Rate

  Unlike individual life insurance where the mortality rate of the insured individual is taken into account, in group insurance, the average mortality rate of the group is used. This method reflects the collective risk of the group and allows for a lower cost per insured individual due to risk pooling and distribution.

- Acquisition Cost and Management Expenses

  As with individual insurance, the cost of acquiring customers, administration, and other operational costs is also factored into group insurance premiums.

- Profit Margin

  Insurers also factor in a margin for profit. This is a part of the loading that ensures the insurer can remain solvent, make a reasonable profit, and continue to offer services.

In group insurance, the risk is spread over a larger number of individuals, which can allow for lower premiums per person compared to individual policies. However, the overall health and claims history of the group can significantly impact these premiums. This is why a group with a generally healthy lifestyle and lower claims experience may enjoy lower group insurance premiums, contributing to the affordability and appeal of group insurance plans.

13.7 PREMIUM MODIFICATIONS

Over the term of a life insurance policy, premiums might be modified due to a variety of factors. These adjustments could either increase or decrease the premium, depending on the specific situation and the type of policy. Here are some common reasons for premium modifications:

- Dividends/Cash Bonuses and Policyholder Participation

  Some life insurance policies are participating policies, meaning the policyholder is eligible to receive dividends/Cash Bonuses if the insurance company performs well financially.

  In Malaysia, there are typically four ways to handle these dividends or cash bonuses:

i. Receive the Dividend/Cash Bonus in Cash: Policyholders can choose to receive their dividends or cash bonuses as cash payouts.
ii. Apply the Dividend/ Cash Bonus to Pay Any Premium Due: Dividends or cash bonuses can be used to pay upcoming premiums, including any outstanding Automatic Premium Loans (APL).
iii. Leave the Dividend/Cash Bonus with the Company to Accumulate Interest: Dividends or cash bonuses can be left with the insurance company to accumulate at an interest rate determined by the company.
iv. Combination of Options 2 and 3: Policyholders can choose to partially use the dividends or cash bonuses to pay premiums and leave the remainder with the company to accumulate interest.

These options provide flexibility for policyholders to manage their dividends or cash bonuses in a way that best suits their financial needs.

- Non-smoker Discounts

  Non-smokers generally have a lower mortality rate than smokers, and insurance companies often reward this lower risk with discounted premiums. If a policyholder quits smoking, they can apply for these discounts, potentially lowering their premiums.

- Age-Based Adjustments

  The risk of death increases as the insured ages, and therefore, age is a key factor in calculating life insurance premiums. Some policies may increase premiums as the insured reaches certain ages, while others lock in a level premium at the start of the policy.

- Riders and Policy Add-Ons

  Adding riders or additional coverage to a life insurance policy will generally increase the premium. These can include riders for accidental death, disability income, long-term care, and more.

- Health Changes

  Significant changes to a policyholder's health can lead to premium modifications. For example, if the policyholder's health improves significantly, they may qualify for lower premiums.

- Lifestyle Changes

  Certain changes in lifestyle can also lead to premium adjustments. For example, a policyholder might receive lower premiums if they lose weight, stop risky hobbies, or improve their overall health in a measurable way.

- Investment-Linked Policy Sustainability

  For investment-linked policies, premiums may need to increase to ensure the policy's sustainability over the long term, especially in volatile market conditions.

- Premium Repricing for Non-Guaranteed Premium Policies

  Policies with non-guaranteed premiums, such as medical products, may undergo premium repricing based on the insurer's claim experiences and changing risk factors.

Premium modifications allow insurance companies to adjust to changing risk factors and other circumstances over the term of a policy. They help ensure that premiums stay aligned with the amount of risk the insurer is taking on.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*Which of the following statements is NOT true concerning life insurance premiums?*
A	a. Premium rating tables are designed in accordance with age and term of insurance. b. Net premium is pure risk premium for mortality plus an element of interest added to it. c. Gross premium is the net premium plus a loading for management expenses and profit. d. Participating life insurance policies will not be charged extra premium or loading.

2	**Review Question**
Q	*What is the method of charging a uniform premium throughout the duration of a life insurance policy despite the rate of death increasing with age?*
A	a. Level payment system b. Level premium system c. Increasing premium system d. Decreasing term assurance

3	**Review Question**
Q	*The expenses of running an insurance business can be categorised into three types EXCEPT*
A	a. initial expenses. b. renewal expenses. c. termination expenses. d. procurement expenses.

4	**Review Question**
Q	*Which of the following is NOT a major factor influencing mortality?*
A	a. Age b. Gender c. Ethnicity d. Occupation

5	**Review Question**
Q	*What is the factor that does not affect the cost of risk?* *I. Mortality table* *II. Interest and time value of money* *III. Management Expenses* *IV. Agent's Commission*
A	a. I and II b. I, II and III c. I, III and IV d. All of the above

6	**Review Question**
Q	*What are the main factors which an actuary would use in pricing life insurance premiums?* *I. Mortality* *II. Morbidity* *III. Investment returns* *IV. Management expenses*
A	a. I, III and IV b. I, II and III c. I and II d. I, II, III and IV

7	**Review Question**
Q	*Which of the following are classified as 'termination expenses'?* *I. Agent's commissions and procurement cost* *II. Refund of premiums during the cooling-off period* *III. Payment of cash value upon surrender of policy* *IV. Claims administration expenses*
A	a. I, III and IV b. II, III and IV c. I, II and III d. I, II, III and IV

8	**Review Question**
Q	*Which of the following best describes a life insurance contract?*
A	a. Short term and renewable b. Investment and saving plan c. Long term and permanent d. Long term and renewable

9	**Review Question**
Q	*Why do insurance companies charge a loading for payment of bonus for participating policies?*
A	a. To pay bonus to employees and shareholders b. To increase the profits of the company c. To ensure adequate premium is charged for the risk d. To allow participating policyholders a share in the profits of the company

10	**Review Question**
Q	*The premium rates for group life insurance*
A	a. are based on the mortality rate using burning cost method. b. are based on the experience rated using the average mortality rate. c. are based on the level premium system using mortality rate. d. are based on the past claims experience of the group.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

14

CHAPTER 14 LIFE INSURANCE UNDERWRITING AND DOCUMENTS

Pooling of similar or homogenous risks in large numbers is a fundamental concept in the insurance industry, and it holds particular importance in life insurance. The purpose of this practice is to reduce uncertainties and accurately measure risk by leveraging the power of statistics. By gathering a large number of policyholders with similar risk profiles, insurers can more reliably calculate the chance or probability of an event occurring.

While death is an inevitable event, the law of large numbers provides a safeguard against the volatility and financial impact caused by exceptional circumstances. Extraordinary events such as pandemics, air crashes, earthquakes, or tsunamis can have a significant adverse effect on the underwriting results and financial stability of an insurer. However, when risks are pooled in large numbers, the impact of these exceptional events becomes more manageable and predictable.

By spreading the risk across a diverse group of policyholders, insurers can mitigate the financial burden of unexpected and catastrophic events. The statistical analysis of large data sets allows insurers to make more accurate predictions and set appropriate premiums that reflect the underlying risk. This helps ensure the long-term sustainability and stability of the insurance industry, providing individuals and their families with the necessary protection and peace of mind.

14.1 RISK SELECTION

Risk selection is a critical aspect of the underwriting process in life insurance. It involves assessing and evaluating various factors to determine the level of risk associated with a potential policyholder. Insurers typically classify risks into different categories or risk classes, such as "preferred," "standard," or "substandard," based on their evaluation. Let us explore specific examples of high-risk and low-risk profiles and delve into the risk classes commonly used by insurers.

14.1.1 HIGH-RISK PROFILES

- Age
  Advanced age can be considered a higher risk factor in life insurance underwriting. Older individuals may have a higher probability of experiencing health issues or mortality-related concerns.

- Pre-existing Medical Conditions
  Policy applicants with chronic illnesses, such as heart disease, diabetes, cancer, or other significant health conditions, are generally categorized as higher risk due to the potential for increased medical expenses or mortality risk.

- Lifestyle Habits
  Certain lifestyle choices, such as smoking, excessive alcohol consumption, or participation in hazardous activities like extreme sports, can elevate the risk level for insurance underwriting.

- Occupation
  Certain occupations, such as firefighters, pilots, or offshore oil rig workers, involve higher inherent risks, which can influence the risk assessment process.

- Financial Stability
  Individuals with unstable financial situations, high levels of debt, or inconsistent income may be considered higher risk. This is because financial instability can lead to missed premium payments or policy lapses, which impacts the insurer's risk exposure.

14.1.2 LOW-RISK PROFILES

- Young and Healthy Individuals
  Younger individuals who have no significant medical history and lead a healthy lifestyle are typically considered lower risk for life insurance underwriting.

- Non-Smokers
  Non-smokers generally have a lower risk of developing smoking-related health issues and are typically placed in a more favorable risk class.

- Stable Financial Standing
  Individuals with stable financial situations, such as a steady income and low debt levels, are often viewed as lower risk for life insurance underwriting.

- Safe Occupations
  Individuals working in low-risk occupations, such as office professionals, teachers, or administrators, may be considered lower risk due to the reduced likelihood of work-related accidents or injuries.

14.1.3 RISK CLASSES

Insurers often categorize risks into different classes to simplify underwriting and pricing processes. Here are some common risk classes:

- Preferred Risk
  This class includes individuals who possess excellent health, have no significant medical history, and lead a healthy lifestyle. They are considered the lowest risk and may receive the most favorable rates and terms.

- Standard Risk
  This class comprises individuals who meet the insurer's standard underwriting guidelines without any significant health issues or high-risk factors. They are generally considered average risk.

- Substandard Risk
  Individuals in this class have certain health conditions, lifestyle habits, or other factors that increase their risk level. They may face higher premiums or specific policy exclusions based on their unique risk factors.

Insurers use risk classes to classify applicants based on their risk profiles. These risk classes, such as "preferred," "standard," or "substandard," help insurers simplify underwriting and pricing processes. Preferred risk class includes individuals with excellent health and low-risk factors, while standard risk class comprises applicants who meet the insurer's standard underwriting guidelines. Substandard risk class consists of individuals with higher-risk factors that may result in higher premiums or specific policy exclusions.

14.2 UNDERWRITING GUIDELINES

Underwriting guidelines serve as criteria used by insurance companies to assess risk, determine insurability, and set appropriate premiums. They consist of both medical underwriting and financial underwriting, each focusing on specific aspects of the risk proposed for life insurance.

14.2.1 MEDICAL UNDERWRITING

Medical underwriting involves evaluating the physical hazards associated with the risk proposed for life insurance. Factors such as age, height, weight, personal and family medical history, and lifestyle habits are considered. In cases where adverse features or medical conditions, such as diabetes, are revealed, insurers may require additional questionnaires or a medical examination to gather necessary information for a proper assessment.

14.2.2 FINANCIAL UNDERWRITING

Financial underwriting aims to assess the moral hazard inherent in the risk and is relatively subjective compared to the tangible physical hazard. It involves examining the presence of insurable interest and determining whether the applied-for insurance amount aligns with the applicant's financial standing or earning capacity. Financial underwriting also includes verifying if the applicant holds multiple insurance policies with other insurers and checking if any previous applications for insurance coverage have been declined and the reasons behind those decisions.

14.2.3 CLASSIFICATION OF RISKS

Underwriting guidelines classify risks based on factors such as age, gender, occupation, lifestyle habits, and medical information, among others. This classification helps determine the likelihood of early death by illness or accident. Higher-risk individuals are typically required to pay higher premiums to receive the same level of protection as those considered lower risk.

14.2.4 CHARACTERISTICS OF SUB-STANDARD AND BELOW AVERAGE RISKS

Underwriting guidelines further categorize risks into standard risks, substandard risks, and below-average risks:

- Standard risks
  Applicants without adverse risk factors are considered acceptable for coverage on standard terms and premiums.

- Substandard risks
  Applicants with health or occupational hazards may be accepted for coverage but with additional premiums, loadings, or limitations on coverage.

- Below-average risks
  These risks may not be accepted or may be deferred for a specific period, depending on the severity of risk factors.

14.2.5 HANDLING ADVERSE RISKS

Insurers employ various strategies to handle adverse risks and counter the effects of adverse selection (anti-selection), where individuals with higher risks seek more insurance coverage. These strategies may include:

- Charging extra premiums or loadings to account for the increased risk.

- Adjusting the death benefit or sum assured while maintaining standard premium rates.

- Recommending alternative insurance plans, such as yearly renewable term assurance instead of whole life policies.

- Excluding specific conditions or impairments or restricting participation in certain sports or activities.

- Modifying bonuses in participating policies, although this method is rarely used.

By utilizing underwriting guidelines and implementing appropriate measures to handle adverse risks, insurers aim to accurately assess risk levels, determine fair premiums, and maintain the overall financial stability of the insurance company.

By effectively evaluating and selecting risks, insurers aim to ensure that the premiums charged appropriately reflect the level of risk involved. This allows them to maintain financial stability and fulfill their commitments to policyholders, providing the necessary financial protection and peace of mind.

14.3 ASSUMPTION OF RISK

The assumption of risk is a crucial concept in life insurance, referring to the point at which an insurer takes on the responsibility of covering the insured individual. Here are some additional details to enhance and consolidate the understanding of the assumption of risk:

- Essentials for the Assumption of Risk by a Life Insurer
  Upon receipt of the first premium after the acceptance letter is issued, the insurer assumes the risk. The acceptance letter typically includes a request for payment of the first premium within a specified period, usually around 30 days. If the premium is not paid within this period, the insurer may require re-confirmation of acceptance, which would involve a declaration of good health from the insured. It is important to note that any material changes to the insured's health, occupation, or other circumstances from the date of the original proposal should be promptly notified to the insurance company for re-assessment.

- Premium payment is a precondition for the assumption of risk in life insurance

  When an initial premium is paid along with a completed proposal form and an official receipt is issued by the insurer, the proposer becomes covered against accidental death for a specified period of time. However, the actual commencement of life insurance coverage occurs once the insurer evaluates the information in the proposal form, makes a decision regarding the acceptance or decline of the risk, and issues the policy with its respective terms and conditions to the policy owner.

- Cooling Off or Free Look Period

  A policy owner is entitled to a "cooling off" or "free look" period which typically lasts for fifteen (15) days after the policy's delivery. During this period, the policy owner has the option to return the life policy to the insurer. Upon doing so, the insurer is obligated to promptly refund any premium that has been paid, deducting only the expenses incurred for the medical examination of the life insured. Once the premium is refunded, the policy is considered cancelled, and the insurer's liability ceases.

- Extra Premium Charges or Loadings

  In cases where the insurer imposes extra premium charges or loadings, this information must be provided to the proposer in writing, effectively constituting a "counter-offer." If the proposer agrees to the revised terms, they must provide written consent by signing and returning a copy of the letter, allowing the insurance policy to be issued based on the agreed-upon terms.

- Backdating of Insurance Commencement Date

  In certain situations, the commencement date of insurance may be backdated for up to six months. This practice allows the proposer to benefit from paying a lower premium that corresponds to a lower age at the time of application.
  Note: The backdating of the insurance commencement date applies specifically to Traditional Life Insurance policies.

These essentials of the assumption of risk help ensure clarity and transparency between the insurer and the policy owner, establishing clear guidelines and procedures for premium payment, policy cancellation, and modifications to policy terms. By understanding these principles, both parties can navigate the life insurance process with confidence and assurance.

14.4 ROLE OF THE INSURANCE AGENT IN THE UNDERWRITING PROCESS

Insurance agents play a pivotal role in the underwriting process, serving as intermediaries between the insurer and the potential policyholder. They are entrusted with ethical responsibilities and have a significant impact on the integrity and success of the underwriting process, specifically emphasizing the importance of full disclosure by both the applicant and the agent.

Insurance agents are essential in prospecting for business and assisting underwriters in selecting good risks. They act as the primary point of contact with prospective clients, representing the insurer and its products. Agents are expected to demonstrate professionalism, integrity, and an in-depth understanding of the insurance products they offer.

One of the ethical responsibilities of insurance agents is to provide potential customers with accurate and comprehensive information about the insurance products available. They should clearly explain the salient features, benefits, and limitations of the policies to enable customers to make informed decisions. Agents should also help customers understand the importance of full disclosure during the underwriting process.

Full disclosure by both the applicant and the agent is crucial for the integrity of the underwriting process. Applicants have the responsibility to truthfully and completely answer all underwriting questions asked by the insurer. Failure to provide accurate information may lead to adverse consequences, such as claim denials or policy cancellations, if the non-disclosure or misrepresentation is discovered later.

Similarly, insurance agents must emphasize the significance of full disclosure to applicants. They should guide potential customers in understanding the information requested in the proposal form and ensure that all material facts are disclosed. Agents need to inform applicants about the potential consequences of non-disclosure or misrepresentation, highlighting the impact on the underwriting decision, coverage terms, and premium rates.

Maintaining a high standard of ethics and professionalism is essential for insurance agents throughout the underwriting process. They should act in the best interests of their clients, providing objective advice and recommendations. Agents should also respect customer confidentiality and handle personal information securely and responsibly.

By fulfilling their ethical responsibilities, insurance agents contribute to a transparent and trustworthy underwriting process. Full disclosure by both the applicant and the agent helps ensure accurate risk assessment, appropriate coverage, and fair premiums. Ultimately, this promotes mutual trust between insurers and policyholders, establishing a solid foundation for long-term relationships and the effective protection of individuals and their families.

14.5 INSURANCE DOCUMENTS

Insurance documents are essential components in the underwriting process of life insurance. These documents provide crucial information for evaluating risk and establishing the terms and conditions of the insurance contract. Let us consolidate the information provided and highlight the significance of each document:

14.5.1 THE PROPOSAL FORM

The proposal form is a document presented to the consumer by the insurer. It contains specific questions that help the insurer assess the risk and determine the appropriate rates and terms for the insurance contract. Consumers have a duty to provide accurate and complete information and take reasonable care not to make misrepresentations. Failure by the insurer to ask relevant questions or follow up on incomplete answers may be deemed a waiver of the consumer's duty of disclosure. Consumers are also obligated to disclose any additional information relevant to the insurer's decision.

14.5.2 MEDICAL EXAMINER'S REPORT

The medical examiner's report includes the proposer's medical history and the examination findings conducted by a doctor. This report provides essential information on the proposer's health, including measurements, tests, and the doctor's opinion on insurability. It helps the insurer assess the potential risks associated with the applicant's health and determine appropriate coverage and premiums.

14.5.3 AGENT'S REPORT

The agent's report is prepared by the insurance agent and offers their perspective on the applicant. It includes information about the applicant's habits, appearance, character, and financial status. The agent's report, along with a fact-finding sheet, provides additional insights into the applicant's overall suitability for insurance coverage and assists the insurer in assessing the risk.

14.5.4 THE POLICY FORM

The policy form is the final written contract between the insured individual and the insurance company. It outlines the terms, conditions, and coverage provided by the insurer. The policy incorporates the information provided in the proposal form and serves as legal evidence of the insurance contract. It is crucial for policyholders to thoroughly review the policy, including coverage limits, exclusions, conditions, and any additional endorsements or riders attached to the policy. Understanding the policy terms is vital to ensure clarity on the rights and obligations of both parties.

Insurance documents, including the proposal form, medical examiner's report, agent's report, and policy form, collectively contribute to the underwriting process. They provide essential information for evaluating risk, determining appropriate coverage, and establishing the terms of the insurance contract. Policyholders should carefully review and understand these documents, seeking clarification from the insurer or their insurance agent if needed, to ensure they have a comprehensive understanding of their insurance coverage.

In conclusion, the practice of pooling similar risks in large numbers is a vital aspect of the insurance industry, particularly in life insurance. By underwriting every policy application following standard rules, insurers work towards the common good of every policyholder in the pool. This practice allows insurers to reduce uncertainties, accurately measure risk, and harness the power of statistics.

The concept of pooling risks helps protect against the volatility and financial impact of exceptional circumstances, such as pandemics or natural disasters. While these events can have a significant adverse effect on insurers, the law of large numbers provides stability and predictability. By spreading the risk across a diverse group of policyholders, insurers can manage the financial burden associated with unexpected and catastrophic events.

This approach enables insurers to make informed decisions, set appropriate premiums, and ensure the long-term sustainability and stability of the insurance industry. It provides individuals and their families with the necessary protection and peace of mind. By upholding the principles of pooling and underwriting, insurers can fulfill their role in serving the common good and protecting the interests of policyholders.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*An underwriter is best described as an insurance professional who does the following except:*
A	a. accepts or rejects risks. b. implements an insurer's strategic plan. c. invests the capital of an insurer's shareholders. *d.* decides on premium pricing.

2	**Review Question**
Q	*Which of the following method is NOT used by Insurers when dealing with adverse risk?*
A	a. Charging an extra premium b. Recommending an alternative insurance plan c. Reducing the benefits *d.* Providing a premium discount

3	**Review Question**
Q	*A sub-standard or below average risk is best described as*
A	a. an acceptable risk on standard terms and premium rates. b. a risk with health or occupational hazards accepted on special terms. c. not acceptable on any account. *d.* an uninsurable risk, such as a person with terminal illness.

4	**Review Question**
Q	*Which of the following is NOT part of the underwriting process?*
A	a. Establishing policy coverage terms and conditions b. Evaluating, assessing, and selecting of risks for insurance c. Establishing claim procedure and documentation *d.* Pricing of insurance to charge premium commensurate with risk

5	**Review Question**
Q	*Which of the following underwriting factors is NOT associated with physical hazard?*
A	a. height and weight b. family medical history c. earning capacity *d.* lifestyle

6	**Review Question**
Q	*What is the purpose of financial underwriting in life insurance?*
A	a. To evaluate the physical hazard of an applicant for life insurance b. To assess the moral hazard attached to a potential customer c. To select customers of sound financial status to pay premiums *d.* To ensure the purchaser has insurable interest in the life insured

7	**Review Question**
Q	*Which of the following documents is a major source of information for underwriting life insurance?*
A	a. Proposal form b. Financial report c. Agent's report *d.* Sales illustration

8	**Review Question**
Q	*What is the role of the insurance agent in the underwriting process?*
A	a. Assists the underwriter in calculating the premium payable b. Offers financial advice to potential customers c. Assists in filling up the proposal form for the customer *d.* Ensures all material facts are disclosed so that both customer and underwriter make an informed decision

9	**Review Question**
Q	*When can a life insurer assume a risk for life insurance?*
A	a. On receipt of the first premium after a letter of acceptance is issued b. On receipt of a completed proposal form c. After the underwriter has assessed the information in the proposal form *d.* After the policy is issued and/or delivered to the policy owner

10	**Review Question**
Q	*What is meant by 'cooling off' or 'free look' period?*
A	a. It allows a policyholder to cancel the life policy after 15 days of free cover. b. It allows a policyholder to return the life policy within 15 days for a full refund. c. It allows a policyholder to reject the life policy after 15 days of free cover. *d.* It allows a policyholder to cancel the life policy not later than 15 days after its delivery.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

15

CHAPTER 15 LIFE INSURANCE CLAIMS

In the realm of life insurance, understanding the claims process is of vital importance. Life insurance is designed to offer financial support in the face of life's most challenging moments, and this support materializes through the claims process. However, this process can often be complex, with different types of claims necessitating different procedures and documentation.

In this chapter, we will walk you through the intricacies of the life insurance claims process. We will explore various types of claims such as death, maturity, critical illness, and others. Each section will outline what these claims are, the circumstances under which they can be filed, and the specific steps policyholders or beneficiaries need to follow to file these claims.

Additionally, we will delve into the process of dealing with claim denials and disputes, as well as how insurance companies generally handle claim payouts. We aim to equip you with the knowledge you need to navigate this complex process, providing real-life case studies, answering frequently asked questions, and keeping you updated on changes in the claims process.

Whether a policyholder wanting to understand the value of the life insurance policy or a beneficiary trying to navigate the aftermath of a loved one's passing, this chapter is designed to provide a comprehensive understanding of life insurance claims.

Remember, while the process may seem daunting, knowing what to expect and how to navigate it can make a significant difference. So, let's delve into the world of life insurance claims together.

The moment of truth for most insurance companies comes when a claim notification is received, and when the insurance agent and the policy sold by him would be tested to see if they are up to the customer’s expectations or not. Claim handlers should show sensitivity and compassion, particularly when handling death claims and try to make the claims process as simple and straightforward as possible.

15.1 CLAIM PROCEDURE

Filing a life insurance claim usually involves several standard steps. While the specific requirements can vary slightly between different insurance companies and types of policies, the process generally involves the following:

- Notification of Claim
  The first step in the claims process is notifying the insurance company about the event (e.g., death, illness, accident, or policy maturity). This notification is usually required to be made as soon as possible, often within a specific timeframe as stipulated in the policy document.

- Submission of Claim Forms
  The insurer will provide the claimant with the necessary claim forms, either in person, by mail, or online. These forms need to be completed accurately and comprehensively. They typically ask for details about the policyholder and the event that triggered the claim.

- Documentation
  Along with the claim forms, the claimant is required to submit certain supporting documents. In case of a death claim, this would include the original death certificate. Other claims may require medical reports, police reports (for accidents), or proof of identity, depending on the claim's nature.

- Claim Assessment
  After the claim forms and documents have been submitted, the insurance company will assess the claim by verifying the information and documents provided to ensure their accuracy. Additionally, in order to maintain the integrity of the claims process, the insurer may conduct due diligence checks, especially in cases where the claim appears to be early or suspicious in nature.

- These due diligence checks may involve further investigation, such as reviewing medical records, contacting relevant parties involved in the claim, or consulting with experts in the field. The purpose of these checks is to ensure that the claim is valid and in accordance with the terms and conditions of the insurance policy.

- By conducting due diligence checks, insurance companies can protect themselves against fraudulent or exaggerated claims, safeguarding the interests of both the policyholders and the insurer. It helps maintain the fairness and sustainability of the insurance system, ensuring that legitimate claims are paid out promptly while deterring fraudulent activities.

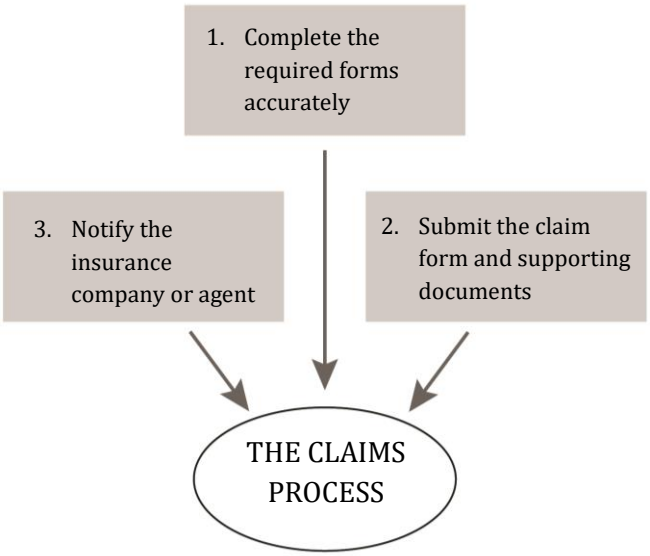
- Claim Approval or Denial
  If the claim is approved, the insurance company will determine the payout amount based on the policy terms and conditions. If the claim is denied, the insurer will provide a reason for the denial.

- Payout
  Once approved, the insurer will proceed to make the payout. The method of payout (lump sum, annuity, etc.) will depend on the policy's terms and the nature of the claim.

- Dispute Resolution (if needed)
  If a claim is denied and the policyholder or beneficiary disagrees with the decision, they may need to enter into a dispute resolution process, which could involve internal review, mediation, arbitration, or legal action.

By knowing these steps, an insurance advisor can make the claims process smoother and more efficient, be better prepared when encountering any issues or challenges along the way.

FIGURE 15-1 ***Claim Procedure***



15.2 TYPES OF CLAIMS

There are several types of claims that policyholders or their beneficiaries can make. Here are some of the common types:

- Death Claims
  This is the most common type of life insurance claim. In the event of the policyholder's death, the nominated beneficiaries can file a death claim to receive the death benefit as specified in the policy.

- Total and Permanent Disability Claims
  If the policyholder becomes totally and permanently disabled, they can make a claim to receive a payout from their life insurance policy. The definition of total and permanent disability varies by policy

- Critical Illness Claims
  Some life insurance policies include critical illness coverage, which pays out a lump sum if the policyholder is diagnosed with a serious illness specified in the policy. The illnesses covered vary by policy but often include conditions like heart attack, stroke, or certain types of cancer.

- Maturity Claims
  If the policyholder outlives the term of the policy, they can make a maturity claim. This type of claim applies to term life insurance policies with a return of premium feature or endowment policies, where a lump sum is paid out at the end of the policy term.

- Hospitalisation & Surgical (H&S) Claims
  Life insurance policies often provide a Hospitalisation & Surgical (H&S) benefit that includes a medical card. This benefit covers the costs associated with hospitalization and surgical procedures as specified in the policy. H&S claims can be processed through two methods: cashless or reimbursement, depending on the hospital's affiliation with the insurance company's panel.

  - ✓ For cashless claims, policyholders can present their medical card at panel hospitals. The insurance company will then issue a guarantee letter to the hospital, ensuring that the costs of treatment or hospital stay are directly settled between the insurer and the healthcare provider. This eliminates the need for the policyholder to make upfront payments.

  - ✓ In the case of non-panel hospitals, policyholders will need to pay for the medical expenses themselves and then submit a reimbursement claim to the insurance company. The insurer will review the claim, assess the validity of the expenses, and reimburse the policyholder accordingly, subject to the policy's terms and conditions.

- Personal Accident Claims
  Some life insurance policies offer additional coverage for accidents. If the policyholder is involved in an accident that results in death or disability, a personal accident claim can be made.

Each of these claim types has its own specific requirements in terms of the claim process and the documentation needed.

15.3 DEATH CLAIMS

The death claim process in life insurance policies is a critical one, designed to provide beneficiaries with the financial protection promised by the policy following the policyholder's demise.

The process can vary somewhat depending on the policy terms and the circumstances of the death, but it typically involves the following steps:

15.3.1 NATURAL DEATH/ DEATH DUE TO ILLNESS

- Notification of Death
  This is usually a written statement notifying the insurance company about the death of the policyholder. It is typically given by the nominee or the legal heirs of the deceased.

- Submission of Claim Forms and Documents
  The claimant is required to complete a claim form provided by the insurer. This form must be accompanied by several important documents, such as:

  ✓ Claimant's Statement
  This is a form filled out by the nominee or legal heirs, providing details about the policyholder and the claimant. It may include information about the circumstances and cause of death.

  ✓ Doctor's Statement (some companies will waive this requirement if the for policy is more than 5 years from date of commencement or date of reinstatement, whichever is later)

- CTC (Certified true copy) of Death Certificate
  The official document confirming the death, its date, and its cause, issued by the relevant government authority.

  ✓ CTC of Detailed Post Mortem Report, if any
  ✓ Certified true copy of Deceased's NRIC
  ✓ Certified true copy of the claimant's NRIC
  ✓ Grant of Probate/Letter of Administration, for policy without nomination
  ✓ Policy Document
  The original life insurance policy document. In case it is lost, an insurer may require a legally binding document affirming the loss. However, most companies have waived this requirement.

- Claim Review and Payout
  The insurance company will review the claim and all provided documents. If approved, the death benefit payout will be made to the beneficiary in accordance with the policy's terms, such as a lump sum, an annuity, or another form of payment.

- Claim Denial and Dispute Resolutiom
  If the claim is denied (due to reasons such as suicide within the exclusion period, misrepresentation of information, or death due to excluded causes), the insurer will provide reasons for denial. Beneficiaries have the right to dispute the denial and can opt for an appeals process, potentially involving legal assistance.

15.3.2 ACCIDENTAL DEATH

Explores the additional steps or considerations when the death is due to an accident.

Additional Requirements for Death due to Accident

- Accidental Death Benefit Claim Form
- Copy of Newspaper Cutting, if any
- CTC of Deceased' s Driving License
- CTC of Police Investigation Report, if any
- CTC of Police Report
- CTC of Detailed Post Mortem and Toxicology Report

15.3.3 DEATH OF NON-MALAYSIAN OR DEATH OUTSIDE MALAYSIA

If the Deceased is a non-Malaysian or if the death event occurred outside Malaysia (usually except Singapore)

Additional Requirements

i) CTC of Deceased's Full Passport Book/Citizenship Certificate
ii) CTC of Confirmation letter from National Registration Department (for death outside of Malaysia)

15.3.4 DEATHS IN SPECIAL CIRCUMSTANCES

Death claims made under special circumstances, such as when a policyholder is missing and presumed dead, often require unique procedures. The process becomes more complex as a presumption of death must be legally established.

a. Missing and presumed dead
   - Presumption of Death
     If a person goes missing and all reasonable efforts to locate them have been exhausted, they can be legally presumed dead. The specific time frame varies by jurisdiction but often involves a period of seven years.

   - Statutory Declaration
     A court of competent jurisdiction must issue a statutory declaration or presumption of death, confirming that the missing individual is presumed dead. This document is vital in proceeding with a death claim for a missing person.

   - Submission of Claim Forms and Documents
     Just like any other death claim, the claimant is required to complete a claim form and provide all necessary documents. However, in this case, instead of a traditional death certificate, the statutory declaration of death is used. Other standard documents like the policy document and proof of identity of the claimant are still required.

   - Claim Review and Payout
     Upon receiving the claim form and all necessary documents, the insurance company will review the claim. If the claim is approved, the death benefit is paid out to the beneficiary in accordance with the policy terms.

- Claim Denial and Dispute Resolution
  Should the claim be denied, the insurer will provide reasons for the denial. The beneficiary can dispute the decision and engage in an appeals process, which may require legal assistance.

Example

Claim Denial and Dispute Resolution

1 MH17 Incident July 17, 2014: In the unfortunate event like the MH17 incident where the plane was shot down over Ukraine, and there were no survivors. In such a case, the death certificate might be issued based on the official investigation report declaring all passengers onboard as deceased.

2 2004 Indian Ocean Tsunami: For the devastating Indian Ocean Tsunami in 2004, there were instances where the bodies of victims could not be recovered or identified.

These examples might not precisely mirror reality, but they can give you a general idea of how the process might work in similar situations.

b. Evidence Act 1950 and the Civil Law Act 1956

- Under the **Evidence Act 1950**, a person who has not been heard of for **seven years** by those who would naturally have heard of them is **considered dead** (Section 108). This is referred to as the 'seven-year rule' and it operates as a presumption of law. This means if a person is missing and has not been heard from for seven years, they are presumed dead.

- The **Civil Law Act 1956** provides the power to apply to the court for a declaration that a missing person is deemed dead. This application can be made by the spouse or any relative of the missing person or by a person who is a beneficiary of an insurance policy on the life of the missing person. The court may then make a **presumption of death order** if it is satisfied that the missing person is dead or has not been known to be alive for a period of at least seven years.

Overall, the death claim process seeks to validate claims in accordance with policy terms. By understanding the specific steps and requirements, claimants can navigate this process more efficiently during what is typically a difficult time.

15.3.5 PAYMENT OF POLICY MONEYS UNDER LIFE AND PERSONAL ACCIDENT POLICY
SOURCE: FINANCIAL SERVICES ACT 2013, SCHEDULE 10 SECTION 130

In the realm of insurance, understanding the intricate details of life insurance and personal accident policies, as well as the accompanying legal obligations, proves to be of paramount importance. This topic on the payment of policy money in the event of death claims, aiming to enhance the understanding of this crucial aspect.

Insurance is not just a financial product, but a promise of security and financial stability during challenging times. Life Insurance and Personal Accident policies serve a vital role by providing financial support to the nominees or beneficiaries of the policyholder after their unfortunate demise. However, the path from policy inception to claim settlement is often marked by complex processes and legal nuances. The role of the advisor is essential in this context.

In this topic, the exploration of key aspects such as the power of nomination, the revocation of nomination, the process of payment where a nomination exists or does not, and the role of trusts and assignments will take place. The obligations of a licensed insurer, the concept of interest on claim amounts, and the legal standing of this schedule over other laws will also be scrutinized.

a. Power to Make Nomination

An insurance advisor should be aware of when guiding clients through the nomination process:

- Insurance advisors should guide clients who are at least 16 years old through the nomination process. This includes helping them understand how to nominate an individual(s) to receive the policy money upon the client's death and ensuring the client provides all necessary details about the nominee, such as their name, date of birth, national identification number, and address.

- Advisors should inform clients that nominations can be made when the policy is issued or even afterward. In case of nominations after the policy has been issued, clients must notify the insurer in writing or request an endorsement on the existing policy.

- Advisors must ensure clients understand that any nomination should be witnessed by a person who is at least 18 years old, of sound mind, and not named as a nominee.

- An advisor has a vital role in clarifying to the client that if they wish their **nominee (other than their spouse, child, or parent)** to benefit from the policy, they must **assign** the policy benefits to the nominee. The advisor should confirm with the insurer that the nomination is recorded in the insurer's register of policies and an endorsement is issued and returned to the policy owner.

b. Revocation of Nomination

Advisors should inform clients that a nomination, may be revoked under the following conditions:

1 If the nominee, or in the case of multiple nominees, all nominees, pass away during the policy owner's lifetime.

2 If the policy owner provides a written notice to the licensed insurer indicating the desire to revoke the nomination.

3 If the policy owner makes a subsequent nomination, effectively replacing the previous one.

Advisors should also make it clear to clients that a nomination **cannot be revoked by a will or any other act**, event, or means, except as described above.

If a client has more than one nominee and one nominee predeceases the policy owner, the advisor should explain that, in the absence of any subsequent nomination by the policy owner concerning the deceased nominee's share, the licensed insurer will distribute the deceased nominee's share among the remaining nominees in proportion to their respective share.

c. Payment of Policy Moneys Where There Is Nomination

- Advisors should inform clients that upon the policy owner's death, given a nomination has been made, the insurer is obligated to pay the policy money as directed in the nomination. This payment is made when the **nominee submits a claim** accompanied by proof of the policy owner's death.

- Advisors should make clients aware that if a **nominee does not claim** the policy money within **sixty days** of the insurer learning about the policy owner's death, the insurer is required to notify the nominee about their entitlement to claim the policy money. This notification is sent to the nominee's last known address.

- Insurance advisors should explain to clients that if a nominee **fails to claim** the policy money **within twelve months** of the insurer learning about the policy owner's death, despite being notified, the policy will be treated as if no nomination was made.

- If a nominee, other than his spouse or child, parent (where there is no spouse or child living at the time of nomination), **dies after the policy owner** but before receiving any policy money, advisors should explain to clients that either be treated as no nomination was made or nomination has been revoked, depending on the situation.

d. Trust Policy Moneys

- An insurance advisor should inform clients, other than Muslim policy owners, that a nomination can **create a trust** in favor of the nominee for the policy money payable upon the policy owner's death. This applies if the **nominee is the client's spouse, child, or parent** (if there is no living spouse or child at the time of nomination).

- Advisors should ensure clients understand that payments made under these circumstances do not form part of the deceased policy owner's estate and are **not subject to their debts**.

- An insurance advisor should guide clients on how to **appoint a trustee** for the policy moneys. This can be done via the policy or by written notice to the insurer. If no trustee is appointed, the nominee (if competent to contract) or the parent of an incompetent nominee (or the Public Trustee or a nominated trust company, if there is no surviving parent) becomes the trustee.

- In cases where more than one competent nominee exists, the advisor should explain to clients that these nominees will act as joint trustees, and all must give consent for purposes related to the trust.

- It is crucial for advisors to make it clear that policy owners cannot alter a policy creating a trust without the written consent of the trustee. Alterations include revoking a nomination, adding a nominee other than a spouse, child, or parent, varying, or surrendering the policy, or using the policy as security.

- Lastly, advisors should inform clients that if the policy was effected and premiums were paid with an **intent to defraud a creditor**, the creditor is entitled to receive from the policy moneys an amount equal to the premiums paid.

e. Non-Trust Policy Moneys

Non Trust Nominees are nominees other than the client's spouse, child, or parent (if there's no living spouse or child at the time of nomination).

- An advisor should inform clients that if the nominees are non-trust nominees, they will receive the policy money upon the policy owner's death as **an executor, not as a beneficiary**. The payment to the nominee then becomes part of the deceased policy owner's estate and is **subject to their debts**. Once payment is made, the insurer is relieved of liability regarding the policy money.

- The advisor should also make it clear that the **nominee**, referred to in the first point, is responsible for **distributing the policy money** during the administration of the deceased policy owner's estate. This distribution should follow the will of the policy owner or the law pertaining to the distribution of a deceased person's estate, whichever is applicable to the policy owner.

- Lastly, insurance advisors should convey to clients that despite the above stipulations, if policy money has been assigned to a nominee, the nominee receives the policy money solely as a beneficiary, not as an executor.

f. Assigned or Pledged Policy Moneys

Advisors should inform clients that even if a nomination is made, or a trust is created, if the policy money has been pledged as security or assigned to another individual (wholly or partially), the claim of that person or **assignee takes precedence** over the nominee's claim. After safeguarding the rights under the security or assignment, the insurer will pay the remaining policy money to the nominee.

In cases where multiple people have rights under the security or assignment, advisors should clarify that the order of priority depends on when the insurer received written notification of the security or assignment. Both security and assignment are treated as one class for determining this order.

g. Payment of Policy Moneys Where There Is No Nomination

Advisors should explain that in the absence of a nomination, the insurer will pay the policy moneys to the lawful executor or administrator of the deceased policy owner's estate.

If there is no lawful executor or administrator of the deceased policy owner's estate at the time of payment, and the insurer is satisfied with this, the policy moneys can be paid to the deceased's spouse, child, or parent.

Advisors must make clear that if there is no spouse, child, or parent and if the policy moneys do not exceed RM100,000, the insurer can pay the policy moneys to a person who can demonstrate entitlement to the deceased's property under the deceased's will or law.

If the policy moneys exceed RM100,000, the insurer may pay up to the specified amount to the person referred to above and pay the balance to the lawful executor or administrator of the deceased's estate.

Advisors must inform clients that probate or letters of administration or distribution order from a court, or its certified copy, are considered sufficient proof for the insurer to pay policy moneys to the named lawful executor or administrator.

Finally, advisors need to ensure clients understand that policy moneys paid under these circumstances are considered duly paid, and the insurer will not be held liable for these paid policy moneys, despite any absence or invalidity of, or defect in the probate or letters of administration or distribution order or other such document.

Any person who receives a payment under this condition should provide a receipt, which will be deemed as a valid receipt.

h. Payment to Person Incompetent to Contract

As an insurance advisor, it is crucial to clarify the insurer's protocol when dealing with policyholders or beneficiaries who are minors (under 18 years of age) or deemed incapable of managing themselves and their property due to mental or physical infirmity.

For a trust nominee under who is incompetent, the insurer will pay the policy moneys to the trustee appointed. If no such trustee is appointed, the insurer will pay to the parent of the nominee.

If there is no surviving parent of the nominee and the policy moneys do not exceed RM50,000, the insurer may pay the policy moneys to a person who can demonstrate that they will use the policy moneys for the nominee's maintenance and benefit.

For policy moneys exceeding fifty thousand Ringgit, the insurer will pay the moneys to the Public Trustee or a trust company nominated by the policy owner.

Lastly, for persons deemed incompetent who are entitled to receive policy moneys, the insurer will make payment to the Public Trustee or a trust company nominated by the policy owner.

The aim is to ensure that the person unable to contract receives the benefits as intended by the policy owner while being protected from potential exploitation or mismanagement of funds.

i. Distribution of Policy Moneys in Due Course of Administration

In certain circumstances, an individual may receive policy moneys not just as a beneficiary but in the role of an executor. This condition applies to those who can receive policy moneys under no nomination.

As an executor, this individual is responsible for distributing the policy moneys in the course of the administration of the deceased person's estate. This distribution should occur as per the specifications laid out in the deceased person's will.

However, if the deceased person did not leave a will, the distribution must follow the laws applicable to the deceased's estate in a situation of intestacy. In this situation, laws govern the administration, distribution, and disposition of the deceased person's estate.

The recipient in this scenario has a responsibility to ensure the deceased person's estate, including the insurance policy moneys, is distributed appropriately and in accordance with the law.

j. Licensed Insurer's Responsibility Regarding Application of Policy Moneys

In terms of the application of policy moneys, a licensed insurer is not required to oversee or ensure how the policy moneys it has paid out are utilized. This rule applies irrespective of the person to whom the insurance policy moneys have been paid under the provisions of this Schedule.

Simply put, once the insurer has made a payout under the policy, its role and responsibility regarding those funds are considered fulfilled. The insurer is not obliged to track, verify, or ensure that the funds are applied or used in any specific manner by the recipient.

k. Interest on Unpaid Claim Amount

If a claim made under a life insurance policy or a personal accident policy (in case of the policy owner's death) is not paid by the licensed insurer within **60 days** of notification of the claim, the insurer is required to pay interest on the unpaid policy money.

The interest to be paid is compound in nature, and is calculated using the average **fixed deposit rate for a 12-month** period as published by the Bank, **plus an additional one percent**. This rate may be modified by the Bank as needed. The interest is calculated from the end of the 60-day period until the date of the actual payment.

In cases where the remaining policy money is to be paid to the lawful executor or administrator of the deceased policy owner's estate, the interest as described above would only apply to the balance of the policy money. The calculation would commence 60 days after the lawful executor or administrator presents the grant of probate or letters of administration or distribution order, and would continue until the date of payment.

In short, this provision ensures that the beneficiaries are compensated for any delay in the payment of the policy money by the insurer.

l. Primacy of the Schedule Over Other Documents and Laws

This Schedule 10 of FSA 2013 holds supremacy over the actual policy and any other written law when it comes to the matters it covers. This is valid for any policy in force on or after the appointed date, and it applies to any nomination made before, on, or after the appointed date. Nothing contained in a policy can deviate from, or be interpreted as deviating from, this Schedule.

Furthermore, this Schedule has full power and effect, even if there are aspects that contradict other written laws related to probate (legal process of verifying a will), administration, distribution, or disposition of estates of deceased persons. This also overrides any practices or customs related to these matters.

In essence, the rules outlined in this Schedule take precedence over any conflicting policy provisions or laws. This provision ensures that the regulations within this Schedule are adhered to in any circumstances related to the payout of policy moneys.

15.3.6 GRANT OF PROBATE OR LETTER OF ADMINISTRATION OR DISTRIBUTION ORDER

A grant of probate or letter of administration is a legal document issued by a court that authorizes and empowers the named individual or individuals to administer the estate of a deceased person. The specific term used may vary depending on the jurisdiction.

- Grant of Probate GP
  A grant of probate is issued when the deceased person has left a valid will. The court examines the will to confirm its validity and appoints the person named as the executor in the will as the legal representative of the estate. The executor is responsible for carrying out the instructions outlined in the will, including distributing assets and settling debts. Once the Grant of Probate has been issued, the Executor(s) named in the Will is authorised to administer the estate.

- Letter of Administration LA
  A letter of administration is issued when the deceased person did not leave a valid will or did not appoint an executor. In such cases, the court appoints an administrator to handle the estate. The administrator is typically a close relative of the deceased and is granted the authority to distribute the assets in accordance with the laws of intestacy. In Malaysia, there are only 3 institutions with the authority to grant LA, which are the High Court, AmanahRaya and the Small Estate Distribution Unit. AmanahRaya grants LA in the form of a Declaration or Order as governed by Public Trust Corporation Act 1995 (PTCA 1995).

  In the context of life insurance policies, a grant of probate or letter of administration may be required if the policy owner passes away without having made a nomination or without leaving a will. If there is no spouse, child, or parent to establish the lawful executor or administrator of the estate, a court order becomes necessary to determine the rightful recipient of the policy proceeds.

15.3.7 ASSIGNMENT OF POLICY PROCEEDS

In Malaysia, a life insurance policy can be assigned, which means the rights and benefits of the policy are transferred from the policyholder (assignor) to another person or entity (assignee). The assignment of a life insurance policy can occur for several reasons, including securing a loan, fulfilling a contract, or managing estate planning.

There are two types of assignments: absolute assignment and conditional assignment.

- Absolute Assignment
  In this case, the policyholder transfers all the rights and benefits of the policy to another person or entity permanently. After the absolute assignment, the assignee becomes the new owner of the policy, and the original policyholder no longer has any rights or claims on the policy. This type of assignment is often used in estate planning or business agreements.

  In the case of Hospitalisation & Surgical (H&S) Claims, an absolute assignment results in the assignee becoming the new owner of the policy, while the original policyholder relinquishes all rights and claims to the policy.

- Conditional Assignment
  As the name suggests, this type of assignment is conditional or temporary. The policyholder assigns the policy to another person or entity for a specified period or under certain

conditions. Once those conditions are met, or the specified period expires, the rights of the policy revert back to the original policyholder. Conditional assignment is commonly used when a life insurance policy is used as collateral for a loan.

When assigning a life insurance policy in Malaysia, the assignment needs to be documented in writing and this document is typically subject to stamp duty, in order to make it legally effective. The assignment document (either endorsed on the policy or separate) should be stamped by the revenue authority, indicating that the necessary duty has been paid.

15.4 TOTAL AND PERMANENT DISABILITY (TPD) CLAIMS

Total and Permanent Disability insurance provides financial protection if the policyholder becomes totally and permanently disabled. Here is an overview of how TPD claims typically work:

- Occurrence of Total and Permanent Disability
  If the policyholder becomes totally and permanently disabled as defined in their policy, they are eligible to make a TPD claim. The exact definition of total and permanent disability can vary between policies and insurance providers.

- Notification of Claim
  The policyholder or their representative should notify the insurance company of the disability as soon as possible. The insurer will provide a claim form and information on the next steps in the claim process.

- Submission of Claim Forms and Documents
  The policyholder completes the claim form and submits it along with necessary supporting documents. These typically include medical reports, proof of the policyholder's identity, and potentially documentation related to the policyholder's employment and income if the policy includes income replacement benefits.

  Additional Documents may be required as below:
  - ✓ CTC of all relevant investigation test results or reports
  - ✓ CTC of Employment Letter
  - ✓ CTC of Employment Termination Letter
  - ✓ CTC EPF Withdrawal Letter
  - ✓ CTC of PERKESO Offer Letter and PERKESO 'Keputusan Jemaah Doktor'
  - ✓ CTC of Medical Report for application of PERKESO Keilatan
  - ✓ CTC of Medically Boarded Out Letter from Employer with Medical Report
  - ✓ CTC of Newspaper Cutting (accidental cause), if any
  - ✓ CTC of Police Report (accidental cause)

- Claim Review
  Once the claim form and supporting documents are submitted, the insurance company reviews the claim. They may request additional information or documents or may require the policyholder to undergo a medical examination by a doctor appointed by the insurer.

- Claim Approval and Payout
  If the claim is approved, the insurer will pay the TPD benefit. Depending on the specifics of the policy, this may be a lump sum payment, a series of payments over time, or a combination of both.

- Claim Denial and Appeals
  If the claim is denied, the insurance company should provide the reasons for the denial. The policyholder has the right to appeal the decision, and this may involve legal assistance.

15.5 CRITICAL ILLNESS CLAIMS

Critical illness insurance provides financial protection to the policyholder if they are diagnosed with a specific illness covered under the policy. This form of insurance can help offset medical expenses and financial hardships that might arise during treatment and recovery.

A general process of how critical illness claims are made:

- Diagnosis of Critical Illness
  If the policyholder is diagnosed with one of the critical illnesses covered by their insurance policy, they are eligible to make a claim. The illnesses covered and the specific terms can vary between policies and insurance providers.

- Notification of Claim
  The policyholder or their representative should notify the insurance company of the claim as soon as possible after the diagnosis. The insurer will provide a claim form and information on the next steps in the claim process.

- Submission of Claim Forms and Documents
  The policyholder completes the claim form and submits it along with the necessary supporting documents. This typically includes medical reports, a detailed diagnosis report, and proof of the policyholder's identity. Some insurers may also require additional evidence such as laboratory test results or imaging studies.

- Claim Review
  Once the claim form and supporting documents are submitted, the insurance company reviews the claim. They may ask for additional information or documents, or they may require the policyholder to undergo a medical examination by a doctor appointed by the insurer.

- Claim Approval and Payout
  If the claim is approved, the insurer will pay the critical illness benefit as a lump sum. This payout is intended to help cover treatment costs and compensate for income loss during the recovery period.

- Claim Denial and Appeals
  If the claim is denied, the insurance company should provide the reasons for the denial. The policyholder has the right to appeal the decision, and this may involve legal assistance.

Keep in mind that the exact process and requirements can vary depending on the insurance company and the specifics of the insurance policy.

15.6 MATURITY CLAIMS

Indeed, in many cases, insurance companies in Malaysia automatically process maturity benefits and directly credit the payout to the policyholder's bank account on record. This simplifies the procedure and ensures that the policyholder receives their maturity benefit without needing to submit a claim.

A brief overview of this process:

- Policy Maturity
  When the policy reaches the end of its term and matures, the policyholder is entitled to the maturity benefit. This benefit typically consists of the sum assured plus any accumulated bonuses or dividends, as per the terms of the policy.

- Notification of Maturity
  Many insurance companies send a notification letter to the policyholder ahead of the policy's maturity date. This notice typically includes details of the maturity benefit due.

- Automatic Processing
  Instead of waiting for the policyholder to file a maturity claim, the insurer automatically processes the maturity benefit. They calculate the amount due based on the terms of the policy and prepare to disburse it.

- Direct Credit of Maturity Benefit
  The insurer directly credits the maturity benefit to the policyholder's bank account on record. The method of disbursement could be a direct bank transfer. This automatic direct credit system is convenient and ensures the policyholder receives their benefit promptly.

- Disputes and Resolution
  If the policyholder disagrees with the calculated maturity amount or encounters any other issues, they can contact the insurer for resolution. The process for this will depend on the insurer's policy and may, in some cases, require legal assistance.

This approach to maturity claims can vary from one insurance company to another.

15.7 HOSPITALISATION & SURGICAL (H&S) CLAIMS

A medical card in Malaysia is an integral part of a health insurance policy that provides policyholders with access to various medical treatments. It serves as proof that the insurer will cover the costs of the policyholder's medical treatments as per the terms and conditions of the policy.

15.7.1 PANEL HOSPITAL

The claim process for medical card claims typically involves the following:

- Seeking Medical Treatment
  When policyholders require medical care, they have the option to visit a panel hospital approved by the insurance company. Presenting their medical card at the admission counter helps facilitate the process.

- Verification
  The hospital or clinic verifies the details of the medical card with the insurance company. This verification process ensures that the policyholder is eligible for coverage and may involve confirming the policyholder's identity, policy details, and coverage limits.

- Guarantee Letter (GL) Issuance
  When a policyholder requires treatment that is covered under their insurance policy, the insurer may issue a Guarantee Letter (GL) to the hospital. The GL serves as a guarantee of payment for the treatment costs, up to a specific limit outlined in the policy.

  However, if a GL is not issued, policyholders have the option to self-pay for the treatment and submit a claim for reimbursement, which will be subject to review.

- Payment
  The hospital or clinic provides the necessary medical services to the policyholder. The insurer directly settles the payment with the healthcare provider, within the coverage limit specified in the policy.

- Excess Charges and Co-Payment
  When the cost of treatment exceeds the coverage limit or requires a co-payment or deductible as specified in the policy, policyholders are responsible for directly paying the excess charges, co-payment amounts, or deductible to the healthcare provider. These financial responsibilities should be considered and planned for accordingly.

15.7.2 NON PANEL HOSPITAL

However, it is important to note that some medical insurance policies also provide coverage for treatments received at non-panel hospitals or clinics. In such cases, the claim process may involve additional steps, such as reimbursement claims. The policyholder may need to pay for the medical expenses upfront and later submit a reimbursement claim to the insurance company.

The process for reimbursement claims typically involves the following:

- Pay and Collect Receipts
  The policyholder pays for the medical treatment at the non-panel hospital or clinic and collects all relevant bills, receipts, and medical reports.

- Claim Submission
  After receiving the treatment, the policyholder submits a claim form, along with the original bills, receipts, and medical reports, to the insurance company for reimbursement.

- Claim Review
  The insurance company reviews the reimbursement claim, verifying the authenticity of the expenses and evaluating whether they are covered under the policy terms and conditions.

- Claim Approval and Reimbursement
  If the reimbursement claim is approved, the insurance company reimburses the policyholder for the eligible medical expenses, based on the policy's coverage limits and reimbursement policies.

It is important for policyholders to thoroughly understand their insurance policy, including coverage limits, policy terms and conditions, and the claim process for both panel and non-panel hospital treatments. This will ensure a smoother and more efficient claims experience.

15.7.3 PRE- AND POST-HOSPITALIZATION CLAIMS

- Pre- and Post-Hospitalization Claims:

  Pre- and post-hospitalization claims refer to the medical expenses incurred before and after hospitalization, respectively. These claims typically cover consultations, diagnostic tests, medication, and other necessary treatments related to the medical condition requiring hospitalization. The coverage period for pre- and post-hospitalization expenses may vary depending on the policy terms and conditions, typically ranging from 30 to 180 days before and after hospitalization.

  The claim process for both pre- and post-hospitalization claims usually follows these steps:

  1. Medical Treatment
     Policyholders receive the required medical treatment, either before or after hospitalization.

  2. Payment and Receipt Collection
     Policyholders pay for the medical treatment and collect all relevant bills, receipts, and medical reports.

  3. Claim Submission
     After the hospitalization period (pre-hospitalization) or the completion of post-hospitalization treatment, policyholders submit a claim form along with the original bills, receipts, and medical reports to the insurance company.

  4. Claim Review
     The insurance company reviews the claim, ensuring that the expenses are eligible as per the policy terms and conditions. They may request additional information or documents if necessary.

  5. Claim Approval and Reimbursement
     If the claim is approved, the insurance company reimburses the policyholder for the eligible medical expenses, up to the coverage limit specified in the policy.

  It is important to note that the specific requirements and coverage limits for pre- and post-hospitalization claims can vary depending on the insurance policy. Policyholders should carefully review their policy documents to understand the coverage period and any exclusions or limitations that may apply.

- Claim Denial and Dispute
  If the claim is denied, the insurance company will provide reasons for the denial. In case of disputes, the policyholder can submit an appeal to the insurance company for consideration with supporting documents. If the insurance company maintains their decision to deny the claim, Policyholders may seek redress from the Ombudsman for Financial Services (OFS).

15.8 PERSONAL ACCIDENT CLAIMS

Personal accident insurance provides coverage in the event of accidental bodily injury, disability, or death. It offers financial protection to policyholders and their beneficiaries in case of accidents that result in bodily harm or loss.

Here is an overview of the personal accident claim process:

- Accident Occurrence
  The policyholder experiences an accident resulting in bodily injury, disability, ojr death. It is crucial to notify the insurance company about the accident as soon as possible.

- Medical Treatment
  In case of bodily injury, the policyholder seeks medical treatment. It is essential to keep all medical records, including doctor's reports, bills, and receipts related to the accident.

- Claim Notification
  The policyholder or their representative informs the insurance company about the accident and initiates the claim process. The insurer provides the necessary claim forms and guides the policyholder through the required documentation.

- Claim Documentation
  The policyholder completes the claim forms, providing accurate details about the accident, injury sustained, and any other relevant information. Supporting documents, such as medical reports, bills, and receipts, should be included to substantiate the claim.

  Additional Documents may be required:
  - ✓ Accident Claim Form – Attending Physician's Statement
  - ✓ CTC of Driving License, if due to road traffic accident
  - ✓ CTC of Police Report(s)
  - ✓ Original or CTC of Medical Certificate(s)

- Claim Review
  The insurance company evaluates the claim, reviewing the submitted documents and assessing the eligibility based on the policy terms and conditions. They may request additional information or clarification if needed.

- Claim Approval and Payout
  If the claim is approved, the insurance company will provide the compensation or benefit amount as per the terms of the policy. The payment could be a lump sum or distributed in instalments, depending on the nature of the claim.

- Claim Denial and Dispute
  If the claim is denied, the insurance company will provide reasons for the denial. In case of disputes, the policyholder can engage in an appeals process, which may involve providing additional evidence or seeking legal assistance.

15.9 CLAIMS REGISTER

In compliance with regulations, insurance companies are required to maintain claims registers as official records of all claims that have been notified and filed. The claims register serves as a comprehensive and organized log of the claims process, helping insurers track and manage claims efficiently.

Here are some key points about claims registers:

- Purpose

The primary purpose of a claims register is to provide a centralized and documented record of all claims received by the insurer. It ensures transparency, accountability, and regulatory compliance in the claims management process.

- Contents
  The claims register includes essential information about each claim, such as the policyholder's details, claimant's information (if different from the policyholder), date of claim notification, claim type (e.g., death claim, critical illness claim), claim amount, status of the claim, and any relevant remarks or comments.

- Ongoing Claims
  Claims that are still outstanding and yet to be settled should remain in the claims register until they are fully resolved. This ensures a comprehensive view of the insurer's open claims and facilitates tracking and follow-up actions as necessary.

- Record Keeping
  The claims register can be maintained manually using physical books or stored electronically in a computer database. Many insurers utilize computerized systems or dedicated claims management software to efficiently manage and update the register. Some insurers may even adopt a hybrid approach, maintaining both manual and electronic records.

- Regulatory Compliance
  The maintenance of a claims register is typically a regulatory requirement imposed on insurance companies. Compliance with these regulations helps ensure proper governance, accurate reporting, and auditing of claims processes.

- Confidentiality and Data Protection
  Insurance companies must adhere to data protection and privacy laws to safeguard the confidentiality and security of the information contained in the claims register. Access to the register should be limited to authorized personnel to protect sensitive customer data.

The claims register serves as a valuable tool for insurers to monitor and track the progress of claims, identify any patterns or trends, and ensure timely and fair claims settlement. It also facilitates internal audits, reporting to regulatory bodies, and effective communication with policyholders regarding the status of their claims.

In conclusion, understanding the types of claim processes is crucial in the realm of life insurance. This chapter has provided a comprehensive overview of the intricacies involved in navigating the claims process. Whether you are a policyholder seeking clarity on the value of your life insurance policy or a beneficiary coping with the loss of a loved one, this knowledge will empower you to navigate the claims journey with confidence.

While the claims process may appear complex, being well-informed about what to expect and how to proceed can make a significant difference. Insurance companies and agents play a vital role during this critical phase, as they are tested to meet and exceed the customer's expectations. By demonstrating sensitivity, compassion, and expertise, claim handlers strive to simplify and streamline the claims process, particularly when dealing with death claims.

For a deeper understanding of the claims landscape in Malaysia, please refer to the table below, which showcases the total claim payouts from 2018 to 2022. Armed with this knowledge, you can approach the life insurance claims process with the necessary understanding and prepare for any challenges that may arise.

Table 15-1 ***Total Claims Payout in Malaysia (LIAM Annual Reports 2018 - 2022):***

RM / Benefit	2018	2019	2020	2021	2022
Death	1,422,474,881	1,518,538,660	1,496,939,637	1,830,154,284	1,814,532,683
Disability	121,945,710	112,575,767	119,285,276	89,540,934	107,946,280
Medical	4,088,416,357	4,939,645,443	4,508,524,205	4,610,672,441	6,163,799,351
Bonuses	3,675,023,537	3,644,139,331	3,492,025,312	3,346,160,919	3,162,473,293
Others	1,523,663,948	1,720,410,364	1,944,308,423	2,003,810,013	2,144,558,651
Total Claims Pay-out	10,831,524,433	11,935,309,565	11,561,082,853	11,880,338,591	13,393,310,258

By equipping yourself with knowledge and guidance, you can confidently navigate the life insurance claims process and secure the financial support that the policy is designed to provide in times of need. Your policyholders will thank you.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*A life claim can arise under any of the following situations, EXCEPT:*
A	a. death of the insured. b. death of the beneficiary. c. maturity of the life policy. *d.* critical illness.

2	**Review Question**
Q	*In the case of a missing person, what is the time lapse before a statutory presumption of death can be issued by a court?*
A	a. 1 year b. 3 years c. 5 years *d.* 7 years

3	**Review Question**
Q	*What are the supporting documents required for a death claim?* *I. Death certificate* *II. Post-mortem report* *III. Statutory presumption of death (for missing persons)* *IV. Burial certificate*
A	a. I and IV b. I, II and III c. I, II and IV *d.* I, II, III and IV

4	**Review Question**
Q	*A death claim must be paid within ___ days of receipt of notification of the claim; otherwise, the law requires compound interest to be charged on the amount payable.*
A	a. 15 days b. 30 days c. 60 days *d.* 7 days

5	**Review Question**
Q	*What types of claims are handled in the insurance claims department?* *I. Death claim* *II. Total and Permanent Disability benefit* *III. Critical Illness* *IV. Personal Accident rider*
A	a. I & II only b. I, II & III c. II and IV *d.* All of the above

6	**Review Question**
Q	*Before a maturity claim under endowment insurance is paid, the life insurer requires proof of the following EXCEPT*
A	a. proof of age of the life assured. b. proof of death of the life assured. c. identity of the person entitled to the policy monies. *d.* proof of survival of the life assured.

7	**Review Question**
Q	*Where there is a nomination in a life policy, who will receive the policy monies?*
A	a. Policy owner b. Spouse, child, or parent c. Nominee *d.* Estate of the deceased

8	**Review Question**
Q	*The following documents are required for a total and permanent disability claim due to an accident, EXCEPT:*
A	a. a duly completed claim form. b. a certified copy of the police report. c. a medical certification by the attending doctor. *d.* a certified copy of the attending doctor's credentials.

9	**Review Question**
Q	*Where the policy owner dies without having made a nomination, the insurer shall pay the policy monies to the*
A	a. lawful executor or administrator of the deceased's estate. b. policy owner's spouse, child or parent. c. nominee. *d.* policy owner's next of kin.

10	**Review Question**
Q	*Which documents are NOT required according to the concessions under the Financial Services Act 2013, for a death claim below RM 100,000 payable to the lawful beneficiaries?* *I. post mortem or coroner's report* *II. grant of probate* *III. death certificate* *IV. letters of administration*
A	a. I, II and III b. I only c. II and IV *d.* I and III

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

16

CHAPTER 16 CODE OF PRACTICE FOR LIFE INSURANCE AGENTS

Life insurance is a lucrative yet highly regulated industry. This chapter emphasizes the importance of professionalism for insurance agents. Adhering to regulatory guidelines and ethical practices builds trust with clients, enabling agents to provide excellent service and thrive in the industry.

This chapter will also provide valuable insights and practical strategies to help you develop a professional mindset, enhance your communication skills, and build a strong foundation for success. Let us begin our journey towards becoming a highly effective and respected insurance agent.

16.1 LIAM CODE OF ETHICS & CONDUCT

FIGURE 16-1 ***LIAM Code of Ethics & Conduct***

The Life Insurance Association of Malaysia (LIAM) introduced the Code of Ethics and Conduct in 1990 as part of the broader Code of Ethics and Conduct for the life insurance sector in Malaysia. The objective of the code is to promote and maintain high standards of integrity among employees and intermediaries in the sector. It applies to all directors (executive and non-executive), employees, and intermediaries working in this industry.

Along with the Guidelines, the Code of Ethics and Conduct for Life Insurance Selling and the Statement of Life Insurance Practice are also included in this framework. Companies are required to submit quarterly reports to Bank Negara Malaysia on any breaches observed and the corrective or punitive actions taken. Insurers are also obligated to report any cases of fraud to Bank Negara Malaysia and the police.

The introduction of the Code of Ethics and Conduct aimed to promote consumer confidence in the life insurance industry by ensuring that it operates with the highest levels of integrity and professionalism.

- As an agent in the life insurance industry, it is important to understand the responsibility that comes with being a trustee of policy owners' savings. Policy owners place their trust in life insurers to ensure the safety of their savings and to conduct business with integrity and professionalism.

- To maintain the trust of policy owners, it is crucial for agents to conduct business with the highest level of integrity. This means acting honestly and ethically in all interactions with policy owners, colleagues, and other industry professionals.

- While there may be informal and generally accepted codes of ethics in the industry, it is important for agents to understand and follow any formal ethical guidelines or codes of conduct issued by their company or regulatory authorities. These guidelines are in place to ensure a uniform ethical standard throughout the industry and to promote and maintain the confidence of policy owners in the integrity of the life insurance sector.

- Ultimately, agents play a vital role in upholding the trust and confidence of policy owners in the life insurance industry. By conducting business with integrity and professionalism, agents can help safeguard the integrity and credibility of their company and the industry.

Summary of the main contents of Code of Ethics and Conduct (2nd Edition, February 1999)

Part I: Guidelines on The Code of Conduct

- Code of Ethics (Statement of Philosophy) with coverage and monitoring devices.
- Seven Principles of the Guidelines.
- Code of Conduct as a guide.

Part II: Life Insurance Selling

- Introduction to general sales principles, including identification and suitability of policies.
- Explanation of the contract, including provisions, restrictions, and tax relief.
- Disclosure of underwriting information.
- Accounts and financial aspects, including proper handling of moneys.

Part III: Statement of Life Insurance Practice

- Claims, emphasizing fair claim rejection practices, time limit for notification, and prompt payment.
- Proposal forms, their design, and disclosure of material facts.
- Policies and accompanying documents, including surrender values and clear information.
- Sales materials/advertisements, ensuring correctness and non-misleading information.

Appendix I: Recommendations for Bonus/Interest/Dividend/Yield/Illustrations

- Recommendations for preparing illustrations, including cautionary statements and realistic assumptions.

Definition Of Terms

- Clarification of terms used in the Code of Ethics and Conduct.

Overall, the code focuses on ethical conduct, appropriate sales practices, clear disclosure of information, fair claim handling, and adherence to industry standards in the field of life insurance.

The Code of Ethics and Conduct plays a crucial role in promoting ethical practices and maintaining professional standards within the life insurance industry. As part of the licensing process, individuals associated with the Life Insurance Association of Malaysia are required to complete a Declaration of

Observance form. This form serves as a confirmation of their understanding and commitment to uphold the principles outlined in the Code.

The Declaration of Observance form serves as a vital component of the licensing process within the life insurance industry. By signing this document, individuals affirm their understanding and commitment to uphold ethical standards and conduct in their professional roles. It serves as a record that they have acknowledged their responsibilities and are dedicated to maintaining the integrity of the industry.

16.2 CUSTOMER SERVICE GUIDE

The industry has introduced a Service Guide (Revised as at 19 February 2020) to enhance consumer awareness of financial advisory services for insurance products to allow consumers to be aware of and to anticipate the level of service when purchasing insurance products from life insurance agents and sales intermediaries. The aim is to align the customer's expectations of service from the life insurance agents and sales intermediaries versus the obligations to provide such service in return for the remuneration received from their customers. These include assisting policyholders in choosing the right insurance plan, explaining the product features, assisting in policy application, explaining the policy terms and conditions, continuous policy servicing and assisting in making a claim.

Most insurers offer life insurance products through agency, bancassurance distributions etc. If potential policyholders intend to purchase a life insurance product from agents and sales intermediaries, they can expect to enjoy the following value-added services.

What Services can potential policyholders expect from an Agent? They can expect agents are equipped with the knowledge and skills to help them choose the right insurance plan that meets their insurance needs and financial goals.

There are generally three (3) stages in the sales and service processes: Before buying, Decide Buying, and During the policy term:

1. Before Buying
   Here are the steps an agent should follow before a client decides to buy and sign an insurance proposal form as outlined in the Service Guide.

   Objective
   To utilize the Customer Fact-Find form effectively in order to understand the needs; priorities, financial capability of the Clients in order to recommend appropriate plans.

   Step 1: Understand Client's Insurance Needs and Financial Goals
   - The importance of conducting a comprehensive Customer Fact Find
   - Techniques to gather information about the client's financial situation, objectives, and risk tolerance.
   - Identify the client's insurance needs and financial goals.

   Step 2: Assess Client's Needs and Recommending Suitable Insurance Plans
   - Evaluate the client's insurance needs based on their financial goals and risk tolerance.
   - Familiarise with different insurance products and the features
   - Match insurance products with the client's needs and recommend suitable plans.
   - Explain the rationale for the recommendations

Step 3: Explaining Product Features, Benefits, and Exclusions

- Communicate clearly the product features, benefits payable, and exclusions to clients
- Address the client's questions and concerns about the recommended plan(s)
- Explain how premiums and charges are determined and its impact on the policy.

Step 4: Provide Product Disclosure Sheets (PDS) and Facilitate Informed Decisions

- Refer to the information in the PDS to assist the clients in making informed decisions.
- Provide a copy of PDS to clients.
- Encourage the clients to compare different insurance products using the PDS.
- Guide the clients through the decision-making process and ensure they understand the implications of their choices.

By completing these steps, insurance agents and sales intermediaries have demonstrated the necessary skills and knowledge to effectively help their clients to identify their insurance needs, recommend suitable plans, provide detailed information on the chosen plan, and ensure clients have the necessary information to make an informed choice. This will lead to higher client satisfaction and trust, ultimately resulting in long-lasting relationships and a successful career in the insurance industry.

2. Decide Buying

Here are the steps for Insurance Agents and sales intermediaries - Guide the Clients Through Policy Purchase and Application Process.

Objective

To equip insurance agents with the knowledge and skills to assist clients during the policy purchase and application process, ensuring they understand the policy terms and conditions.

Step 1: Assist Clients with Policy Applications

- Explain the importance of answering the questions in the proposal form fully and accurately
- Submit application for underwriting and understand the underwriting process
- Arrange medical examinations, when required, and coordinate with panel clinics.
- Provide information on making nominations to ensure policy monies are received by their desired beneficiaries.

Step 2: Explaining Policy Terms and Conditions

- Ensure timely delivery of policy documents to the clients
- Review policy terms and conditions with the clients to confirm they understand the coverage.
- Address client’s concerns and clarify policy details
- Confirm with the clients that they have purchased the right plan for their needs.

Conclusion

By completing these steps, insurance agents and sales intermediaries had performed their duties with the necessary knowledge and skills to effectively guide their clients through the policy purchase and application process. Agents and sales intermediaries will be able to assist their clients in understanding the importance of accurate proposal form answers, submitting applications for underwriting, arranging medical examinations when needed, and making nominations. Additionally, agents and sales intermediaries will learn how to explain policy terms and conditions clearly and confirm with their clients to have purchased the right plan for their needs, leading to increased client satisfaction and long-lasting relationships.

3. During the Policy Term
   Insurance Agents and sales intermediaries should follow these steps in Supporting their Clients During the Policy Term and Claims Process.

   Objective
   Prepare insurance agents and sales intermediaries to provide continuous policy servicing and assistance during the claims process, ensure a high level of client satisfaction and maintain long lasting relationships.

   Step 1: Continuous Policy Servicing During the Policy Term
   - Assist the clients in renewing their policies.
   - Provide continuous service, such as policy modifications, address changes, and premium payment frequency adjustments
   - Manage agent transitions and arrange to appoint new agents to service clients, if necessary

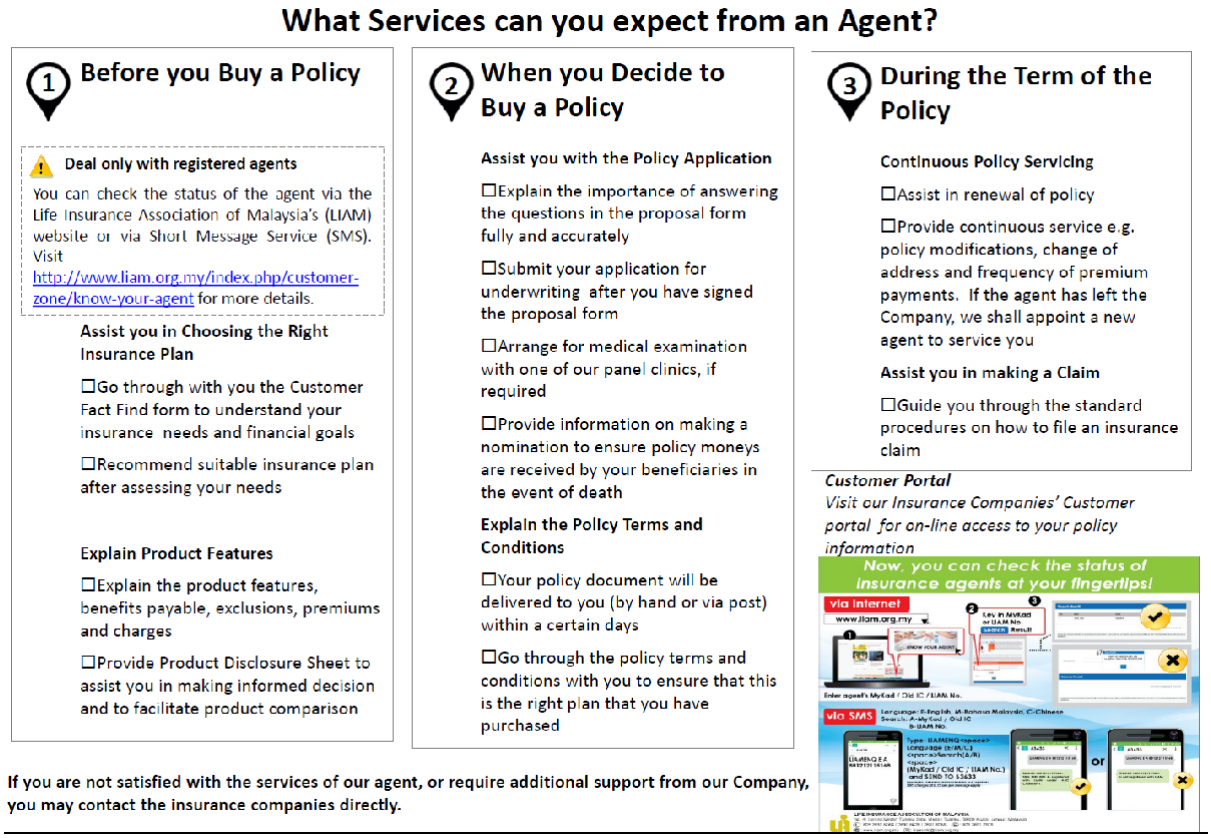
   Step 2: Assisting Clients in Making a Claim
   - Understand the standard procedures for filing insurance claims
   - Guide the clients through the claims process, including documentation and communication requirements
   - Help the clients to navigate any challenges or obstacles during the claims process.
   - Ensuring prompt resolution and fair settlements for clients' claims

Conclusion

These steps will prepare insurance agents and sales intermediaries to provide continuous policy servicing and assist their clients during the claims process. Agents and sales intermediaries will learn to support their clients with policy renewals, modifications, and agent transitions. Additionally, agents and sales intermediaries will be equipped with the knowledge and skills to guide their clients through the claims process, helping them navigate challenges and ensure fair settlements. This comprehensive support will lead to increased client satisfaction and long-lasting relationships.

Adhering to all the above proper sales standards will ultimately help to increase insurance premium persistency ratio specifically and insurance penetration rate in the industry in the long-term.

FIGURE 16-2 ***What Services can you expect from an Agent?***



16.3 MINIMUM TRAINING REQUIREMENTS AND CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

16.3.1 TRAINING UNDER THE MINIMUM QUALITATIVE CRITERIA (MQC) FOR LIFE AGENCY FORCE

The objective of Continuing Professional Development (CPD) is to raise the standard of competency and professionalism of life insurance intermediaries. The CPD Guidelines serves as a guide on the type of training programmes and criteria for accreditation of CPD hours that intermediaries should pursue to improve their skills and knowledge in providing good service and advice to their customers.

Compliance of CPD would be enforced by the respective insurance companies. The CPD requirement is part of the requirements for maintenance of contract under the Guidelines on Minimum Qualitative Criteria for Life Agency Force and should be met on a yearly basis. Every life insurance company is required to keep a proper record of the CPD hours and types of training courses attended by each of its intermediaries.

A Life Insurance Company shall ensure that its appointed agents attend courses or training to achieve the minimum required CPD hours in each calendar year. The minimum CPD hours required for each type of agent is as follows:

Table 16-1 *CPD Hours Required for Agents*

Category of Agents	Minimum CPD hours Requirement
Newly Appointed agents who are fresh entrants to the insurance industry are to complete	20 hours training within the first six (6) months of appointment
Existing agents with more than one (1) year of experience in the insurance industry (including agents who are reappointed by another ITO)	30 CPD hours, compromising i. Technical Training, and ii. Non-technical Training

16.3.2 RFP REQUIREMENT

In addition, a Life Insurance Company shall ensure that its appointed agents pass the relevant examinations for the modules specified in the table below if the appointed agents intend to be involved in the related activities, in particular, the distribution of life insurance or family takaful products, as the case may be:

Table 16-2 *RFP Requirement*

Qualifications	Mandatory Areas of Knowledge
a. (Module 2 of Registered Financial Planner (RFP) offered by the Malaysian Financial Planning Council (MFPC); or	for (a) & (b) 1. Risk management; and 2. Insurance planning.
b. (Module 2 of Certified Financial Planner (CFP) offered by the Financial Planning Association of Malaysia (FPAM); or	for (c) 1. Completion of all modules of FCLP
c. Fellow Certified Life Practitioner (FCLP) offered by the National Association of Malaysian Life Insurance and Family Takaful Advisors (NAMLIFA).	

Source: BNM Professionalism of Insurance and Takaful Agents, BNM/RH/PD 029-59, Issued on: 17 April 2023
Bancassurance distribution channel may have different requirements in the CPD guidelines.

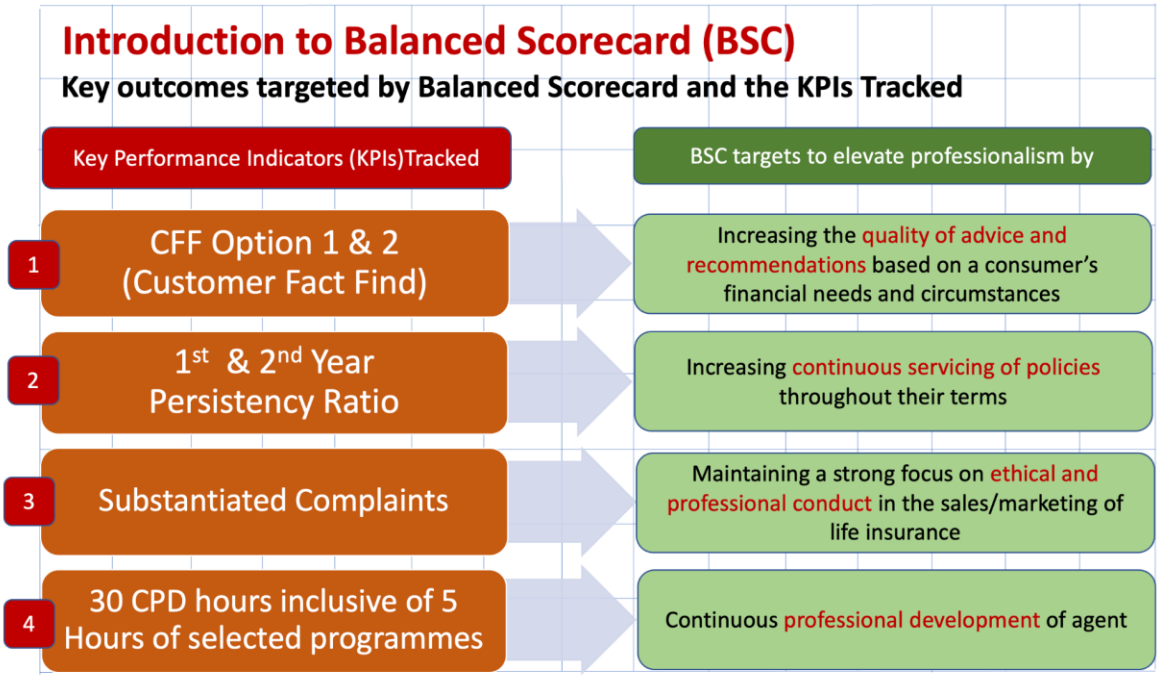
16.4 BALANCE SCORECARD (BSC) FRAMEWORK

The Life Insurance and Family Takaful Framework ("Life Framework") issued by Bank Negara Malaysia ("BNM") on 23 Nov 2015 requires Life Insurance Companies amongst other requirements, to implement a Balanced Scorecard ("BSC") effective from 1 Jan 2018.

The objective of the BSC is to elevate the level of professionalism in the life insurance industry.

The key outcomes targeted by BSC and Key Performance Indicators ("KPI") being tracked as follows:

FIGURE 16-3 *Balance Score Card*



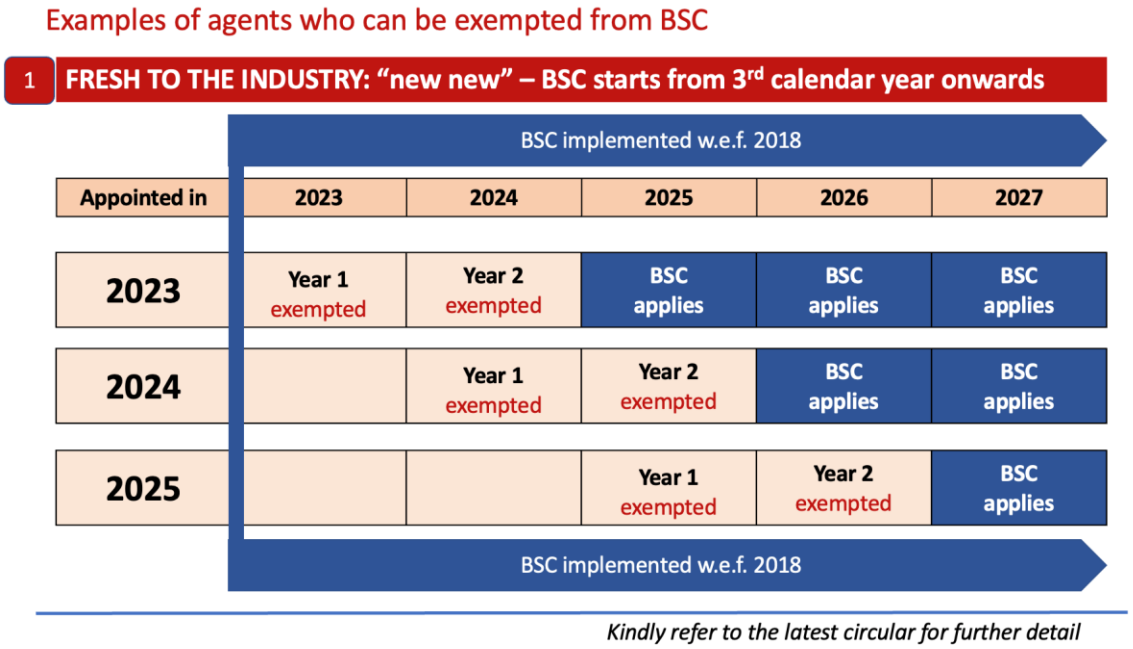
To achieve the targets above, BNM requires 25% of total commissions allowed under the Operations Cost Control ("OCC") and Investment-Linked guidelines to be paid upon meeting the minimum BSC scores for each KPI. The BSC commissions are spread in accordance to the weight allocated for each KPI.

Table 16-3 T*he current (as at date of writing) BSC KPIs, scores and weight*

KPI	2020 – June 2023					
BSC Score	Weightage %	Under Performer		Normal	Out-Performer	
		50%	75%	100%	125%	150%
1. Completion rate of CFF form (option 1 or 2)	20	50%	60%	70%	80%	90%
2a. 1st year persistency rate	25	-	85%	90%	92.5%	95%
2b. 2nd year persistency rate	30	-	75%	80%	85%	90%
3. Number of substantiated complaints	10	-	-	0	-	-
4. CPD hours	15	-	-	30	-	-

All enforced agents and agency leaders are subjected to the BSC requirements. Agents fresh to the industry (new agents) are exempted from BSC for the first 2 years and will only be subject to BSC from the third calendar onward.

FIGURE 16-4 *Examples of Agents who can be exempted from BSC*



In conclusion, while the life insurance industry is highly regulated, the parameters and guidelines set forth actually provide a blessing rather than a limitation for insurance agents. These regulations, including the LIAM Code of Ethics & Conduct, MFPC Financial Planning Process, Customer Service Guide, Minimum Training Requirements & CPD, and BSC Framework, establish a framework that ensures professionalism and ethical practices.

By adhering to these parameters, agents can build trust with their clients, provide exceptional service, and thrive in their careers. The regulations serve as a compass, spelling out the "do's" and "don'ts" that agents should follow. Within these boundaries, agents have the freedom to exercise their expertise, knowledge, and skills to meet the unique circumstances and needs of their clients.

This chapter has emphasized the importance of professionalism and the significance of aligning with ethical practices and regulatory guidelines. By embracing this approach, agents can establish themselves as highly effective and respected professionals in the industry. Let us embrace these necessary parameters as a foundation for success and continue our journey towards becoming exceptional insurance agents, serving our clients with integrity and dedication.

SELF-ASSESSMENT QUESTIONS

1	**Review Question**
Q	*Which of the following is not a part of the Code of Ethics and Conduct for the life insurance sector in Malaysia?*
A	a. Guidelines on the Code of Conduct b. Code of Ethics and Conduct for Life Insurance Selling c. Statement of Life Insurance Practice *d.* Guide to stock market investment

2	**Review Question**
Q	*What is one of the key responsibilities of companies under the Code of Ethics and Conduct for the life insurance sector in Malaysia?*
A	a. Submit a quarterly report to Bank Negara Malaysia on breaches observed. b. Donate a percentage of profits to charitable causes c. Ensure all employees hold a PhD degree. *d.* None of the above

3	**Review Question**
Q	*Which of the following steps is NOT part of the "Before Buying" stage in the sales and service process according to the Service Guide?*
A	a. Understanding client's insurance needs and financial goals b. Explaining product features, benefits, and exclusions. c. Assisting clients with policy applications. *d.* Providing Product Disclosure Sheets (PDS) and facilitating informed decisions.

4	**Review Question**
Q	*What is the primary objective of the "Decide Buying" stage in the sales and service process according to the Service Guide?*
A	a. To understand the client's insurance needs and financial goals. b. To assist clients during the policy purchase and application process, ensuring they understand the policy terms and conditions. c. To provide continuous policy servicing and assistance during the claims process. *d.* None of the above

5	**Review Question**
Q	*Which of the following is NOT a step an agent or sales intermediary should take during the policy term according to the Service Guide?*
A	a. Assist clients in renewing their policies. b. Guide clients through the claims process c. Conduct a new comprehensive Customer Fact Find *d.* Manage agent transitions and arrange to appoint new agents to service clients, if necessary

6	**Review Question**
Q	*What is one of the Key Performance Indicators (KPIs) that a licensed person should follow in the design of the Balanced Scorecard (BSC) Framework?*
A	a. The agent's age b. The number of friends the agent has c. The completion rate of Customer Fact Find (CFF) form. *d.* The number of insurance policies the agent owns.

7	**Review Question**
Q	*What is the primary objective of completing a Customer Fact Find (CFF) form as part of the professional practices in the life insurance industry?*
A	a. To assess the agent's selling skills. b. To understand the needs, priorities, and financial capability of the clients. c. To determine the number of policies an agent can sell. *d.* To calculate the commission rate for the agent.

8	**Review Question**
Q	*What is one of the techniques agents should use to understand a client's insurance needs and financial goals?*
A	a. Techniques to gather information about the client's financial situation, objectives, and risk tolerance. b. Evaluate the client's insurance needs based on their financial goals and risk tolerance. c. Address the client's questions and concerns about the recommended plan(s). *d.* Guide the clients through the decision-making process and ensure they understand the implications of their choices.

9	**Review Question**
Q	*In which step of the 'Before Buying' process do insurance agents assist clients in making informed decisions by providing and referring to certain essential documents?*
A	a. Step 1: Understand Client's Insurance Needs and Financial Goals. b. Step 2: Assess Client's Needs and Recommending Suitable Insurance Plans. c. Step 3: Explaining Product Features, Benefits, and Exclusions. *d.* Step 4: Provide Product Disclosure Sheets (PDS) and Facilitate Informed Decisions.

10	**Review Question**
Q	*What is the main objective of the 'Before Buying' stage in the insurance sales and service process according to the Customer Service Guide?*
A	a. To assess the client's risk tolerance. b. To explain the policy terms and conditions. c. To assist the client in filling in the policy application form. *d.* To utilize the Customer Fact-Find form effectively to understand the client's needs and financial capabilities.

YOU WILL FIND THE ANSWERS AT THE END OF THE BOOK.

LIST OF FIGURES

LIST OF TABLES

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CHAPTER 2
Answers: 1-a, 2-b, 3-c, 4-c, 5-a, 6-b, 7-b, 8-c, 9-d, 10-c

CHAPTER 3
Answers: 1-a, 2-b, 3-c, 4-a, 5-c, 6-b, 7-c, 8-d, 9-c, 10-b

CHAPTER 4
Answers: 1-d, 2-b, 3-d, 4-b, 5-b, 6-c, 7-d, 8-b, 9-b, 10-c

CHAPTER 5
Answers: 1-c, 2-d, 3-c, 4-a, 5-c, 6-d, 7-d, 8-c, 9-c, 10-b

CHAPTER 6
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CHAPTER 7
Answers: 1-b, 2-b, 3-b, 4-b, 5-d, 6-c, 7-b, 8-d, 9-a, 10-c

CHAPTER 8
Answers: 1-c, 2-d, 3-b, 4-b, 5-c, 6-a, 7-c, 8-b, 9-b, 10-c

CHAPTER 9
Answers: 1-b, 2-b, 3-b, 4-d, 5-c, 6-c, 7-a, 8-b, 9-b, 10-d

CHAPTER 10
Answers: 1-c, 2-b, 3-c, 4-b, 5-d, 6-b, 7-a, 8-b, 9-a, 10-d

CHAPTER 11
Answers: 1-b, 2-a, 3-d, 4-b, 5-b, 6-b, 7-d, 8-d, 9-b, 10-d

CHAPTER 12
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PRE-CONTRACT EXAMINATION FOR INSURANCE AGENTS

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